

Trends in the Social Security and Supplemental Security Income Disability Programs

Social Security Administration

Office of Policy

Office of Research, Evaluation, and Statistics

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Preface

The Social Security Disability Insurance program celebrates its 50th anniversary in 2006. As part of the Social Security Administration's recognition of this milestone, the agency's Office of Policy compiled these *Trends in the Social Security and Supplemental Security Income Disability Programs*. This volume combines much of the information on SSA's disability programs that is available in other publications. However, information from across decades of program data appears in a user-friendly format that is accessible to both the disability policy researcher and the interested private citizen. The topics covered are:

- program cost and size;
- entry into and exit from the disability programs;
- population factors influencing program size;
- changes in program policy influencing program size;
- changes in incentives influencing program size; and
- projected future course for SSA programs.

This publication was conceptualized and written by L. Scott Muller, Brett O'Hara, and John R. Kearney, all researchers in the Office of Policy's Office of Research, Evaluation, and Statistics. Staff of the Office's Division of Information Resources edited the report and prepared the print and electronic versions for publication. This and other Office of Policy reports on the Social Security and SSI disability programs are available on the Web at <http://www.socialsecurity.gov/policy>.

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Notes

The Old-Age and Survivors Insurance (OASI) program provides benefits to retired workers and their dependent family members and to survivors of deceased workers. The Disability Insurance (DI) program provides benefits to disabled workers, their spouses, and children (whether or not disabled).

Benefits are paid from the OASI and DI trust funds. However, not all disabled beneficiaries are paid from the DI trust fund. All disabled widow(er)s' and most disabled adult children's benefits are paid from the OASI trust fund. Disabled persons receiving disability benefits from either trust fund are referred to in this report as disabled Social Security beneficiaries.

The Supplemental Security Income program provides monthly cash benefits to aged, disabled, and blind individuals who meet income and resource limits as well as the medical eligibility requirements. Benefits are paid to blind and disabled children under the age of 18 and adults aged 18 or older.

With respect to the SSI blind and disabled, unless otherwise specified—

- recipients are persons receiving federally administered payments
- all payments are federal payments only, and
- SSI blind and disabled adults include only persons aged 18-64.

With respect to the data contained herein, unless otherwise specified—

- all cost, award, and termination data are for calendar years, and
- all counts of Social Security beneficiaries, SSI recipients, and the insured population are as of December of the given year.

With respect to projections of the future of the programs, unless otherwise specified—

- all estimates were made by SSA's Office of the Chief Actuary (OCACT),
- all estimates for the trust funds come from the 2005 Trustees Report,
- all estimates for the SSI program come from OCACT's 2005 annual report on the SSI program, and
- all estimates are based on the Trustees' intermediate assumptions.

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Introduction

The Social Security Administration administers two of the largest disability programs in the United States, and perhaps the world: the Social Security Disability Insurance (DI) program and the Supplemental Security Income (SSI) disability program. In 2003, these programs combined paid more than \$90 billion in cash benefits to nearly 11.2 million disabled persons (more than 12.8 million persons including dependents of DI beneficiaries).¹ Both programs have grown substantially in cost and number of participants, although the level of growth has varied from time to time and both programs have had periods of contraction, mainly in the early 1980s.

The programs share a common definition of disability for adults: the inability to engage in substantial gainful activity based on a medically determinable impairment that is expected to last at least 12 months or result in death.² Both programs also consider blindness when defining disability. The SSI children's benefit category has a different definition of disability.³

Other than the common definition, the programs differ in many respects. Social Security disability benefits are an earned right. Individuals must have worked in employment covered by Social Security for a specified time to be insured for benefits. However, disabled adult children and disabled widow(er)s may qualify on the record of a parent or spouse. There is no means- or resource-testing of Social Security benefits, although there are limitations on earned income in some situations. Social Security benefits are funded by a dedicated payroll tax paid by the worker and the worker's employer and by taxes paid by a self-employed person. SSI benefits are intended to alleviate poverty and are means-tested. There is no insured status or prior-work requirement for SSI, and the program is funded from general revenues rather than from a dedicated tax.

The following sections briefly describe the features of SSA's disability programs and two other federal programs—Medicare and Medicaid—that provide health benefits to, among others, the disabled beneficiaries of the Social Security and SSI programs.

Social Security Disability

The Social Security Disability Insurance program was enacted in 1956, more than two decades after the original Social Security Act. Before the cash benefit program was instituted in 1956, a disability freeze provision had been in place for 1 year that protected only the disabled worker's retirement benefit. At inception, the DI program covered only workers aged 50 or older and disabled adult children whose disability began before the age of 18. Dependents' benefits were added in 1958, and the age 50 requirement was eliminated in 1960. In 1967, disability benefits were added for disabled widow(er)s. In 1972, disabled adult children who were disabled after the age of 18, but before the age of 22, became eligible.

The program is funded by a payroll tax of 7.65 percent of earnings (subject to a maximum) that applies to both the worker and the employer (15.3 percent total) and funds all Social Security programs and most of Medicare.⁴ Self-employed individuals pay both portions, or 15.3 percent. The tax is allocated to separate trust funds: the employee and employer each contribute 0.9 percent to the Disability Insurance Trust Fund, 5.3 percent to the Old-Age and Survivors Insurance (OASI) Trust Fund, and 1.45 percent to the Hospital Insurance (HI) Trust Fund. The tax rate and the allocation of taxes to the trust funds have varied over time.

The benefits payable are calculated on the basis of the worker's earnings from Social Security-covered employment, and there are requirements to establish insured status. The worker's benefit is based on a measure of lifetime predisability earnings: average indexed monthly earnings (AIME). There is a 5-month waiting period before benefits can start, and Medicare coverage is available after the worker has been entitled to disability benefits for 24 months. Benefits cease if the individual demonstrates the ability to engage in substantial gainful activity (SGA), medically improves, or dies.⁵ At full retirement age (65 and

1. Beneficiary counts are as of December 2003 and include disabled widow(er)s and disabled adult children who are paid from the Old-Age and Survivors Insurance Trust Fund.

2. The SSI program for adults has a provision (1619a) that permits recipients whose earnings exceed the substantial gainful activity (SGA) level to remain in the program.

3. Disabled children, for SSI purposes, are children who are not engaging in substantial gainful activity and whose impairment, or combination of impairments, results in marked and severe functional limitations and is expected to last at least 12 months or result in death (42 U.S.C. 1382c(a)(3)(C)(i)).

4. Medicare is also funded, in part, from general revenue and other sources.

5. To be eligible for disability benefits, a person must be unable to engage in substantial gainful activity. A person who is earning

8 months in 2006), disability benefits are converted automatically to retirement benefits. There are work incentive provisions and access to vocational rehabilitation services to promote return to work, though few beneficiaries leave the program by returning to work. In December 2004, the average monthly benefit paid to a disabled worker was \$880. Workers with a dependent spouse, children, or both had an average monthly benefit of about \$1,390.

Benefits may be paid to the disabled worker, to qualified dependents of the worker, or to both on the basis of dependency or the disability of a dependent. Dependents' benefits are generally equivalent to one-half of the worker's benefit; benefits for disabled widow(er)s and surviving disabled adult children are equivalent to 71.5 percent and 75 percent, respectively, of the worker's benefit. The combined benefit for the disabled worker and all dependents is subject to a maximum family benefit amount, which ranges from 100 percent to 150 percent of the worker's benefit. The following disability benefits are paid from the Social Security (OASI and DI) trust funds:

- From the DI trust fund
 - Worker's benefit (paid to the holder of the Social Security number on the basis of his or her disability)
 - Spouse's benefit (paid to a spouse aged 62 or older or who has an entitled child in his or her care who is under age 16 or disabled)
 - Child's benefit (paid to a child under age 18 (under 19 if a full-time student) who is a dependent of a disabled worker)
 - Disabled adult child's benefit (paid to the child of a disabled worker)
- From the OASI trust fund
 - Disabled widow(er)'s benefit (paid to a disabled widow(er) who is over age 50 and whose deceased spouse was an insured worker)
 - Disabled adult child's benefit (paid to the child of a retired or deceased worker)

Low-income Social Security disability beneficiaries may concurrently collect Supplemental Security

more than a certain monthly amount (net of impairment-related work expenses) is ordinarily considered to be engaging in SGA. The monthly SGA amount for 2006 is \$1,450 for statutorily blind individuals and \$860 for nonblind individuals. Both SGA amounts rise with increases in the national average wage index.

Income benefits if they meet certain income and resource requirements.

Medicare

Social Security beneficiaries receiving benefits that are based on their own disability are eligible for Medicare benefits beginning in the 25th month of entitlement. Medicare was established in the 1965 Amendments to the Social Security Act, providing medical benefits to complement Social Security benefits. When the amendments were implemented in 1966, most persons aged 65 or older were covered by Medicare. In 1972, legislation was passed extending Medicare benefits to disabled workers, beginning in 1973, after a 24-month waiting period. Medicare is funded mainly through the HI portion of the Social Security tax (1.45 percent of payroll from the worker and the same from the employer); additional sources of funding include general revenues, premiums, and a portion of the taxes collected on Social Security benefits.

Until recently, Medicare had two parts: Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance, or SMI). In 1997, a third part was added to Medicare, known as Medicare Advantage, or Part C, which offers beneficiaries options for participating in private-sector health plans. In 2003, a fourth part, Part D, offering prescription drug coverage was added and was implemented in 2006. Hospital Insurance, which covers the cost of inpatient hospital care and is generally provided free to persons who are eligible for Medicare, is paid out of the HI trust fund. There are deductibles and copayments under HI. Supplementary Medical Insurance covers doctors and other services and requires a premium equivalent to 25 percent of the average expenditure for the aged for this coverage (\$88.50 per month in 2006) to be paid by the beneficiary or on the beneficiary's behalf. Most of the balance comes from the Treasury Department in the form of general revenue contributions. The coverage and cost of Medicare Advantage varies by plan and receives funding from the HI and SMI trust funds and beneficiary premiums. During 2005, temporary, or "transitional," prescription coverage was offered through prescription discount cards. Part D prescription coverage with deductibles and copayments became effective on January 1, 2006. Beneficiaries pay a premium that varies by income level. A subsidy benefit for Part D is available to assist low-income beneficiaries who meet certain income and resource requirements.

Supplemental Security Income for the Blind and Disabled

The Supplemental Security Income program is a means-tested, federally administered income assistance program that was enacted in 1972 (Public Law [P.L.] 96-603) and began in 1974. The program provides monthly cash benefits to aged, blind, and disabled individuals who meet income and resources limits as well as the medical eligibility requirements. The SSI program replaced the state-administered Old-Age Assistance means-tested programs for individuals aged 65 or older. For the blind and disabled, it replaced the federally mandated programs of Aid to the Blind, which was established in the original 1935 Social Security Act, and Aid to the Permanently and Totally Disabled, which was established in the 1950 Amendments to the Social Security Act.

Under the earlier programs, federal matching funds were provided to the states to administer programs. The SSI program federalized the earlier state programs, although states can supplement benefits, and some states have been required to maintain state expenditures at levels in place before SSI. SSI was intended to provide a basic national income program for the elderly, blind, and disabled, with a uniform minimum benefit level. By having the program operate under the auspices of the Social Security Administration, it was intended that the program be uniformly and fairly administered with the same approaches that are used in the Social Security Disability Insurance program. Unlike Social Security, the SSI program is funded by general revenues.

Benefits are payable only to blind or disabled individuals, not to their dependents. There are two types of SSI disability benefits:

- Disabled child's benefit—paid to disabled children under the age of 18; and
- Disabled adult's benefit—paid to disabled persons aged 18 or older.

There is no waiting period required to qualify for SSI cash benefits, and, in most states, Medicaid benefits are available to most SSI recipients, also without a waiting period. Benefits cease if the individual medically improves or dies. With a few exceptions, SSI payments are suspended if income or resources exceed levels established for eligibility. Since 1980, SSI recipients can work above the SGA level and remain eligible for reduced cash benefits and continuing Medicaid benefits. There

is no conversion to old-age benefits at the age of 65, and persons receiving disability benefits remain as disability recipients. Unless otherwise noted, the charts for SSI adults in this book include only persons aged 18–64. The SSI program provides work incentives and access to vocational rehabilitation services to promote return to work, although few SSI recipients leave the program through work.

In 2006, the SSI benefit paid to disabled persons (known as the federal benefit rate) is \$603 (\$904 for an eligible couple). The benefit is reduced for earned and unearned income and may be supplemented by the state. Disabled Social Security beneficiaries who receive a low benefit and have limited resources may also be eligible to receive a reduced SSI disability benefit.

Medicaid

As mentioned above, most SSI disability recipients receive Medicaid coverage for their health expenses. Medicaid was established in 1965 as a joint federal/state program to provide medical coverage to the needy. States administer the program and, within federal guidelines, establish their own eligibility standards, types and levels of services, and rates of payment. Since the establishment of the SSI program in 1974, most SSI recipients have been eligible for Medicaid benefits, although in some states SSI is not a specific eligibility category. However, most SSI recipients in those states qualify for Medicaid under another eligibility category. In some states, a Medicaid “buy-in” is available for certain categories of disabled individuals that allows them to enroll in Medicaid even though they would not otherwise qualify because their income and resources exceed established limits. States may require the individual to share the cost of Medicaid through the payment of a premium or other cost-sharing arrangements, although these cost-sharing arrangements are generally assessed on a sliding scale based on income. In addition, under section 1619b provisions, Medicaid coverage may continue indefinitely for SSI recipients who work above the SGA level and no longer receive cash benefits.

The federal government pays a percentage of total state Medicaid expenses. The federal percentage is determined by a formula that is based on state per capita income, with higher-income states receiving a smaller federal contribution rate. The federal contribution cannot be less than 50 percent or more than 83 percent. States may impose deductibles, copayments, or both for some

services. And, as mentioned above, some categories of persons are eligible for a Medicaid buy-in and pay part or all of the cost of the coverage. For persons eligible for both Medicare and Medicaid, Medicare is the primary payer, and Medicaid supplements the payments.

Definition of Disability and the Determination Process

Section 223(d)(1) of the Social Security Act defines “disability” in an adult as

1. Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months;⁶ or
2. In the case of an individual who has attained age 55 and is blind (within the meaning of “blindness” as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

The Social Security Administration (SSA) makes a decision on whether an individual is disabled using a five-step sequential evaluation process. An outline of the process follows.

1. Is the individual engaging in substantial gainful activity? If yes, deny. If no, proceed to step 2.
2. Is the impairment severe and does it meet the duration requirement? If no, deny. If yes, proceed to step 3.
3. Does the impairment meet, or equal in severity, one of the medical listings? If yes, allow. If no, proceed to step 4.
4. Can the individual perform his or her past work? If yes, deny. If no, proceed to step 5.
5. Can the individual (considering his or her age, education, and prior work) perform any other work? If yes, deny. If no, allow.

6. A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities that can be shown by medically accepted clinical and laboratory diagnostic techniques. An impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings.

This five-step framework is followed by all SSA adjudicators in making disability decisions for adults at all levels of the administrative process.

The definition of disability and the sequential evaluation process for SSI children (under the age of 18) is similar to that for adults, but the severity requirement is more strict. For children, the impairment(s) must cause “marked and severe functional limitations,” which means that the child’s impairment must meet, medically equal, or be functionally equal to the listings.

Program Administration

The Social Security and Supplemental Security Income disability programs are administered jointly by the federal and state governments. Applications for disability benefits are taken by SSA field staff by phone, in one of the 1,300 local field offices, or, increasingly, on the Web. Decisions on technical eligibility (insured status, resources, and so on) are handled by field office staff. The claim is forwarded to the state Disability Determination Services (DDS) for a medical determination. The state disability examiner generally collects medical evidence, orders consultative examinations (when required), and makes a medical determination using the five-step disability decision process. If the claim is allowed, the case is returned to the SSA field office to be paid. If the claim is denied, the claimant is notified of the denial and has 60 days to file an appeal at the SSA field office.

The first level of appeal is called reconsideration, and the case is returned to the DDS for reconsideration by a different disability examiner.⁷ If the denial of the claimant’s application is affirmed at reconsideration, the next level of appeal is a hearing before an SSA administrative law judge (ALJ). The hearing occurs in one of about 140 hearings offices located across the country (or through videoconferencing), and the claimant has the first opportunity to appear in person before the decisionmaker, who is a federal, rather than a state, employee. Further appeals can be made to the Appeals Council and the federal courts.

In addition to the initial claims process, there are postadjudicative processes for Social Security and SSI disability beneficiaries. Such processes include redeterminations and benefit adjustments

7. Since 1999, 10 states have been operating under an alternative process that does not include a reconsideration step. Appeals of the initial decision at the DDS go directly to the hearings level.

for SSI recipients, continuing disability reviews, and the monitoring of work activity. Processes dealing with work and earnings verification are handled by SSA field staff; field offices and program service centers handle benefit computations. SSA initiates continuing disability reviews to ensure that persons who are no longer disabled are removed from the program. The state DDS reviews the medical evidence and decides whether the individual has medically improved and is no longer disabled. The beneficiary may appeal a decision that he or she is no longer disabled. The first level of appeal is the disability hearings unit in the DDS, where a state employee reviews the cessation of disability. In this level, the claimant is permitted a face-to-face meeting with a state disability hearings officer. The payment of benefits is permitted during the appeals process. A second level of appeal of a cessation is to a federal administrative law judge at the hearings office.

History of Major Program Changes

This book shows trends in the size and cost of the disability programs from 1970 to 2003 and links these trends to major changes in the disability programs during the same period. Below is a brief history of major program changes and other events discussed in this book.

January 1970 Congress authorizes ad hoc 15 percent increase in benefits (P.L. 91-172).

January 1971 Congress authorizes ad hoc 10 percent increase in benefits (P.L. 92-5).

July 1972 Congress authorizes ad hoc 20 percent increase in benefits and provides for automatic indexing of benefits to the consumer price index, with the first automatic increase effective in June 1975 (P.L. 92-336).

October 1972 Congress passes legislation (P.L. 92-603)

- providing Medicare coverage for disabled Social Security beneficiaries after 24 months of entitlement (effective 1973),
- reducing the waiting period for disability benefits from 6 months to 5 months,
- establishing the SSI program (first SSI payments made January 1974) and permitting states to provide Medicaid to SSI recipients, and

- extending benefits to disabled adult children disabled after the age of 18 but before the age of 22.

1974 Congress authorizes ad hoc two-step 11 percent increase in benefits effective March 1974 (7 percent) and June 1974 (4 percent) (P.L. 93-233).

1977 Amendments to the Social Security Act (P.L. 95-216) include new formula for benefit calculations to decouple the cost-of-living adjustment from wage increases; freeze minimum benefit.

1980 Amendments to the Social Security Act (P.L. 96-265)

- place cap on family benefits for disabled workers,
- reduce the number of dropout years in calculating average indexed monthly earnings (AIME) for younger disabled workers, reducing the primary insurance amount (PIA) for young workers,
- require periodic continuing disability reviews for nonpermanent disabilities,
- establish preeffectuation reviews of favorable initial decisions, and
- establish new work incentives (an extended period of eligibility and continuation of Medicare for DI beneficiaries; sections 1619a and 1619b, which continue reduced cash benefits and Medicaid for SSI recipients working above SGA).

1981 Omnibus Budget Reconciliation Act (P.L. 97-35) eliminates the minimum benefit for Social Security beneficiaries and establishes the “mega-cap” offset of public disability benefits for disabled workers.

1982–1983 Continuing disability reviews are accelerated, with special attention to certain impairment categories.

1983 P.L. 97-455 provides temporary continuation of benefits (through June 1984) for persons appealing the decision from a continuing disability review and establishes a hearing (personal appearance) in the DDS at reconsideration as part of the appellate process.

June 1983 Secretary of the Department of Health and Human Services (DHHS) announces (1) a moratorium on denial or termination of disability claims for most mental impairments pending review and (2) revisions of the disability standards for mental impairments.

April 1984 Secretary of DHHS announces a moratorium on continuing disability reviews following state-level moratoriums declared earlier by governors of several states.

1984 Amendments to the Social Security Act (P.L. 98-460) require SSA to

- temporarily codify SSA policy on evaluating pain,
- consider the combined effect of multiple nonsevere impairments,
- place emphasis on evidence from treating physicians,
- develop new criteria for adjudicating mental impairments (in place in 1986),
- establish a “medical improvement standard” for continuing disability reviews,
- emphasize review by a psychiatrist or psychologist of a denial involving mental impairments, and
- make permanent the continuation of benefits during the appeal of a cessation resulting from a continuing disability review.

1986 Omnibus Budget Reconciliation Act (P.L. 99-509) gives states the option to provide full Medicaid coverage to Medicare beneficiaries whose income is below 100 percent of the poverty threshold and whose resources do not exceed the SSI resource limits.

1988 Medicare Catastrophic Coverage Act (P.L. 100-360) mandates that states provide coverage of Medicare Part B premiums, deductibles, and coinsurance through Medicaid for Medicare beneficiaries whose income is below 100 percent of the poverty threshold and whose resources do not exceed twice the SSI resource limits (Qualified Medicare Beneficiaries).

1990 *Zebley* court decision—the Supreme Court rules that SSA must establish new criteria for the SSI children’s disability program. The ruling states that applying the SSI adult listings to

children without applying the vocational rules does not result in “comparable severity” as required in the Social Security Act.

1990 The definition of “disability” for disabled widow(er)s is changed so that it is the same as that for disabled workers.

1990 SSA initiates a series of outreach activities designed to identify persons who are potentially eligible for SSI.

1990 States are mandated to cover Part B Medicare premiums through Medicaid for Medicare beneficiaries whose income is less than 120 percent of the poverty threshold and whose resources are less than twice the SSI resource level (Specified Low-income Medicare Beneficiaries).

1991 New childhood rules, based on the *Zebley* decision, are implemented. The rules include “functional equivalence” to find listings-level severity and an individualized functional assessment for evaluating children whose impairments are not listings-level severity.

1994 Requirements that were already in place for SSI recipients who were disabled on the basis of drug addiction and alcoholism (DA&A) are extended to Social Security disabled beneficiaries (P.L. 103-296).

1996–1998 Welfare reform era, which includes the Contract with America Advancement Act of 1996 (P.L. 104-121); Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193); and Balanced Budget Act of 1997 (P.L. 105-33). These pieces of legislation and subsequent revisions

- change the policy for drug addiction and alcoholism to exclude from eligibility individuals for whom DA&A is a materially contributing factor in disability; requires representative payees for SSI recipients who had a DA&A condition (1996, P.L. 104-121).
- tighten disability standards for SSI children, changing the statutory standard from “comparable severity” to “marked and severe functional limitations,” eliminating “maladaptive behaviors” in the childhood mental listings, and eliminating the “individualized functional assessment” (1996, P.L. 104-193).

- require SSA to review all SSI childhood cases based on individual functional assessment or maladaptive behavior within 1 year (1996, P.L. 104-193). The requirement was later modified to extend the period for review to 18 months (1997, P.L. 105-33).
- require SSA to review children awarded SSI benefits on the basis of low birth weight before the first birthday (1996, P.L. 104-193). The requirement was later modified to permit SSA to schedule the review after the first birthday if medical improvement is unlikely within the 12 months (1997, P.L. 105-33).
- provide dedicated funding to conduct continuing disability reviews for Social Security and SSI disability beneficiaries from 1996 to 2002 (1996, P.L. 104-121).
- require SSA to conduct SSI redeterminations at age 18 using adult standards within 1 year of the 18th birthday (1996, P.L. 104-193). The requirement was later modified to give SSA more discretion in scheduling this redetermination (1997, P.L. 105-33).
- limit immigrants' eligibility for SSI (1996, P.L. 104-193). Several changes to this limitation were made in 1997, 1998, and thereafter.
- permit states to provide Medicaid coverage to the disabled on the basis of less stringent income and resource tests or to permit a buy-in to Medicaid based on a sliding scale related to income (1997, P.L. 105-33).
- prohibits SSA from conducting a continuing disability review while a person is using the Ticket and prohibits using work to demonstrate medical improvement.
- permits states to offer a buy-in for Medicaid coverage for working-age persons with disabilities.

1999 Ticket to Work program (P.L. 106-170) passes and

- establishes Ticket to Work with provisions for services from private providers as well as from state vocational rehabilitation. Payment for services under Ticket to Work are based on milestone and outcome or pure outcome payments for a successful return to work (traditional cost-reimbursement payment method remains an option for state vocational rehabilitation).
- establishes “easy-back-on” provisions for persons terminated for return to work.
- increases the period of extended Medicare coverage.

1999 SSA increases the substantial gainful activity level by regulation from \$500 per month to \$700 per month in July and, in 2000, establishes automatic annual indexing of the SGA level to growth in average wages. (The history of increases in the SGA level appears in Chart 57.)

Sources of Data

The data in this book are, to the extent possible, the most recent data available at the time the analysis was done. In some cases, data from 2003 or 2004 are available, while in other cases older data have been used. The most recent data on Medicare and Medicaid expenditures for the disabled, for example, are from 2001.

The data come from a number of sources. The reader can find much of the data used in the Social Security and Supplemental Security Income charts in publications from the Social Security Administration, such as

- *Annual Statistical Supplement to the Social Security Bulletin*
- *Annual Statistical Report on the Social Security Disability Insurance Program*
- *SSI Annual Statistical Report*.

These publications are available from the Office of Policy on the Social Security Administration's Web site at <http://www.socialsecurity.gov/policy>.

The estimates of when the trust fund will be exhausted and the future size and cost of the Social Security Disability Insurance program come from the annual report of the Social Security Board of Trustees, which is available online at <http://www.socialsecurity.gov/OACT/TR>. Other beneficiary and cost data come from the Office of the Chief Actuary, much of which can be located at <http://www.socialsecurity.gov/OACT>. That office also issues the *Annual Report of the Supplemental Security Income Program*.

The data used for international comparisons were obtained from the Organisation for Economic Co-operation and Development. Specifically, much of the data come from *Facts and Figures on Disability Welfare: A Pictographic Portrait of an OECD Report* by Bernd Marin and Christopher Prinz (Vienna: European Centre for Social Welfare Policy and Research, 2003), available at http://www.euro.centre.org/detail.php?xml_id=469.

These and other sources of data are listed in the bibliography at the end of this report.

To facilitate access to data contained in the charts in this book, tabular data for all charts are available at <http://www.socialsecurity.gov/policy>.

PROGRAM COST AND SIZE

Introduction

Social Security Disability

Medicare for the Disabled

SSI for the Blind and Disabled

Medicaid for the Disabled

Benefit Costs as a Percentage of GDP

International Expenditures on Disability Programs

Disability Programs and Self-Reported Disability

International Prevalence of Disability

INTRODUCTION

This section describes the overall size and cost of the Social Security disability program and the Supplemental Security Income (SSI) program for the disabled. The costs considered include only the costs of the programs' cash benefits; they do not include the administrative costs associated with managing the programs. Except for Chart 10, all data on SSI costs are federal payments only.

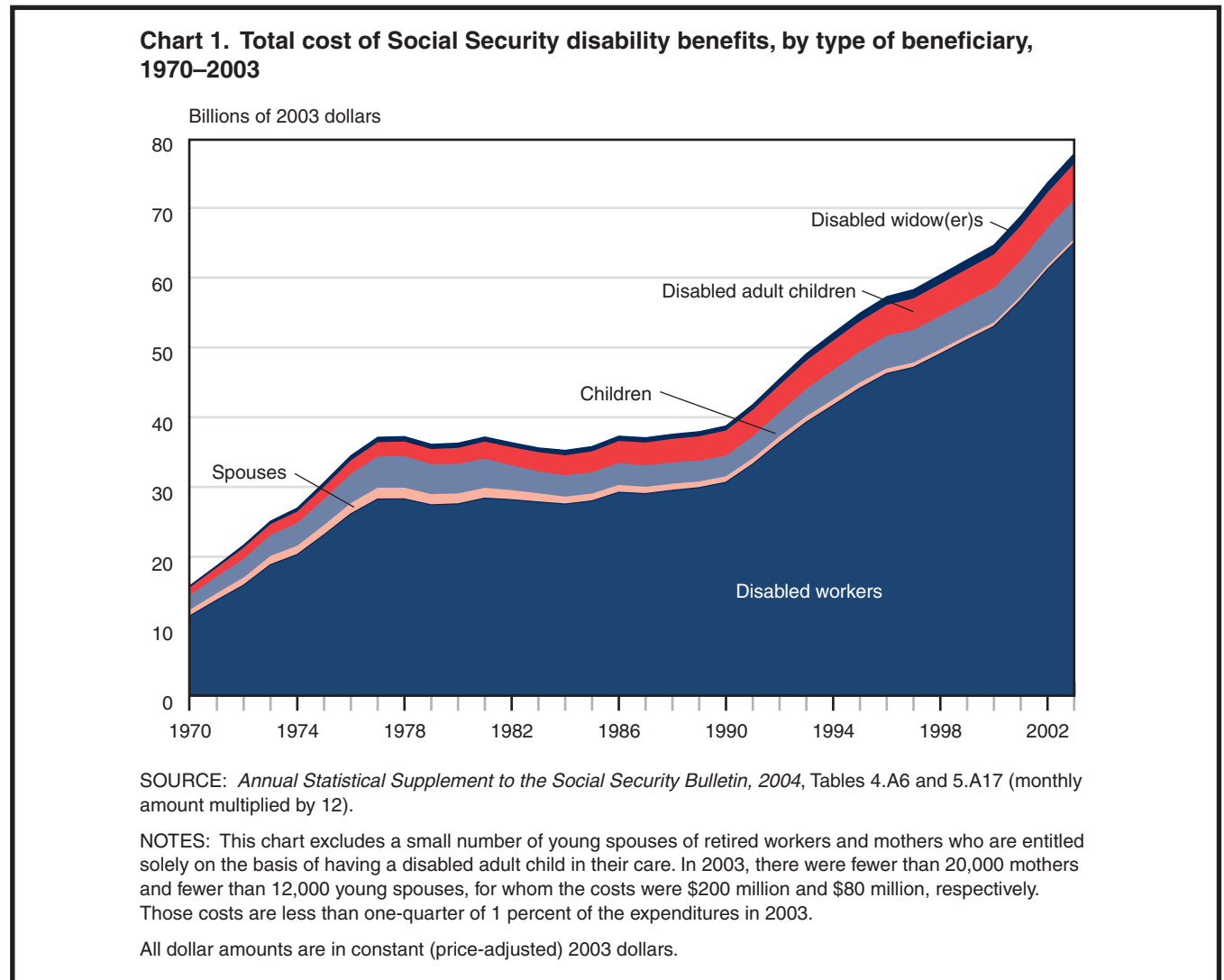
The section first examines trends in the cost of these programs and then seeks to determine how these trends are generated, looking initially at trends in the number of disabled beneficiaries (and dependents) and SSI recipients and then at the trends in average cost per individual over time. It also looks at the cost and size of the Medicare and Medicaid programs.

Costs for each of the programs have risen dramatically over time: in nominal dollars, in real (inflation-adjusted) dollars, and as a percentage of gross domestic product. The programs have grown in terms of numbers of beneficiaries and recipients; relative to the eligible population, however, the programs have tended to go through periods of contraction and expansion. Perhaps the most significant finding is that the costs of health coverage for the disabled under Medicare and, even more dramatically, Medicaid are rising faster than the cost of the disability programs' cash benefits.

Social Security Disability

TOTAL COST OF BENEFITS

The total cost of cash benefits for the Social Security disability program has increased dramatically since its inception. Since 1990 the total cost of disability has risen 93 percent in real terms (160 percent in nominal terms).



The cost of Social Security disability benefits in constant dollars has increased over time, though not consistently.¹ Benefit costs grew rapidly during the 1970s and peaked in 1978. A decline in those costs occurred in the early 1980s as the result of changes in program administration that reduced the number

of applications and awards as well as the number of disabled-worker beneficiaries. By the late 1980s, benefit costs had begun to increase again, and they continue to rise. The largest increase in cost is among disabled-worker beneficiaries, who accounted for nearly \$65 billion of the total \$77 billion in 2003.

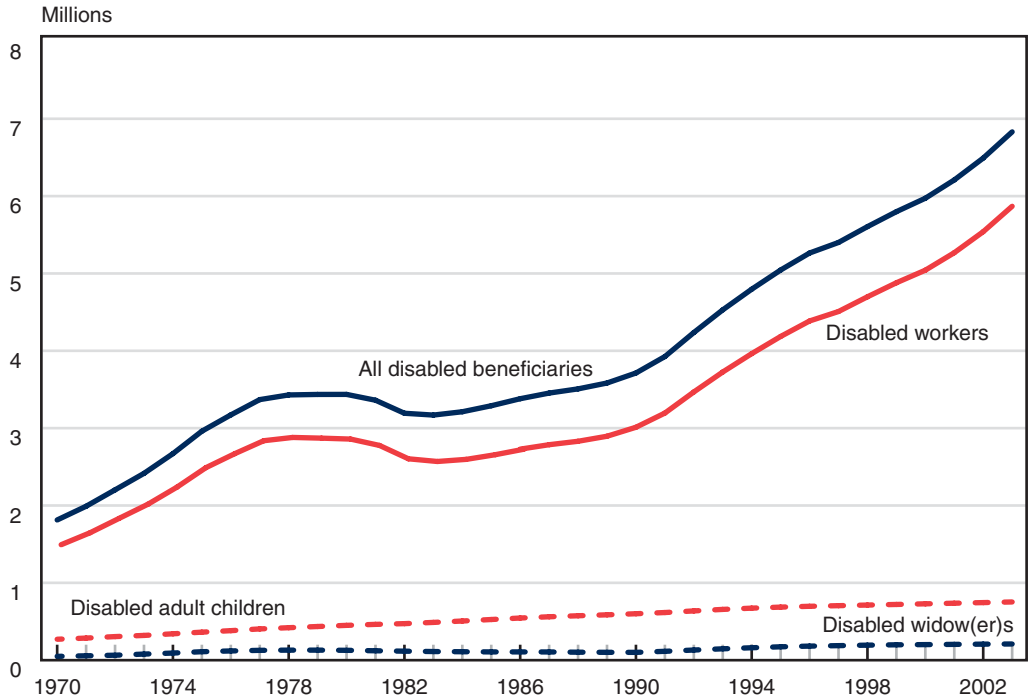
1. Social Security disability includes benefits paid from the DI trust fund to disabled workers and their dependents, as well as benefits paid from the OASI trust fund to disabled widow(er)s and some disabled adult children.

Social Security Disability

NUMBER OF BENEFICIARIES

Much of the increase in costs for Social Security disability benefits is due to increases in the number of beneficiaries. Since 1990, the number of disabled-worker beneficiaries has increased 84 percent; disabled widow(er)s, 105 percent; and disabled adult children, 24 percent.

Chart 2. Number of disabled Social Security beneficiaries, by type of beneficiary, December 1970–2003



SOURCES: *Annual Statistical Report on the Social Security Disability Insurance Program, 2004*, Table 1; *Annual Statistical Supplement to the Social Security Bulletin* (authors' compilation of missing years).

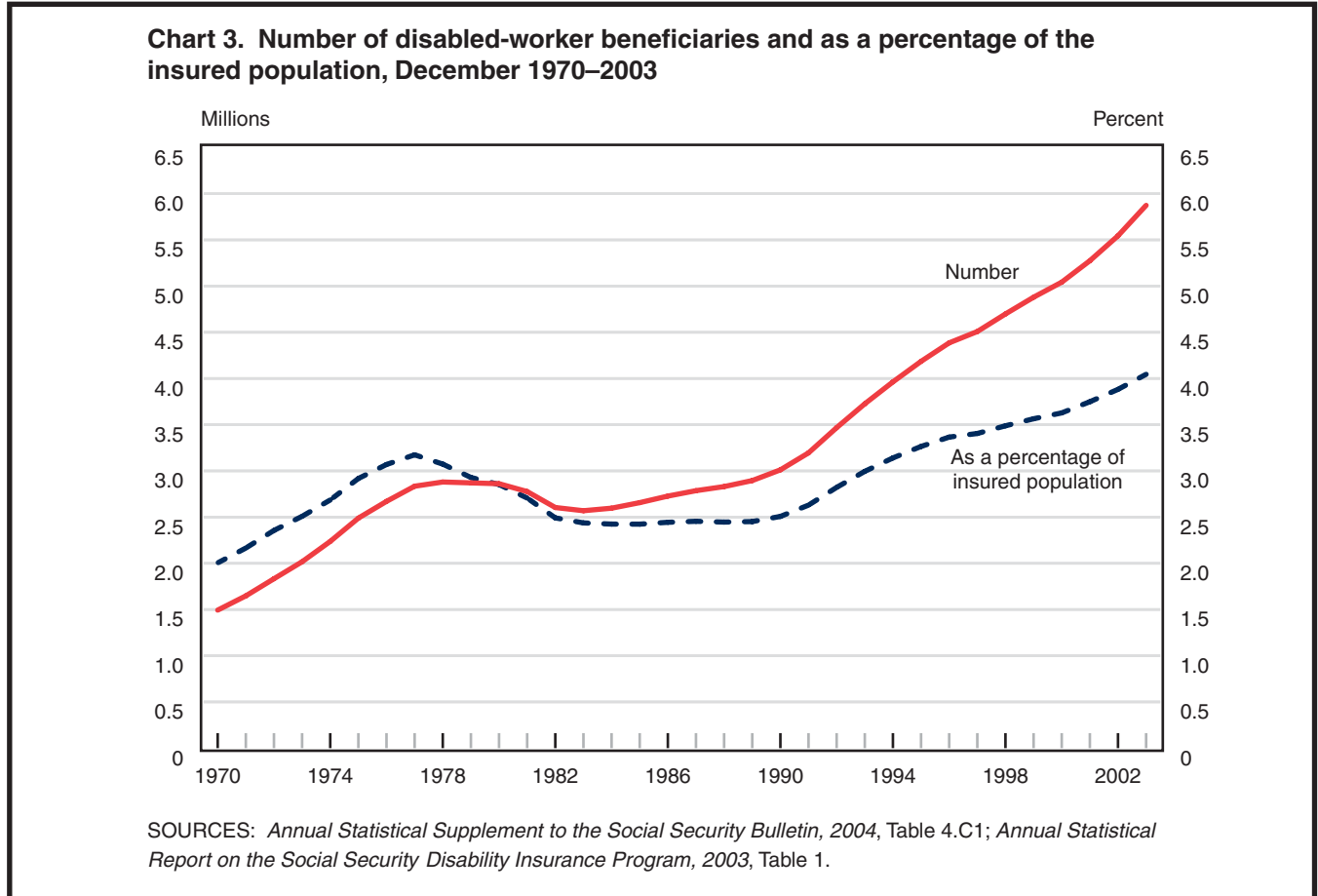
The number of disabled beneficiaries in each beneficiary category is shown for the period 1970–2003. All of the categories have shown steady increases in the number of beneficiaries, with few exceptions. One exception is the period of the early 1980s, when the

number of disabled workers declined as the result of changes in the structure of benefits in the 1977 and 1980 Amendments and increased stringency in adjudicating claims and conducting continuing disability reviews.

Social Security Disability

NUMBER OF DISABLED-WORKER BENEFICIARIES

Although the number of disabled workers has been increasing since 1983, their growth as a percentage of the insured population has been considerably slower.



When considered relative to the number of workers insured in the event of disability, the growth in disabled workers has been more moderate than what is suggested by raw numbers. After a period of stability (in terms of the number of beneficiaries relative to the number insured for disability) between 1982 and 1989,

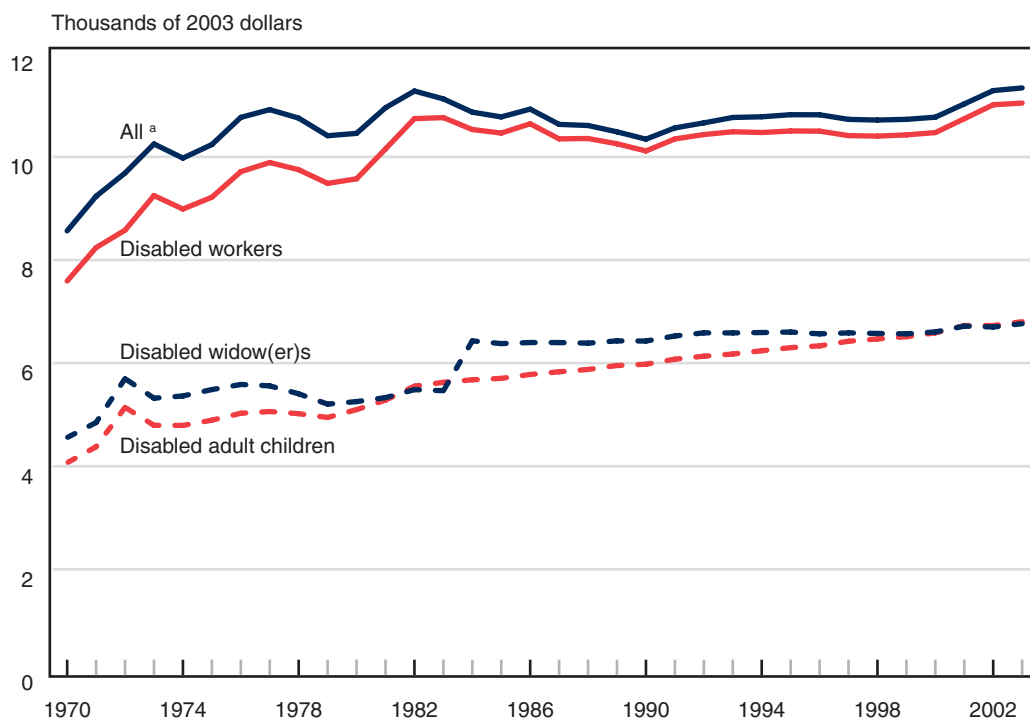
the program is again growing. A number of factors are contributing to this increase, including the aging of the baby boomers into more disability-prone years. (The baby-boom generation was born after World War II, between 1946 and 1964. The number of births peaked in 1957.)

Social Security Disability

AVERAGE COST PER BENEFICIARY

In real terms, the average cost per beneficiary of all Social Security disability cash benefits has increased 33 percent since 1970. Yet the average costs for disabled workers and disabled widow(er)s were relatively stable from the mid-1980s until recently. Thus, increased benefit costs are not strictly due to increasing numbers of beneficiaries.

Chart 4. Average annual cost per beneficiary of Social Security disability benefits, 1970–2003



SOURCES: *Annual Statistical Supplement to the Social Security Bulletin, 2004*, Tables 4.A6 and 5.A17; *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Table 1.

NOTE: All dollar amounts are in constant (price-adjusted) 2003 dollars. Costs have been annualized for disabled widow(er)s and disabled adult children paid from the Old-Age and Survivors Insurance Trust Fund.

a. Includes all types of disability beneficiaries (disabled workers, disabled adult children, and disabled widow(er)s), with any benefits paid to dependents (for example, spouses or minor children) included in the average.

The average cash benefit cost per disabled beneficiary has generally risen during the period 1970–2003, although the cost declined slightly in the early 1980s. The increase in average benefits in the early to mid-1970s was probably related to ad hoc benefit increases of 15 percent, 10 percent, and 20 percent that became effective in January 1970, January 1971, and September 1972, respectively. An additional ad hoc benefit increase of 11 percent occurred in two steps in March and June 1974. Legislation in 1972 resulted in

an automatic benefit adjustment for annual increases in the consumer price index beginning in June 1975. Although this adjustment was intended to stabilize benefits, the way the adjustment was made resulted in overcompensation for inflation, because it did not factor in inflation-related wage increases.

In the late 1970s and early 1980s, there were small reductions in average benefit costs, probably because of changes in the benefit computation that applied to

Social Security Disability

AVERAGE COST PER BENEFICIARY (CONT.)

future beneficiaries. These changes, enacted in 1977, 1980, and 1981, “decoupled” the benefit formula from wages to end the “double indexing” from the 1972 legislation, capped family benefits and reduced dropout years, and eliminated the minimum benefit, respectively. Delaying scheduled cost-of-living adjustments in 1983 may have also contributed to this result. From the late 1980s to the late 1990s, the average cost was fairly stable for disabled workers and disabled widow(er)s, while benefits for disabled adult children rose. The stability of the average cost over 20 years is surprising, since benefit calculations are wage indexed and would tend to increase benefits over time. It has been suggested that lower-wage workers have been increasingly attracted to the disability rolls because of implicit increases in replacement rates for low earners resulting from increasing disparity in the wage distribution. This could help explain the stability of costs per beneficiary during this period. Similarly, increases in the number

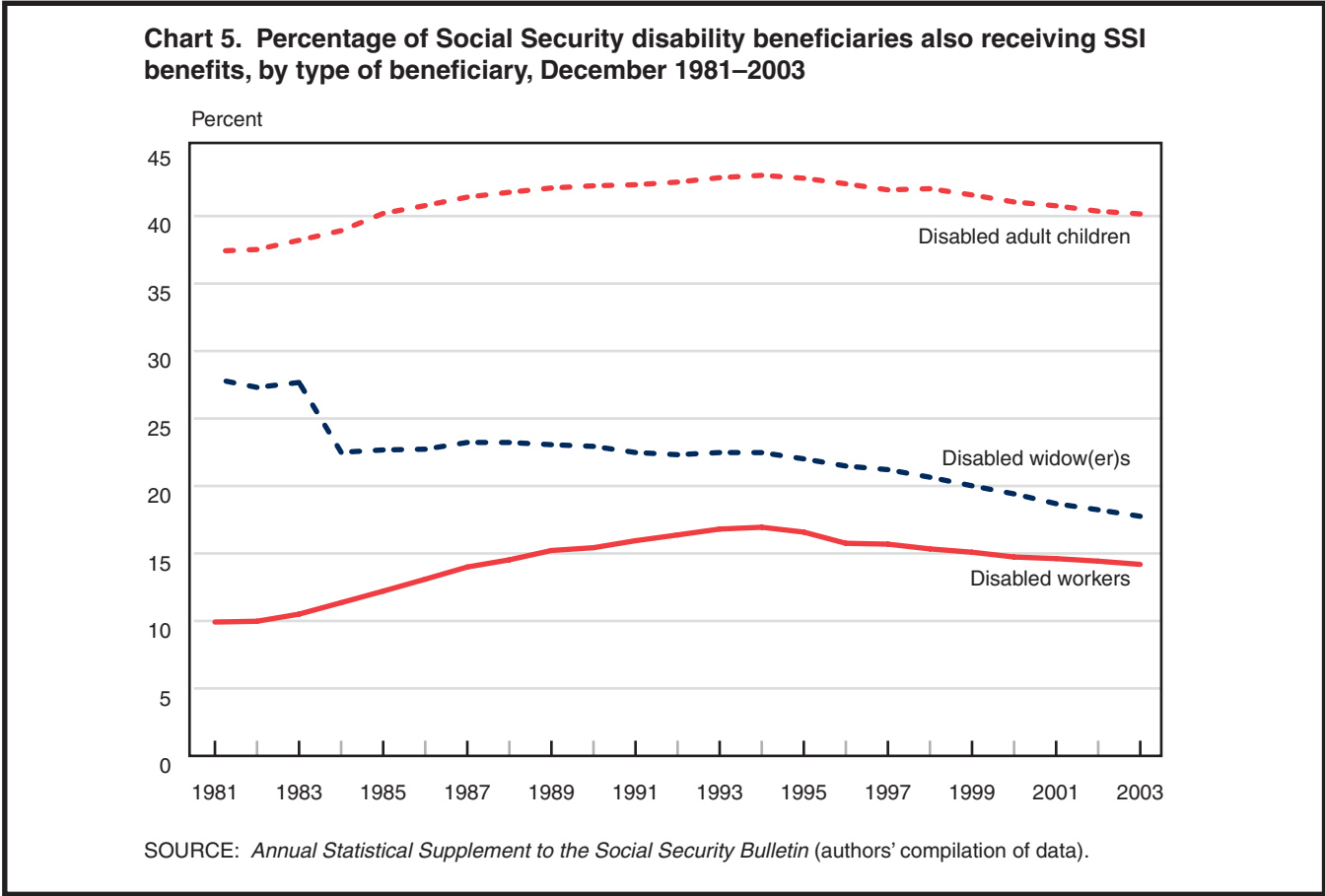
of women insured for disability, whose numbers are a growing portion of the total number of disabled, could also account for this result, since women, on average, have lower earnings than do men. Further research is required to fully understand the underlying patterns affecting average benefit costs.

The cost per beneficiary for disabled adult children, on the other hand, has increased the most (67 percent) during this period. Since 2000, the average benefit cost for workers and widow(er)s has begun to increase. One possible reason for the increase in the cost per beneficiary is that wage increases exceeded price increases in the mid- to late 1990s, yielding higher real benefits. The average expenditure on all disability benefits, including benefits to dependents, increased by a third from 1970 to 2003, but more slowly (10 percent) between 1990 and 2003.

Social Security Disability

BENEFICIARIES ALSO RECEIVING SUPPLEMENTAL SECURITY INCOME

The rates of concurrency reached a peak for disabled workers and disabled adult children in the mid-1990s and have decreased slightly since then. The rate of concurrency for disabled widow(er)s declined abruptly in 1983 because of a change in the benefit calculation and generally has continued to decline.



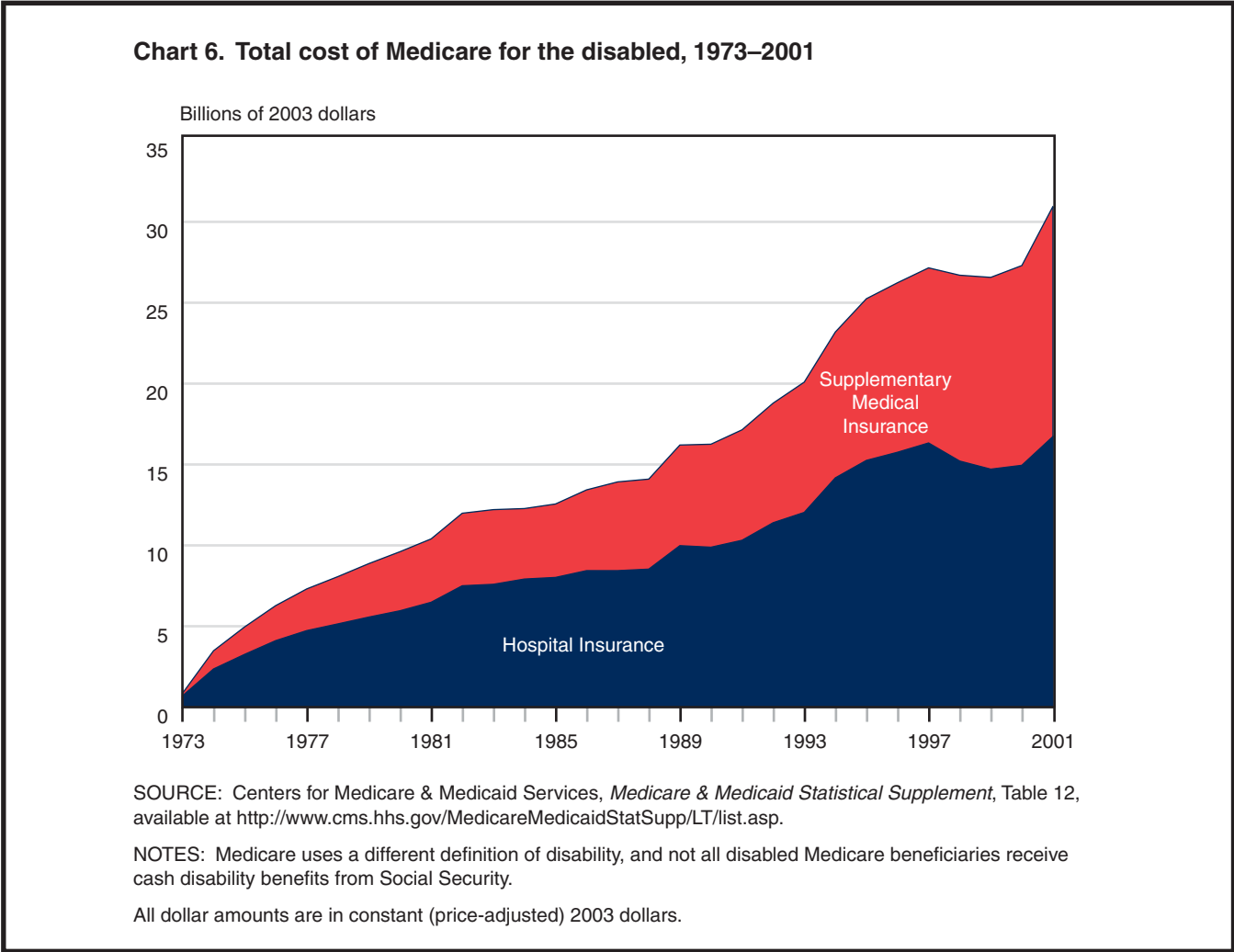
The rate of concurrency, that is, the percentage of Social Security disability beneficiaries who also receive SSI for the blind and disabled, increased for disabled workers and disabled adult children until the mid-1990s and has decreased slightly since then. The change was particularly large for disabled workers, with an increase from 10 percent receiving SSI payments in 1981 to 17 percent in 1993. Since then, the rate has fallen to 14 percent.

A policy change in 1983, which changed the actuarial reduction for disabled widow(er)s under the age of 60, resulted in an abrupt decline in the percentage receiving SSI. That change capped the actuarial reduction for disabled widow(er)s aged 50–59 at the level of reduction effective for widow(er)s at age 60, resulting in increased benefits for disabled widow(er)s younger than 60. The percentage of disabled widow(er)s receiving SSI payments has generally continued to decline since that time.

Medicare for the Disabled

TOTAL COST OF BENEFITS

The cost of Medicare benefits, which are provided to disabled Social Security beneficiaries (but not to dependents) after a 24-month waiting period, has been rising dramatically, with costs increasing 90 percent in real terms between 1990 and 2001.



Medicare is provided to Social Security disabled beneficiaries (but not to dependents) after a 24-month waiting period. Medicare Hospital Insurance (Part A) is provided for free, but Supplementary Medical Insurance (Part B), which covers doctor bills, requires a monthly premium paid by the beneficiary or on the beneficiary's behalf.

Medicare benefit costs for the disabled have been rising dramatically, with costs increasing by 90 percent

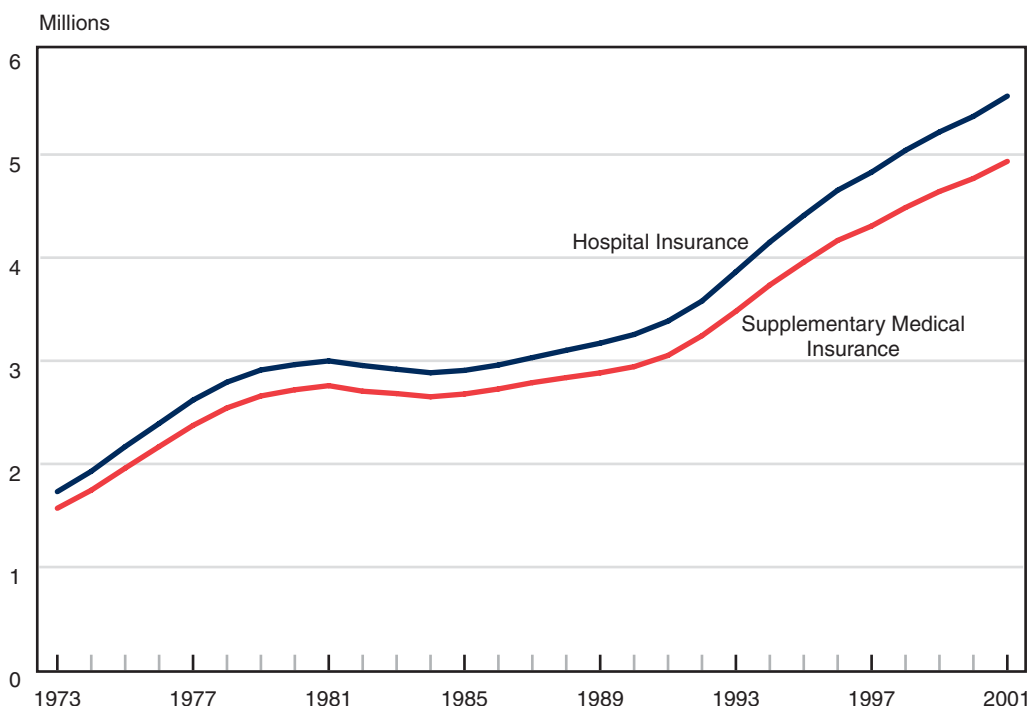
in real terms between 1990 and 2001. Supplementary Medical Insurance has been increasing as a share of all Medicare costs, rising from 34 percent of total cost in 1975, to 39 percent in 1990, and to 46 percent in 2001. Much of the increase in the cost of Medicare is due to an increase in the number of Medicare beneficiaries. However, the increasing cost in medical services has also contributed to the overall increase in benefit costs.

Medicare for the Disabled

NUMBER OF BENEFICIARIES

The number of disabled Medicare beneficiaries has increased in conjunction with the increase in disabled Social Security beneficiaries, up nearly 70 percent since 1990 (see Chart 2). The proportion of Medicare beneficiaries with Supplementary Medical Insurance has declined since the mid-1980s.

Chart 7. Number of disabled Medicare beneficiaries with Hospital Insurance and Supplementary Medical Insurance as of July 1, 1973–2001



SOURCE: Centers for Medicare & Medicaid Services, *Medicare & Medicaid Statistical Supplement*, Table 5, available at <http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp>.

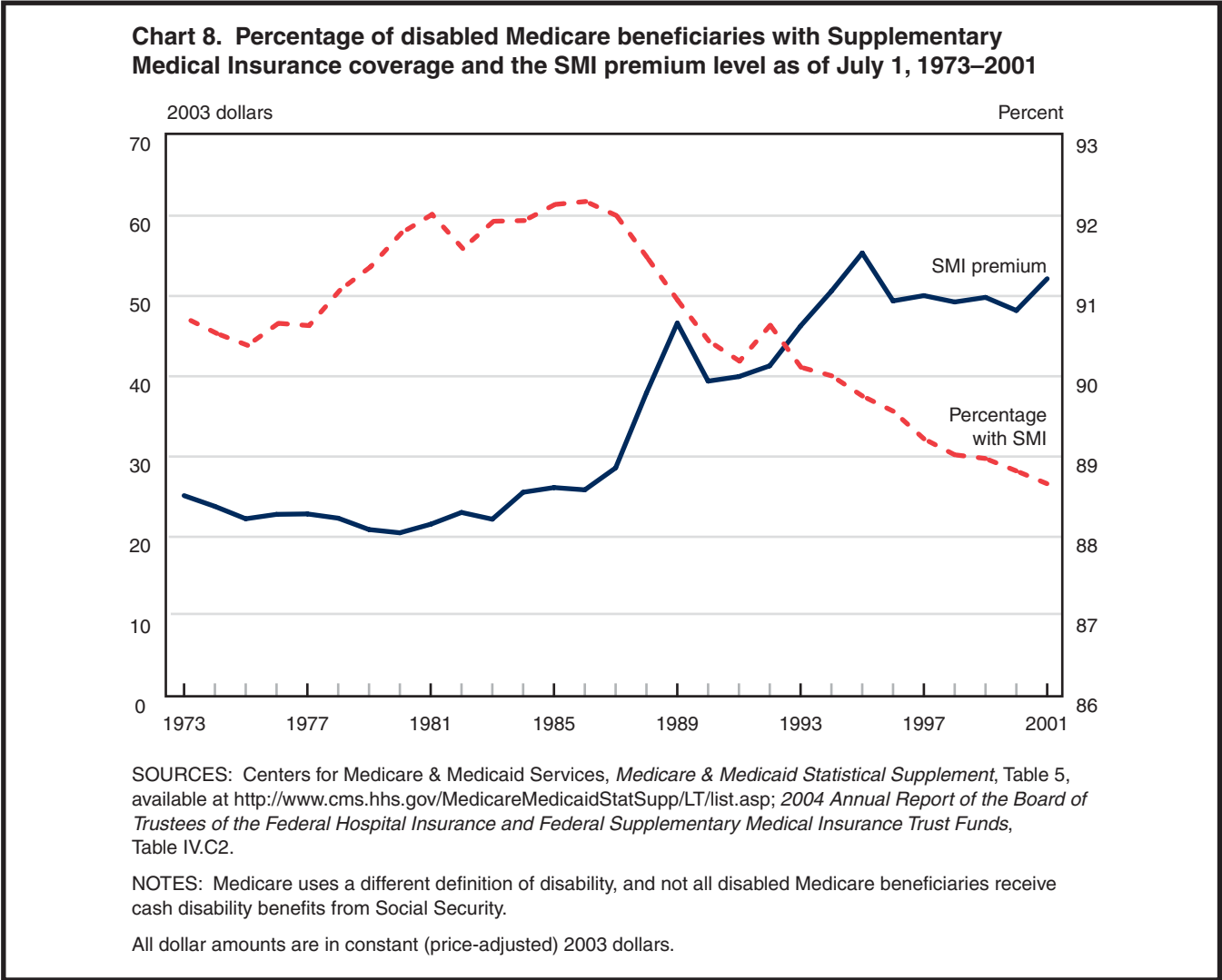
NOTE: Medicare uses a different definition of disability, and not all disabled Medicare beneficiaries receive cash disability benefits from Social Security.

The number of disabled Medicare beneficiaries has increased in near lockstep with the increase in disabled Social Security beneficiaries, and it is up nearly 70 percent since 1990 (Chart 7). The proportion of disabled Medicare beneficiaries with Supplementary Medical Insurance (SMI) has varied over time (Chart 8). SMI coverage increased from 90.4 percent in 1975 to a peak of more than 92 percent in the mid- and late 1980s and dropped fairly consistently to a historical low of 88.6 percent in 2001.

It is unclear why fewer persons are electing SMI coverage, although the cost of premiums for individuals has been rising. For some low-income Medicare beneficiaries, special state programs funded through Medicaid pay all or part of the premium for SMI, making the decline in SMI coverage even more surprising. In 1988, the Qualified Medicare Beneficiary program mandated that states use Medicaid to pay all Medicare cost sharing (including Part B premiums) for Medicare beneficiaries with income less than 100 percent of

Medicare for the Disabled

NUMBER OF BENEFICIARIES (CONT.)



poverty and resources less than twice the SSI resource limit. Beginning in 1990, the Specified Low-income Medicare Beneficiary program mandated that states pay the Part B premium for Medicare beneficiaries who are between 100 percent and 120 percent of poverty and whose resources are less than twice the

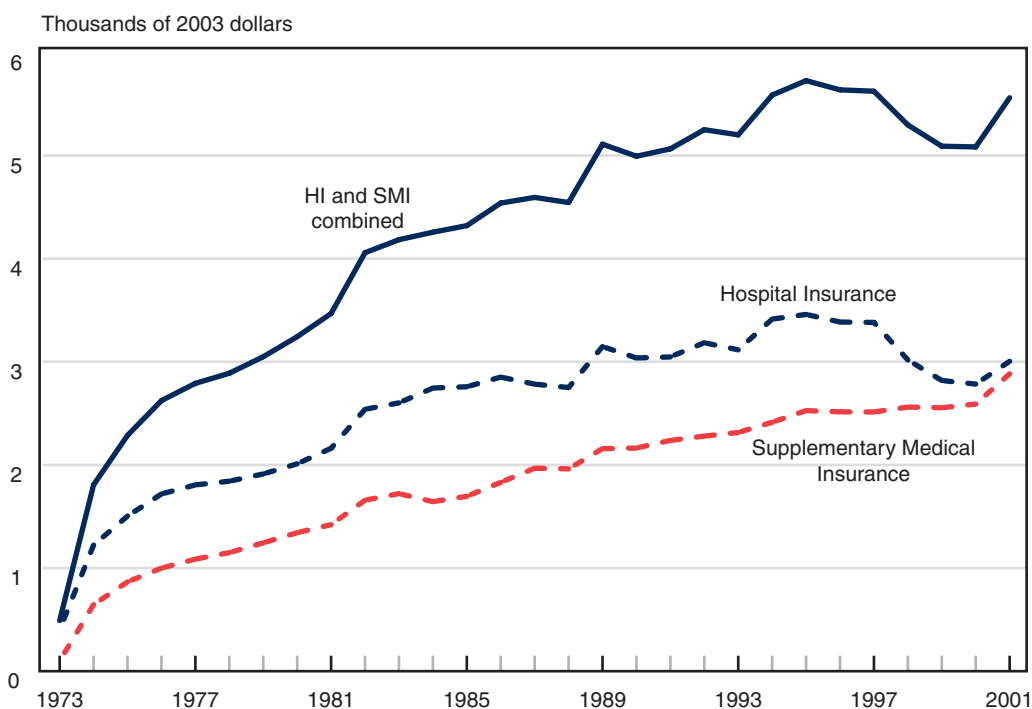
SSI resource limit. In recent years, the proportion of disabled SMI enrollees who received this state SMI buy-in has risen slightly, from 39.7 percent in 1998 to 41.2 percent in 2001, yet overall SMI enrollment continues to decline.

Medicare for the Disabled

AVERAGE COST PER BENEFICIARY

The average cost of Medicare benefits for disabled Medicare beneficiaries has generally increased over time; however, in the late 1990s, reductions in hospital payments helped reduce average Medicare costs, although costs are once again rising. Average Supplementary Medical Insurance benefits have increased consistently during this period.

Chart 9. Average annual cost per disabled beneficiary of Medicare benefits, 1973–2001



SOURCE: Centers for Medicare & Medicaid Services, *Medicare & Medicaid Statistical Supplement*, Tables 5 and 12, available at <http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp>.

NOTES: Medicare uses a different definition of disability, and not all disabled Medicare beneficiaries receive cash disability benefits from Social Security.

All dollar amounts are in constant (price-adjusted) 2003 dollars.

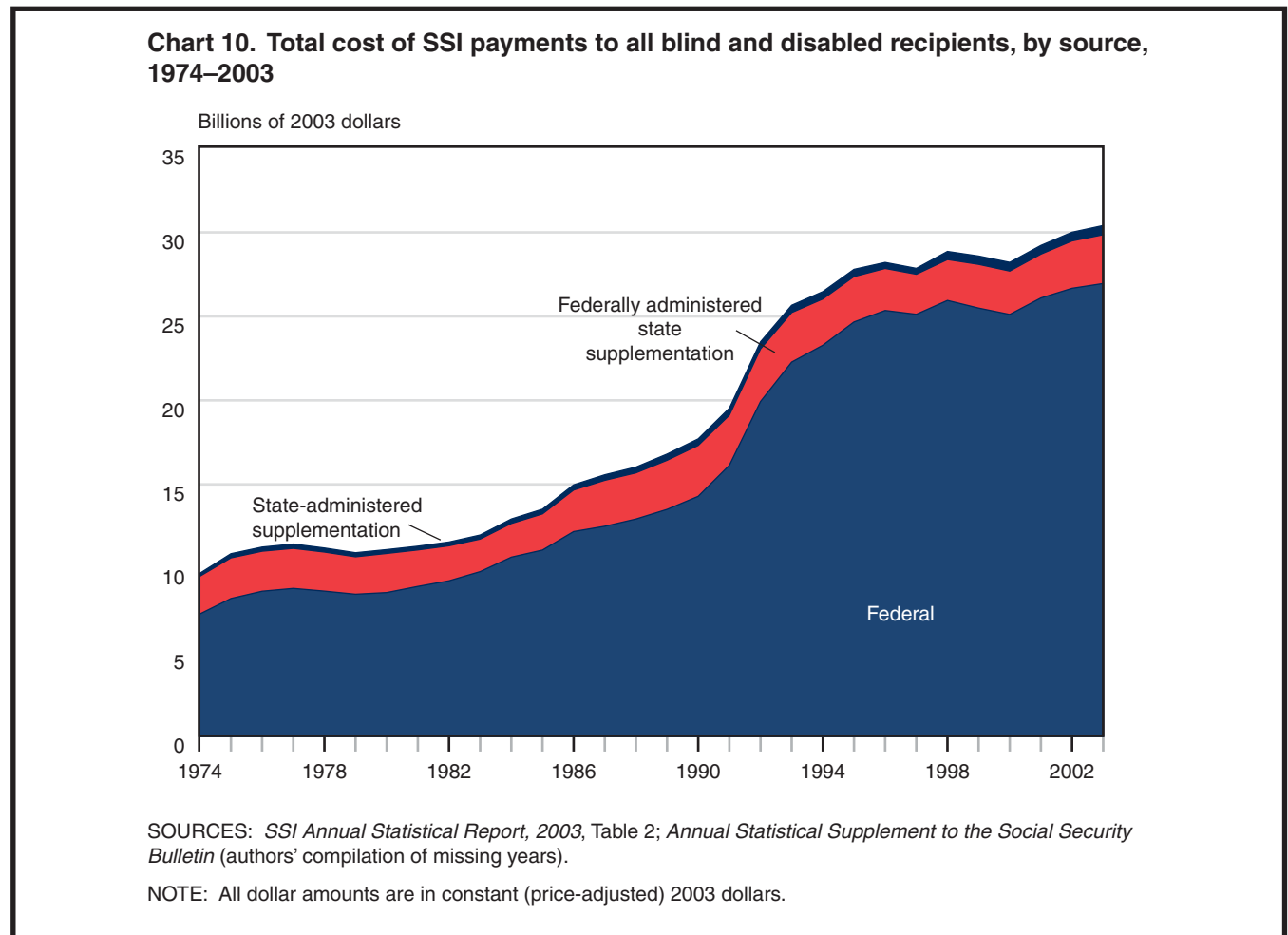
The average cost of Medicare per beneficiary rose from 1973, when disabled Social Security beneficiaries were first eligible for Medicare, until the mid-1990s. In the late 1990s, the average cost of Medicare per beneficiary declined as the cost of Hospital Insurance declined. Cost containment in hospital reimbursements has probably contributed to the reductions in this

component of Medicare costs. Hospital Insurance costs began to increase again in 2000, and overall Medicare costs are again rising in real terms. The average cost per beneficiary of Supplementary Medical Insurance has continued to rise through the 1990s, and the increase accelerated between 2000 and 2001.

SSI for the Blind and Disabled

TOTAL COST OF PAYMENTS

The cost to the federal government of the Supplemental Security Income (SSI) disability program has increased nearly 90 percent in real terms (150 percent in nominal terms) since 1990. At the same time, the states' share of SSI has decreased.



The cost to the federal government of SSI disability payments has increased nearly 90 percent in real terms (150 percent in nominal terms) since 1990. The states' share of SSI payments has decreased over time, with federal payments now making up nearly 89 percent of the total, up from 75 percent at the program's inception. The federal share peaked in 1997 at slightly more than 90 percent of the cost and has declined slightly since then. The reason for the diminishing role of the state dates back to the birth of the SSI program, when Congress mandated that states maintain, at a minimum, payment expenditures equal to the 1974 level: Congress did not require increases in state

funding to make up for changes in the cost of living or in the number of persons participating in the SSI program.² Although states' expenditures have increased over time, they have not kept pace with increases in the cost of living and the number of recipients.

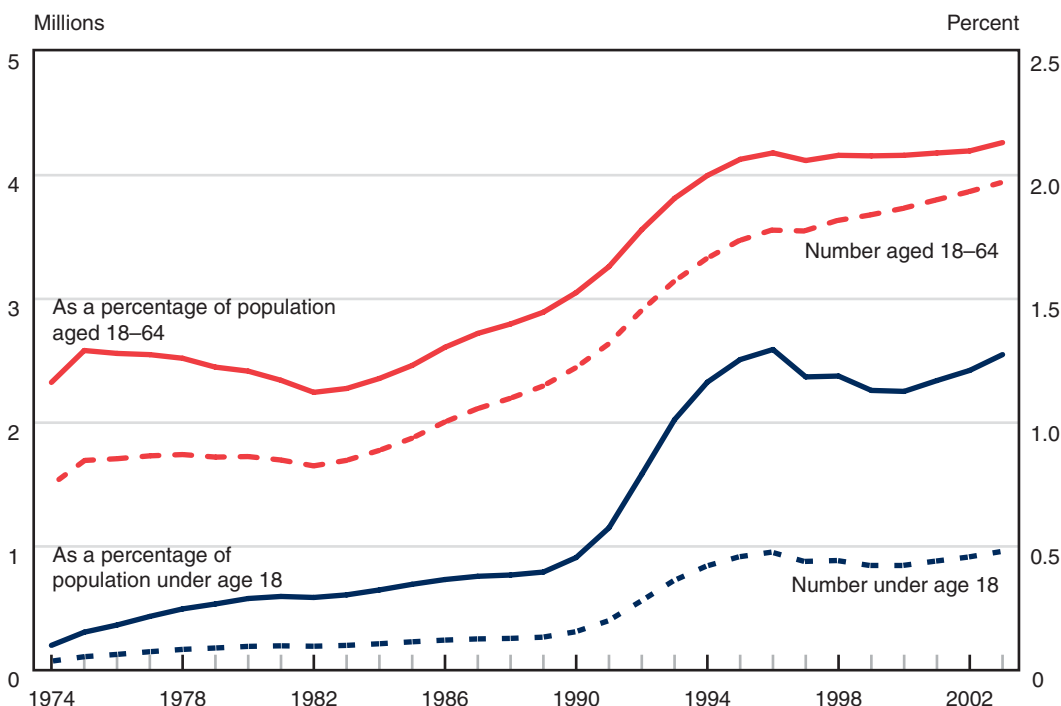
2. For a description and history of the SSI program, see the section on Program Descriptions and Legislative History of the *Annual Statistical Supplement to the Social Security Bulletin*. A specific discussion of state supplementation of SSI payments can be found under the heading "SSI: History of Provisions."

SSI for the Blind and Disabled

NUMBER OF RECIPIENTS

Increasing numbers of blind and disabled SSI recipients contribute to the higher cost of the SSI program; however, since the mid-1990s the number of SSI recipients has been relatively constant as a percentage of the population in each age group.

Chart 11. Number of SSI blind and disabled recipients and as a percentage of the population in each age group, December 1974–2003



SOURCES: SSI Annual Statistical Report, 2003, Table 3; 2004 Annual Report of the Supplemental Security Income Program, Table IV.A1.

NOTE: The reference population is the “Selected Social Security Area Population” of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

The number of blind and disabled SSI recipients has been increasing since the program began, with a few exceptions. The number of SSI disabled children grew dramatically after the *Zebley* decision in 1990. As the result of this growth, Congress enacted welfare reform legislation in 1996 (Public Law [P.L.] 104-193) that revamped the SSI definition of disability for children, and the program witnessed a small contraction thereafter. Currently, the SSI children’s category is growing again, and in 2003 the number of recipients surpassed the 1996 peak. The SSI blind and disabled adult category was affected by legislation in 1996 (P.L. 104-121), which eliminated drug addiction and alcoholism as a basis for receiving benefits. As a result of this legislation, the number of SSI adults aged 18–64 in

1997 decreased slightly. Several pieces of legislation have also limited the access of noncitizens to SSI, which has, for the most part, limited the number of new awards to noncitizens.

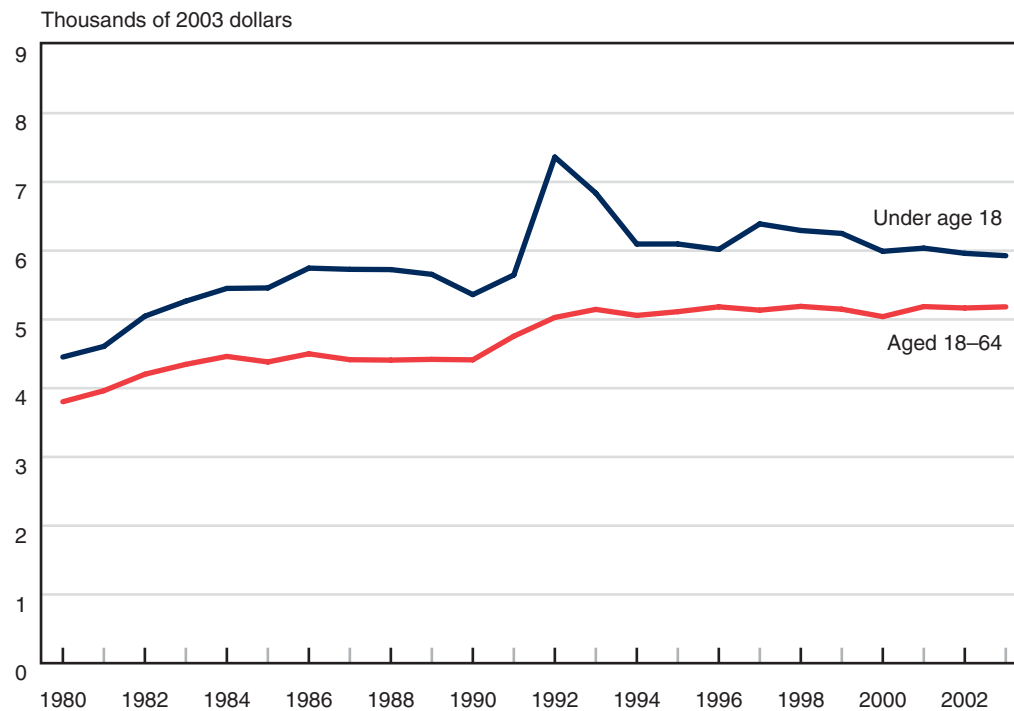
Asset limits, which have not changed in two decades, combined with disregards of earned and unearned income that have been unchanged since the program started, may have served to tighten the program’s financial eligibility criteria over time. As a percentage of the general population, SSI has been growing very slowly since the mid-1990s, much more slowly than was the case in the 1980s and early 1990s. The slow growth is particularly evident in the 18–64 age group.

SSI for the Blind and Disabled

AVERAGE COST PER RECIPIENT

Although there were some increases in the average cost per SSI recipient in the early to mid-1990s and some reductions thereafter, the average cost has been fairly stable since 1980.

Chart 12. Average annual cost per blind and disabled recipient of SSI payments, by age, 1980–2003



SOURCES: SSI Annual Statistical Report, 2003, Table 3; 2004 Annual Report of the Supplemental Security Income Program, Table IV.C1.

NOTE: All dollar amounts are in constant (price-adjusted) 2003 dollars.

The average cost per SSI recipient has remained fairly stable since 1980. It increased slightly in the early to mid-1990s and declined slightly thereafter. This result is not unexpected for a program with a fixed benefit rate that is indexed to inflation. Changes over time are possible because of changes in countable income, backlogs, and retroactive payments, as well as other factors. The large increase in the average annual cost for SSI children in 1992 is probably an anomaly caused by the *Zebley* court decision. That decision produced a large increase of 40 percent in the number of disabled child recipients in a single year. Retroactive payments for new awards based on the *Zebley* decision probably

resulted in the increased average expenditure that year, which exceeded the full means-tested payment.³

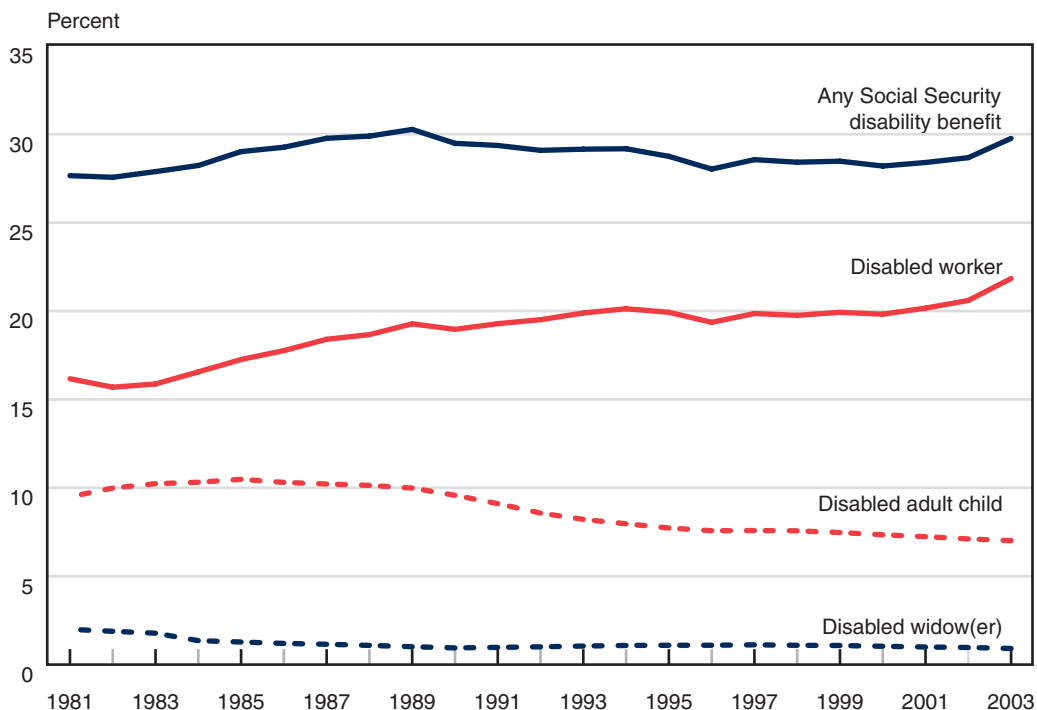
3. A large influx of awards (without retroactive payments) could be expected to reduce average cost because, on average, the new awards will collect only 6 months of benefits rather than 12 months for other beneficiaries, thus increasing the denominator (beneficiaries) more than the numerator (total payments). An influx of persons with large retroactive payments could alter this expectation and serve to increase the average annual cost.

SSI for the Blind and Disabled

DISABLED SSI RECIPIENTS ALSO RECEIVING SOCIAL SECURITY DISABILITY BENEFITS

The proportion of SSI recipients aged 18–64 receiving a Social Security disability benefit has remained fairly constant at around 30 percent since 1981. The proportion of SSI recipients receiving disability benefits as a disabled worker increased from 16 percent in 1981 to 21.8 percent in 2003, while the proportion receiving disability benefits as a disabled adult child has declined since the late 1980s.

Chart 13. Percentage of SSI blind and disabled adults also receiving Social Security disability benefits, by type of benefit, December 1981–2003



SOURCE: SSI Annual Statistical Report, 2003, Tables 3 and 16.

SSI recipients aged 18–64 who are blind or disabled were much more likely to receive disabled-worker benefits under the Disability Insurance program in 2003 (21.8 percent) than they were in 1981 (16 percent). A number of factors may play a role in this increase. It has been suggested that the incentives may have increased for low earners to apply for disability benefits. Changes to SSI work incentives in 1980, most notably sections 1619a and 1619b, may have led to more SSI recipients working and thus earning insured status, which would make them eligible for a worker benefit. The Social Security Administration has been processing a special disability workload in recent years to determine whether

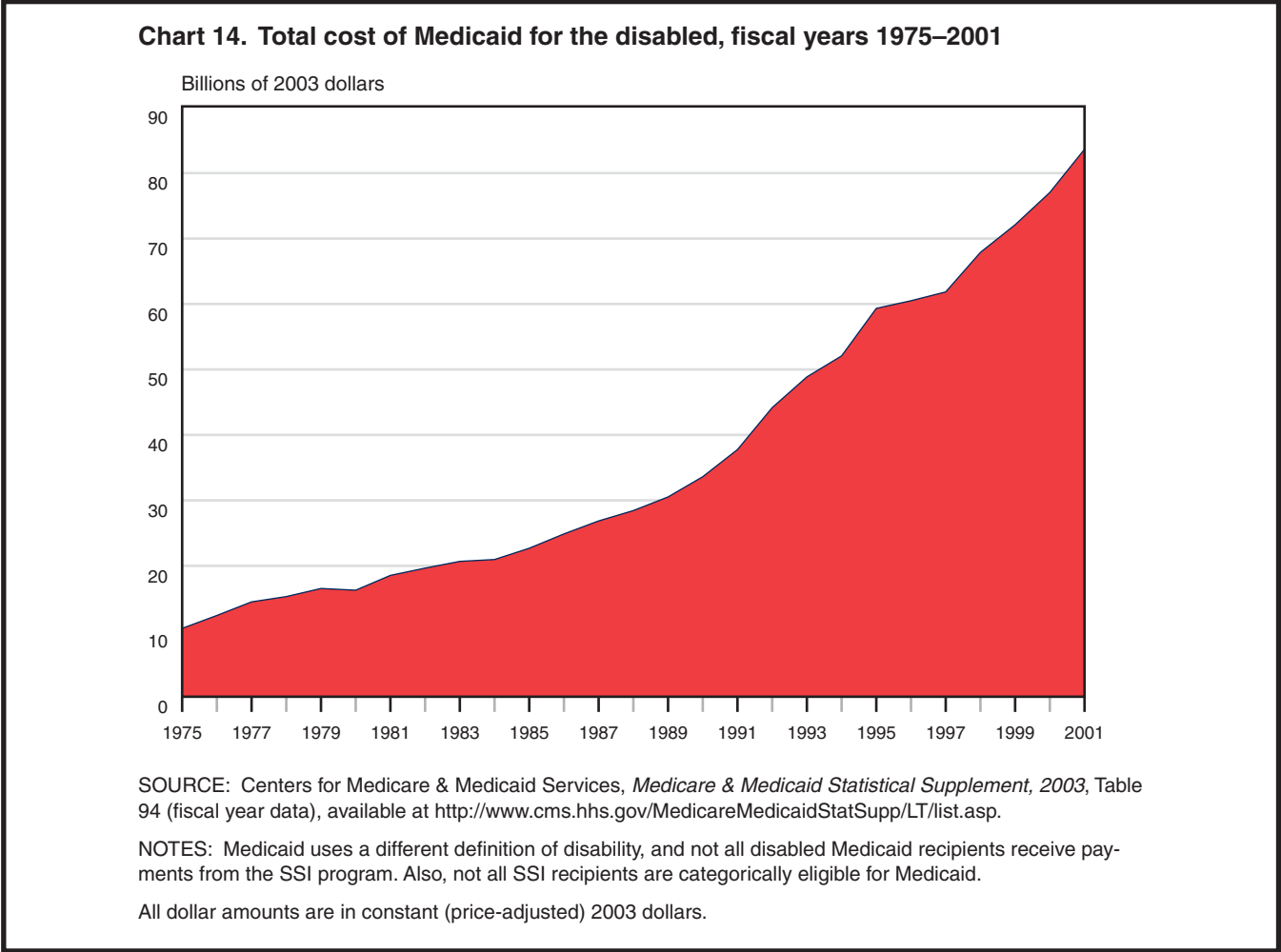
SSI recipients might be eligible for a Social Security DI benefit on the basis of their own earnings record.

The proportion of SSI recipients aged 18–64 receiving any Social Security disability benefit—disabled worker, disabled adult child, disabled widow(er)—has remained fairly constant at around 30 percent since 1981. The percentage collecting Social Security DI benefits as disabled adult children has been declining since the late 1980s, and the percentage receiving disabled-widow(er) benefits declined slightly in the early 1980s and has remained at about 1 percent of SSI recipients since then.

Medicaid for the Disabled

TOTAL COST OF PAYMENTS

Medicaid payments for the disabled have increased greatly in real terms since fiscal year 1975. Between 1990 and 2001, Medicaid payments for the disabled grew nearly 150 percent in real terms, the highest growth rate in costs among the programs under study.



Medicaid benefits are available to the vast majority of disabled SSI recipients, supplementing Medicare benefits for SSI recipients who also receive Social Security disability benefits and have been through the 24-month waiting period. Medicaid is also available to other categories of disabled persons, in some cases with a buy-in for coverage.

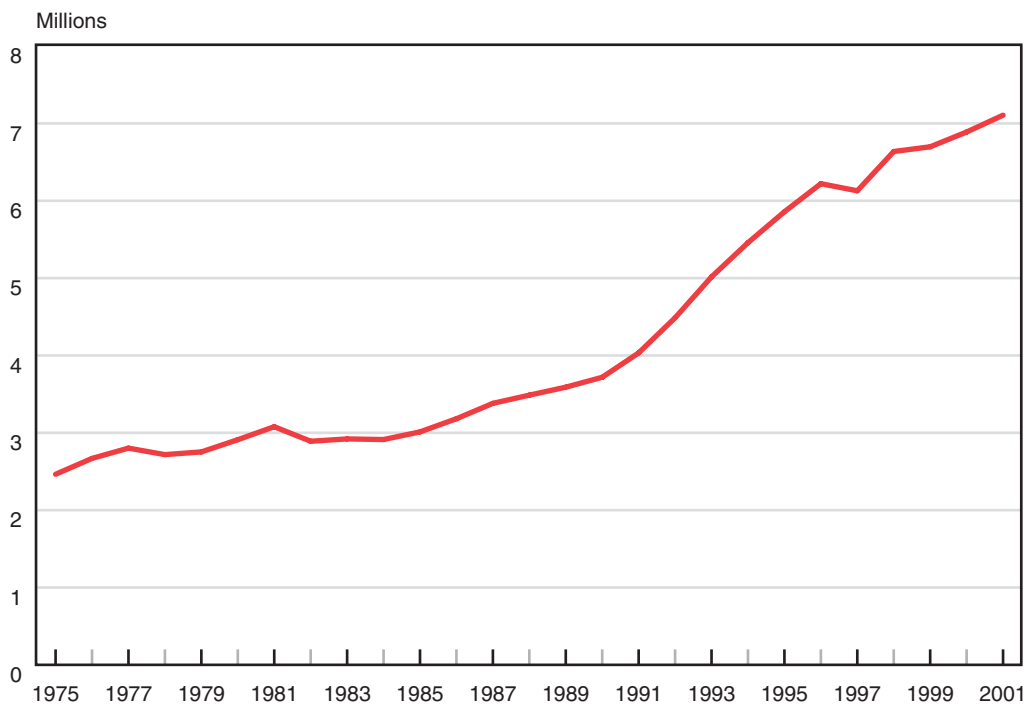
Medicaid payments for the disabled have increased greatly in real terms since 1975. Between 1990 and 2001, they rose nearly 150 percent in real terms, the highest growth rate in costs among the programs under study. Costs associated with covering Qualified Medicare Beneficiaries (under a program established in 1988) and Specified Low-income Medicare Beneficiaries (a program that dates to 1990) contribute to the overall rise in payments.

Medicaid for the Disabled

NUMBER OF RECIPIENTS

The number of disabled Medicaid recipients nearly tripled between fiscal years 1975 and 2001 and increased 90 percent between 1990 and 2001. Part of the increase is due to new Medicaid programs for the disabled, such as buy-ins.

Chart 15. Number of disabled Medicaid recipients, fiscal years 1975–2001



SOURCE: Centers for Medicare & Medicaid Services, *Medicare & Medicaid Statistical Supplement, 2003*, Table 88, available at <http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp>.

NOTE: Medicaid uses a different definition of disability, and not all disabled Medicaid recipients receive payments from the SSI program. Also, not all SSI recipients are categorically eligible for Medicaid.

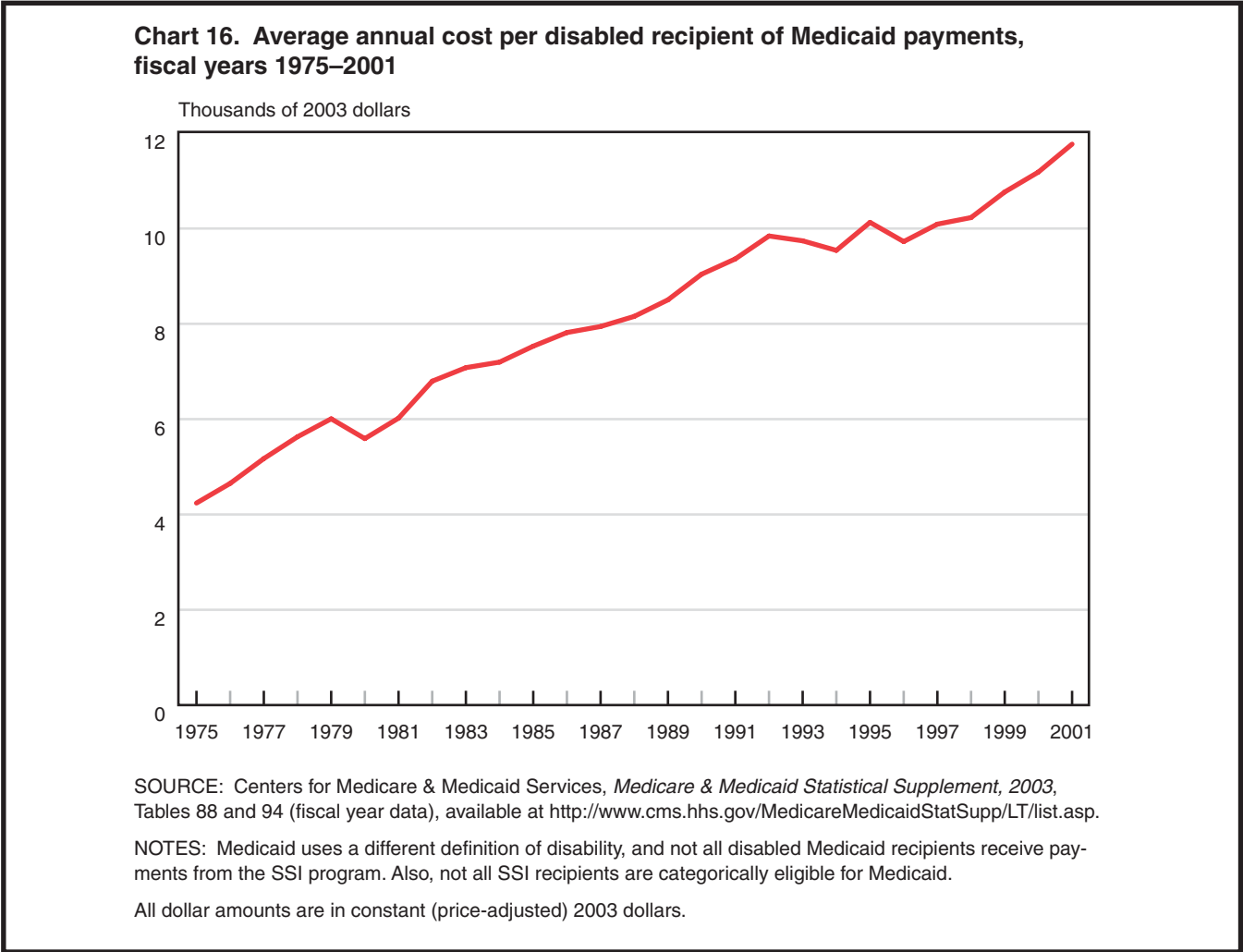
The number of disabled Medicaid recipients nearly tripled between 1975 and 2001 and increased 90 percent between 1990 and 2001. This number includes not only most SSI recipients but also other qualified disabled persons. Although some of this increase is due to growth in the number of disabled individuals in the general population and the number of SSI recipients, some of the increase is due to expansions in the Medicaid program since the late 1980s. Congress enacted several changes to the Medicaid program that increased the number of disabled persons eligible for the program. The numbers above include disabled Medicare beneficiaries who are Qualified Medicare Beneficiaries (covered under a program

established in 1988) and Specified Low-income Medicare Beneficiaries (since 1990). Another legislated expansion for the disabled involved provisions for states to establish buy-in programs, through which a disabled individual who was working or had relatively high income or resources, and who would not normally qualify for Medicaid, could pay a premium to buy Medicaid coverage. States may subsidize the buy-in premium for persons with low income. These optional buy-in programs were permitted by Congress in 1997 and expanded in 1999. Many states do not have buy-in programs, and the number of participants is small in states with programs.

Medicaid for the Disabled

AVERAGE COST PER RECIPIENT

Average cost of Medicaid payments for the disabled nearly tripled (an increase of 177 percent) between 1975 and 2001 and increased 30 percent in real terms from 1990 to 2001. Costs per disabled recipient exceeded \$11,000 in 2001.



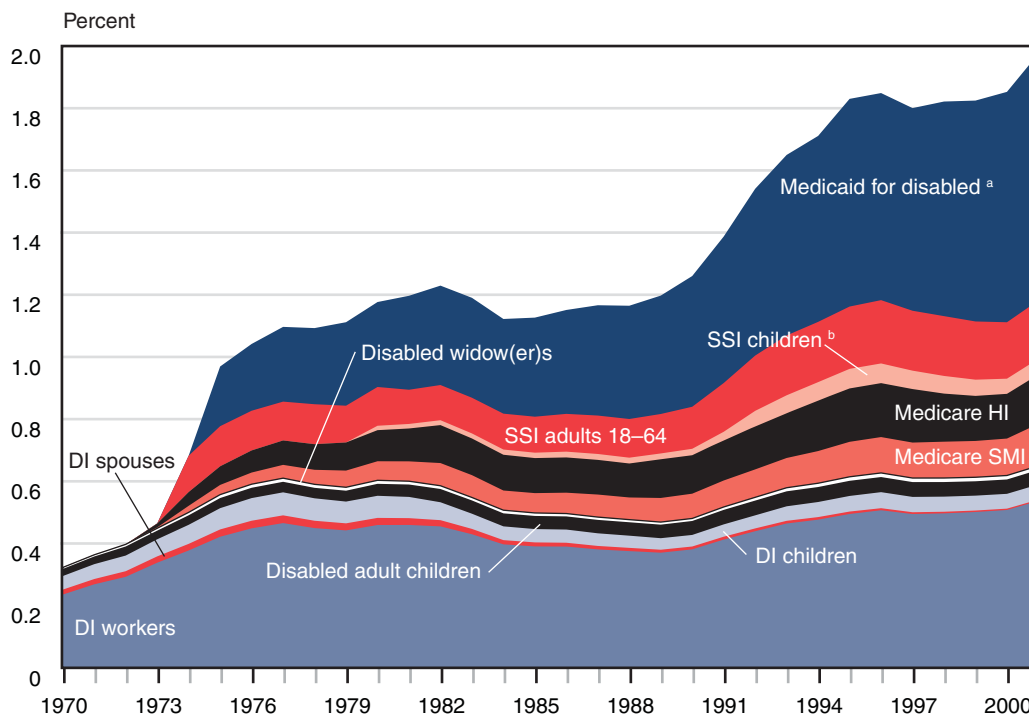
The average cost of Medicaid per recipient has been increasing over time, indicating that the increase in the number of Medicaid recipients does not fully account for the increased cost of the Medicaid program. From 1975 to 2001, the cost per disabled recipient increased 177 percent in real terms, compared with a rise of 143 percent in Medicare over the same period. The cost of Medicaid per recipient in real terms increased at a slower rate over the period 1990 to 2001, increasing only 30 percent, while the total cost of Medicaid increased 150 percent during the same period. The 90 percent increase in the number of Medicaid recipients

between 1990 and 2001 was the greater contributor to the increase in Medicaid cost over that period. In the most recent years, the increase in average Medicaid costs has accelerated. The impact of the Qualified Medicare Beneficiary and Specified Low-income Medicare Beneficiary programs on average costs is unclear, although one might expect the expense associated with cost sharing and Part B premiums, respectively, to be less than the cost of providing full Medicaid coverage for the disabled, thus holding down the increase in average costs.

Benefit Costs as a Percentage of GDP

The cost of benefits for the disability programs as a portion of gross domestic product (GDP) rose dramatically during the 1990s, increasing from 1.26 percent of GDP in 1990 to nearly 2 percent in 2001.

Chart 17. Cost of disability benefits as a percentage of gross domestic product, by type of benefit, 1970–2001



SOURCES: Centers for Medicare & Medicaid Services, *Medicare & Medicaid Statistical Supplement, 2003*, Tables 12 and 94 (fiscal year data), available at <http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp>; *2004 Annual Report of the Supplemental Security Income Program*, Table IV.C1; *Annual Statistical Supplement to the Social Security Bulletin, 2004*, Tables 4.A6 and 5.A17; Bureau of Economic Analysis, gross domestic product, available at <http://www.bea.gov/bea/dn/home/gdp.htm>.

NOTE: Medicaid data are for the fiscal year. All other data are for the calendar year.

a. Medicaid is for disabled persons, including those aged 65 or older.

b. Before 1980, SSI children were counted in the category "SSI adults 18–64."

Although earlier charts showed that benefit costs have increased dramatically, nearly doubling in real terms since 1990, it is important to view these benefits relative to the size of the economy. Chart 17 presents the major disability programs as a percentage of gross domestic product. Expenditures on cash and medical benefits for the disabled, as a percentage of GDP, increased 57 percent between 1990 and 2001, consuming 1.98 percent of GDP in 2001, up from 1.26 percent in 1990.

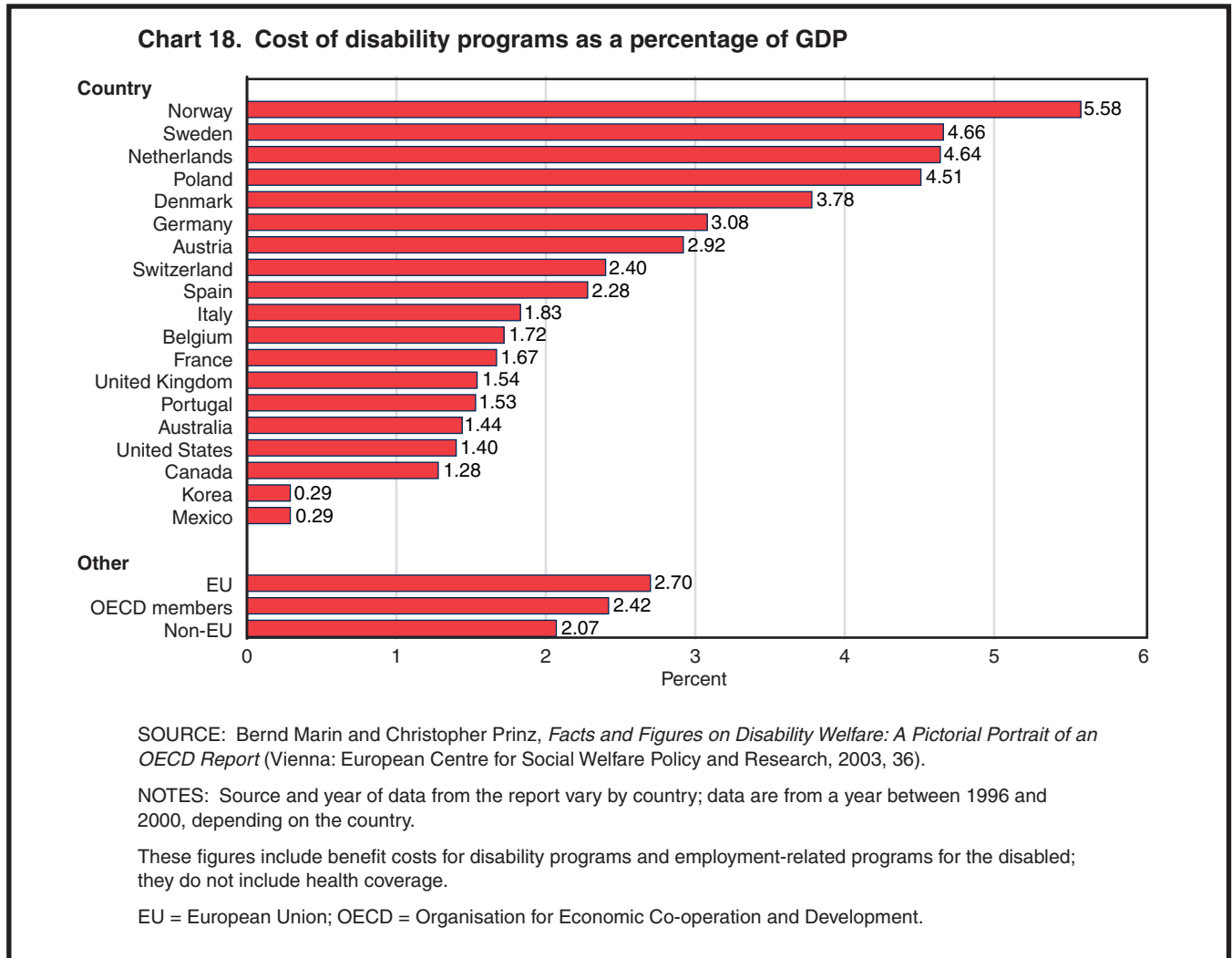
Although many of the expenditures have increased over time, the most dramatic growth is seen in Medicaid expenditures for the disabled. As shown earlier, Medicaid costs have increased because of a tripling of

the number of disabled individuals receiving Medicaid since 1975 and a 175 percent increase in the average cost of Medicaid benefits during the same period.

Before implementation of SSI in 1974, the Aid to the Permanently and Totally Disabled and Aid to the Blind programs addressed the needs of the low-income population. These state-administered programs are not included in the chart for the period 1970–1974, so costs during that period are understated. Both programs were considerably smaller and less expensive than is SSI. In 1972, the two programs paid \$1.4 billion in cash payments to 1.2 million recipients. After SSI was fully implemented in 1975, 1.9 million disabled recipients were receiving \$3.3 billion in SSI payments.

International Expenditures on Disability Programs

As a percentage of gross domestic product (GDP), the costs of disability programs in the United States are considerably smaller than those of most other countries.



It is interesting to compare the level of benefit costs for disability programs in the United States with those in other countries. The Organisation for Economic Co-operation and Development (OECD) recently released a report comparing the costs of disability programs across countries, from which international data in this book are drawn. The data show the percentage of GDP that is expended on all disability-related programs in each of the countries. Analyzing the OECD figures shows that the United States spent a lower percentage of its GDP on disability programs than did all other countries under study except Canada, Korea, and Mexico.⁴ Norway, Sweden, and the Netherlands

spent three times as much on their disability programs as did the United States.

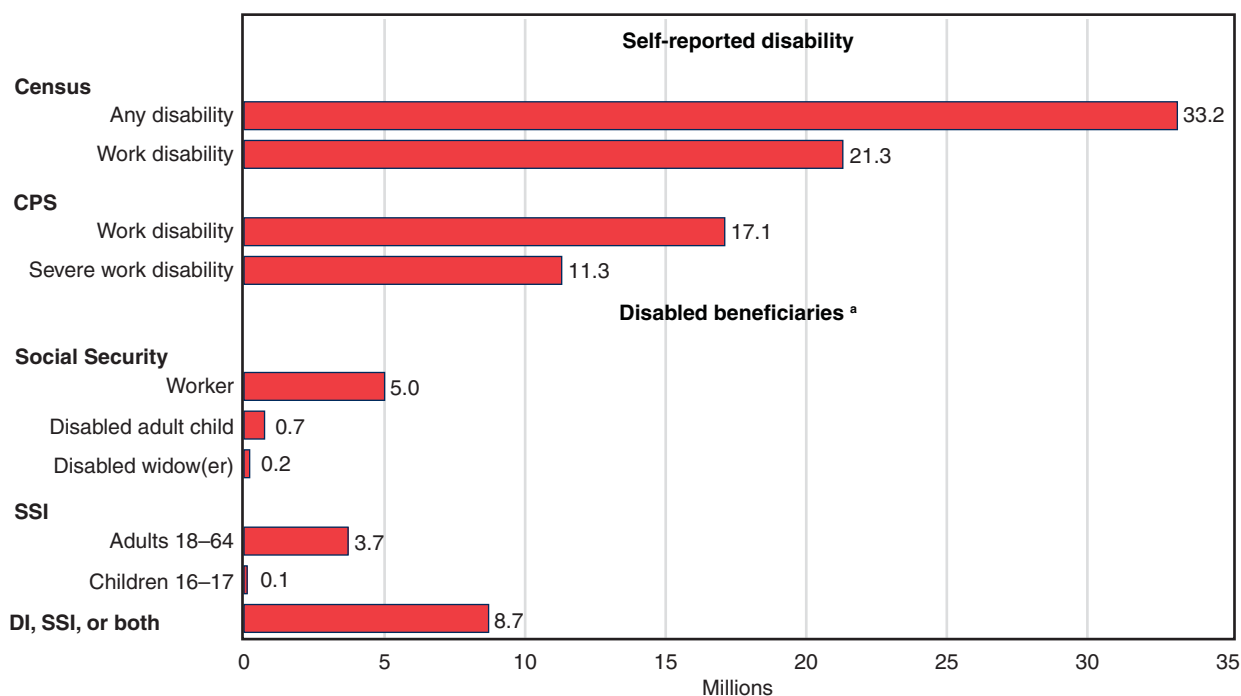
There are many reasons why the cost of the disability programs is lower in the United States. The definition of disability is very strict in the United States, which includes only persons who are unable to work for extended periods, whereas many countries offer temporary and partial disability benefits. Moreover, many European countries have more generous disability benefits than does the United States, and some countries have used the disability programs as early retirement programs, particularly when economic conditions are poor.

4. OECD figures differ somewhat from those generated from SSA administrative data; however, the OECD approach is consistent across countries, and relative magnitudes should be correct.

Disability Programs and Self-Reported Disability

The disability programs serve only a portion of the population self-reporting a disability. Although fewer than 9 million disabled persons received benefits from Social Security disability, SSI disability, or both in 2000, estimates of the disabled population vary between 11 million and 33 million, depending on the definition of disability.

Chart 19. Disability as self-reported by persons aged 16–64 compared with the size of the disability programs, 2000



SOURCES: Census Bureau data available at <http://www.census.gov/hhes/www/disability.html>; Current Population Survey (CPS) data available at <http://www.bls.census.gov/cps/cpsmain.htm>; *Annual Statistical Supplement to the Social Security Bulletin, 2001*, Tables 5.A1, 7.A1, and 7.D1.

a. Data are for December 2000.

The disability programs served 8.7 million disabled persons aged 16–64 in 2000. The population self-reporting a disability ranged between 11 million and 33 million persons, depending on the definition and the survey.⁵ Using the definition yielding the smallest estimate of the disabled population—the definition of severe work disability in the Current Population Survey

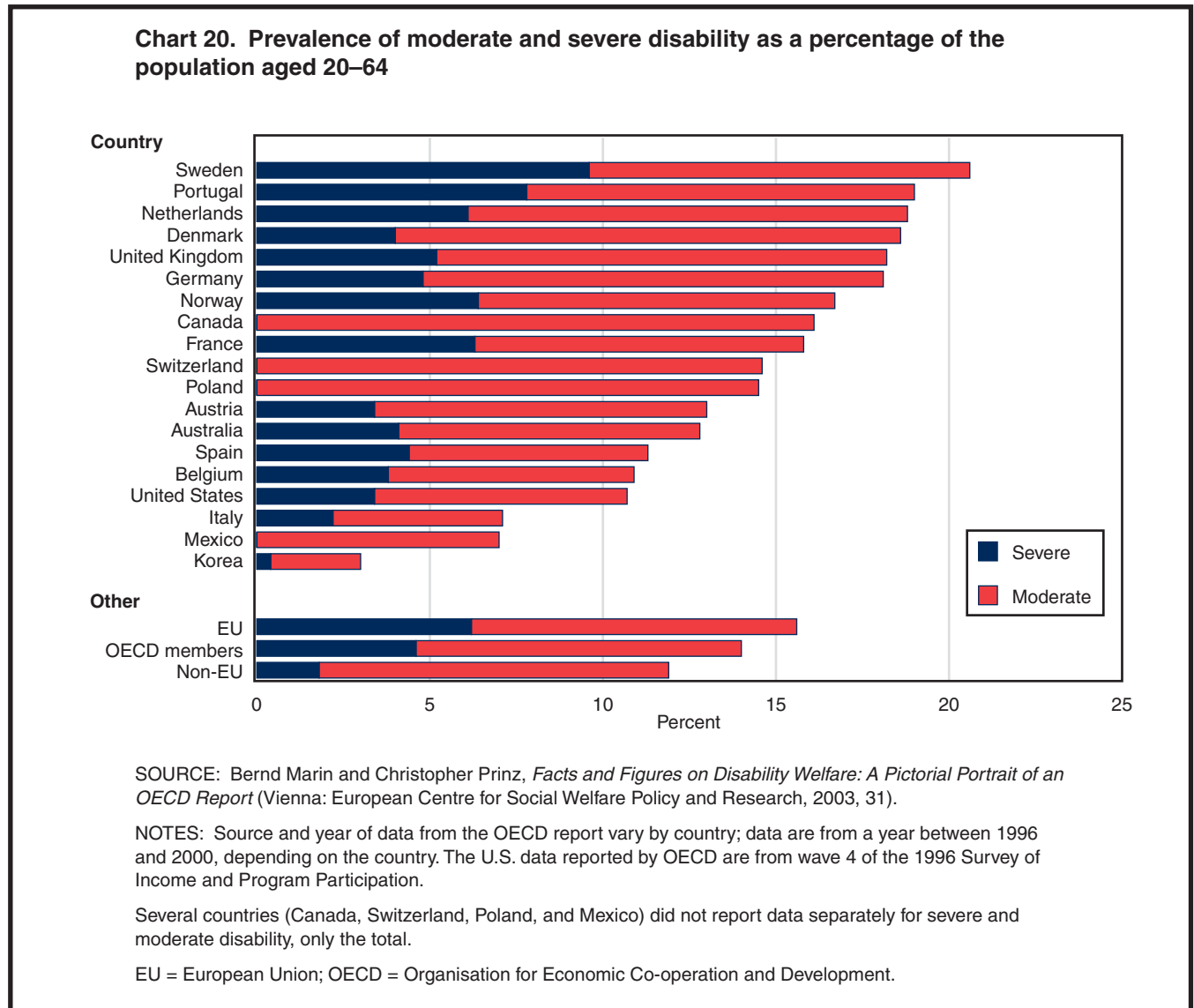
(CPS)—nearly a quarter of these persons were not on the disability rolls.⁶ This suggests that there may be additional potential for increases in the number of disability beneficiaries in the future. Estimates based on other, less stringent definitions of disability suggest that programs directed at temporary or partial disability could attract a large number of potential beneficiaries.

5. The variability from one source to another in estimates of the percentage of the general population that reports being disabled is evident in the chart above. The Decennial Census of 2000 and the Current Population Survey collected data using a definition of work disability in 2000, yet one estimate was 25 percent higher than the other: 21.3 million vs. 17.1 million, respectively.

6. The Current Population Survey is a monthly survey conducted by the Census Bureau for the Bureau of Labor Statistics in the Department of Labor. The survey has been conducted for more than 50 years. Data on disability in the CPS come from the March Supplement to the survey. Additional CPS data on disability are provided in Chart 46.

International Prevalence of Disability

The overall prevalence of disability in the United States is relatively low compared with prevalence in other countries. The prevalence of severe disability is also lower in the United States than it is in many other countries, although the differences in rates of severe disability across countries do not seem as large as the differences in overall prevalence rates.



The overall prevalence of disability in the United States is relatively low compared with that in other countries, exceeding the prevalence in only Italy, Mexico, and Korea. The prevalence of severe disability is also lower in the United States than it is in many other countries, although the differences in rates of severe disability across countries do not seem as large as the differences in overall prevalence rates. Persons with a severe disability make up a greater portion of the disabled in the United States than they do in some of the countries with high disability prevalence rates (for example, Denmark and Germany). On the one hand,

the lower rates of disability in the United States could suggest that the U.S. disability programs may be less at risk than are programs in other countries. On the other hand, if the prevalence of disability in the U.S. population were to begin to mirror that of other countries, U.S. disability programs could experience more growth in the future. The attractiveness of disability programs in some countries (for example, those in northern Europe) may actually influence the perception of disability and increase the number of people reporting disabilities or severe disabilities.

ENTRY INTO AND EXIT FROM THE DISABILITY PROGRAMS

Introduction

Entry and Exit by Disabled Workers

Entry and Exit by SSI Blind and Disabled Adults and Children

Entry by Disabled Workers

Entry by SSI Blind and Disabled Adults

Entry by SSI Disabled Children

Exit by Social Security Disabled Beneficiaries

Exit by Disabled Workers

Exit by SSI Blind and Disabled Adults and Children

INTRODUCTION

This section provides further insight into the size of the disability programs by examining, from year to year, the number of persons entering and leaving each program. In addition to entry and exit, the size of the program is influenced by one other factor: duration of the stay. Duration is largely a factor of the age of entrants and their diagnosis, both of which influence the amount of time they are likely to remain on the rolls.

Entry into the disability programs is measured by the number of disability awards for each program. It is not always clear how many individuals enter the programs because in some benefit categories, such as disabled adult children, the individual may leave the benefit category as a beneficiary of the Disability Insurance Trust Fund and immediately enter the same benefit category as a beneficiary of the Old-Age and Survivors Insurance Trust Fund. For this reason, this section focuses on disabled workers and SSI recipients. The reader is also cautioned that some individuals may enter both disability programs at the same time, or nearly the same time, depending on the waiting period and other factors. Thus, simply adding the number of entrants to the programs will yield a total that is greater than the total number of unique individuals entering the programs.

The termination of benefits in the Social Security disability program is based predominantly on four factors: conversion to the retirement program (that is, attainment of full retirement age), death, medical recovery, and work recovery. In addition, benefits to disabled widow(er)s and disabled adult children can be terminated for marriage or for entitlement to a larger benefit.

In the SSI program, termination is a quite different concept. Although payments are terminated for death and medical recovery, suspension of payments is common, particularly for financial reasons. Payments may be suspended because the recipient has excess earnings, excess unearned income, excess resources, or a change in living arrangements. For the purposes of this book, individuals who have had their SSI payments suspended for 12 months or longer are considered terminated from the SSI program.

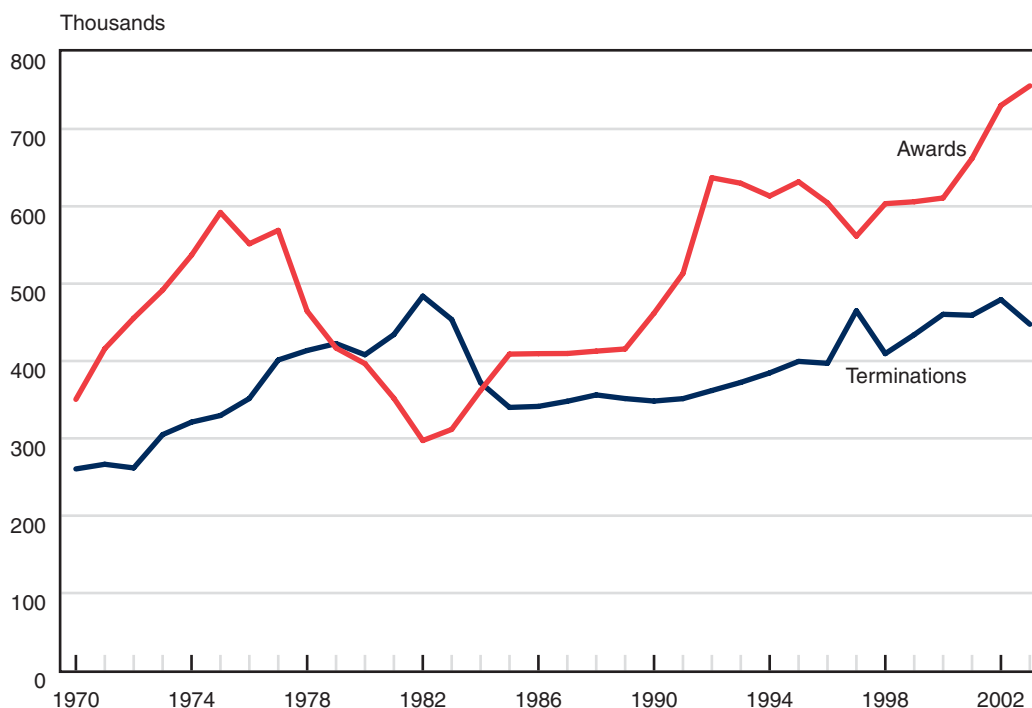
There are other differences in the reasons for termination between the Social Security and SSI programs. For blind and disabled adults in the SSI program, there is no conversion to the aged category at age 65; the disability designation continues although medical recovery is no longer an issue after the age of 65. There is no termination for substantial gainful activity in the SSI program: benefits are reduced \$1 for each \$2 of earnings exceeding \$65 per month until cash benefits are no longer paid. Even after cash benefits are suspended because of earnings, eligibility for Medicaid benefits can be maintained under the provisions of section 1619b. SSI disabled children are subject to a redetermination at the age of 18, during which an assessment is made as to whether they meet adult disability standards. Nearly one in three SSI children is terminated at the age of 18 for not meeting the adult standards.

Entry and Exit by Disabled Workers

NUMBER AND RATE OF AWARDS AND TERMINATIONS

The number and rate of entry and exit by disabled workers in the Social Security Disability Insurance (DI) program vary considerably over time. The number of awards is at a historical high. The rate of entry, though currently rising, is considerably lower than peaks reached in the mid-1970s. Although the number of terminations is relatively high by historical standards, the rate of terminations has been generally falling since the early 1980s.

Chart 21. Number of awards and terminations for disabled workers, 1970–2003



SOURCES: *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Tables 31 and 45; *Annual Statistical Supplement to the Social Security Bulletin* (authors' compilation of missing years).

The number of annual awards to disabled workers rose from 1970 to 1975, declined until 1982, and has generally been increasing since then (Chart 21). The rate of program entry, measured as the number of awards to disabled workers per 1,000 persons insured for disability, provides a better idea of the relative size of program entry and tends to vary over time (Chart 22). This measure reached a historical high in the mid-1970s—increases often attributed to a poor economy, increasing incentives from higher benefits, the addition of Medicare, and the establishment of the SSI program in 1974. The decline from 1975 to 1982 was the result of legislation and policy changes that tightened

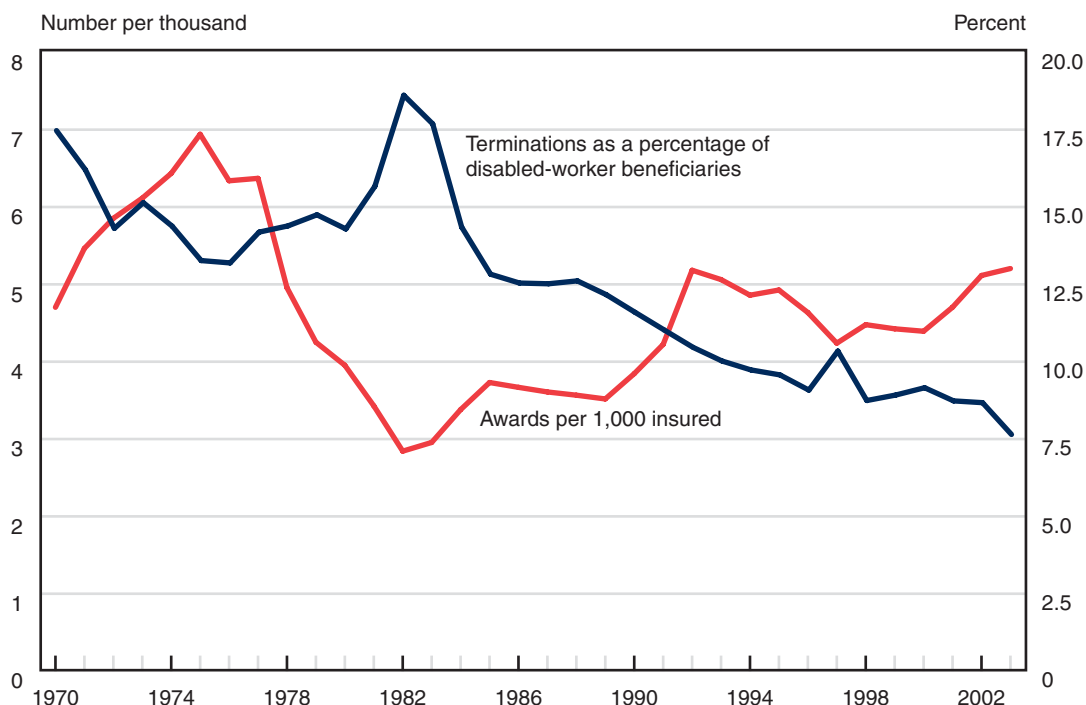
program eligibility and reduced benefit levels. Since that time, the entry rates into the DI program have risen, though not consistently, and are considerably lower than the peak level of the 1970s.

The number of exits, or terminations, rose until 1982, when it fell for a few years because of the moratorium on continuing disability reviews. The number of terminations has increased since the mid-1980s and in 2002 was close to the historical peak reached in 1982. Terminations declined in 2003, in part because of the increase in the full retirement age in that year from age 65 to age 65 and 2 months (Chart 21).

Entry and Exit by Disabled Workers

NUMBER AND RATE OF AWARDS AND TERMINATIONS (CONT.)

Chart 22. Rate of awards for disabled workers per 1,000 disability-insured workers and terminations as a percentage of disabled-worker beneficiaries, 1970–2003



SOURCES: *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Tables 1, 31, and 45; *Annual Statistical Supplement to the Social Security Bulletin* (authors' compilation of missing years); *Annual Statistical Supplement to the Social Security Bulletin, 2004*, Table 4.C1.

Exits of disabled workers from the DI program, as a percentage of disabled-worker beneficiaries, have varied over time, reaching a peak in 1982 when the pace of continuing disability reviews accelerated, producing large numbers of terminations due to recovery that increased the overall termination rate.¹ Since that time, the medical improvement review standard, along with demographic and diagnostic trends, has led to reductions in the overall termination rate. One notable exception occurred in 1997, when legislation

resulted in the review and termination of persons who had been entitled on the basis of drug addiction and alcoholism, contributing to a temporary increase in the overall rate of termination. Noteworthy demographic trends include more baby boomers entering the program (which has resulted in a change in the age distribution of beneficiaries and thus relatively fewer persons reaching retirement age each year) and more allowances for persons with mental disorders, who tend to stay on the rolls longer. Recently the increase in the retirement age has reduced the number of exits that would be due to conversion to the retirement program.

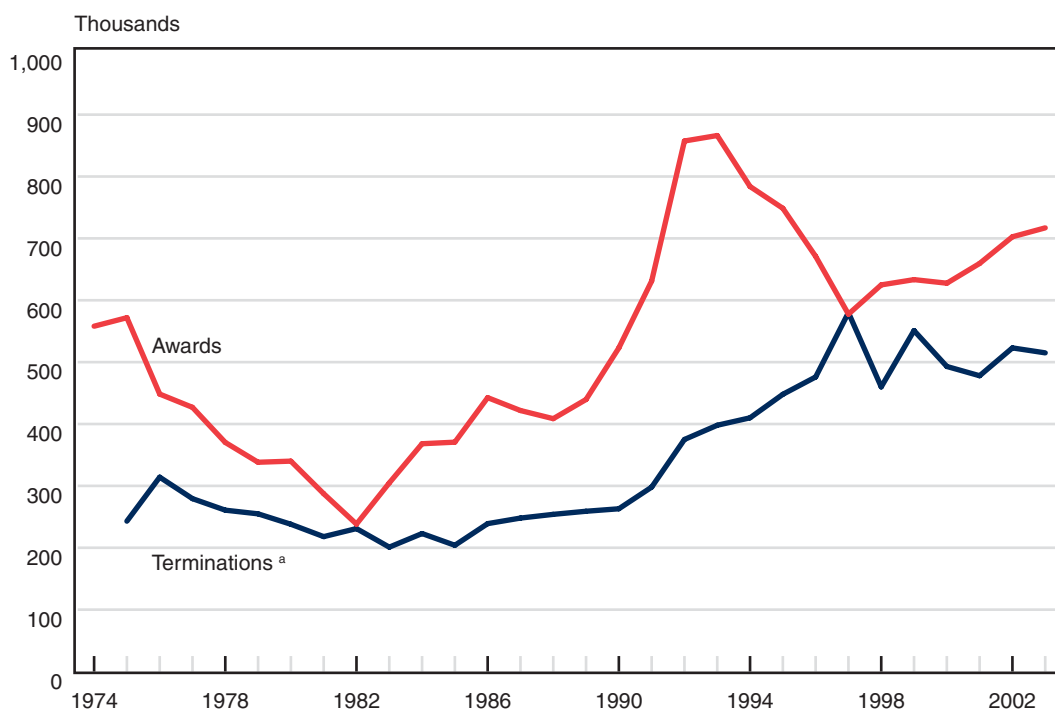
1. Terminations from the disabled-worker program are due to death, recovery (medical or a return to work), or conversion to retirement benefits at the full retirement age.

Entry and Exit by SSI Blind and Disabled Adults and Children

NUMBER AND RATE OF AWARDS AND TERMINATIONS

The number of SSI awards and terminations and the entry and exit rates for disabled SSI recipients under 65 years of age have varied over time. The number of awards in 1993 was more than 3½ times that in 1982, and the entry rate was nearly 3 times as great. The rate of terminations has shown less variation, running between 10 percent and 13 percent of recipients since the late 1970s.

Chart 23. Number of awards and terminations for blind and disabled adults and children, 1974–2003



SOURCES: SSI Annual Statistical Report, 2003, Tables 3 and 47; 2004 Annual Report of the Supplemental Security Income Program, Table IV.B5.

a. SSI benefits that have been suspended for 12 months or longer are referred to as terminations, even though in some cases (for example, workers under section 1619b) eligibility has not been terminated.

The number of awards of SSI to disabled recipients has varied over time, declining from 1975 to 1982, before increasing rapidly from 1983 to 1993 (Chart 23). The number of awards in 1993 was more than 3½ times the number of awards in 1982.

The entry rate is based on the number of SSI awards per 1,000 in the population aged 0–64 (Chart 24). SSI entry reached a low of 1.1 awards per 1,000 in 1982, before rising to a peak of 3.7 per 1,000 in 1992. This increase in awards is due, in part, to the *Zebley* decision and to Congressionally mandated SSI

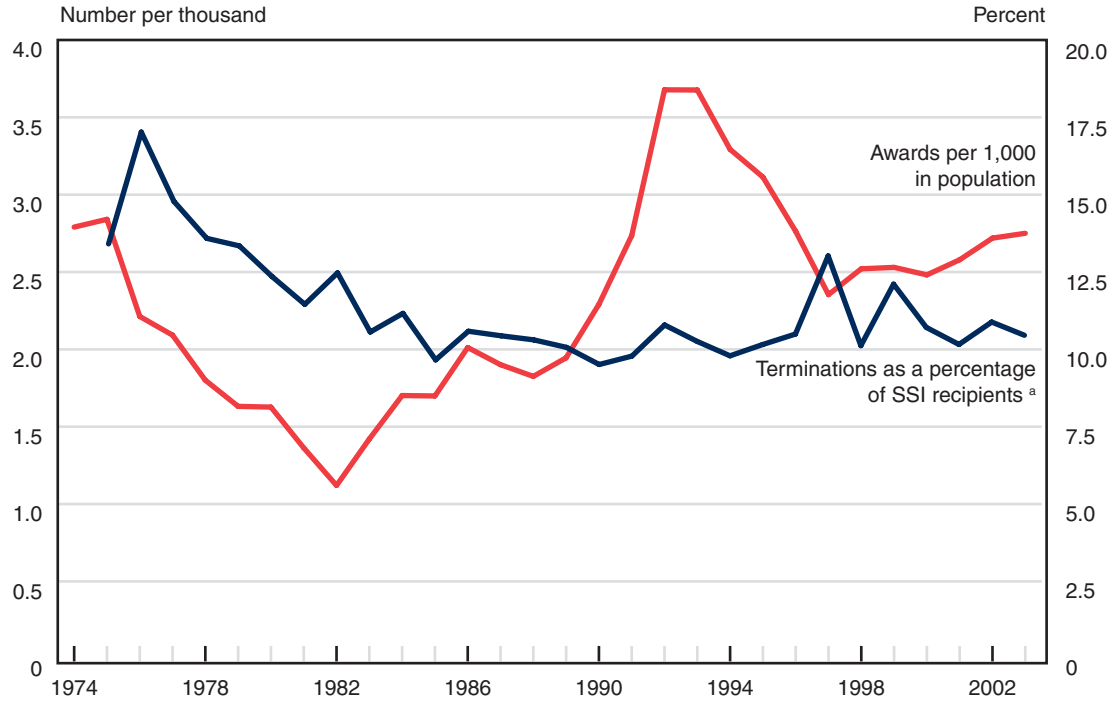
outreach efforts in the early 1990s. The SSI entry rate stabilized in 1997 after 4 years of declines.

Exit from the SSI program can be due to death, medical recovery, excess income (earned or unearned), excess resources, or a change in living arrangements. In many cases, for instance when dealing with excess income, payments are suspended. Suspension of payments for 12 months or longer is generally considered a termination for SSI program purposes, and as such it is counted as a termination in this book. There is no termination for substantial gainful activity. However,

Entry and Exit by SSI Blind and Disabled Adults and Children

NUMBER AND RATE OF AWARDS AND TERMINATIONS (CONT.)

Chart 24. Rate of awards per 1,000 in population aged 0–64 and terminations as a percentage of SSI recipients, 1974–2003



SOURCES: SSI Annual Statistical Report, 2003, Tables 3 and 47; 2004 Annual Report of the Supplemental Security Income Program, Table IV.B5.

NOTE: The reference population for the award rate is the “Selected Social Security Area Population” of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

a. SSI benefits that have been suspended for 12 months or longer are referred to as terminations, even though in some cases (for example, workers under section 1619b) eligibility has not been terminated.

payments are reduced \$1 for every \$2 earned in a month above a \$65 earned income disregard, and cash payments can be eliminated under this offset. Even if cash payments end because of earnings, eligibility for Medicaid can continue under the provisions of section 1619b.

The number of exits from the SSI program declined from 1976 until the mid-1980s (Chart 23). Since 1985 the number of terminations has increased considerably, peaking in 1997 because of welfare reform and other changes.

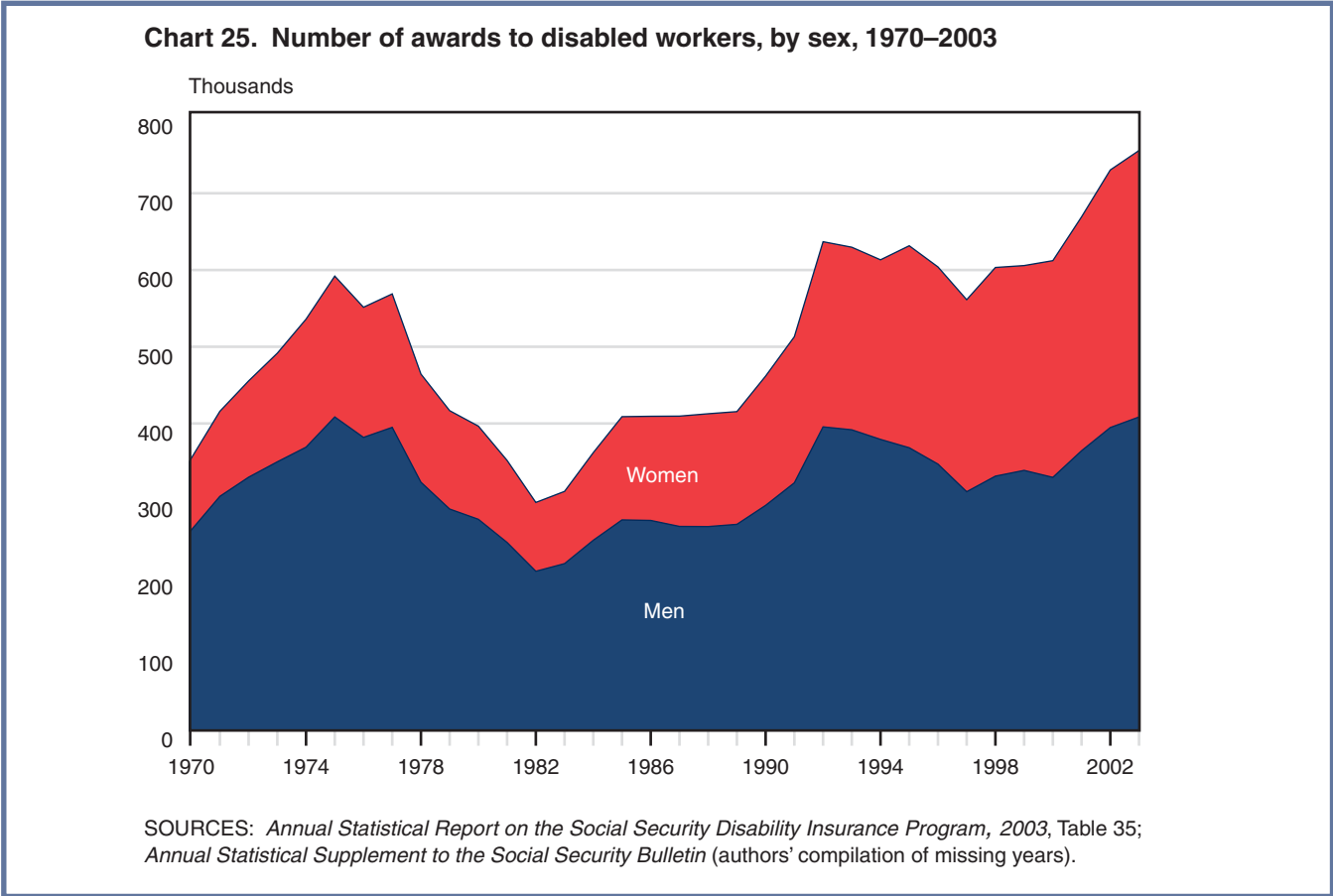
The SSI exit rate, as a proportion of SSI recipients, has generally fluctuated in a narrow band of 10 percent to 13 percent since the late 1970s (Chart 24).

Terminations trended downward in the early 1980s, before the exit rate stabilized for nearly a decade beginning in 1985. In the 1990s, the exit rate increased in 2 years: in 1997 and again in 1999. The increase in 1997 is directly related to two pieces of legislation from 1996: P.L. 104-121, which eliminated drug addiction and alcoholism as a disability, and P.L. 104-193, which changed the definition of disability for SSI children and mandated the review of certain SSI childhood cases. The decrease in 1998 and subsequent increase in 1999 reflect SSA administrative policies that rereviewed SSI children who were terminated as the result of welfare reform and were offered continuation of payments to permit appeals on those cases. The increase in the rate of exit in 1999 reflects, in part, final dispositions of the reviews of SSI children.

Entry by Disabled Workers

NUMBER OF AWARDS, BY SEX

The number of disabled-worker awards has varied over time for both sexes; however, the number of awards has been generally increasing since the early 1980s. Awards to women have been increasing more rapidly than have those for men, both in absolute numbers and as a percentage of awards.



Disabled-worker awards have fluctuated over the period for both sexes. However, since the early 1980s there has been a clear pattern of increase in the number of awards to women. In fact, the proportion of awards to women has increased fairly consistently over the entire period, rising from 26 percent in 1970 to 46 percent in 2003. Although the fact that more women have participated in the labor force and the rate of insured

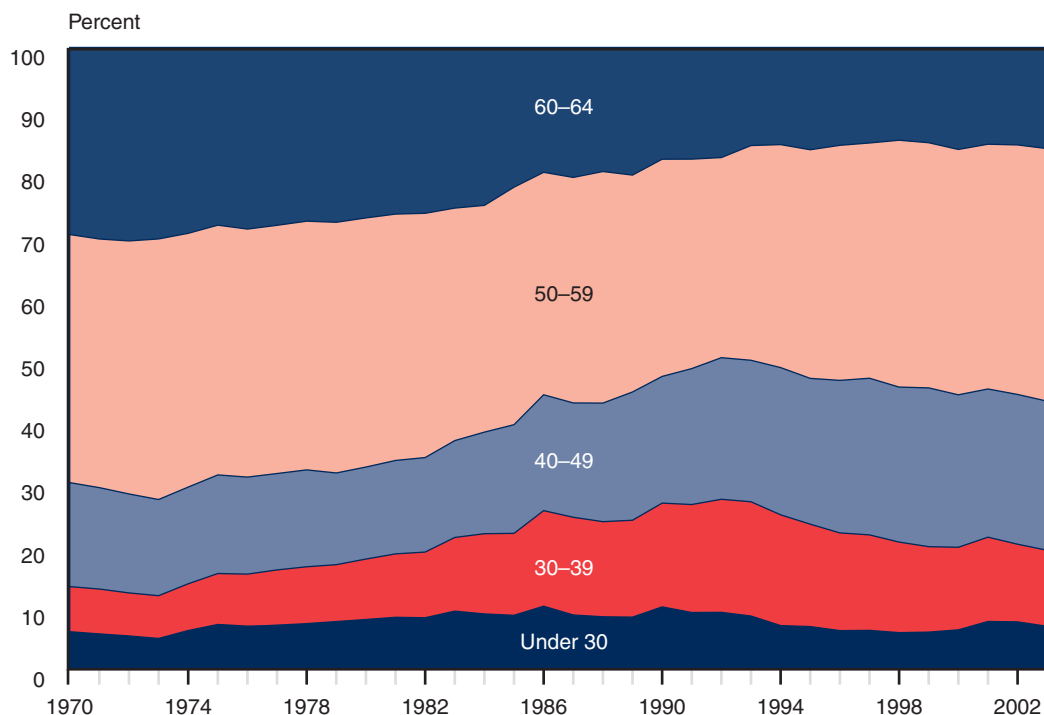
status has played a role in increased awards to women, disabled-worker incidence rates for women have also increased and are now similar to the incidence rates for men. Changes in the structure of occupations generally, as well as the trend toward women filling jobs traditionally held by men, may play a role, as may trends in the incidence of various disabling impairments.

Entry by Disabled Workers

PERCENTAGE DISTRIBUTION OF AWARDS, BY AGE

Since 1970, older workers (aged 60 and older) have constituted a generally decreasing share of new disabled-worker awards. Persons in the middle age groups—those aged 40–49 and 50–59—have represented an increasing percentage of worker awards.

Chart 26. Percentage distribution of awards to disabled workers, by age at entitlement, 1970–2003



SOURCES: *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Table 35; *Annual Statistical Supplement to the Social Security Bulletin* (authors' compilation of missing years).

The number of awards has varied in each age group over time but has tended to increase, particularly for the age groups 40–49 and 50–59. As a percentage of awards, these two age groups make up increasingly large shares of the disability awards over time. At the same time, the oldest age group, 60–64, has had a decreasing share of awards over most of the period, although the percentage has increased slightly since 1998. This change is partially due to the shifting demographics, specifically the aging of the baby boomers, who were born between 1946 and 1964. Changing demographics as a source of this change is further supported by the transitory increase and decrease in the percentages of persons who were under 30 and

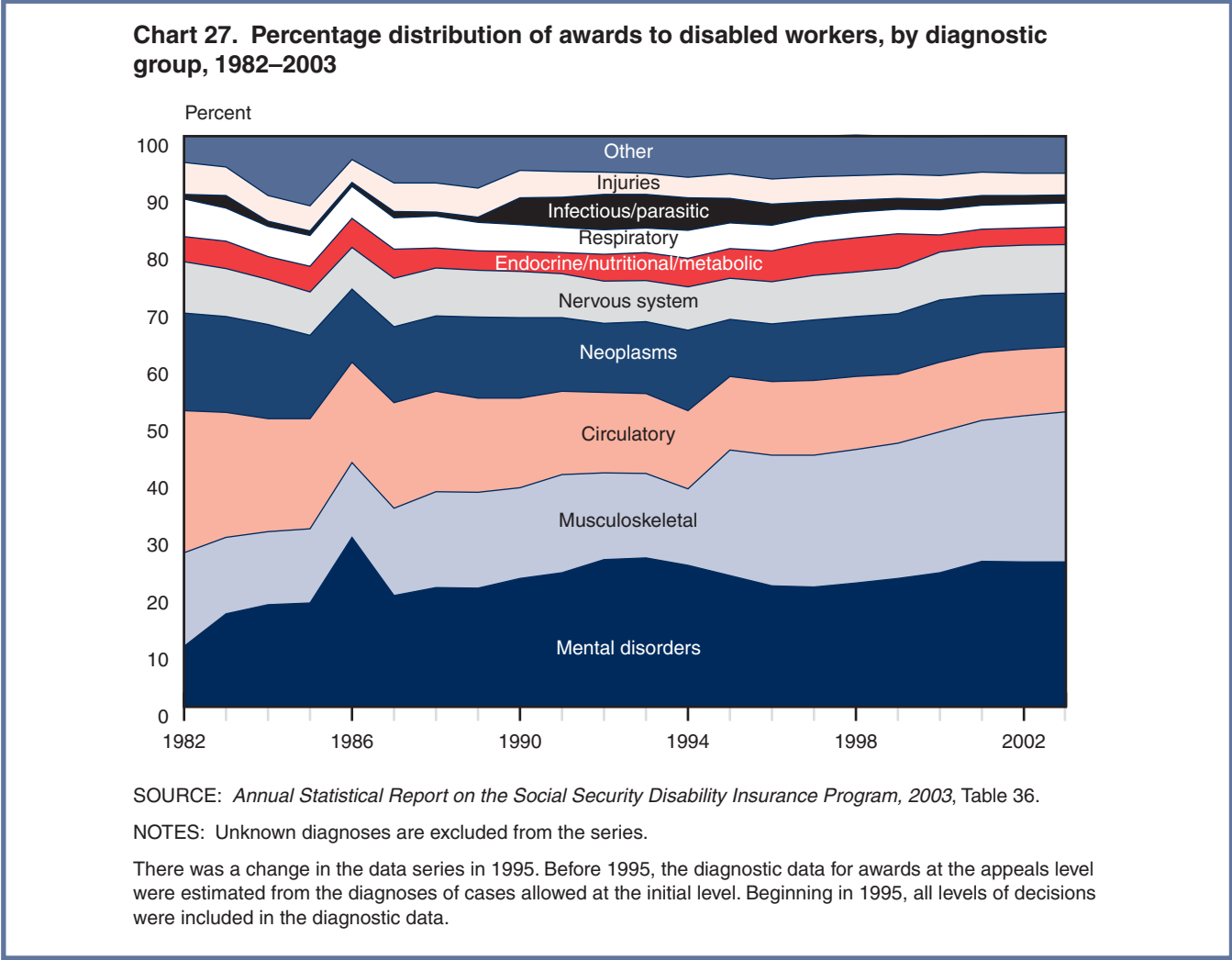
those who were aged 30–39 in the 1980s and early 1990s, as baby boomers first increased and then decreased the number of persons in these age groups. Other data show that while there has been a general trend toward lower age-specific disability incidence rates since the mid-1970s among those aged 45 and older, the decline has been smaller or nonexistent among those younger than 45.²

2. See Tim Zayatz, *Social Security Disability Insurance Program Worker Experience*, Actuarial Studies No. 114 (June 1999) and No. 118 (June 2005) (Washington, DC: Social Security Administration, Office of the Chief Actuary).

Entry by Disabled Workers

PERCENTAGE DISTRIBUTION OF AWARDS, BY DIAGNOSTIC GROUP

The percentage of awards to disabled workers resulting from mental and musculoskeletal impairments has increased significantly, while the percentage of cases attributed to circulatory, neoplasms, and infectious diseases has decreased.



The number of disabled-worker awards for mental and musculoskeletal impairments has grown substantially since 1982. The large increase in mental disorders in 1986 is directly attributable to changes in the decisionmaking process due to the 1984 Social Security Disability Benefits Reform Act (including mandatory specialist reviews of denials) and the fact that many cases were not adjudicated until new mental regulations were issued in 1986. The changes in 1984 also mandated that SSA revise the way it assesses pain,

and after that point musculoskeletal awards began to slowly rise. Other factors may also play a role in the increase in these awards over time, such as an aging population and increases in the number of appeals to administrative law judges.

The percentages of awards represented by mental and musculoskeletal impairments have grown since 1982, while neoplasms and circulatory diseases have declined. Infectious and parasitic diseases show an

Entry by Disabled Workers

PERCENTAGE DISTRIBUTION OF AWARDS, BY DIAGNOSTIC GROUP (CONT.)

increase in the late 1980s, which then began to subside in the mid-1990s. HIV/AIDS cases probably accounted for much of this increase, while new or improved treatments and adjustments to policy may have helped reduce the relative prevalence of HIV/AIDS cases among awards in the late 1990s and after.³ Between

1999 and 2000, the percentage of awards represented by nutritional and metabolic diseases dropped by half and thereafter continued at a lower rate. Elimination of the medical listing for obesity in late 1999 may have accounted for this decline.

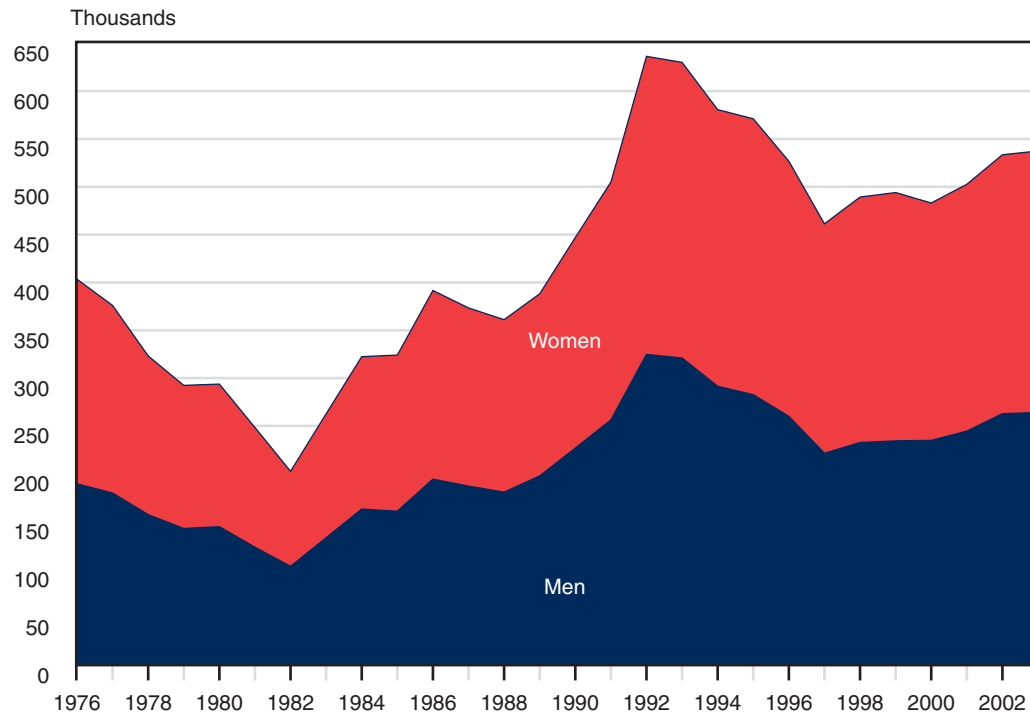
3. Before 1990, HIV/AIDS was not counted in the “Infectious and parasitic disease” category but was included in the “Other” category.

Entry by SSI Blind and Disabled Adults

NUMBER OF AWARDS, BY SEX

The percentage of awards of SSI payments for disability has been fairly constant for men and women: women aged 18–64 represent roughly half of all awards, varying between 49 percent and just under 53 percent from 1976 to 2003. The small variations by sex show no systematic trend.

Chart 28. Number of awards to blind and disabled adults (aged 18–64), by sex, 1976–2003



SOURCE: *SSI Annual Statistical Report, 2003*, Table 49.

NOTE: Unpublished data for missing time points were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 10 percent sample.

The profile of SSI awards to disabled adults changed very little from 1976 to 2003. The percentage of awards to disabled women aged 18–64 has been fairly constant at roughly half of all awards, varying between 49 percent and just under 53 percent during this period. The small variations have no systematic trend. The result is somewhat surprising, since one might expect that fewer women would be awarded SSI payments

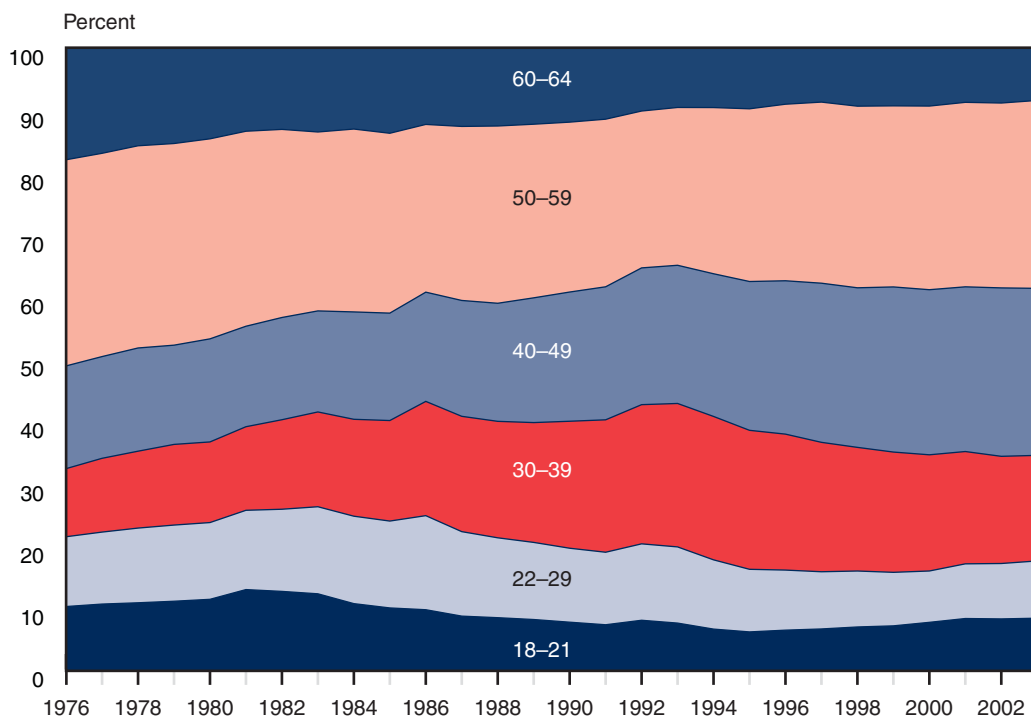
because of the sharp increase in the number of women awarded disabled-worker benefits during this same period. Given that more women are becoming insured for Disability Insurance and that, in general, they are earning more, the share of SSI for women might be expected to decrease. Other factors may be at play as well.

Entry by SSI Blind and Disabled Adults

PERCENTAGE DISTRIBUTION OF AWARDS, BY AGE AT FIRST RECEIPT

Awards of SSI payments to recipients in the middle age groups have increased, which may in part reflect the movement of the baby boomers through the age categories over time.

Chart 29. Percentage distribution of awards to blind and disabled adults (aged 18–64), by age at first receipt, 1976–2003



SOURCE: SSI Annual Statistical Report, 2003, Table 49.

NOTE: Unpublished data for missing time points were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 10 percent sample.

As can be observed in the chart, new awards to recipients in the age group 40–49 increased over the entire period. Awards to persons aged 30–39 also increased, but that growth moderated in the mid-1990s. The changing age profile for SSI blind and disabled adults

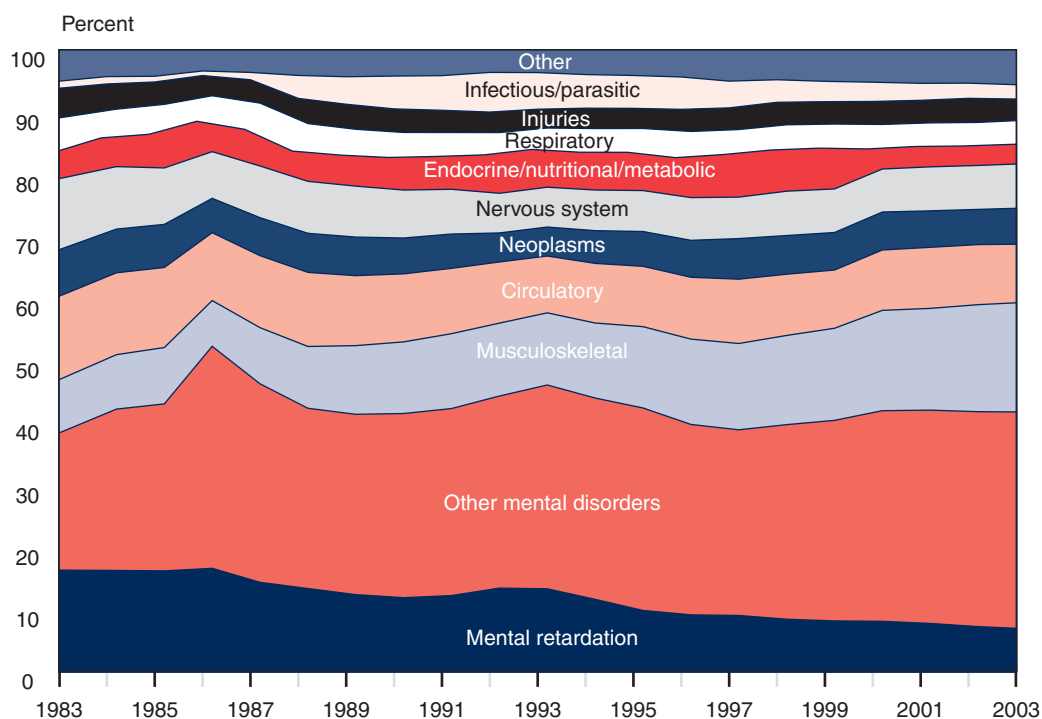
is similar to that observed in the DI worker program. Given the timing and size of the increases in the 30–39 and 40–49 age groups, at least part of this age shift may be demographic, though the changing diagnostic profile may also play a role.

Entry by Blind and Disabled Adults

PERCENTAGE DISTRIBUTION OF AWARDS, BY DIAGNOSTIC GROUP

The proportion of SSI awards based on mental disorders (other than mental retardation) and musculoskeletal diseases among all SSI awards has increased over time, while the proportion based on mental retardation has declined.

Chart 30. Percentage distribution of awards to blind and disabled adults (aged 18–64), by diagnostic group, 1983–2003



SOURCE: SSI Annual Statistical Report, 2003, Table 49.

NOTES: Unpublished data for missing time points were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 10 percent sample.

Unknown diagnoses are excluded from the series.

A change in the data series occurred in 1995. Before 1995, the diagnostic data for awards at the appeals level were estimated from the diagnoses of cases allowed at the initial level. Beginning in 1995, all levels of decisions were included in the diagnostic data.

There are clear trends showing increasing SSI awards for mental disorders (other than mental retardation) and for musculoskeletal diseases. The same increases were found for awards to disabled workers. Adult SSI awards for mental retardation have declined both in number and as a percentage of awards during most of the 1983–2003 period. As was true with awards to disabled workers, the percentage of SSI awards for circulatory

diseases declined from 1983 to 2003, and the increase in the number and percentage of awards for infectious and parasitic diseases (mostly HIV/AIDS) that began in the late 1980s moderated somewhat in the mid-1990s.⁴

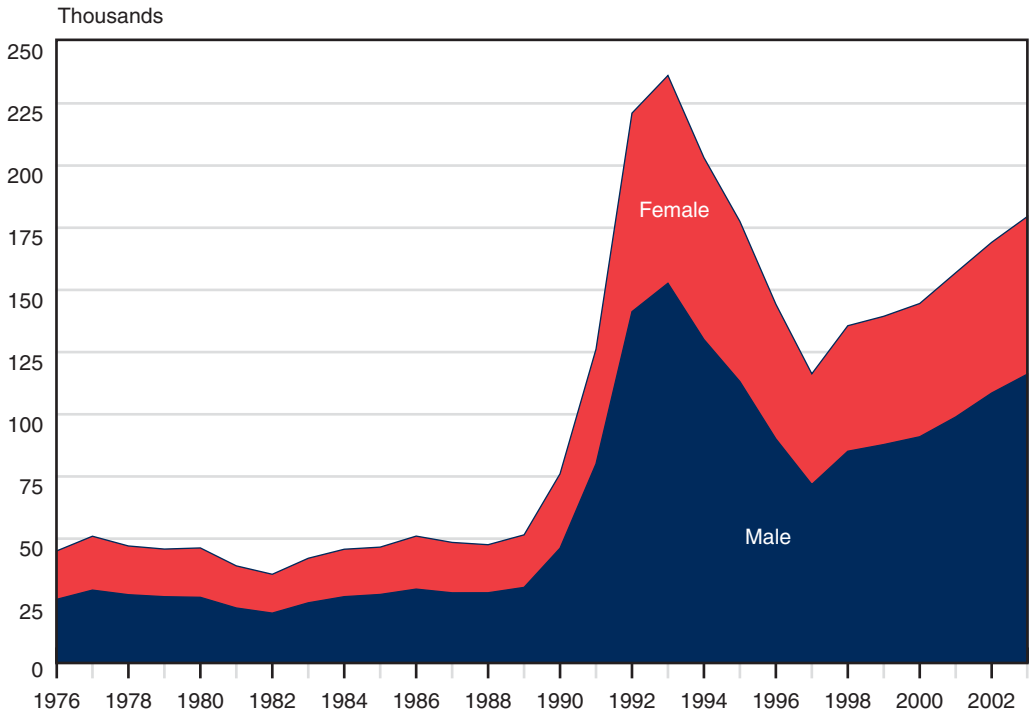
4. Before 1990, HIV/AIDS was not counted in the “Infectious and parasitic disease” category but was included in the “Other” category.

Entry by SSI Disabled Children

NUMBER OF AWARDS, BY SEX

From 1976 to 2003, the percentage of males being awarded SSI children's benefits increased from 57 percent to nearly 65 percent. There was a large increase in the proportion of awards to males after the *Zebley* decision in 1990.

Chart 31. Number of awards to disabled children, by sex, 1976–2003



SOURCE: *SSI Annual Statistical Report, 2003*, Table 48.

NOTE: Unpublished data for missing time points were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 10 percent sample.

The category of SSI disabled children has seen changes to its profile of awards over time. Awards to males have historically outnumbered awards to females, and there has been a substantial increase in awards to males over the period 1976 to 2003. In 2003, there were nearly twice as many awards to males as to females. The percentage of awards to males increased

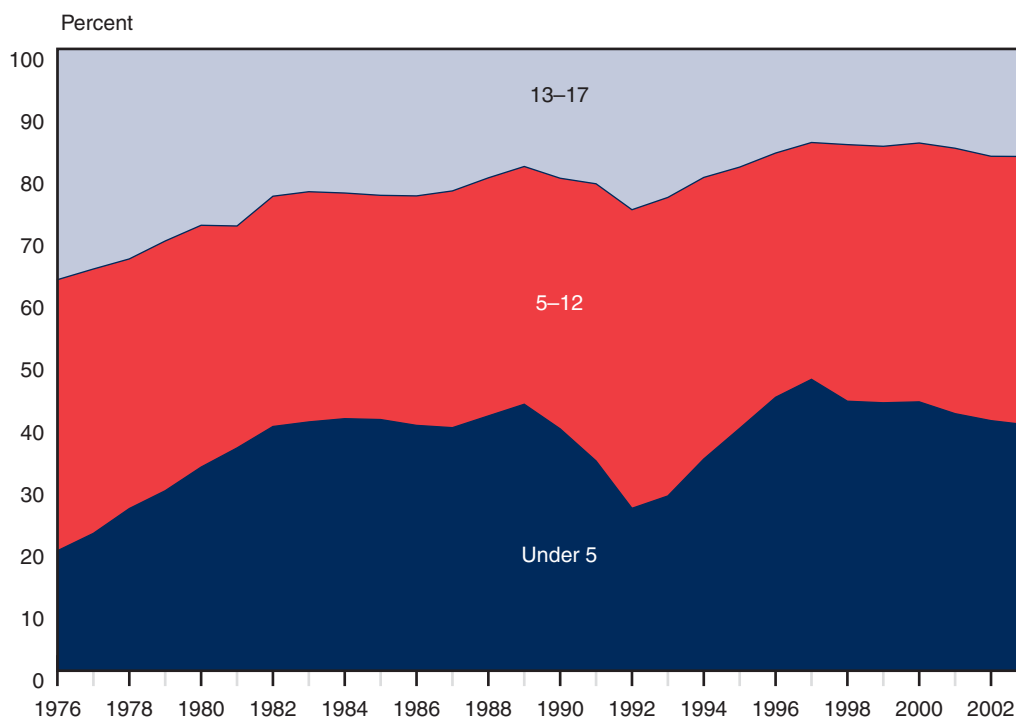
dramatically after the *Zebley* decision in 1990, rising to nearly 65 percent in 1993. The percentage of males awarded benefits declined from 1993 until 1997 and has been increasing since. In 2003, the percentage of males was again nearing 65 percent and reached a historical high.

Entry by SSI Disabled Children

PERCENTAGE DISTRIBUTION OF AWARDS, BY AGE

In the early 1990s following the *Zebley* decision, the percentage of awards going to children in the older age groups increased for a time, particularly in the age group 5–12. In 1992 the percentage of awards to children under the age of 5 began to increase; however, since 1997, it has been decreasing.

Chart 32. Percentage distribution of awards to disabled children, by age at first receipt, 1976–2003



SOURCE: *SSI Annual Statistical Report, 2003*, Table 48.

NOTE: Unpublished data for missing time points were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 10 percent sample.

The *Zebley* decision in 1990 led to a large but temporary increase in the percentage of awards for children aged 5–12 and, to a lesser extent, for those aged 13–17. The proportion of awards to children 13 and older has shown slight increases since 1997, reversing the trend of significant decreases in the late 1970s and 1980s. The percentage of awards to children aged 5–12 increased dramatically after *Zebley* and began to decline even before the implementation in 1996 of statutorily mandated changes to the children’s criteria, which altered the way that SSA assessed behavioral problems. Since 1997, both the number and percentage of awards to children aged 5–12 have been increasing modestly. With the exception of the temporary increase in other age groups mentioned above, the percentage

of SSI disabled child awards to children under the age of 5 generally increased until it reached a peak in 1997 and has decreased slightly since then. The increase in awards to children under 5 that began in 1993 is due, in part, to SSA regulations issued in 1991 that made low birth weight functionally equivalent to meeting a medical listing.⁵ The number of awards based on low birth weight in this age group has continued to increase, despite the trend toward a smaller proportion of awards for children under 5.

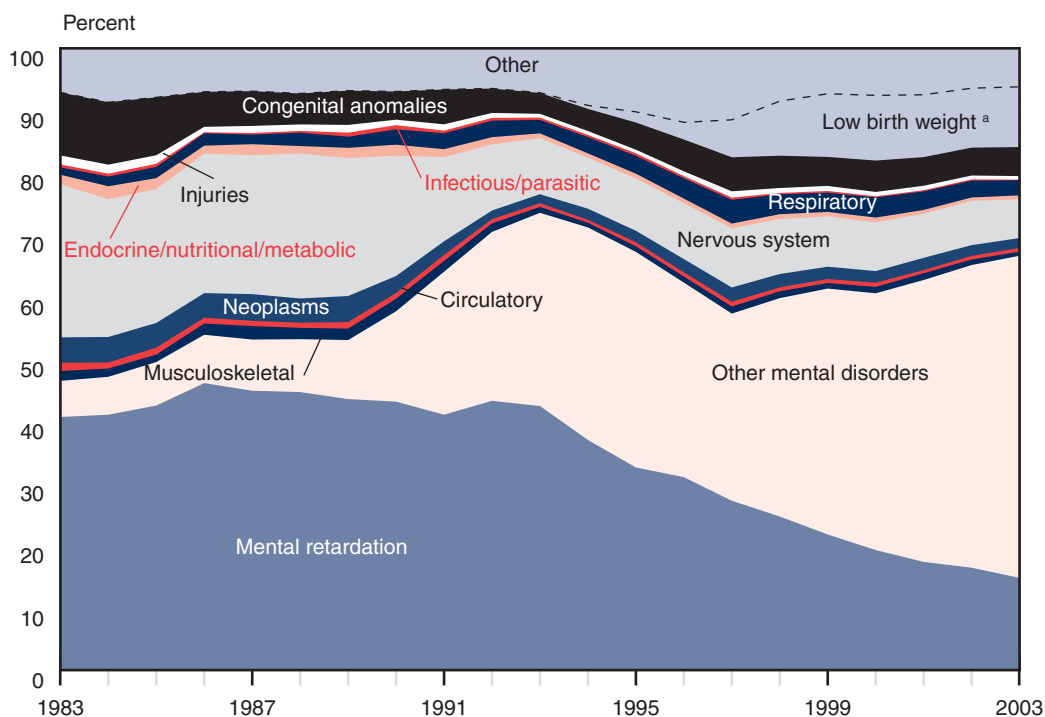
5. Other factors included removal of prematurity as a requirement for an allowance based on low birth weight in 1993. Specific impairment codes for low birth weight were adopted in February 1994. Before 1994, low birth weight awards fell under the “Other” category.

Entry by SSI Disabled Children

PERCENTAGE DISTRIBUTION OF AWARDS, BY DIAGNOSTIC GROUP

Significant changes in the distribution of diagnoses have occurred among awards to SSI disabled children. The percentage of awards due to mental retardation has been declining since the mid-1980s, while the percentage of awards for other mental disorders has increased dramatically. Nervous system impairments declined as a percentage of awards throughout the 1980s into the early 1990s, while awards for low birth weight increased after 1992.

Chart 33. Percentage distribution of awards to disabled children, by diagnostic group, 1983–2003



SOURCE: SSI Annual Statistical Report, 2003, Table 48.

NOTES: Unpublished data for low birth weight and missing time points were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 10 percent sample.

Unknown diagnoses are excluded from the series. Before 1995, the diagnostic data for awards at the appeals level were estimated from the diagnoses of cases allowed at the initial level. Beginning in 1995, all levels of decisions were included in the diagnostic data.

a. "Low birth weight" is part of the "Other" category but is shown separately here.

Very significant changes have occurred in the distribution of diagnoses among awards to SSI disabled children. The percentage of awards based on mental retardation has been declining since the mid-1980s, while the percentage of awards for other mental

disorders has increased dramatically. The increase in the percentage of awards based on other mental disorders is likely due to several factors: the 1984 Amendments and revised mental listings; the *Zebley* case in 1990 that resulted in increased awards for

Entry by SSI Disabled Children

PERCENTAGE DISTRIBUTION OF AWARDS, BY DIAGNOSTIC GROUP (CONT.)

mental disorders that cause behavioral problems; and a change to more precise diagnostic coding for children with certain cognitive limitations, that is, a change in the diagnostic coding of “borderline mental retardation” from the “Mental retardation” diagnostic group to the “Other mental disorders” group. The change in diagnostic coding cannot account for the entire reduction in the diagnoses for mental retardation, however, since the decline began before 1993.

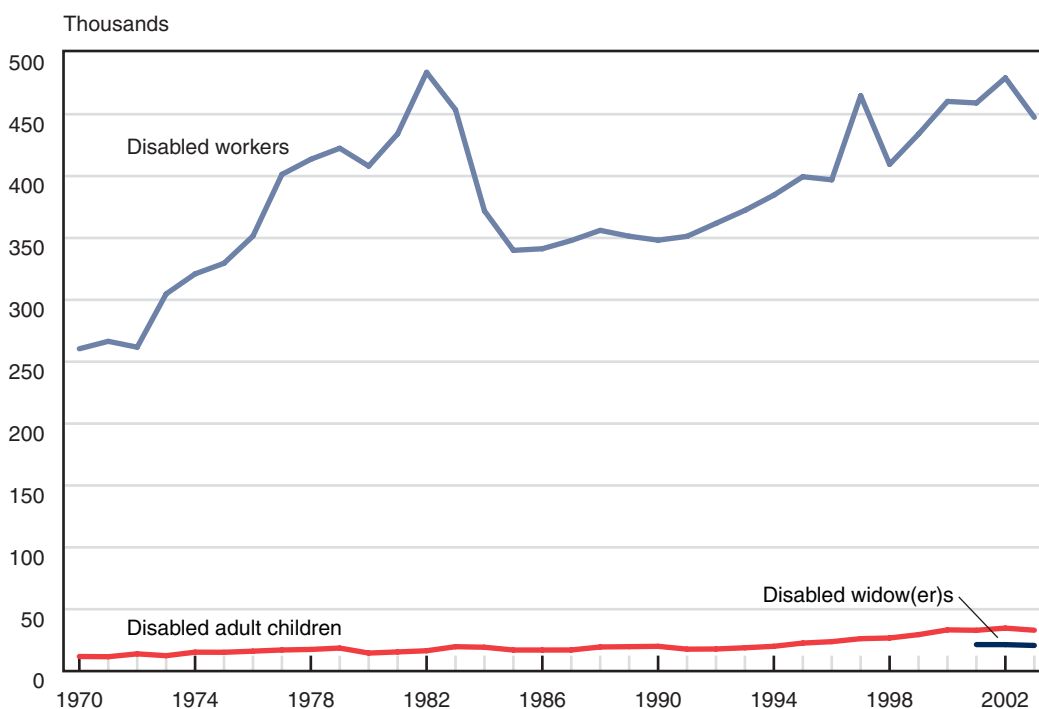
“Nervous system” diseases declined as a percentage of awards throughout the 1980s into the early 1990s, while the percentage of awards for “Other” disorders increased considerably after 1993. The increase in awards for “Other” and “Low birth weight” are due, in part, to *Zebley*-related changes. After the *Zebley* decision, SSA instituted a policy in which low birth weight was considered functionally equivalent to meeting a medical listing.

Exit by Social Security Disabled Beneficiaries

NUMBER AND RATE OF TERMINATIONS

The number of terminations from the Social Security disability program has generally been increasing since the mid-1980s. The rate of termination of disabled workers declined from 1982 until 1996, and, with the exception of 1997 and terminations for drug addiction and alcoholism, the rate was fairly stable until 2002.

Chart 34. Number of terminations for disabled Social Security beneficiaries, by type of beneficiary, 1970–2003



SOURCE: Annual Statistical Report on the Social Security Disability Insurance Program, 2003, Table 45.

NOTE: Data for disabled widow(er)s were not available before 2001.

The number of terminations of disabled workers rose fairly consistently from 1970 to 1982, after which terminations began to decline because of reductions in the processing of continuing disability reviews by some states. This was followed by a nationwide moratorium on continuing disability reviews in April 1984 and the medical improvement review standard that was enacted in 1984.⁶ The number of terminations began to rise again in 1986 and grew consistently with two

exceptions: a large and temporary increase in 1997 that resulted from welfare reform legislation that ended entitlement to benefits based on drug addiction and alcoholism; and a decline in the number of terminations in 2003. The legislated increase in the full retirement age that took place for workers attaining age 62 in 2000, and the resulting decrease in retirement conversions, would account for much of this decline in 2003.⁷ The number of terminations of disabled adult children has varied but increased overall during the 1970–2003 period.

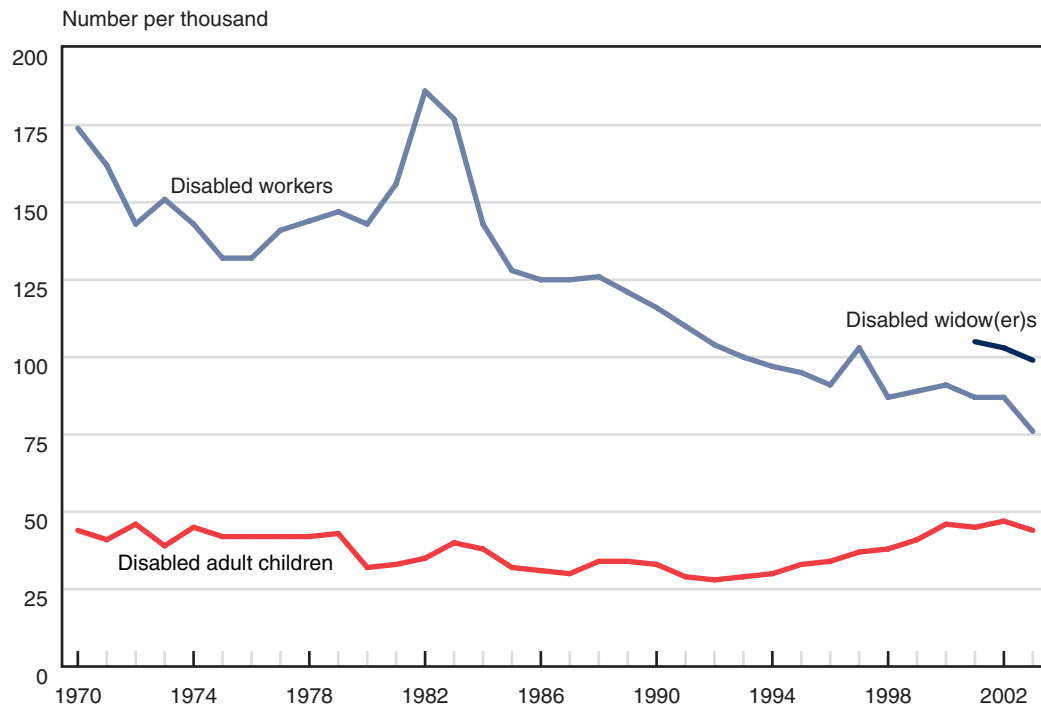
6. Although the Secretary of Health and Human Services implemented the nationwide moratorium on CDRs, the governors of many states had ordered the Disability Determination Services to stop conducting CDRs long before that date. CDRs were resumed at a much diminished pace under the medical improvement review standard in 1986.

7. Disabled widow(er)s did not have an increase in their full retirement age (and age of conversion) until 2005, because those who attained the age of 60 in 2000 were the first affected.

Exit by Social Security Disabled Beneficiaries

NUMBER AND RATE OF TERMINATIONS (CONT.)

Chart 35. Rate of termination per 1,000 disabled Social Security beneficiaries, by type of beneficiary, 1970–2003



SOURCE: *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Table 45.

NOTE: Data for disabled widow(er)s were not available before 2001.

Despite the general pattern of increasing numbers of terminations in the Social Security disability program, terminations have not kept pace with the number of disability awards, and the program has grown. The rate of termination per 1,000 disabled-worker beneficiaries declined nearly every year between 1982 and 1996. Although part of this decline is likely due to the medical improvement review standard enacted in 1984, it is also likely that increased awards of benefits to younger persons based on mental disorders contributed to this result. The brief increase in the rate of terminations of disabled workers in 1997 was due, at least in part, to the change in the drug addiction and alcoholism policy and the dedicated funding for continuing disability reviews that began in 1996 as part of P.L. 104-121.

Between 1998 and 2002, the rate of termination of disabled workers remained relatively stable at

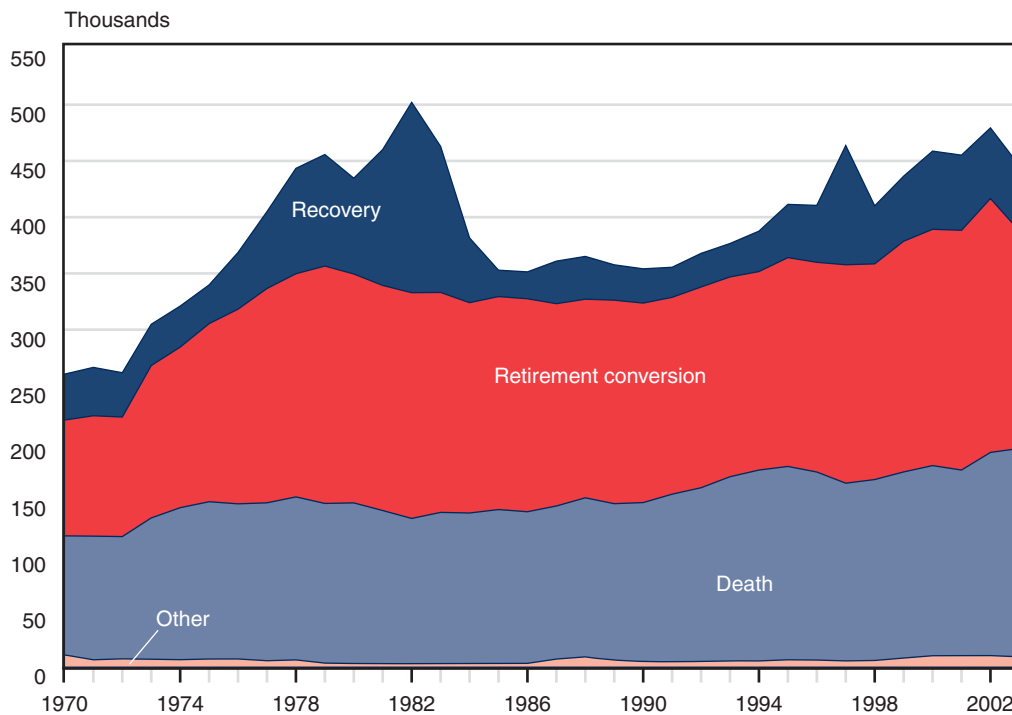
historically low rates, despite the dedicated CDR funding that was in place from 1996 to 2002. In 2003, the first increase in the full retirement age reduced the rate of termination for disabled workers. Although the termination rate of disabled adult children dipped in 1980 and again in 1991, it has been increasing since then. Termination rates for disabled workers and disabled adult children have been converging since the early 1990s, although the rate for workers remains nearly twice that of adult children. Chart 35 shows that, from the limited data available, the termination rate for disabled widow(er)s is higher than that for disabled workers. This higher termination rate may be due to the fact that widow(er)s are not eligible for benefits until they are 50 and are consequently closer to a conversion to Social Security (OASI) widow(er)s benefits.

Exit by Disabled Workers

NUMBER AND RATE OF TERMINATIONS, BY REASON

The result of changes in policy concerning drug addiction and alcoholism is evident in the large, temporary increase in recoveries in 1997. The overall rate of termination decreased consistently until the 1-year rise in 1997 resulting from terminations of benefits for drug addiction and alcoholism.

Chart 36. Number of terminations for disabled workers, by reason, 1970–2003



SOURCES: Tim Zayatz, *Social Security Disability Insurance Program Worker Experience*, Actuarial Studies No. 114 (June 1999) and No. 118 (June 2005) (Washington, DC: Social Security Administration, Office of the Chief Actuary), Table 5; *Annual Statistical Supplement to the Social Security Bulletin* (authors' compilation of missing data).

Terminations of disabled-worker beneficiaries peaked in 1982 (both in number and as a rate), driven mostly by recovery terminations as a result of accelerated CDRs.⁸ After dropping off dramatically, the number of

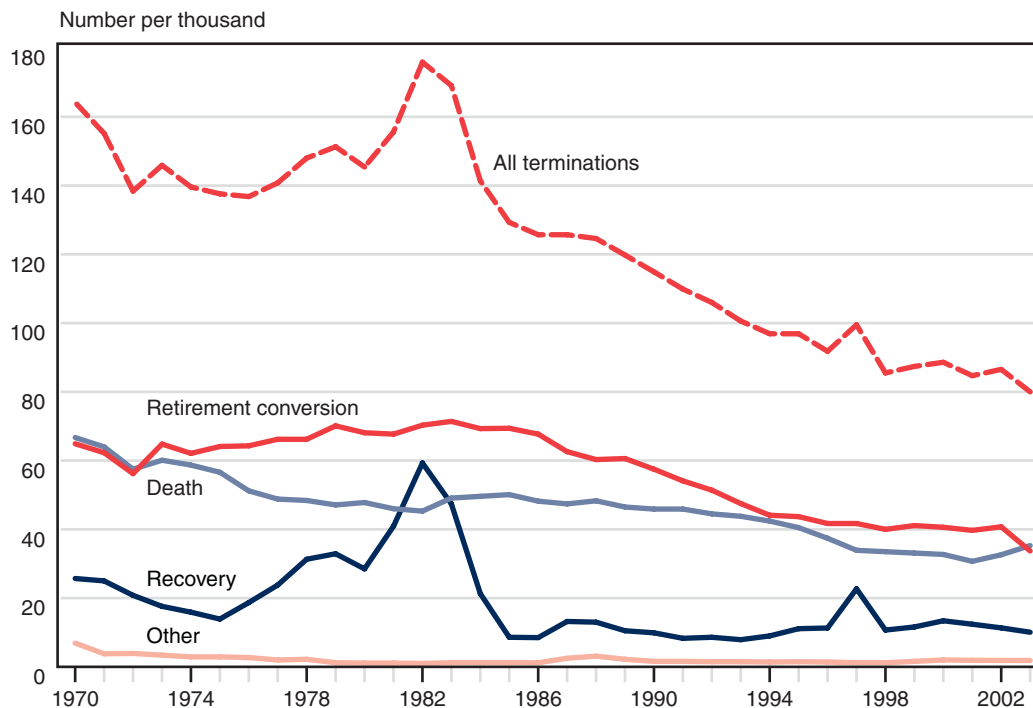
recoveries (which includes medical improvement and terminations for substantial gainful activity, or SGA) has increased since the mid-1980s (Chart 36). The result of changes in drug addiction and alcoholism policy is evident in the large, temporary increase in recoveries in 1997.

8. The history of policy changes that influenced terminations is discussed in greater detail in a later section.

Exit by Disabled Workers

NUMBER AND RATE OF TERMINATIONS, BY REASON (CONT.)

Chart 37. Rate of termination per 1,000 disabled-worker beneficiaries, by reason, 1970–2003



SOURCES: Tim Zayatz, *Social Security Disability Insurance Program Worker Experience*, Actuarial Studies No. 114 (June 1999) and No. 118 (June 2005) (Washington, DC: Social Security Administration, Office of the Chief Actuary), Table 5; *Annual Statistical Supplement to the Social Security Bulletin* (authors' compilation of missing data).

Although the number of terminations of disabled workers has generally been rising since the mid-1980s, the overall (or total) rate of terminations decreased consistently until the 1-year rise in 1997, which was the result of terminations for drug addiction and alcoholism (Chart 37). The rate has been relatively stable since then.

The rate of termination for recovery (medical improvement and earnings above the SGA level) generally increased from the early 1990s until 2000,

then began to decline. Special funding of continuing disability reviews in recent years may have helped increase terminations for medical recovery.

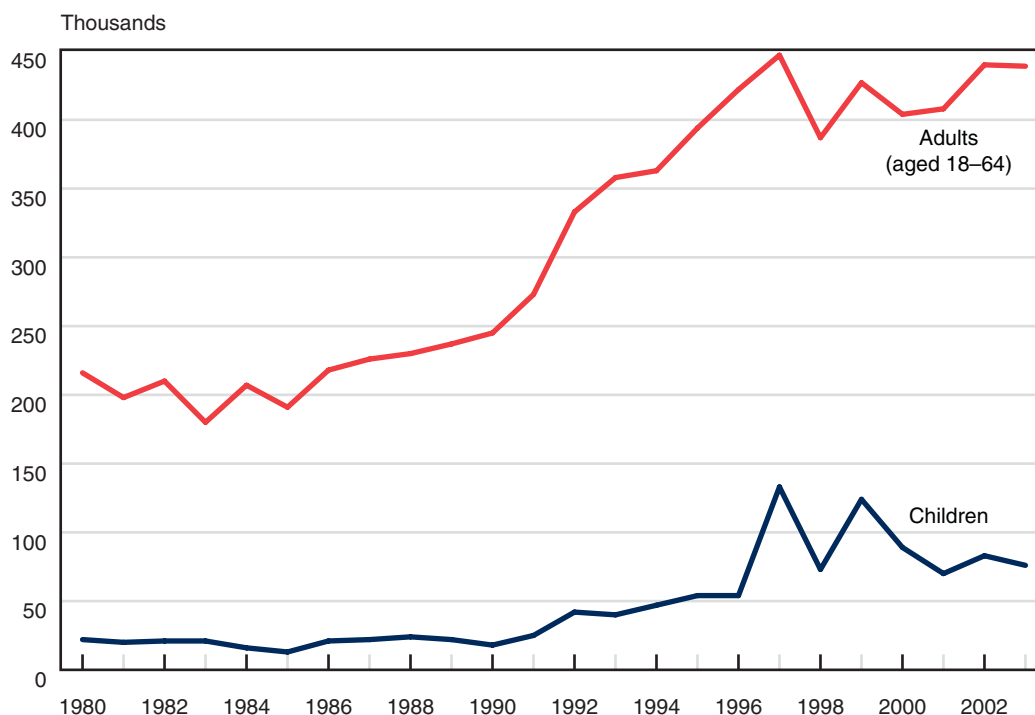
Terminations due to death and conversion to retirement (old-age) benefits have been declining, reflecting the changing age profile of the beneficiary population, which was discussed earlier. The decline in old-age conversions in 2003 is the result, in part, of the delay of conversions because of the increases in the retirement age that are being phased in.

Exit by SSI Blind and Disabled Adults and Children

NUMBER AND RATE OF TERMINATIONS

The number of terminations of SSI payments rose fairly consistently for blind and disabled adults and children until 1997. Since then the number of terminations has varied at levels slightly lower than those attained in 1997. The rate of terminations of disabled adult SSI recipients remained fairly constant from 1980 to 2003, while the rate of terminations of disabled child recipients has fluctuated greatly.

Chart 38. Number of terminations for blind and disabled adults and children, 1980–2003



SOURCE: 2004 Annual Report of the Supplemental Security Income Program, Table IV.B5.

NOTE: SSI benefits that have been suspended for 12 months or longer are referred to as terminations, even though in some cases (for example, workers under section 1619b) eligibility has not been terminated.

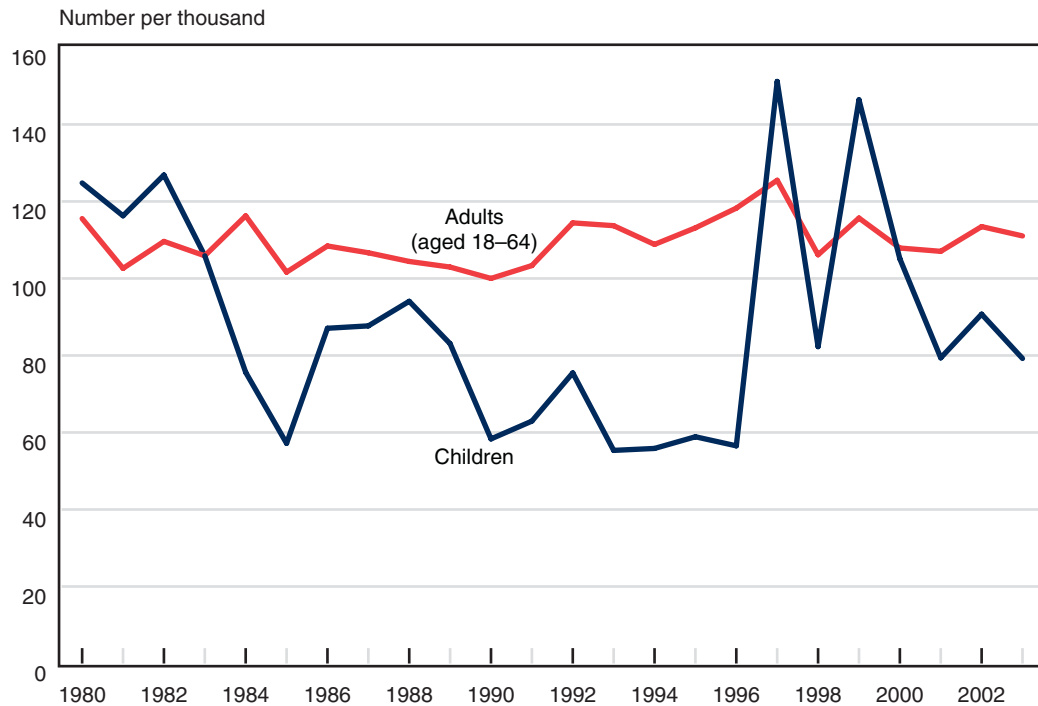
The number of terminations of blind and disabled adult SSI recipients (aged 18–64) generally increased between 1980 and 1997 and, despite some reductions in the late 1990s, has roughly doubled. The moratorium in 1984 on continuing disability reviews (and earlier state actions) seems to have had little impact on the number of SSI terminations, although the rate of

terminations for SSI disabled children may have been affected. After reaching a peak in 1997, in part because of the 1996 changes that terminated payments based on drug addiction and alcoholism and altered SSI policy toward children, SSI terminations decreased; however, for SSI adults, terminations are once again approaching the 1997 level.

Exit by SSI Blind and Disabled Adults and Children

NUMBER AND RATE OF TERMINATIONS (CONT.)

Chart 39. Rate of termination for blind and disabled adults and children per 1,000 recipients in age group, 1980–2003



SOURCES: 2004 Annual Report of the Supplemental Security Income Program, Table IV.B5; SSI Annual Statistical Report, 2003, Table 3.

NOTE: SSI benefits that have been suspended for 12 months or longer are referred to as terminations, even though in some cases (for example, workers under section 1619b) eligibility has not been terminated.

The rate of terminations for blind and disabled adult SSI recipients has been relatively consistent from 1980 to 2003, varying modestly but staying within the range of 100 to 120 per thousand, except in 1997. In contrast, the rate of terminations for SSI disabled children has witnessed large fluctuations, with the rate falling below 60 per thousand and rising to 150 per thousand. The large decline between 1982 and 1985 probably reflects the moratorium on continuing disability reviews and earlier state actions. The peaks in 1997 and 1999 reflect the childhood redeterminations mandated by welfare reform legislation in 1996 (and the administrative reviews of those redeterminations that followed). The mandated redeterminations of SSI

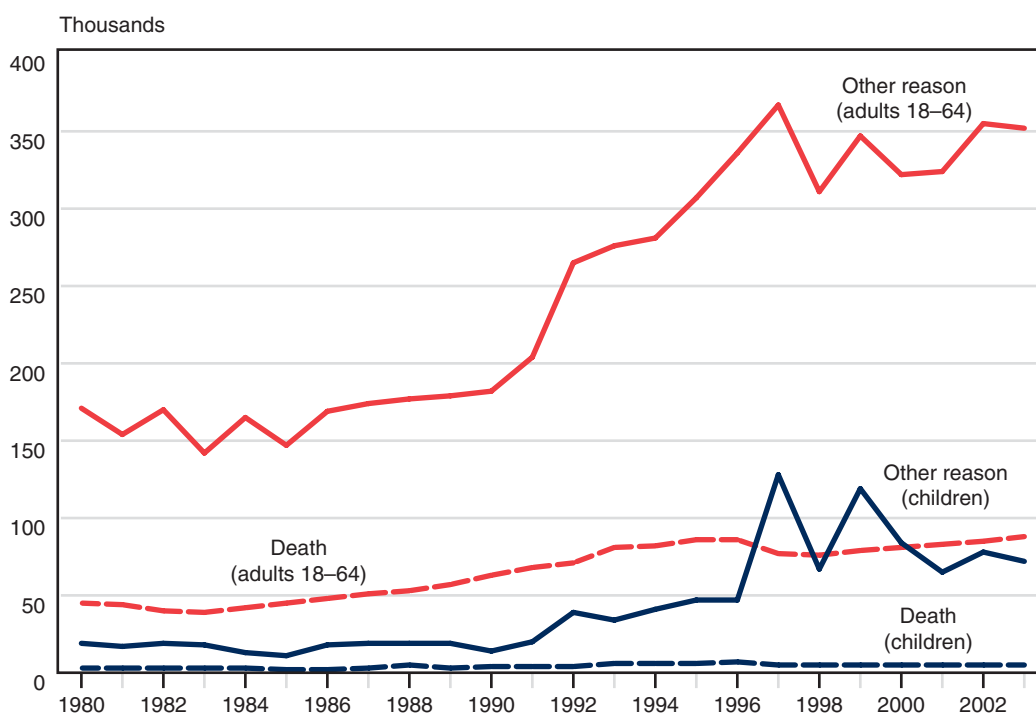
children attaining the age of 18 and reviews by the first birthday of children with low birth weight (P.L. 104-193) have also contributed to the higher rate of terminations of SSI disabled children since 1997. Before 1996, few continuing disability reviews were conducted on SSI disabled recipients. In 1994, Congress mandated that continuing disability reviews be conducted on a minimum of 100,000 SSI recipients a year between 1996 and 1998 (P.L. 103-296). In 1996, Congress provided special dedicated funding for the agency to conduct CDRs on the disabled (both Social Security and SSI disabled) from 1996 to 2002 (P.L. 104-121), which led to increased SSI terminations for medical improvement during that period.

Exit by SSI Blind and Disabled Adults and Children

NUMBER, RATE, AND PERCENTAGE DISTRIBUTION OF TERMINATIONS, BY REASON

The result of changes during the welfare reform era is evident in the large, temporary increase in the number of terminations for disabled adults and children in 1997. The rate of terminations for death and for other reasons has been relatively stable for disabled adult SSI recipients during the 1980–2003 period. The rate of termination for death among SSI disabled children has been low and decreasing, while the rate of terminations for all other reasons has varied dramatically for SSI children and adults.

Chart 40. Number of terminations for blind and disabled adults and children, by reason, 1980–2003



SOURCE: 2004 Annual Report of the Supplemental Security Income Program, Tables IV.B3 and IV.B4.

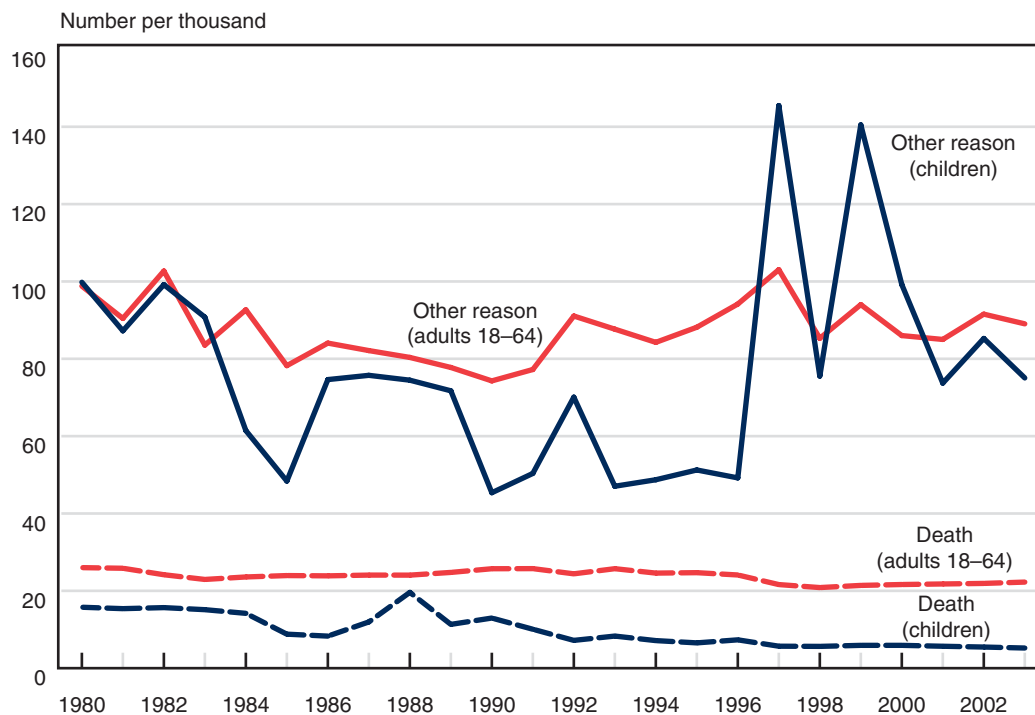
Detailed data on the reason for terminations for disabled SSI recipients is available only for 1988 and later years. The data in Charts 40 and 41 for the period 1980 to 2003 are limited to terminations of SSI disabled recipients for death and all other reasons. Charts 42 and 43 show the percentage of terminations by additional categories for a shorter period (1988 to 2003).

The number of deaths of SSI disabled children was relatively constant, while deaths of SSI disabled adults (aged 18–64) rose from the mid-1980s to the mid-1990s. The rate of termination for reasons other than death has varied over time. The total number of terminations for SSI adults peaked in 1997, in part because of program changes in the welfare reform era.

Exit by SSI Blind and Disabled Adults and Children

NUMBER, RATE, AND PERCENTAGE DISTRIBUTION OF TERMINATIONS, BY REASON (CONT.)

Chart 41. Rate of termination for blind and disabled adults and children per 1,000 recipients in age group, by reason, 1980–2003



SOURCES: 2004 Annual Report of the Supplemental Security Income Program, Tables IV.B3 and IV.B4; SSI Annual Statistical Report, 2003, Table 3.

Note, however, that the number of adult SSI recipients found to be no longer disabled (Chart 42) peaked in 1996, following implementation of P.L. 104-121, which mandated the removal of persons for whom drug abuse or alcoholism was a materially contributing factor to their disability. Changes in the SSI program related to welfare reform (P.L. 104-193) resulted in a high number of terminations of disabled children from SSI in 1997. As the result of continuation of payments and reviews of these redeterminations of children, terminations fell in 1998 and rose again in 1999 as final dispositions were entered. The effect of these changes on the size of the SSI program for disabled children is shown dramatically in Chart 43. The percentage of terminations due to no longer being disabled increased

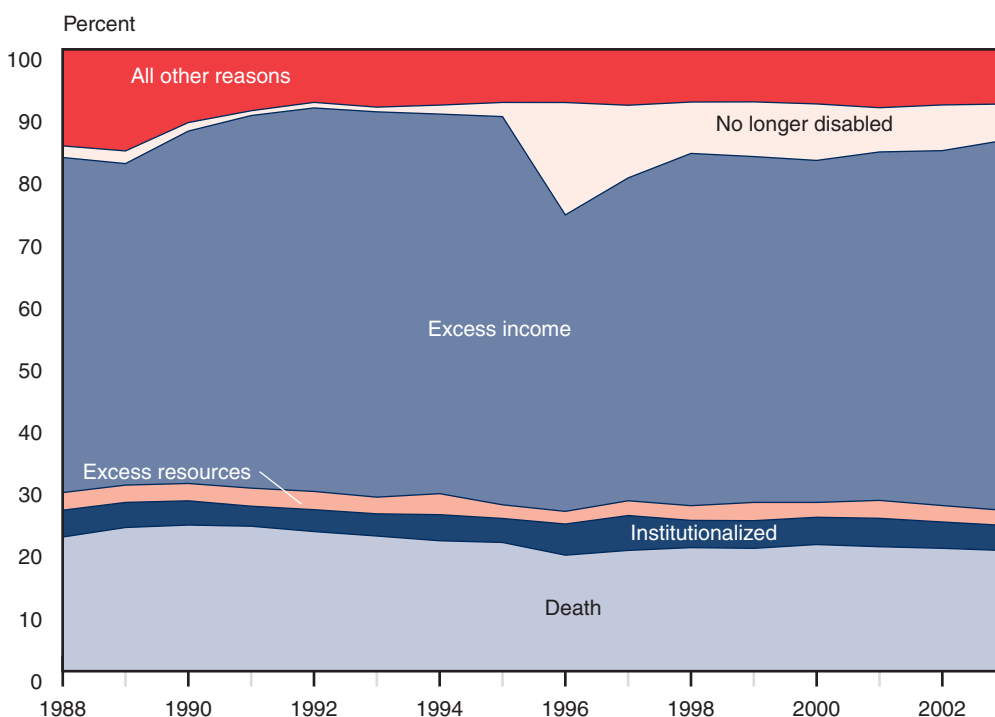
dramatically in 1997, then began to tail off. The trend has clearly been toward higher numbers of terminations for reasons other than death.

The death rates were relatively constant for SSI children and adults until downward trends began in the mid-1980s for children and around 1995 for adults (Chart 41). Even though the decline in death rates for children began before the *Zebley* decision in 1990, there has been a consistent decline in the death rates for children since 1990 that probably reflects, at least in part, changes resulting from the *Zebley* decision and increased numbers of children with mental disorders receiving SSI.

Exit by SSI Blind and Disabled Adults and Children

NUMBER, RATE, AND PERCENTAGE DISTRIBUTION OF TERMINATIONS, BY REASON (CONT.)

Chart 42. Percentage distribution of terminations for blind and disabled adults (aged 18–64), by reason, 1988–2003



SOURCES: *SSI Annual Statistical Report, 2003*, Table 61; data for earlier years were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 1 percent sample.

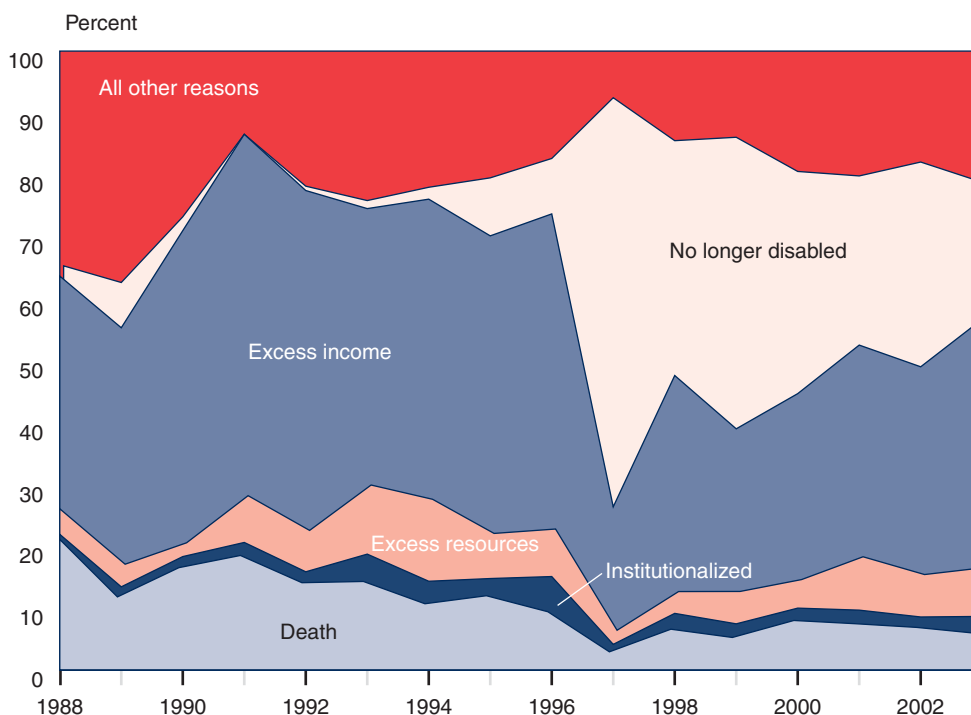
The rate of termination for reasons other than death has varied over time, particularly for SSI children. The rate of termination for SSI adults peaked twice—in 1982 during the period of accelerated disability reviews and again in 1997 after Congress mandated changes to the SSI program (Chart 41). Terminations of SSI children for reasons other than death peaked twice, once in 1997 and again in 1999. In 1996, welfare reform legislation changed the statutory definition of

disability for children and ordered redeterminations of cases allowed on the basis of the criteria resulting from the *Zebly* decision. In 1998, benefit continuation while cases were reviewed and appeals undertaken was offered to children who had been terminated. The final disposition of the welfare reform redeterminations occurred in 1999, resulting in the higher termination rate.

Exit by SSI Blind and Disabled Adults and Children

NUMBER, RATE, AND PERCENTAGE DISTRIBUTION OF TERMINATIONS, BY REASON (CONT.)

Chart 43. Percentage distribution of terminations for disabled children, by reason, 1988–2003



SOURCES: *SSI Annual Statistical Report, 2003*, Table 61; data for earlier years were obtained from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 1 percent sample.

As can be seen in Charts 42 and 43, the impact of Congressionally mandated CDRs for SSI, particularly for children awarded payments because of low birth weight and redeterminations of SSI children reaching age 18, coupled with dedicated CDR funding, resulted in larger proportions of terminations because recipients were found to be no longer disabled. Blind and disabled adult SSI recipients for whom drug abuse or alcoholism

was material to a prior finding of disability were no longer considered disabled after 1996, which increased terminations of disabled adult SSI recipients. The various other reasons for termination have represented a relatively constant proportion of terminations for adults, although they have varied somewhat for SSI children.

POPULATION FACTORS INFLUENCING PROGRAM SIZE

Introduction

Population Growth

Number of Workers Insured for Disability

Prevalence of Work Disability

Disabled-Worker Incidence Rates

SSI Blind and Disabled Incidence Rates

INTRODUCTION

Various factors affect the size of the disability programs. One factor is population growth. As the size of the population increases, other things remaining the same, one would expect that the size of the disability programs would increase proportionately, although it is rare for all other factors to stay the same. Another factor is change in the eligible population, which can be the result of changes in program eligibility criteria (for example, increases in the full retirement age result in disabled workers staying in the Disability Insurance program longer) or changes in the population vis-à-vis eligibility (for example, a greater proportion of workers being insured for disability). A final factor that influences program size is the incidence and prevalence of disability in the population.¹

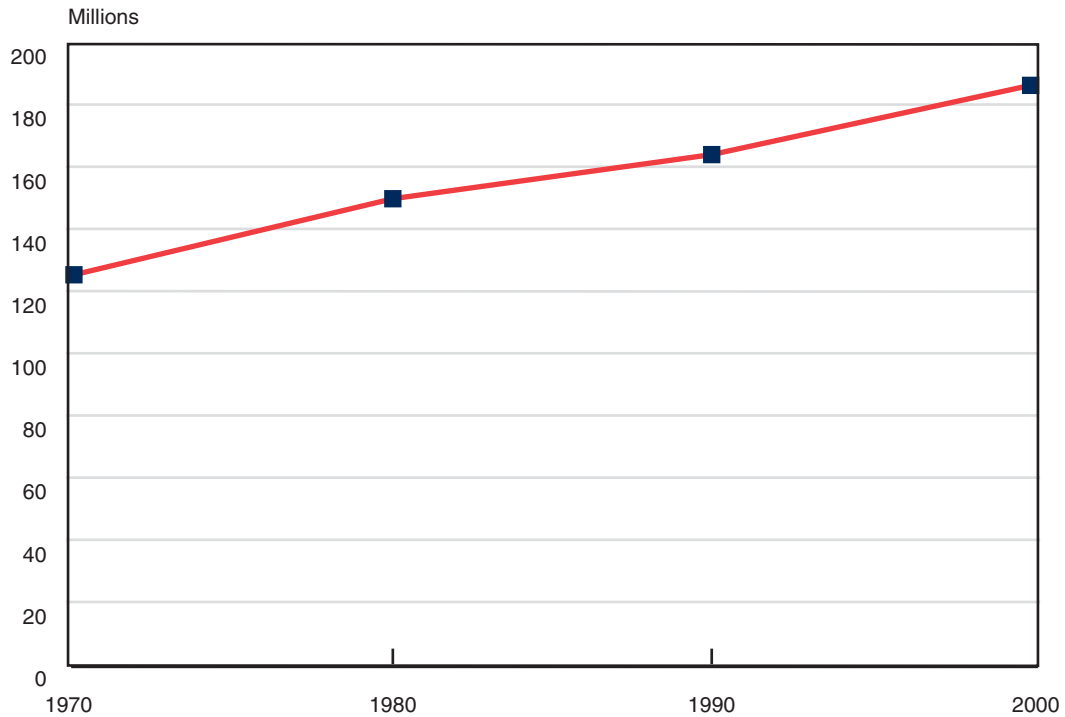
A number of factors influence incidence and prevalence rates of disability in the general population. One is the general health of the population and the incidence rates for disease and disabling impairments. Another is the social environment that leads a person with an impairment to be disabled. Contributing factors may include economic conditions, social mores, environmental factors, and financial incentives such as benefits. Demographic trends (such as the aging of the baby boomers) also play a role. However, the incidence rate is not simply a function of the factors discussed above but is also affected by the standards and methods that the Social Security Administration applies in determining medical eligibility. As the decision process becomes more or less stringent, the number of persons entering the disability programs changes. Similarly, perceived changes in the standards that SSA applies to medical decisions may influence the decision to apply for disability benefits.

1. Incidence is a flow concept, indicating the number of persons entering a state, such as the number who become impaired or the number of new entrants to a disability program. Prevalence is a stock concept, indicating the cumulative number in a state, in this case the number of persons with impairments (new and existing) or the number of persons on the disability rolls (new entrants and existing disabled beneficiaries).

Population Growth

Between 1970 and 2000, the population of the United States aged 15–64 increased by nearly 50 percent. This increase made a major contribution to growth in the disability programs.

Chart 44. Population of the United States aged 15–64, 1970–2000



SOURCE: U.S. Census Bureau, Decennial Census.

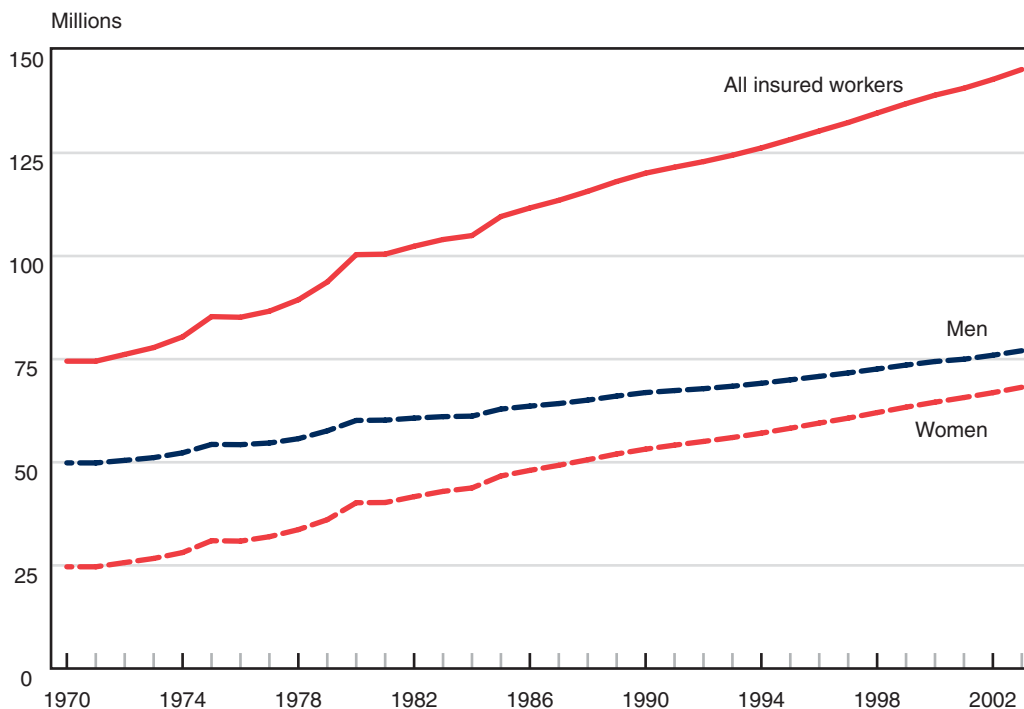
The working-age population of the United States (ages 15–64) grew 49 percent between 1970 and 2000, from 125 million to 186 million. Over that same period, the number of disabled-worker beneficiaries increased nearly 240 percent, from 1.5 million to more than 5 million. The Supplemental Security Income program did not exist until 1974, but the population of blind and disabled adult SSI recipients aged 18–64 increased

150 percent, from 1.5 million in 1974 to 3.7 million in 2000. Many things have changed that alter the direct relationship between the size of the population and the size of the disability rolls: the change in the age distribution due to the baby boomers, the health of the population, improvements in medical treatments, economic circumstances, and changes in disability policy, to name a few.

Number of Workers Insured for Disability

The number of workers insured in the event of disability increased by 95 percent from 1970 to 2003, nearly twice the rate of population growth. The number insured for disability is increasing more rapidly for women than for men, reflecting the emergence of the two-earner household and increased participation in the labor force by women.

Chart 45. Number of workers insured for disability, by sex, December 1970–2003



SOURCE: *Annual Statistical Supplement to the Social Security Bulletin, 2004, Table 4.C2.*

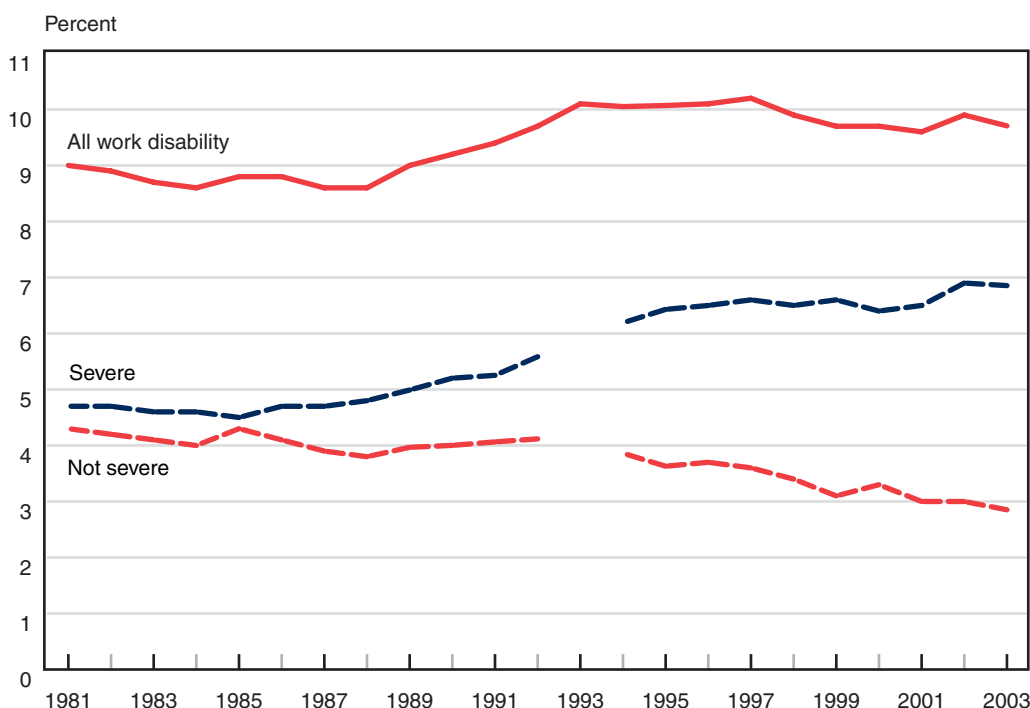
Although the growth of the population plays a role in the size of SSA's disability programs, potential participants in the Disability Insurance program must be insured in the event of disability. The number of persons insured has increased steadily from 1970 to 2003, rising by 95 percent—nearly double the 49 percent growth in the population. This growth indicates that the DI program is likely to grow faster than the population, because workers are being insured for disability at proportionately higher rates.

The number of women insured in the event of disability has increased by 176 percent during the period, compared with 55 percent (about the rate of population growth) for men. The larger increase in the number of women insured for disability can be attributed to the emergence of the two-earner household and stronger labor force attachment for women than in the past.

Prevalence of Work Disability

After increasing from 9 percent of the population in 1981 to 10 percent in 1993, the percentage of the working-age population (16–64) reporting a work disability has been fairly stable at around 10 percent from 1993 until 2003, declining slightly after 1997. However, the percentage of the working-age population reporting a severe work disability has increased from less than 5 percent in 1981 to nearly 7 percent in 2003.

Chart 46. Prevalence of self-reported work disability for persons aged 16–64, 1981–2003



SOURCE: Authors' compilation of published statistics from the U.S. Census Bureau, Current Population Survey.

NOTES: In the Current Population Survey (CPS), people are categorized as "work disabled" if they are receiving disability benefits (such as persons aged 0–64 who are on Medicare or Medicaid or who receive DI or SSI benefits) or if the person has a problem working (or is not working) because of illness or disability.

There was a minor change in the CPS definition of disability in 1996, but the trends in the series were well established before, and continued after, the change.

The Census Bureau did not publish CPS data on severity of disability for 1993.

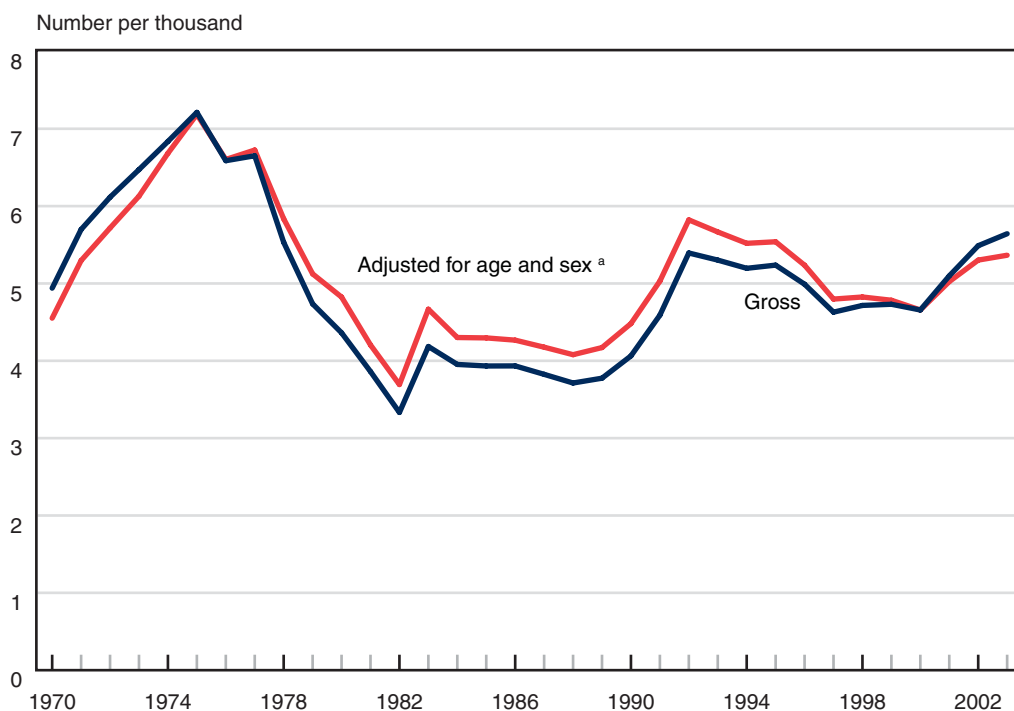
Obtaining a good, consistent measure of the disabled population in the United States is difficult. Different surveys use different definitions of disability and, depending on the context of the questions, respondents formulate their answers differently. Even when surveys use the same definition of disability, the estimates can differ. Given those caveats, the Current Population Survey permits one to track work disability on an annual basis using comparable measures. According to the CPS data, work disability increased slightly during the late 1980s and early 1990s, before moderating some in the late 1990s.

Perhaps most striking is the continuing increase in the percentage reporting a severe work disability since 1985 (from less than 5 percent of the population to nearly 7 percent), along with a corresponding drop in the percentage reporting a nonsevere work disability. The increase in severe work disability that occurred while the overall prevalence of work disability remained relatively constant suggests that persons are viewing their impairments as more disabling. This is significant because persons with severe work disabilities are those most likely to seek benefits from SSA's disability programs.

Disabled-Worker Incidence Rates

Disabled-worker incidence rates varied considerably from 1970 to 2003. Incidence rates adjusted for age and sex closely track gross incidence rates, indicating that trends in the incidence of disability cannot be accounted for by the aging of the population or the greater presence of women in the workforce.

Chart 47. Gross and age-sex adjusted incidence rates for disabled workers, 1970–2003



SOURCE: 2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Figure V.C3.

NOTE: The disabled-worker incidence rate is the number of awards of DI worker benefits per 1,000 exposed (workers insured for disability but not receiving disability benefits).

a. The adjustment uses the population distribution of 2000 as its base. A description of the method used to adjust for age and sex can be found in the 2005 Trustees Report, p. 114.

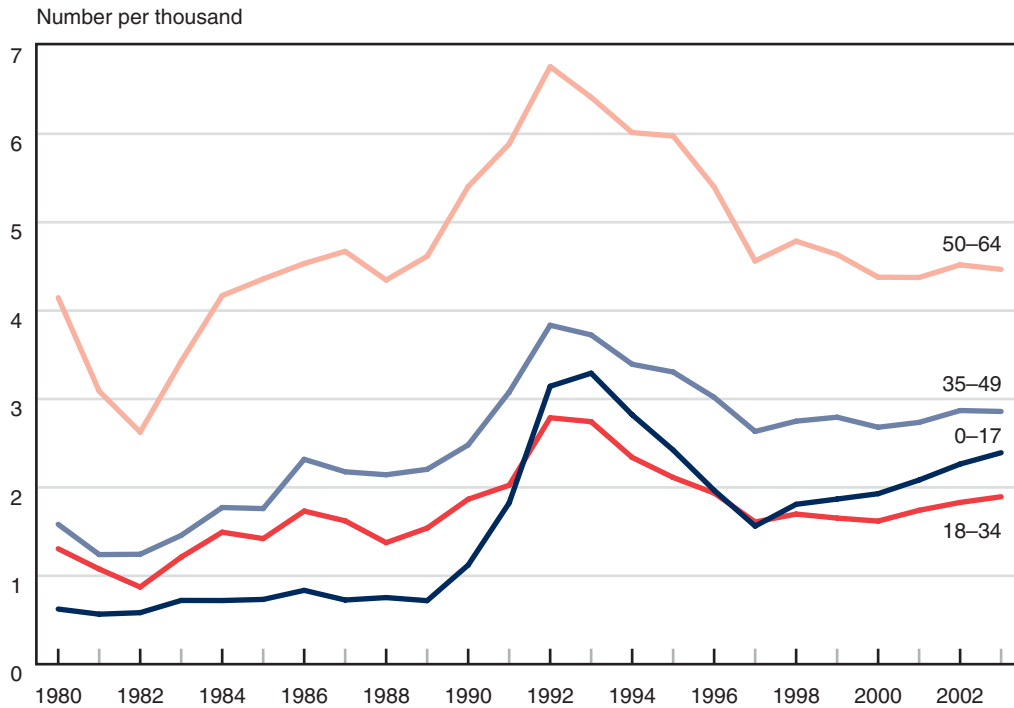
The gross and age-sex adjusted incidence rates measuring the rate of entry into the DI worker program from the disability-insured population show considerable variation between 1970 and 2003. There is also a significant trend in the age distribution of the population: the population bulge of baby boomers (persons born between 1946 and 1964 and aged 39–59 in 2005) is reaching the age at which the rate of disabilities increases. To the extent that sex and age play a role in disability, gross incidence rates may lead to incorrect conclusions about the actual incidence of disabling conditions. For that reason, incidence rates adjusted for age and sex provide a better indication of the trend in disability.

Incidence rates adjusted for age and sex closely track gross incidence rates for the 1970–2003 period. Although the gross incidence rate sometimes exceeds the adjusted rate, and vice versa, the similar patterns of the two trends over time indicate that trends in the incidence of disability cannot be accounted for solely by the aging of the population and increasing presence of women in the workforce. Instead, the greater impact on incidence rates appears to come from other factors including, among other things, program administration and the economy.

SSI Blind and Disabled Incidence Rates

The rate of entry of blind and disabled SSI recipients, regardless of age, increased in the late 1980s and early 1990s, showing that population growth and a changing age distribution cannot explain all of the growth of the SSI program.

Chart 48. Entry rate of SSI blind and disabled, by age group, 1980–2003



SOURCE: 2004 Annual Report of the Supplemental Security Income Program, Tables IV.A1 and IV.B2.

NOTE: The incidence rate is the number of blind and disabled SSI entrants per 1,000 in population. The reference population is the "Selected Social Security Area Population" of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

The change in incidence for the SSI disability program was examined by comparing blind and disabled SSI entrants per 1,000 persons in the population in various age groups. As expected, incidence rates of SSI disability vary over time. In contrast, incidence rates within each of the age groups tend to follow the same pattern over time. That pattern is similar to the one

found for the DI program, with declines in the early 1980s, followed by increases in the late 1980s and early 1990s. The pattern clearly shows that factors other than population growth and a changing age distribution are affecting the growth of the SSI disability program.

CHANGES IN PROGRAM POLICY INFLUENCING PROGRAM SIZE

Introduction

Changes in Policy Influencing—

Disability Awards

Disability Awards for Mental Disorders

Disability Terminations

Disability Terminations for Return to Work

INTRODUCTION

Policy changes can have direct effects on program size. Changes in the way that the Social Security Administration makes disability decisions can affect the number of persons entering the disability programs, as was the case with the changes in the criteria for determining disability for mental disorders that were enacted as part of the 1984 Amendments. In the overview section of this book, a brief history of policy changes was presented (see pp. 7–9). In this section, those changes will be discussed with reference to program size, particularly with respect to entry into and exit from the disability programs.

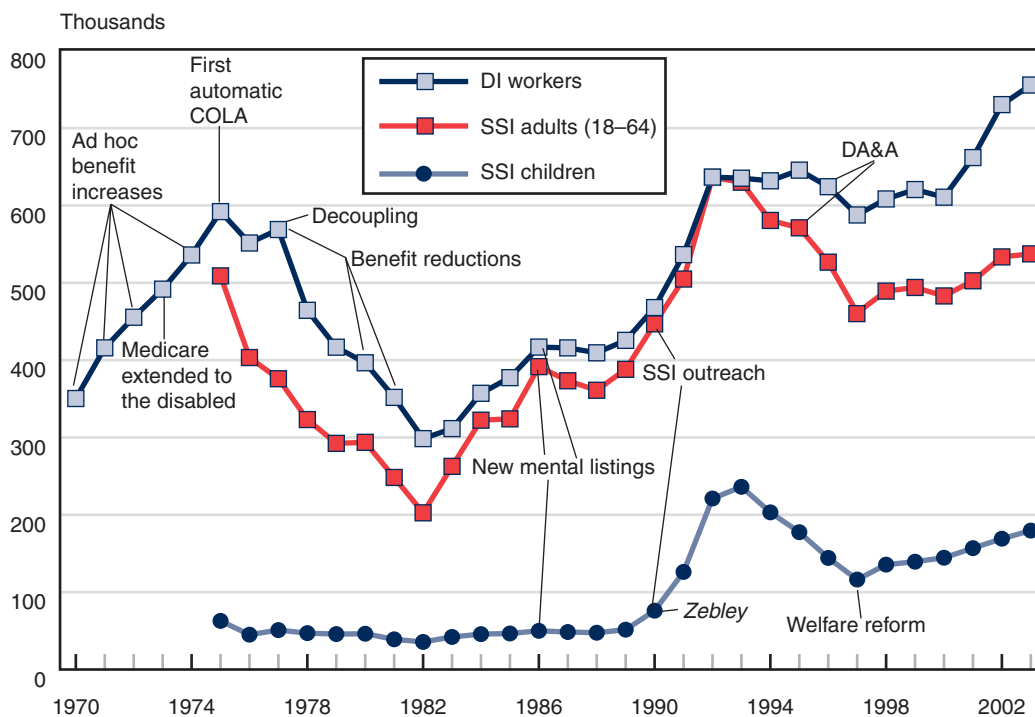
The purpose of this section is to show trends leading up to policy changes and the trends that follow them. It is not possible to measure definitively the contribution each policy change has made to the trends of the disability programs, because numerous other factors play a role in influencing trends. The reader is cautioned that correlation does not imply causality, and one must keep in mind the totality of factors that may have contributed to trends in the disability programs.

Changes in Policy Influencing—

DISABILITY AWARDS

Policy changes appear to play predictable roles in determining awards of disability benefits. Reductions in benefits for the DI program and program changes in the late 1970s and early 1980s appear to have led to fewer applications and fewer awards for the DI and SSI programs.

Chart 49. Number of awards of disability benefits and policy changes affecting them, 1970–2003



SOURCES: Annual Statistical Report on the Social Security Disability Insurance Program, 2003, Table 31; SSI Annual Statistical Report, 2003, Table 47.

NOTE: COLA = cost-of-living adjustment; DA&A = drug addiction and alcoholism.

In the early 1970s, Congress enacted changes that increased the levels of benefits paid under the Social Security disability program. These changes included ad hoc, across-the-board benefit increases of 15 percent in 1970, 10 percent in 1971, 20 percent in 1972, and 11 percent in 1974. Automatic cost-of-living adjustments (COLAs) began with the first COLA in June 1975. Medicare was added to the disability program effective in 1973. The increasing benefits (higher cash benefits and Medicare) probably contributed to the growth of the disability program in the early to mid-1970s.

Growth in the disability rolls during the early to mid-1970s prompted Congress to enact legislation to slow the growth, in part by reducing benefits. The 1977 Amendments “decoupled” the effects of inflation on earnings and the adjustments of the consumer price index (CPI) in the benefit formula to reduce the unintended increase in disability benefits and replacement rates. This decoupling was accomplished by indexing earnings in the benefit formula and applying CPI adjustments to benefits rather than to the benefit formula. As part of the 1980 Amendments, additional benefit reductions were instituted by capping the family benefit

Changes in Policy Influencing—

DISABILITY AWARDS (CONT.)

amount and reducing the number of dropout years in the benefit calculation. In 1981, Congress eliminated the Social Security minimum benefit (minimum primary insurance amount) and placed a cap on the replacement rate from all public disability program benefits. As can be seen in Chart 49, fairly significant reductions in benefits and replacement rates probably contributed to a decline in awards from 1977 to 1982. The 1980 Amendments also required SSA to conduct more preeffectuation quality reviews for favorable decisions.

The 1984 Amendments, enacted in response to public outcry over disability policy in the early 1980s, mandated that SSA develop new disability standards for individuals with mental disorders, evaluate pain as part of the decision process, place emphasis on evidence from treating physicians in the decision process, and consider the impact of multiple nonsevere impairments in determining disability. The decline in award rates and the decrease in disability beneficiaries in the early 1980s began to reverse itself, and growth accelerated in the late 1980s and early 1990s. Awards for mental disorders continued to increase, both in absolute numbers (Chart 50) and as a percentage of awards (Charts 27, 30, and 33), after the new mental listings, which focused on functioning, were implemented in 1986. Awards for mental disorders continue at higher levels today.

SSA has, from time to time, conducted outreach activities to increase public awareness of the disability programs and help potentially eligible individuals apply for benefits. In 1990, a major outreach program was instituted for the SSI disability program. This program came in the aftermath of a period of deinstitutionalization of the disabled, particularly those with mental disorders, and an increase in homelessness. The outreach efforts probably contributed not only to the increase in the SSI recipient population but also to an increase in concurrent beneficiaries (that is, persons eligible for disability benefits under both Social Security and SSI) in the early 1990s.

The *Zebley* court case was initiated by advocates for children with disabilities who objected to disability decisions for children that were based solely on the medical listings as not being of comparable severity to adult standards, as stated in the law. The decision process had no consideration of factors that contributed to disability at a level that was less severe than that in the listings (that is, there was no decision equivalent to steps 4 and 5 in the adult decision process). In 1990, the U.S. Supreme Court ruled for the plaintiffs, and SSA was required to make changes to the way claims for SSI disabled children were decided. The new decision process centered on the functioning of the child (for example, age-appropriate behavior), and, as with the mental listings for adult applicants, the number of awards rose quickly. The number of SSI child recipients more than tripled between 1989 (before *Zebley*) and 1995. The number of SSI awards to children based on mental disorders increased significantly, with a heightened awareness surrounding attention deficit hyperactivity disorder (ADHD) and mental disorders that resulted in maladaptive behavior. Awards for low birth weight also increased dramatically.

In 1996, Congress passed reform legislation that resulted in changes to the way noncitizens were treated by the SSI program and eliminated drug addiction and alcoholism (DA&A) as the basis for a finding of disability. These changes probably produced only small changes in awards. The effect of the DA&A change probably had a larger effect on the SSI program than it did on the DI program, since it led to larger numbers of SSI terminations. Later that same year, welfare reform legislation changed the *Zebley*-based criteria for SSI children and may have reduced SSI awards to children, because the comparable severity standard was replaced with a stricter requirement of “marked and severe functional limitations.” The legislation also ended the use of individualized functional assessment, and it targeted mental disorders that manifested themselves as maladaptive behavior.

Changes in Policy Influencing—

DISABILITY AWARDS (CONT.)

Other internal policy changes have occurred within the disability programs that are too numerous to mention. There have been revisions to medical listings, including elimination of the obesity listing in 1999 and the issuance of new musculoskeletal listings in 2002.

There are also nondisability policy changes that influence the disability programs. Legislation in 1983 designed to make the Social Security program solvent raised the age for full retirement to 67 in staged increases. Early retirement is still available for persons aged 62, but beginning in 2003 the larger actuarial reduction for persons younger than the full retirement age may serve to increase the attractiveness of the DI program. Although it is too early to know with certainty the magnitude of the effect on the DI program, there

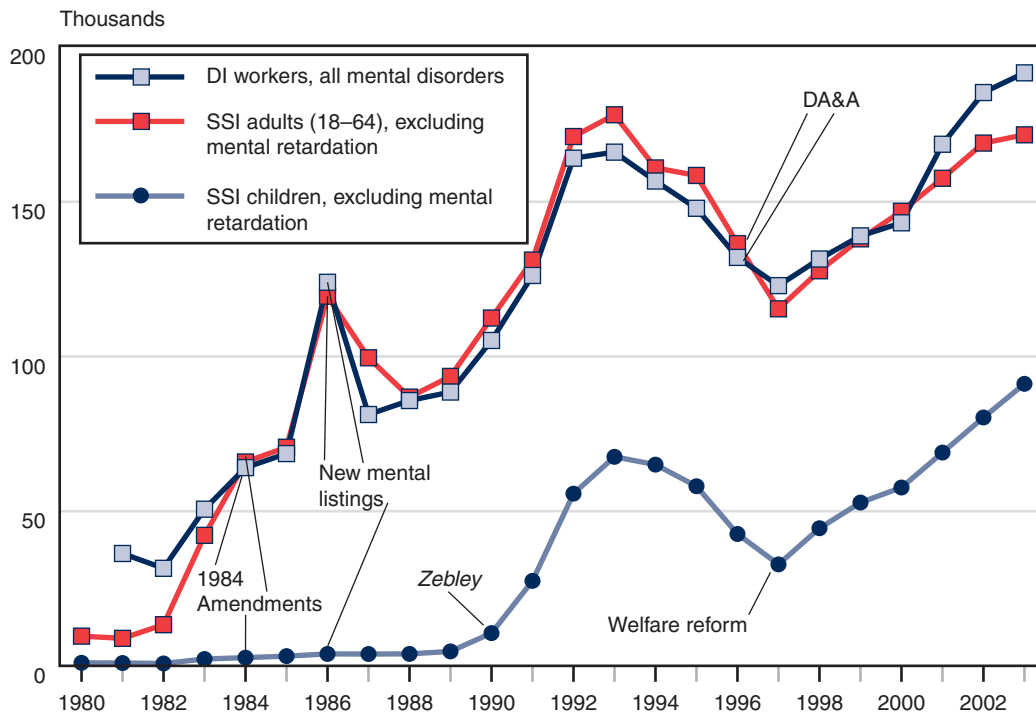
are many reasons to believe this change is likely to increase the number of DI beneficiaries. The number of older beneficiaries entering the DI program will increase as the retirement age increases to 67 and additional older workers are eligible for the DI program. The increase in the full retirement age to 67 will also result in longer stays on the DI rolls for many beneficiaries, since conversion to the retirement program will occur at older ages. Again, the increase in the full retirement age could increase incentives to seek disability benefits, particularly for persons in their 60s who face higher actuarial reductions for early retirement.

Changes in Policy Influencing—

DISABILITY AWARDS FOR MENTAL DISORDERS

New mental listings put in place in 1986 seem to have led to continuing increases in the number of awards for mental disorders other than mental retardation, initially from the 1984 backlog and then continuing for several more years. Changes from welfare reform legislation, which mandated a stricter definition of disability for children and which were put in place in late 1996, do not seem to have reduced awards to SSI children with mental disorders, because these awards began to increase shortly thereafter.

Chart 50. Number of awards for the diagnostic category of mental disorders and policy changes affecting them, 1980–2003



SOURCES: *Annual Statistical Report on the Social Security Disability Insurance Program, 2003*, Table 36; *SSI Annual Statistical Report, 2003*, Tables 48 and 49.

NOTES: Between 1995 and 1996, changes were made in the series, and data are not directly comparable. The SSI series includes only mental disorders other than mental retardation. Because of limitations in the historical data series, the DI workers series includes all mental disorders and does not exclude mental retardation. In recent years, awards based on mental retardation have consistently accounted for 10 percent to 13 percent of awards to DI workers based on mental disorders, with nearly 90 percent being other mental disorders.

DA&A = drug addiction and alcoholism.

In the 1984 Amendments, Congress mandated that SSA develop new disability standards for individuals with mental disorders, including mandatory specialist reviews of denials. Awards for mental disorders continued to increase after new mental listings, which focused on functioning, were implemented in 1986, and they continue at higher levels today.

The *Zebley* court case in 1990 resulted in new disability criteria for deciding claims for SSI disabled children's benefits. The new criteria centered on the functioning of the child (for example, age-appropriate behavior), and the program saw awards to children increase dramatically and the number of SSI child recipients more than triple between 1989 (before

Changes in Policy Influencing—

DISABILITY AWARDS FOR MENTAL DISORDERS (CONT.)

Zebley) and 1995. A significant portion of the increase in awards involved mental disorders other than mental retardation, with much attention directed at awards based on attention deficit hyperactivity disorder (ADHD) and various mental disorders manifesting themselves in maladaptive behaviors.

Welfare reform legislation passed by Congress in 1996 changed the definition of disability for SSI children, eliminating the individualized functional

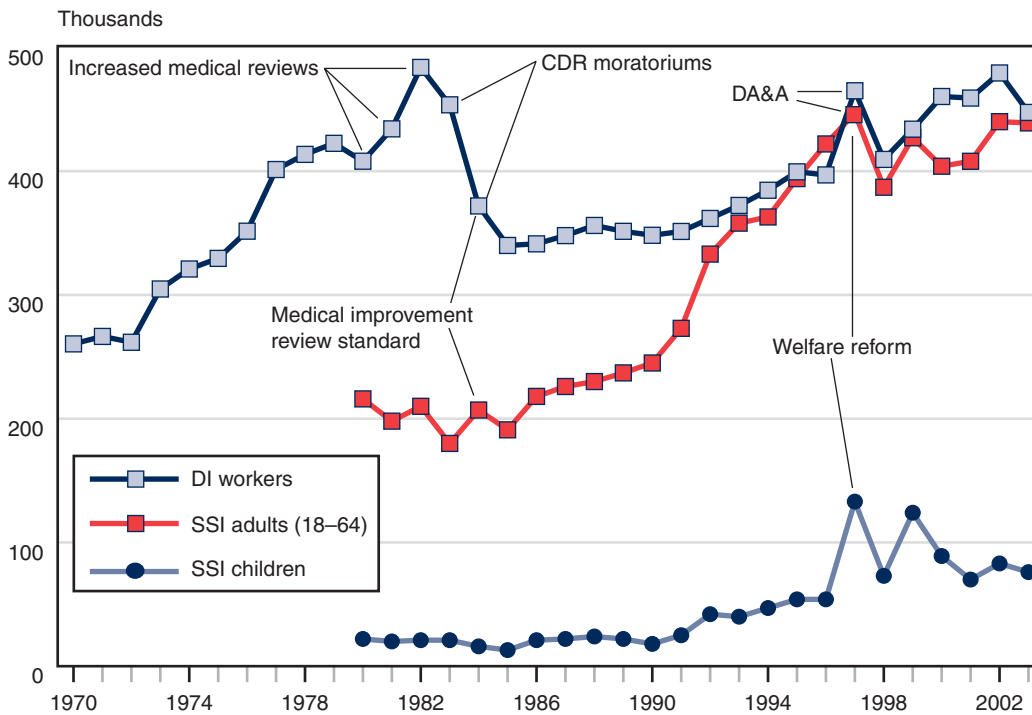
assessment and certain references to maladaptive behaviors in the mental listings that had been in place since 1991, pursuant to the *Zebley* decision. This change established a listings-level standard for disabled children under the SSI program that could be expected to reduce awards. However, the number of SSI awards to children for mental disorders began increasing again after 1997, and in 2003 reached an all-time high.

Changes in Policy Influencing—

DISABILITY TERMINATIONS

Policy changes enacted in 1980 and accelerated reviews in 1982 and 1983 increased the number of terminations. The moratoriums on continuing disability reviews on mental disorders in 1983 and on all CDRs in 1984 and the adoption of the medical improvement review standard resulted in large reductions in terminations.

Chart 51. Number of terminations of disability benefits and policy changes affecting them, 1970–2003



SOURCES: Annual Statistical Report on the Social Security Disability Insurance Program, 2003, Table 45; 2004 Annual Report of the Supplemental Security Income Program, Table IV.B5.

NOTE: CDR = continuing disability review; DA&A = drug addiction and alcoholism.

The 1980 Amendments included a requirement that SSA conduct continuing disability reviews (CDRs) every 3 years, except for persons expected to be permanently disabled.¹ In the early 1980s, these medical reviews were accelerated, with large numbers of beneficiaries terminated by the reviews under a new standard. The outcry over the high termination rate, as well as numerous court cases, led to a nationwide

moratorium on continuing disability reviews for most mental disorders in 1983 and for all cases in 1984, although some states had suspended all CDRs before the national moratoriums.

In 1986, SSA began to conduct CDRs again, employing the new medical improvement review standard mandated by Congress in the 1984 Amendments. In 1994, legislation (P.L. 103-296) mandated that SSA conduct continuing disability reviews on a minimum of 100,000 SSI recipients a year from 1996 to 1998. Before 1996, very few CDRs were conducted on SSI

1. CDRs may be done more frequently than every 3 years, as is generally the case for persons who are expected to improve medically.

Changes in Policy Influencing—

DISABILITY TERMINATIONS (CONT.)

recipients, and the reviews were predominantly on concurrent beneficiaries receiving Social Security benefits.

In 1996, during the era of welfare reform, Congress enacted changes that required SSA to change disability criteria. First, in P.L. 104-121, drug addiction and alcoholism was removed as a basis for disability, which led to an increase in terminations of adults in the DI and SSI programs in 1996. That legislation also provided dedicated funding for SSA to conduct continuing disability reviews of both Social Security and SSI disability beneficiaries from 1996 to 2002. Second, legislation (P.L. 104-193) tightened the definition of disability and eligibility criteria that were established for SSI children after the *Zebley* decision; required rede-

terminations of awards to SSI children awarded on the basis of the *Zebley* decision that initiated individualized functional assessment and certain diagnostic criteria; mandated redeterminations that applied adult disability standards for all SSI children who were within a year of their 18th birthday; and mandated the review of all awards for low birth weight for children nearing their first birthday. These reviews and redeterminations led to an increase in terminations of SSI children in 1997 but were followed by the reinstatement of provisional benefits for some children whose payments were ceased while SSA initiated a rereview of those cases. Terminations peaked a second time in 1999 as appeals were exhausted and SSA rereviews were completed.

Changes in Policy Influencing—

DISABILITY TERMINATIONS FOR RETURN TO WORK

It does not appear that policy changes have resulted in any significant increases in successful returns to work. Consequently, changes in policy appear to have had little influence on termination rates.

There have been various changes to program work incentives to encourage return to work and increase program exit, although it does not appear that any of these changes resulted in any significant increase in successful return to work and consequently appear to have done little to influence termination rates.

The 1980 Amendments made several major changes to work incentives. A 15-month extended period of eligibility, which permits beneficiaries whose disability benefits are ceased because of work to regain their benefits if their earnings fall below the substantial gainful activity level, and a 36-month period of extended Medicare were added to the Disability Insurance program. Provisions were added to the SSI program that enabled SSI recipients to work without the fear of losing cash payments or Medicaid eligibility (sections 1619a and 1619b were implemented for a limited period and were made permanent in 1986). Impairment-related work expenses were added to the SSI and DI programs, and the Plan for Achieving Self-Support was added to SSI. The 1980 Amendments eliminated the need to serve a second waiting period for cash benefits for disability beneficiaries who returned to the program within 60 months of a termination. They also eliminated a second Medicare waiting period for a disabled worker returning to the disability rolls within 60 months and for a disabled widow(er) or disabled adult child returning to the DI program within 84 months of termination.

Beginning in 1988, the extended period of eligibility was increased from 15 months to 36 months. In 1989, DI beneficiaries who exhausted their extended Medicare eligibility were permitted to buy into the Medicare program to maintain coverage.

The trial work period was established in 1960 to encourage the disabled to test their ability to work. It permitted beneficiaries to work for 9 months (which need not be consecutive) and earn as much as they were able to without losing cash benefits. Beginning in 1992, the 9-month trial work period was changed to a rolling 9 months in any 60-month period, permitting persons who failed at a work attempt to obtain additional months of trial work.

In 1999, the Ticket to Work and Work Incentives Improvement Act made further major changes to work incentives. Extended Medicare coverage was increased to 102 months from 36 months. The Ticket to Work made private vocational rehabilitation providers eligible for payments for successful rehabilitation. Under the Ticket, providers receive outcome payments for months in which the beneficiary's cash benefit is suspended for work. They also have the option to elect milestone payments, which reduce later outcome payments. The legislation permits disabled beneficiaries who can no longer work an "easy-back-on" option to again receive cash payments. The law prohibits SSA from using a beneficiary's return to work to trigger a continuing disability review, prohibits termination for medical improvement if the beneficiary is using the Ticket, and precludes SSA from using evidence from work to show medical improvement. The law also authorized additional options for states to offer Medicaid buy-ins for the disabled who work.

CHANGES IN INCENTIVES INFLUENCING PROGRAM SIZE

Introduction

Changes in Prices and Wages

Replacement Rates for Disabled Workers

Maximum SSI Payment Amount

Changes in Substantial Gainful Activity Level

**Substantial Gainful Activity Level and
Application Rates**

**Unemployment Rate and Application and
Incidence Rates for Disabled Workers**

**Unemployment Rate, SGA, and Application
Rates for Disabled Workers**

**Unemployment Rate and SSI Application and
Incidence Rates for Adults (18–64)**

INTRODUCTION

Empirical evidence suggests that the incentives to seek Disability Insurance and Supplemental Security Income are positively related to the size of the benefit. The relationship between the real value of earnings and benefits or payments is one factor that determines the attractiveness of the program.

As will be shown in this section, the increase in wages lagged behind the increase in prices through much of the 1970s and 1980s, and individuals in the disability programs gained relative to those in the workforce. In such periods, the promise that future Social Security benefits will be adjusted for inflation can increase incentives to seek benefits.

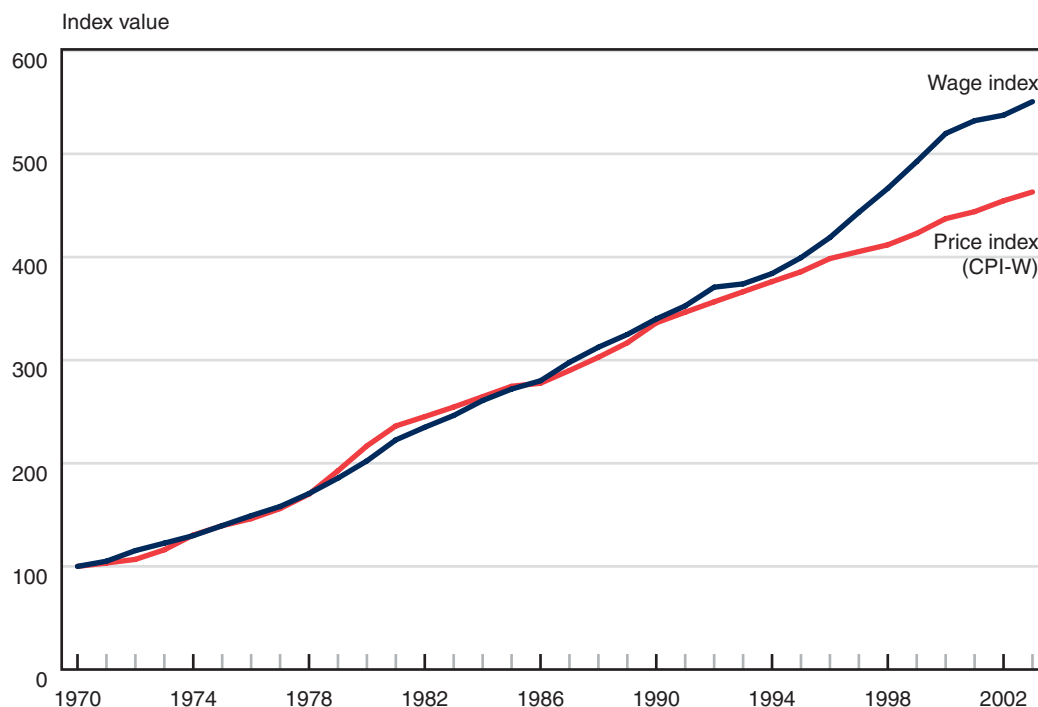
Furthermore, disparity in the distribution of income has increased, with low earners realizing proportionately smaller wage gains than high earners. Because the formula used to calculate Social Security benefits is indexed to the average growth in wages, systematic disparities in earnings growth will result in altered incentives. A slower rate of wage growth for low earners than for high earners (that is, widening disparity in the distribution of earned income), as has been reported in recent years, coupled with SSA's calculation of average indexed monthly earnings (AIME), which uses an indexing formula based on average wages, have been hypothesized to result in higher replacement rates and increased incentives among lower earners to apply for benefits.

This section focuses on several changes that may have altered program incentives and program size: indexation of benefits, changes in the replacement rate and maximum SSI cash payments, changes in the level of earnings considered to be substantial gainful activity, and economic conditions as measured by the unemployment rate.

Changes in Prices and Wages

Through much of the 1970s, wages did not grow any faster than prices, and in the late 1970s and early 1980s the increase in wages lagged behind the increase in prices. Individuals in SSA's disability programs gained relative to those in the workforce. The effect has been greater on low earners, and the decline in real wages may be continuing for this group.

Chart 52. Changes in prices and wages, 1970–2003



SOURCES: Office of the Chief Actuary, Automatic Increases, Average Wage Index Series, available at <http://www.socialsecurity.gov/OACT/COLA/AWIgrowth.html>; Bureau of Labor Statistics, CPI-W, available at <http://www.bls.gov/cpi>.

NOTES: 1970 = 100 for both series.

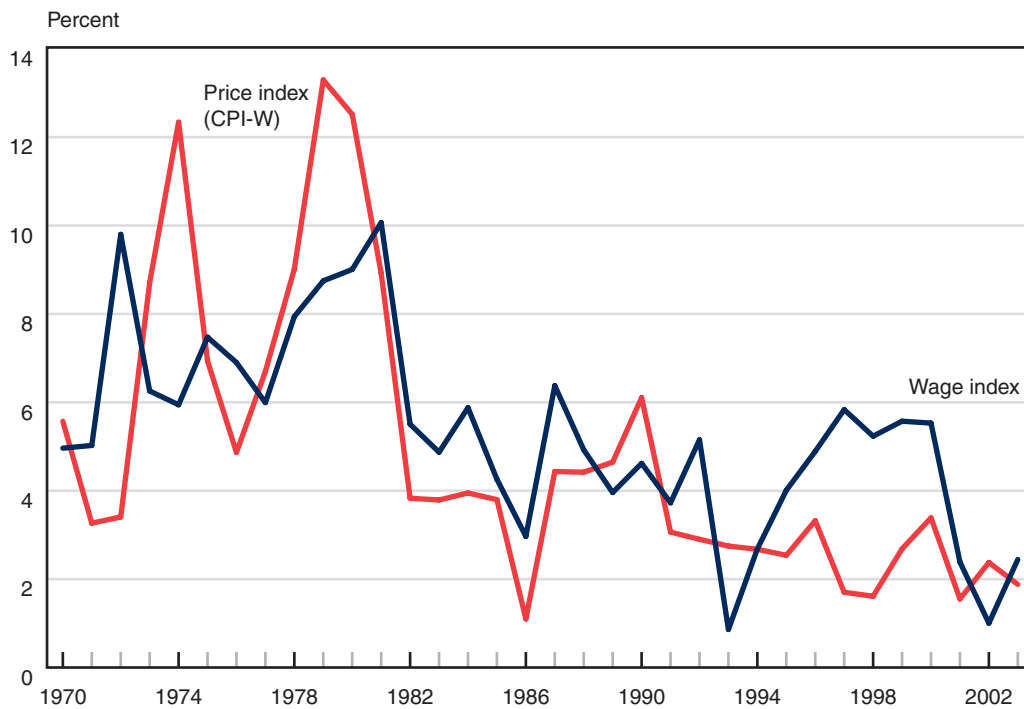
CPI-W = consumer price index for urban wage earners and clerical workers.

Chart 52 shows that, in the aggregate, increases in wages kept pace with price increases during much of the 1970s, leaving no real wage growth. Then, in the late 1970s and early 1980s, wage growth actually lagged behind price increases.

Chart 53 shows that the annual percentage change in price and wage indexes over the 1970–2003 period has not had a consistent pattern, with greater wage growth and price increases alternating from year to year. However, large ad hoc increases in

Changes in Prices and Wages (cont.)

Chart 53. Annual percentage change in prices and wages, 1970–2003



SOURCES: Office of the Chief Actuary, Automatic Increases, Average Wage Index Series, available at <http://www.socialsecurity.gov/OACT/COLA/AWlgrowth.html>; Bureau of Labor Statistics, CPI-W, available at <http://www.bls.gov/cpi>.

NOTE: CPI-W = consumer price index for urban wage earners and clerical workers.

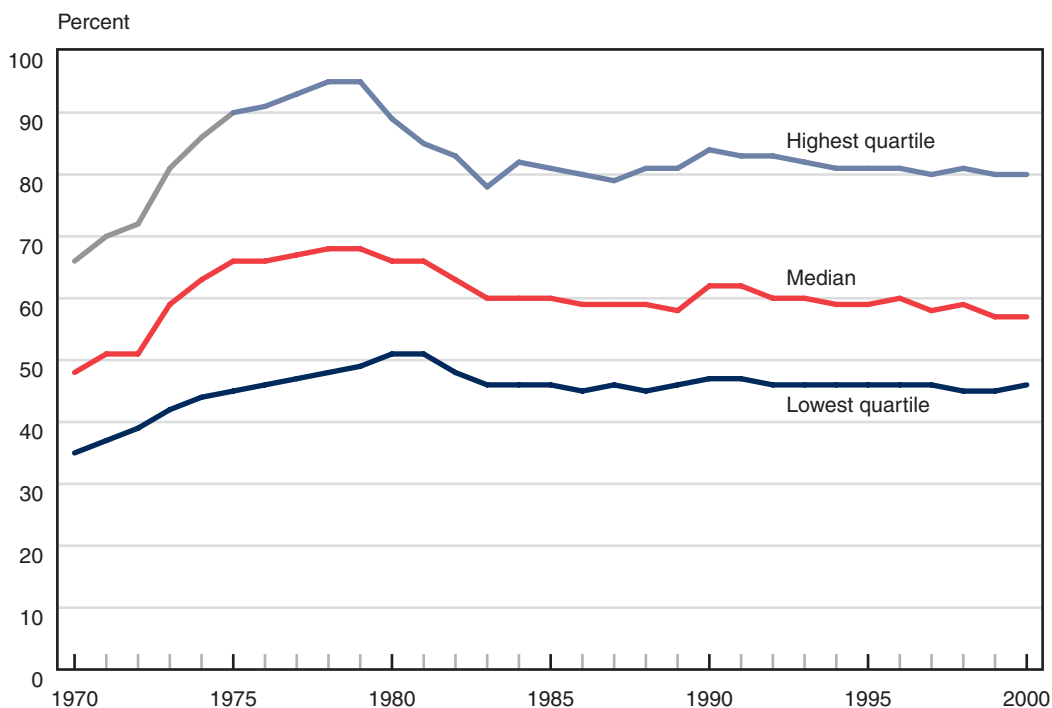
Social Security benefits in the early 1970s, followed by automatic cost-of-living adjustments beginning in June 1975, may have increased incentives to apply for Social Security disability benefits during this period and contributed to the growth experienced by the program

in the late 1970s and early 1980s. Furthermore, these charts do not show the impact that price increases have had on real wages of low earners, who have continued to see declining real wages over time.

Replacement Rates for Disabled Workers

Replacement rates for disabled workers increased significantly from 1970 to the late 1970s or early 1980s. Congressional action in 1977, 1980, and 1981 resulted in reductions in DI benefits and replacement rates, which have since stabilized.

Chart 54. Median and quartile replacement rates for newly entitled disabled workers, 1970–2000



SOURCE: Unpublished data compiled by the authors using the 1% Continuous Work History Sample.

NOTE: Replacement rates are based on average indexed monthly earnings.

A better sense of the relationship between benefits and earnings is provided by examining replacement rates, which is the ratio of workers' DI benefits to predisability earnings.¹ This simple measure provides a glimpse of the adequacy, equity, and incentives associated with disability benefits.

Although there are many caveats related to taxes, multiple sources of disability income, and other factors, high replacement rates for DI benefits increase incen-

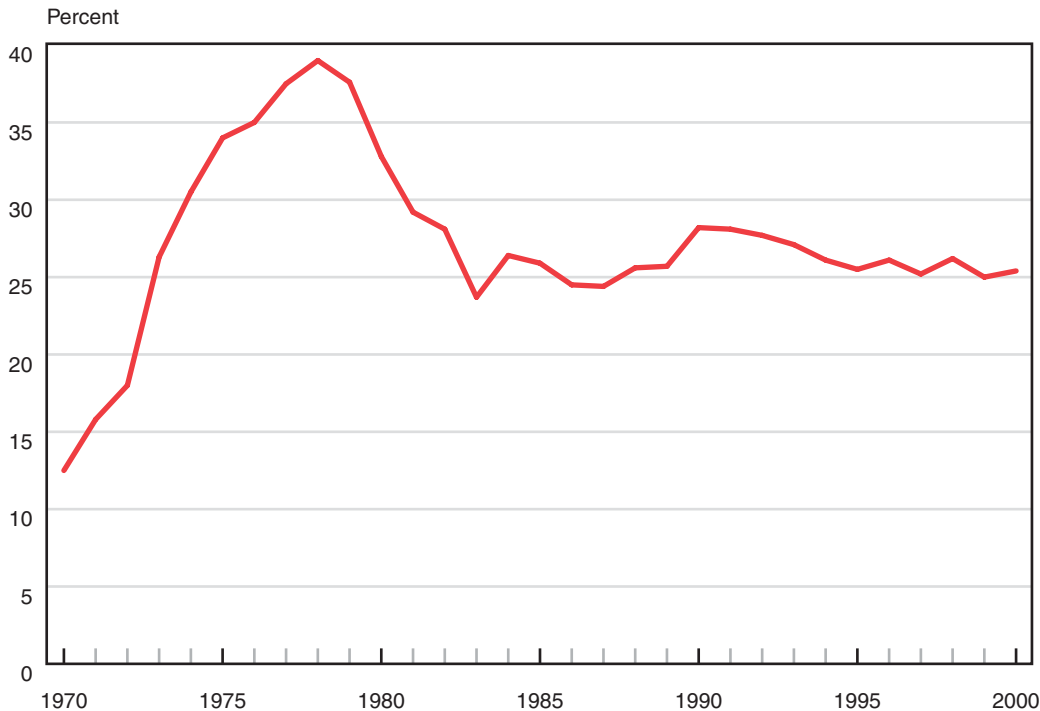
tives for individuals to apply for benefits rather than to continue working. High replacement rates also reduce incentives for beneficiaries to return to self-supporting work. Replacement rates in the United States vary with workers' earnings histories and earnings levels, because the Social Security benefit formula is designed to replace a higher fraction of earnings for low earners than for high earners, thus giving low earners a higher replacement rate than that for high earners.

Charts 54 and 55 show trends of replacement rates for newly entitled DI beneficiaries from 1970 to 2000 that are based on a measure of actual lifetime earnings up to the year before the year of disability onset. The numerator is the amount of DI benefits paid to the worker and to any dependents.

1. The measure of predisability earnings used in the computation of replacement rates was average indexed monthly earnings, which is basically the same formula used by SSA since 1980 to compute benefits. Earnings are indexed by average wages for each year and, depending on age, up to 5 years of lowest earnings after the age of 22 are dropped from the calculation.

Replacement Rates for Disabled Workers (cont.)

Chart 55. Percentage of newly entitled disabled workers with high replacement rates, 1970–2000



SOURCE: Unpublished data compiled by the authors using the 1% Continuous Work History Sample.

NOTE: Replacement rates are based on average indexed monthly earnings. High replacement rates are those that exceed 80 percent of predisability earnings.

As can be seen from these charts, replacement rates rose from the early to late 1970s, declined in the early 1980s, and have stabilized considerably since. The reduction in replacement rates resulted from Congressional action to stem the increase in replacement rates after the program experienced significant growth in the mid-1970s. Replacement rates began to rise dramatically after Congress passed automatic cost-of-living adjustments (COLAs) in 1972. The rise in replacement rates was partially the result of the method used to index benefits, which overcompensated new DI beneficiaries for the effects of inflation. In 1977, Congress enacted legislation intended to stabilize replacement rates by “decoupling” the COLA increase for current beneficiaries from the calculation of benefits for new beneficiaries. Current DI beneficiaries would receive COLA adjustments for price increases, and new beneficiaries would have their benefits based on wage-indexed earnings and on a benefit formula that

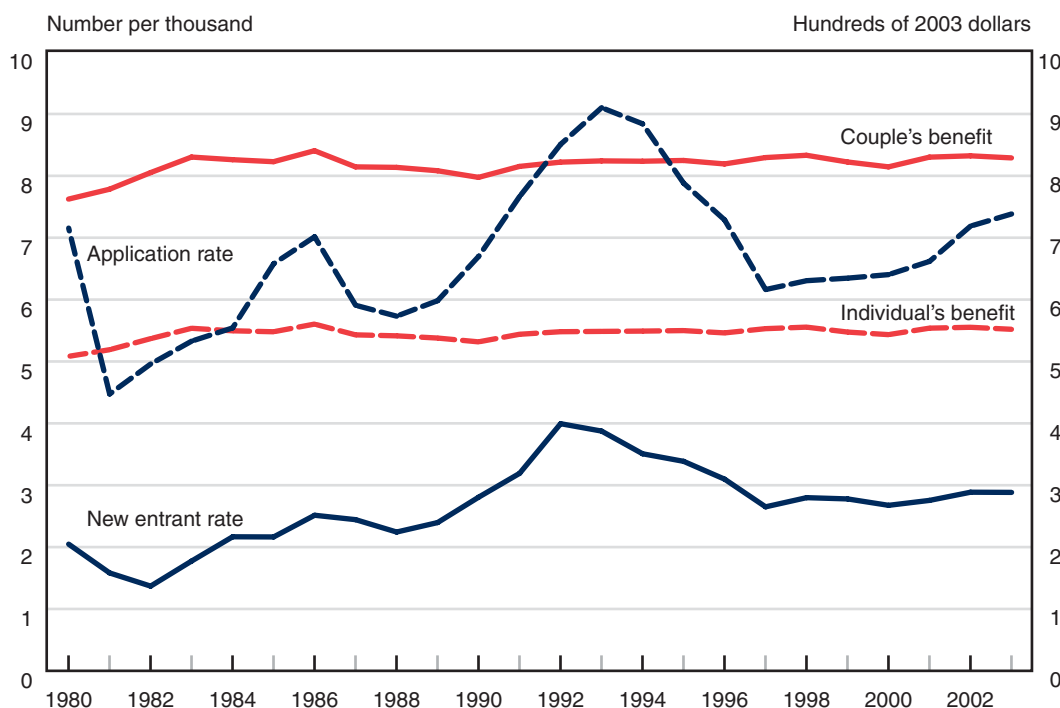
was adjusted for increases in average wages. The new benefit calculation generally applied to disabled-worker beneficiaries becoming eligible in January 1979 and later. This legislation also froze the minimum benefit at its 1979 level.

In 1980, Congress took further action to limit replacement rates for disabled workers, targeting younger workers and those with dependents. That legislation made the formula for these workers less generous and placed caps on family benefits. In 1981, Congress eliminated the minimum benefit for all Social Security beneficiaries and placed an offset for multiple sources of public disability benefits (except veterans and means-tested programs) to ensure that replacement rates from all disability benefits would not be excessive. Replacement rates have not been a subject of controversy or legislation since that time.

Maximum SSI Payment Amount

The maximum federal SSI payment, known as the federal benefit rate, is fixed and indexed to the cost of living, and the real value does not change over time. Thus federal SSI payment amounts are stable and do not correlate with changes in applications for benefits and awards.

Chart 56. Incidence of SSI applications and new adult entrants (aged 18–64) and the maximum monthly federal SSI payment amount for individuals and couples, 1980–2003



SOURCES: SSI Annual Statistical Report, 2003, Table 1; 2004 Annual Report of the Supplemental Security Income Program, Tables IV.A1, IV.B1, and IV.B2.

NOTES: Incidence is the number of SSI applicants and new entrants aged 18–64 per 1,000 in population aged 18–64. The reference population is the “Selected Social Security Area Population” of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

All dollar amounts are in constant (price-adjusted) 2003 dollars.

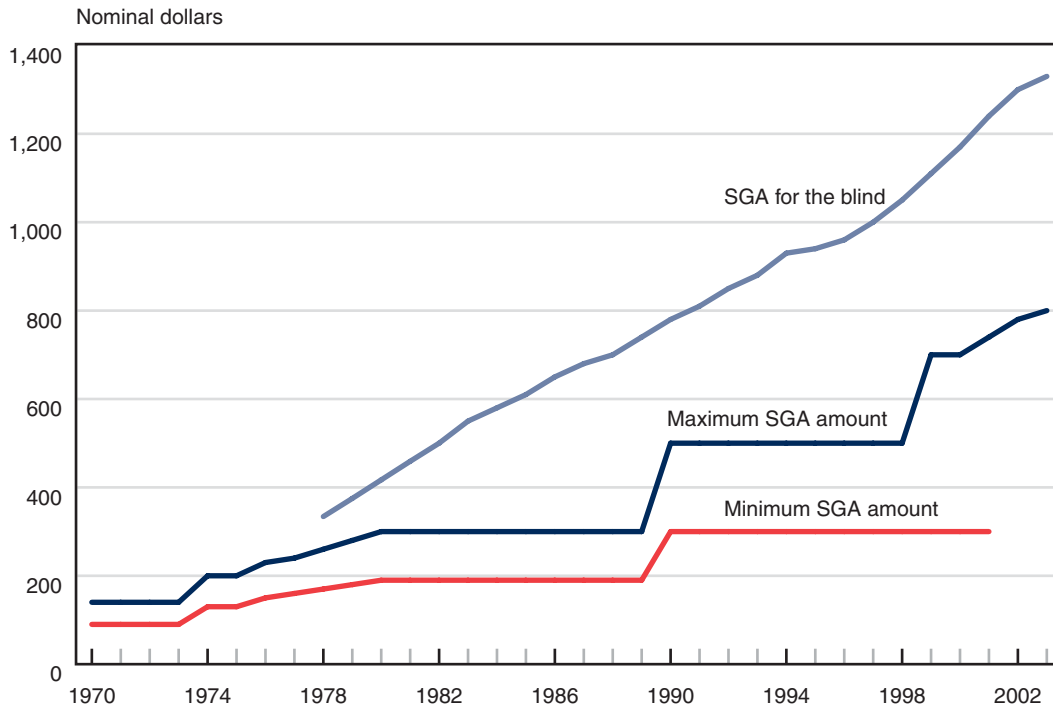
Many SSI recipients have limited or no earnings history, so replacement rates are not as relevant a measure for the SSI program. Less than one-quarter of recipients had sufficient work experience to qualify for even a small Social Security benefit. Furthermore, the federal benefit amount for SSI is relatively static over time, as the benefit is indexed to inflation. Chart 56 illustrates that the inflation-adjusted benefits are fairly stable over time, and changes in applications and awards of SSI payments do not correlate with benefit amounts. The periods of growth and contraction in applications and awards seem to follow patterns similar to those observed for the DI program. The patterns seem to have some correlation with economic and policy changes, but the precise relationship is not known.

One other factor may contribute to incentives to seek SSI payments: the income and resource test. SSI limits the amount of assets, earned income, and unearned income the individual may have and still qualify for benefits. The asset limit (\$2,000) has not been increased since 1984, and the disregards for earned and unearned income (\$65 and \$20 per month, respectively) have not been changed since the program began. The effect that inflation has had on the real level of these tests may have served to tighten eligibility criteria, although spend-down provisions, under which individuals must divest themselves of assets to qualify for SSI, may have lessened the impact of the asset test.

Changes in Substantial Gainful Activity Level

For long periods, the monthly level of substantial gainful activity for the nonblind, in nominal dollars, did not change. Since 2001, the level automatically increases as a consequence of changes in the wage index.

Chart 57. Maximum and minimum SGA amounts for the nonblind and the SGA level for the blind, 1970–2003



SOURCE: *Annual Statistical Supplement to the Social Security Bulletin, 2004, Table 2.A30.*

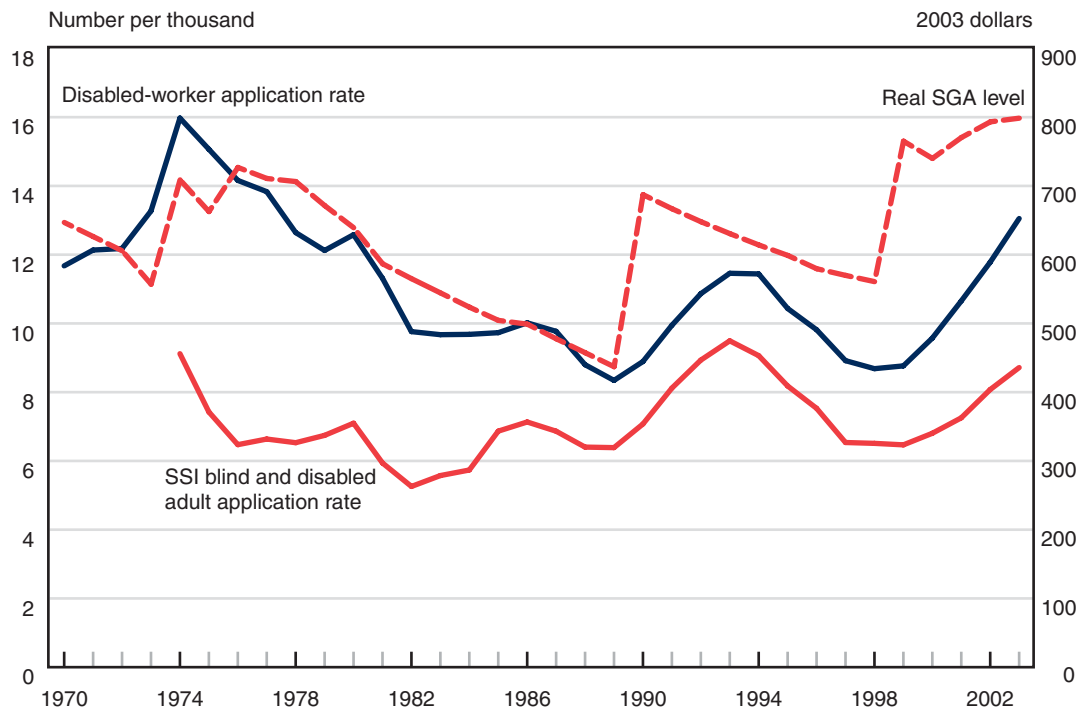
The level of substantial gainful activity (SGA) has long been established by regulation. Before 2002, there was a maximum and minimum SGA amount. Monthly earnings (minus impairment-related work expenses) that fell below the minimum SGA amount were not considered to constitute SGA. Monthly earnings between the maximum and minimum SGA amounts required that consideration be given to all circumstances related to work activities to determine whether the work activity was SGA. Work activity that resulted in monthly earnings that were above the maximum SGA amount was automatically determined to be SGA. Beginning in 1978, the SGA level for the blind was tied to the early

retirement test exempt amount and has thus been automatically adjusted for changes in the average wage. Until 2001, the SGA level for the nonblind had been subject to ad hoc increases as determined to be appropriate by the Commissioner of Social Security, with the last two ad hoc increases occurring in 1990 and 1999. Since 2001, the SGA level for the nonblind has also been subjected to automatic adjustments for changes in the wage series, albeit at a lower absolute level than that established for the blind. For 2006, the monthly SGA amount is \$1,450 for statutorily blind individuals and \$860 for nonblind individuals.

Substantial Gainful Activity Level and Application Rates

Changes in the real (price-adjusted) SGA level for nonblind individuals suggests that increasing the real value of substantial gainful activity may influence the application rates for the DI and SSI programs.

Chart 58. Application rates for disabled-worker benefits and SSI blind and disabled adult payments and real SGA level, 1970–2003



SOURCES: *Annual Statistical Supplement to the Social Security Bulletin, 2004*, Tables 2.A30, 4.C1, and 6.C7; *2004 Annual Report of the Supplemental Security Income Program*, Table IV.A1; *SSI Annual Statistical Report, 2003*, Table 41.

NOTES: Application rates are per 1,000 disability-insured workers for disabled workers and per 1,000 in population aged 18–64 for SSI blind and disabled adults. The reference population for SSI adults is the “Selected Social Security Area Population” of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

All dollar amounts are in constant (price-adjusted) 2003 dollars.

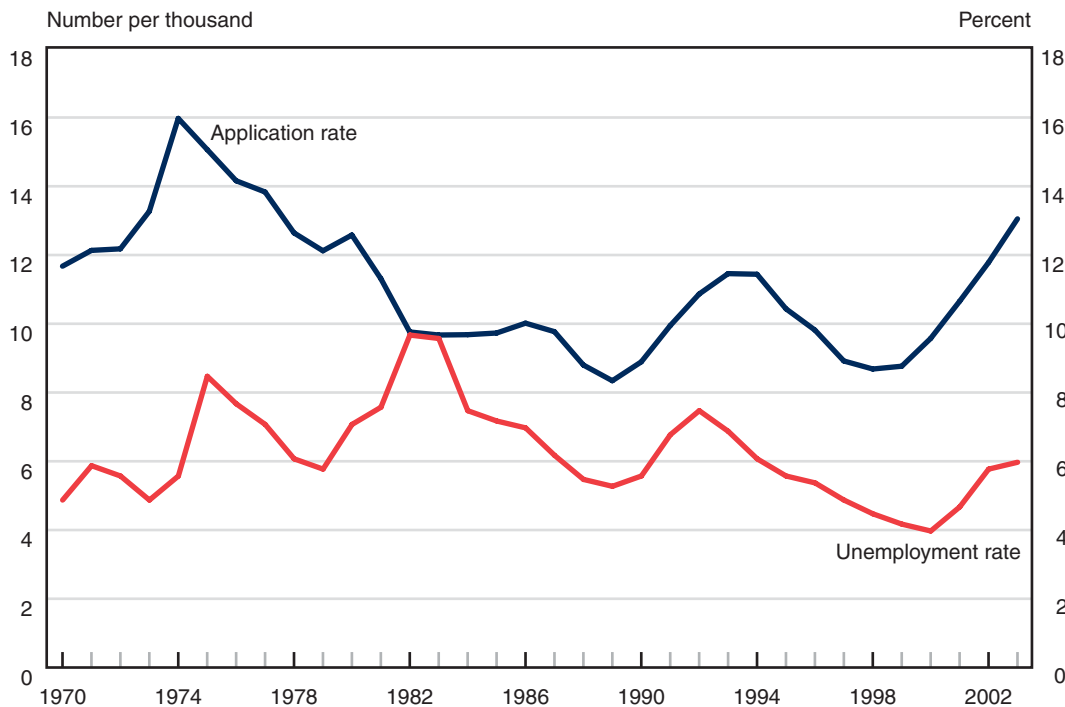
The changes in the real (price-adjusted) SGA level for nonblind individuals during the period 1970 to 2003, along with trends in the rate of applications for disabled-worker benefits and SSI disabled adult benefits (aged 18–64), suggest that increasing the real value of SGA may influence the application rates for

both programs. However, the policy decisions to raise the SGA level in 1990 and in 1999 came at peaks in the economic cycle, just as the economy was tilting toward recession, and it is difficult to determine the extent to which the change in SGA influenced applications or to what extent the tightening labor market did.

Unemployment Rate and Application and Incidence Rates for Disabled Workers

Disabled-worker application rates and incidence rates have tended to rise in periods of increasing unemployment and fall in periods of decreasing unemployment with the exception of the early 1980s, when the program was tightened and the benefits were reduced.

Chart 59. Rate of disabled-worker applications per 1,000 disability-insured workers and the unemployment rate, 1970–2003



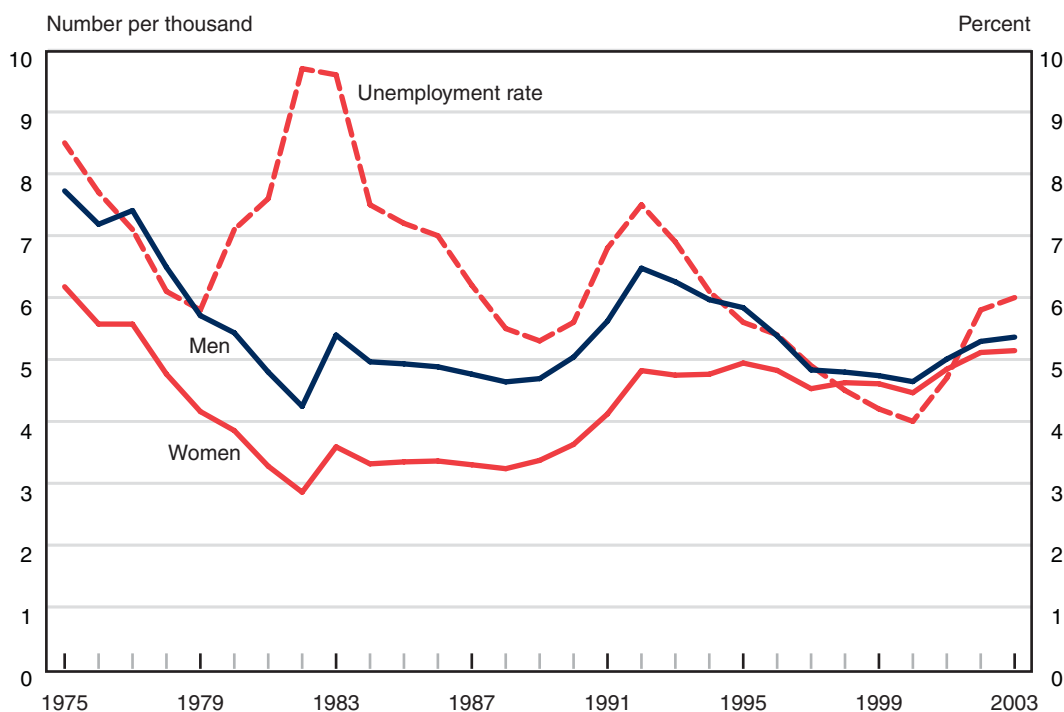
SOURCES: *Annual Statistical Supplement to the Social Security Bulletin, 2004*, Tables 2.A30, 4.C1, and 6.C7; Bureau of Labor Statistics, unemployment rate, available at http://www.bls.gov/cps/prev_yrs.htm.

Economic changes influence applications to the DI and SSI programs. Historically, when unemployment rises, applications and awards for the DI program have increased as well. Disabled-worker application rates have tended to rise in periods of increasing unemployment and fall in periods of decreasing unemployment, with the notable exception of the early 1980s, when unemployment approached 10 percent and the rate of applications declined dramatically (Chart 59). However,

at the same time, a tightening of the program and reductions in benefits were taking place and may have had a greater influence that resulted in declining application rates. The incidence rate for DI workers (awards per 1,000 in the disability-insured population) also tends to follow the unemployment rate (and application rate), with the same caveat about the period of the early 1980s (Chart 60).

Unemployment Rate and Application and Incidence Rates for Disabled Workers (cont.)

Chart 60. Age-adjusted incidence rates for disabled workers, by sex, and the unemployment rate, 1975–2003



SOURCES: Tim Zayatz, *Social Security Disability Insurance Program Worker Experience*, Actuarial Studies No. 114 (June 1999) and No. 118 (June 2005) (Washington, DC: Social Security Administration, Office of the Chief Actuary), Table 4; Bureau of Labor Statistics, unemployment rate, available at http://www.bls.gov/cps/prev_yrs.htm.

NOTE: Incidence rates are the number of awards of disabled-worker benefits per 1,000 disability-insured workers.

Economic factors in addition to the unemployment rate may also influence applications, awards, and the size of the DI program. These factors could include changes in the wage distribution and changes in the occupational structure of the economy, as well as a multitude of other factors. Quantifying such changes is difficult and beyond the scope of this book; however, it is clear that the distribution of income and wages has widened and that low-income workers are falling behind higher-income workers.² The occupational structure in

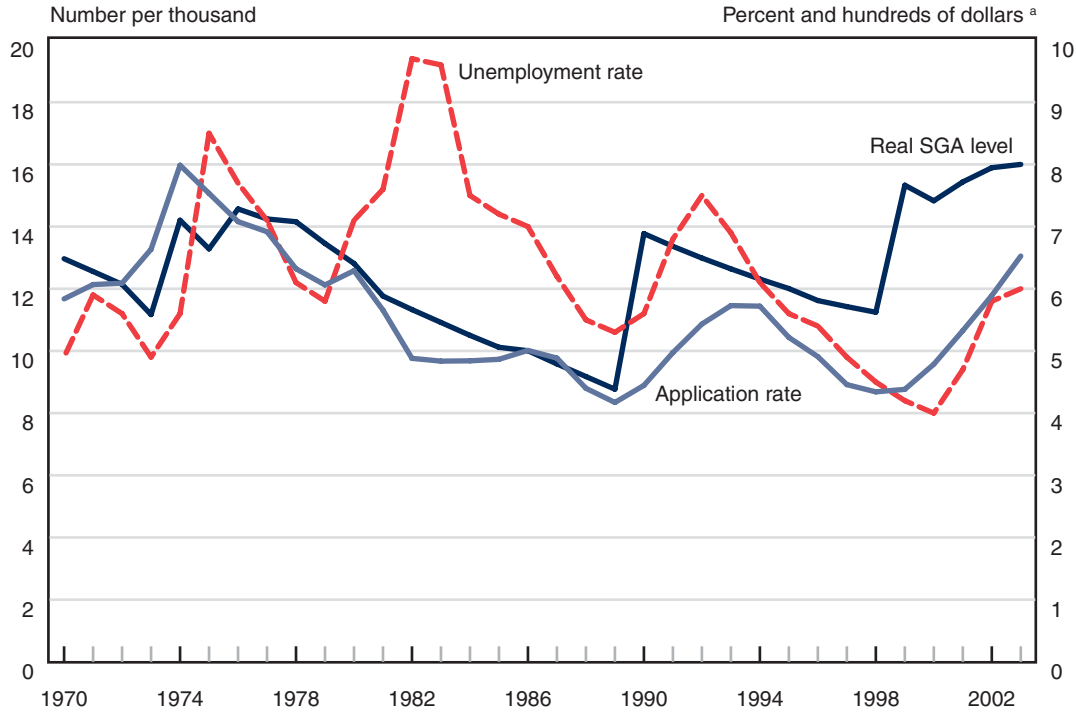
the United States has moved away from manufacturing and toward service jobs, which has an indeterminate effect on applications and awards. Although service jobs tend to be less physically demanding, the mental and cognitive requirements are greater.

2. See, for example, Arthur F. Jones, Jr., and Daniel H. Weinberg, *The Changing Shape of the Nation's Income Distribution, 1947–1998*, Current Population Reports P60-204 (Washington, DC: Census Bureau, 2000), which shows a generally consistent pattern of a widening of the earnings distribution from 1981 to 1998.

Unemployment Rate, SGA, and Application Rates for Disabled Workers

Although the application rate seems to follow the same trends as changes in real substantial gainful activity level (in 2003 dollars) and the unemployment rate, it is difficult to determine the factors that affect growth and to disentangle the effects of those factors.

Chart 61. Rate of disabled-worker applications per 1,000 disability-insured workers, real SGA level, and the unemployment rate, 1970–2003



SOURCES: *Annual Statistical Supplement to the Social Security Bulletin, 2004*, Tables 2.A30, 4.C1, and 6.C7; Bureau of Labor Statistics, unemployment rate, available at http://www.bls.gov/cps/prev_yrs.htm.

a. Unemployment rate in percent; real SGA level in hundreds of 2003 dollars.

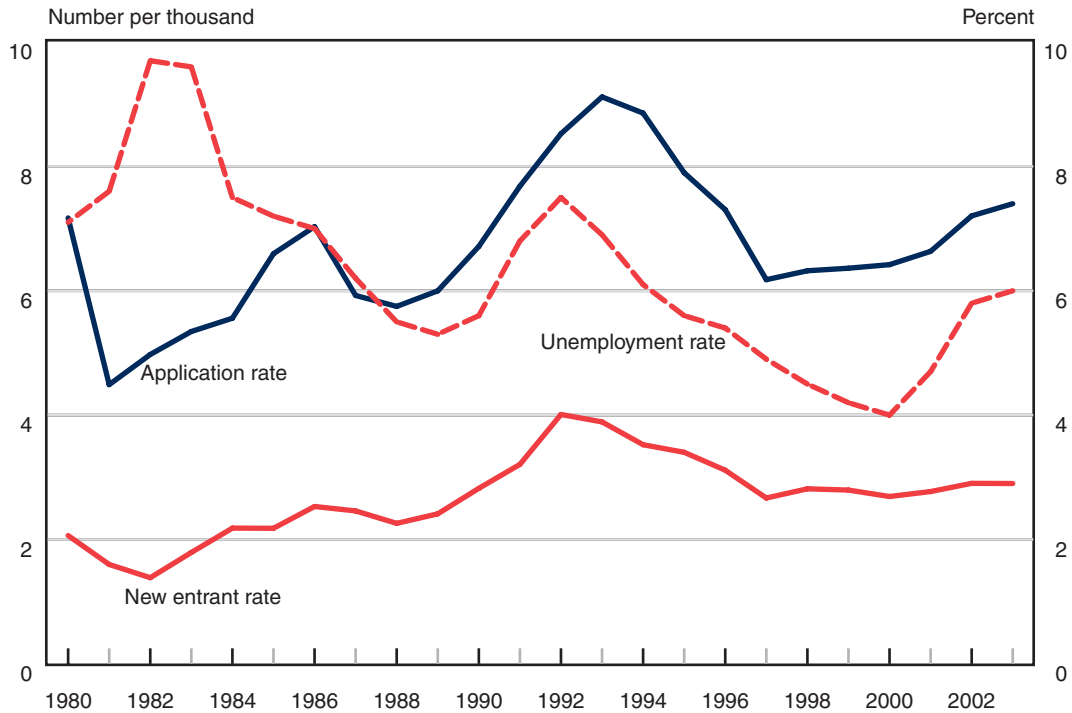
This chart shows the application rate for disabled-worker benefits along with the unemployment rate (an external factor) and the level of substantial gainful activity in constant dollars (an internal factor). It is interesting that the unemployment rate and the real SGA level follow similar trends, perhaps because, in the

past, SGA levels received ad hoc increases near the peak in the economic cycle. Although these data are suggestive of relationships, it is difficult to determine the factors that affect growth and to disentangle the effects of those factors.

Unemployment Rate and SSI Application and Incidence Rates for Adults (18–64)

Because of the limited work history of SSI applicants, one might not expect their rates of applications and new entrants to follow unemployment rates in the same pattern as the rates for DI applicants, who have a substantial work history. The patterns, however, are quite similar.

Chart 62. Rates of SSI applications and entry for blind and disabled adults per 1,000 in population aged 18–64 and the unemployment rate, 1980–2003



SOURCES: 2004 Annual Report of the Supplemental Security Income Program, Tables IV.A1, IV.B1, and IV.B2; Bureau of Labor Statistics, unemployment rate, available at http://www.bls.gov/cps/prev_yrs.htm.

NOTE: The reference population is the “Selected Social Security Area Population” of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

The SSI program tends to serve persons with no, or very limited, work history. As demonstrated in Chart 13, the proportion of SSI recipients who concurrently receive a DI worker’s benefit increased from 16 percent in 1981 to about 20 percent in 1993 and has remained near that level ever since. This would seem to suggest that the SSI program would be less influenced by

economic conditions than would the DI worker program. The application rate of disabled adults and the rate of new entrants to the SSI program follow a pattern similar to that of DI workers, with rates of applications and incidence tracking the unemployment rate after the mid-1980s, but not in the early 1980s.

PROJECTED FUTURE COURSE FOR SSA DISABILITY PROGRAMS

Introduction

Growth in DI Beneficiaries per Covered Worker

Income and Costs of the DI Trust Fund

Solvency of the DI Trust Fund

Growth in the SSI Population

Costs of the SSI Program

Number of SSI Recipients

INTRODUCTION

This section charts the projected future course of the Social Security Administration's disability programs. Projections for the Disability Insurance program show increasing costs and declining trust fund income, leading toward insolvency of the DI trust fund. By contrast, projections for the Supplemental Security Income disability program show that it appears to be on track to stabilize in size relative to the population and to actually decrease in cost as a portion of gross domestic product.

The data for all charts in this section come from SSA's Office of the Chief Actuary and are based on the intermediate assumptions of the Board of Trustees.¹ The data on the DI program come from, or were used in the preparation of, the *2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*. The Board of Trustees reports each year on the current and projected financial condition of the Social Security Administration's two separate trust funds: the Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund. The projections for future years reflect the Trustees' considered judgment about the demographic, economic, and program factors that affect income and expenditures. The Board of Trustees has historically produced estimates focused on 10-year (the short range) and 75-year (the long range) time frames, although in recent years estimates have been provided for the infinite time horizon. Projections are based on current Social Security law and do not anticipate any future changes that Congress might make.

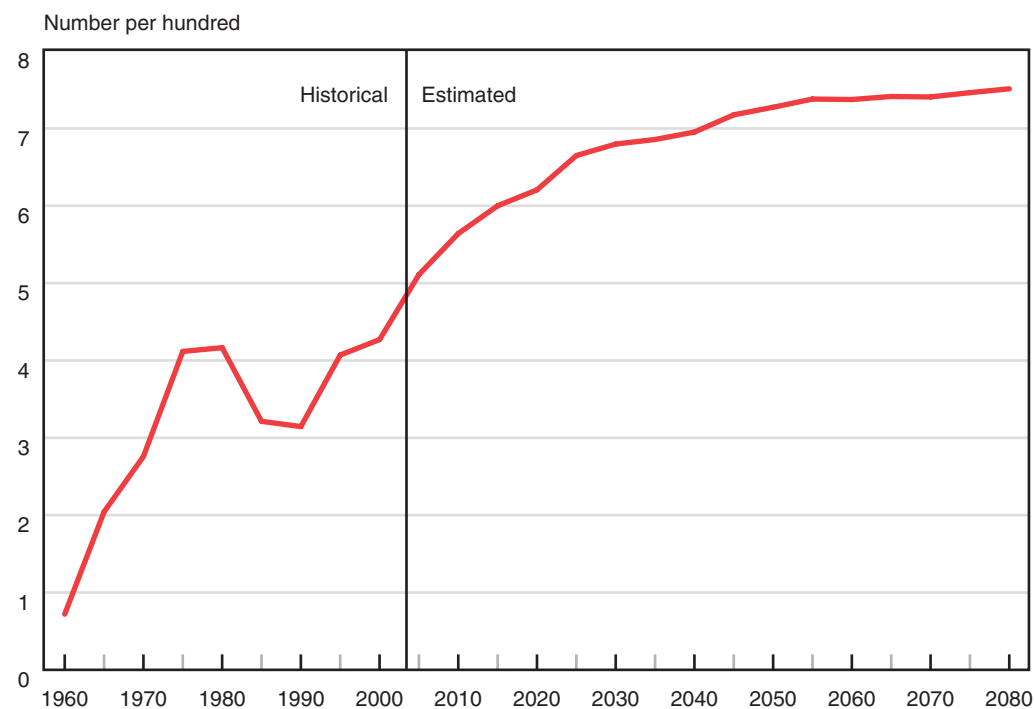
Data on the SSI program come from, or were used in the preparation of, the *2004 Annual Report of the Supplemental Security Income Program*. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) requires the Commissioner of Social Security to report annually to the President and Congress on the status of the Supplemental Security Income program. These reports are required to provide projections of program participation and costs at least 25 years into the future.

1. Because any projection of future experience is uncertain, the Trustees use three alternative sets of assumptions to show a range of possible outcomes: the intermediate set of assumptions (alternative II) reflects the Trustees' best estimate of the future financial outlook of the two trust funds; the low-cost alternative I is more optimistic, and the high-cost alternative III is more pessimistic.

Growth in DI Beneficiaries per Covered Worker

The root cause of future insolvency in the DI program, as in the retirement program, is the increasing number of beneficiaries relative to the number of workers paying into the system. The number of DI beneficiaries per 100 covered workers is projected to grow by more than 40 percent between 2004 and 2030, from 4.8 to 6.8 per 100.

Chart 63. DI beneficiaries per 100 covered workers



SOURCE: 2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table IV.B2.

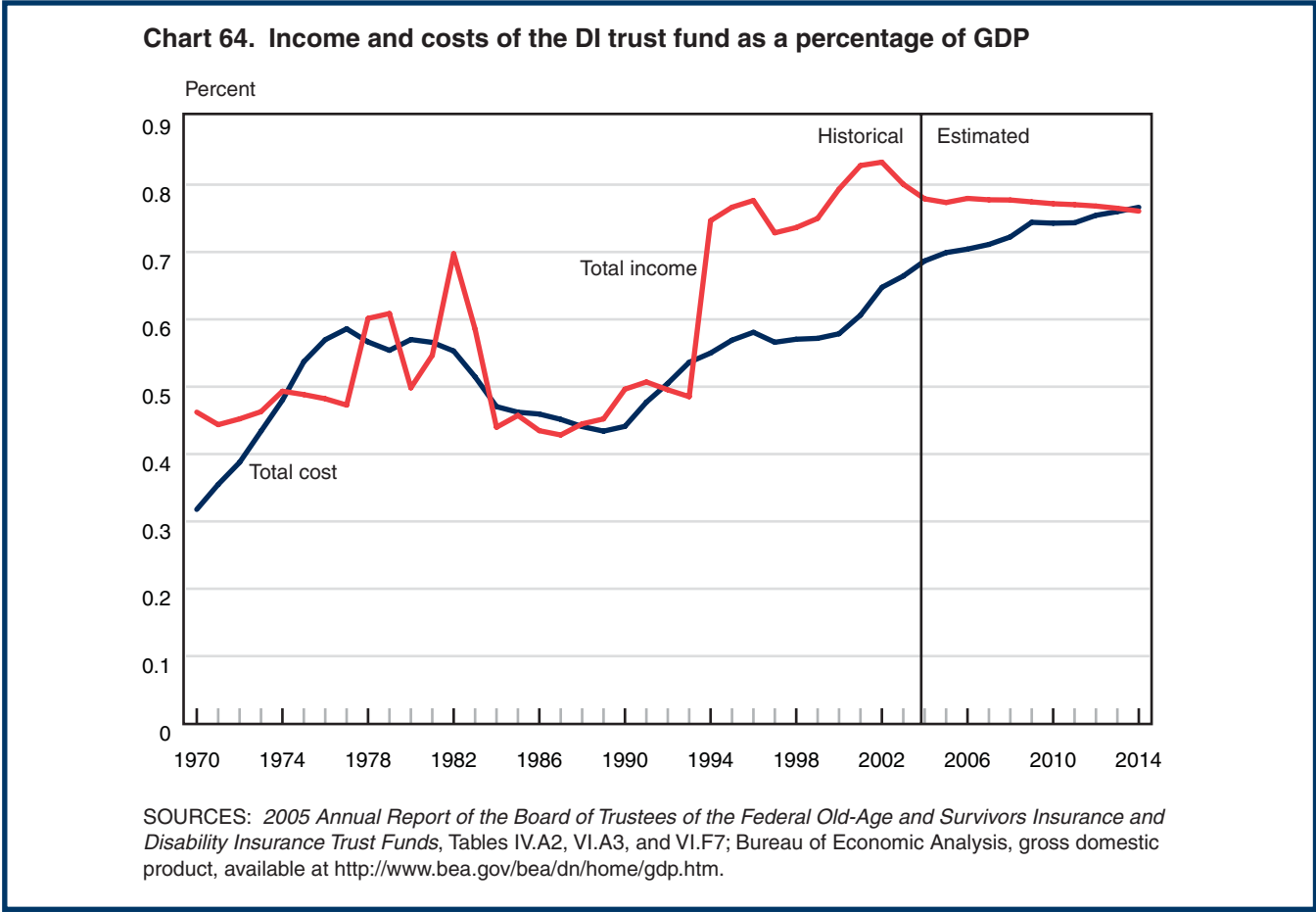
NOTE: Data reflect the intermediate set of assumptions (alternative II), which represents the Trustees' best estimates of the future financial outlook of the trust funds.

The root causes of future insolvency in the DI program are similar to those facing the retirement program. For example, the number of DI beneficiaries supported by 100 covered workers is increasing rapidly. In 1970, there were fewer than 3 beneficiaries per 100 covered workers; in 2004 there were 4.8. By 2030 the dependency ratio is projected to be 6.8 beneficiaries per 100 workers who are paying into Social Security, more than a 40 percent increase from the 2004 level. The same is true in the retirement program, though at even higher rates of dependency.

According to the 2005 Trustees Report, much of the increase in the ratio is attributable to the demographics of an aging population, with baby boomers entering the prime disability age group. Although age-adjusted incidence rates have increased in recent years, the Trustees Report projects that these rates will return to lower levels in the future.

Income and Costs of the DI Trust Fund

Income to the DI trust fund is projected to plateau as a percentage of gross domestic product while costs are projected to continue to grow, contributing to the solvency problem for the DI program.



Overall, the disability programs have generally been increasing as a proportion of gross domestic product (GDP) over the past few decades. As shown in Chart 17, the cost of Social Security’s disability programs (including Medicaid and Medicare) increased from 0.32 percent of GDP in 1970 to 1.98 percent of GDP in 2001.

Chart 64 shows income and expenditures of the DI trust fund as a percentage of GDP from 1970 to

2014. Expenditures from the trust fund as a percentage of GDP rose from 0.3 percent in 1970 to nearly 0.6 percent in 1977 and then declined to 0.45 percent in 1989. Since then, expenditures have risen to a historical high of 0.69 percent of GDP in 2004 and are projected to continue to rise over the next decade. Income to the DI trust fund is projected to decline slightly, contributing to the solvency problem for DI.

Solvency of the DI Trust Fund

Social Security is facing issues of long-term solvency, with the DI trust fund facing exhaustion in 2027, 16 years before the insolvency of the Old-Age and Survivors Insurance (OASI) trust fund. The Hospital Insurance (HI) Trust Fund, which funds the Medicare program, will be exhausted even earlier, in 2020.

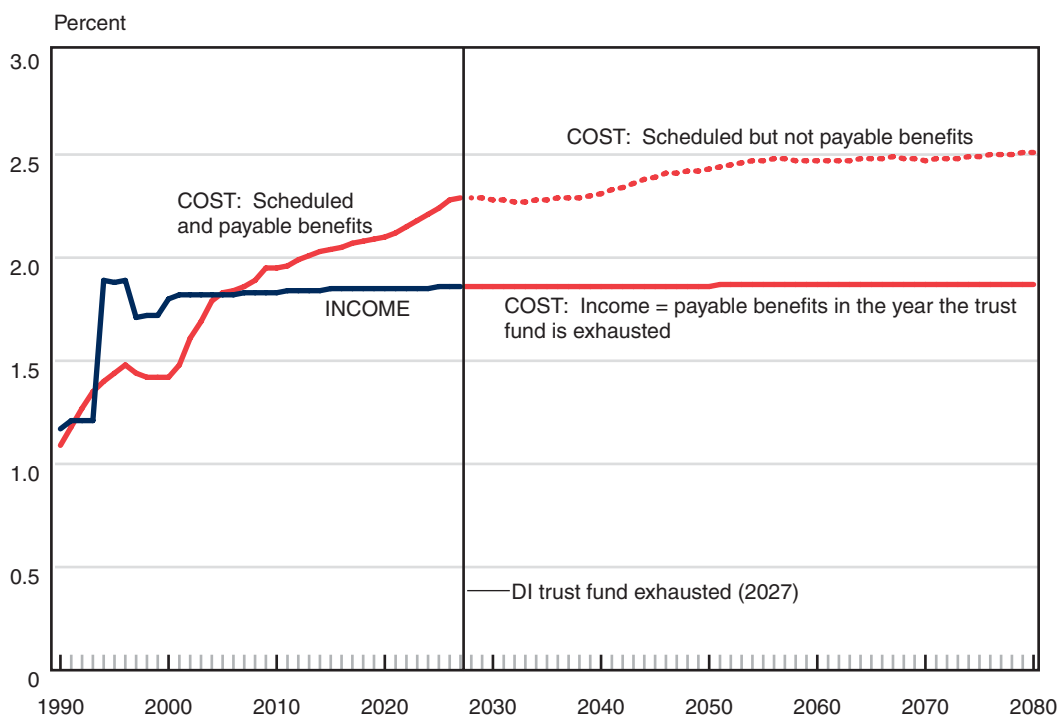
Table 1. Key insolvency dates for the Social Security trust funds, 2005

Key dates	OASI	DI	OASDI	HI
First year that outgo exceeds income				
Excluding interest	2018	2005 ^a	2017	2004
Including interest	2028	2014	2027	2012
Year that trust fund assets are exhausted	2043	2027	2041	2020

SOURCES: 2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds and 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

a. In 2005, the DI trust fund met this threshold with total expenditures of \$88.0 billion; income excluding interest was \$87.1 billion. The DI trust fund, however, increased by \$9.4 billion because of interest payments.

Chart 65. Income and cost of the DI program as a percentage of taxable payroll



SOURCE: 2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table IV.B1.

Solvency of the DI Trust Fund (cont.)

The increasing size and costs of the Social Security disability and Medicare programs are having adverse impacts on program solvency. The Trustees project that the DI trust fund will become insolvent in 2027, 16 years before the OASI trust fund. Furthermore, in 2005, total expenditures from the DI trust fund actually exceeded the inflow of tax receipts by \$868 million, although the DI trust fund continued to increase because of interest payments. Note that this estimate does not include the costs of Medicare benefits provided to DI beneficiaries, which are also growing (Charts 6–9). The Hospital Insurance (HI) Trust Fund, which funds Medicare, is also facing a solvency problem, with that trust fund projected to be exhausted in 2020, 7 years earlier than the DI trust fund. Because all disabled widow(er)s and the majority of disabled adult children collect benefits from the OASI trust fund, disability policy has an effect, albeit very small, on the solvency of the retirement and survivors (OASI) trust fund as well.

Congress has numerous options to deal with the projected future insolvency of the DI trust fund, such as altering the benefit formula or eligibility rules, altering the share of payroll taxes devoted to the DI trust fund, raising overall payroll taxes, or undertaking more fundamental reform of the DI and OASI programs.

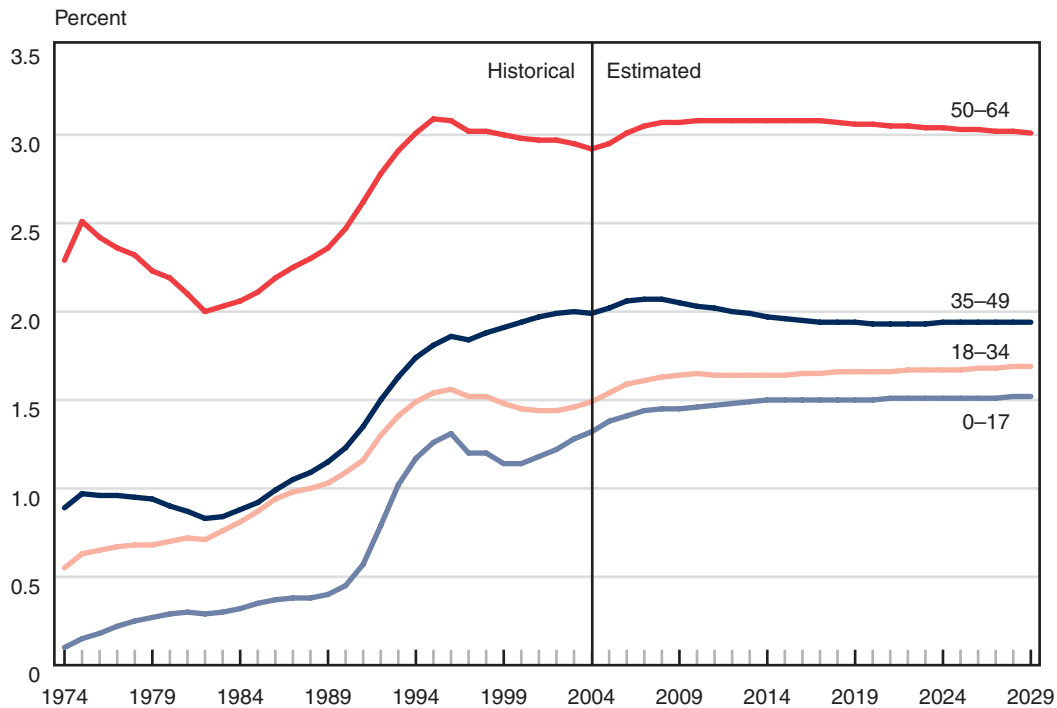
However, in the absence of any Congressional action, the Trustees' intermediate projections suggest that in 2027 the DI trust fund will have insufficient resources to pay all scheduled benefits to DI beneficiaries.

This is not the first time the Disability Insurance Trust Fund has faced insolvency. As recently as the early 1990s, the DI trust fund was facing imminent insolvency and, in 1994, Congress enacted a change in the allocation of payroll taxes between the DI and OASI trust funds. The allocation of tax revenue to the DI trust fund was increased from 1.2 percent of taxable payroll to 1.8 percent. The 1995 Trustees Report estimated that, on the basis of the intermediate assumptions, the reallocation of taxes that occurred in 1994 would leave the DI trust fund solvent until 2016. Reallocations have also been made in the opposite direction, with Congress reallocating taxes away from the DI trust fund to the OASI trust fund. For example, the 1983 Amendments reduced the allocation to the DI trust fund and established a future schedule of tax allocations between the DI and OASI trust funds to help ensure solvency of the retirement program. As discussed earlier, benefit cuts and program tightening have also been used to control program costs, most notably in the late 1970s and early 1980s.

Growth in the SSI Population

Blind and disabled SSI recipients, as a percentage of the population in their age group, are projected to be relatively stable in the future, although anticipated growth in the population will lead to increases in the number of SSI recipients.

Chart 66. Blind and disabled SSI recipients as a percentage of the population in their age group, December 1974–2029



SOURCE: 2005 Annual Report of the Supplemental Security Income Program, Table IV.B7 and Figure IV.B5.

NOTE: The reference population is the “Selected Social Security Area Population” of the appropriate age group and includes the population of the United States and several additional areas. See the glossary for a complete definition.

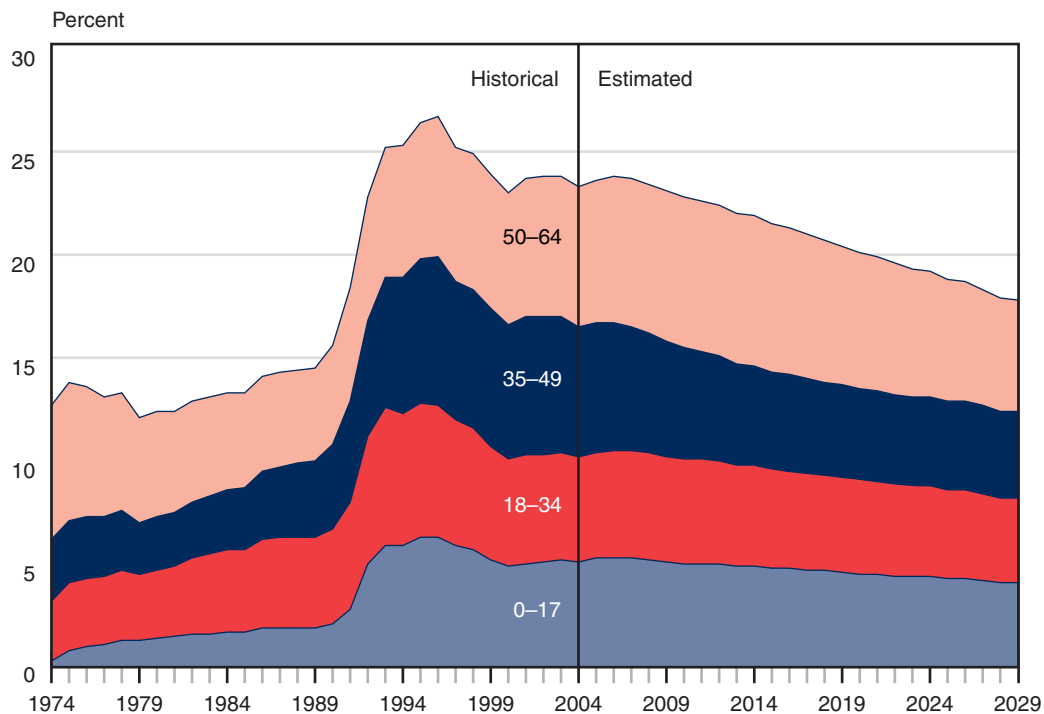
The SSI program does not have a trust fund and is financed through general revenues. Thus, although there is no solvency issue for SSI, the potentially long-term deficit in general revenue receipts compared with expenditures makes it imperative to assess various budget priorities. The future of the SSI program looks to remain relatively stable, with the percentage of adults in the older age groups (35–64) projected to decrease

slightly and the percentage in the younger age group (18–34) to increase modestly. The percentage of SSI disabled children (0–17) is also projected to increase slightly, with the projected increase moderating after 2014. Because the general population is expected to grow over this period, the number of SSI recipients is projected to continue increasing.

Costs of the SSI Program

The future of SSI for the blind and disabled is brighter than the future of the DI program, because the cost of the SSI program is projected to decline as a percentage of gross domestic product. However, the cost of the SSI program does not include costs related to Medicaid.

Chart 67. Federal SSI payments to the blind and disabled as a percentage of GDP, by age group, 1974–2029



SOURCE: 2005 Annual Report of the Supplemental Security Income Program, Table IV.D1 and Figure IV.D1.

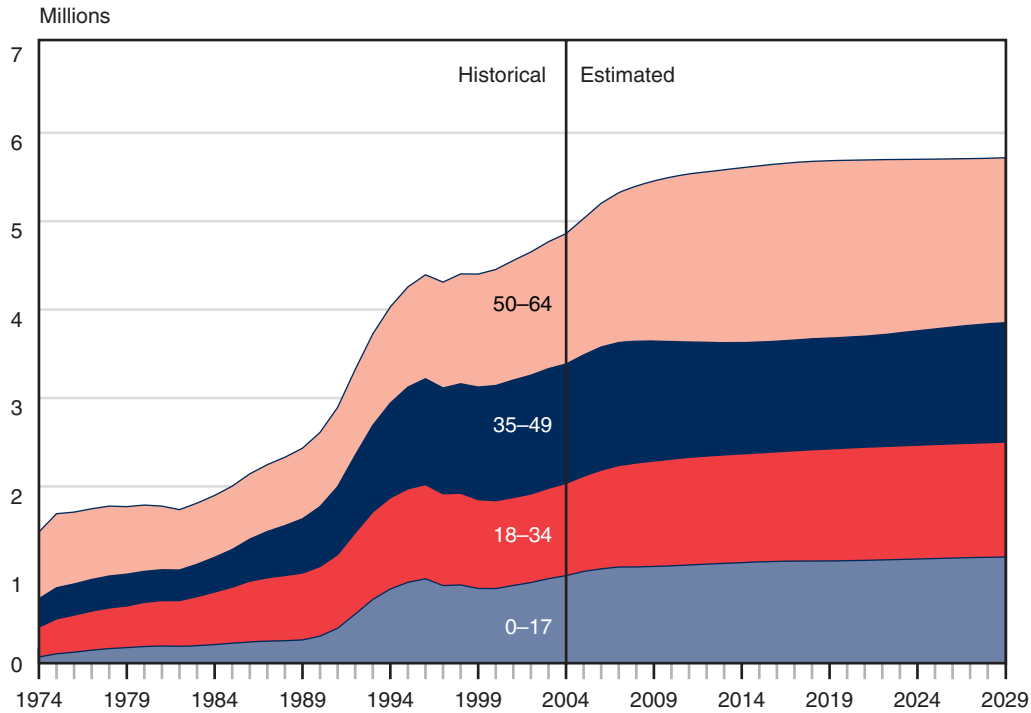
The cost of federal SSI payments to the blind and disabled is shown as a percentage of gross domestic product (GDP). Although the cost of the program as a percentage of GDP was higher in 2004 than it was in 1974, the cost relative to GDP actually declined between 1996 and 2000, before increasing slightly in the past several years. Overall, however, the financial

future of SSI is brighter than that of the DI program, because the cost of the SSI program is projected to decline as a percentage of GDP. As noted in Chart 66, age plays little role in determining the future composition of the SSI rolls, so costs relative to GDP decline for all age groups.

Number of SSI Recipients

The projected decline in costs relative to gross domestic product is not a function of decreasing numbers of SSI disabled recipients, since the number of recipients is projected to increase well into the future.

Chart 68. Blind and disabled recipients of federally administered SSI payments, by age group, December 1974–2029



SOURCE: 2005 Annual Report of the Supplemental Security Income Program, Table IV.B9 and Figure IV.B4.

The projected decline in costs relative to gross domestic product is not a function of decreasing numbers of SSI disabled recipients, since the number of recipients is projected to increase, albeit slowly, well into the future. The increase in the number of recipients appears to be related to the size of the population, rather than to an increase in the prevalence of disability, since the SSI population is projected to be relatively

stable or even decline as a portion of the population in each age group (Chart 66). This relationship indicates that the projected growth in the economy will play a role in diminishing the cost of the program relative to GDP. This analysis does not include the cost of Medicaid for the disabled, which, as shown in Chart 17, has been growing much more quickly than has the cost of the disability programs.

Glossary

Appeals Council. The third—and final—level of appeal in the disability determination process, following the administrative law judge. Subsequent appeals go to federal courts.

average indexed monthly earnings (AIME). An average of a beneficiary's lifetime (or predisability) earnings on which the primary insurance amount, or basic Social Security benefit amount, is calculated.

administrative law judge (ALJ). The second level of appeal in the determination process, following reconsideration. It is the first opportunity for the claimant to appear in person and the first decision by a federal adjudicator.

award. An award occurs when there has been a medical allowance and all technical criteria have been met so that a benefit payment can be made.

benefit suspension. Benefits are suspended for various reasons, including excess income for Supplemental Security Income recipients and work above the substantial gainful activity level for Social Security Disability Insurance beneficiaries, among others. Under benefit suspension, the individual remains eligible for the program but does not collect a cash benefit.

benefit termination. Benefits are terminated when the individual is no longer eligible for the program.

continuing disability review (CDR). A review of the beneficiary's medical condition to determine whether there has been sufficient medical improvement so that the individual is no longer disabled or whether an individual has demonstrated the ability to engage in substantial gainful activity.

constant (real) or current (nominal) dollars. Constant (real) dollars have been adjusted for inflation to reflect what expenditures would have been if the value of the currency had not changed and the cost of living had not increased. By contrast to current (nominal) dollars are the actual dollar figures in each year, not considering the value of the currency or the cost of living. The base year for constant dollars is the year in which its value is the same as that of the current (nominal) dollar.

Current Population Survey (CPS). A monthly survey of 50,000 households conducted by the Census Bureau for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years. The CPS is the primary source of information on the labor force characteristics of the U.S. population. Data on disability come from the annual March Supplement to the survey.

disabled adult child. A dependent child aged 18 or older—a son, daughter, or eligible grandchild of a retired, deceased, or disabled worker entitled to Social Security benefits—whose disability began before age 22.

Disability Determination Services (DDS). The state agency responsible for developing medical evidence and rendering the initial determination and reconsideration on whether a claimant is disabled or a beneficiary continues to be disabled within the meaning of the law.

disabled widow(er). The disabled dependent spouse of a deceased worker who was insured for Social Security purposes. Eligibility begins at age 50.

low birth weight. Defined for the SSI disabled children's program as a birth weight under 1,200 grams or under 2,000 grams and small for gestational age.

Glossary (cont.)

medical improvement review standard. The standard, since 1984, that applies when reexamining disability cases in the Social Security and SSI disability programs. Before ceasing disability beneficiaries, it must be demonstrated that there has been medical improvement, not simply that the individual no longer meets current disability criteria. This standard is not applicable to age 18 redeterminations of SSI children.

Listing of Impairments. Issued by the Social Security Administration and used to identify medical conditions for purposes of determining disability. Also referred to as the medical listings.

medical recovery. A reason for termination that is based on evidence that the beneficiary's medical condition has improved sufficiently so that the individual is no longer medically disabled.

Medicaid. The program that offers medical coverage under means-tested criteria that vary from state to state. The vast majority of SSI recipients are eligible for this program. Some states offer buy-in programs for Medicaid coverage.

Medicaid disabled. The category used for classifying Medicaid eligibles. It includes low-income individuals of any age who are eligible as persons meeting SSA's programmatic definition of disability. Individuals who meet that definition are those receiving SSI disability benefits as well as those whose income is too high for SSI but who qualify under separate Medicaid income standards. This latter group includes Medicare beneficiaries who receive cost sharing or assistance with Supplementary Medical Insurance premiums as a Qualified Medicare Beneficiary or as a Specified Low-income Medicare Beneficiary and disabled persons using a state's buy-in program.

Medicare. The program that offers hospital coverage (Part A) and optional supplemental medical coverage (Part B) to Social Security disability beneficiaries 24 months after entitlement to benefits. More recently, Medicare has added the Medicare Advantage option (Part C), which offers beneficiaries the opportunity to participate in private plans, and prescription coverage (Part D) which became effective on January 1, 2006.

Medicare disabled. The category used for classifying Medicare eligibles. It includes disabled individuals under age 65 who are eligible by virtue of receiving Social Security or Railroad Retirement disability insurance benefits for 24 months or longer, as well as individuals under age 65 who have been diagnosed with end-stage renal disease.

preeffectuation review. A federal review of a state disability allowance before payment effectuation. The purpose of the review is to ensure greater uniformity and consistency of the decisions made by various adjudicators within a state agency and of decisions made by the various states.

primary insurance amount (PIA). The monthly amount payable to a retired worker who begins to receive benefits at full retirement age or to a disabled worker who has never received a retirement benefit reduced for age. This amount, which is derived from the worker's average monthly wage or average indexed monthly earnings, is also used as a base for computing all types of benefits payable on the basis of one individual's earnings record.

Organisation for Economic Co-operation and Development (OECD). An international organization that, among other things, provides statistics for international comparative work. OECD provided the international statistics for this book.

Glossary (cont.)

redetermination. A redetermination of disability applies the rules used for new applicants. The medical improvement review standard does not apply. Disability redeterminations were required on some SSI childhood recipients after the 1996 welfare reform legislation and are required on SSI children who attain age 18 (redetermination is based on adult standards).

replacement rate. The ratio of disability benefit income to predisability income. The measure provides information about the adequacy and equity of benefit programs, as well as information about incentives to participate in the program.

section 1619a. The section of the 1980 Amendments that provides a work incentive for SSI recipients by permitting them to work above the substantial gainful activity level without being terminated. SSI payments continue to be offset \$1 for each \$2 earned.

section 1619b. The section of the 1980 amendments that provides a work incentive for SSI recipients by continuing Medicaid coverage for those whose earnings are high enough to result in the SSI cash benefit being ceased. The individual must continue to be disabled and use Medicaid services.

Selected Social Security Area Population. The population comprising residents of the 50 states and the District of Columbia (adjusted for net census undercount); civilian residents of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; federal civilian employees and persons in the armed forces abroad and their dependents; crew members of merchant vessels; and all other U.S. citizens abroad.

substantial gainful activity (SGA). The level of earnings that is used

- to determine eligibility for disability benefits upon application;
- to determine whether the individual is eligible to receive the disability benefit during the extended period of eligibility; and
- to establish that an individual, after completing the trial work period and extended period of eligibility, has successfully returned to work and is no longer eligible for cash benefits.

The SGA level in 2006 is \$860 a month for the nonblind and \$1,450 for the blind. The level is adjusted annually by the wage index.

SGA recovery. A reason for termination that is based on the individual's successful completion of the trial work period and extended period of eligibility and the demonstration that the individual has the capacity to do work that is substantial and gainful and is therefore no longer eligible for cash benefits.

technical denial. A denial of disability benefits for reasons other than medical, such as excess income or resources for SSI applicants or lack of insured status for Social Security applicants. Technical denials can occur before or after receiving a medical decision.

work disability. A disability that affects one's ability to work. Definitions vary, but a work disability typically means that the individual is limited in the amount or kind of work that can be performed. A severe work disability reflects an inability to do any work.

Zebley. The 1990 Supreme Court decision (*Sullivan v. Zebley*) that fundamentally changed the SSI definition of disability as it applies to children. Before *Zebley*, SSA used a "listings-only" standard for children. The Court found that this usage did not comport with the "comparable severity" criterion in the Social Security Act and mandated that SSA find a way to provide children with an "individualized functional assessment" that would parallel steps 4 and 5 for adults. In 1996, Congress replaced the "comparable severity" standard with a more strict standard of "marked and severe functional limitations."

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