



House Democrats Seek to Shift SSDI costs to Workers' Compensation and Impose Federal Standards

A review of the specifics of the request from Representative George Miller (D-CA) and Rep. Lynn Woolsey (R-CA) last week clearly revealed the political agenda that they plan to pursue when the opportunity arises. The request for a report from GAO, instead of seeking an objective review of the relationship between SSDI and workers' compensation 1) presumes that there has been a cost shift from state workers' compensation to SSDI going back to the 1990s, 2) suggests that the existing reverse offset provisions in 15 states should be discontinued, and 3) that once GAO has verified the assumed cost shift that measures should be adopted to "recover" the amounts shifted, imposing increasing costs on employers, insurers and state funds.

UWC coordinated a workers' compensation group meeting last week with representatives from AIA, PCI, NCSI, TPAs and the US Chamber to point out the flaws in the request to GAO, including 1) despite numerous studies of the relationship between state workers' compensation and SSDI, none of them concluded that changes in state WC had "caused" increases in SSDI applications or benefit costs, there was no "correlation" and not even an "association" between them. Instead, studies by the Congressional Budget Office showed that there was a causal connection between SSDI policy and legislative changes in the 1980s, changes in demographics, and changes in the economy that were responsible for increases in SSDI applications and costs.

The request to GAO asks that the report identify ways to "recover" amounts that were shifted due to changes in WC laws beginning in the 1990s.

As GAO reviews the research literature and finds it difficult to find a direct cost shifting, they are likely to focus on the effect on SSDI of the reverse offset provisions in 15 states, including Colorado, Florida, Hawaii, Illinois, Louisiana, Minnesota, Montana, Nevada, New Jersey, New York, North Dakota, Ohio, Oregon, Washington, and Wisconsin.

GAO is now beginning to contact state workers' compensation agencies in the 15 reverse offset states in effort to determine the impact of the reverse offsets and provide a quantifiable "cost shift" to SSDI. Contacts with these state workers' compensation agencies, to assure that the state realizes that the GAO requests for information are part of a political agenda to shift costs from SSDI to state WC would help to assure that any responses to GAO have a complete perspective.

Our group is formulating a coordinated response to the Miller/Woolsey initiative. Even though the majority in the House changed in 2011 and legislation is not likely to move this year to "recover" cost shifts, we expect the GAO study to be completed by 2012 and that it will be used as a basis for SSDI "reform" proposals in the years to come. An early response which provides an effective rebuttable demonstrating the lack of causation and the impact of elimination of the reverse offset provisions is key.

MAJORITY MEMBERS:

GEORGE MILLER, CALIFORNIA, Chairman
DALE E. KILDEE, MICHIGAN, Vice Chairman
DONALD M. PAYNE, NEW JERSEY
ROBERT F. ANDREWS, NEW JERSEY
ROBERT C. "BOBBY" SCOTT, VIRGINIA
LYNN C. WOOLSEY, CALIFORNIA
RUBÉN HINOJOSA, TEXAS
CAROLYN MCCARTHY, NEW YORK
JOHN F. TIERNEY, MASSACHUSETTS
DENNIS J. KUCINICH, OHIO
DAVID WU, OREGON
RUSH D. HOLT, NEW JERSEY
SUSAN A. DAVIS, CALIFORNIA
RAUL M. GRIJALVA, ARIZONA
TIMOTHY H. BISHOP, NEW YORK
JOE SESTAK, PENNSYLVANIA
DAVID LOEBACK, IOWA
MAZIE HIRONO, HAWAII
JASON ALTMIRE, PENNSYLVANIA
PHIL HARE, ILLINOIS
YVETTE D. CLARKE, NEW YORK
JOE COURTNEY, CONNECTICUT
CAROL SHEA PORTER, NEW HAMPSHIRE
MARCIA FUDGE, OHIO
JARED POLIS, COLORADO
PAUL TONKO, NEW YORK
PEDRO R. PIERLUISI, PUERTO RICO
GREGORIO KILILI-CAMACHO SABLÁN,
N. MARIANA ISLANDS
DINA TITUS, NEVADA
JUDY CHU, CALIFORNIA



COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

MINORITY MEMBERS:

JOHN KLINE, MINNESOTA,
Senior Republican Member
THOMAS E. PETRI, WISCONSIN
HOWARD P. "BUCK" McKEON, CALIFORNIA
PETER HOEKSTRA, MICHIGAN
MICHAEL N. CASTLE, DELAWARE
MARK E. SOUDER, INDIANA
VERNON J. EHLERS, MICHIGAN
JUDY BIGGERT, ILLINOIS
TODD RUSSELL PLATTS, PENNSYLVANIA
JOE WILSON, SOUTH CAROLINA
CATHY McMORRIS RODGERS, WASHINGTON
TOM PRICE, GEORGIA
ROB BISHOP, UTAH
BRETT GUTHRIE, KENTUCKY
BILL CASSIDY, LOUISIANA
TOM McCLINTOCK, CALIFORNIA
DUNCAN D. HUNTER, CALIFORNIA
DAVID P. ROE, TENNESSEE
GLENN THOMPSON, PENNSYLVANIA

December 17, 2010

Mr. Gene L. Dodaro
Acting Comptroller General
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Dodaro:

Following a November 17, 2010, hearing in the Workforce Protections Subcommittee entitled "Developments in State Workers' Compensation Systems," we are writing to request that the Government Accountability Office (GAO) evaluate whether and to what extent cuts to benefits paid under state workers' compensation programs are shifting costs to the federal Social Security Disability Insurance Program (SSDI). To the extent such cost shifting has been identified, we are asking GAO to identify policy options for the federal government to recover funds from insurers where retrenchment in state workers' compensation benefits have resulted in a cost shift, and to quantify the amount recoverable by the Social Security Administration if such policies were enacted.

Since 1990, states have been reducing workers' compensation benefits by restricting eligibility, imposing stricter evidentiary requirements and reducing compensation levels for both partial and total disability.

States have been limiting compensation when an injury aggravates a pre-existing condition, restricting compensation for particular conditions, and restricting compensation for permanent disability. For example, Oregon, Florida, South Dakota and Nevada now all require that work be the primary cause of any disability. Missouri excludes claims when work is merely the triggering factor. Kentucky, Missouri and Wyoming exclude disability claims that are part of the "natural aging process".

States have also reduced amounts paid in approved claims, particularly permanent partial disability benefits designed to compensate workers for lost income even when they return to the workforce. States have also worked to reduce the share of medical costs that employers (or their insurers) must pay as part of worker's compensation. This downwards ratcheting of benefit

levels appears to be driven by states competing with each other to lower costs to business, and has been described by some academics as a “race to the bottom.”

There are reasons to believe that workers who have found workers’ compensation inadequate, or were denied eligibility, could turn to SSDI instead. SSDI can be paid to any worker with a disability that precludes substantial gainful employment, regardless of whether or not the condition developed on or off the job. On the other hand, many of those denied workers’ compensation would not be eligible for SSDI, as the stringent eligibility criteria for SSDI will exclude many cases that do not involve permanent or long term disability.

Data developed by the National Academy of Social Insurance shows that SSDI payments have an inverse relationship to worker’s compensation benefit payments as a percentage of overall wages, raising questions about whether retrenchments in workers’ compensation may be partly responsible for the increasing costs of SSDI.

While workers with the most severe impairments may be able to receive both SSDI and workers’ compensation, in 35 states SSDI benefits may be offset by workers’ compensation benefits; thus, if workers’ compensation benefits are not being paid due to state retrenchments, Social Security Disability costs are also higher than they would otherwise have been. In other states, there is a so-called reverse offset, in which certain types of workers’ compensation benefits are reduced by the amounts paid by SSDI.

If employers are able to externalize costs for workplace injuries and shift these to the federal government’s disability program (or, in too many cases go uncompensated and fall on the shoulders of the injured worker), then the employer is insulated from market signals transmitted through higher insurance premiums that could incentivize stronger workplace safety efforts.

Workers’ compensation experts have identified several policy options, including a subrogation mechanism whereby the Social Security Administration (SSA) could recover the costs shifted to SSDI from employers or insurers where the eligibility and benefit levels for paid workers’ compensation falls below an established minimum. Criteria established in the Model Workers’ Compensation Law which was developed by the Council of State Governments in 1974 may be a useful starting place for setting a minimum threshold.

A thorough review of the extent of the cost shift which may have occurred as a result of these state law changes is now in order. We would therefore appreciate your assistance in developing the information that will enable us to conduct that review of the extent to which changes in state workers’ compensation benefits affect SSDI outlays and have constituted a cost-shift from insurance carriers or self insured plans to the federal government.

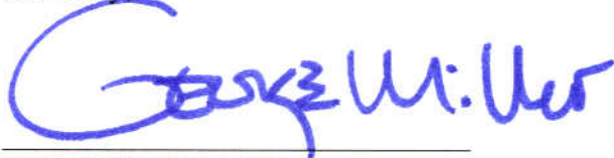
Mr. Gene L. Dodaro
December 17, 2010
Page 3

The Committee asks that you provide us with:

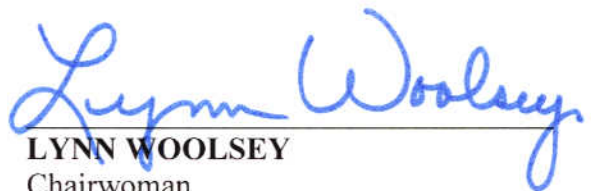
- 1) an analysis of changes to state workers' compensation laws since 1990 that have reduced permanent partial or permanent total disability payments, imposed stricter evidentiary requirements, or adopted any other legislative or policy changes that are designed or intended to reduce eligibility for benefits or payments to injured workers; identify those states, if any, where changes to workers' compensation laws has caused a cost shift to SSDI, and estimate the amount of such shift using, for example, case file reviews to determine if claims adjudicated by SSDI would have been otherwise compensable under state workers' compensation but for the retrenchment in benefits or eligibility;
- 2) identify policy options which could allow SSA to recover costs shifted to SSDI from state workers' compensation programs; and
- 3) in consultation with the Social Security Administration actuaries and its Office Quality Performance, estimate the amount that has been shifted to SSDI over the past 20 years due to changes in state laws, and what amounts could be recoverable from insurers or self-insured in the future, if changes in policy were made which authorized SSA to recover such costs.

Please contact Richard Miller at the Committee on Education and Labor at 202-225-3725, or Erika Hunter with Representative Lynn Woolsey at 202-225-5161, if you have any questions.

Sincerely,



GEORGE MILLER
Chairman



LYNN WOOLSEY
Chairwoman
Subcommittee on Workforce Protections

cc: Hon. Sander Levin, Chairman, Committee on Ways and Means
Hon. John Kline, Ranking Member, Committee on Education and Labor
Hon. Cathy McMorris Rodgers, Subcommittee on Workforce Protections

Social Security Disability Insurance: Participation Trends and Their Fiscal Implications

The Social Security Disability Insurance (DI) program pays cash benefits to nonelderly adults (those younger than age 66) who are judged to be unable to perform “substantial” work because of a disability but who have worked in the past; the program also pays benefits to some of those adults’ dependents. In 2009, the Disability Insurance program paid benefits to almost 8 million disabled beneficiaries and about 2 million of those beneficiaries’ spouses and children.¹

Between 1970 and 2009, the number of people receiving DI benefits more than tripled, from 2.7 million to 9.7 million.² That jump, which significantly outpaced the increase in the working-age population during that period, is attributable to several changes—in characteristics of that population, in federal policy, and in opportunities for employment. In addition, during those years, the average inflation-adjusted cost per person receiving DI benefits rose from about \$6,900 to about \$12,800 (in 2010 dollars). As a result, inflation-adjusted expenditures for the DI program, including administrative costs, increased nearly sevenfold between 1970 and 2009, climbing from \$18 billion to \$124 billion (in 2010 dollars).³ Most DI beneficiaries, after a two-year waiting period, are also eligible for Medicare; the cost of those benefits in fiscal year 2009 totaled about \$70 billion.

Under current law, the DI program is not financially sustainable. Its expenditures are drawn from the Disability Insurance Trust Fund, which is financed primarily through a payroll tax of 1.8 percent; the fund had a

balance of \$204 billion at the end of 2009. The Congressional Budget Office (CBO) projects that by 2015, the number of people receiving DI benefits will increase to 11.4 million and total expenditures will climb to \$147 billion (in 2010 dollars; see Figure 1). However, tax receipts credited to the DI trust fund will be about 20 percent less than those expenditures, and three years later, in 2018, the trust fund will be exhausted, according to CBO’s estimates. Without legislative action to reduce the DI program’s outlays, increase its dedicated federal revenues, or transfer other federal funds to it, the Social Security Administration (SSA) will not have the legal authority to pay full DI benefits beyond that point.⁴

A number of changes could be implemented to address the trust fund’s projected exhaustion. Some would increase revenues dedicated to the program; others would reduce outlays. One approach to reducing expenditures on DI benefits would be to establish policies that would make work a more viable option for people with disabilities. However, little evidence is available on the effectiveness of such policies, and their costs might more than offset any savings from reductions in DI benefits.

1. In this brief, the term “disabled beneficiaries” refers to people with disabilities who are receiving benefits from the DI program as a result of their own disability and whose DI benefits are calculated on the basis of their work history. (Such beneficiaries are also referred to as “disabled worker beneficiaries,” “disabled workers,” or “disabled insured beneficiaries.”)

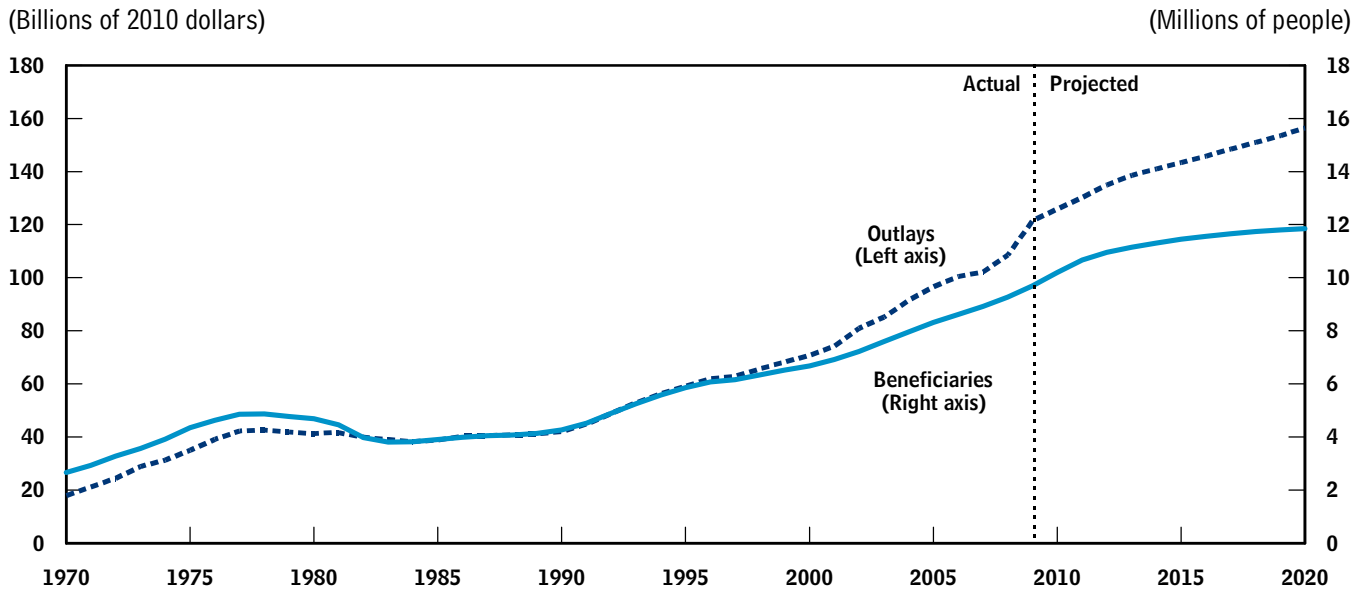
2. Unless otherwise specified, all years are calendar years.

3. Supplemental Security Income (SSI) is the other major federal program that provides cash benefits to people with disabilities; it serves only those people with disabilities who have low income and few assets. In fiscal year 2009, SSI outlays totaled \$45 billion, of which about 90 percent went to people who were disabled, including children and elderly people. About 16 percent of disabled beneficiaries also receive SSI benefits. [For information about SSI as well as additional background on the DI program, see Congressional Research Service, *Primer on Disability Benefits: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)*, CRS Report for Congress RL32279, February 2, 2010.] In addition, disabled veterans and people with work-related injuries and disabilities receive benefits through two smaller programs.

4. For further discussion of Social Security’s financing and trust funds, see Congressional Budget Office, *Social Security Policy Options* (July 2010), pp. 3–5.

Figure 1.

Social Security Disability Insurance Outlays and Number of Beneficiaries



Source: Congressional Budget Office.

Note: Outlays are calculated under current law, even after exhaustion of the Disability Insurance Trust Fund, and are adjusted for inflation using the consumer price index for all urban consumers.

How Does the Disability Insurance Program Work?

The DI program provides income to nonelderly adults—those younger than the full retirement age—who have worked in the past but who are deemed unable to work now because of a medical condition that is expected to last more than a year or to result in death.⁵ Disabled beneficiaries receive monthly payments based on their past earnings for as long as they remain in the program. Some family members of disabled beneficiaries, including certain spouses, minor children, and disabled adult children, are also eligible for benefits. If disabled beneficiaries remain disabled and live to the full retirement age, they then transfer to the Social Security retirement program.

Entry into the Program

To be eligible for the DI program, workers must have a sufficient record of work. Generally, people over the age of 30 must have worked during one-quarter of the years since they were 21 and during 5 of the past 10 years;

younger workers are subject to slightly different rules.⁶ Eligibility for benefits also requires that workers have monthly earnings below a threshold known as the “substantial gainful activity amount”—currently \$1,000 a month, or \$1,640 for blind beneficiaries—for at least the past five months. The rules governing the program place no limit on the nonwage income or assets of DI beneficiaries.

The DI program is intended to provide income to people who can no longer perform substantial work because of a disability. But the dividing line between those who can and cannot perform such work is not always clear. Some people who are employed have medical conditions that would allow them to qualify for the program if they stopped working (for instance, people who are deaf). By the same token, some disabled beneficiaries could probably work and would leave the DI rolls if they found a suitable job. The specific laws, regulations, and administrative procedures used to determine a worker’s medical eligibility for the program have a big effect on the num-

5. The full retirement age (currently, 66) is the age at which a person becomes eligible for unreduced Social Security retirement benefits.

6. See “How We Determine Disability Insured Status,” 20 C.F.R. 404.130, at www.ssa.gov/OP_Home/cfr20/404/404-0000.htm.

ber of DI beneficiaries, as do workers' decisions about whether to seek DI benefits.

Typically, applicants are considered to be disabled if they have a condition that appears on SSA's "listings of impairments" or if they are judged to be unable to perform substantial work for medical reasons that are not included in those listings.⁷ Initially, determining whether an applicant's disability qualifies him or her for benefits is the job of the Disability Determination Services (DDSs), which are agencies funded by SSA but administered by the states. Of the applications for benefits that the DI program received in 2005 (the most recent year for which nearly complete data are available), 39 percent were approved at the DDS level.⁸

Even with explicit rules about the medical conditions that make a person eligible for DI benefits, determining whether an individual applicant has such a condition is often difficult and necessarily subjective. Moreover, differences in administrative policies among the DDSs and in the circumstances of their applicants appear to have a large effect on decisionmaking. For instance, in 2004, the percentage of all initial claims for disability benefits approved at the DDS level varied from about 25 percent in Tennessee and Mississippi to more than 50 percent in Hawaii, New Jersey, and New Hampshire.⁹

If a DDS rejects an application, the applicant may appeal the decision and request a hearing before an administra-

tive law judge. Of the applications received in 2005 and rejected by DDSs, appeals were filed in one-third of the cases, and in three-quarters of the appealed cases, the initial decisions were reversed.¹⁰ In recent years, the number of appeals has greatly outstripped the ability of administrative law judges to process cases, leading to large backlogs and long delays.¹¹ For example, in fiscal year 2000, judges issued decisions an average of 300 days after an appeal was filed; processing time reached 514 days at the end of fiscal year 2008.

Over the past few years, SSA has received significant increases in funding to tackle the backlogs of DI claims. As a result, the average processing time for an appeal has fallen to 442 days. Maintaining that improvement will be difficult, though, because the number of applications for DI benefits increased by 21 percent between 2008 and 2009 and applications so far this year are running 4 percent higher than in 2009. The surge in applications, propelled in part by a shortage of job opportunities attributable to the weak economy, will probably result in longer delays in processing future appeals unless further increases in funding are provided.

Benefits in the Program

Average monthly benefits for disabled beneficiaries were \$1,065 in May 2010. Benefits for spouses and children were lower, averaging around \$300 per month. Disabled beneficiaries usually receive the same amount of benefits each month, boosted by annual cost-of-living adjustments, for the rest of their lives.

DI benefits, like all Social Security benefits, are tied to a worker's past earnings through a progressive formula.

-
7. Simply having a listed condition does not make an applicant medically qualified for benefits. The listings describe in detail the specific medical criteria that make a condition "severe enough to prevent an individual from doing any gainful activity." See Social Security Administration, *Disability Evaluation Under Social Security* (Blue Book), SSA Pub. 64-039 (September 2008), at www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm.
 8. Social Security Office of Retirement and Disability Policy, "2005 Longitudinal Disability Claims and Appeal Data" (unpublished analysis, April 30, 2009). Some approvals resulted from appeals conducted within a DDS, a process known as "reconsideration."
 9. Those differences partly reflect differences among those states in the types of medical impairments that applicants have, but they also stem from differences in approval rates for a given impairment. For example, the share of applicants with mental disorders who were approved for benefits varied from about 30 percent in North Carolina to almost 90 percent in North Dakota. See John D. Stobo, Michael McGeary, and David K. Barnes, eds., *Improving the Social Security Disability Decision Process* (Washington, D.C.: National Academies Press, 2007), pp. 58–62.

-
10. Several factors may help explain that high reversal rate. First, unlike what happens in the DDS process, applicants usually attend hearings and may present their case directly to the judge. Second, applicants are likely to have retained a lawyer for the appeal, whereas the federal government has no such representative at the hearing. Third, applicants are permitted to submit additional medical evidence at the hearing, so the judge's decision may be based on new information. Fourth, an applicant's condition may have worsened since the initial decision by the DDS. Finally, only applicants who believed they had a strong case would be expected to appeal.
 11. When a delay occurs in the approval of a DI claim, the amount of benefits a person receives over his or her lifetime is not reduced: Payments missed during the application process are paid in a lump-sum payment after a person's application for benefits is approved. For many people, however, a long wait for those payments presents a financial hardship.

That is, workers who have higher earnings receive larger benefits, but the replacement rate—the portion of earnings that benefits replace—declines with earnings.¹² For example, a 55-year-old worker who has had earnings equal to the nationwide average (in 2008, \$41,000) during all of his or her working life and who becomes disabled this year will receive monthly benefits of \$1,544, replacing 45 percent of those earnings. Yet if that person's earnings had been half as much, the benefit would have been \$993, replacing 58 percent of earnings. Because the benefit formula is linked to the growth of average earnings nationwide, average initial DI benefits grow at approximately the same rate as average earnings.

Disabled beneficiaries are also eligible for health insurance through Medicare after a two-year waiting period. The recipients generally find those benefits particularly valuable: People who have qualified for disability insurance are less likely than other workers to have been offered health insurance through an employer, and they also tend to need a great deal of health care.¹³ In 2009, Medicare spending per disabled beneficiary enrolled in that program averaged about \$10,500, which is equivalent to more than 80 percent of the amount of DI benefits that the average disabled beneficiary received that year.¹⁴

Exit from the Program

Disabled beneficiaries leave the DI program's rolls for three main reasons: They reach the full retirement age and transfer to the Social Security retirement program; they die; or they are found to be no longer disabled, in some cases because they have returned to work. Each year, about 7 percent of disabled beneficiaries leave the program. Of those, almost half transfer to the retire-

ment program, about 40 percent die, and about 10 percent—less than 1 percent of all disabled beneficiaries—are judged to be no longer disabled.

SSA periodically reexamines cases by conducting continuing disability reviews (CDRs) to determine whether beneficiaries are still eligible for DI benefits. Outlays for CDRs are expected to total about \$330 million in fiscal year 2010. The frequency of the reviews varies, depending on a beneficiary's characteristics. Beneficiaries classified as "medical improvement expected" are generally supposed to have a CDR every 6 to 18 months; in contrast, those classified as "medical improvement not expected" are supposed to have one every 5 to 7 years.¹⁵ Less than 1 percent of CDRs result in the termination of a beneficiary's benefits.

Benefits eventually end if a person returns to work and earns more than the program's limit of \$1,000 a month. To encourage people to return to work, SSA allows exceptions to that limit. For example, beneficiaries who return to work continue to receive DI payments for nine months, no matter how much they earn.¹⁶

Why Has the Number of Disability Insurance Beneficiaries Grown?

Changes in some characteristics of the working-age population, changes in policy, and changes in employment opportunities all contributed to the rise in the number of DI beneficiaries in recent decades. Other changes dampened that increase.

12. Most recipients do not pay taxes on DI benefits, but they did pay taxes on their earnings. So, net of taxes, replacement rates would usually be higher than the before-tax rates discussed here.

13. Jonathan Gruber and Jeffrey Kubik, *Health Insurance Coverage and The Disability Insurance Application Decision*, NBER Working Paper 9148 (Cambridge, Mass.: National Bureau of Economic Research, September 2002).

14. On average, Medicare spending per capita is roughly the same for disabled beneficiaries and for elderly beneficiaries. See Department of Health and Human Services, "2009 CMS Statistics," Tables I.1 and III.5, at www.cms.hhs.gov/Research-GenInfo/02_CMSSStatistics.asp.

15. General Accounting Office, *Social Security Disability: Reviews of Beneficiaries' Disability Status Require Continued Attention to Achieve Timeliness and Cost-Effectiveness*, GAO-03-662 (July 2003).

16. See Social Security Administration, "SSDI and SSI Employment Supports," in *A Summary Guide to Employment Supports for Individuals with Disabilities Under the Social Security Disability Insurance and Supplemental Security Income Programs* (Red Book; 2010) at www.ssa.gov/redbook/2010/ssdi-and-ssi-employment-supports.htm. SSA also provides a "Ticket to Work" program, under which beneficiaries may request employment or vocational rehabilitation services. Very few do; see Mathematica Policy Research, Inc., *Evaluation of the Ticket to Work Program: Ticket to Work at the Crossroads—A Solid Foundation with an Uncertain Future* (Princeton, N.J.: Mathematica Policy Research, Inc., September 2008).

Changes in the Characteristics of the Working-Age Population

The number of DI beneficiaries depends in part on the size and characteristics of the working-age population. In the past several decades, the aging of the workforce and increases in the number of women working have boosted the number of people receiving DI benefits. The effects of changes in the general health of the population, in contrast, are less clear.

Aging of the Workforce. The aging of the baby-boom generation (people born between 1946 and 1964), and consequently of the workforce, has led to an increase in the share of people who enter the DI program. Older workers are far more likely than younger ones to qualify: More older people suffer from debilitating conditions; also, they face less strict qualification standards because they are assumed to be less able to adapt to new types of work. Among people whose work history would qualify them for benefits, about 2 of every 1,000 people ages 30 to 34 began receiving DI benefits in 2008, compared with about 17 of every 1,000 people ages 60 to 64.¹⁷

Increased Employment of Women. Growth in the share of the working-age population that is disability insured—that is, in the share of those age 20 and older, up to the full retirement age, whose work history qualifies them to apply for disability insurance—has been spurred by a rise in the number of employed women. The disability-insured share expanded from 62 percent in 1970 to 73 percent in 1990 and then roughly stabilized; it was 75 percent in 2009. Between 1970 and 2009, the share of working-age women who were insured grew from 41 percent to 72 percent; for men, the share fell from 83 percent to 77 percent.¹⁸

The increased number of women who are employed and the subsequent increase in the share of those who are disability insured have resulted in more disabled beneficia-

ries and a rise in outlays for the DI program. At the same time, the increase in the number of working women has also boosted revenues for the DI program through the payroll taxes collected on their earnings.

Changes in the Health of the Population. How changes in the general health of the U.S. population between 1970 and 2009 have affected the number of disabled beneficiaries is unclear. Mortality rates declined steadily during that time, which suggests that the overall health of the population improved and fewer people might have received DI benefits than would otherwise have been the case. For instance, the introduction of more effective treatment for HIV in the late 1990s substantially improved the health of many infected people, resulting in a drop in the number of HIV-positive disabled beneficiaries.¹⁹ But a declining mortality rate also suggests that fewer people died from medical conditions that might once have been fatal. Advances in health care that allow people to live longer after the onset of a disability increase the amount of time that someone receives benefits from the DI program, producing a rise in the number of beneficiaries in a given year.²⁰

Changes in Federal Policy

The size and cost of the DI program increased dramatically during the early and mid-1970s (see Figure 1 on page 2). The Social Security Disability Amendments of 1980 attempted to contain that growth and apparently succeeded, for the number of DI beneficiaries subsequently declined. In the Disability Benefits Reform Act of 1984, however, policymakers reversed some of the more restrictive policies associated with the 1980 legislation; in particular, they expanded the ways in which a person could medically qualify for the DI program. The law's easing of the medical eligibility criteria led to renewed growth in the number of people who participated in the program and in the program's outlays. In

17. Personal communication to CBO staff from SSA's Office of the Actuary.

18. CBO based those calculations on Social Security Administration, "Statistical Tables: Disability Insured Workers—Estimated Number of Workers Insured in the Event of Disability, by Age Group and Sex, on December 31, 1970–2010" (July 1, 2010), at www.ssa.gov/OACT/STATS/table4c2DI.html.

19. Social Security Administration, Office of the Chief Actuary, *Social Security Disability Insurance Program Worker Experience*, Actuarial Study 118 (June 2005), p. 11.

20. Between 1980 and 2008, the mortality rate for disabled beneficiaries fell by 40 percent, or twice as fast as the decline in the rate for the general population. Still, the rate for disabled beneficiaries—about 3 percent in 2008—remains about five times higher than the rate for the general population.

1996, policymakers temporarily boosted spending for continuing disability reviews. Because the average reduction in benefits associated with a CDR is significantly greater than the cost of the review itself, the increased spending for CDRs helped lower overall spending for the DI program from what it would otherwise have been. Nevertheless, annual outlays continued to rise.

Easing of Eligibility Criteria. Under the 1984 legislation, the focus of the disability standards that people had to meet to be eligible for DI benefits shifted from a list of specific impairments to a more general consideration of an individual's medical condition and ability to work. Applicants could now qualify on the basis of the combined effect of multiple medical conditions, each of which taken alone might not meet the criteria. The legislation also allowed symptoms of mental illness and pain to be considered in assessing whether a person qualified for benefits, even in the absence of a clear-cut medical diagnosis.²¹

The easing of the eligibility criteria has interacted with the workforce's changing demographics to increase the average time spent in the program: People now are claiming DI benefits at younger ages, and they are less likely to die as a result of their qualifying condition. For example, the share of beneficiaries with mental or musculoskeletal disorders has increased in recent decades, from less than 40 percent in 1986 to about 60 percent today.²² That growth has contributed to an increase in the length of time beneficiaries spend receiving DI benefits, because those conditions are less likely than many other qualifying conditions to result in death.²³ In addition, the average age of new beneficiaries fell—from 51 in 1980 to 48 in the early 1990s—before increasing slightly to its current level of about 49.

21. See Frank S. Bloch, "Medical Proof, Social Policy, and Social Security's Medically Centered Definition of Disability," *Cornell Law Review*, vol. 92 (2006–2007), p. 189; David H. Autor and Mark G. Duggan, "The Growth in the Social Security Disability Rolls: A Fiscal Crisis Unfolding," *Journal of Economic Perspectives*, vol. 20, no. 3 (Summer 2006), pp. 71–96; and Social Security Administration, *Social Security Disability Insurance Program Worker Experience*.

22. Social Security Administration, *Social Security Bulletin: Annual Statistical Supplement* (various years), and *Annual Statistical Report on the Social Security Disability Insurance Program* (various years).

In addition, the increase in the full retirement age has caused DI beneficiaries to shift from the DI program to the retirement program later than participants did in previous years. Between 2002 and 2009, the age at which that shift occurred rose from 65 to 66; it is scheduled to rise further, to age 67, by 2027.²⁴ Because of the earlier age of entry to the program, lower mortality rates, and the higher age for shifting to retirement benefits, the share of disabled beneficiaries moving from the disability to the retirement rolls each year has fallen substantially, dropping from 7 percent of disabled beneficiaries in 1980 to about 3½ percent in 2008.

Changes in the Frequency of Continuing Disability

Reviews. CDRs tend to reduce the DI program's outlays, because the average reduction in benefits associated with a CDR is significantly greater than the average cost of the review. Yet in many cases, the DI program does not carry out the targeted number of CDRs because of limited administrative resources.

In 1996, responding to a backlog of more than 4 million reviews, lawmakers authorized \$4 billion in additional CDR funding, and the backlog was eliminated by the end of 2000. That special funding was not maintained, however, and the number of reviews declined, dropping by 65 percent between fiscal years 2004 and 2008. In response, lawmakers have increased the funding dedicated to CDRs over the past few years, but according to SSA's estimates, by the end of September of this year, a backlog of 1.5 million reviews will remain. SSA's Office of the Inspector General has estimated that DI outlays for 2011 will be between \$556 million and \$1.1 billion

23. Musculoskeletal disorders include, for example, disorders of the spine (such as osteoarthritis that compromises a nerve root or the spinal cord), certain amputations (for instance, of both hands), and the major dysfunction of a joint, which affects the ability to ambulate effectively or perform fine and gross movements effectively. Details are available at www.ssa.gov/disability/professionals/bluebook/1.00-Musculoskeletal-Adult.htm#1.01%20Category%20of%20Impairments,%20Musculoskeletal.

24. When the full retirement age was 65, a person who entered the DI program at age 51 and remained in it would have received DI benefits for 14 years. However, for a person who entered the program today at age 49 and remained in the program until the scheduled full retirement age of 67, that period would be 18 years, or 29 percent longer.

higher than they would have been if all CDRs had been completed on a timely basis.²⁵

Changes in Employment Opportunities

An important determinant of whether people apply for benefits from the DI program is how those benefits compare with the opportunities for employment in the workforce and the earnings and benefits (for instance, health insurance) associated with working.

Availability of Jobs. When opportunities for employment are plentiful, some people who could qualify for DI benefits find working more attractive. Conversely, when employment opportunities are scarce, some of those people participate in the DI program instead. Indeed, applications to the program increased during and immediately following the recessions that occurred in the early 1990s, in 2001, and over the past few years, as did the number of people receiving DI benefits (see Figure 1 on page 2).²⁶ Moreover, the number of beneficiaries tends to increase even after the economy begins to recover from downturns: Many people who have been out of the labor force for extended periods find it difficult to return to work, and new beneficiaries rarely leave the DI program to return to work simply because the economy has improved. CBO projects that as a result of the most recent recession, the number of DI beneficiaries will continue to rise over the next few years by more than otherwise would have occurred, contributing to the long-term trend of rising enrollment already under way.

Availability of Health Insurance. Most disabled beneficiaries and their disabled dependents are covered by Medicare after a 24-month waiting period.²⁷ Therefore, the availability of private health insurance for people who are not receiving DI benefits probably affects whether some of those people apply for benefits.

For people who are not currently offered health insurance in their job and who do not expect to have such coverage in the future, the eventual eligibility for Medicare that comes with participation in the DI program may be quite valuable and probably encourages them to apply. But for workers who have health insurance through their job, the appeal of eventual Medicare coverage is generally weaker: If they stopped work, they would probably spend at least part of the Medicare waiting period without health insurance or would face high costs to purchase it.²⁸

The recently enacted health care legislation is likely to influence the application rates for DI benefits, but whether it will result in more or fewer beneficiaries is difficult to predict.²⁹ Among other changes, the legislation will make it easier for people with health problems to buy their own insurance; it will also provide new subsidies for individually purchased coverage and expand eligibility for Medicaid. On the one hand, applications to the DI program might decline, because people who do not have employment-based health insurance will find it easier to obtain subsidized coverage without applying for DI benefits. On the other hand, applications to the DI program might increase, because people who would lose employment-based health insurance if they left their jobs to apply for DI benefits will be able to obtain subsidized or lower-cost coverage while awaiting eligibility for Medicare.

Value of DI Benefits Relative to Earnings. The DI benefit formula is progressive, so benefits replace a larger share of earnings for people whose earnings are relatively low before they become disabled. Furthermore, the growth of initial DI benefits is tied to the growth of overall average wages, the pace of which has tended to be faster than the growth of wages for less-skilled workers during the past few decades. Thus, for less-skilled workers, average initial DI benefits grew faster than did the earnings they could have received by remaining in the workforce. That

25. Social Security Administration, Office of the Inspector General, *Full Medical Continuing Disability Reviews* (March 2010), at www.ssa.gov/oig/ADOBEPDF/auditxt/A-07-09-29147.html.

26. The recessions of the early 1980s were not associated with an increase in the number of beneficiaries. However, the 1980 legislation that constrained growth in the DI program had just been implemented.

27. People with end-stage renal disease or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease) qualify for Medicare immediately. Disabled beneficiaries with low income and few assets may qualify for Medicaid coverage sooner (through the SSI program) than they qualify for Medicare.

28. Some of those individuals would have the option of continuing their employment-based insurance as allowed under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but they would have to pay the full amount of the premium without any contribution from their employer.

29. The relevant legislation is the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

circumstance probably increased the number of DI applicants from that group.³⁰

Possible Approaches to Changing the Disability Insurance Program

CBO projects that under current law, the Disability Insurance Trust Fund will be exhausted in 2018. At that point, legislative action would be necessary to avoid a sudden drop in the amount of benefits paid. Of the alternatives available to address that fiscal imbalance, some would increase revenues dedicated to the DI program or reduce outlays by adjusting the program's rules (such as the benefit formula or the definition of disability). Others, much broader in scope, would aim to make work a more viable option for people who could qualify for DI benefits under current law.

Alternatives for increasing revenues for the DI program include increasing payroll or other taxes. In addition, policymakers could choose to redirect a portion of the payroll tax dedicated to Social Security's Old-Age and Survivors Insurance (OASI) Trust Fund to the Disability Insurance Trust Fund, as was done in the 1990s. However, redirecting resources from the OASI trust fund to the DI program would advance the date on which the OASI trust fund itself would be exhausted.

Alternatives that would reduce DI outlays include reducing benefits, performing CDRs more frequently, implementing stricter definitions of work-limiting disabilities, or providing benefits only to individuals with little income and few assets. The effects of any one of those options on DI outlays could vary widely, depending on the way the change was structured.

Approaches for modifying the program might also include steps to strengthen incentives for people with disabilities to continue to work. For example, early intervention programs—to help employees likely to apply for DI benefits identify viable job alternatives, including less demanding positions—could help those employees stay in the workforce. Policies might also provide incentives

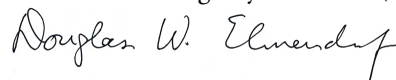
for employers to offer additional support to people with disabilities beyond that mandated by the Americans with Disabilities Act (for example, by making special accommodations, such as retraining or allowing a period of leave for rehabilitation). Or the federal government might provide added support more directly by paying a portion of a disabled worker's wages.

Allowing people with disabilities to receive partial disability benefits for conditions that precluded full-time employment but allowed part-time employment could also encourage people to stay in the workforce. That approach would allow people with less severe disabilities to receive benefits, but it would pay them less than people with more severe disabilities would receive, on average. Some workers who would not be eligible for DI benefits under current law would be eligible under such an approach, which would increase outlays. However, over time, the existence of the option might persuade some people who would otherwise leave the workforce and collect full DI benefits to remain in the workforce part time and collect smaller benefits—thus reducing DI outlays.

Changes made with the intent of lowering the DI program's future outlays might have other consequences for the federal budget. For example, if lawmakers established stricter eligibility requirements or provided substantially smaller benefits in the DI program, spending for Supplemental Security Income would increase. Similarly, an early intervention program might reduce spending for DI benefits but raise costs to the federal government overall, because such an option would result in some spending for interventions directed toward people who would not have applied for DI benefits in any case.

30. See Autor and Duggan, "The Growth in the Social Security Disability Rolls," pp. 80–83.

This brief was prepared by Molly Dahl and Noah Meyerson. It and other CBO publications are available on the agency's Web site (www.cbo.gov).



Douglas W. Elmendorf
Director