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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 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.

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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.

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).

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.
- 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 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.