



Social Security

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## Articles

**1 Workers' Expectations About Their Future Social Security Benefits:  
How Realistic Are They?**

*by John A. Turner and David Rajnes*

This study examines workers' expectations about their future Social Security benefits. The authors compile and analyze results of more than 60 individual surveys covering 1971 through 2020, with more than 130,000 respondents in total. The authors compare results over time and by demographic group to examine how Social Security expectations vary. They investigate possible explanations for the variations they find as well as for the finding that workers' expectations tend to be more pessimistic than Social Security actuarial projections.

**19 How Does Mortality Among Disability-Program Beneficiaries Compare  
with That of the General Population? A Summary of Actuarial Estimates**

*by Javier Meseguer*

Using period mortality estimates from Social Security Administration actuarial studies published over the period from 1977 to 2015, this article compares the long-term mortality trends of Disability Insurance (DI) beneficiaries aged 25 or older with those of the general population. The author finds substantial longevity gaps between the groups. Mortality rates among DI beneficiaries are highest in their first year on the DI rolls; rates are lower among those with longer durations on the rolls. Although period mortality for DI beneficiaries improved significantly over the study period, it remains today at levels similar to those experienced by the general public in the early years of the 20<sup>th</sup> century.



# WORKERS' EXPECTATIONS ABOUT THEIR FUTURE SOCIAL SECURITY BENEFITS: HOW REALISTIC ARE THEY?

by John A. Turner and David Rajnes\*

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*This study examines workers' expectations about their future Social Security benefits. We analyze data from 18 different one-time and recurring surveys, totaling more than 60 individual survey iterations conducted during 1971–2020 with a total sample size of more than 130,000. We examine how Social Security expectations vary over time and by demographic group. Although we find differences in workers' expectations over time and among subgroups, surprisingly high percentages of young workers consistently expect that they will not receive future Social Security benefits. Many other workers expect to receive benefits but their expectations about benefit amounts are more pessimistic than actuarial projections. We investigate possible explanations for these findings.*

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## Introduction

This study examines workers' expectations about their future Social Security retirement benefits. We compile and analyze data from surveys and associated economic studies that cover 50 years, from 1971 to 2020. The surveys show that some workers substantially underestimate their future Social Security benefits relative to projections from the Social Security actuaries. This finding suggests that efforts to inform workers about the value of their future Social Security benefits need to improve. This article catalogs many of the various past and present surveys that have asked Americans about their expectations of the future of the Social Security program and their own benefits, and reports the various surveys' findings. The article provides insight into ways the Social Security Administration (SSA) can improve its communication and outreach, particularly regarding the future of Social Security and the way benefits are calculated.

We first discuss different theories on the formation of expectations, which may explain some of the errors workers make in assessing their prospects for Social Security benefits. We then discuss the survey results on expectations about future benefits. We compare the results across several dimensions—different survey

questions, different years, and different demographic and socioeconomic groups.

## Theories About Expectation Formation: What Do We Know About Workers' Expectations?

Das, Kuhnen, and Nagel (2017) identified socioeconomic status (SES) categories based on income and educational attainment and found that people with higher SES are more optimistic about future macroeconomic developments, including business conditions, the national unemployment rate, and stock market returns. A comparison of the study participants' predictions with those of professional forecasters and with historical data reveals that the difference by SES in

### Selected Abbreviations

ACLI	American Council of Life Insurance
EBRI	Employee Benefit Research Institute
RCS	Retirement Confidence Survey
SEE	Survey of Economic Expectations
SSA	Social Security Administration
UAS	Understanding America Study

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expectations reflects excessive pessimism among low-SES individuals. This finding suggests that forecasts made by people with high SES may be closer to objective forecasts than those of people with low SES.

Norr (2017) attributed pessimistic views on the future of Social Security to negativity bias—the tendency to exaggerate negative information, such as reports of the need to reform Social Security to ensure program solvency. Bordalo, Gennaioli, and Schleifer (2018) presented a “diagnostic expectations” model that accounts for a behavioral tendency to overweight a narrow range of possible future events in light of incoming information. One example of this tendency is an overreaction to news; in response to negative news, people may develop overly pessimistic expectations.

Lack of information about Social Security benefits may explain why some workers’ expectations about their future benefits differ substantially from estimates based on the projections of the Social Security actuaries. Surveys have found low levels of Social Security program literacy among U.S. workers (Mitchell 1988; Lusardi and Mitchell 2007; Yoong, Rabinovich, and Wah 2015). Although many workers have some basic knowledge about program rules, they often lack the knowledge of program details that would allow them to make informed retirement-saving and other financial decisions (Smith and Couch 2014). Of key relevance to our study, Greenwald and others (2010) found that only 32 percent of survey respondents aged 25–65 felt that they were very knowledgeable about how much they will receive in future Social Security benefits. Only 22 percent of the youngest workers (those aged 25–34) felt very knowledgeable, but the percentages rose with age. This finding raises the question of whether low-knowledge workers will generally underestimate or overestimate their future benefits, or whether the error in their estimates will be random. Another factor that may affect workers’ uncertainty about their future Social Security benefits may be how much labor market uncertainty they face (Mitchell and Turner 2010).

### ***Surveys on Social Security Expectations***

We examine data on expectations from 18 singular or recurring surveys, of which some of the latter have been conducted for many years. In all, we reviewed more than 60 individual surveys with more than 130,000 respondents. Appendix A profiles the surveys and provides some key details about them. It identifies the sponsor or name of each survey; whether the survey was conducted by phone, via the Internet, or in

person; the periodicity and date or dates of the survey; and the size and type of the group or groups sampled for the survey. The appendix profiles provide a high-level overview rather than a precise, detailed delineation of all the surveys reviewed.

Surveys such as those conducted by the Employee Benefit Research Institute (EBRI), Gallup, the Transamerica Institute, the Nationwide Retirement Institute, and Aegon recur regularly. The questionnaires for recurring surveys often differ in content across the years; in some cases, the differences are substantial enough that they might be considered distinct surveys. Other surveys have occurred irregularly or were conducted one time only. Our analysis, though extensive, does not encompass all possible sources of survey information on Social Security benefit expectations.<sup>1</sup>

### ***Findings***

In this section, we first examine expected likelihoods of receiving Social Security benefits. Then, we examine expectations about benefit levels. Finally, we examine uncertainty and differences in expectations among subgroups.<sup>2</sup>

### ***Workers’ Expectations About Future Receipt of Social Security Benefits***

Although nearly all workers will eventually receive Social Security benefits, many survey respondents expect not to receive them. Whitman, Reznik, and Shoffner (2011) estimated that 86 percent of individuals aged 62–84 were current Social Security beneficiaries in 2010, and projected that another 10 percent were to be future beneficiaries, leaving only 4 percent who would not receive benefits. Many of the workers who never qualify to receive Social Security benefits have an insufficient work history in covered employment; these workers are likely to have low earnings or to be immigrants, and in particular to have immigrated at older ages. In addition, some workers will not qualify for benefits because they work for a state or local government that provides substantial pension coverage, which exempts them from Social Security coverage. Roughly one-quarter of state and local government employees, or 6.5 million workers, are not covered by Social Security (Quinby, Aubry, and Munnell 2020).

EBRI has conducted its Retirement Confidence Survey (RCS) since 1991. In the 1996 RCS, 23 percent of respondents expected that Social Security benefits would “not [be] a source of income in retirement” (EBRI 2016). Respondents were not asked why they thought they would not receive future benefits.



However, in 1996, the trustees of the Social Security trust funds projected that the Old-Age and Survivors Insurance program would become insolvent 35 years later, in 2031 (Board of Trustees 1996).<sup>3,4</sup> RCS respondents expressed similarly high levels of pessimism in each year from 2010 through 2013, when 21 percent did not expect to receive future Social Security benefits (EBRI 2016).

Concerning results for survey questions that elicit a yes or no response about future expectations, Dominitz and Manski (2006) suggested that respondents answer “no” when they view the probability of the queried outcome to be less than 50 percent. Thus, in the case of the 1996 RCS, Dominitz and Manski would argue that 23 percent should be interpreted as the share of respondents who viewed the probability of receiving future benefits as less than 50 percent, not as the share of respondents who viewed the probability as necessarily zero. Nevertheless, 23 percent seems to represent a high degree of pessimism, given the reality that all but about 4 percent of U.S. workers eventually receive Social Security benefits and that even potential insolvency would not eliminate benefits.

Armour (2017), using various 2010–2017 iterations of the RAND Corporation’s American Life Panel, found that only about half of the respondents who were not receiving Social Security benefits at the time of the survey expected to receive them in the future. The author examined whether SSA’s use of *Social Security Statements* to inform workers of program provisions and their earnings histories, and to estimate their future benefits, affected their expectations. The *Statement* is available online to individuals who sign up for a *my Social Security* account. For workers aged 60 or older who are not yet receiving benefits and who do not have a *my Social Security* account, SSA automatically mails a *Statement* each year until the benefit is claimed. From fiscal year 2000 through February 2011, SSA had mailed the *Statement* annually to all nonbeneficiary workers aged 25 or older. In a regression analysis, Armour found that having received a *Social Security Statement* raised the percentage of respondents expecting to receive a future Social Security benefit from about 50 percent to 62 percent—meaning that 38 percent of *Statement* recipients still expected not to receive benefits.

In a later study, Armour (2020) used a specialized American Life Panel survey to examine the effect of receiving a *Social Security Statement* during the years 2014–2016 on workers’ expectations. He limited his sample to people who had worked at least 10 years (and

earned 40 credits) in covered employment, enough to qualify for Social Security benefits. Because SSA had mailed *Statements* only to workers reaching a multiple-of-5 age during the study period, the sample allowed comparisons between *Statement* recipients and nonrecipients. Armour found that *Statement* recipients were likelier than nonrecipients to expect to receive future benefits, but they were also more likely to expect Congress to reduce future benefits. Among respondents who in 2013 had not expected to receive Social Security benefits, receiving a *Statement* increased the likelihood of expecting benefits by nearly 49 percentage points as of 2017. The effects on expectations were larger for workers who had lower knowledge about Social Security before receiving the *Statement* than for those with greater prior knowledge. The likelihood of expecting to receive Social Security benefits increased from 64 percent for those who had not received a *Statement* since 2011 to 71 percent among those who received one in 2014 or 2015 and to 78 percent for those who most recently received one in 2016. However, all of the effects were short-lived. For respondents who had last received the *Statement* 2 or more years before the survey, none of the effects were significant. Among *Statement* nonrecipients who reported that they did not expect to receive Social Security benefits, 53 percent cited as their reason that they did not expect Social Security to “be around long enough.” Future research might investigate why that belief is prevalent. The second most common reason was the belief that the respondent would not accrue enough work credits to qualify for benefits, even though the sample consisted entirely of workers with sufficient work histories to qualify at the time of the survey.

These results provide insights into how SSA communications might better inform the public and minimize the erroneous expectation among many workers that they will not receive Social Security benefits. However, the *Statement*’s effect on younger workers’ expectations may be limited, because only 44 percent of respondents younger than 40 who were mailed a *Statement* recalled having received it (Armour 2020). Smith (2020) found that receipt of two or more *Statements* had a stronger effect on workers’ benefit-claiming decisions (specifically, the decision to defer claiming) than receipt of one *Statement*. Her results show that an informational intervention (such as *Statement* mailings) can be an effective way to improve people’s expectations and that a comprehensive financial literacy program is not required to achieve that goal.

## **Expectations About Level of Benefits**

Bernheim (1987) used SSA's longitudinal Retirement History Survey, with respondents initially surveyed at ages 58 to 63 in 1969, to study the difference between the Social Security benefit amounts the respondents expected as workers and the amounts they later received as retirees. Because the survey was longitudinal, Bernheim was able to compare responses to the same question across various survey intervals. He found that the expected future benefits reported in the 1971 survey, when the respondents were aged 60 to 65, were about 10 percent lower than the amounts they later received, on average. He concluded that people near retirement tended to underestimate their future benefits. Widows and single women tended to underestimate by the largest amount—18.9 percent and 16.0 percent, respectively. However, not all workers underestimated their future Social Security benefits. One in six overestimated their future benefits by at least 25 percent, while one in twelve overestimated their future benefits by at least 50 percent. Men were more likely to overestimate their future benefits than women. For example, among singles, one-fifth of men overestimated their future benefits, compared with one-tenth of women.

The next set of surveys we analyze asked respondents how confident they were about the future of Social Security. In 1977, Congress established a National Commission on Social Security to examine potential fundamental changes to the entire system. A survey of workers conducted in 1979 for the Commission's report found that only 32 percent of respondents were confident that Social Security would have sufficient funds to provide full benefits for them (National Commission on Social Security 1981, Appendix A). In this survey, the respondents who expressed confidence presumably considered the likelihood of future benefit receipt to be greater than 50 percent, but they were not asked to report their degree of confidence between 50 percent and 100 percent.

Researchers have used a variety of approaches to measure workers' uncertainty about future Social Security benefits. Studies have measured the subjective probability that workers place on the chances that they will receive any benefits or that they will receive the full amount of promised benefits. Delavande and Rohwedder (2011) used a 2007 Internet supplement to the University of Michigan's 2006 Health and Retirement Study. They found that 25 percent of respondents aged 52 or older assign a 62 percent or lower probability of receiving any Social Security benefits. This

result is congruent with the previously mentioned 2010–2013 RCS results (EBRI 2016), which can be interpreted as indicating that 21 percent of respondents assigned a 50 percent or lower probability to the eventual receipt of Social Security benefits.

Yoong, Rabinovich, and Wah (2015), using the University of Southern California's Understanding America Study (UAS), found that only 4 percent of nonretirees are "very confident" that Social Security retirement benefits will "be there for [them] when [they] retire," while 41 percent are "not at all" confident. The wording "be there" is ambiguous, with different respondents probably assigning different meanings, making it difficult to interpret that particular result. For example, some workers may be answering not that they expect to receive no benefits but rather that they expect to receive benefits that will be inadequate for their needs.

Aegon Retirement Readiness Surveys found that 32 percent of respondents in 2015 were concerned that their Social Security benefits would be less than they expected, a proportion that rose to 37 percent in 2017 (Aegon 2015, 2017). In addition, according to AARP (2015), 19 percent of survey respondents incorrectly think that the potential depletion of the Social Security trust funds' reserves means that the system would not be able to pay any benefits.

As noted earlier, interpreting the results of many of the earlier surveys reviewed here is complicated by the uncertainty over the probability that workers assign to receiving *no* benefits from Social Security. The University of Wisconsin's Survey of Economic Expectations (SEE) was a 1999–2002 telephone poll that included several unambiguously worded questions about Social Security expectations (Dominitz and Manski 2006). The first such question was "Think ahead to when you are about to turn 70 years old and suppose that you are not working at that time. What is the per cent chance that you will be eligible to collect any Social Security retirement benefits at that time?" Respondents who reported a positive probability of eligibility were then asked a series of questions designed to elicit the range within which they expected their benefit amount to be (conditional on eligibility). However, the potential specificity of these responses was hindered by relatively lower response rates to those questions. The response rate for the full set of Social Security questions was only 66 percent, compared with an 80 percent response rate for questions on expectations of personal income 1 year ahead. Further, about 80 percent of the nonresponses for the



Social Security questions occurred when people did not report the lowest and highest possible benefits they thought they might receive.

Among all respondents, 9.4 percent reported expecting zero chance of receiving Social Security benefits. This share of respondents is much lower than those found in surveys on Social Security benefit expectations wherein the percentage likelihood of receiving no Social Security benefits is not specified.

### **Differences in Benefit Expectations Across Demographic Categories and Over Time**

Brown and others (2017) conducted a UAS survey module that innovatively addressed people’s expectations about future Social Security benefits. The survey posed a hypothetical scenario in which potential beneficiaries could pay or receive a one-time lump sum in exchange for a lifetime \$100 increase or decrease in monthly Social Security benefits, then asked respondents to advise a hypothetical 60-year-old about the lump sum amounts to demand for such trade-offs. The advice the survey respondents provided presumably reflected their expectations about future Social Security benefits being paid as promised, expectations shaped in part by news and rhetoric they had heard about future Social Security financing. If people believed that Social Security would cease providing benefits in the future, they presumably would pay nothing for increased benefits and would be willing to “sell” a decrease in monthly benefits for a relatively low lump sum. The median amount people were hypothetically willing to pay for an extra \$100 a month in benefits for the remainder of their life was \$4,750, while the median amount they were willing to accept to take a \$100 a month cut in benefits was \$16,250. Thus, people would require substantially more money to accept a cut in benefits than to purchase a benefit increase of the same amount.

About 12 percent of the UAS module respondents were not willing to pay anything for the extra benefits, while another 10 percent were willing to pay very little. About 10 percent were willing to purchase the increased annuity stream for about \$1,200, an amount they would get back in the first year. According to the authors, these results indicate that respondents would not be willing to purchase an increase in their Social Security benefits equivalent to purchasing a price-indexed annuity on an extremely favorable basis. Thus, the results are consistent with a small

percentage of the population having very negative views about the future of Social Security.

Because studies have found heterogeneity in worker expectations about other future circumstances, it is not surprising that heterogeneity is also found for expectations about Social Security benefits. The next subsections investigate survey data on expectations disaggregated by selected demographic and economic group.

### **Different Expectations by Age**

The 1999–2002 SEE asked its respondents (aged 18–69) questions designed to gauge their combined expectations of personal eligibility for Social Security benefits and the program’s ability to provide benefits to eligible participants. For the entire sample, the median reported probability of benefit receipt was 60 percent, meaning that 50 percent of the sample thought that their chance of receiving benefits was less than 60 percent. The study found that for people aged 30, the median probability of receiving benefits at age 70 was 40 percent, and that the median probability rose as the respondents’ age increased, to 100 percent at age 65 (Table 1) (Dominitz and Manski 2006).

In addition, the percentage of people who reported a zero percent chance that they would receive Social Security benefits at age 70 rose from 10 percent for respondents aged 20 to 17 percent among those aged 30, then decreased to 2 percent for those aged 65. Although most surveys do not ask their participants why they chose their particular responses, the SEE had

**Table 1.**  
**Perceived probability of receiving Social Security benefits at age 70: 1999–2002 SEE respondents, by age (in percent)**

Age	Median probability of receiving Social Security benefits	Respondents reporting zero chance of receiving Social Security benefits
All	60	--
20	50	10
30	40	17
40	50	13
50	70	6
60	90	4
65	100	2

SOURCE: Dominitz and Manski (2006).

NOTES: Ages reflect 2-year moving averages.

-- = not available.

an open-ended question asking why people thought they would not receive Social Security benefits. About two-thirds of those who reported they had a zero percent chance of receiving future Social Security benefits believed that the program would either cease to exist or no longer provide benefits (not shown). Much smaller shares of the respondents reporting zero chance for benefits believed that they would not live long enough to receive them (1 percent) or that prospective rule changes such as raising the retirement age or means-testing benefits would prohibit them from receiving benefits (4 percent). In addition, some believed that they would not receive benefits because they would not have worked the required 40 credits (or at least 10 years) in covered employment (12 percent).

Dominitz and Manski found that at the individual level, subjective uncertainty about the range of likely benefits is large among young people but it decreases with age. The authors measured the subjective uncertainty as the difference between the minimum level of benefits that the respondents expected to receive with 25 percent likelihood and the minimum level of benefits that they expected to receive with 75 percent likelihood. Dominitz and Manski argued that decreasing uncertainty with age makes sense because uncertainty about both the person's earnings history and the future structure of Social Security decrease, at least for those nearing retirement. They noted, however, that even for middle-aged persons, uncertainty remains fairly high. They found that the cross-sectional median of the interquartile range of expectations (25<sup>th</sup> percentile versus 75<sup>th</sup> percentile of expected annual benefits) for respondents aged 55 was \$6,100.

By separately measuring the probability of eligibility for benefits and expectations of benefit levels conditional on receipt, Dominitz and Manski concluded that variations by age in expected benefits stem mainly from different expectations about the survival of the Social Security system, rather than different expectations about its generosity should it continue to exist. The authors did not investigate why young people are more likely to think that Social Security will cease to exist, but that may in part reflect the greater uncertainty that naturally accompanies a longer projection period.

Luttmer and Samwick (2015) designed and fielded a module of the Ipsos KnowledgePanel Internet survey and found that expected benefits as a percentage of scheduled benefits rise with age, which fits the perception that people near retirement will both have realistic expectations and be less likely to face future benefit

reductions. The authors reported that 91 percent of respondents were aware of projected future financial shortfalls for Social Security. They found that, on average, individuals aged 25–59 expected to receive only 60 percent of the Social Security benefits that they were scheduled to receive. On average, individuals aged 25–29, 30–34, and 35–39 expected to receive roughly 50 percent of promised benefits, with individuals in older age groups expecting higher percentages.

In a Gallup news release, McCarthy (2018) reported the response to this survey question: “Now I am going to read a list of problems facing the country. For each one, please tell me if you personally worry about this problem a great deal, a fair amount, only a little bit, or not at all. Do you worry about the Social Security system?” Since 2005, the percentage of working-age respondents who said they worry “a great deal” about the future of Social Security has increased with age. This result—increasing worry with age—is not necessarily inconsistent with the previously discussed finding that the percentage of promised benefits one expects to receive also increases with age. The Gallup survey may indicate that people think more seriously about retirement as they get older.

The 2010 EBRI RCS found that only 67 percent of workers aged 25–34 expected to receive Social Security benefits, compared with 92 percent of workers aged 55 or older. In the 2012 RCS, only 65 percent of workers aged 25–34 expected to receive future Social Security benefits (EBRI 2010, 2012).

The American Academy of Actuaries provided us with unpublished survey data for 2016 indicating that the percentage of Americans expecting to receive Social Security benefits increases with age, from 48.7 percent for those aged 18–34 to 69.7 percent for those aged 35–54 and to 90.9 percent for those aged 55–64. Thus, from this survey, roughly 50 percent of workers younger than 35 had pessimistic benefit expectations. However, this survey aligns with other studies in finding that worker age is inversely associated with pessimism about the receipt of future Social Security benefits.

The finding that 69.7 percent of workers aged 35–54 expect to receive any Social Security benefits is of particular interest. Of these workers, who are old enough to be saving and planning for their retirement, 30 percent did not expect to receive benefits. Although some retirees do not receive benefits for various reasons, those individuals account for about 4 percent of the retirement-age population. Thus, roughly 25 percent

of respondents aged 35–54 erroneously expect not to receive any benefits from Social Security.

An online survey conducted in 2019 as part of Morning Consult’s Longevity Project (Konish 2020) asked participants which financial resources they were counting on in retirement. Among baby boomers (born 1946–1964), 83 percent said they were counting on Social Security. That percentage declined for each successively younger generation—64 percent for generation X (born 1965–1980), 42 percent for millennials (born 1981–1994), and 38 percent for generation Z (born 1995–2015).

### ***Differences by Race and Ethnicity***

Cohen, Luttig, and Rogowski (2017), using the Gen-Forward Survey, explored the views of millennials (persons aged 18–34 in 2017) by race and ethnicity and found that most were not confident in the future of Social Security. White respondents were the most likely to lack confidence (77 percent), and 37 percent did not expect to rely on Social Security at all. Latino respondents were the least pessimistic, yet 66 percent of them lacked confidence, and 32 percent expected not to receive any benefits. Black respondents were the least likely to expect not to receive benefits (29 percent). Among both Asian and Black respondents, 73 percent lacked confidence; and like the Latino participants, 32 percent of Asian respondents did not expect to receive benefits.

### ***Differences by Income***

The 2016 American Academy of Actuaries survey asked respondents with different earnings levels whether they expected to receive income from selected sources, including Social Security, in retirement. The percentage of people expecting to receive Social Security benefits increased with earnings: 55.8 percent of those with earnings under \$40,000, 74.5 percent of those with earnings from \$40,000 to \$99,999, and 71.2 percent of those with earnings of \$100,000 or more. This pattern is roughly consistent with higher-income people having greater financial literacy (Lusardi and Mitchell 2014) and thus being more likely to understand that they will receive Social Security benefits. It is also consistent with the finding, cited earlier, that people with higher income tend to report being more optimistic about the economy in the future. However, it may also reflect the fact that income tends to rise with age, and the percentage of people expecting to receive Social Security benefits also rises with age.

Since 2005, Gallup has tracked respondents’ views on the future of Social Security. Consistently, lower-income Americans have been more likely to register a “great deal” of worry about the future of Social Security than those in other income groups, while the highest income group has been least likely to express a great deal of worry (McCarthy 2018). A possible explanation is that lower-income Americans depend the most on the program as a source of retirement income. However, because they tend to have relatively low financial literacy (Lusardi and Mitchell 2014), it could also be that they are the least knowledgeable about the future of Social Security.

### ***Differences by Education and Cognitive Ability***

Perez-Arce, Rabinovich, and Yoong (2019) conducted a randomized survey as part of the UAS in which they presented respondents with alternative Social Security reforms: raising the payroll tax rate, raising the payroll tax rate ceiling, or reducing benefits. The authors found that people with higher educational attainment, financial literacy, and cognitive ability were more likely to adjust their expectations about future Social Security benefits rationally and consistently in response to changes caused by the potential alternative reforms.

### ***Differences Over Time***

Changes over time in Americans’ expectations about future Social Security benefits is a topic of particular interest because differing expectations may provide evidence of the effects of changes in the Social Security actuaries’ predictions of future Social Security financing. Beginning in 1968, the American Council of Life Insurers (then known as the American Council of Life Insurance [ACLI]) surveyed Americans’ confidence in Social Security’s future in its annual Monitoring Attitudes of the Public survey; our review focuses on the 1975–1988 iterations. The 1975 survey found that 63 percent of Americans were very or somewhat confident about the future of Social Security, with only 10 percent reporting that they were not at all confident (Reno and Friedland 1997). This survey established a baseline of high positive expectations among respondents. Three years later, in 1978, only 39 percent reported confidence, while 21 percent felt “not at all confident.” Notably, the 1978 survey followed media reporting of negative information about the future of Social Security that had emerged from public policy discussions related to reform legislation

passed in 1977. A brief and modest rebound in confidence followed; but it fell again around the time of the 1983 Social Security reforms, to percentages in the low 30s in 1982–1984. Following the 1983 reforms, confidence rose until 1990, but then declined once again until 1994, perhaps because of further negative portrayals of the Social Security system by interest groups, which were later amplified in the media (Myers 1997).<sup>5</sup>

In their analysis of the ACLI data, Reno and Friedland (1997) found that people who have low confidence in Social Security nonetheless indicate that they expect to receive benefits, although they tend to underestimate their likely future benefit amounts. Using earlier ACLI surveys, Sherman (1989) presented data for selected years 1975–1988 on workers’ level of confidence in the future of Social Security (Table 2). She found that a majority of workers did not express that they were “very or somewhat” confident in the future of Social Security after 1976.

Since 2001, Gallup has asked workers “When you retire, will Social Security be a major source of income, a minor source of income, or not a source at all?” (Gallup 2020). Since 2016, the share of respondents expecting Social Security not to be an income source has trended downward (Table 3). Broadly consistent with Gallup, EBRI has found a downward trend since 2013 in the percentage of people expecting Social Security not to be a retirement income source. The trend may be due in part to the effect of SSA *Statement* mailings in 2014–2016 (Smith 2020). As noted earlier, from 2010 through 2013, the EBRI

**Table 2.**  
**Workers expressing confidence in Social Security, selected years 1975–1988 (in percent)**

Year	Very or somewhat confident	Not too confident	Not at all confident	Don't know or no answer
1975	63	27	10	0
1976	57	32	10	1
1977	50	30	20	0
1978	39	39	21	1
1981	42	39	18	1
1982	32	43	24	1
1983	34	38	26	2
1984	32	43	25	0
1985	35	37	24	3
1986	39	37	21	4
1988	49	30	15	6

SOURCE: Sherman (1989, Table 2).

RCS found that 21 percent of workers expected not to receive Social Security benefits in retirement. The shares of respondents expecting no benefits declined to 20 percent in 2014, 19 percent in 2015, and 15 percent in 2016 (EBRI 2016). Those figures dipped further in 2017 and 2018, to 12 percent and 13 percent of workers, respectively (EBRI 2017, 2018). The decline from 2016 to 2017 may be due in part to the switch from a phone survey to an online survey, given that some of the characteristics of phone respondents and online respondents may differ. Nonetheless, there is clear evidence of a decline in the percentage of the population expecting Social Security benefits not to be a retirement income source.

Not all the data are consistent across surveys. The 2016 American Academy of Actuaries survey found that 34 percent of Americans did not expect to receive any Social Security benefits, in contrast with 15 percent of workers in the EBRI RCS for that year (and 12 percent of those in the 2017 RCS). Some of the discrepancy may be the result of different samples: The RCS interviews persons aged 25 or older, while the Actuaries survey covers persons aged 18 or older. In the 2018 RCS, 20 percent of workers younger than 45

**Table 3.**  
**Workers expecting Social Security not to be a source of income in retirement: Two surveys, selected years 1991–2020 (in percent)**

Year	Gallup	EBRI RCS
1991	...	10
1996	...	23
2001	14	...
2003	12	17
2005	18	19
2007	20	17
2008	...	19
2009	18	18
2010	...	21
2011	20	21
2012	21	21
2013	17	21
2014	...	20
2015	14	19
2016	20	15
2017	19	12
2018	14	13
2019	16	...
2020	12	...

SOURCES: Gallup (2020); EBRI (2016, 2017, 2018).

NOTE: ... = not applicable.



did not expect to receive Social Security benefits, so differences in the age distribution of the two samples could be a factor; but they are not large enough to fully explain the difference.

### Differences by Sex

The longitudinal Transamerica Retirement Survey annually asked workers to identify their greatest fears about their eventual retirement, such as the fear that Social Security benefits would be reduced or cease to exist in the future. The 2015 survey restricted the sample to workers aged 50 or older but subsequent surveys queried workers aged 18 or older. The older workers surveyed in 2015 were less likely to express that fear (33 percent) than younger workers surveyed later (Table 4). In 2017, 48 percent of workers in for-profit companies expressed that fear, but the percentage fell to 39 percent in 2019. In 2007, the same question had been asked of a sample of single women, who constitute about half the adult female U.S. population, and

45 percent expressed concern about Social Security (not shown; Transamerica 2008). A similar question in the 2012 survey asked respondents to indicate a single greatest fear, rather than being able to indicate several fears about retirement. In that survey, 18 percent of women and 12 percent of men listed Social Security ceasing to exist or reducing benefits as their single greatest fear (Transamerica 2013).

Responding to another annual Transamerica survey question from 2014 through 2018, roughly three-quarters of workers expressed concern that Social Security would “not be there” for them (Table 5). Of particular interest, women were more pessimistic than men, with roughly 80 percent of women and 72 percent of men expressing that concern each year. Other studies have found evidence that women are more financially risk-averse than men are. For example, Hinz, McCarthy, and Turner (1997) presented evidence that women are more conservative in their pension investments.

**Table 4.**  
**Workers in for-profit companies expecting Social Security to be reduced or to cease to exist in the future (in percent)**

Year	Workers	Sample characteristics	
		Worker ages	Employment size of workplace
2015	33	50 or older	10 or more
2016	47	18 or older	10 or more
2017	48	18 or older	5 or more
2018	44	18 or older	1 or more
Full-time workers	43	18 or older	1 or more
Part-time workers	47	18 or older	1 or more
2019	39	18 or older	1 or more

SOURCE: Transamerica Retirement Surveys.

**Table 5.**  
**Workers who believe that Social Security "will not be there for them" at retirement, by sex and educational attainment (in percent)**

Year	All	Sex		Educational attainment			
		Men	Women	High school diploma or less	Some college or trade school	College degree	Postgraduate study or degree
2014	76	72	80	81	75	73	71
2015	76	71	81	81	76	74	67
2016	77	72	82	79	78	75	73
2017	76	72	81	79	78	76	74
2018	77	74	80	<sup>a</sup> 79	<sup>a</sup> 79	<sup>b</sup> 73	<sup>b</sup> 73

SOURCE: Transamerica Retirement Surveys.

a. Results for a merged "high school to some college" category.

b. Results for a merged "college degree or more" category.



## **Differences by Worker/Retiree Status**

Although most of the surveys we reviewed were administered to workers, the two surveys we discuss here asked current retirees to compare their actual Social Security benefit levels with the levels they had expected before retirement.

Using a UAS survey module administered to retirees, Prados and Kapteyn (2019) found that 21.4 percent of respondents reported that the Social Security benefits they received differed substantially from the amount they had expected. Most retirees reported receiving less than they had expected. Respondents with lower educational attainment were more likely to have expected their benefits to be substantially higher than the amount they received.

A Nationwide Retirement Institute survey conducted in 2019 asked recent retirees, “Is your Social Security benefit what you expected?” Eight percent of respondents were receiving higher Social Security benefits than they had expected, while 22 percent were receiving lower Social Security benefits than they had expected (Harris Poll 2019).

These results indicate that workers are more likely to overestimate their future benefits than to underestimate them. One possible explanation is that some respondents received lower-than-expected benefits because they retired earlier than they had expected.

## **Conclusions**

This article examines data from 18 different surveys—some of them recurring—that explore workers’ expectations about their future Social Security benefits. The surveys span 50 years, from 1971 to 2020. We review results from more than 60 distinct survey instruments with a total sample size of more than 130,000.

We find considerable heterogeneity in workers’ expectations of their future Social Security retirement benefits by sociodemographic characteristics. We also find changes in expectations over time. Many workers are pessimistic about their future Social Security benefits, while some are overly optimistic. Evidence suggests that people’s expectations become more accurate and more optimistic as they age.

This article contributes six findings. First, workers’ expectations about Social Security have changed considerably over time. Second, a substantial minority of workers have expressed pessimistic views on the future of Social Security. Third, the extent of pessimism about the future of Social Security varies among racial and ethnic groups. Fourth, pessimism about

receiving Social Security benefits tends to decrease with age. Fifth, women tend to be more pessimistic about the future of Social Security than men. Sixth, a small minority of workers are overly optimistic about their future Social Security benefits. The article also investigates theories of why some workers have negative expectations about Social Security benefits. Our findings support the use of informational intervention to provide workers with more realistic expectations about their future Social Security benefits. We elaborate on each of these findings, on our investigation on negative expectations, and on the role of informational interventions below.

1. *Workers’ expectations about Social Security have changed over time.* A 1975 survey conducted by the ACLI found that 63 percent of Americans were very confident or somewhat confident about the future of Social Security, with only 10 percent reporting that they were not at all confident. That survey provides an important baseline, marking a high point in optimism about Social Security in our study period. In the data we examine, a majority of Americans have not expressed confidence in the future of Social Security since 1976.
2. *A substantial minority of workers are pessimistic about their future Social Security benefits.* Some workers believe that their future benefits will be substantially lower than the projections of the Social Security actuaries (or even that the program will no longer exist). Recent research by Smith (2020) suggests that effective informational interventions by SSA could provide workers with more realistic expectations about future Social Security benefits.
3. *Some groups of workers are more likely than others to have pessimistic expectations about Social Security.* For example, a 2017 survey found that 37 percent of White workers aged 18–34 expected to receive nothing from Social Security, compared with 29 percent of Black workers in that age group. A better understanding of which racial/ethnic groups have pessimistic views about future Social Security benefits could inform targeting strategies for informational interventions.
4. *Pessimism about expected future Social Security benefits decreases with age.* This does not appear to be a function of age but instead, a logical result of being closer in time to benefit eligibility, and therefore having less predictive uncertainty. Thus, workers with overly pessimistic views at younger ages tend to have more realistic expectations as they approach retirement age.

5. *Women tend to be more pessimistic about the level of their future Social Security benefits than men.* Some degree of pessimism may be viewed as conservative planning. People who underestimate their future benefits and react by increasing their retirement savings will be in relatively better financial condition in retirement. This gender difference might be a fruitful topic for further research.
6. *Although many workers are pessimistic about future Social Security benefits, some workers, particularly those with lower income or education, overestimate their future benefits as they near retirement.* As noted in item 4, workers' expectations change as they age. Thus, some workers who are pessimistic at younger ages make the opposite error as they approach retirement. Surveys of workers' Social Security expectations have generally overlooked the possibility of workers expecting higher benefits than they will receive.
7. *We investigate factors that might account for pessimistic expectations.* In addition to the effects of age, financial literacy, and income on worker expectations, psychologists have theorized that pessimistic overreactions are a common response to negative news, such as Social Security's well-publicized future financing problems if Congress does not enact reforms. Despite the availability of accurate information about Social Security's future finances, some people believe misleading statements suggesting that the system is "going bankrupt" and assume that, in the event of trust fund insolvency, no benefits will be paid at all. Further, a general pessimism has been observed among lower socioeconomic status groups (Das, Kuhnen, and Nagel 2017). These findings suggest a role for informational interventions, such as providing *Social Security Statements* and other communications more frequently.<sup>6</sup>
8. *Informational interventions improve workers' understanding of their future Social Security benefits and can enable them to form more realistic expectations.* In light of the findings and investigation listed above, the content and effective targeting of information from SSA could reduce worker apprehension and misunderstanding about their future benefits. Informing people that Social Security will continue paying benefits even if trust fund reserves are depleted would likely alleviate the unrealistic expectations of some workers. Although a broad program to raise financial literacy could address the lack of knowledge about future Social Security benefit levels among some groups of workers, we argue that

a more direct, targeted approach may be more effective in promoting realistic expectations. For example, SSA communications could be targeted to younger workers and those with relatively low earnings when they qualify for future benefits, to apprise them that they have attained that significant milestone.

## **Appendix A: Survey Profiles**

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The entries below highlight the key characteristics of the 18 surveys we reviewed for this analysis, including name, sponsor (if different from the name), and mode. We provide the dates of the survey iterations we reviewed for this article, which do not necessarily encompass a given survey's full history. We identify the type and size of the sampled populations. We also provide a link to the survey's home page or other source of information, if one is available.

The surveys listed below share many sampling and methodological characteristics. They generally seek nationally representative samples of respondents and the results are weighted by common demographic characteristics such as age, sex, race, ethnicity, education, region, and income (among others) to reflect the distribution of the general population, based on sources such as the Census Bureau's Current Population Survey or American Community Survey. Significant additions or exceptions are briefly noted.

### **AARP Retirement Survey**

*Mode:* Telephone

*Iteration(s) reviewed:* June 4–28, 2015

*Sampled population:* Adults aged 18 or older

*Sample size:* 1,200 (717 workers, 483 retirees)

*Selected methodological notes:*

Conducted for AARP, a nonprofit advocacy group supporting older Americans, by GfK Roper. The survey used a dual-frame design with separate subsamples of landline and mobile phone numbers subsequently combined into one sample. For each subsample, subjects were recruited using random-digit dialing. Quotas held each subsample to 600 respondents. The landline subsample was stratified by census region; mobile phone numbers were not stratified.

*For more information:* AARP (2015, 29).

### **Aegon Retirement Readiness Survey**

*Mode:* Internet

*Iteration(s) reviewed:* 2015 and 2017 waves

*Sampled population:* Workers and retirees

*Sample size:* About 1,000 in each of 15 countries, including the United States

*Selected methodological notes:*

Aegon is a multinational financial services firm. Its annual survey produces a retirement readiness index to measure attitudes and behaviors related to retirement planning. The first Aegon Retirement Readiness Survey was conducted in nine countries in 2012; the 2017 survey was conducted in 15 countries. About 90 percent of respondents are workers and the remaining 10 percent are retirees.

*For more information:* <https://www.aegon.com/research/our-research-approach/>.

### **American Academy of Actuaries**

*Mode:* Internet

*Iteration(s) reviewed:* November 2016

*Sampled population:* Adults aged 18–64 divided into three income-level subgroups

*Sample size:* 888

*Note:* This article discusses unpublished results of the survey that we obtained directly from the American Academy of Actuaries. Other results of that survey, along with results of parallel surveys conducted in the United Kingdom and Australia by those countries' actuarial associations, were published in 2017 (<https://www.actuary.org/files/imce/Retirement-Readiness.pdf>).

### **American Life Panel (ALP)**

*Sponsor:* RAND Corporation

*Mode:* Internet

*Iteration(s) reviewed:* 2010, 2017

*Sampled population:* Adults aged 18 or older (English or Spanish speakers)

*Sample size:* More than 6,000

*Selected methodological notes:*

RAND is a nonprofit research consultant. ALP respondents are interviewed online at regular intervals. The initial panel in 2003 comprised 800 participants. RAND provides Internet services and computers to members who would otherwise be unable to participate. Respondents complete quarterly updates and requests to complete other surveys, receiving incentives for doing so. The 2010 module included a seven-question sequence on general Social Security knowledge on topics such as

types of eligibility, claiming age, benefit taxation, and inflation adjustment.

*Survey home page:* <https://www.rand.org/research/data/alp/panel.html>.

### **Gallup**

*Mode:* Telephone

*Iteration(s) reviewed:* Various dates 1998–2020

*Sampled population:* Adults aged 18 or older

*Sample size:* Varies from about 500 to about 1,500

*Selected methodological notes:*

Gallup is a business analytics and management consulting firm with an extensive history of public opinion research. Samples are weighted to correct for unequal selection probability, nonresponse, phone status (mobile only, landline only, both, mobile mostly), population density of place of residence, and a wide array of demographic variables.

*For more information:* <https://news.gallup.com/poll/1693/social-security.aspx>.

### **GenForward Survey**

*Mode:* Telephone and Internet (bilingual Spanish and English)

*Iteration(s) reviewed:* April 14–May 1, 2017

*Sampled population:* Adults aged 18–34

*Sample size:* 1,853

*Selected methodological notes:*

Ninety-three percent of completed surveys were completed online, the rest were conducted by phone. Completion rate was 32 percent.

*For more information:* <https://genforwardsurvey.com/about/>.

### **Greenwald & Associates**

*Mode:* Telephone

*Iteration(s) reviewed:* March 1, 2010

*Sampled population:* Adults aged 25–65 who believe they are or will become eligible for Social Security benefits

*Sample size:* About 2,000

*Selected methodological notes:*

Greenwald & Associates (known as Mathew Greenwald & Associates in 2010) are research consultants. A 20-minute telephone questionnaire was administered to respondents who were randomly assigned to one of two groups, each of which

received a slightly different questionnaire. Most of the questions were asked of all 2,000 respondents.

*For more information:* Greenwald and others (2010, 5–6).

### **Health and Retirement Study (HRS)**

*Sponsor:* University of Michigan

*Mode:* Internet

*Iteration(s) reviewed:* 2006–2007 surveys of the 2006 wave

*Sampled population:* Individuals aged 51 or older and their spouses

*Sample size:* See below

*Selected methodological notes:*

Includes a biennial core survey of about 20,000 individuals and spouses aged 51 or older in about 13,000 households who are representative of the U.S. population in that age group. In 2006, respondents to the 2004 and 2006 core HRS survey who reported regular use of the Internet were eligible to participate in a supplementary survey; one group was invited to participate in a spring 2006 survey and the other group was invited to participate in a summer 2007 survey. Sample sizes varied because respondents to the 2006 HRS wave who also answered questions on Social Security in the Internet supplement were grouped into various subsamples for analysis.

*For more information:* <https://hrs.isr.umich.edu/about>.

### **Longevity Project**

*Sponsor:* Morning Consult

*Mode:* Internet

*Iteration(s) reviewed:* December 26–29, 2019

*Sampled population:* Adults

*Sample size:* About 2,200

*Selected methodological notes:*

Morning Consult is a private market research firm. Respondents were selected using a stratified sampling process.

### **Luttmer and Samwick Module of the KnowledgePanel Internet Survey**

*Mode:* Internet

*Iteration(s) reviewed:* June 2, 2020

*Sampled population:* Adults aged 25–59

*Sample size:* 3,053

*Selected methodological notes:*

Conducted as a module of the Ipsos Knowledge-Panel, an ongoing Internet panel that was established in 1999, with an address-based sample drawn from the U.S. Postal Service’s Delivery Sequence File. Households without Internet access were provided with a laptop computer and Internet service to enable their participation.

*For more information:* Luttmer and Samwick (2015).

### **Monitoring Attitudes of the Public**

*Sponsor:* American Council of Life Insurance (ACLI)

*Mode:* In-person interview

*Iteration(s) reviewed:* Annual surveys 1975–1988

*Sampled population:* Noninstitutionalized adults aged 18 or older

*Sample size:* About 1,500

*Selected methodological notes:*

Although questionnaires varied from year to year, questions on respondent’s confidence in Social Security’s future appeared in most iterations.

### **Nationwide Retirement Institute**

*Mode:* Internet

*Iteration(s) reviewed:* March 1, 2019

*Sampled population:* Adults who currently collect or plan to collect Social Security benefits.

*Sample size:* 1,315 (455 who plan to retire within the next 10 years, 439 who retired within the last 10 years, and 421 who retired more than 10 years ago)

*Selected methodological notes:*

Conducted for the Nationwide Retirement Institute, a division of Nationwide Investment Services Corporation, by Harris Poll. Along with demographic characteristics, sample was weighted for propensity to use the Internet.

### **Nationwide Survey of Attitudes Toward Social Security (“Hart Survey”)**

*Sponsor:* National Commission on Social Security

*Mode:* In-person interview

*Iteration(s) reviewed:* November 1979

*Sampled population:* Adults aged 18 or older

*Sample size:* 1,549 (see below)

*Selected methodological notes:*

Conducted for the Commission by Peter D. Hart Research Associates. One adult respondent per



household was selected randomly from a national sample of households then interviewed in person (Sherman 1989).

### **Retirement Confidence Survey (RCS)**

*Sponsor:* Employee Benefit Research Institute (EBRI)

*Mode:* Telephone (through 2015); Internet (beginning 2016)

*Iteration(s) reviewed:* Various dates 1996–2019

*Sampled population:* Workers and retirees aged 25 or older

*Sample size:* Has increased from about 1,000 (for example, 902 workers and 251 retirees in 2010) to about 2,000 (1,002 workers and 1,040 retirees in 2018)

*Selected methodological notes:*

EBRI is a nonprofit research center. Before 2016, RCS was conducted by telephone in 20-minute interviews. EBRI used random-digit dialing to obtain a representative cross-section of the U.S. population. A mobile phone supplement was added to the sample around 2010 to further increase representation. Since 2016, EBRI has conducted the RCS online with larger sample sizes.

*For more information:* Methodological highlights are included in the press release that accompanies the results for each annual RCS from 2010 forward, available at <https://www.ebri.org/retirement/retirement-confidence-survey>. Paywalled press releases are also available for earlier surveys.

### **Retirement History Survey (RHS)**

*Sponsor:* SSA

*Mode:* In-person interview

*Iteration(s) reviewed:* 1971, 1973

*Sampled population:* Retirees aged 58–63 in 1969

*Sample size:* Initial panel comprised 11,153 respondents

*Selected methodological notes:*

Conducted by the Census Bureau for SSA, the longitudinal RHS followed a sample of retirees for 10 years, beginning in 1969 with follow-up interviews every 2 years through 1979. The 1969 wave included 11,153 men and unmarried women approaching or entering retirement, but substantial attrition occurred over successive waves. In 1969, 1971, and 1973, respondents reported the level of Social Security benefits they expected to receive

upon retirement. In follow-up surveys, respondents reported actual retirement benefits.

*For more information:* <https://www.icpsr.umich.edu/web/ICPSR/series/49>.

### **Survey of Economic Expectations (SEE)**

*Sponsor:* University of Wisconsin

*Mode:* Telephone

*Iteration(s) reviewed:* Summer 1999–fall 2002 (waves 12–16)

*Sampled population:* Adults aged 18 or older

*Sample size:* 2,850 overall (see below)

*Selected methodological notes:*

For the Social Security questions, 2,457 of the SEE's 2,850 respondents were age-eligible (18–69), and 97 percent (2,384) of them replied to the question on their perceived chances of being eligible for benefits at age 70.

*For more information:* Dominitz and Manski (n.d.).

### **Transamerica Institute**

*Mode:* Telephone (through 2006); Internet (beginning 2007)

*Iteration(s) reviewed:* Annual surveys 2001–2020

*Sampled population:* Workers aged 18 or older in for-profit companies

*Sample size:* Varies from about 3,000 to more than 6,000 (see below)

*Selected methodological notes:*

The Transamerica Institute is a nonprofit private research foundation funded primarily by the Transamerica Life Insurance Company. Through 2006, the survey was conducted by telephone with a nationally representative random sample. In preparing to migrate the survey from telephone- to Internet-based in 2007, a parallel omnibus phone study was conducted to provide the basis for weighting the data to account for differences between the population available via the Internet and the population accessed via telephone in previous years. Harris Online Polls conducts the online surveys for Transamerica Institute. From 2007 to 2019, the length of the questionnaire expanded; the online interviews increased from 16 minutes in 2007 to 29 minutes in 2019.

Sample sizes and composition, listed below for selected survey iterations, have varied:

—2007 survey: 3,012 workers (2,011 full-time and 1,001 part-time)



- 2012 survey: 3,609 workers (1,818 women and 1,791 men)
- 2015 survey: 4,550 workers (2,421 women and 2,129 men)
- 2017 survey: 6,372 workers. Sample weighting also adjusted for attitudinal and behavioral differences between Internet users and nonusers, those who join online panels and those who do not, and survey respondents versus nonrespondents.
- 2019 survey: 5,277 workers divided into generational subgroups: 2,418 millennials, 1,424 members of generation X, 1,287 baby boomers, 64 members of generation Z, and 84 mature workers (born prior to 1946). (Because these subgroup samples are small, they are not included in the generation comparisons in this article.)

*Survey home page:* <https://transamericacenter.org/retirement-research/retirement-survey>.

### **Understanding America Study (UAS)**

*Sponsor:* University of Southern California Center for Economic and Social Research

*Mode:* Internet

*Iteration(s) reviewed:* 2015, 2017, and 2019 waves

*Sampled population:* Adults aged 18 or older

*Sample size:* About 6,000 (see below)

*Selected methodological notes:*

The UAS consists of linkable module surveys. Some of the modules focus primarily on Social Security knowledge or expectations; others address Social Security as part of a broader examination of retirement planning or attitudes. Panel members are recruited exclusively through address-based sampling, in which invitation letters are sent to randomly selected households using address lists obtained from the U.S. Postal Service. This method provides a broadly representative sample because individuals lacking Internet access are provided with a tablet and broadband connectivity.

The 2015 wave contained small oversamples (about 5 percent) of Native Americans and residents of Los Angeles County, with data collected and fielded in both English and Spanish, among the 1,413 individuals aged 18–91 who completed the survey. Of these, 261 individuals had already retired.

The 2019 wave contained a supplement to the Social Security expectations survey that collected additional data on household demographics, attitudes and

perceptions of retirement planning in general, understanding of Social Security eligibility and entitlements, and qualitative views or expectations about Social Security, assets, and income. The sample comprised 4,632 nondisabled adults aged 20 or older.

*Survey home page:* <https://uasdata.usc.edu/index.php>.

### **Notes**

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<sup>1</sup> Dominitz and Manski (2006) list some earlier surveys not reviewed here.

<sup>2</sup> We focus on U.S. workers and Social Security. Turner and others (2019) analyzed international heterogeneity in expectations.

<sup>3</sup> The projection was based on the Social Security actuaries' intermediate-case assumptions of future economic conditions.

<sup>4</sup> Then, as now, if Congress were to enact future reforms to improve Social Security's long-term finances, one might assume that any changes would protect current retirees.

<sup>5</sup> For more information on the 1977 and 1983 Social Security reforms, see <https://www.ssa.gov/history/pdf/crs9436.pdf>.

<sup>6</sup> In 2021, SSA released several new *Social Security Statement* supplemental fact sheets. SSA's cover letter states: "In an effort to educate the public, we have introduced nine informational fact sheets to accompany the Online *Social Security Statement* available as part of [one's] [my Social Security](#) [account]. The targeted fact sheet PDF links will appear below the *Statement* PDF link and will appear to people based on their age group and earnings situation." Thus, SSA is targeting situational program information by age group (18–48, 49–60, 61–69, 70 or older) and for specific worker groups such as new workers, workers not yet fully insured for benefits, and workers who have earnings not covered by Social Security.

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# HOW DOES MORTALITY AMONG DISABILITY-PROGRAM BENEFICIARIES COMPARE WITH THAT OF THE GENERAL POPULATION? A SUMMARY OF ACTUARIAL ESTIMATES

by Javier Meseguer\*

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*Using period mortality estimates published in Social Security Administration actuarial studies, this article compares the mortality experiences of Disability Insurance (DI) beneficiaries and the general population for various periods 1970–2015 with historical comparisons from as early as 1900. Advances (and setbacks) in health care and other factors have contributed to trends and fluctuations in mortality rates overall and for DI beneficiaries. Legislative changes and administrative factors have additionally affected trends in DI awards, benefit terminations, diagnostic distributions, and mortality for beneficiaries. Although the longevity gap between the general population and DI beneficiaries has narrowed in recent decades, it remains large as of 2015. For example, DI beneficiaries aged 25 and older in their first year on the rolls have faced mortality rates far exceeding those associated with the 1918 influenza pandemic for the general public at those ages.*

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## Introduction

How does the mortality experience of Disability Insurance (DI) beneficiaries compare with that of the general population? Since at least the late 1970s, the Social Security Administration's (SSA's) Office of the Chief Actuary (OACT) has published a number of studies estimating the period mortality and, in some cases, life expectancy of DI disabled-worker beneficiaries, covering study periods that, taken together, encompass more than three decades (the 1970s, 1990s, and 2000s, as well as 2011–2015). Because mortality among DI beneficiaries is highest in the first few years of benefit receipt, the estimates are calculated both by age and for different durations of survival on the disability rolls. In this article, I analyze estimates published in nine SSA actuarial studies:

- Study No. 74. “Graduated select and ultimate death termination rates for male and female disabled workers, 1968–1974 OASDI [Old-Age, Survivors, and Disability Insurance] experience” (Bayo and Wilkin 1977, Tables 8–9).

- Study No. 75. “Graduated select and ultimate death termination rates for male and female disabled workers, 1973–1976 OASDI experience” (Bayo, Goss, and Weissman 1978, Tables 9–10).
- Study No. 81. “Graduated select and ultimate death termination rates for male and female disabled workers, 1975–1978 OASDI experience” (Schobel 1980, Tables 4–5).
- Study No. 93. “Male and female death rates by calendar age at entitlement and duration of disability per 1,000 currently entitled from the

### Selected Abbreviations

AIDS	acquired immunodeficiency syndrome
CDR	continuing disability review
DDS	Disability Determination Service
DI	Disability Insurance
FRA	full retirement age
HAART	highly active antiretroviral therapy

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### Selected Abbreviations—Continued

HIV	human immunodeficiency virus
OASDI	Old-Age, Survivors, and Disability Insurance
OASI	Old-Age and Survivors Insurance
OCACT	Office of the Chief Actuary
SSA	Social Security Administration
SSI	Supplemental Security Income

1977–1980 Disabled Worker Termination Study” (Kelley and Lopez 1984, Tables 5–6).

- Study No. 114. “DI male and female disabled worker probability of death (1991–1995 Social Security disability experience)” and “DI male and female disabled worker expected future lifetime (1991–1995 Social Security disability experience)” (Zayatz 1999, Tables 7A–7B and 12A–12B).
- Study No. 118. “Male and female disabled workers probability of death (1996–2000 Social Security DI disability experience)” and “Male and female disabled workers expected future lifetime (1996–2000 Social Security DI disability experience)” (Zayatz 2005, Tables 7A–7B and 9A–9B).
- Study No. 122. “Male and female disabled workers probability of death (2001–2005 Social Security DI disability experience)” and “Male and female disabled workers expected future lifetime (2001–2005 Social Security DI disability experience)” (Zayatz 2011, Tables 7A–7B and 9A–9B).
- Study No. 123. “Male and female disabled workers probability of death (2006–2010 Social Security DI disability experience)” and “Male and female disabled workers expected future time on combined DI and OASI [Old-Age and Survivors Insurance] rolls (excluding possibility of recovery) (2006–2010 Social Security DI disability experience)” (Zayatz 2015, Tables 7A–7B and 9A–9B).
- Study No. 125. “Male and female disabled workers probability of death (2011–2015 Social Security DI disability experience)” and “Male and female disabled workers expected future time on combined DI and OASI rolls (excluding possibility of recovery) (2011–2015 Social Security DI disability experience)” (Barrick-Funk 2020, Tables 7A–7B and 9A–9B).

This article consists of eight sections, including this introduction. The next section provides a chronology of demographic, economic, epidemiological, and regulatory events that have affected the disability program

and influenced mortality among the pool of DI beneficiaries. The third section reports DI period mortality by age and sex over different periods of survival on the rolls and includes absolute and relative comparisons with both historical and contemporaneous (same-period) mortality in the general population. The fourth section centers on period life expectancy, focusing on the years of premature death associated with qualifying for DI benefits. The fifth section discusses two recent distributional trends that have likely contributed to mortality decline among DI beneficiaries: the changing composition of the beneficiary population by diagnostic group and the growing role of medical-vocational considerations in determining disability-benefit eligibility. The sixth section addresses the widening gap in mortality and life expectancy for people with different earnings and education levels in the general population. This distributional gap is particularly pertinent, given that DI beneficiaries tend to have lower earnings and educational attainment prior to disability onset. The seventh section discusses the interaction between mortality, morbidity, and the ability to work, as well as ongoing trends in self-reported disability measured in national surveys. Chronic disorders are becoming the main cause of death at older ages, suggesting that a longer life may not necessarily be a healthy one and that increasing life expectancy may be problematic as a measure of improvement in the average health of the population. A summary section concludes the article.

### **Factors Affecting Mortality Among DI Beneficiaries: A Chronology**

DI is funded through payroll tax contributions and aims to protect workers who cannot work because of a disability. State Disability Determination Service (DDS) agencies make the initial medical determination of benefit eligibility, although denied claimants can pursue multiple levels of appeal or can reapply. SSA assesses disability through a sequential evaluation process, described in detail in Wixon and Strand (2013). If a claimant has an impairment that is severe but does not meet or equal the medical criteria contained in SSA’s Listing of Impairments,<sup>1</sup> the agency evaluates the applicant’s ability to do past work, based on his or her physical and mental residual functional capacity (RFC). RFC accounts for the claimant’s medically related exertional and nonexertional limitations (such as capacity to stand, lift, and understand or follow instructions). If the claimant is unable to do past work, factors known as vocational considerations are

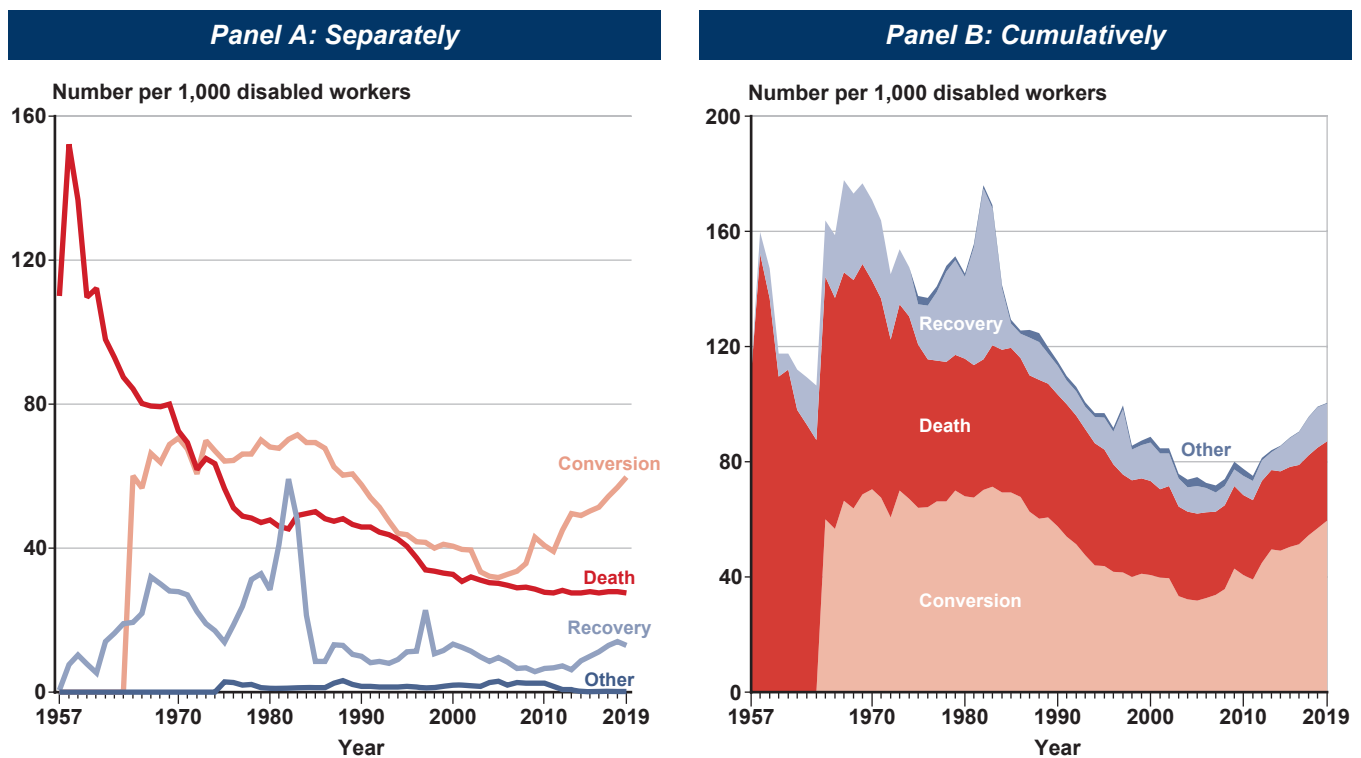
then used to determine the claimant’s ability to do any other work in the national economy. For a given RFC (for example, ability to do sedentary work versus light or heavy work), age, education, past work experience, and transferable skills provide a decisional framework commonly referred to as the vocational grid. Age, for example, is a vocational factor because older workers are assumed to have a harder time adjusting to new work environments and learning new skills.

Broad trends in DI program entry and exit are affected by economic, demographic, technological, administrative, and regulatory factors in addition to an individual’s medical condition. This section provides a chronology of events that may have influenced the relative health of beneficiaries entering and exiting the rolls in a given period, which might contribute to changes in the mortality experience of beneficiaries over time.<sup>2</sup> The discussion proceeds chronologically, with subsections dedicated to various periods from the 1950s to the present, although certain themes and topics are relevant to and discussed in more than one subsection.

### The 1950s and 1960s

The first disability cash benefits were paid in 1957 to disabled workers aged 50–64 with a permanent disability. Throughout the 1960s, legislative changes to the DI program expanded eligibility substantially. For instance, the age-50 requirement was dropped in 1960, enabling younger disabled applicants to enter the rolls. The effects of removing the age-50 requirement had largely been absorbed by 1965, when the definition of a qualifying disability was changed from “permanent” to “expected to last at least 12 months,” thereby expanding the pool of potential beneficiaries.<sup>3</sup> In 1967, legislation relaxed the insured-status requirements for individuals younger than 31, making it easier for workers in their 20s to qualify for benefits. Given the enormous differences in eligibility criteria that these legislative changes brought about, the mortality experience of DI beneficiaries before the late 1960s is not comparable with that of beneficiaries in subsequent periods. As shown in Chart 1, there were about 152 deaths per thousand beneficiaries in 1958, compared with 72.5 by 1970.

**Chart 1.**  
DI disabled-worker benefit gross termination rates (age-unadjusted), by reason, 1957–2019



SOURCES: Schobel (1980, Table 3); Kelley and Lopez (1984, Table 4); Zayatz (1999, 2005, 2011, 2015, Table 5); and Barrick-Funk (2020, Table 5).

NOTE: Conversion to OASI retired-worker benefits occurs automatically at full retirement age (FRA). “Other” consists largely of elective OASI conversions at ages 62 to FRA.

## 1970–1975

The first half of the 1970s witnessed a rapid increase in the number of DI awards, jumping from 350,000 in 1970 to about 592,000 by 1975 (Chart 2). This was a period of economic stagflation, oil supply shocks, and a stock market crash. According to Schobel (1980), the legislative changes to the program in the 1960s cannot fully explain the growth in awards during this period. Rather, three distinct events likely contributed to the large volume of applications and awards. First, there were economic recessions in 1970 and 1973–1975 (indicated by the shaded areas in Chart 2). The volume of applications tends to increase during recessions and the characteristics of claimants during these periods can vary substantially. Workers in poor health are more likely to lose their jobs and have greater difficulty finding new ones during economic downturns. As a result, recessions tend to be associated with higher numbers of applications and awards, but lower allowance rates.<sup>4</sup>

A second factor contributing to the observed surge in awards during this period was the introduction of two new programs: Black Lung Benefits in 1970 and Supplemental Security Income (SSI) in 1974. SSI provides means-tested cash payments for individuals with

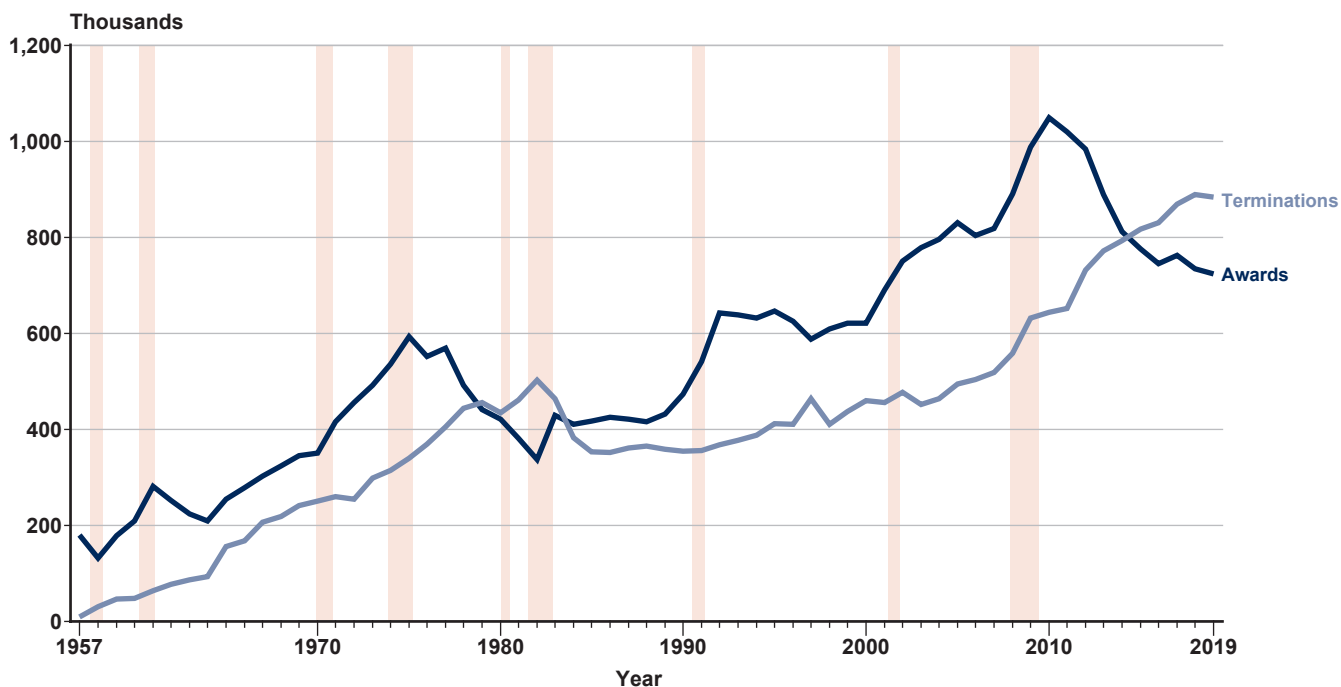
disabilities; SSI applicants who have not reached full retirement age (FRA) and are insured under DI are required to apply for DI benefits concurrently. Black Lung Benefit applicants from Appalachia frequently filed for OASDI benefits as well (Puckett 2010).

According to Bayo and Wilkin (1977),

by fiscal year 1974, not only was the SSA taking in over 1,200,000 [DI] claims per year, but it had also taken in over 500,000 disability claims under the black lung program ... and it was taking in over 1,000,000 disability claims per year under the [SSI] program.

Third, various legislative changes contributed to the surge in applications and awards by making disability benefit receipt relatively more attractive. In particular, Congress enacted across-the-board benefit increases to protect beneficiaries against inflation, first with a series of specially legislated increases in the early 1970s and then with annual automatic indexing of benefits beginning in 1975. Consequently, new benefit levels began to replace a higher share of predisability earnings; the rising replacement rates thus provided a stronger incentive to apply for benefits. According to Kearney (2005/2006), the share of new beneficiaries

**Chart 2.**  
**Number of DI disabled-worker benefit awards and terminations, 1957–2019**



SOURCES: National Bureau of Economic Research (2021); Schobel (1980, Tables 1 and 3); Kelley and Lopez (1984, Tables 1 and 4); Zayatz (1999, 2005, 2011, 2015, Tables 3 and 5); and Barrick-Funk (2020, Tables 3 and 5).

NOTE: Shaded areas indicate economic recessions.

with a replacement rate of 80 percent or higher rose from 13 percent in 1970 to about 40 percent in 1980. In addition, by 1973, Medicare benefits became available to DI beneficiaries after 2 years on the rolls.

As a quality control measure, SSA is required to review a certain percentage of benefit allowances determined at the DDS level. This process is called preeffectuation review.<sup>5</sup> In addition, beneficiaries are subject to periodic continuing disability reviews (CDRs), through which the agency can suspend benefits if it determines a beneficiary is no longer disabled. The large volume of applications during the first half of the 1970s placed a great deal of strain on SSA's resources, drastically curtailing the capacity to conduct both types of review. According to Kearney (2005/2006), the proportion of awards undergoing preeffectuation reviews dropped to 5 percent during the early 1970s, compared with previous levels of about 70 percent. Further, SSA suspended CDRs for several years during this period to reallocate resources toward processing Black Lung Benefit and SSI claims (Puckett 2010).

Diminished quality control—and pressure on disability adjudicators to make quick determinations to avoid a large backlog of cases—may have further contributed to the observed rise in awards. Meanwhile, the suspension of CDRs likely led to the decline in benefit terminations tied to medical improvement. For instance, in 1970, about 28 of every 1,000 program enrollments were terminated because of recovery (Chart 1). By 1975, the gross recovery rate had dropped by half, to 13.9 beneficiaries per 1,000 enrollments. The high earnings replacement rates during this period provided further incentive to stay in the program. The number of applicants with claims denied at the DDS level who then pursued appeals at the hearing level, where administrative law judges make disability determinations, also increased in the early 1970s.

### **1976–1982**

The volume of DI awards declined sharply from 1977 to 1982, while terminations climbed rapidly. Prior to 2015, the period 1979–1983 is the only window in the historical DI data in which annual terminations exceeded awards, peaking in 1982 (Chart 2). In that year, 166,000 more DI beneficiaries exited the program than entered it. The first in a series of efforts to control rising costs associated with the disability programs came in the late 1970s. The automatic cost-of-living adjustment (COLA) had led to a substantial rise in replacement rates, in part because the benefit

indexing formula was implemented in 1974, when prices were rising much faster than wages. The Social Security Amendments of 1977 adjusted the benefit formula downward to decouple COLAs from price increases and to stabilize replacement rates (Kearney 2005/2006). Workers' earnings under the revised formula were indexed to changes in average wages instead of prices.

Changes to disability law in 1980 led to further restrictions on the DI program, such as capping total family benefits and imposing tighter DDS performance standards—for example, requiring a 65 percent preeffectuation review rate by 1983. The law added incentives to return to work and restricted the introduction of new evidence in a hearing-level decision (Kearney 2005/2006). It also required more frequent CDRs (at least every 3 years) for beneficiaries without a permanent disability.

Several General Accounting Office reports in the late 1970s criticized SSA for not conducting CDRs, suggesting that significant numbers of beneficiaries might no longer be disabled. In response, SSA began an aggressive effort that resulted in the termination of benefits for a substantial portion of beneficiaries, particularly among those with mental impairments, although many eventually returned to the rolls on appeal. The CDRs were “de novo reviews” (reopening the initial determination) and retroactive, which led to public controversy. According to Puckett (2010),

collecting disability payments that were now deemed erroneous from former beneficiaries became a major piece of SSA's debt management initiative. SSA issued overpayment notices asking for repayment of huge sums of money to people with a history of mental impairments who were no longer receiving a monthly check. A few of these individuals committed suicide, and these tragedies were widely reported on newspaper front pages.

From 1980 to 1982, the number of benefit terminations because of recovery almost doubled, reaching more than 169,000 former beneficiaries. Exits associated with recovery reached a historical maximum in 1982 and only in that year did recovery exceed death in both volume and gross termination rates (Charts 1 and 3). This unprecedented number of benefit terminations occurred in the middle of a severe recession. Moreover, the large volumes of CDRs and ensuing appeals led to enormous workloads at all levels of adjudication, including a record number of 50,000 cases pending in Federal Court by mid-1984.<sup>6</sup> Among the



latter was a lawsuit by the Association of Administrative Law Judges, which perceived the de novo reviews as a challenge to the judges' independent decision making. Many states feared the financial consequences, as the burden of the terminations would fall disproportionately on state programs, particularly for the mentally ill. Under pressure from constituents, Congress held dozens of hearings on the subject. Eventually, the governors of 23 states ordered the suspension of CDRs, leading SSA to impose a temporary moratorium.

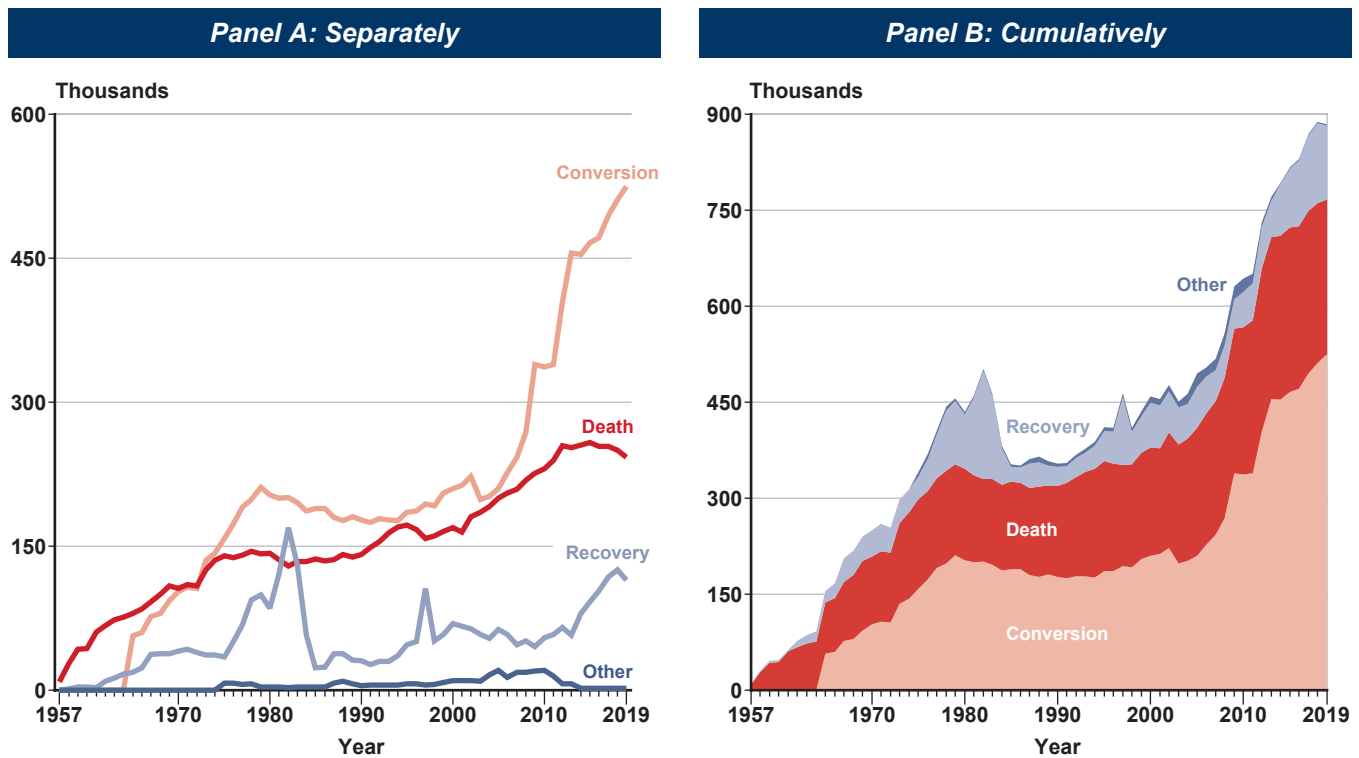
A number of court decisions challenged SSA policy through the first half of the 1980s. "By the end of 1984, all circuits of the U.S. Court system, led by a Ninth Circuit ruling, had ruled that SSA must apply some form of medical improvement standards or a presumption of continuing disability before benefits could be terminated" (Puckett 2010). Another ruling found SSA in violation of the law in its review of cases involving mental impairments. Court decisions challenging SSA policy culminated in the threat of contempt proceedings against the Secretary of Health and Human Services for nonacquiescence.<sup>7</sup> The court

objected to SSA's practice of restoring benefits to a successful appellant who had been removed from the rolls without changing its policy to reflect the circuit court decision.

### 1983–1990

In 1983, awards and terminations began to level off. The Social Security Disability Benefits Reform Act of 1984 aimed to reverse the prior trends of sharp increases (or declines) in awards and terminations, and the numbers of both would hold relatively steady through the rest of the 1980s. As part of the standard of proof in a CDR decision to terminate benefits, the law required a finding of medical improvement. In addition, greater emphasis was placed on the roles of multiple nonsevere impairments, pain, and the opinion of the treating physician. SSA released final rules for the revised listings of mental impairments in 1986. According to SSA (2006), the large one-time spike in mental-impairment awards in 1986 (Chart 4) reflects the fact that "many cases were not adjudicated until new mental regulations were issued in 1986." The net

**Chart 3.**  
Number of DI disabled-worker benefit terminations, by reason, 1957–2019

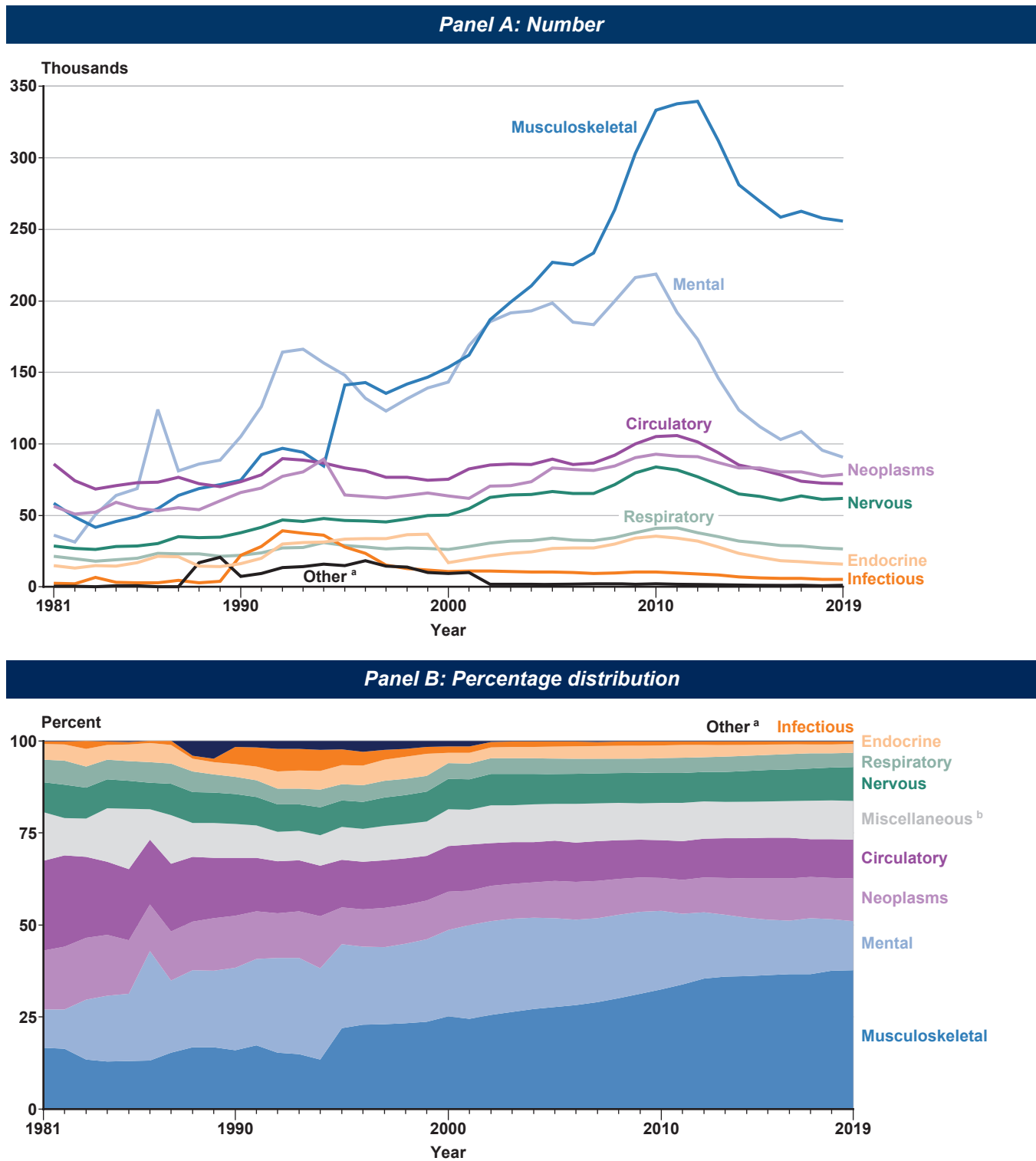


SOURCES: Schobel (1980, Table 3); Kelley and Lopez (1984, Table 4); Zayatz (1999, 2005, 2011, 2015, Table 5); and Barrick-Funk (2020, Table 5).

NOTE: Conversion to OASI retired-worker benefits occurs automatically at FRA. "Other" consists largely of elective OASI conversions at ages 62 to FRA.



**Chart 4.**  
**Number and percentage distribution of DI disabled-worker benefit awards, by body system of primary diagnosis, 1981–2019**



SOURCE: SSA (2020, Table 40).

- a. HIV/AIDS-related impairments were classified under "other" impairments until 1990, when they were reclassified under infectious and parasitic diseases.
- b. Comprises congenital anomalies; injuries; diseases of blood and blood-forming organs, the digestive system, the genitourinary system, and skin and subcutaneous tissue; and ill-defined impairment codes classified as "unknown."

effect on mortality of the various legislative changes that took place throughout the 1980s is unclear. Many of the benefit terminations in the early part of the decade were reversed on appeal and the 1984 law made substantial changes to the determination process and the rules for conducting CDRs. To date, no actuarial studies have documented the mortality experience of DI beneficiaries during the 1980s.

### **1991–1995**

As the economy weathered a recession in 1990–1991, the number of DI awards began a brief but rapid rise, particularly for mental disorders (Chart 4). In 1993, there were more than 635,000 awards and 26 percent of them were associated with a mental primary impairment. The early 1990s were also peak years of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)-related deaths in the United States.

In SSA's *Annual Statistical Report on the Social Security Disability Insurance Program*, HIV and AIDS cases were not categorized under "infectious and parasitic diseases" until 1990, having been included in the "other" category in prior years. This shift is evident in the increasing share of awards for infectious and parasitic impairments in the 1990s, reaching a maximum of 6.2 percent of all awards in 1992 (Chart 4).<sup>8</sup>

The Estimates of Period Mortality section below illustrates the unusually high period mortality among young male DI beneficiaries during their first few years of entitlement in the early 1990s (Zayatz 1999), which can be traced to HIV/AIDS-related deaths. According to Barrick and Zayatz (2005),

the death rate among those afflicted was so high that monthly benefit payments were often made only for a relatively short period of time, if at all. Many never received payments, failing to survive the requisite 5-month waiting period under the DI program. One third of those who made it onto the rolls because of HIV impairments had died by the end of the calendar year in which they became entitled; two-thirds had died by the end of the following year.

### **1996–2000**

The second half of the 1990s witnessed a leveling in the number of awards while benefit terminations rose steadily. The Contract with America Advancement Act of 1996 provided funding specifically for CDRs

and disqualified applicants and beneficiaries for whom drug addiction or alcoholism contributed materially to disability. This led to a sharp spike in benefit terminations because of recovery in 1997 (Charts 1 and 3). Specifically, from 1996 to 1997, the number of terminations because of recovery more than doubled, as beneficiaries with a material addiction were removed from the rolls, while the gross recovery rate experienced a one-time jump from 11.3 to 22.7 per thousand disabled-worker beneficiaries (Chart 1).<sup>9</sup>

Awards based on HIV diagnoses declined throughout the second half of the 1990s (Chart 4). Barrick and Zayatz (2005) reported dramatic reductions in mortality consistent with Centers for Disease Control and Prevention findings that attributed the change to the widespread use of an effective treatment called highly active antiretroviral therapy (HAART) beginning in 1996. Accompanying the HIV-related mortality improvement during this period was a documented shift in the composition of HIV diagnoses from symptomatic toward asymptomatic impairments. Based on the period tables in Barrick and Zayatz (2005), a man entering the DI/SSI rolls with an AIDS-related diagnosis at age 35 was, during 1992–1996, expected to live 4.88 years. By the 1997–2001 period, the corresponding life expectancy had increased to 12.89 years. In comparison, life expectancy at age 35 during the first year of entitlement among the entire male DI-beneficiary population in 1991–1995 was 23.29 years (Zayatz 1999).

Both the effective treatment of HIV diagnoses beginning in 1996 and the 1997 legislative changes involving addiction are credited with lowering DI award rates and mortality during the late 1990s. According to Zayatz (2015),

age-specific disability incidence among female workers is typically lower than males. However, beginning in the late 1990s, female incidence began to exceed that for males at ages 30–54. Although both genders were experiencing a general decline in incidence beginning in the mid-90s, the decline is more pronounced among males. This is likely due to the elimination of [drug addiction or alcoholism] as a disabling impairment and a sharp decline in HIV impairments, both of which are predominantly male incidence categories. Note that the decline in incidence rates among females did not come from a decline in the number of awards, but rather from an increase in the exposed population.

From 1986 to 1996, increases in women’s labor force participation resulted in an additional 10.7 million disability-insured women. The female share of DI beneficiaries in current-payment status rose from less than one-third (31.3 percent) in 1975 to almost half (49.5 percent) by 2019 (Barrick-Funk 2020).

In 1995, SSA began to capture information on final determinations after all appeals and thereby improved the accuracy of its reported data on awards by primary diagnostic group. Through 1994, the primary diagnostic group of cases awarded at the appeals hearing level and beyond had been imputed from the information available on the original DDS determination. The main effect of improved accuracy in the data collected after 1994 appears to involve a large jump in awards associated with musculoskeletal impairments, from 85,000 in 1994 to 141,000 in 1995, and a decline in awards associated with malignant neoplasms, from 89,000 in 1994 to 64,000 in 1995 (Chart 4). This change predates the removal of obesity from SSA’s medical Listing of Impairments in 1999, which is reflected in Chart 4 by the decline in awards associated with endocrine, nutritional, and metabolic diseases from 37,000 in 1999 to 17,000 in 2000.<sup>10</sup>

### **2001–2010**

The first half of the decade was characterized by a large increase in DI awards—from more than 621,000 new disabled-worker beneficiaries in 2000 to almost 830,000 by 2005 (Chart 2 and Chart 5, panel A)—and an economic recession in 2001 (reflecting the bursting of the dot-com bubble and the terrorist attacks on September 11). That period was followed by a brief, modest decline in awards in 2006–2007, then another sharp jump in awards in 2008–2010, driven by the Great Recession (characterized by the subprime mortgage crisis and the global financial collapse).<sup>11</sup>

Notable shifts in DI exits because of conversion occurred in the 2000s. DI benefits automatically convert to OASI benefits when the beneficiary reaches FRA.<sup>12</sup> However, beginning at age 62, DI beneficiaries can choose to switch to OASI and receive retirement benefits (reduced for claiming before FRA) instead.<sup>13</sup> For those choosing to switch, common reasons include differences in the maximum family benefits payable under the DI and OASI programs and a desire to avoid a partial or full offset of worker’s compensation benefits that retaining DI could trigger. Fear of losing disability benefits could also motivate a switch.

DI conversions to OASI benefits increased steadily throughout the decade, except for an unusual temporary

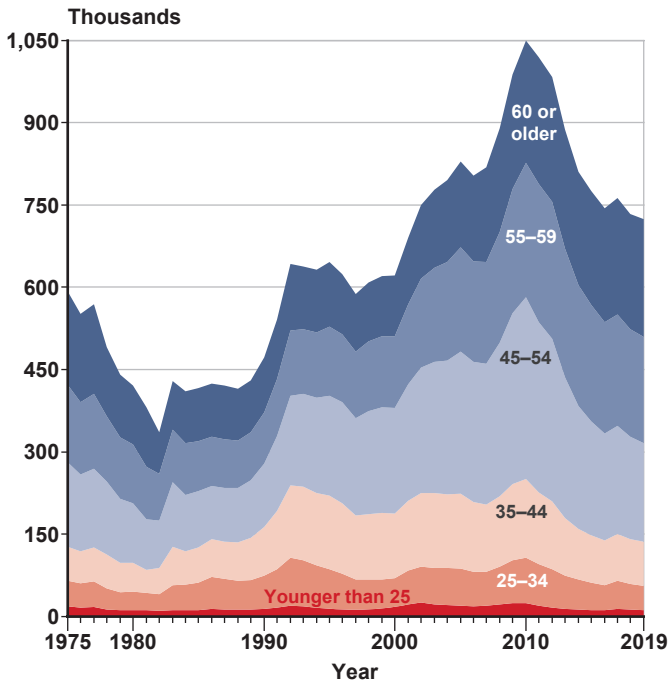
decline in 2003–2004 (Charts 1 and 3). The 1983 Social Security Act Amendments established incremental increases in FRAs for workers born in 1938 and later years; 2003 was thus the first year in which workers reaching age 65 did not necessarily reach their FRA.<sup>14</sup> The effect is most evident in the “dip” in the gross conversion rate between 2003 and 2006 illustrated in Chart 1. In addition, the often-negligible “other” category of terminations, which typically consists largely of beneficiaries switching to reduced retirement benefits before FRA, increased throughout the 2000s. That increase resulted mostly from a Special Disability Workload that SSA undertook from 2001 to 2011 after discovering errors in the determinations of insured status for approximately 130,000 SSI recipients, many of whom were found to qualify for concurrent DI benefits (Zayatz 2015). Unlike the early-retirement-age beneficiaries who switch to OASI benefits and usually constitute most of the “other” benefit-termination category, many of these special workload cases involved young recipients with mental impairments.

Throughout the 2000s, the large cohort of baby boomers (born from 1946 through 1964) began entering peak disability-onset ages and drove an increase in the median age of the population. By 2010, baby boomers ranged from 46 to 64 years of age. Chart 5, panel B shows that the proportion of awards to individuals younger than 45 declined from 30.6 percent in 2001 to 23.9 percent by 2010, reversing the pattern of increase observed during the 1980s and early 1990s. Conversions also rose very rapidly during the second half of the decade, from 42.5 percent of benefit terminations in 2005 to 52.4 percent by 2010.

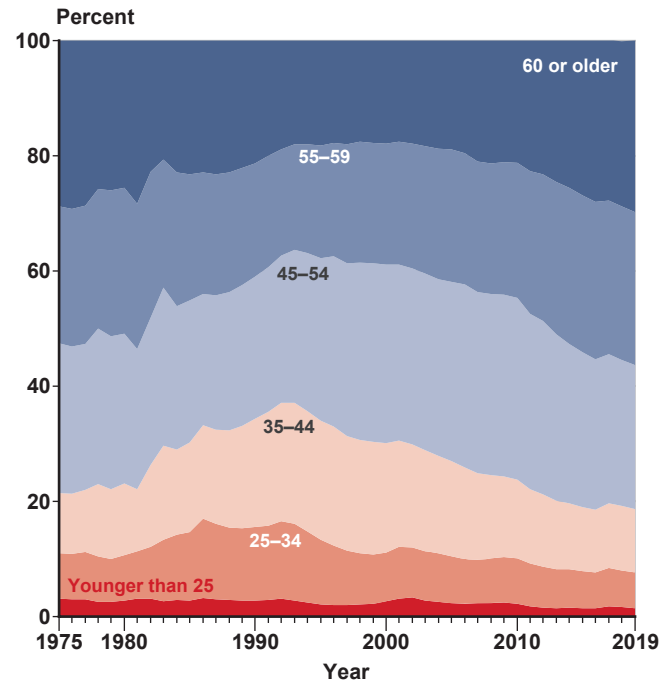
The rapid expansion of the DI rolls throughout the 1990s and 2000s contributed to a perception that the program might be on an unsustainable path. For instance, Autor and Duggan (2006) identified contemporary labor market trends that incentivized low-wage workers to apply for benefits, along with the changes in the disability determination process enacted in 1984, as key factors in DI unsustainability. However, according to Pattison and Waldron (2013), “three factors—(1) population growth, (2) the growth in the proportion of women insured for disability, and (3) the movement of the large baby boom generation into disability-prone ages—explain 90 percent of the growth in new disabled-worker entitlements over the 36-year subperiod (1972–2008).” Although Pattison and Waldron analyzed growth in new DI awards (incidence), Liebman (2015) reached qualitatively similar conclusions by focusing on prevalence

**Chart 5.**  
**Number and percentage distribution of DI disabled-worker benefit awards and beneficiaries in current-payment status, by age group, 1975–2019**

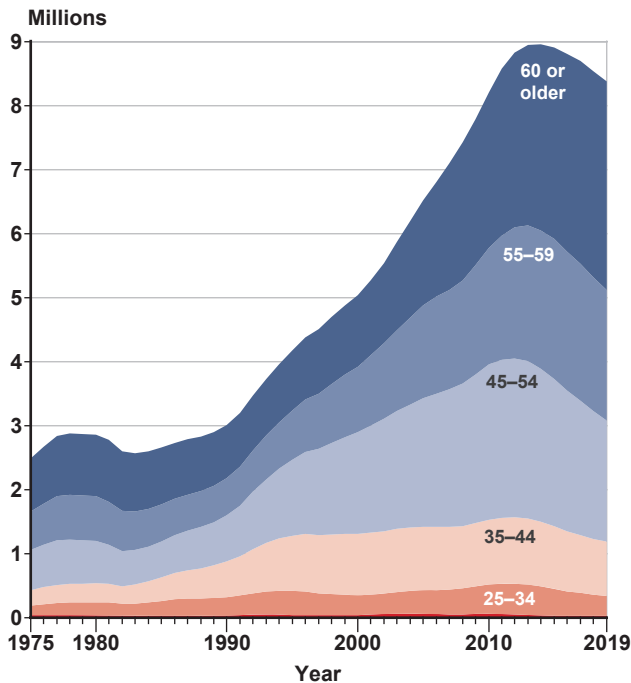
**Panel A: Number of awards**



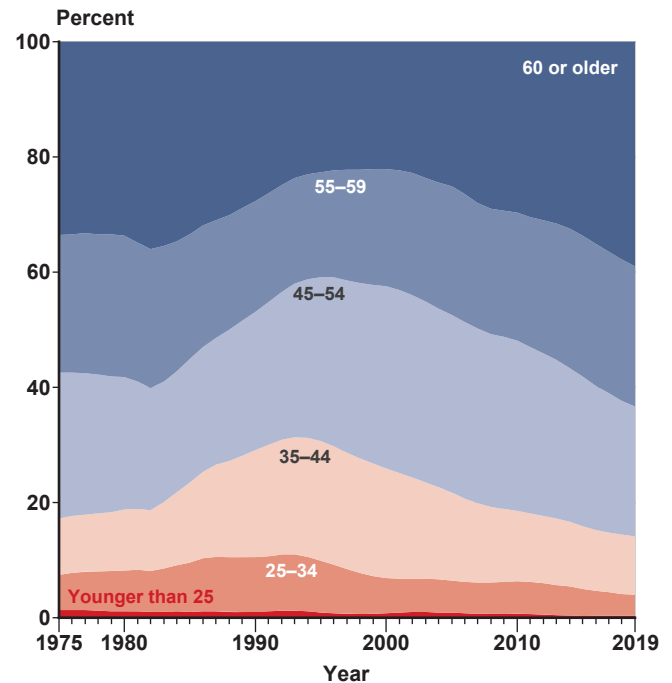
**Panel B: Percentage distribution of awards**



**Panel C: Number of beneficiaries**



**Panel D: Percentage distribution of beneficiaries**



SOURCES: Zayatz (1999, 2005, 2011, 2015, Tables 3 and 6); and Barrick-Funk (2020, Tables 3 and 6).



(the total number of beneficiaries as a share of the insured population):

The impression in policy circles that disability enrollment and spending are “out of control” appears to be the result of confounding the legislatively induced bounce-back of incidence rates in the late 1980s and early 1990s with the largely demographically induced increases of the past two decades.<sup>15</sup>

### **2011–2019**

The most recent DI trend is a steep decline in awards and a large increase in benefit terminations. In Chart 5, panels A and B show the number and percent-age distribution of awards by age group, while panels C and D show the same for DI beneficiaries in current-payment status. The latter is a stock variable, while the former is a flow variable. Specifically, the number of beneficiaries on the DI rolls at a given time  $t$  is determined by the number of beneficiaries in current-payment status during the previous period ( $t-1$ ) plus the difference between the flow of awards and terminations from  $t-1$  to  $t$ .

The number of awards has been declining since 2010, while terminations began to exceed awards after 2014 (Chart 2). From 2015 through 2019, more than half a million more beneficiaries exited the DI rolls than entered them. In 2019 alone, there were 524,927 exits via conversion, representing 59.4 percent of benefit terminations. Historically, the only other period with more annual terminations than awards was 1979–1983, as noted earlier, although the circumstances were very different then. Some of the factors reversing the gap between awards and terminations in the last decade appear to be low unemployment and a growing population of older disabled beneficiaries. The proportion of DI beneficiaries in current-payment status who are aged 60 or older has been steadily increasing in the last two decades, from 22.2 percent in 2000 to 39.0 percent by 2019 (Chart 5, panel D).

Note that the oldest baby boomers (the 1946 birth cohort) reached age 66—their FRA—in 2012, and the youngest baby boomers will reach their FRAs throughout the 2020s. The uptick in OASI conversions since the late 2000s shown in Chart 3 also reflects a pattern of deferrals resulting from scheduled progressive increases in FRAs. According to Zayatz (2015), the introduction of higher FRAs for later birth cohorts implies a greater actuarial reduction in early retirement benefits and may induce older workers to seek disability benefits as an alternative to reduced

retirement benefits. In addition, the decline in labor-force participation rates since the early 2000s suggests that many potential claimants may no longer satisfy the recency-of-work test for DI insured status, which could play a role in the downward trend in awards since 2010 (Chart 2 and Chart 5, panel A).

Another consequence of an older population is a change in the diagnostic composition of new DI beneficiaries. As I discuss in detail in the Recent Trends in Disability Awards section, different disorders have different ages of likely onset; for example, mental impairments such as schizophrenia and affective/mood and anxiety disorders have peak incidence among young adults. The highest incidence probabilities for a primary or secondary diagnosis of affective/mood disorder among 2009 disabled-worker benefit applicants at the DDS level involved claimants in their late 20s and early 30s. By contrast, the peak ages for a primary or secondary diagnosis of a disorder of the back were late 40s and early 50s. The age group with the highest share of claimants diagnosed with the two impairments combined was the early 40s (Meseguer 2018, Chart 8).

Chart 4, panel B shows that the percentage of awards with a mental impairment as the primary diagnosis was 25.5 percent in 2001 but had dropped to 13.3 percent by 2019. In the same period, the share of awards with musculoskeletal-disorder primary diagnoses rose from 24.5 percent to 37.7 percent. In fact, since 2002, musculoskeletal impairments have become the leading primary diagnosis for new awards. As the median age of the population rises, the diagnostic composition of awards and of beneficiaries in current-payment status is likely to skew further toward disorders with higher incidence at older ages.<sup>16</sup>

### ***Estimates of Period Mortality***

In this Section, I compare mortality of DI beneficiaries with that of their counterparts in the general population. Mortality among DI beneficiaries is highest during the first few years of entitlement (that is, of benefit receipt), regardless of age at entitlement; thereafter, mortality declines with each additional year survived on the DI rolls. For this reason, the SSA actuarial studies calculate period mortality either by age at entitlement or by attained (current) age at various lengths of time on the DI rolls. All DI mortality measures in the charts and tables that follow are indexed by attained age, or age at entitlement plus number of years on the rolls.

Consider as a concrete example Table 7A in Zayatz (2015), reproduced here as Table 1. Zayatz notes: “The value  $q_{[x]+t}$  at duration  $t$  represents the probability of

**Table 1.****Men entitled to DI disabled-worker benefits 2006–2010: Death probabilities, by age and time on the rolls**

Age at entitlement	Completed duration (years since entitlement)											Ultimate age
	0	1	2	3	4	5	6	7	8	9	10 or more	
16	0.004005	0.007118	0.005243	0.005808	0.004028	0.002434	0.009198	0.007122	0.005716	0.006213	0.008136	26
17	0.005733	0.008269	0.006200	0.006732	0.004814	0.004741	0.007013	0.007116	0.006395	0.005513	0.006905	27
18	0.007308	0.008883	0.006932	0.007155	0.006209	0.007076	0.004693	0.006643	0.006733	0.005497	0.006352	28
19	0.009912	0.008377	0.007283	0.007686	0.006205	0.006500	0.004569	0.005458	0.007248	0.005377	0.005880	29
20	0.010149	0.008646	0.006905	0.007953	0.006470	0.006162	0.004441	0.006121	0.007672	0.005341	0.006108	30
21	0.011103	0.010265	0.007296	0.007620	0.006774	0.005655	0.005015	0.004967	0.006140	0.006874	0.007012	31
22	0.012094	0.011228	0.009187	0.008027	0.007389	0.006408	0.006813	0.005581	0.006505	0.006665	0.007916	32
23	0.013836	0.011179	0.009447	0.007643	0.006611	0.007118	0.007323	0.005613	0.007006	0.006227	0.008116	33
24	0.015161	0.011926	0.009826	0.008297	0.009101	0.009227	0.007863	0.007654	0.007651	0.007779	0.009324	34
25	0.018140	0.014673	0.011113	0.010623	0.011169	0.008417	0.008942	0.008349	0.008298	0.008464	0.009091	35
26	0.018564	0.016495	0.013518	0.011573	0.010589	0.008277	0.009743	0.010199	0.009877	0.010236	0.009375	36
27	0.020113	0.017388	0.013371	0.013152	0.011160	0.008675	0.011310	0.010835	0.010458	0.010874	0.010365	37
28	0.020724	0.018155	0.013458	0.014264	0.011917	0.010631	0.011378	0.011353	0.010614	0.011099	0.011003	38
29	0.021458	0.016934	0.013899	0.012967	0.012085	0.013262	0.011405	0.011686	0.012879	0.012467	0.011339	39
30	0.023200	0.017115	0.015756	0.014714	0.011684	0.012936	0.012060	0.012233	0.012293	0.013085	0.011527	40
31	0.024571	0.017734	0.015653	0.015981	0.012800	0.012994	0.013193	0.013713	0.013573	0.014216	0.013354	41
32	0.024515	0.017861	0.017122	0.014963	0.013807	0.014220	0.013867	0.013669	0.013467	0.014543	0.013894	42
33	0.025472	0.019277	0.015627	0.015147	0.014157	0.014467	0.014338	0.014137	0.013848	0.015326	0.014453	43
34	0.026543	0.021196	0.016385	0.016307	0.015505	0.015411	0.014422	0.015058	0.015485	0.015910	0.015402	44
35	0.028307	0.020641	0.016911	0.016015	0.015144	0.015943	0.015318	0.015467	0.017319	0.017290	0.015730	45
36	0.029553	0.021818	0.015583	0.017742	0.015664	0.015792	0.016567	0.016336	0.016864	0.018095	0.016623	46
37	0.031385	0.024737	0.018076	0.017275	0.016308	0.016980	0.017910	0.017621	0.017296	0.019528	0.017254	47
38	0.031170	0.024702	0.020663	0.018570	0.016709	0.017127	0.016991	0.017793	0.018280	0.020344	0.018444	48
39	0.031760	0.023666	0.020930	0.019676	0.017793	0.016971	0.018185	0.019764	0.019799	0.020364	0.019330	49
40	0.033996	0.025886	0.021615	0.020828	0.018276	0.019744	0.019021	0.020915	0.019346	0.020367	0.021099	50
41	0.037454	0.027476	0.021614	0.019927	0.021049	0.020233	0.021340	0.020950	0.021474	0.022797	0.022125	51
42	0.042254	0.029028	0.024078	0.021666	0.021654	0.021111	0.020751	0.022591	0.024108	0.024209	0.022946	52
43	0.043253	0.030026	0.025109	0.023848	0.021864	0.023325	0.022413	0.023813	0.024088	0.025639	0.024665	53
44	0.047810	0.030554	0.025663	0.024035	0.024225	0.023838	0.025207	0.025413	0.026245	0.028749	0.026031	54
45	0.048081	0.031913	0.028376	0.025577	0.025257	0.026351	0.026729	0.026663	0.026773	0.028648	0.027221	55
46	0.052341	0.033774	0.028944	0.026922	0.026840	0.026631	0.026597	0.027912	0.029313	0.030353	0.028951	56
47	0.058179	0.037569	0.030009	0.029002	0.028099	0.028074	0.027621	0.029062	0.030591	0.032001	0.030184	57
48	0.063102	0.039881	0.032815	0.030991	0.029464	0.029392	0.029290	0.029774	0.030323	0.032387	0.031587	58
49	0.064043	0.043206	0.033119	0.031247	0.029065	0.030218	0.030251	0.031965	0.031652	0.032654	0.033641	59
50	0.047733	0.034242	0.029994	0.029417	0.028782	0.028373	0.029795	0.031248	0.030506	0.033644	0.034318	60
51	0.060387	0.040972	0.033382	0.030202	0.030311	0.030353	0.031738	0.032343	0.033140	0.036774	0.036444	61
52	0.064606	0.042419	0.034941	0.032608	0.030983	0.032156	0.032335	0.033528	0.034646	0.036037	0.038363	62
53	0.067887	0.045619	0.037972	0.034237	0.032802	0.032727	0.031872	0.034376	0.037637	0.038761	0.041034	63
54	0.069555	0.046707	0.035569	0.034591	0.032746	0.033390	0.034824	0.037122	0.038282	0.041385	0.042186	64
55	0.053986	0.039017	0.032103	0.030704	0.030946	0.031538	0.033814	0.035627	0.037044	0.040646	0.041976	65
56	0.062545	0.042695	0.034206	0.033525	0.032278	0.033869	0.035190	0.039125	0.039132	0.041303	0.047624	66
57	0.063949	0.043076	0.035000	0.033490	0.033836	0.036481	0.038043	0.040093	0.040390	0.045543	0.049946	67
58	0.066925	0.045721	0.037491	0.035357	0.036548	0.038511	0.040046	0.038783	0.045576	0.048301	0.052884	68
59	0.066950	0.046406	0.038999	0.036654	0.037211	0.037375	0.038736	0.043914	0.047481	0.051386	0.055771	69
60	0.064286	0.046916	0.039314	0.037607	0.037372	0.037410	0.043402	0.045616	0.048726	0.052754	0.058466	70
61	0.074153	0.049555	0.041682	0.039464	0.038908	0.043873	0.047364	0.048433	0.052576	0.054822	0.061678	71
62	0.081539	0.054098	0.044189	0.042764	0.045562	0.045980	0.049717	0.052812	0.055874	0.057919	0.065458	72
63	0.095425	0.063973	0.051745	0.050283	0.050324	0.054444	0.056046	0.060056	0.065220	0.065203	0.069131	73
64	0.115021	0.070370	0.055579	0.055825	0.056144	0.062203	0.061766	0.064501	0.073359	0.073558	0.073835	74
65	0.123763	0.074767	0.055770	0.060810	0.060725	0.062011	0.064728	0.066258	0.081121	0.081981	0.079210	75

SOURCE: Zayatz (2015, Table 7A).

NOTE: Refer to age at entitlement for men with 0 to 9 years duration. Refer to ultimate age (age at last birthday) only for those with 10 or more years.

death—in a multiple-decrement environment—during the ( $t+1$ ) year of entitlement for those originally entitled to disability benefits at entitlement age [ $x$ ] who have attained age [ $x+t$ .” The table shows that a male beneficiary who attained age 35 during the first year of entitlement (duration  $t=0$ ) faced a mortality rate of 0.028307 in 2006–2010. By contrast, a male beneficiary who attained age 35 after 1 year on the rolls (that is, who was entitled at age 34), faced a mortality rate of 0.021196 during the second year of entitlement (duration  $t=1$ ). Stepwise tracking of the table entries diagonally upward and to the right maintains an attained-age constant across each additional year survived on the rolls.

The methodology for constructing the actuarial period mortality tables is detailed in Zayatz (1999, 59–64) and Zayatz (2015, 99–104). The earlier actuarial studies, which cover often-overlapping subperiods in the 1970s, generally present mortality estimates for a 5-year “select period”—that is, for each of six durations on the DI rolls (0 [year of entitlement], 1, 2, 3, 4, and 5 or more years).<sup>17</sup> The more recent studies—encompassing the DI mortality experience in the 1990s, in the 2000s, and for 2011–2015—employ a 10-year select period.<sup>18</sup> After 10 years on the rolls, a beneficiary’s chance of dying is assumed not to be affected by an incremental increase in duration; thus, the probabilities of death for such beneficiaries depend only on ultimate age. In other words, in Table 1, the probability of death for a 60-year-old man with 10 or more years on the rolls is 0.034318 regardless of whether he has received benefits for 30 years (since age 30) or for 20 years since age 40 (Zayatz 2015, 99).

Notice also that Table 1 accounts only for postentitlement deaths. Thus, claimants who die during the 5-month waiting period fall outside the scope of measurement:

The mortality experience reported in this study is affected by several unique circumstances. First, it is recognized that a claimant may die while waiting for a disability determination. Since observation of a participant is contingent upon entitlement, a disability which results in death prior to entitlement will not be an “observed” death. As a result, the probability of death during the first year of entitlement may be artificially low. (Zayatz 1999, 59)

Chart 6 plots the logarithm of period mortality as a function of age for men (panel A) and women (panel B). It covers the general population as of

selected years and the DI-beneficiary population during the first year of entitlement (zero duration) in various periods. The three general-population lines, spanning the entire 0–100 age range, derive from OCACT’s historical period mortality tables.<sup>19</sup> They represent the general population in 1900, the earliest year available in the historical data file; 1918, the year of the influenza pandemic that killed an estimated 50 million to 100 million people worldwide; and 2013, the midpoint of the study period (2011–2015) of the most recent actuarial study (Barrick-Funk 2020). In 1918, the influenza virus was of a strain unusually deadly to young healthy adults, as documented by Taubenberger and Morens (2006) and reflected in Chart 6, which shows how period mortality after about age 8 was higher in 1918 than in 1900 for males until age 59 and females until age 47. Unsurprisingly, the chart shows a significantly lower log mortality for 2013 than those for 1900 and 1918, reflecting nearly a century of advances in medicine, science, diet and nutrition, public health, workplace safety, and many other factors.<sup>20</sup>

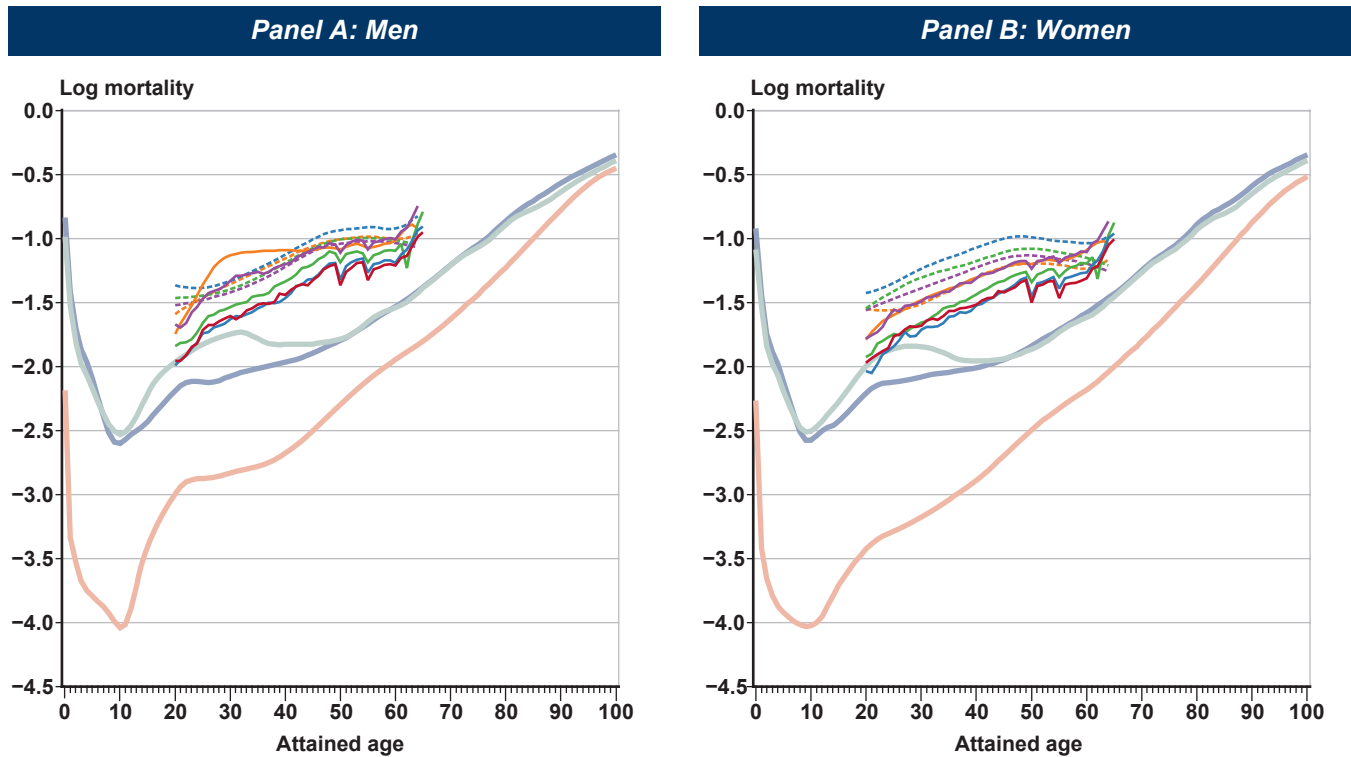
Chart 6 also plots the log mortality age profiles of DI beneficiaries during the first year of entitlement (zero duration) from the nine actuarial studies I survey. The plots are clustered in a generally descending pattern from earlier to later periods.

For a wide age range (such as from birth to age 100 in Chart 6), mortality is commonly graphed in the logarithmic scale. The reason for this is a well-established empirical regularity known as Gompertz’s law, wherein the mortality rate of human populations increases exponentially with age and thus linearly in the logarithmic scale. If Chart 6 were graphed in the original scale, mortality differences between the series for younger ages would be impossible to discern because of the overpowering influence of the exponentially higher mortality values for older ages. However, it is still possible to render a meaningful depiction of mortality in its original scale over the narrower age range relevant to the DI program.

Charts 7 and 8 plot male and female mortality, respectively, at ages 14 to 75 for the general population and for DI beneficiaries in each of the first 5 years of entitlement (durations 0–4) and for those surviving at least 10 years on the rolls.<sup>21</sup> Together, Charts 6–8 reveal a number of relevant patterns. Clearly, mortality among DI beneficiaries is highest at every age during the first few years of entitlement and declines with the number of years on the DI rolls. From their early 20s into their early 60s, DI beneficiaries during the most recent period available (2011–2015) faced much higher

**Chart 6.**

**Period log mortality rates, by sex and age: DI disabled-worker beneficiaries in the first year of entitlement, various periods 1968–2015; and general population, selected years 1900–2013**



SOURCES: Bell and Miller (2005, Table 6); Bayo and Wilkin (1977, Tables 8 and 9); Bayo, Goss, and Weissman (1978, Tables 9 and 10); Schobel (1980, Tables 4 and 5); Kelley and Lopez (1984, Tables 5 and 6); Zayatz (1999, 2005, 2011, 2015, Tables 7A and 7B); and Barrick-Funk (2020, Tables 7A and 7B).

mortality in the first year of entitlement than their general-population counterparts did during the 1918 influenza pandemic (Chart 6 and panel A in Charts 7 and 8).

The longer DI beneficiaries survive on the rolls, the more mortality rates in different periods converge. After surviving at least 10 years on the DI rolls (panel F in Charts 7 and 8), DI beneficiary mortality exhibits an exponential rise as a function of age (linear in the logarithmic scale), similar to that of the general population. Nevertheless, the actual mortality experience for these DI beneficiaries is closer to that of the general population in the early 1900s, before the DI program or Social Security existed. Panel F in Charts 7 and 8 shows that beneficiaries who enter the rolls with impairments that are not immediately deadly and who survive for a long period thereafter still end up with much higher

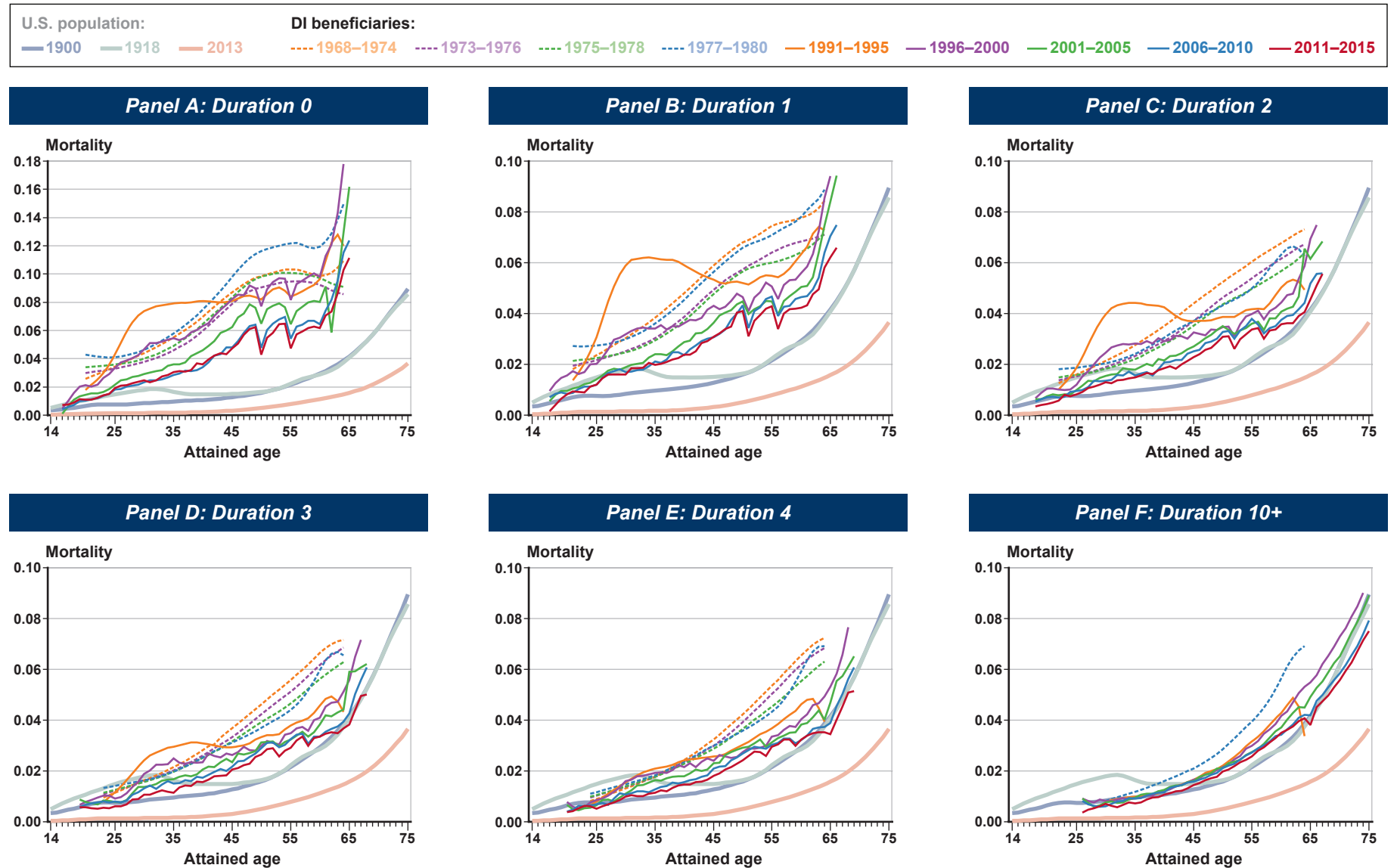
contemporaneous mortality than their counterparts in the general population.

One remarkable feature in Chart 7 is the unusually high mortality among young male beneficiaries during the first few years of entitlement in 1991–1995, which can be attributed largely to HIV/AIDS-related deaths, as noted earlier. This pattern is evident through the first 4 years of entitlement (durations 0–3) and appears to a lesser extent for the 1996–2000 period as well, before dissipating at longer durations. For male beneficiaries aged roughly 25–40, mortality during the first 4 years of entitlement was substantially higher in 1991–1995 than at any time during the 1970s (Chart 7). This is in sharp contrast with the experience of female beneficiaries over the same period (Chart 8), with mortality far higher during most subperiods of the 1970s than during the 1990s.



Chart 7.

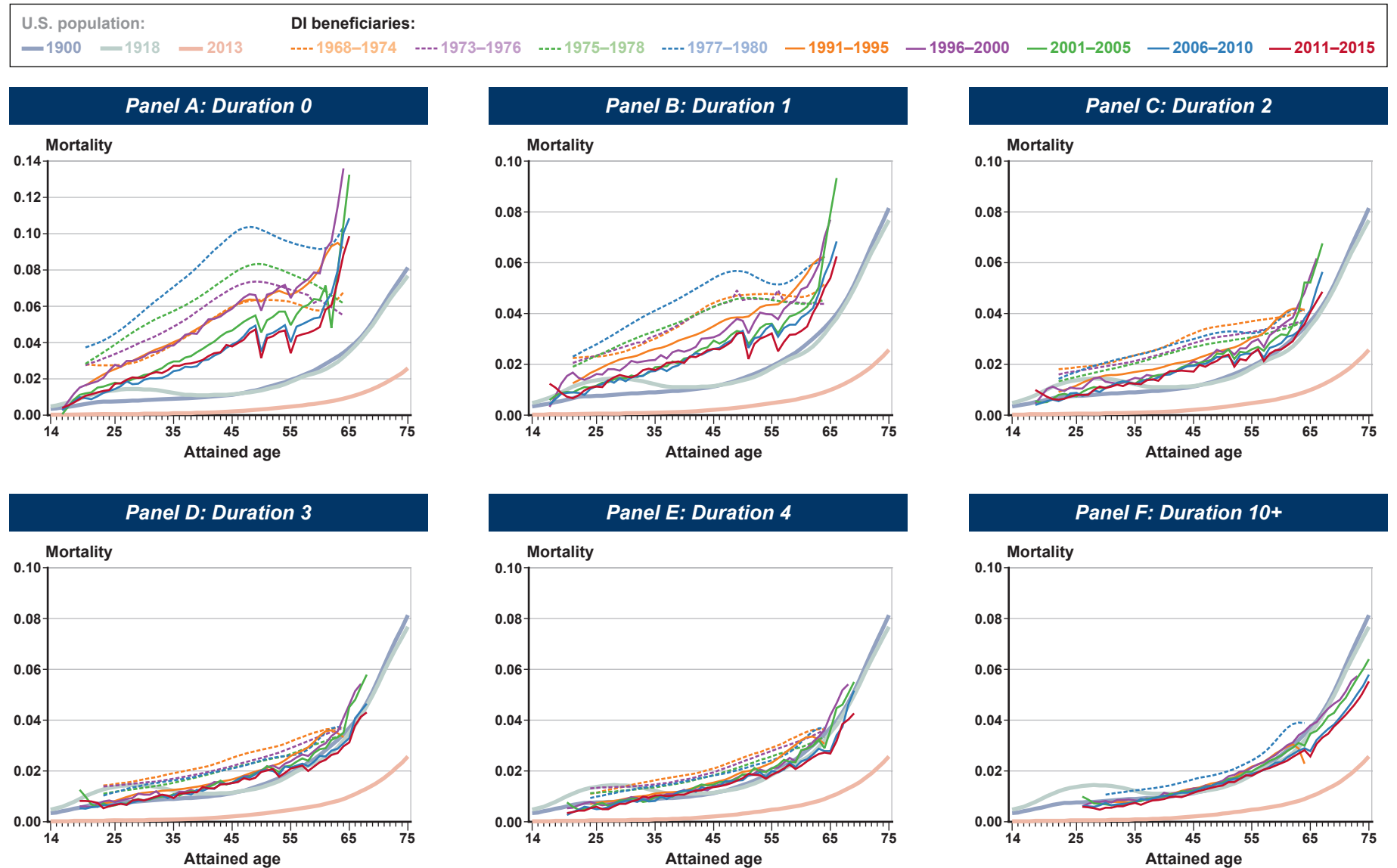
Male period mortality rates, by age: DI disabled-worker beneficiaries by duration of entitlement, various periods 1968–2015; and general population, selected years 1900–2013



SOURCES: Bell and Miller (2005, Table 6); Bayo and Wilkin (1977, Table 8); Bayo, Goss, and Weissman (1978, Table 9); Schobel (1980, Table 4); Kelley and Lopez (1984, Table 5); Zayatz (1999, 2005, 2011, 2015, Table 7A); and Barrick-Funk (2020, Table 7A).

Chart 8.

Female period mortality rates, by age: DI disabled-worker beneficiaries by duration of entitlement, various periods 1968–2015; and general population, selected years 1900–2013



SOURCES: Bell and Miller (2005, Table 6); Bayo and Wilkin (1977, Table 9); Bayo, Goss, and Weissman (1978, Table 10); Schobel (1980, Table 5); Kelley and Lopez (1984, Table 6); Zayatz (1999, 2005, 2011, 2015, Table 7B); and Barrick-Funk (2020, Table 7B).

As discussed in the Chronology section, DI enrollment expanded substantially in the first half of the 1970s. Multiple recessions, rapid increases in award volumes, declines in benefit terminations based on medical recovery, temporary suspension of CDRs, fewer quality control reviews, high benefit-to-predisability earnings replacement rates, and increasing workloads for disability examiners handling two new programs (Black Lung Benefits and SSI) all contributed to the expansion. These developments, reflecting economic and administrative changes rather than broad health trends, nevertheless appear consistent with a population of DI beneficiaries who are relatively healthier (and thus have lower mortality), on average, than those of other periods. By contrast, the 1977–1982 period was contractionary, with steep declines in awards, frequent CDRs targeting beneficiaries with mental impairments, and a sharp increase in exits based on recovery, all of which hint at possibly higher DI-beneficiary mortality. Female DI mortality during the first year of entitlement seems to confirm this supposition, increasing across all ages for successive 1970s subperiods. Male mortality at zero duration in 1977–1980 was also higher than in any other subperiod of the 1970s, although the pattern across successive subperiods is less clear-cut than that for female beneficiaries.

Another interesting pattern in Charts 7 and 8 is the considerable flattening in mortality growth as a function of age during the first year of DI entitlement, beginning around ages 45 to 50. The vocational grid provides one potential explanation. For the 1990s and particularly for the post-2000 periods, the mortality curves dip sharply around ages 50 and 55, corresponding to less-restrictive age thresholds for DI allowances in the vocational grid. Clearly, the decline in mortality at the age thresholds has become more pronounced over time, which is consistent with the steady increase in the share of awards based on medical-vocational criteria. Another factor that can affect DI mortality is the possibility of conversion to reduced retirement benefits beginning at age 62. In this context, it is worth noting the sharp drop in mortality at age 62 during the first year of entitlement for both men and women in 2001–2005 (panel A in Charts 7 and 8). This steep decline in mortality overlaps the previously discussed drop in benefit terminations based on conversion in 2003 (Charts 1 and 3) driven by the higher FRAs of the 1938 and later birth cohorts.

The distinctive DI mortality patterns at the vocational-grid age thresholds suggest that the mortality of beneficiaries at older ages would be higher if not

for the effect of the grid. After all, without the grid, older claimants would be able to enter the rolls based only on medical factors. Notice also a similar, albeit smoothed, slow-down of period mortality at older ages during the first year of DI entitlement in the 1970s subperiods. Fewer claimants entered the rolls through medical-vocational considerations in those years.

Whatever effect the vocational grid may have on DI mortality, beneficiaries who enter the rolls at older ages face a much higher mortality than do their counterparts in the general population, regardless of observation period. For instance, during 2011–2015, a 50-year-old male beneficiary in the first year of entitlement faced a mortality rate of 0.04266, which because of the age-threshold effect was slightly lower than the mortality faced by a 43-year-old male beneficiary in similar circumstances. Yet, this death rate exceeded that of a 50-year-old man in the general population more than a century earlier (in 1900) by a factor of 2.7. The same 50-year-old male beneficiary faced a mortality rate higher than that of a contemporary 76-year-old man in the general population.<sup>22</sup>

### ***Contemporaneous Differences in Mortality by Age and Sex***

Chart 9 plots the ratios of DI-beneficiary mortality to contemporaneous general-population mortality at every available age. For brevity, I refer to this as the “DI mortality ratio” hereafter. Panels A and B respectively plot the male and female mortality ratios during the first year of DI entitlement and panels C and D respectively plot the male and female mortality ratios after surviving at least 10 years on the rolls. Notice that by focusing on the two duration extremes (0, 10 or more) in this article, I highlight the maximum range in mortality differences between DI beneficiaries at a given age. Such a range illustrates the mortality experience of DI beneficiaries in varying degrees of poor health.

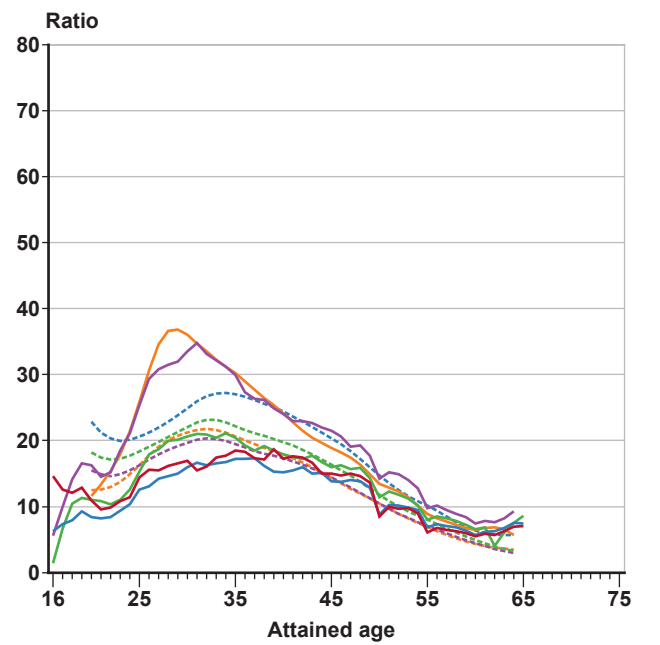
All the plotted mortality ratios in Chart 9 are greater than 1, indicating that DI-beneficiary mortality is always higher than general-population mortality regardless of age, enrollment period, and duration on the rolls. However, the difference can range from a factor of about 3 (for men aged 60 in 2011–2015 after surviving on the rolls for at least 10 years) to more than 70 (for women in their mid-20s to mid-30s and in their first year receiving benefits during 1977–1980).

In both the general and DI-beneficiary populations, male mortality is typically higher than female mortality at any age. Nevertheless, the female DI mortality ratios are higher than the ratios for men. This shows

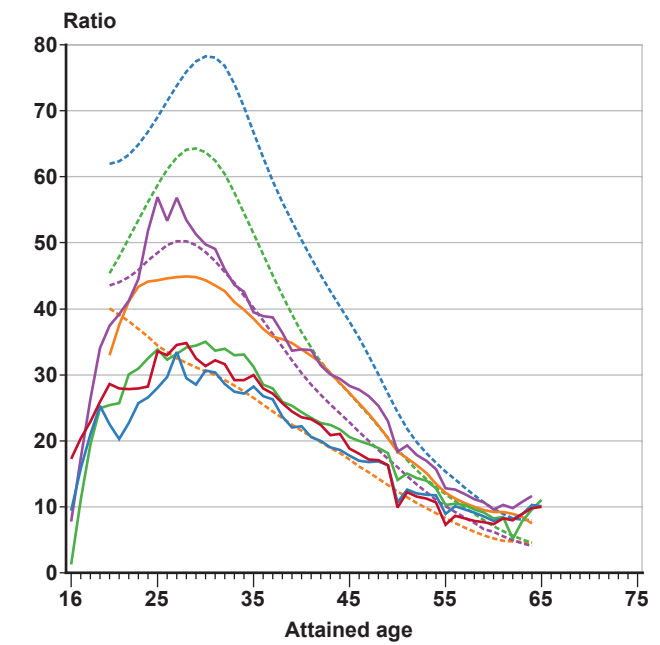
**Chart 9.**  
**Mortality-rate ratios of DI disabled-worker beneficiaries to the general population, by sex, age, and duration of DI entitlement, various periods 1968–2015**



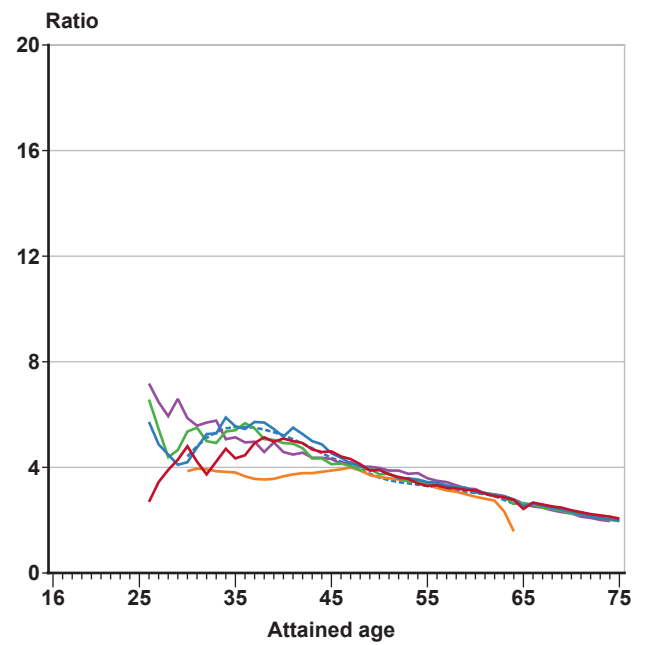
**Panel A: Male, duration 0**



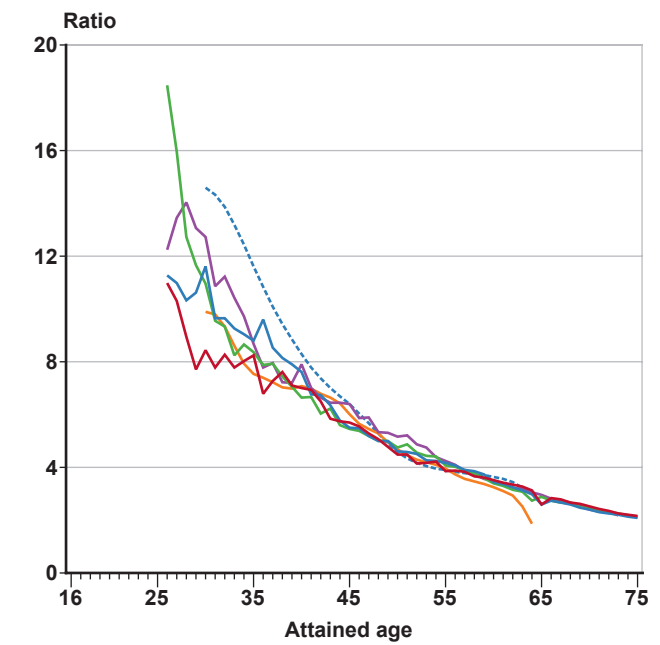
**Panel B: Female, duration 0**



**Panel C: Male, duration 10+**



**Panel D: Female, duration 10+**



SOURCES: Bell and Miller (2005, Table 6); Bayo and Wilkin (1977, Tables 8 and 9); Bayo, Goss, and Weissman (1978, Tables 9 and 10); Schobel (1980, Tables 4 and 5); Kelley and Lopez (1984, Tables 5 and 6); Zayatz (1999, 2005, 2011, 2015, Tables 7A and 7B); and Barrick-Funk (2020, Tables 7A and 7B).



that the mortality gender gap is wider in the general population than among DI beneficiaries. Put differently, male mortality exceeds female mortality by a larger factor in the general population than in the DI-beneficiary population. For instance, mortality for a 40-year-old man was about 17 times higher for a DI beneficiary in the first year of entitlement during 2011–2015 than for his counterpart in the general population. On the other hand, mortality for a 40-year-old woman was 23.5 times higher for a DI beneficiary in her first year of entitlement in 2011–2015 than for her counterpart in the general population. This result appears to be consistent across different enrollment periods and entitlement durations.

A second broad pattern revealed by Chart 9 involves age. The male and female mortality ratios are highest at younger ages (mid-20s and 30s). Mortality increases with age regardless of DI participation, but the mortality rates of young adults in the general population are comparatively very low. As a result, DI-beneficiary mortality at these ages exceeds general-population mortality by a much larger factor. In conclusion, in absolute terms (magnitude), older beneficiaries have higher mortality than younger ones and male beneficiaries tend to have higher mortality than do female beneficiaries. However, in relative terms (compared to their reference group in the general population), female and young DI beneficiaries are worse off by a larger factor. This finding is also evident in Chart 6, which shows higher mortality rates for older beneficiaries, but the vertical distances between DI-beneficiary log mortality rates and general-population log rates are greater for the young than for the old.

In general, the male DI mortality ratio at benefit duration 0 was highest for beneficiaries in their 20s and 30s during the 1990s. However, the ratio for 2001–2005 was similar to that of the early 1970s. The female DI mortality ratio at benefit duration 0 was highest at ages 20–60 during 1977–1980. Of particular note is the monotonic increase in the ratio across successive 1970s subperiods, mirroring the mortality-rate pattern in Chart 8, panel A.

### **Mortality Improvement**

Table 2 summarizes the average rate of change in mortality for both the general and DI-beneficiary populations in the period 1977–2015 and, separately, in only the latter portion of it (1991–2015). All changes are negative, indicating mortality improvement (decline) over time. Consider, for instance, the experience of men aged 30–39. For DI beneficiaries at

zero duration, the mortality rate declined by 63.0 percent, on average, from 1991 to 2015.<sup>23</sup> By contrast, the average rate of mortality improvement among men aged 30–39 in the general population over the most comparable available period (1993–2013) was substantially lower, at 35.3 percent. However, the average rate of mortality improvement for DI beneficiaries reaching their thirties after at least 10 years on the rolls (21.5 percent) was lower than that for the contemporary general population.

The periods of coverage in Table 2 were determined by data availability, which may bias the findings. Specifically, 1991–1995 was a period of unprecedented high mortality, driven by AIDS-related deaths, for young male beneficiaries; but it also provides the earliest mortality estimates from the most recent actuarial studies. Similarly, mortality during the first year of entitlement was substantially higher at all ages in the latter part of the 1970s than in the early part of that decade. However, of the actuarial studies covering the 1970s, I chose to use only the one encompassing the 1977–1980 period because it alone extends the mortality estimates to 10 or more years of benefit duration. Table 2 clearly shows that during the first year of entitlement, DI-beneficiary mortality for men and women aged 20–59 improved at often substantially higher average rates than those in the general population throughout both the 1977–2015 and 1991–2015 periods. Mortality at zero duration has also improved at a much faster rate over time, relative to the experience of beneficiaries with at least 10 years on the rolls.

Chart 10 compares general-population mortality at ages 35, 50, and 60 over the period 1900–2014 with the DI mortality estimates from the six actuarial studies with 10-year select periods. Dual plots for DI beneficiaries track mortality during the first year of entitlement and after at least 10 years of entitlement. These plots represent the mortality experience of the least healthy and the healthiest DI beneficiaries, in terms of longevity. Notice that for a given year, the vertical distance between the general-population mortality and the midpoint of the DI mortalities measures the difference in contemporaneous mortality between the two populations.<sup>24</sup>

The mortality gap between the most and least longevous DI beneficiaries has narrowed considerably over time. At age 35, for instance, the distance between the upper and lower bounds in Chart 10 declined by a factor of approximately 3 for women over the 1977–2015 period and for men over the 1991–2015 subperiod. For male DI beneficiaries in the first year of entitlement,

**Table 2.**

**Average percentage change in mortality rates over the periods 1977–2015 and 1991–2015 for the general population and for short- and long-term DI disabled-worker beneficiaries, by age group**

Age group	From 1977–1980 to 2011–2015			From 1991–1995 to 2011–2015		
	U.S. population <sup>a</sup>	DI beneficiary for—		U.S. population <sup>b</sup>	DI beneficiary for—	
		Less than 1 year	10 years or longer		Less than 1 year	10 years or longer
<b>Men</b>						
20–29	-32.56	-59.53	...	-23.88	-56.05	...
30–39	-23.98	-49.41	-33.37	-35.33	-63.03	-21.46
40–49	-36.30	-49.49	-32.86	-28.15	-41.10	-14.74
50–59	-38.08	-52.03	-33.94	-18.51	-34.65	-16.11
60–64	-44.80	-40.61	-40.71	-27.78	-31.64	-10.94
<b>Women</b>						
20–29	-26.05	-65.39	...	-11.96	-35.60	...
30–39	-16.23	-63.25	-43.64	-12.70	-35.85	-16.52
40–49	-28.41	-60.67	-31.41	-8.76	-34.23	-12.96
50–59	-27.60	-55.87	-24.74	-13.95	-38.09	-12.58
60–64	-33.91	-31.76	-32.01	-26.21	-26.96	-7.19

SOURCES: Author's calculations based on Bell and Miller (2005, Table 6); Bayo and Wilkin (1977, Tables 8 and 9); Bayo, Goss, and Weissman (1978, Tables 9 and 10); Schobel (1980, Tables 4 and 5); Kelley and Lopez (1984, Tables 5 and 6); Zayatz (1999, 2005, 2011, 2015, Tables 7A and 7B); and Barrick-Funk (2020, Tables 7A and 7B).

NOTES: Percentages are computed by averaging individual rates of decline by single year of age.

... = not applicable.

a. For the period 1978–2013.

b. For the period 1993–2013.

mortality at age 35 declined from more than 30 times the magnitude of mortality for 35-year-old men in the general population in 1991–1995 to 18.5 times greater by 2011–2015 (Chart 9). Likewise, the female DI mortality ratio at age 35 and duration 0 declined from 66.7 in 1977–1980 to about 30 by 2011–2015. At age 35 after surviving at least 10 years on the rolls, DI mortality ratios during the most recently available period (2011–2015) were 8.2 for women and 4.3 for men. In historical terms, male beneficiary mortality in 2011–2015 at age 35 and 10 or more years on the rolls was greater than general-population mortality in 1921 for that age.

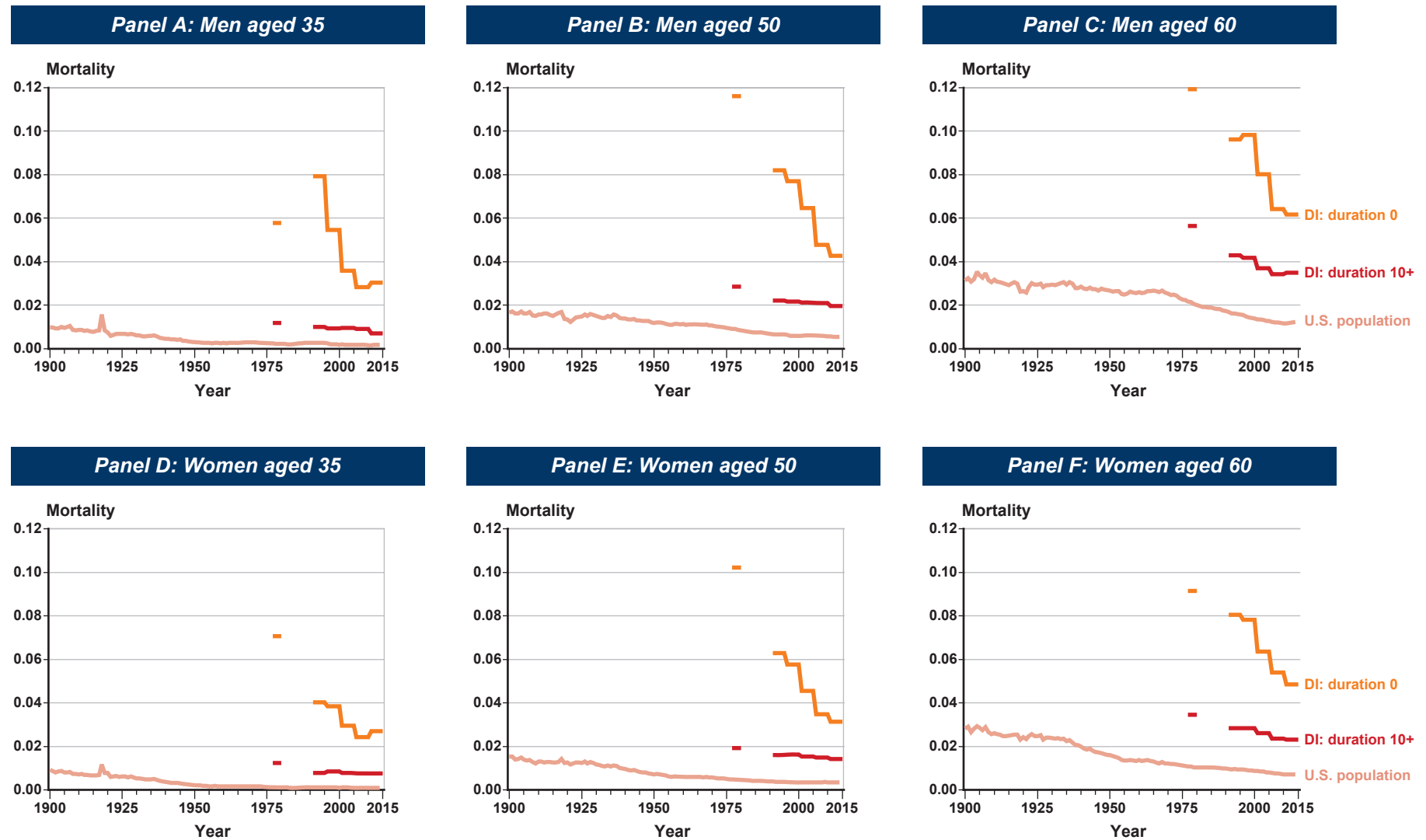
At age 50, the gap in DI mortality by duration was 3.8 times wider for men in 1977–1980 than in 2011–2015 and 4.9 times wider for women over the same span (Chart 10, panels B and E, respectively). Recall from Chart 8 that because 50 is an age threshold in the vocational grid, DI-beneficiary mortality upon entering the rolls at age 50 is substantially lower than those at the neighboring ages 49 and 51. The pattern is particularly significant in the most recent periods and is observed also for age 55 (another grid threshold). Nevertheless, for beneficiaries in their first year on the DI rolls, mortality at age 50 during 2011–2015

exceeded contemporaneous general-population mortality by factors of 8.5 and 9.9 for men and women, respectively. Even at 10 or more years on the DI rolls, mortality at age 50 in 2011–2015 was 3.9 times higher for men and 4.5 times higher for women than for their general-population counterparts. From a historical perspective, both male and female DI-beneficiary mortality at age 50 after surviving at least 10 years on the rolls exceeded the general-population mortality at age 50 from more than a century earlier, in 1900.

Finally, by age 60 (panels C and F in Chart 10), the mortality gap between the most and least longevous DI beneficiaries declined by half from 1991–1995 to 2011–2015. For beneficiaries aged 60 in their first year on the DI rolls, mortality during 2011–2015 exceeded contemporaneous general-population mortality by factors of 5.5 and 7.4 for men and women, respectively. For beneficiaries aged 60 after surviving on the rolls for at least 10 years, female mortality in 2011–2015 was higher than general-population mortality at age 60 had been in 1919, while male beneficiary mortality exceeded the 1900 level of its general-population counterpart.

In general, the patterns displayed in Charts 6–10 and Table 2 document a substantial if rather uneven

**Chart 10.**  
**Mortality rates at ages 35, 50, and 60, by sex: DI disabled-worker beneficiaries by entitlement duration, and general population, selected years 1900–2015**



SOURCES: Bell and Miller (2005, Table 6); Kelley and Lopez (1984, Tables 5 and 6); Zayatz (1999, 2005, 2011, 2015, Tables 7A and 7B); and Barrick-Funk (2020, Tables 7A and 7B).

improvement over time in the mortality of DI beneficiaries at all ages during the first year of entitlement. For men, mortality—particularly at older ages—increased from the period 1968–1974 to 1977–1980. At the height of the AIDS epidemic in the early 1990s, male mortality among DI beneficiaries increased dramatically at younger ages (25–41), relative to that of the 1968–74 period. Then, during the second half of the 1990s, the death rate for young adult men contracted significantly. That mortality-rate decline was likely linked to the systematic use of HAART beginning in 1996 and to the permanent policy change regarding the treatment of drug addiction and alcoholism in disability determinations beginning in 1997. Nevertheless, DI-beneficiary mortality increased between the first and second halves of the 1990s for beneficiaries older than 44, except at the vocational grid’s age thresholds. The transition from the second half of the 1990s to the first and second halves of the 2000s led to significant mortality improvement at all ages. Yet the most recent experience has been mixed: Mortality declined modestly from 2006–2010 to 2011–2015 for beneficiaries aged 45 or older, but it increased at younger ages.

The mortality experience of female DI beneficiaries during the first year of entitlement differed from that of male beneficiaries in important ways. Mortality increased dramatically for all ages in successive sub-periods from 1968–1974 to 1977–1980. By the early 1990s, female DI-beneficiary mortality was substantially lower than it had been in the late 1970s, but it was still similar to that of the 1968–1974 period for beneficiaries in their mid-20s to about age 50. Female DI-beneficiary mortality improved little between the first and second halves of the 1990s, but it improved significantly across all ages from 1996–2000 to 2006–2010. The most recent data reveal a modest and continued mortality decline through 2011–2015 for beneficiaries older than 48, but higher mortality at younger ages.

### ***Estimates of Period Life Expectancy***

One intuitively appealing measure associated with mortality is life expectancy. Specifically, period life expectancy at a given age and year represents the expected length of life for a hypothetical person if the cross-section of death rates at each subsequent age is applied. In other words, period life expectancy uses age-specific mortality rates from a single year and assumes that those rates apply through the remainder of a person’s life. Chart 11 shows male and female life expectancy for both the general population and

DI beneficiaries at selected ages (35, 50, 55, and 60). As with Chart 10, the dual plots showing the bounds for the estimated period life expectancy of DI beneficiaries for 1991–2015 correspond to the two entitlement-duration extremes.<sup>25</sup> In this case, however, the upper bounds reflect the experience of the most longevous beneficiaries (10 or more years on the rolls), while the lower bounds represent life expectancy during the first year of entitlement (zero duration).

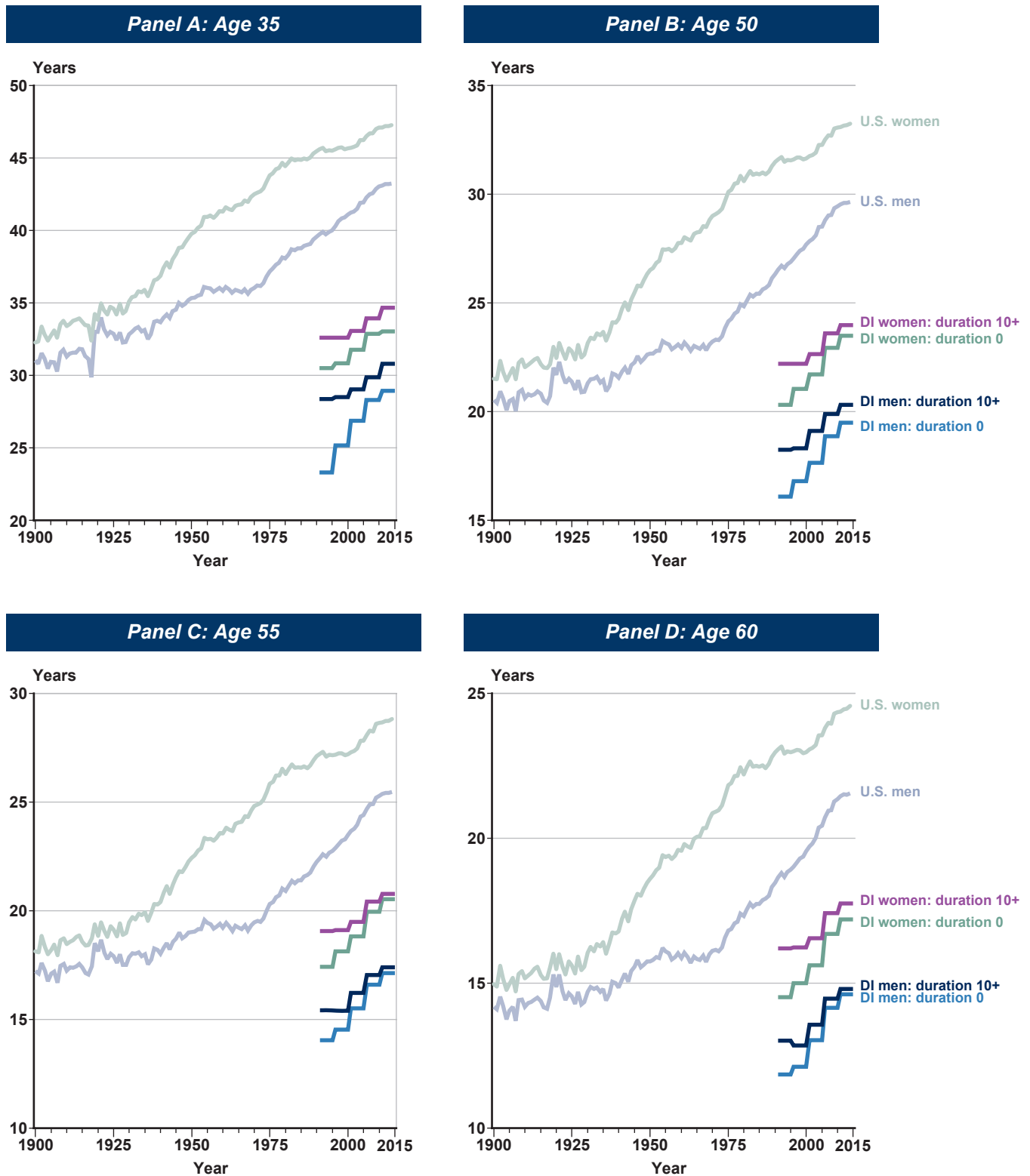
Consistent with the discussion in the previous section, rapid recent improvement in DI mortality at zero duration has dramatically reduced the gap in mortality and life expectancy between the least and most longevous beneficiaries. For instance, at age 35, the difference in DI life expectancy between duration extremes for men and women during 1991–1995 was 5.1 years and 2.1 years, respectively. However, by 2011–2015, the gap in life expectancy for beneficiaries stood at 1.9 years for men and 1.6 years for women. Similarly, after surviving on the DI rolls for at least 10 years and attaining age 50 during the 1991–1995 period, male and female beneficiaries were expected to outlive their counterparts at zero duration by 2.1 and 1.9 additional years, respectively. By 2011–2015, for DI beneficiaries aged 50, the gap in life expectancy by benefit duration had shrunk to 0.8 years for men and 0.5 years for women.

Chart 11 provides a historical perspective on the comparison of life expectancy between DI beneficiaries and the general population. It shows how long ago one must look to find a life expectancy for the general population that is similar to that of recent DI beneficiaries. Panel A shows that a man in the first year after entering the DI rolls at age 35 (zero duration) had a remaining life expectancy of 23.3 years in the first half of the 1990s and 28.9 years in the first half of the 2010s. By contrast, period life expectancy in the general population for a 35-year-old man during the 1918 influenza pandemic was about 30 years. For a woman in the first year after entering the rolls at age 35 (zero duration), remaining life expectancy was 30.5 years in 1991–1995 and about 33 years in 2011–2015; period life expectancy for a 35-year-old woman in the general population in 1918 was 32.4 years. Among DI beneficiaries attaining age 35 after surviving on the rolls for 10 or more years, period life expectancy in 2011–2015 was 30.8 years for men and 34.7 years for women.

Panel B of Chart 11 shows period life expectancy at age 50. A man in his first year of entitlement after entering the DI rolls at age 50 was expected to live, on average, 16.1 years in the early 1990s and 19.5 years



**Chart 11.**  
**Period life expectancy at ages 35, 50, 55, and 60, by sex: DI disabled-worker beneficiaries by entitlement duration, and general population, selected years 1900–2015**



SOURCES: Bell and Miller (2005, Table 6); Zayatz (1999, Tables 12A and 12B); Zayatz (2005, 2011, 2015, Tables 9A and 9B); and Barrick-Funk (2020, Tables 9A and 9B).

in the first half of the 2010s. By contrast, the lowest general-population life expectancy in the historical series for men at age 50 was 20 years, in 1907. Likewise, a woman entering the rolls at age 50 (zero duration) was expected to live 20.3 years in the early 1990s and 23.5 years during 2011–2015. The latter closely corresponds to U.S. female life expectancy at age 50 in 1930 (23.2 years). After surviving on the rolls for at least 10 years, a male DI beneficiary attaining age 50 was expected to live 18.2 years in 1991 and 20.3 years in 2015. Expected future lifetimes for a female beneficiary in similar circumstances were 22.2 and 24.0 years, respectively. Put differently, at age 50 in the first half of the 2010s, the “healthiest” male DI beneficiaries had a period life expectancy comparable to that of a 50-year-old man in the general population in 1900, while the “healthiest” female DI beneficiaries had a life expectancy similar to that of their counterparts in the general population in 1938.

A comparison of period life expectancy at age 55 appears as panel C of Chart 11. A man in his first year after entering the DI rolls at age 55 was expected to have 14.1 years of life remaining in 1991–1995 and 17.2 years remaining in 2011–2015. The latter amount is about the same period life expectancy for a 55-year-old man in the general population in 1903 (17.3 years). A female beneficiary in her first year of entitlement at age 55 in 1991–1995 had a life expectancy of 17.4 years. By 2011–2015, female beneficiary life expectancy at age 55 and zero duration (20.6 years) was similar to that of 55-year-old women in the general population in 1940. Among the “healthiest” DI beneficiaries attaining age 55 (those surviving 10 or more years on the rolls), life expectancies across the 1991–2015 entitlement period ranged from 15.4 to 17.4 years for men and from 19.1 to 20.8 years for women.

Chart 11, panel D plots period life expectancy at age 60. In a beneficiary’s first year on the DI rolls at age 60 in 1991–1995, expected remaining years of life were 11.8 for men and 14.5 for women. By 2011–2015, male DI life expectancy at age 60 during the first year of entitlement (14.6 years) was similar to that of men in the general population in 1902, while female DI life expectancy was comparable to that of women in the general population in 1941 (17.2 years). After 10 or more years of entitlement, life expectancy at age 60 was 13.0 years in 1991–1995 and 14.8 years in 2011–2015 for men; the corresponding expectancies for women were 16.2 and 17.8 years.

Overall, the life expectancies of both male and female DI beneficiaries at zero duration during the

1991–2015 period have improved at substantially higher rates than those of the general population. For the most longevous beneficiaries (10 or more years on the rolls), however, relative changes in life expectancy were more nuanced. Female DI life expectancy at the longest entitlement duration improved at a higher rate than that of women in the general population, but male DI life expectancy improved at roughly similar rates as those of men in the general population. This finding reflects the fact that mortality in the general population has declined more rapidly for men than for women. Note also the uneven rate of improvement in the life expectancy of DI beneficiaries from one 5-year sub-period to the next. Specifically, period life expectancy at 10 or more years on the rolls remained essentially flat throughout the 1990s for both male and female beneficiaries then rose substantially from 2001 through 2010.

### ***Contemporaneous Differences in Life Expectancy***

In Chart 11, the vertical distance from a given point on the men’s or women’s general-population curve to the midpoint between the zero and 10-or-more duration plots for male and female DI beneficiaries represents the contemporaneous gap in life expectancy between beneficiaries and the general population. This gap provides a measure of the reduction in normal remaining life expectancy associated with DI entitlement, based on the definition of period life expectancy.

Chart 12 plots the differences in contemporaneous life expectancy between DI beneficiaries and the general population by age and sex. Paired lines plot the upper and lower bounds for each of the 5-year study periods (1991–1995, 1996–2000, 2001–2005, 2006–2010, and 2011–2015) and correspond to the least and most longevous beneficiaries, respectively. Specifically, the vertical axes in the panels indicate the reduction in normal life expectancy because of disability. In addition, Table 3 shows similar information for four selected ages, by sex and study period. For example: In 1993, a man in the general population aged 35 was expected to live to age 74.74. By contrast, a 35-year-old male DI beneficiary in his first year of entitlement during 1991–1995 was expected to live to age 58.29. Table 3 and Chart 12 show that the difference is 16.45 fewer years for the beneficiary. Likewise, a male beneficiary aged 35 in 1991–1995 after 10 or more years on the rolls was expected to live to age 63.36, which represents a premature death of 11.38 years.

One interesting feature of Chart 12, panel A is the gap in life expectancy corresponding to the

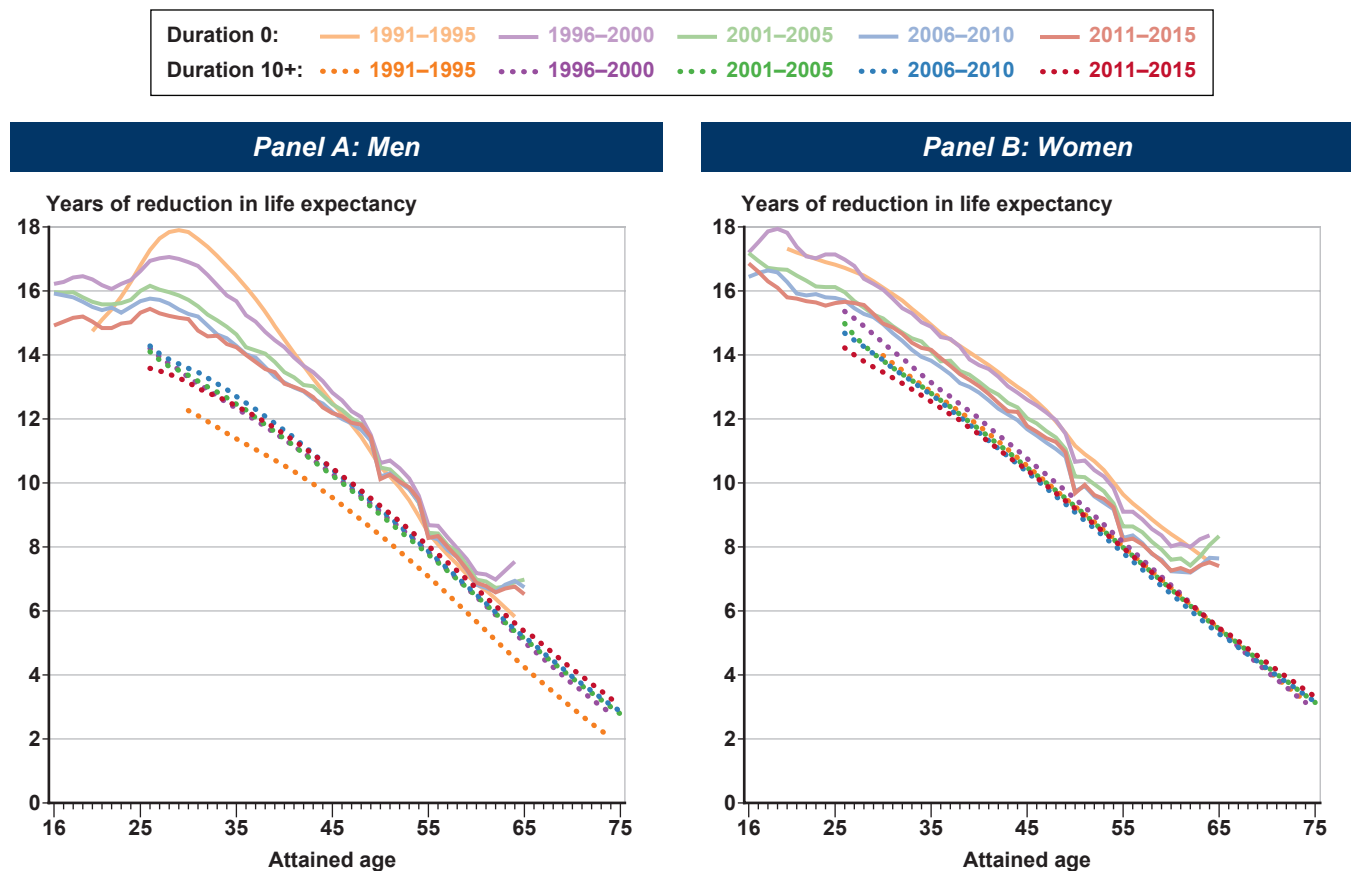
“healthiest” male DI beneficiaries (those with 10 or more years on the rolls), which is visibly smaller in the first half of the 1990s than in the remaining subperiods. For example, at age 50, the male gap in life expectancy in 1991–1995 was 8.36 years, but it exceeded 9 years in all other subperiods (Table 3). Chart 11 helps to explain why this is the case. Specifically, life expectancy for male and female DI beneficiaries at 10 or more years of duration remained flat throughout the 1990s. However, life expectancy in the general population increased sharply for men through this period, while it stayed relatively flat for women. As a result, between the first and second half of the 1990s, the number of years of premature death among DI beneficiaries stayed roughly similar for women but jumped noticeably for men.

The most remarkable feature of Charts 11 and 12 and Table 3 is the magnitude of the gap in period life expectancy between the two populations. During the first year of entitlement at age 35, the number of expected years of premature death for DI beneficiaries

ranged from 14.24 to 16.45 for men and from 13.82 to 14.94 for women across the study periods (Table 3). At age 50, the first threshold of the vocational grid, male and female beneficiaries were expected to live for 10.11–10.62 and 9.69–11.17 fewer years, respectively, than their counterparts in the general population, depending on the study period. Likewise, the range of the life-expectancy gaps for 55-year-old beneficiaries during the first year of entitlement was 8.27–8.67 years for men and 8.20–9.65 years for women. Finally, at age 60, the number of years of premature death at zero duration ranged from 6.82 to 7.18 for male beneficiaries and 7.25 to 8.40 for female beneficiaries.

DI beneficiaries who survived for a decade or longer on the rolls enjoyed greater life expectancy than at zero duration, although the gap with the general population remained substantial (Table 3 and lower bounds in Chart 12). For instance, at age 50, the number of expected years of premature death was 8.36–9.28 for men and 9.09–9.51 for women, depending on the study

**Chart 12.**  
**Difference between DI disabled-worker beneficiaries and the general population in period life expectancy by sex, age, and duration of DI entitlement, various periods 1991–2015**



SOURCES: Bell and Miller (2005, Table 6); Zayatz (1999, Tables 12A and 12B); Zayatz (2005, 2011, 2015, Tables 9A and 9B); and Barrick-Funk (2020, Tables 9A and 9B).

**Table 3.**  
**Period life expectancy for the general population and for DI disabled-worker beneficiaries with less than 1 year and 10 or more years on the rolls, by sex, selected age, and study period**

Study period	Men					Women				
	Life expectancy <sup>a</sup>			Difference (years) between general population and DI beneficiaries with—		Life expectancy <sup>a</sup>			Difference (years) between general population and DI beneficiaries with—	
	General population	DI beneficiaries with—		Zero duration	10+ years duration	General population	DI beneficiaries with—		Zero duration	10+ years duration
		Zero duration	10+ years duration				Zero duration	10+ years duration		
<b>Age 35</b>										
1991–1995	74.74	58.29	63.36	16.45	11.38	80.45	65.51	67.59	14.94	12.86
1996–2000	75.83	60.16	63.50	15.67	12.33	80.72	65.83	67.58	14.89	13.14
2001–2005	76.49	61.85	64.03	14.64	12.46	80.87	66.75	68.06	14.12	12.81
2006–2010	77.56	63.29	64.86	14.27	12.70	81.68	67.86	68.92	13.82	12.76
2011–2015	78.18	63.94	65.79	14.24	12.39	82.20	68.04	69.65	14.16	12.55
<b>Age 50</b>										
1991–1995	76.60	66.10	68.24	10.50	8.36	81.48	70.31	72.21	11.17	9.27
1996–2000	77.41	66.79	68.31	10.62	9.10	81.70	71.04	72.19	10.66	9.51
2001–2005	78.11	67.64	69.11	10.47	9.00	81.92	71.72	72.65	10.20	9.27
2006–2010	79.05	68.86	69.88	10.19	9.17	82.69	72.94	73.60	9.75	9.09
2011–2015	79.59	69.48	70.31	10.11	9.28	83.17	73.48	73.97	9.69	9.20
<b>Age 55</b>										
1991–1995	77.49	69.06	70.42	8.43	7.07	82.09	72.44	74.07	9.65	8.02
1996–2000	78.22	69.55	70.41	8.67	7.81	82.26	73.15	74.11	9.11	8.15
2001–2005	78.97	70.53	71.22	8.44	7.75	82.48	73.83	74.50	8.65	7.98
2006–2010	79.91	71.60	72.05	8.31	7.86	83.26	74.97	75.44	8.29	7.82
2011–2015	80.42	72.15	72.40	8.27	8.02	83.75	75.55	75.78	8.20	7.97
<b>Age 60</b>										
1991–1995	78.67	71.84	73.01	6.83	5.66	82.92	74.52	76.19	8.40	6.73
1996–2000	79.29	72.11	72.85	7.18	6.44	83.03	75.00	76.54	8.03	6.49
2001–2005	80.01	73.03	73.56	6.98	6.45	83.22	75.62	76.54	7.60	6.68
2006–2010	80.96	74.14	74.46	6.82	6.50	83.95	76.70	77.42	7.25	6.53
2011–2015	81.49	74.61	74.79	6.88	6.70	84.46	77.19	77.75	7.27	6.71

SOURCES: Author's calculations based on Bell and Miller (2005, Table 6); Zayatz (1999, Tables 12A and 12B); Zayatz (2005, 2011, 2015, Tables 9A and 9B); and Barrick-Funk (2020, Tables 9A and 9B).

a. For uniformity across ages and study periods, life expectancies are shown as expected length of life from birth.

period. Clearly, the mortality experience of DI beneficiaries at any age, study period, and duration on the disability rolls is one of severe reduction in life expectancy relative to the contemporary general population.

### **Recent Trends in Disability Awards**

As discussed earlier, specific events, such as the widespread use of effective HIV medication and the legislative exclusions involving material drug and alcohol addiction, have helped to drive the observed decline in DI-beneficiary mortality from the early 1990s into the first half of the 2010s, particularly among younger men. Two broad distributional trends

have likely further contributed to the mortality improvement of the DI-beneficiary population over time: the changing composition of the beneficiary population by diagnostic group and the growing role of medical-vocational considerations.

### **Differences in Diagnostic Composition**

A recent report identifies the relative contribution of various impairments, injuries, and risk factors to U.S. morbidity and death in the period 1990–2010 (U.S. Burden of Disease Collaborators 2013). The most years of life lost to premature mortality in 2010 were attributed to ischemic heart disease, lung cancer,



stroke, chronic obstructive pulmonary disease, and road injury. On the other hand, the impairments that accounted for the most years lived with a disability in 2010 involved lower back pain, major depressive disorder, other musculoskeletal disorders, neck pain, and anxiety disorders.<sup>26</sup>

As shown in Chart 4, the number of DI awards with a mental disorder as the primary diagnosis rose rapidly in the late 1980s and the early 1990s, surpassing all other diagnostic groups, although their relative share has been declining since at least 2002. Given the peak onset ages of most mental disorders, this declining trend could continue as the median age of the population continues to rise. Likewise, awards involving primary diagnoses of musculoskeletal disorders began surpassing any other diagnostic group by the early 2000s and their share has increased rapidly since then.

DI beneficiaries entering the rolls with musculoskeletal and mental impairments have higher survival rates and are likely to enter the program earlier and stay longer than those with other disorders such as circulatory-system diseases or malignant cancers.<sup>27</sup> As a result, 63 percent of disabled-worker beneficiaries in current-payment status by 2019 had joined the DI rolls with either a mental or musculoskeletal-system primary diagnosis (SSA 2020, Chart 6). This shift in diagnostic composition has likely contributed to the mortality improvement of DI beneficiaries over time. SSA's actuarial studies do not provide period death rates by diagnostic group, except in the specific case of AIDS-related awards during 1992–1996 and 1997–2001 (Barrick and Zayatz 2005) and during 2001–2005 (Zayatz and Barrick 2012).

Raut (2017) used a competing-risks model to estimate DI beneficiary exit probabilities by reason for exit and selected primary diagnostic group, based on administrative data for 1980–2000 from SSA's Continuous Work History Sample.<sup>28</sup> He estimated that the cumulative probability of exit via recovery through the first 9 years on the rolls exceeded the probability of death only for the youngest age group (20–30) in his study (Raut 2017, Table 2). By comparison, Zayatz (2015, Tables K2 and K6) suggested that duration-adjusted recovery rates exceeded death rates for beneficiaries aged 20–34 during 1996–2010 and at ages 35–39 during 1996–2005.

In terms of broad diagnostic groups, Raut estimated that the cumulative probability of recovery through the first 9 years of entitlement exceeded the probability of death for only two categories: beneficiaries entitled at ages 20–40 with a mental disorder as the primary

diagnosis and those entitled at ages 20–50 with a musculoskeletal-system primary diagnosis (Raut 2017, Table 4). Consistent with the results discussed earlier in this section, Raut found that mortality was highest at every age group among beneficiaries with malignant cancer, followed by those with circulatory impairments. Meanwhile, beneficiaries with musculoskeletal and mental impairment diagnoses had the lowest and second lowest probabilities of death, respectively.

Raut found that beneficiary mortality generally declined from the 1980s to the 1990s, except for young beneficiaries (aged 20–30) in either the mental impairment or “other remaining diagnosis” categories, for beneficiaries aged 31–40 with a musculoskeletal impairment, and for those aged 41–55 with a circulatory-system disorder (Raut 2017, Table 6). Because Raut's “other remaining diagnosis” category included infectious diseases, that result is consistent with the high mortality rates throughout the 1990s driven by AIDS-related deaths at young ages. The finding of increased mortality in the 1990s relative to the 1980s for young beneficiaries with mental and musculoskeletal impairments (and for middle-aged beneficiaries with a cardiovascular impairment), however, is surprising. As previously mentioned, no actuarial reports cover the mortality experience of DI beneficiaries in the 1980s. Thus, the net effect on mortality of the various legislative changes that took place throughout the 1980s is unclear.

The distributional shift in diagnostic categories among DI beneficiaries is open to multiple interpretations. Some observers view it as the result of more relaxed standards in the disability determination process after 1984. However, it is also possible that labor market conditions have prompted workers with certain impairments to apply for benefits, some of whom might otherwise have deferred applying until a few years later, perhaps under a different diagnostic category. Declining DI mortality rates during periods in which adjusted disability incidence rates are stable suggests a distributional shift in diagnoses toward less deadly impairments. According to Liebman (2015),

although it is conceivable that medical progress has significantly reduced mortality for a wide range of conditions without improving functional capacity, it seems likely that a significant portion of the decline in mortality rates among DI recipients is the result of a change in the composition of the beneficiary population.

The dramatic improvements in mortality (Chart 10) and life expectancy (Chart 11) among the least longevous beneficiaries (those in their first year on the rolls) are consistent with a compositional shift toward less deadly impairments.

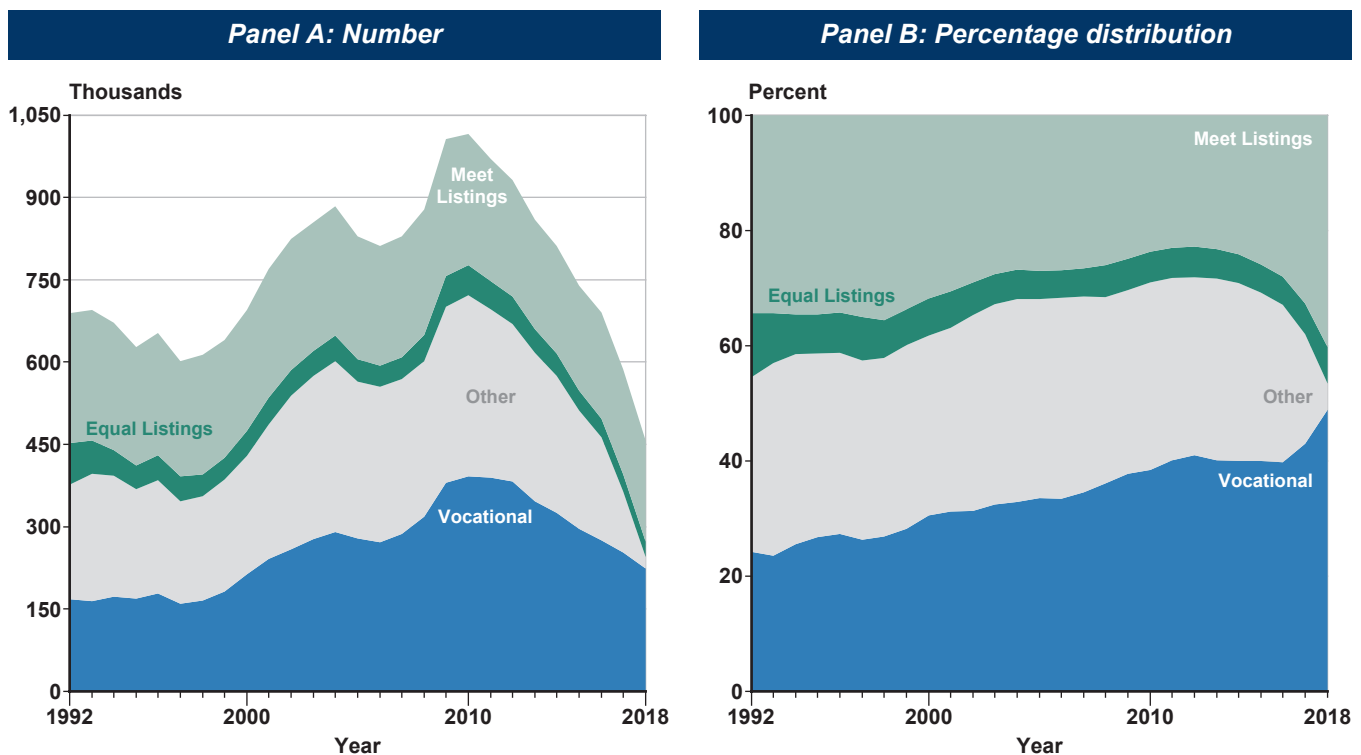
### Shifts in the Composition of Vocational Awards

In recent decades, the share of awards based on medical factors alone has declined, lending greater prominence to medical-vocational considerations and the vocational grid. In 2010, 54.7 percent of adult DI allowances at the DDS level were based on medical-vocational considerations, as were 50.7 percent of SSI allowances (Wixon and Strand 2013, Tables 1 and 2). Although those figures provide an illuminating snapshot, they do not represent final decisions.<sup>29</sup>

Charts 13 and 14 respectively show the number and percentage distribution of final awards and final denials by year of application and reason for the decision for the period 1992–2018. The charts cover DI-only and concurrent DI/SSI disabled-worker applications and reflect the final adjudicative level of the disability determination.

Chart 13 illustrates important recent changes in the decisional basis of allowances. Specifically, the share of final awards involving vocational considerations increased from 24.3 percent in 1992 to 40.1 percent by 2015. The share rose further, to 48.9 percent, for 2018, the most recent year with available data—although subsequent final decisions on cases pending in 2018 will adjust that figure, most likely downward. Moreover, Chart 13 provides only a lower bound for the vocational-basis share of final allowances because the “other” category includes awards for which data on the basis of the determination were not available (this applies mostly to cases decided at the hearing level). Typically, a majority of these determinations are also vocational in nature.<sup>30</sup> Hence, as the share of allowances based strictly on the medical listings has been declining, a substantial majority of recent awards were based on the vocational grid. Furthermore, if one were to assume that all of the final awards in the “other” category in Chart 13 were vocational-based decisions, the upper-bound estimate of their share of final decisions would rise to 54.6 percent in 1992 and 69.2 percent by 2015.

**Chart 13.**  
Number and percentage distribution of final DI disabled-worker awards, by basis of determination, application years 1992–2018



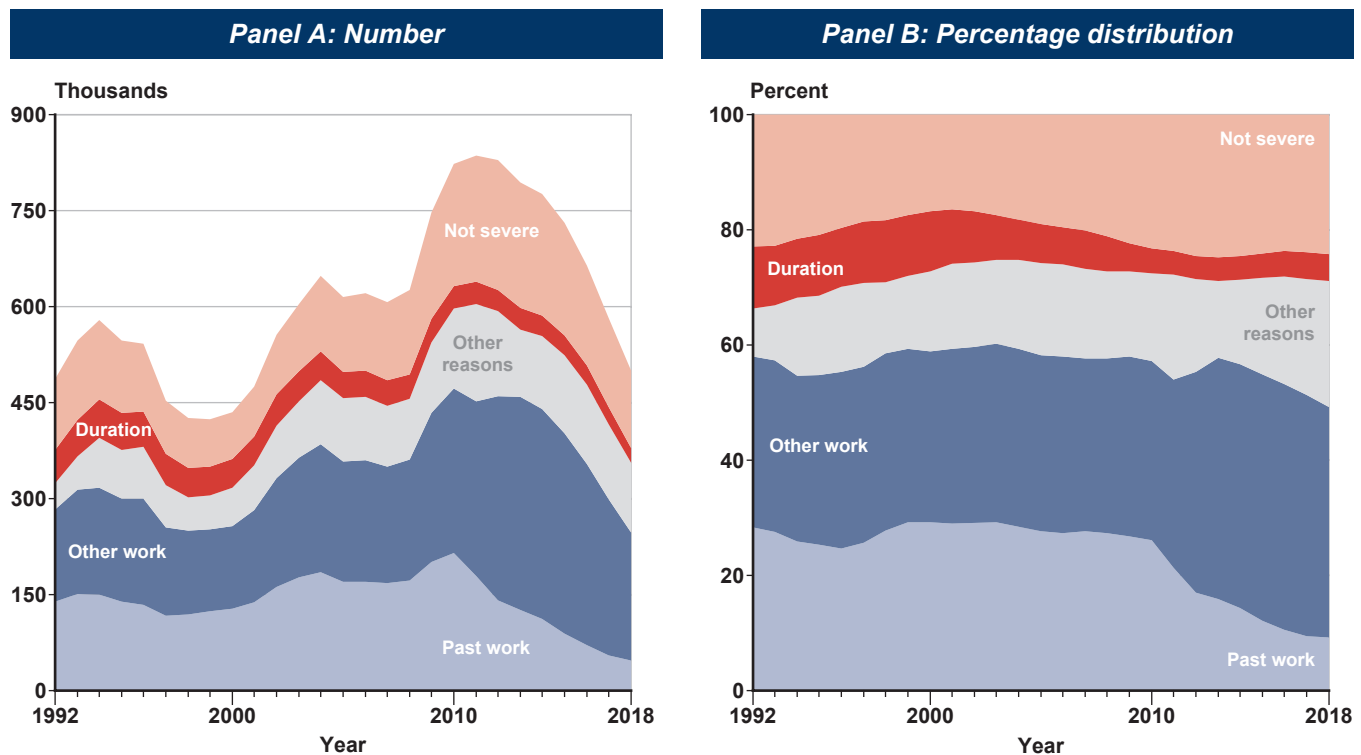
SOURCE: SSA (2020, Table 64).

Vocational considerations account for a majority of denials as well (Chart 14). More than half of final denials involve a finding of capacity to do either the applicant’s past work or other work available in the national economy. Although the vocational-basis share of denials appears to have been stable in recent decades, its internal composition has shifted, as denials based on the capacity to do past work declined from 28.4 percent of final denials in 1992 to 12.2 percent of them in 2015. Notice that the decline in the share of denials based on capacity to do past work accelerated substantially after 2010, coinciding with the end of the Great Recession and a secular declining trend in awards (Chart 2). Because of the sequential nature of the disability determination process, claimants with applications denied for ability to do past work are generally deemed to have greater work capacity than those with denials for the ability to do any other work. Thus, the shrinking composition of “past-work” denials in panel B might suggest a pool of denied applicants with lower capacity for work than in previous decades, although there could be alternative explanations.

Vocational denials stand in contrast to those involving medical conditions that are deemed insufficiently severe or are expected to last less than 12 months, which also result in denial of benefits. In addition, the “other reasons” category includes cases denied at or above the hearing level for which data on the basis of determination were not available, as well as denials for various other reasons, such as return to substantial gainful activity, drug addiction or alcoholism, insufficient medical evidence, and failure to cooperate or follow prescribed treatment.

The distributional shift from medical toward vocational allowances remains puzzling. Focusing on initial DI determinations, Michaud, Nelson, and Wiczer (2018) found that workers’ changing composition by age, education, and occupation could not explain this shift. Claimants aged 55–59 drive the growth in both applications and vocational-based allowances. The sheer size of the baby-boom cohort has led to a recent increase of that age group’s share of workers (and, therefore, DI applicants), which would imply an increase in vocational-based allowances; yet its higher

**Chart 14.**  
**Number and percentage distribution of final DI disabled-worker denials, by basis of determination, application years 1992–2018**



SOURCE: SSA (2020, Table 65).

educational attainment relative to prior cohorts has an offsetting effect. The authors note:

Attainment of a high school degree lowers awards both through lower application rates and a higher rate of denial at the vocational stage. This is in line with the *de jure* objective of the vocational grid in the [DI] award process. The vocational grid also treats occupations in an interesting way. Workers in their 50s in service or production sectors drove the incidence of awards with vocational considerations, but they also contribute greatly to overall applications and awards at the medical stage.

It is plausible that the growth in the medical-vocational share of allowances has contributed to the improvement over time in DI mortality. However, the magnitude of that contribution is uncertain. Recall that panel A of Charts 7 and 8 shows the probability of death for DI beneficiaries during the first year of entitlement, by age, for men and women, respectively. As noted earlier, mortality during the first year of entitlement climbs rapidly as a function of age until about age 45 and then begins to flatten. This pattern appears for all subperiods covered in the actuarial studies, including the 1970s and early 1990s, when the vocational-based share of awards was much lower than it is today.<sup>31</sup> Notice in particular that mortality in many of the subperiods in the 1970s actually declined for men after about age 55 and for women after about age 50. In addition, the “dips” in mortality at the grid threshold ages 50 and 55 shift from imperceptible in the 1970s to moderate in size in the early 1990s and pronounced during the most recent period (2011–2015). This pattern seems consistent with the increasing share of awards attributable to vocational factors, as shown in Chart 13.

Clearly, claimants entering the rolls in recent decades at the 50 and 55 age thresholds experienced significantly lower mortality than their respective counterparts at ages 49 and 54. This suggests that a somewhat “healthier” population of new DI beneficiaries clusters at the vocational age thresholds and is consistent with the discontinuities often observed in the allowance rate at those ages.<sup>32</sup> For instance, in 2011–2015, the male probability of death at age 49 during the first year of DI entitlement was 0.062, while the corresponding probability at age 50 was substantially lower at 0.043. However, the probability of death at age 60 during the first year of entitlement was also similar to that at age 49 (0.062), highlighting

the overall flattening of DI-beneficiary mortality at older ages. Notably, the lower mortality among those who entered the DI rolls at the 50 and 55 age thresholds persisted beyond the year of entitlement. For instance, the probability of death for a 52-year-old man 2 years after entering the DI rolls at age 50 during 2011–2015 (0.026) was lower than that of a 51-year-old male beneficiary 2 years after entitlement at age 49 (0.031; Chart 7, panel C).

SSA follows a “borderline age policy” in implementing the medical-vocational rules.<sup>33</sup> In particular, suppose that a claimant will reach the next age category of the grid within 6 months of the date of adjudication and that such age, in conjunction with all other factors of the case, would result in a finding of disability, while current chronological age alone would result instead in a denial of benefits. Under very specific guidelines, a disability examiner is permitted to use the higher age and grant benefits. This practice is justified by administrative efficiency; it saves the cost and time of processing the same claim again in the near future, with the certain knowledge that it would result in an allowance.

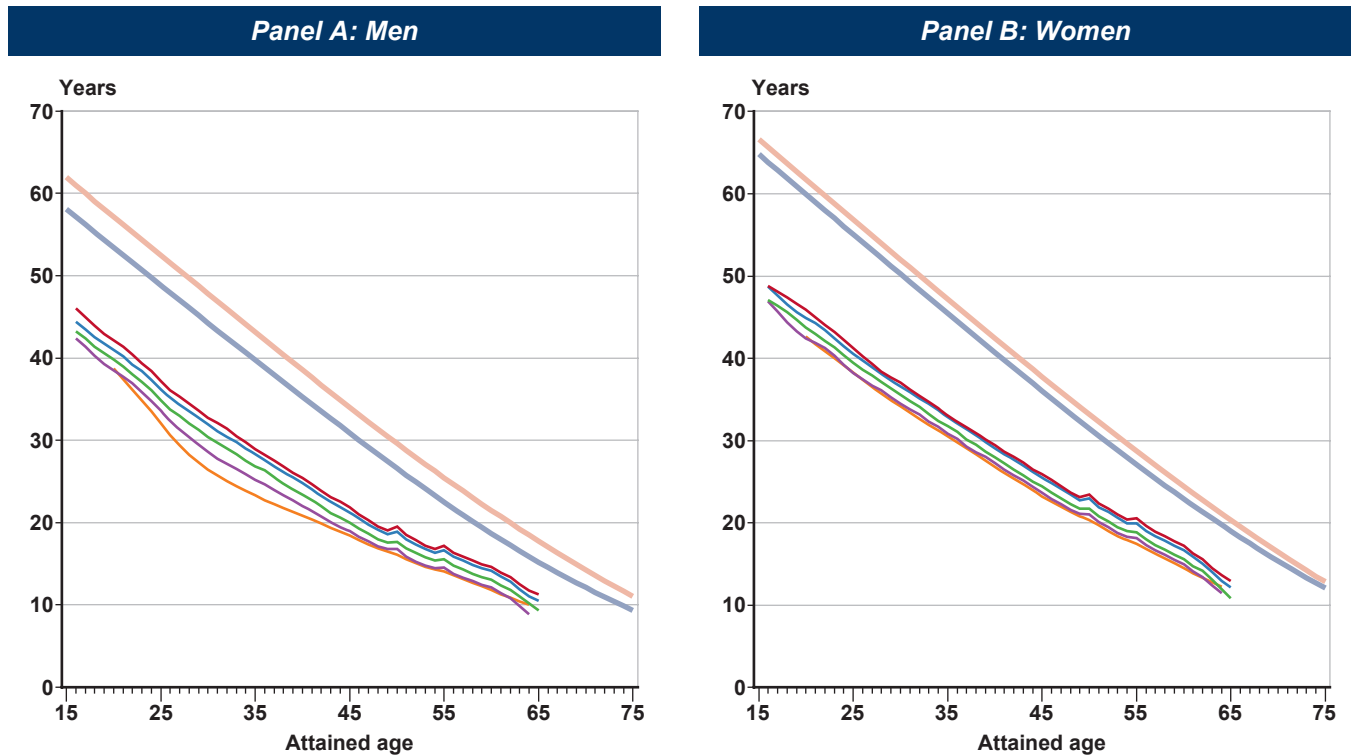
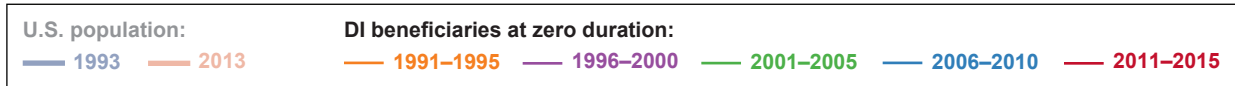
Interestingly, although the likelihood of an allowance rises with the age thresholds of the vocational grid, claiming behavior does not cluster around those ages (Strand and Messel 2019, Figure 3). This suggests that applicants do not decide when to apply based on maximizing the chance of receiving benefits. In addition, the lower mortality rates around the vocational grid thresholds have a modest effect on period life expectancy.

Chart 15 shows period life expectancies as a function of age for the general population in 1993 and 2013 and for DI beneficiaries at zero duration in each of the five 5-year subperiods from 1991 to 2015, by sex. A man entering the DI rolls in 2011–2015 at age 50 had, during the first year of entitlement, a remaining life expectancy of 19.48 years, predictively outliving a 49-year-old DI beneficiary during the same period by one-half of a year and a 51-year-old by one full year. A linear extrapolation of expectancies at ages 49 and 51 suggests that the effect of the age-50 threshold in 2011–2015 was to increase male DI life expectancy by 0.72 years beyond what it would have been if 50 were not a specific age threshold. Similarly, the effect of the age-50 threshold for female beneficiaries during this period appears to equate to 0.77 added years of life.<sup>34</sup>

In conclusion, the observed flattening in DI mortality during the first year of entitlement beginning at about age 45 may be due to the use of vocational

**Chart 15.**

**Period life expectancy for DI disabled-worker beneficiaries in the first year of entitlement and the general population, by age and sex, various periods 1991–2015**



SOURCES: Bell and Miller (2005, Table 6); Zayatz (1999, Tables 12A and 12B); Zayatz (2005, 2011, 2015, Tables 9A and 9B); and Barrick-Funk (2020, Tables 9A and 9B).

considerations by disability examiners, whether informally prior to 1978 or formally after that. The increasingly pronounced discontinuities in mortality at the age thresholds of the vocational grid seem consistent with the growing share of awards decided based on vocational factors in recent decades. This development likely affected the mortality improvement of DI beneficiaries over time. Certainly, period life expectancy is higher at the age thresholds and their effect on mortality persists over multiple years of duration.

### ***Mortality Trends in the General Population***

From 1959 to 2013, U.S. period life expectancy at birth increased by almost a decade, from 69.9 to 78.9 years, but then declined for three consecutive years after 2014 (Woolf and Schoemaker 2019). Beginning in the 1980s, the rate of increase in U.S. life expectancy slowed relative to that of other developed countries, dipping below the average among Organisation of

Economic Cooperation and Development nations by 1998. U.S. life expectancy at birth stopped increasing altogether in 2010, then declined in 2015, 2016, and 2017.<sup>35</sup> This reversal culminated a trend that began in the 1990s, when cause-specific mortality between ages 25 and 64 (midlife) began to rise.

Americans in midlife are experiencing a surge in deaths driven by the near-term effects of drug overdose, alcohol abuse, and suicide, often referred to as “deaths of despair” (Case and Deaton 2015, 2017, 2020). Mortality in midlife has also risen sharply for disorders associated with longer-term effects of drug and alcohol use, such as psychoactive substance use disorders, alcoholic liver disease, and liver cancer; and various organ system disorders, including hypertensive diseases, chronic obstructive pulmonary disease, diabetes, and obesity. Initially, the rising rate of deaths of despair was offset by simultaneous declines in other leading causes of death, such as traffic accidents,



ischemic heart disease, cancer, and HIV infection. However, by 2010, all-cause mortality at ages 25–64 began to rise, and by 2014, it was increasing across all racial groups (Woolf and Schoemaker 2019).

It is well established that mortality declines as earnings and educational attainment increase and that gains in longevity have disproportionately accrued to those with higher earnings (Bor, Cohen, and Galea 2017). The gaps in mortality and life expectancy by income and education widened during the period 1980–2014. Furthermore, although income inequality has been driven by disproportionate growth in incomes at the very top of the distribution, disparities in survival have been borne most acutely by the bottom half of the earnings distribution.

For various demographic groups, mortality has either been stagnant or increasing since the 1990s. For instance, Olshansky and others (2012) found that life expectancy in the 1990s declined for White people without a high school diploma, especially women. However, Bound and others (2015) cautioned that these findings are very sensitive to the substantial compositional changes in the educational attainment of the underlying population and that “focusing on mortality rates of those with less than a high school education over a twenty-year period means looking at a different, shrinking, and increasingly vulnerable segment of the population each year.” Case and Deaton (2015, 2017) reported increased morbidity and all-cause mortality among non-Hispanic White 50- to 54-year-olds after 1998, driven by suicide and drug and alcohol abuse.<sup>36</sup> The disproportionate bulk of this mortality increase fell among those with a high school education or less.

Chetty and others (2016) estimated the difference in period life expectancy at age 40 between individuals in the top 1 percent and the bottom 1 percent of the income distribution to be 14.6 years for men and 10.1 years for women during 2001–2014. In that period, life expectancy at age 40 increased by 2.34 years for men and 2.91 years for women in the top 5 percent of the earnings distribution. For those in the bottom 5 percent of the income distribution, life expectancy increased only 0.32 years for men and 0.04 years for women.

Bor, Cohen, and Galea (2017) found that estimated survival gaps tend to be wider in studies that focus on changes in mortality across birth cohorts instead of changes across periods. This is because as cohort life expectancy rises for successive birth cohorts, period life expectancy discounts that increase by averaging

across multiple cohorts.<sup>37</sup> The implication is that disparities in life expectancy over time mask potentially much wider gaps across generations. According to Waldron (2007),

male Social Security–covered workers born in 1941 who had average relative earnings in the top half of the earnings distribution and who lived to age 60 would be expected to live 5.8 more years than their counterparts in the bottom half. In contrast, among male Social Security–covered workers born in 1912 who survived to age 60, those in the top half of the earnings distribution would be expected to live only 1.2 years more than those in the bottom half.

Medical breakthroughs in technology and improvement in care may extend disability-free life expectancy in the population (Chernew and others 2016). Ironically, those factors could also contribute to the widening gap in health and mortality by socioeconomic status, as they may disproportionately benefit those with higher earnings and educational attainment. For instance, as previously discussed, the widespread use of HAARTs in the mid-1990s is credited with drastically reducing mortality rates among DI beneficiaries with HIV. HAART demands strict patient compliance with a complex timing and sequence regimen for multiple drugs—as many as 24 pills per day. Failure to adhere to the regimen can result in resistance to the drugs. Goldman and Lakdawalla (2005) found growing disparities in tests of immune-system health among HAART users by educational attainment, implying differences in adherence to treatment.

The National Academies of Sciences, Engineering, and Medicine (2015) examined the effect of the growing mortality gap on the major federal entitlement programs (Medicare, Medicaid, OASI, DI, and SSI), documenting the distributional shift in government benefits resulting from the growing gap in mortality. The authors projected a cohort life-expectancy gap of almost a decade within a single generation among the richest and poorest 20 percent of Americans. In particular, life expectancy at age 50 is projected to remain unchanged for men in the poorest quintile and to decline for women in the two poorest quintiles.

In the context of DI, both applicants and beneficiaries have lower earnings and educational attainment, on average, than the general population. In particular, prior to disability onset, DI claimants disproportionately occupy the bottom half of the earnings distribution, especially among those reaching

a vocational-grid threshold age. After adjusting for age and sex, the difference in mean annual earnings in 2005 between the disability-insured population and DI applicants was \$25,000 (Strand and Trenkamp 2015). Likewise, at least half of DI disabled-worker beneficiaries have no more than a high school diploma or equivalent, with other surveys indicating similar or higher proportions (Bailey and Hemmeter 2014; O’Leary, Walker, and Roessel 2015). By contrast, only 40.7 percent of the U.S. adult population had a high school education or less in 2016 (Census Bureau 2016, Table 1). Poterba, Venti, and Wise (2017) estimate that “a large component of the relationship between education and DI participation—more than one-third for men, and over two-thirds for women—can be attributed to the correlation of education with health, and of health with DI receipt.”

Distributional differences in longevity among workers by earnings and educational attainment are wide and growing. Policymakers should therefore be cautious in extrapolating the characteristics of DI beneficiaries from the broader experience in the general population. Nondisabled Americans who are otherwise similar in socioeconomic status to DI applicants experience higher death rates, and mortality improvement that is far more modest, than the national average. Of course, in addition to lower earnings and lower educational attainment, DI beneficiaries (including those entering the rolls through decisions based on the vocational grid) also have medical impairments deemed to be severe by a disability examiner or an administrative law judge, accounting for much of the dramatic mortality gaps documented above.

### ***Mortality, Morbidity, and Ability to Work***

A seminal article by James F. Fries (1980) noted that a longer life may not necessarily mean a healthy one. As chronic disorders have replaced infectious diseases as the main cause of death at older ages, increasing life expectancy can become problematic as a measure of improvement in the general health of the population. As pointed out by Jagger and others (2015):

Indeed, with a constant recovery rate, if the risk of dying diminishes more than the risk of becoming ill, the risk of being ill increases. In other words, the prevalence of chronic disease in the population can increase as a result of a lengthening of duration of survival if the decrease in fatality is not compensated for by an equivalent decrease in incidence.

Three alternative hypotheses have emerged for interpreting the phenomenon of populations with increases in both life expectancy and the prevalence of chronic disease. The first, morbidity compression, posits an increase in the share of disability-free life expectancy. The second, morbidity expansion, posits a decline in the share of disability-free life expectancy. Third, the so-called “dynamic equilibrium” hypothesis foresees the proportion of life spent free of disability remaining constant, as changes in life expectancy with and without disability offset each other. The evidence supporting these three hypotheses has been mixed and depends on the period and population under study, the chosen measures of health (disease, functioning, activities of daily living, and so on), and the methodology.<sup>38</sup>

Using data from the National Health Interview Survey, Crimmins, Zhang, and Saito (2016) estimated life expectancy for U.S. individuals with and without disabilities over the period 1970–2010. Using a much broader definition of disability (“any limitation of activity”) than that of the DI program, the authors found that disability prevalence after 1980 increased for Americans younger than 65, but declined for those aged 65 or older. During working years (ages 20–64), life expectancy for disabled men and women increased 1.1 years and 1.6 years, respectively, while disability-free life expectancy increased by 0.9 years for men but declined by 0.6 years for women. Crimmins, Zhang, and Saito characterized the evolution of life expectancy over the 40-year period as one of dynamic equilibrium with some compression at older ages. However, the authors cautioned that “in sensitivity analyses, we examined the change over time in life expectancy assuming that the working ages were 20 to 70 years; the conclusions were similar to those we present for age 65 years. There is little evidence from this analysis of improving health in this age range that would support increasing the age at retirement.”

Chernew and others (2016) used self-reported limitations in activities of daily living (ADLs) and instrumental ADLs from the Medicare Current Beneficiary Survey as measures of health condition. They found evidence of morbidity compression at ages 65 or older during 1991–2009. In particular, nondisabled life expectancy at age 65 increased by 1.8 years, while disabled life expectancy fell by 0.5 years. Furthermore, the authors attributed 63 percent of the improvement in nondisabled life expectancy to lower incidence of and improved functioning associated with cardiovascular impairments and vision problems.

Rutledge and others (2018) analyzed measures of self-reported health, work limitation, and restrictions in activities of daily living using Survey of Income and Program Participation results matched to administrative records from SSA. Focusing on DI and/or SSI claimants from 1989 to 2013, the authors found little difference over time in applicants' health status in the years before they applied, suggesting that the underlying health of DI and SSI claimants remained essentially unchanged over the period.

Using a health index based on the first principal component of 27 measures of disease, functional limitation, and medical care usage in the Health and Retirement Study, Heiss, Venti, and Wise (2015) compared the health trajectories of DI applicants and nonapplicants aged 50–65 over the period 1992–2010. By the time of application at ages 50–54, the health index of claimants was 31 percentile points lower than that of nonapplicants, suggesting large disparities in average health between the groups. Filers of allowed claims seemed to be in marginally better preapplication health than those who filed denied ones, although the former group suffered a much steeper decline in health in the year before and after application than the latter group. In the 12 years after application, the health status of beneficiaries remained unchanged, but it improved steadily for those whose claims had been rejected. However, this finding could be affected by mortality selection, if the filers of allowed and denied claims died at different rates. Heiss, Venti, and Wise note in particular the similarity in patterns of self-reported health and earnings trajectories for both allowed and denied claimants.

Based on data from the 2014 Survey of Income and Program Participation, Weaver (2020) compared a broad set of characteristics of the subpopulations who are allowed and denied disability benefits. Disproportionate shares of both the allowed and denied groups live in the South, lack a high school diploma, and are Black. For instance, Weaver estimates that 25.8 percent and 20.5 percent, respectively, of the allowed and denied populations are Black, compared with 11.6 percent of the general population. The estimated proportion of SSI recipients who are Black is 28.7 percent. Race and ethnicity are likely to be important, but often overlooked, components of the mortality experience of individuals with disabilities, given the substantial racial and ethnic differences in mortality documented for the general population.

According to Weaver (2020), denied claimants experience higher rates of poverty and material

hardship than both the general and DI-beneficiary populations. In addition, despite having lower income and health insurance coverage rates than the general population, denied DI applicants experience significantly higher levels of health care use in the form of hospitalizations and visits to medical providers. Note that although both allowed and denied claimants have substantially poorer health than nonapplicants do, beneficiaries become eligible for cash benefits and health insurance from Medicare or Medicaid.<sup>39</sup> These facts raise the possibility that DI benefit receipt itself may subsequently affect health and mortality.

García-Gómez and Gielen (2017) analyzed the mortality effects of both stricter eligibility standards and reduced generosity in the Dutch disability insurance program. Changes enacted in the Netherlands in 1993 applied to beneficiaries younger than 45 and based eligibility on observable functional work limitations linked directly to a medical diagnosis. As a result, disability related to mental impairment became particularly hard to prove. In addition, occupational criteria were expanded, which effectively reduced benefit amounts. Exploiting the age discontinuity that the reforms introduced to the program, the authors derived causal estimates of the effects of decreased generosity of disability insurance on beneficiary mortality. García-Gómez and Gielen found that for women with low predisability earnings, a €1,000 reduction in annual benefits led to a 2.4 percentage point increase in the probability of death more than 10 years after the reform. On the other hand, mortality improved for male beneficiaries subjected to the more stringent disability standards. The authors hypothesized that the gender differences in the estimated effects are likely related to differences in earnings and diagnoses, as the prevalence of mental disability diagnoses is higher among women but they experience lower earnings.

For new DI beneficiaries in the period 1997–2009, Gelber, Moore, and Strand (2018) used the discontinuities in the benefit formula to derive local-area estimates of the causal effect of DI benefits on mortality during the first 4 years on the rolls. They found that DI benefits can substantially reduce mortality, particularly for the lowest-income beneficiaries: “At the lower bend point, where mean annual DI income is \$8,543, we estimate that an increase of \$1,000 in annual DI payments decreases beneficiaries' annual mortality rate by 0.26 percentage points.” The authors observe that the magnitude of the annual-mortality elasticity of DI income is comparable to estimates found in other studies involving populations with

high mortality and low income, including old-age pensioners in Russia, U.S. Union Army veterans receiving pensions in the early 1900s, and elderly recipients of conditional cash transfers in Mexico.

Since the formal introduction of the vocational grid in 1978, workers in the general population and DI beneficiaries have both experienced longevity gains, particularly among beneficiaries during the first few years of entitlement. Yet the mortality gap between the two populations remains wide. For instance, as discussed earlier, period life expectancy at age 50 for a disabled-worker beneficiary during the 2011–2015 period was 9 to 10 years shorter than that for a 50-year-old in the general population (Table 3). Further, longevity gains among workers in the general population mask a great deal of heterogeneity in the distribution of those gains by earnings and educational attainment. Additionally, the extent to which long-term gains in life expectancy for DI beneficiaries are associated with improved residual functional capacity is unclear.

Note that the substantive concept in the statutory DI definition of disability is long-term inability to engage in substantial gainful activity caused by a physical or mental impairment. In other words, what matters is an applicant's long-term inability to work, independent of his or her odds of survival. In this context, the role of age as a vocational factor is sometimes confounded with the relationship between age and life expectancy. Age is a vocational factor under the assumption that older workers have greater difficulty adjusting to new work environments and learning new skills, not because older workers have fewer expected remaining years of life than younger ones. Thus, although chronological age might be a poor predictor of an individual's ability to work in the presence of a severe impairment, it raises the question: Do DI beneficiaries at older ages have greater residual capacity to work today than they did in the past? Estimates from Chen and van der Klaauw (2008) and Strand and Messel (2019) suggest that the work disincentives of receiving DI benefits may be much smaller for DI claimants with a vocational allowance than they are for other DI-beneficiary groups. According to Strand and Messel, an increase in the age thresholds of the vocational grid appears more likely to result in postponing DI beneficiary status via appeal and reapplication than to lead to labor-market reentry. In addition, the findings in Gelber, Moore, and Strand (2018) and García-Gómez and Gielen (2017) suggest that an increase in the age thresholds of the vocational grid could have a direct effect on mortality.

Mortality, morbidity, and ability to work are three distinct concepts that interact in complex ways. Although it is often assumed that higher morbidity inevitably leads to higher mortality and less capacity to work, the reality is nuanced. Declining mortality in a population does not necessarily mean better average health, and might actually contribute to higher prevalence of disease over time by increasing the number of years of potential exposure. Similarly, two individuals born in the same year could experience equally insurmountable obstacles to work, while facing very different medical diagnoses and mortality rates. Further, broad labor market trends can shift the set of skills required to find gainful employment in the national economy over time. Moreover, the ability to work of two people with comparable impairments, age, ethnicity/origin, cultural background, geography, educational attainment, work experience, transferable skills, earnings histories, and wealth can hinge on all sorts of external factors, including the level of support they are likely to receive from their social/family network.

## Summary

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Since the 1970s, SSA's OCACT has published mortality tables for DI beneficiaries encompassing various subperiods within the 1970s, the 1990s, and the 2000s, as well as for 2011–2015. In this article, I compare the mortality experiences of disabled-worker beneficiaries and the general population.

In general, any factor affecting entry into and exit from the disability program rolls can affect the mortality of disabled-worker beneficiaries. Such factors include:

1. macroeconomic variables, such as unemployment, labor force participation, and changes in part-time employment affecting insured status;
2. demographic factors, such as population growth or shifts in the age structure and gender composition of the insured population;
3. administrative factors involving staffing and the level of funding for CDRs and preeffectuation reviews;
4. legislative changes enacted by Congress and federal court rulings challenging SSA policy;
5. epidemiological events;
6. advancements in medical treatment or in technology that facilitate work; and



7. changes to certain program variables such as income replacement rates, the amount of earnings that defines substantial gainful activity, medical/vocational age thresholds that loosen eligibility requirements for older applicants, and even the FRA.

Mortality among DI beneficiaries, regardless of age, is highest during the first few years of entitlement (that is, receipt of benefits) and declines with the number of years one survives on the DI rolls. For this reason, I focus on two duration extremes: beneficiaries in their first year of entitlement (zero duration), and those who have received benefits for at least 10 years. These two duration categories provide upper- and lower-bound estimates of mortality for DI beneficiaries in various degrees of poor health. Notice, however, that the upper-bound mortality estimates may understate the true mortality experience at zero duration, because claimants who die during the 5-month waiting period fall outside the scope of measurement.

DI-beneficiary mortality for men and women aged 20–59 during the first year of entitlement improved at an often substantially higher average rate than did mortality in the general population throughout both the 1977–2015 period and the 1991–2015 subperiod. Mortality at zero duration also improved at a much faster rate than that of beneficiaries with at least 10 years on the rolls. As a result, the mortality gap between the most and least longevous DI beneficiaries has narrowed considerably over time. This finding appears consistent with a shift in the composition of DI beneficiaries toward those with less deadly primary diagnoses involving mental and musculoskeletal impairments. Notice, however, that because many factors affect the mortality of DI beneficiaries, improvement has occurred very unevenly. For instance, DI-beneficiary mortality in the first year of enrollment was lower in the early 1970s than in the latter part of the decade, which was contractionary by comparison, with steep declines in awards and frequent CDRs, which led to a sharp increase in exits for beneficiaries with mental impairments. Similarly, because of the AIDS epidemic, mortality for young male beneficiaries during the first 4 years of entitlement was substantially higher in 1991–1995 than it had been at any time during the 1970s. Other developments, such as the use of HAART to treat HIV and the policy change regarding applicants diagnosed with drug addiction and alcoholism, are credited with driving some of the rapid mortality improvement throughout the 2000s.

A comparison of mortality in the general and disabled populations reveals two broad patterns. First, at any given age and duration of entitlement for DI beneficiaries, mortality as a ratio to general-population mortality is higher for women than for men, indicating that the mortality gender gap is wider in the general population than it is among DI beneficiaries. Second, the DI-beneficiary to general-population mortality ratio for both men and women is highest at younger ages (mid-20s and 30s). Thus, in absolute terms (magnitude), older beneficiaries have higher mortality than younger ones and male beneficiaries have higher mortality than their female counterparts. However, in relative terms (compared with their reference group in the general population), female and young DI beneficiaries are worse off by a larger factor.

Another interesting pattern in the data for beneficiaries in the first year of entitlement involves the flattening of mortality as a function of age that occurs at about ages 45–50. One plausible explanation is the vocational grid. For the decade of the 1990s and particularly in the 2000s and 2011–2015, mortality appears to dip sharply around ages 50 and 55, corresponding to age thresholds in the vocational grid. The decline in mortality at the age thresholds has become more pronounced over time, which is consistent with the steady increase in the share of DI awards based on medical-vocational grounds. Similar discontinuities emerge for allowance rates at these ages, indicating that a somewhat “healthier” population of new DI beneficiaries clusters around the age thresholds. It is plausible that the growth in the medical-vocational share of allowances has contributed to the improvement over time in DI mortality. Nevertheless, a similar flattening of mortality at older ages is observed in the 1970s subperiods, suggesting that disability examiners may have used similar criteria informally prior to the formal introduction of the vocational-grid guidelines in 1978.

Despite gains in longevity among DI beneficiaries in recent decades, their experience at every age and duration on the disability rolls is one of severe mortality and reduced life expectancy relative to the general population. During the most recent study period (2011–2015), DI-beneficiary mortality in the first year of entitlement at age 50 exceeded general-population age-50 mortality by factors of 8.5 for men and 9.9 for women. Likewise, relative to the general population, period life expectancy for a DI beneficiary at age 50 and zero duration was 10.1 years shorter for men and 9.7 years shorter for women. Even for the beneficiaries who survived on the rolls for at least



10 years, mortality experience was closer to that of the general population a century earlier, before the existence of Social Security or the DI program, than to their general-population contemporaries. For example, after surviving on the DI rolls for a decade or more, mortality at age 50 in 2011–2015 was 3.9 times higher for men and 4.5 times higher for women than for their counterparts in the general population, and period life expectancy was shorter by at least 9 years.

## Notes

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<sup>1</sup> SSA's Listing of Impairments "describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity. Most of the listed impairments are permanent or expected to result in death, or the listing includes a specific statement of duration. For all other listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months" (SSA n.d.).

<sup>2</sup> Many studies have discussed factors affecting overall DI entry and exit trends. Examples include the nine SSA actuarial studies listed in the Introduction; Kearney (2005/2006); SSA (2006); and Puckett (2010).

<sup>3</sup> Notice that because of the time lag in processing new cases, the full effect of a legislative change in the disability program can take several years. For example, according to Schobel (1980), "the new eligibility of those under age 50 resulted in so many applications from persons disabled before 1960 that the gross incidence rate for 1961 was not exceeded for over ten years."

<sup>4</sup> For instance, Lindner, Burdick, and Meseguer (2017) found that "a higher unemployment rate is associated with a larger share of applicants with high work capacity whose applications are rejected earlier in the eligibility determination process. A substantial fraction of these initially rejected applicants are accepted into the program because of a successful appeal or re-application shortly after the initial application." Although the number of new awards generally increases during recessions, the fraction of applications allowed tends to decline. For example, Goss and others (2013) documented a strong inverse relationship between the total (final) allowance rate and the 2-year lagged unemployment rate. Applicants during recessions also tend to have higher earnings and struggle longer with their health prior to application (Coe and Rutledge 2013; Maestas, Mullen, and Strand 2015).

<sup>5</sup> For a summary description of the preeffectuation reviews and statistics on review volumes, see <https://www.ssa.gov/open/data/preeffectuation-review-of-disability-determinations.html>.

<sup>6</sup> Following enactment of the Social Security Act Amendments of 1980, SSA had reviewed 1.2 million beneficiaries by fall 1984 and terminated benefits for 490,000 of them, although around 200,000 had their benefits restored on appeal (Kearney 2005/2006).

<sup>7</sup> Prior to becoming an independent agency in 1995, SSA was part of the Department of Health and Human Services.

<sup>8</sup> Barrick and Zayatz (2005) provide a detailed account of AIDS-related mortality among DI disabled-worker beneficiaries and SSI adult recipients over the periods 1992–1996 and 1997–2001.

<sup>9</sup> According to Moore (2015), approximately 90 percent of about 100,000 affected DI beneficiaries applied to have their disability reclassified under a different diagnosis and about half of them succeeded.

<sup>10</sup> The two most common impairments in the endocrine, nutritional, and metabolic diseases diagnostic group were obesity and diabetes.

<sup>11</sup> For an assessment of DI application volumes and outcomes during the Great Recession, see Maestas, Mullen, and Strand (2015).

<sup>12</sup> Conversions from DI to OASI benefits are shown as DI program exits in Charts 1 and 3, reflecting their status from SSA's perspective—although "conversion" technically refers to a switch rather than a termination of benefits.

<sup>13</sup> Such discretionary switches are counted as "other" exits in Charts 1 and 3 and account for most of the exits in that category.

<sup>14</sup> The FRA for workers born in 1938 is 65 and 2 months, so although some of them did not attain FRA during 2003, most did.

<sup>15</sup> Ruffing (2014) analyzes findings from various studies of DI enrollment growth.

<sup>16</sup> Chart 4 shows awards by the impairment category of the primary diagnosis. By contrast, Meseguer (2018) measured multimorbidity (the simultaneous expression of multiple disorders in the same person) among initial claimants, as partly reflected in the secondary diagnosis codes in administrative data from SSA.

<sup>17</sup> "Select period" should not be confused with "study period."

<sup>18</sup> Additionally, the actuarial methodology for treating the exposure to death in the more recent studies differs slightly from that of the earlier ones.

<sup>19</sup> All estimates of general-population mortality in this article are from OCACT (Bell and Miller 2015). The Human Mortality Database (HMD), a collaborative research initiative, provides an alternative publicly available source of U.S. general population mortality from as early as 1933 (<https://mortality.org>). The HMD mortality estimates tend to be lower for older ages than those from OCACT. Conversely, the HMD estimates of life expectancy

are generally higher. OCACT uses data on the Medicare-enrolled population aged 65 or older as its source for death counts and population exposed. By contrast, the HMD draws its raw data from state-reported deaths and census population estimates (Goss and others 2015). Barbieri (2018) found that the discrepancies between the HMD and SSA mortality estimates cannot be explained by methodological differences and are due to differences in the data sources.

<sup>20</sup> For a review of factors that led to the increase in life expectancy, see Johnson (2021).

<sup>21</sup> Except for Kelley and Lopez (1984), the earlier actuarial studies follow beneficiaries only to duration  $t=5+$ .

<sup>22</sup> Because the SSA actuarial studies tend to use 5-year study periods, I pick the midpoint of a given period for comparisons with general-population statistics. For example, 2013 is the midpoint of the 2011–2015 actuarial study period. The mortality rate for a 76-year-old man in the general population in 2013 was 0.0403. By contrast, the mortality rate facing a 50-year-old male DI beneficiary at zero duration in the period 2011–2015 was 0.0427.

<sup>23</sup> More specifically, from the 1991–1995 to the 2011–2015 study periods.

<sup>24</sup> Note that the general population also includes all DI beneficiaries in current-payment status as a subpopulation. Their exclusion from the general population estimates would yield an even bigger gap in contemporaneous mortality between the two groups.

<sup>25</sup> Only the five most recent actuarial studies, spanning the period 1991–2015, feature life-expectancy tables.

<sup>26</sup> Notably, in 2010, diabetes ranked eighth in years lived with disability and seventh in years of life lost to premature mortality.

<sup>27</sup> Mental impairments tend to have early ages of onset (Meseguer 2018). For instance, the likelihood of a primary or secondary DDS diagnosis among 2009 applicants involving an affective/mood disorder peaks at ages 26–36, while for a schizophrenia diagnosis, the likelihood declines monotonically as a function of age. Incidence probabilities for musculoskeletal disorders generally peak at older ages than do those for mental diagnoses (for example, ages 46–56 for a disorder of the back). On the other hand, the incidence probabilities of a circulatory-system diagnosis such as cardiomyopathy, or of malignant neoplasms such as lung cancer, increase monotonically with age. Hence, because mental and musculoskeletal impairments have higher survival probabilities and are more predominant at younger ages than cancers and cardiovascular disorders, they make a greater contribution to the stock of DI beneficiaries over time.

<sup>28</sup> Raut's methodology, data source, and study period differ markedly from those of the OCACT studies. Specifically, Raut's exit-probability estimates are based on a

random sample of 157,237 disabled-worker beneficiaries spanning two decades. The actuarial studies cover the entire population of DI worker beneficiaries (in 2014, for example, encompassing more than 14.5 million records) and typically focus on 5-year study periods.

<sup>29</sup> Wixon and Strand's tables provide a useful benchmark for researchers working with the administrative regulation basis codes that identify the steps of the sequential disability determination process. In addition, and by design because of the transactional nature of the administrative data files on which they are based, the tables contain duplicates (that is, multiple records for a single claimant moving through the initial and reconsideration stages).

<sup>30</sup> Vocational allowances also have a medical component. In particular, if an applicant has one or multiple medical conditions that are deemed to be severe but fail to meet or equal the criteria in SSA's official Listing of Impairments, then vocational considerations become a decisional factor. On the other hand, applications with a medical decision may await a final nonmedical decision or be subsequently denied for nonmedical reasons.

<sup>31</sup> Although SSA did not introduce the medical-vocational guidelines until 1978 (and the grid has remained largely unchanged since then), disability adjudicators had informally been considering age and other factors in making disability determinations since 1960 (Strand and Messel 2019).

<sup>32</sup> Allowance rates at various adjudicative levels often jump sharply when applicants reach a vocational age threshold, suggesting a greater likelihood of an allowance (see, for example, Meseguer 2013, Charts 5 and 7).

<sup>33</sup> For a description of the policy, see [https://www.ssa.gov/OP\\_Home/hallex/I-02/I-2-2-42.html](https://www.ssa.gov/OP_Home/hallex/I-02/I-2-2-42.html) and <https://secure.ssa.gov/poms.nsf/lnx/0425015006>.

<sup>34</sup> The effect of the vocational age thresholds on cohort life expectancy would be more pronounced because the improved mortality effect persists over multiple years of duration on the rolls.

<sup>35</sup> The decline reversed in 2018, as life expectancy at birth increased by 0.1 year to 78.7.

<sup>36</sup> Gelman and Auerbach (2016) comment on potential aggregation bias in Case and Deaton (2015).

<sup>37</sup> Cohort life expectancy follows the mortality experience over time of individuals grouped by birth year. Period life expectancy follows the mortality of individuals of different birth cohorts in a given year.

<sup>38</sup> Jagger and others (2015) compare the experiences of 14 European Union member countries with increasing life expectancies and chronic disabilities prevalence.

<sup>39</sup> DI beneficiaries are entitled to Medicare benefits after 2 years on the rolls, while SSI recipients receive Medicaid benefits immediately in most states.

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