Modernizing the SSDI Eligibility Criteria

A Reform Proposal That Eliminates the Outdated Medical-Vocational Grid

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April 2015

MERCATUS WORKING PAPER

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Mark J. Warshawsky and Ross A. Marchand. "Modernizing the SSDI Eligibility Criteria: A Reform Proposal That Eliminates the Outdated Medical-Vocational Grid." Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, April 2015.

Abstract

The Social Security Disability Insurance (SSDI) program, designed to assist individuals unable to work because of permanent disability, has grown substantially over the past 10 years. We document this growth, adjusting for the changing demographics of the US population, and find that the program is covering a higher percentage of the workforce over time despite the fact that actual disability rates are falling. We explain that the medical-vocational grid guidelines that are used to determine whether someone is disabled are an important part of the explanation for increased disability awards. The grid applies much looser standards for applicants as young as 45 and 50. We propose that age be eliminated as a deciding criterion, as well as language ability and education level. We also note that the guideline's list of impairments is outdated and needs to reflect a modern workforce that has access to remedying medical technologies.

JEL codes: H55, I38, J18

Keywords: Social Security, disability, entitlements, adjudication of benefit claims

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Modernizing the SSDI Eligibility Criteria

A Reform Proposal That Eliminates the Outdated Medical-Vocational Grid

Mark J. Warshawsky and Ross A. Marchand

The Social Security Administration (SSA) has been awarding benefits through its Disability Insurance (SSDI or DI) program at an increasing rate over the last 10 years. Even after adjusting for changes in the age and gender composition of the working population, we see that larger and larger shares of the workforce have been getting benefits. This has occurred despite evidence from other sources that rates of disability in the working-age and older populations have been stable or have declined. This paper will document the trend and show that a significant cause for it is the fact that older workers are evaluated with considerably eased standards for eligibility under the medical-vocational grid. The grid process uses the applicant's work ability as a starting point and takes into account age, education, work history, and language skills to evaluate disability claims. This paper will describe the current grid in some detail and demonstrate that it is likely playing a major role in the age- and gender-adjusted increase in DI incidence and prevalence. We propose the elimination of this grid and suggest other intermediate- and long-range eligibility reforms.

Our policy recommendation is to eliminate the medical-vocational grid and replace it with a simpler, fairer, and more uniform eligibility system: that is, the same standards and five-step process currently determining eligibility of those under age 45 should also apply to those above age 45. At the same time, the listing of medical conditions that meet disability requirements needs to be updated frequently and comprehensively. These revisions should be based on the advice of medical, technology, and vocational experts about which disabilities are significant enough to

prevent—permanently and commonly—participation in any job in the national labor force, with due and ample consideration of typical and reasonable use of available assistive technologies and practices. As an intermediate step, the current grid criteria concerning age should be increased by five years, roughly matching the increase in longevity over the last few decades.

The SSDI Trust Fund will run out of money by 2016. A commonly proposed, easy solution—transferring payroll taxes from the retirement to the disability fund—misses the timely opportunity to reform the DI system. Age- and gender-adjusted rates of DI incidence and prevalence have increased substantially. Applying for and being on DI unnecessarily is bad for the individual, whose skills atrophy and who stops contributing to society once out of the labor force. It is also bad for the economy, as the wages and creativity of people on DI are lost, and it is bad for the government, which loses the worker's income and payroll taxes and then must pay out income and health benefits. The current medical-vocational grid, which makes getting DI benefits much easier for middle-aged and older workers, reflects a view of the labor market and disabilities that is old-fashioned and out of date, being based on the industrial economy of the 1950s and 1960s. During that time, physical labor was predominant, and, at least according to the apparent worldview of the grid's authors, there were classes of workers rigidly divided in opportunity and flexibility by their ages, education levels, and language skills. Moreover, in the 1960s and 1970s, everyone, but especially disabled workers, had considerably shorter life expectancies than they do today. Now disability benefits, increasingly given because of mental illnesses and musculoskeletal ailments, are lasting much longer, thus raising system costs. Moreover, with the gradual application of the 1983 Social Security reforms lowering retirement benefits only to cohorts of nondisabled workers through the rise in the normal retirement age, older workers' incentive to get on the disability rolls has increased.

Brief History of the Disability Insurance Program

Kearney (2006) and Derthick (1979) have each compiled a history of the DI program. Below is a summary of their work.

Disability insurance was not included in the original Social Security retirement income program enacted in 1935. Rather, it was added in 1956 and originally covered only disabled workers between the ages of 50 and 65. DI was expanded significantly over the years, but it has always been tied in important ways to the parameters of the basic Social Security program.

Early policy advocates in the 1930s had envisioned a disability insurance component to Social Security to meet the financial needs of disabled workers who, they claimed, were not well served by the operation of private disability insurance markets. But these advocates were deterred by concerns that others had about the difficulties of a federal agency administering such a program and by potentially high costs. The cost concern was bolstered by the large losses experienced by private insurers who were writing individual disability insurance policies. Subsequently, however, the Social Security Administration (SSA) gained experience with adjudicating disability claims when it was assigned responsibility for the Civilian War Benefits program, paying medical and disability claims to those injured or disabled during the course of their civil defense duties during World War II. This experience helped negate the concerns about administrative inexperience and difficulty.

In 1944–1945 and again in 1948, the SSA made official recommendations that the federal government start a national mandatory disability insurance program financed by payroll taxes. The Social Security actuary estimated that such a program would be relatively inexpensive, but insurance company representatives challenged this assessment, recommending instead that federal grants be provided to states for a new program called Aid to the Permanently and Totally

Disabled. This program was included in amendments to the Social Security Act that Congress passed in 1950.

In 1952, the SSA recommended a disability "freeze," whereby any period of disability would be excluded from the required period for retirement insurance status and from the computation of the average monthly wage in determining retirement and survivor benefits. Of course, administration of this freeze would require a determination of disability by the government. This small program was passed in 1954. Disability was defined as an inability to engage in substantial gainful activity due to a medically determinable physical or mental impairment that could be expected to result in death or to be of long-continued and indefinite duration. Eligibility was limited to persons whose disability had lasted for at least six months and whose earning record demonstrated a strong and recent connection to the workforce. Disability determinations would be made by the states, although administrative costs were reimbursed through the Trust Fund.

With this foot in the door, a full-blown disability insurance program was passed in 1956, using many of the concepts from the disability freeze, as well as the experience of the Civilian War Benefits program. The main criterion for getting DI benefits was functional incapacity due to a medically determinable impairment. In particular, the disability evaluation process included the following elements:

1) A person who is performing substantial gainful activity cannot be found disabled.
2) A person must have a medically determinable impairment that significantly limits his or her ability to perform basic work activities, and the impairment must be expected to last for a long time or result in death.

3) The disability determination is made in part based on whether the person has an impairment that meets or equals one or more of the impairments in an official listing.
4) If the person is otherwise qualified for a disability determination but does not meet the listing, then vocational factors (age, education, and work experience and skills) are considered in assessing whether the person is unable to perform either work done in the past or any work in the national economy.

According to Derthick (1979, 310), this willingness to give weight to nonmedical factors, which is the basis of the medical-vocational grid, "put a liberal gloss on the seemingly strict requirement of the law that disability depend on a medically determinable impairment, and administrators became more willing to use discretion as time passed. A study in 1962 showed that 40 percent of the disability cases in a sample universe had been approved on a finding that non-medical factors contributed crucially to the disability, whereas in 1959 the proportion had been only 10 percent."

In this regard, it will be insightful to note what congressional staff in 1959 wrote about in a section titled "Other Factors in Evaluating Disability" (Ways and Means Committee 1959):

> The following are additional factors that influence the extent of handicap imposed by an impairment.
>
> Age
>
> An impairment may be more limiting for an older person than for a younger person. The aging process affects healing, prognosis, psychologic adaptability, general health, speed and efficiency.
>
> As indicated above, a person generally suffers physiological impairment due to the aging process. In addition, employers may have prejudice against hiring older workers. This prejudice may cause a man to be unemployed, but it does not make him unable to do substantial work by reason of a medical impairment. The medically determinable impairments are the primary facts the evaluation team considers in evaluating handicaps.
>
> Education
>
> The amount of education a person has is a factor in determining his adaptability to other occupations if he should become unable to perform his usual occupation. However, lack of schooling is not necessarily proof that applicant is uneducated or not adaptable.

Experience

> A person who all his life has done simple unskilled work may find it difficult to adjust to a different occupation if he acquires a handicap which interferes with his ability to carry on the work in which he is experienced. Limitation to unskilled work, especially when paired with limited education, may indicate limited vocational adaptability. On the other hand, an educated person who has varied experience very often is able to make adjustments more readily.

The DI program was expanded in 1958 by providing benefits to dependents and spouses of disabled workers; in 1960 by extending DI to workers younger than 50 and introducing a trial work period; in 1965 by changing the definition of disability to an impairment that could be expected to last for a period of 12 months or longer, rather than the original definition of long-continued and indefinite duration; in 1967 by introducing benefits for disabled widows and widowers beginning at age 50; and in 1972 by reducing the waiting period from six to five months, and by extending Medicare protection to disability beneficiaries after 24 months of entitlement.

During the 1970s, owing to these and other changes, the number of disability beneficiaries doubled and benefit payments increased by a multiple of five; the DI Trust Fund was declining. Part of the cause was the lack of review by the SSA of state adjudication of claims before effectuation of the award. In addition, continuing disability reviews were cut back, and there was an increased propensity to appeal denials to the hearing level.

In 1980 Congress passed legislation to control these burgeoning costs. In particular, the legislation required periodic reviews (at least once every three years) of all beneficiaries whose disabilities were not permanent. It also put in place performance standards for federal pre-effectuation reviews of state decisions and initiated a review of decisions by administrative law judges. Further, it prohibited the introduction of new evidence after a decision was made at the hearings level.

The new Reagan administration moved aggressively on the continuing disability review program, which proved to be quite controversial because it caused the removal of nearly a half million people from the disability rolls. The states eventually refused to conduct the reviews, many lawsuits were successfully filed against the SSA's actions, and Congress held hearings. As a result, Congress passed new legislation in 1984 to undo some aspects of the earlier legislation and to make other changes that eased standards. In particular, benefits would not be discontinued if there were no medical improvement, as opposed to a de novo review of the disability. Also, the SSA would now consider the combined effect of multiple impairments, and both the SSA and a commission would study the pain and mental illness aspects of the determination of impairment.

Following these changes, the disability rolls and payments started to grow again, in particular for mental impairments, where less weight was given to medical factors and more to functional capacities. Also, owing to federal court opinions not appealed by the SSA, greater weight was now given to the opinion of the applicants' health care providers, who would generally be sympathetic to their patients, rather than to the opinion of a consultative examination.[1]

Rehabilitation has always been a goal in the DI program, but the many efforts over the years to return disabled beneficiaries to work have generally been unsuccessful. One such effort is the Ticket to Work program passed in 1999, whereby new disability beneficiaries receive a ticket to obtain vocational rehabilitation, employment, or other support services from various approved state and private agencies; those using a ticket are exempted from continuing disability reviews.

[1] In the words of a retired administrative law judge, Verrell Dethloff, writing to Senator Hatch in 2011:

> The federal courts early on decided that a treating physician's opinion should be accorded significant weight. In the Ninth Circuit, such an opinion must be accorded controlling weight absent clear and convincing reasons why it should not. Thus, an ALJ, to deny a case, bears a significant burden of justification, which amounts to a burden of proof. The practical effect is to displace the authority to dispense public funds from the agency to physicians, who are interested in the global well-being of their patients, rather than the well-being of the public fisc.

In a notice of proposed rulemaking published in November 2005, the SSA proposed to increase by two years the age categories it uses as one of the criteria in determining disability. The agency stated that its proposal reflected its adjudicative experience, advances in medical treatment and health care, changes in the workforce since the current regulation was published in 1978, and current and future increases in the normal retirement age. The SSA received almost 900 public comments, which were largely adverse, as well as congressional opposition. For example, the Center on Budget and Policy Priorities (2006) strongly opposed the rule change. The SSA abandoned the proposed rule change in May 2009.

Recent Projections, Conditions, and Experience in SSDI

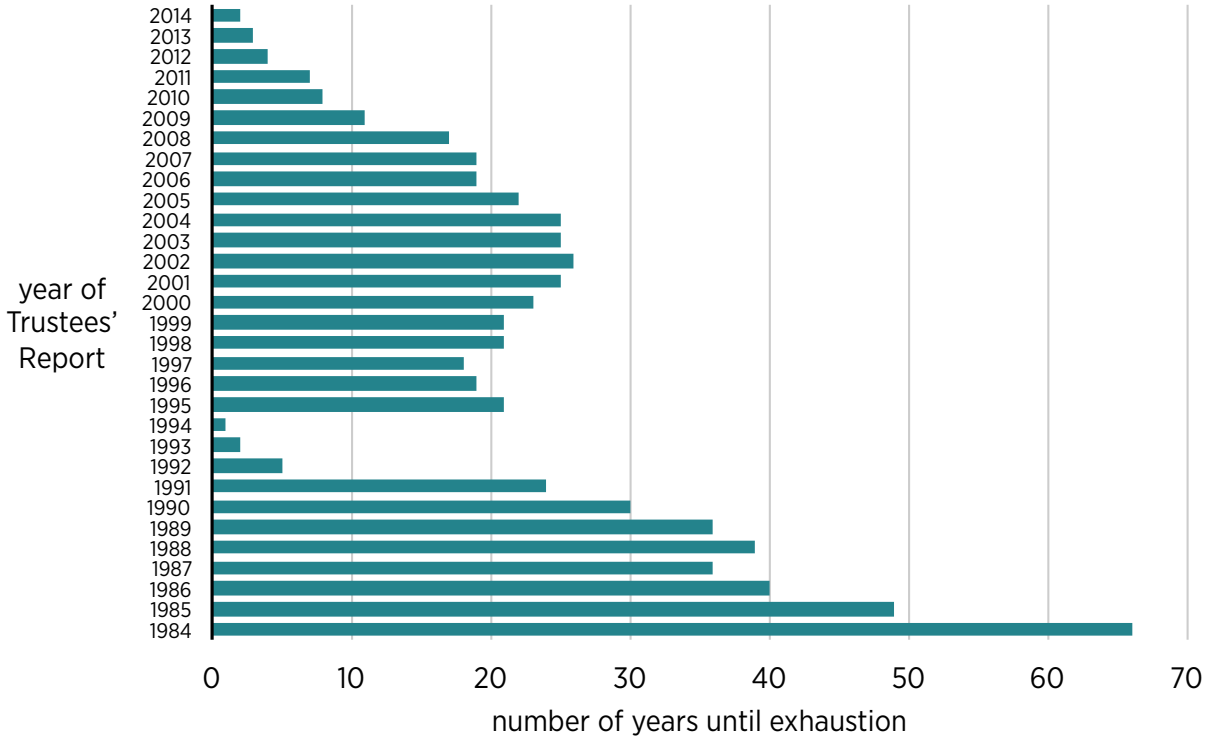
In figure 1, we see the recent history of the projected number of years until DI Trust Fund exhaustion, that is, bankruptcy, according to the annual Trustees' Reports. Since 2004, when the expected exhaustion date was 25 years away, conditions for DI have deteriorated rapidly; in 2014, the exhaustion date was expected to be 2016, just two years away. At that time, the SSA will not be legally able to make full benefit payments to disabled workers; indeed, at that point, it is estimated that payments will have to be cut to 81 percent of scheduled benefits.

When the DI Trust Fund was near exhaustion in 1995, Congress reallocated the Social Security retirement and survivor program contribution rate between the Old-Age and Survivors Insurance (OASI) program and DI. In subsequent years, the expected exhaustion date moved further out as good economic conditions unexpectedly lowered unemployment and increased revenues. From 1995 to 2004, both a tax reallocation and good economic times helped DI finances. All the while, benefit payments from the DI Trust Fund, even after adjusting for

inflation, have increased rapidly in the last two decades, from about $40 billion in 1990 to more than $140 billion in 2013 (see figure 2).

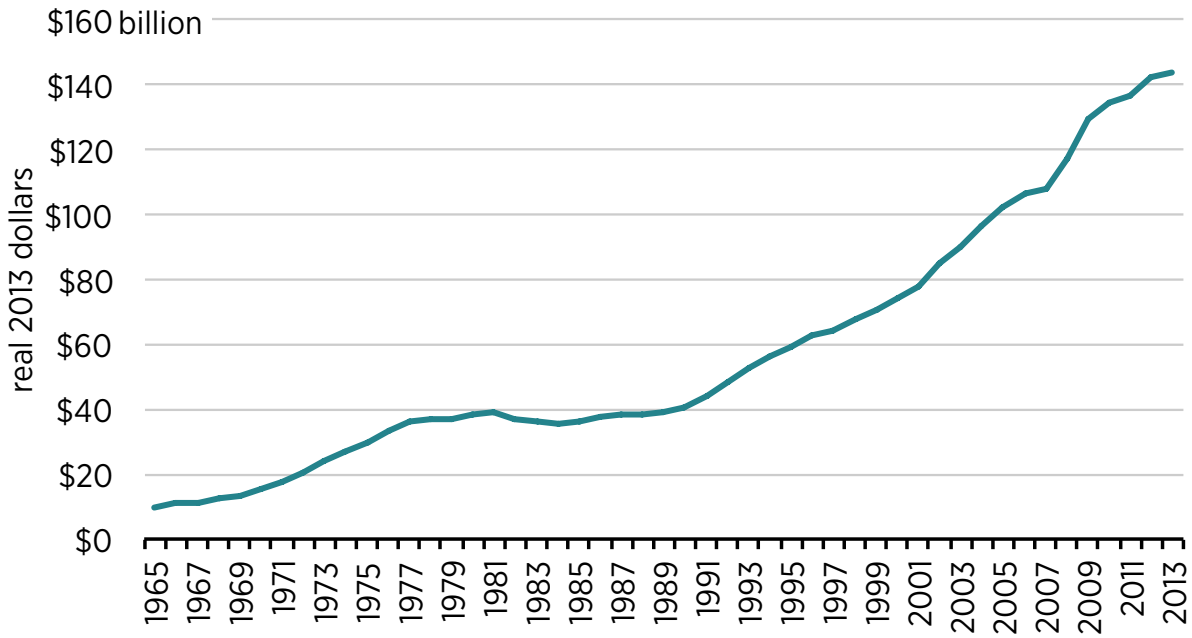
It is worth reviewing the reasons for the needed tax reallocation in 1995. Since 1982, there had been a trend of an increasing proportion of workers applying for and awarded disability benefits, and since 1970, there was a trend of a decreasing proportion of disabled workers whose benefits terminated because of death before normal retirement age. Thus, these trends are long-standing and yet were not addressed in 1995, the last natural legislative opportunity.

Figure 1. Projected Number of Years until the Exhaustion of the SSDI Trust Fund, 1983–2014



Source: Annual Social Security Trustees' Reports.

Figure 2. Disability Insurance Outlays, 1965–2013



Source: Social Security Administration data.

As mentioned above, the DI program will soon go bankrupt. Some have proposed reallocating payroll taxes from the retirement program to avoid this outcome, as was done in 1995. Yet this proposal ignores several critical issues: the dire and worsening finances of the retirement program; the soaring disability rolls consisting of workers removed from productive labor and from paying taxes even as the general health of the population has improved; several scandals involving administrative law judges and fraudulent claimants; and the unchanging criteria for disability determination, especially the easier standards for middle-aged workers at a time when most workers are working longer and despite the development of powerful assistive technologies and more accommodative work conditions.

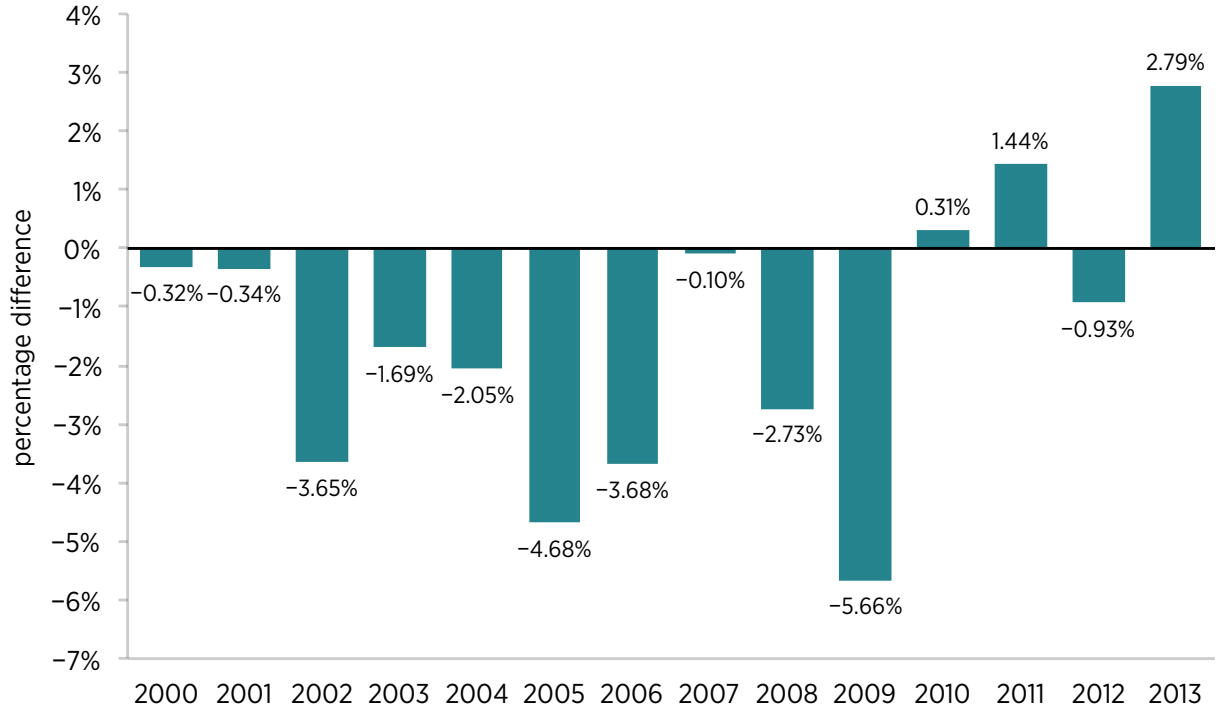
Some have claimed that the deficit in the disability program is the inevitable and predictable product of demographic trends: as the work force ages there will be more disability benefits to be paid. That explanation is not consistent, however, with the fact that the age- and

gender-adjusted prevalence rate of disability in the program has risen significantly, as we will see in more detail below. Indeed, as shown in figure 3, the official actuarial Trustees' projections, which include well-known and broadly projected demographic trends, have consistently underestimated the actual payout costs of the disability program since at least 2000 (in 11 out of 14 years), through times of both rising and falling unemployment (disability claims increase with unemployment, as do awards). And the overestimate in 2013 is almost certainly not caused by a change in fundamental trends or structures. Rather it is largely caused by (perhaps temporary) administrative changes of the SSA that have reduced the demand on administrative law judges to process more and more cases and have imposed on them the requirement to document their awards as well as their denials of claimed benefits. Awarding claims takes less time for a judge than issuing denials, leading many large-caseload judges to allow claims without full consideration of evidence. These recent administrative changes help to counteract these perverse incentives by providing more balanced work incentives in the decision-making process. Moreover, many senior judges, who were more likely to grant claims than newly trained judges, have retired.

To see whether SSDI has ventured beyond the program mandate to serve the genuinely disabled, we review time-series data from sources external to the SSA for rates of disability in the working-age and older populations and compare them with prevalence rates of disability insurance under SSDI. Burkhauser, Houtenville, and Tennant (2014) calculate the percentage of working-age Americans who report work-disrupting disability. Their underlying data come from the Current Population Survey and American Community Survey, both conducted by the US Census Bureau. Although the levels differ depending on the questions and on the particular survey used, in general, rates of disability have been flat over time or have even declined slightly

in recent years. This is true despite an overall aging of the working-age population when one might have expected increases in rates of disability. Moreover, and somewhat surprisingly, the advents of recessions, with their resulting increases in joblessness, do not seem to have had an influence on the prevalence rates of disability, unlike what we will see in SSA claims data.

Figure 3. Percentage Differences between Projections in the Prior Year's Trustees Report and Actual Disability Insurance Expenditures, 2000–2013



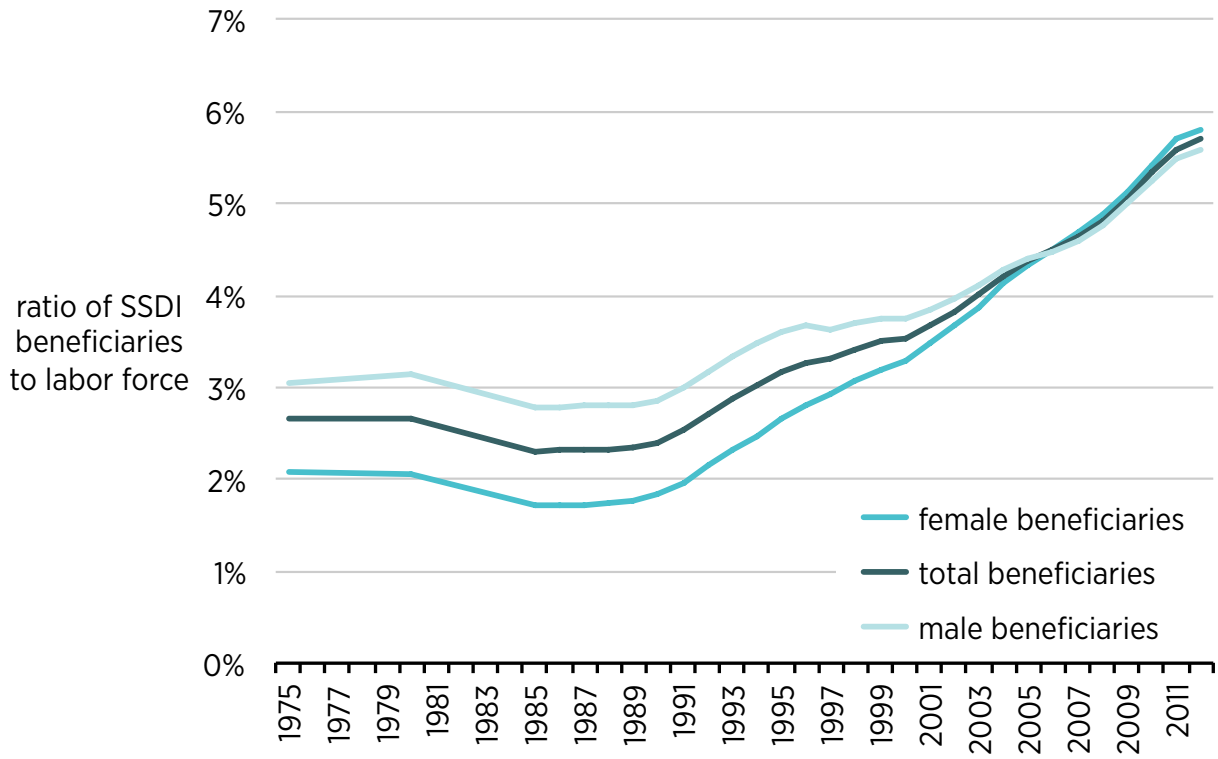
Source: Annual Social Security Trustees' Reports.

Next, we consider age-adjusted rates of disability in the older population, also from a source external to the SSA—a 2013 study by Kaye (2013) based on the Census Bureau's Survey of Income and Program Participation (SIPP). It is difficult to envision medical and technological conditions where rates of disability decrease in the population over age 65 but increase in the working-age population. And yet trend-line rates of disability have declined over time (1984 through 2010) in the older population, both overall and across most disabling

factors. In particular, rates of disability arising from mobility and mental health issues have declined, the opposite of what we will see below from SSA data on the medical reasons for SSDI awards.

In figure 4, we show our own calculation of the SSDI prevalence rate—that is, the ratio of former workers now collecting SSDI benefits to the workforce as a whole—both by gender and in total, over the period 1975 through 2012. For example, in 2012, there were almost 9 million former workers getting SSDI benefits compared to about 155 million people in the labor force; therefore the prevalence rate in 2012 was 5.7 percent. Unambiguously, the SSDI prevalence rate has increased substantially since 1990, when it was about 2.4 percent, after a period in the late 1970s and early 1980s when the SSDI prevalence was flat or declining (owing to the temporary tightening of eligibility criteria and the strict review of benefits already granted). The rate increased particularly rapidly in the early 1990s and again throughout the first decade of the 21st century, so that the overall picture given is that of a hockey stick. Interestingly, while prevalence rates increased for both men and women, they increased far more rapidly for women, so that SSDI prevalence is now higher for women. There is also a relationship between prevalence rates and labor market conditions, whereby SSDI prevalence increases when jobs are being lost. This relationship is different from the external survey data we summarized above, indicating that employment conditions influence the granting of DI benefits, which is indeed consistent with the operation of the medical-vocational grid at older ages, as we will see below. By contrast, in a program that would give benefits solely on the basis of medical conditions, the external data indicate that labor market conditions would not be as influential in trends and cycles.

Figure 4. Prevalence of SSDI Beneficiaries Compared to Labor Force by Gender, 1975–2012

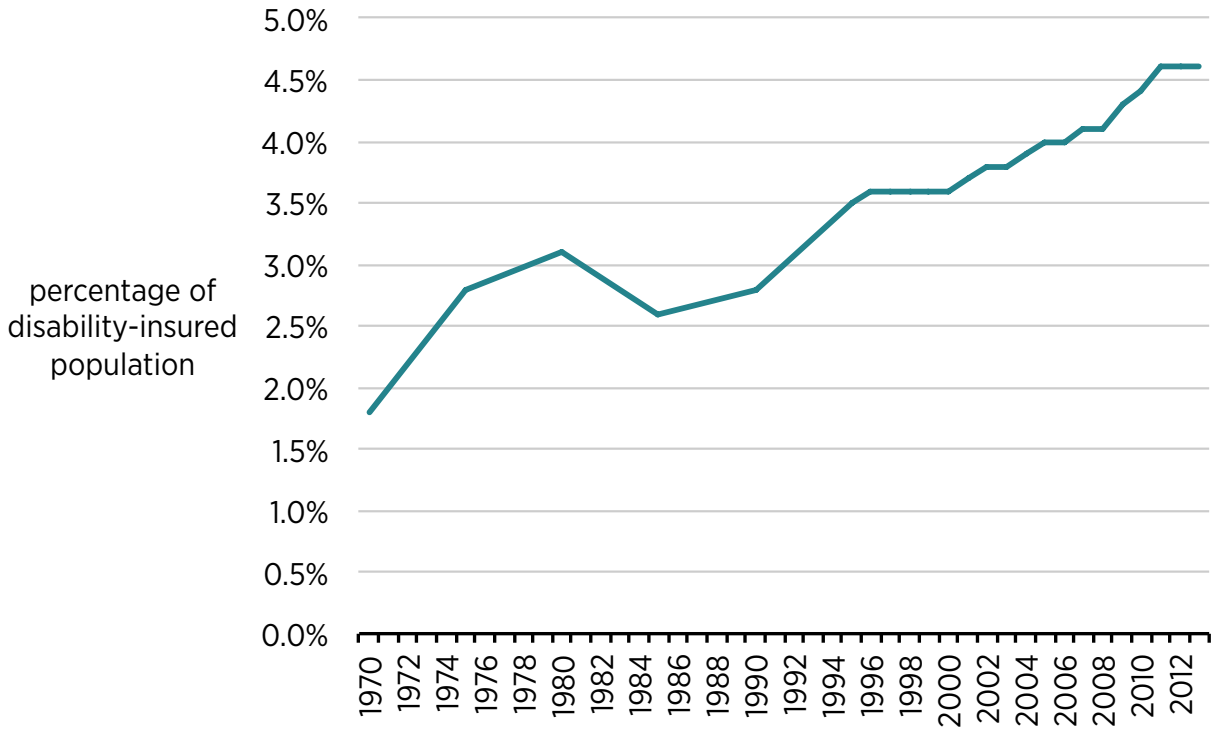


Source: Authors' calculations.

The SSA actuary calculates SSDI prevalence rates on both a gross basis and an age- and gender-adjusted basis, using a slightly narrower base than the one we use above—that is, persons insured for disability benefits. Some workers, particularly younger ones and those with intermittent attachment to the labor force, are not insured for disability benefits from the SSA. Nonetheless, the levels and trends in the SSA measures are nearly identical to our measure. The SSA-calculated prevalence rate on a gross basis, with no adjustment for changes in the age and gender composition of the labor force, increased from 2.5 percent in 1990 to 5.9 percent in 2013, more than doubling. Even on an age- and gender-adjusted basis, the SSA-calculated prevalence rate increased from 2.8 percent to 4.6 percent over this period, a remarkable explosion of former workers getting SSDI benefits (see figure 5). Clearly something more is going on than the simple

aging of the workforce, reaching naturally higher rates of disability and functional limitations. Moreover, as shown in figure 3, year after year large negative payment surprises are hitting the SSA actuarial projections, which already include anticipated demographic changes—further evidence of nondemographic sources for the increase in disability payments.

Figure 5. Age- and Gender-Adjusted Prevalence of Disability Insurance Benefits, 1970–2013



Source: Annual Social Security Trustees' Reports.

The prevalence rate is determined by the flow of workers first getting benefits (incidence) and the flow of beneficiaries leaving DI (termination by death, by recovery, or by gaining retirement status at the full retirement age).

In the late 1970s, the incidence rate of new DI awards (both gross and age- and gender-adjusted) was nearly 0.7 percent of the population who met insurance requirements but were not receiving benefits, according to the annual Trustees' Reports. The incidence rate dropped

to 0.4 percent with a tightening of eligibility standards in the early 1980s, but subsequent legislative loosening of those standards for mental illnesses, as well as changes in economic and program administration factors, have led to a volatile trend of an increasing incidence rate. By 2010 the rate had increased to more than 0.6 percent on an age- and gender-adjusted basis and to nearly 0.75 percent on a gross basis. More recently, the incidence rate has again dropped somewhat, partly owing to an improvement in the labor market, but also owing to the administrative changes in the SSA management of claimant appeals to administrative law judges mentioned earlier.

The termination rate, calculated relative to the average number of disabled worker beneficiaries during the year, has dropped steadily—from 0.6 percent in the late 1980s to less than 0.4 percent in 2012. This drop was not caused by an increase in recoveries (with beneficiaries returning to substantial work for an extended period), as the recovery rate has been low and fairly constant.[2] Similarly the rate of conversion from disability to retirement benefits has been fairly steady. However, the mortality rate of disabled workers has dropped as their functional limitations are more likely to be caused by mental or musculoskeletal limitations, both of which have higher survival rates than the most common disabling conditions of the past, such as serious physical work injuries. While the age- and gender-adjusted mortality rate of disabled workers is clearly higher than that of the general population, its fall from 3.5 percent in 1970 to 1.5 percent in 2010 is much more noticeable and rapid than that of the general population.

[2] Exceptions have occurred in the early 1980s, when a concerted administrative effort was made to critically review past disability awards, and in 1997, when legislation resulted in the review and termination of persons who had been entitled on the basis of drug addiction and alcoholism. Both these developments contributed to a temporary increase in the overall rate of termination.

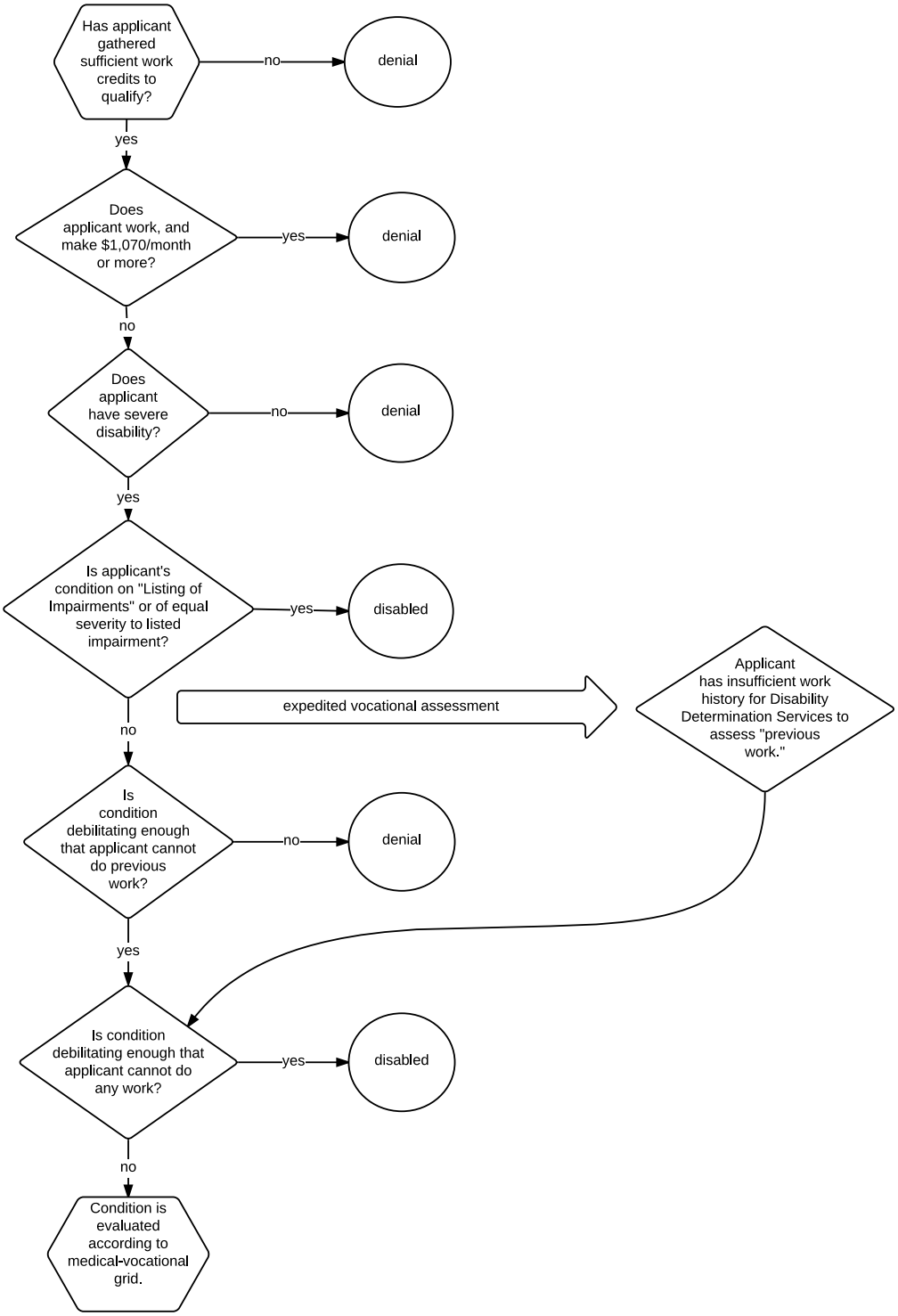
Eligibility Criteria: The Five-Step Evaluation Process and the Medical-Vocational Grid

An individual applying for a Social Security disability insurance award must clear a series of rules and considerations to be deemed "disabled." This section delineates the five-step adjudication process for evaluating disability claims; the last step involves the medical-vocational grid, in which age, educational attainment, and language skills are considered. In the first step of the process, the applicant must demonstrate that he or she has sufficient work history to go through the process. The required amount of experience varies by age; younger applicants have a different work threshold they must meet in order to be insured for SSDI benefits. Generally, each $1,200 earned by a worker results in an official credit for the quarter, and up to four credits can be earned each year.

If the applicant has sufficient work credits, the Disability Determination Services (DDS), the state agency that is the first reviewing level, examines the applicant's *current* employment (see the second row in figure 6). In order to receive an award, the applicant must not be working or must earn less than $1,070 per month. This wage ceiling is considerably higher for blind applicants and will reach $1,820 in 2015.

In the second step, all unemployed or underemployed applicants must have their limitation classified as a severe disability (see the third row in figure 6). The SSA considers disabilities award-eligible if they are of "sufficient severity as to be the basis of a finding of inability to engage in any substantial gainful activity" (Social Security Administration, 2015). The expected duration of the disability is also critical. To be considered award-eligible, the condition must not be likely to improve within 12 months or must be likely to result in death. Multiple nonsevere disabilities may also meet this threshold when combined. However, these limitations must meet the duration requirements or the applicant will be denied.

Figure 6. Determination of Initial Eligibility



Source: Social Security Administration descriptions.

* Some diseases, such as amyotrophic lateral sclerosis, qualify for Compassionate Allowances. This is when the allowance is made immediately.

As seen in figure 7, determinations are complicated by the applicant's mix of exertional and nonexertional limitations. Exertional disabilities reduce "the capacity to sit, stand, walk, lift, carry, push, or pull"; all other disabilities are nonexertional by default (Social Security Administration, 2015). Many applicants have both types of limitation, but the exertional factors are sufficient as a severe disability. The decision then follows evaluation of the exertional limitation, *not* the nonexertional limitation. As discussed later, the nonexertional limitation will be considered if the exertional disability is considered insufficient for an award in step five. However, if the applicant *only* claims a nonexertional impairment, the DDS will focus on that impairment's severity and proceed directly to steps four and five of the determination process.

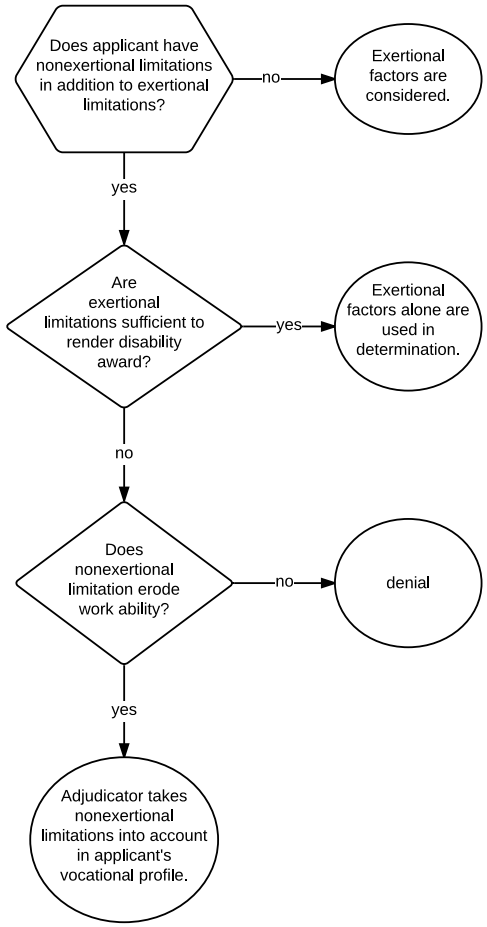
If the applicant's condition meets the required standard of severity, the DDS will move to step three and attempt to look up the condition in the Listing of Impairments. This manual, known informally as the "blue book," contains a list of 14 categories of impairments with detailed descriptions. If the applicant has a disability that isn't listed in the manual but is of equal severity to a listed disability, he or she will be granted the award. In the case of multiple listed disabilities, the applicant will be deemed disabled.

There is a subset of disabilities in the blue book under the Compassionate Allowances category. An applicant with amyotrophic lateral sclerosis, for example, will be granted a faster determination of disability than usual. Additionally, DDS staff use advanced computer software to pre-identify cases with a high chance of approval in order to expedite the process.

Applicants with disabilities that fall *outside* the Listing of Impairments (or equivalent) will move to the fourth step of the process, in which present work ability is examined. To figure out the level of work that the applicant is able to do, the DDS must determine the applicant's residual functional capacity (RFC). The RFC (see figure 8) is determined by the applicant's

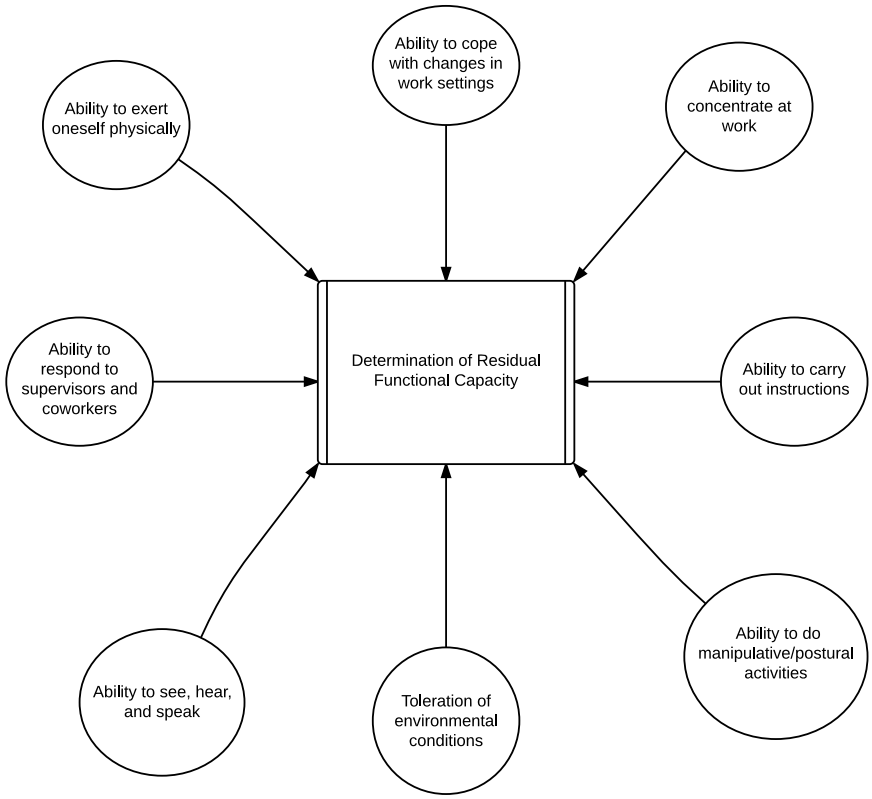
ability to (a) exert himself or herself physically, (b) cope with changes in workplace settings, (c) concentrate/pay attention at work, (d) carry out instructions, (e) undertake manipulative/postural activities, (f) tolerate environmental conditions, (g) exercise primary senses, and (h) respond to supervisors and coworkers. Based on these factors, the applicant is deemed able to undertake (a) very heavy work, (b) heavy work, (c) medium work, (d) light work, or (e) sedentary work. If the applicant has an RFC in line with his or her previous work, then the application is denied.

Figure 7. Consideration of Exertional Factors



Source: Social Security Administration descriptions.

Figure 8. Residual Functional Capacity



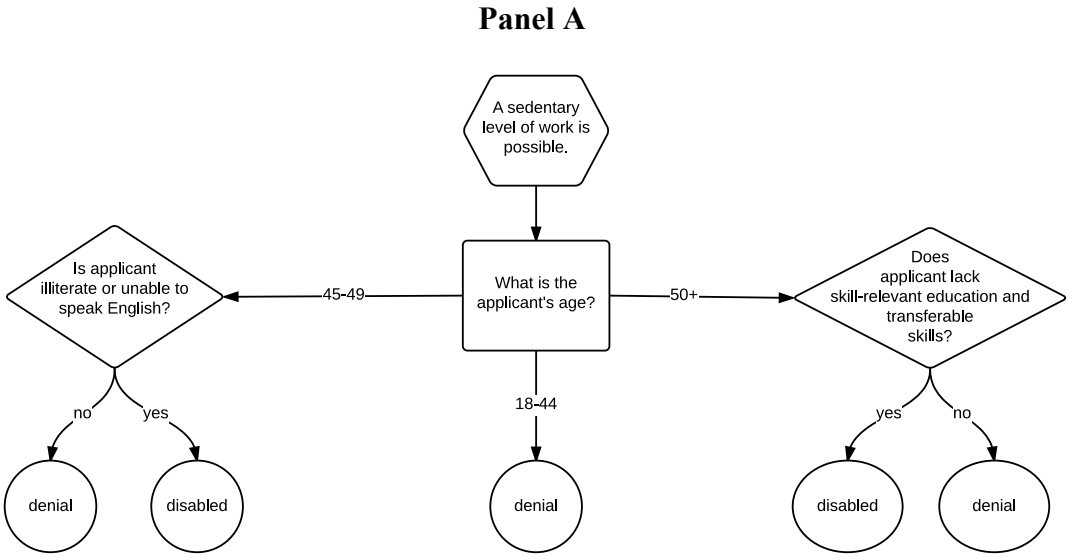
Source: Social Security Administration descriptions.

An inability to engage in previous work coupled with an ability to undertake *some form* of work (see the bottom two rows of figure 6) will put the applicant in step five, which relies on the medical-vocational grid for determination of eligibility. The grid takes into account the applicant's RFC along with the vocational factors of age, level of education, language, and previous work skills. Figure 9 illustrates the eligibility rules when RFC and vocational factors are varied. Generally speaking, the chance of DI awards increases as age increases and as education level and work experience decreases. There are five possible levels of education, ranging from "illiterate or unable to communicate in English" to "[having] recent education that provides for direct entry into skilled work" (Social Security Administration, 2015). The applicant will fall into one of three age categories: younger individual (below 50), closely approaching

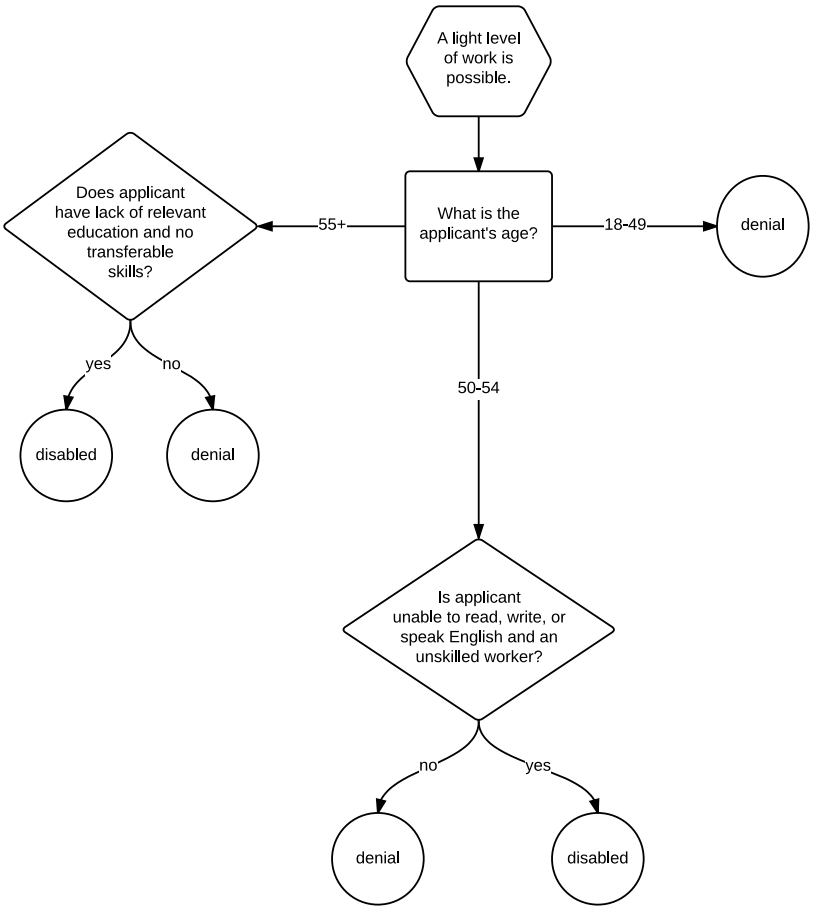
advanced age (50–54), or advanced age (55+). Applicants may be subclassified into the "younger individuals ages 45 to 49" category or the "closely approaching retirement age" category (60+).

Thus, at age 50 a person who can perform only sedentary work and is completely unskilled is presumptively disabled. A 49-year-old is not, unless he or she cannot speak English. The non-English-speaker, limited to sedentary work, is disabled. This rule results in the payment of benefits to non-English-speakers in Puerto Rico despite the fact that the common language there is Spanish. More importantly, many in the baby-boomer generation who wish to retire at age 62 (or even 60) may be found disabled if they have a history of unskilled work or a history of skilled work with skills that will not transfer to other work. This is true even if they are capable of light work (i.e., standing and walking six out of eight hours a day and lifting and carrying 20 pounds occasionally, 10 pounds frequently).

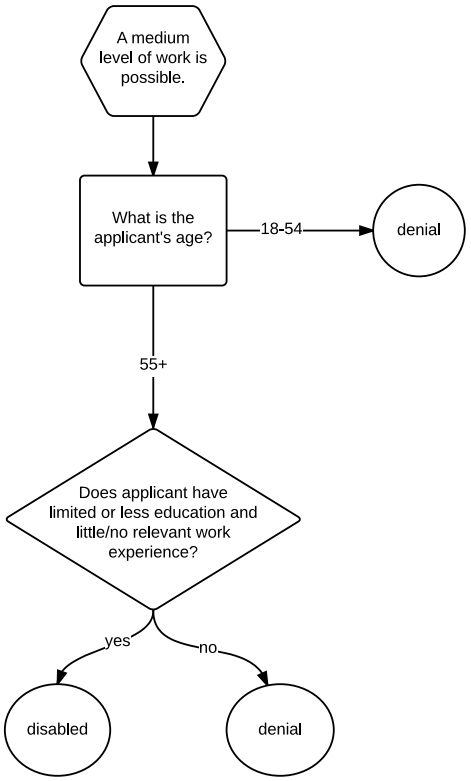
Figure 9. Medical-Vocational Grid



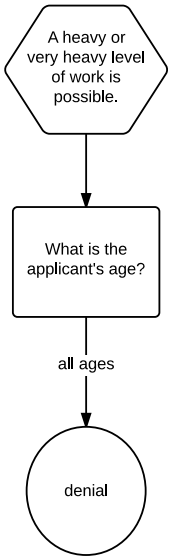
Panel B


A light level of work is possible.
What is the applicant's age?
55+
18-49
denial
Does applicant have lack of relevant education and no transferable skills?
yes
no
disabled
denial
50-54
Is applicant unable to read, write, or speak English and an unskilled worker?
no
yes
denial
disabled

Panel C



Panel D



Source: Social Security Administration descriptions.

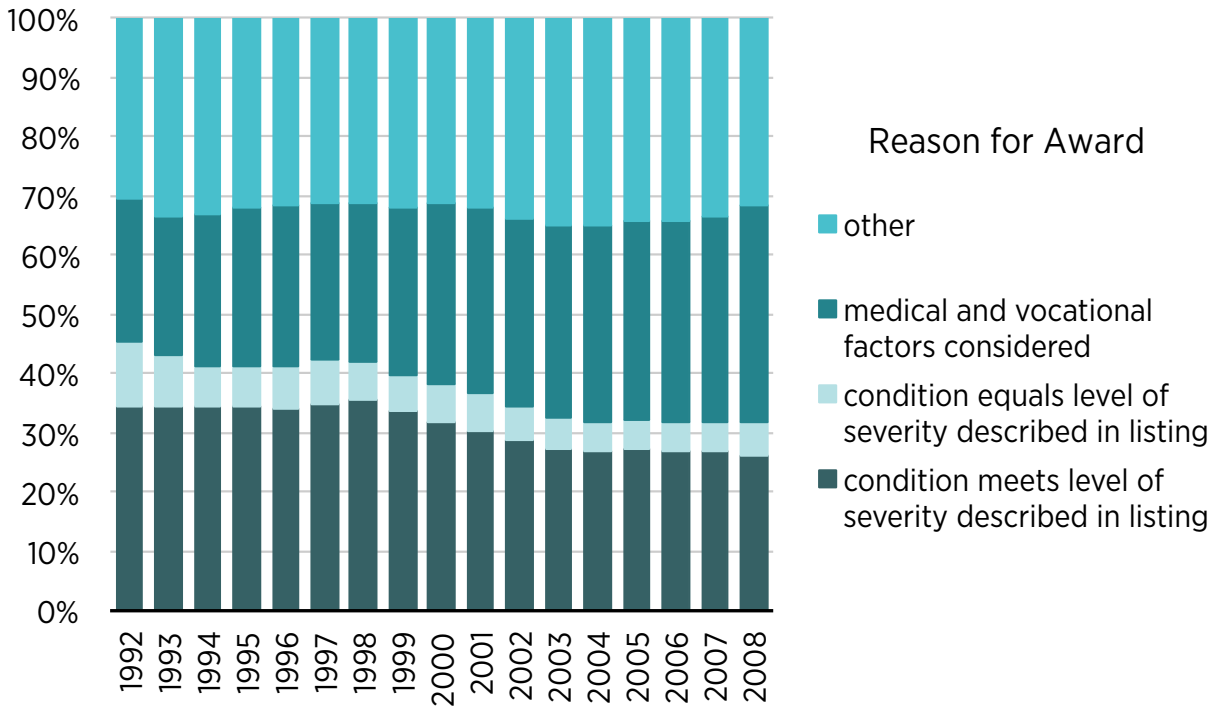
As discussed above, if exertional limitations are deemed not severe enough for an award after a grid determination, any nonexertional issues are taken into account. These factors are added to the applicant's vocational profile to the extent that they erode his or her ability to do work. The adjudicator must determine whether the nonexertional limitation is greater than "minimal." A failure to meet the minimal designation will result in the limitation not being considered at all in the medical determination. Finally, an application with only nonexertional limitations will be put in either the "heavy work" or "very heavy work" RFC category.

Figure 10 gives the reasons for SSDI awards between 1992 and 2008. As explained above, the third step of DI adjudication is to check whether the disability claim meets or equals an item on the Listing of Impairments. If the claim does not meet that criterion, then adjudicators consider the combination of medical condition and functional capacity to hold a job; it is here that loosened standards are applied for middle-aged workers. As can be seen, an increasing share of SSDI awards over time has been given in this medical and vocational factors category. Unfortunately, a large proportion of awards have also been given in the "other" category. The basis for the determination of these cases is not available, but the majority were allowed at or above the hearing level.

We next look at trends in the medical reasons for SSDI awards. As shown in figure 11, a much larger proportion of awards are now given because of mental illnesses and musculoskeletal diseases and problems than in the past. It is inherent in the nature of these ailments that it is more difficult and subjective to judge their extent and severity, and, as numerous cases of fraud recently discovered in New York City and Puerto Rico have shown (Social Security Administration 2014a, 2014b), these disability categories are more vulnerable to applicants gaming the system and misrepresenting their conditions. It should also be noted that legal

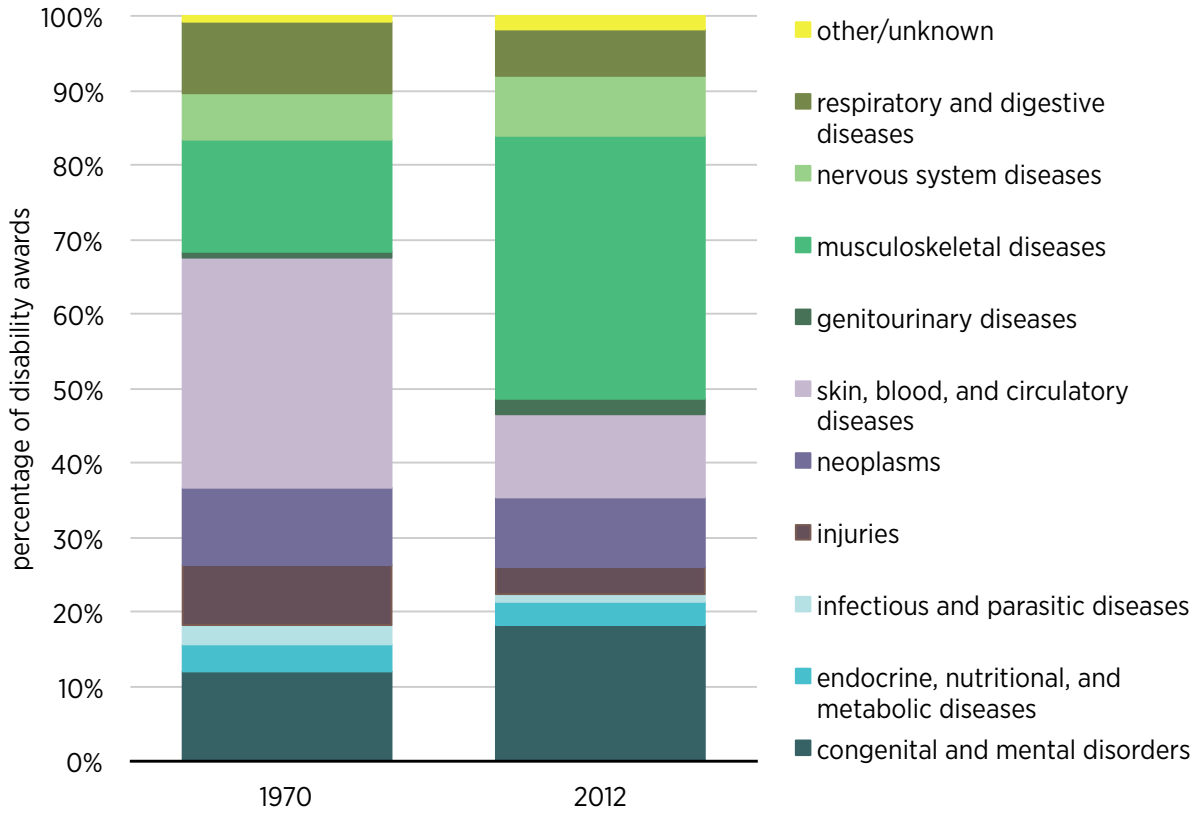
changes in the 1980s eased the standard of proof for these illnesses. Moreover, combined with the easier overall standards applied to middle-aged workers (at which ages musculoskeletal illnesses are more apt to arise), these trends and changes explain much of the increase in overall rates of DI incidence and prevalence. It is also clear that disabled workers with mental and musculoskeletal illnesses live longer than disabled workers with medical conditions more common in the past, such as work injuries; this development increases program costs.

Figure 10. Percentage Distribution of Reasons for SSDI Awards, 1992–2008



Source: Social Security Administration data.

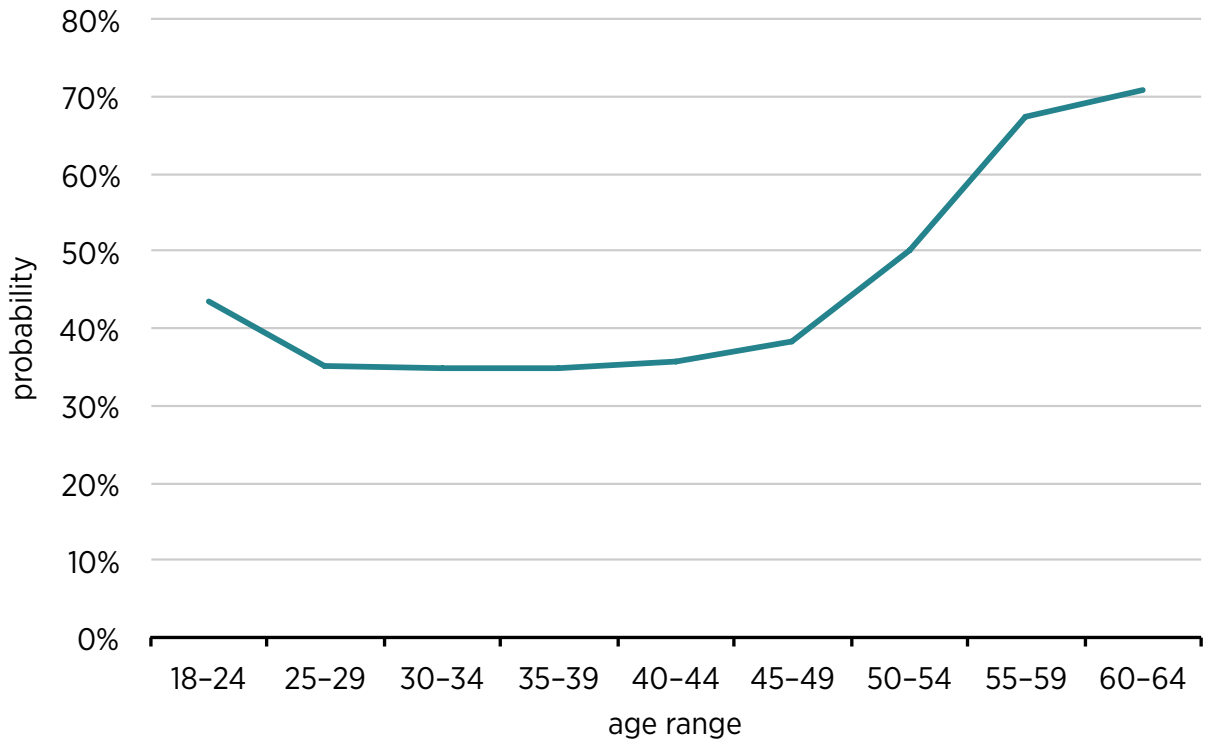
Figure 11. Distribution of Disability Awards by Medical Diagnostic Group, 1970 and 2012



Source: Social Security Administration data.

Finally, we consider formal evidence on the relationship between age and the likelihood of a claimant receiving DI benefits. Veteran SSA researcher Kalman Rupp examined internal SSA data over the period 1993 to 2008 at the initial determination stage—that is, before redeterminations and appeals before administrative judges and in federal court (Rupp 2012). Rupp controlled for various individual and environmental factors, including medical diagnosis, gender, and local unemployment rate, as well as age. The impact of age on the likelihood of getting SSDI benefits is shown in figure 12. Starting at age 45, the probability of an award to a claimant increases noticeably, from less than 40 percent at that age to nearly 70 percent at ages 60 and older. This finding is totally consistent with the grid eligibility criteria used by the SSA.

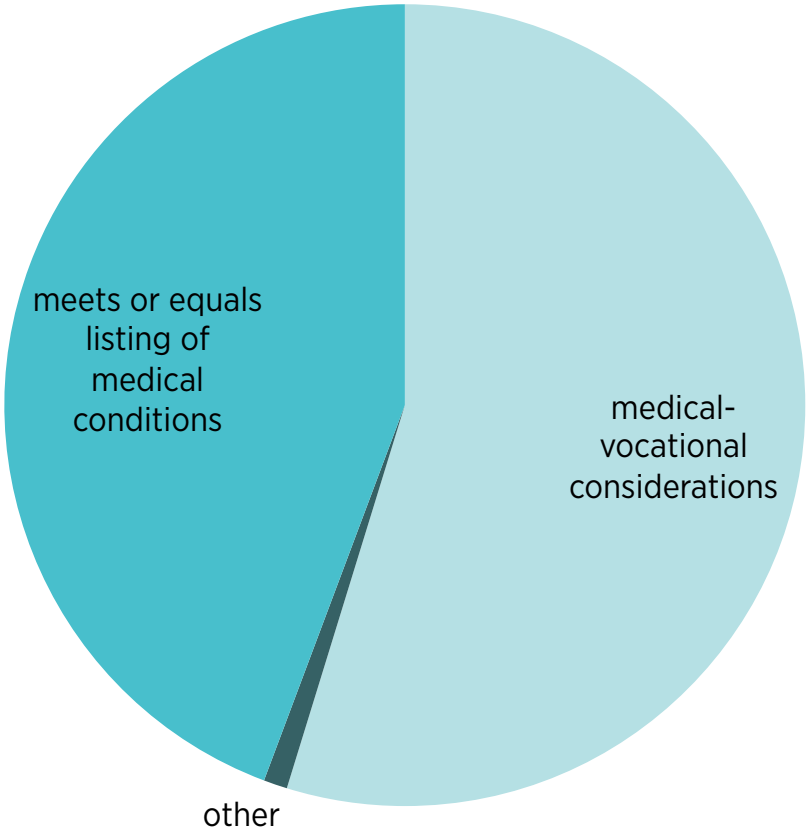
Figure 12. Estimated Probability of Initial SSDI Award by Age, 1993–2008



Source: Based on Rupp (2012).

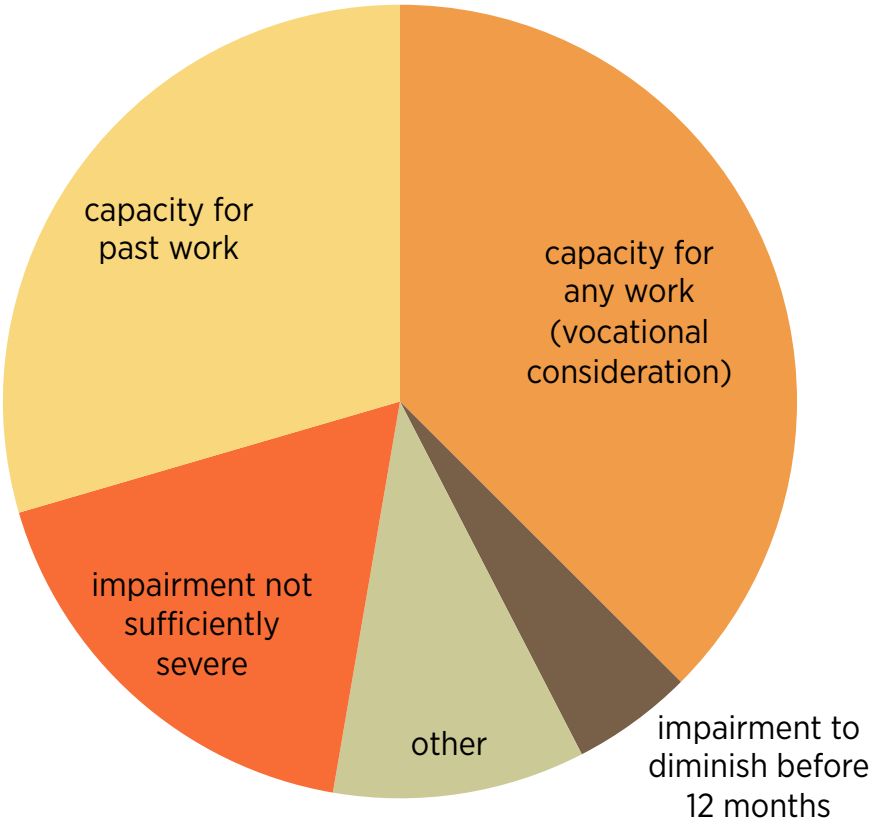
As seen in figures 13 and 14, grid determinations constituted a plurality of all initial application denials and a majority of initial allowances in 2010, according to a study by SSA researchers Wixon and Strand (2013).

Figure 13. Initial Stage Awards for SSDI Applicants by Reason of Award, 2010



Source: Bernard Wixon and Alexander Strand, "Identifying SSA's Sequential Disability Determination Steps Using Administrative Data," Social Security Research and Statistics, Note No. 2013-01, June 2013, US Social Security Administration Office of Retirement and Disability website (June 2013).

Figure 14. Initial Stage Denials for Disability Insurance Applicants by Reason of Denial, 2010



Source: Bernard Wixon and Alexander Strand, "Identifying SSA's Sequential Disability Determination Steps Using Administrative Data," Social Security Research and Statistics, Note No. 2013-01, June 2013, US Social Security Administration Office of Retirement and Disability website (June 2013).

Disability Insurance Policy Proposals

In this section, we outline how to keep the DI eligibility criteria in line with current job and disability realities. We propose that the following aspects of the five-step evaluation process be changed:

1) Currently, the medical listings are updated infrequently, meaning the same lists are used over decades. The pace at which listings are updated needs to be considerably hastened so that they take into account the latest medical and technological knowledge in a rapidly changing field. For example, the existence of scooters is not mentioned in current

regulations that evaluate people's ability to ambulate. It is only fair to taxpayers, and supportive of claimants in the long run, to provide incentives to use current assistive technologies and strategies, especially considering the continuing gains being made in their effectiveness and scope. With a currently valid listing of disabling medical conditions, moreover, we can eliminate nonlisted conditions for consideration in DI medical allowances.

2) In the fourth and fifth steps, the medical-vocational grid (considering age, education, and language skills) should be eliminated. With older working ages, healthier living, less physically stressful jobs, and a workforce that is more open and less segregated by education level and language skills, the grid is no longer fair, necessary, or reflective of current conditions. Rather, the fourth and fifth steps should change to a sole focus on residual functional capacity, combined with an evaluation of jobs available in the national economy and suitable to the claimant, without loosened standards for older, less educated, and foreign-language-speaking workers. Moreover, there should be a more modern and realistic consideration of the physical effort needed to hold most jobs in today's economy, given the changes in the nature of work and the availability of assistive technologies, even for conditions that now receive automatic benefits, such as blindness.
3) If there is a policy desire, in keeping with current law, to still provide some modest and limited consideration of age, out of concern that some may find employment accommodation to their disabilities difficult close to retirement, that could be accomplished by a slightly looser evaluation of job availability or residual functional capacity, above, say, age 60. At the same time, it is critical, whether or not this small accommodation is made, to change the current rule that converts disability benefits to

retirement benefits at the normal retirement age. The SSA actuary recognizes that this rule encourages claims of disability benefits by older workers who would otherwise take early retirement because disability benefits will give them lifetime benefits that are at least 20 percent higher than Social Security. Rather, all disability benefits should be converted to retirement benefits at the early retirement age, currently 62.

4) A complete removal of the medical-vocational grid will require legislation. As an interim step, therefore, all the ages in the medical-vocational grid should be increased by five years, which can be accomplished by regulation. This increase is roughly reflective of the increase in life expectancy since the current grid was first put in place.
5) It would be controversial to apply these new standards to workers who received disability benefits in the past based on past eligibility criteria and the expectation of a steady rule regime. So, to avoid criticism while improving the system, the new criteria should be applied only to new applicants. But it still makes sense to increase the investigative rigor and to improve the targeting of continuing disability reviews to make sure that only those who are legally disabled get benefits. In particular, the SSA should intensively examine a random sample of current beneficiaries of sufficient number to be statistically valid to determine continuing eligibility. The results of this exercise would help the SSA to better utilize the limited resources available for the continuing disability reviews, as opposed to the current approach, which is broad and tardy but relatively shallow.

Further Discussion

As further justification for changing or eliminating the medical-vocational grid, consider the following statistics about changes in life expectancy over time. According to the SSA, projected

life expectancy for average 30-year-old male workers has increased from age 74 in 1960 to 77 in 1980 and 80 currently; for average 30-year-old female workers, the comparable ages are 80, 82, and almost 85. For average 60-year-old male workers, projected life expectancy increased from age 76 in 1960 to more than 78 in 1980 and almost 82 currently; for average 60-year-old women, life expectancy increased from 82 to 83 to more than 85 over the same time period. Even in 1959 it was a stretch to call age 50 "closely approaching advanced age" (as it was in the terminology of the medical-vocational grid) when the life expectancy of workers was around 75 for men and 80 for women. Today, more than 50 years later, it is a ludicrous description when average workers' life expectancies are five and six years older, around 81 for men and 85 for women. The special use of age in eligibility criteria for disability determinations at ages 45, 50, and 55 through normal retirement, now around age 66, is increasingly outmoded and should be removed.

Over time, the nature of work has changed across the national labor force. The focus in the medical-vocational grid on the exertion level of work therefore is increasingly outmoded. According to data from the Bureau of Labor Statistics (2015), in 1994, 58 percent of workers were managers, professionals, salespeople, technicians, and administrators, 15 percent were service workers, and more than 26 percent were production workers, operators, farmers, transportation workers, and natural resources workers. By 2013, by contrast, the shares of these major occupational categories were 61 percent, 18 percent, and 21 percent, respectively. These trends, of course, originate from at least the 1960s, representing changes in the industrial composition of the economy (away from manufacturing) and greater productivity (more computerization and mechanization and less direct physical labor). Even within traditional production and transportation occupations, the nature of work has evolved, causing a reduced reliance on physical labor. Moreover, people switch jobs and occupations more readily in today's

economy than they did in the 1950s, so that flexibility is the norm and is expected. The authors of an administrative and regulatory approach that depends on occupation and a judgment of the exertional component of work lived in a different labor force and market than do today's workers.

According to the Bureau of Labor Statistics (2013),

> the share of the labor force that is foreign born grew steadily from 1996 to 2007, increasing from 10.8 percent to 15.7 percent over that period. After showing little change in 2008 and 2009, the share of the foreign-born labor force resumed a general upward trend, reaching 16.1 percent in 2012. Over the 1996–2012 period, the total labor force increased by about 21 million and more than half (about 11 million) of the increase was among the foreign born.

These trends probably date back to the 1950s, as strict immigration quotas were gradually relaxed and the enforcement of immigration rules and border controls were loosened. As a result, the United States now has a much more diverse workforce—culturally, ethnically, and linguistically—than it did in the 1950s. The use of language skills in the medical-vocational grid is not as relevant a consideration today as it might have been in the more culturally monolithic America of the 1950s—indeed, it may even be a handicap. Therefore, it should be removed.

Hwang, Xi, and Cao (2010) examine US Census data for multiple immigrant groups, and conclude that the relationship between English proficiency and economic success depends on the immigrant's choice of location. If a monolingual Spanish speaker locates in a Spanish-speaking enclave in the United States, for example, he or she will find many opportunities that aren't contingent on English proficiency. This was not the case 50 years ago; the proliferation of foreign language enclaves occurred in the closing decades of the 20th century.

Finally, as is well known, the American labor force is much more educated than it was in the 1950s. According to data from the United States Census Bureau (2015), in 1992, 12 percent of workers above age 25 had less than a high school education while almost 27 percent had at least a bachelor's degree. By 2014, these shares had changed to 8 percent and 38 percent, respectively. In

the 1950s, having a college degree was relatively uncommon and represented a real and permanent advantage in the labor market. Therefore, it might have been reasonable to assume that even with some level of disability and aging, well-educated workers would be advantaged enough to find work. Now college degrees are common and no longer the advantage they once were. As proof, college graduates trying to enter the labor force were hit hard in the recent recession. The opposite is also true. If someone has been in the labor force for decades, even with only a high school education, one may presume that on-the-job and vocational training and years of experience and hard work give that worker skills and talents valuable in the labor force. It is hard to understand the justification for the discrimination in the medical-vocational grid based on educational attainment in the context of today's economy; this factor should be eliminated.

As indicated above from the Rupp study, a strengthening of the eligibility criteria for middle-aged workers will substantially reduce the incidence of disability claims by lowering the approval rate for disability claims in that age group by as much as 30 percent. It may also slightly increase the termination rate as awards for musculoskeletal ailments decline. These changes will naturally improve the long-range finances of the DI Trust Fund. If the SSA actuary determines that these changes in eligibility criteria, combined with the others we advocate, are not timely enough to produce sufficient cash flow to avoid the bankruptcy of the DI system in 2016, then a temporary borrowing of funds from the OASI Trust Fund should be allowed, on a year-by-year basis, and then paid back with interest.

Conclusion

The Disability Insurance program was designed for a different economy from the one the United States has today. It has been allowed to grow without sufficient limit, damaging the work ethic of

this country and its government's finances. The program needs the substantial reforms that we have proposed to make it fair, modern, and sustainable into the future for those workers who need it most.

A DI program for the 21st century must ensure that social and technological changes are taken into account during the process determining eligibility. Arguably the most important consequence of technological development over the past half-century has been the explosion in workplace productivity. This growing opportunity cost means that more value that could have been created and exchanged will be *forgone* if a worker is unnecessarily excused from the labor force.

The economic costs of not reforming this outdated system are large. Ultimately, though, it is the worker that bears the greatest cost of an unnecessary disability decision. Prominent psychologist Martin Seligman of the University of Pennsylvania and his colleagues demonstrated in a 2004 study through experimental evidence that the "learned helplessness" that comes with the perception of powerlessness in the face of hardship is associated with depression and an inability to perform even ordinary tasks (Abela 2004). The disability determination process should prevent such learned helplessness by incentivizing work for those capable of it. Eliminating arbitrary, outdated factors from grid consideration will expand labor participation in the economy at a time of historically low participation. It will also mean an expanded taxation base at a time when revenues need to be enhanced. In short, ensuring that able workers continue to have a stake in the free enterprise system will benefit both the workers and society at large.

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