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CHAPTER 24

SOCIAL SECURITY DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME

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1 INTRODUCTION

SOCIAL Security Disability Insurance (DI) and Supplemental Security Income (SSI) are the foundation of the social safety net for Americans with disabilities. Both provide cash benefits, and because neither program is limited to specific impairments or to workers in particular occupations, as is the case with many public and private disability plans, they are broadly accessible to the American people and the most expensive of the nation's disability benefit programs. Excluding expenditures for health care, DI and SSI combined account for almost three-quarters of annual federal spending on the disabled (U.S. GAO 1999).

Disability benefits policy, though, has long been fraught with controversy. Conservatives have resisted broad income support for disabled workers, preferring, instead, workplace accommodations and limited public assistance. On the other hand, bureaucrats, the federal courts, and interest groups have been instrumental in expanding both social insurance coverage and public assistance to the disabled. As a result of their concerted efforts, DI and SSI have grown irrespective of which party controlled the White House or Congress. Today no other disability benefits program comes close to rivaling them, regardless of whether the measure is persons enrolled or dollars spent. Expansion, however, is not the same as largess, because, despite dramatic growth in DI and SSI since their enactment, poverty and unemployment still remain prevalent among Americans with disabilities.

2 ORIGINS AND DEVELOPMENT

The evolution of Social Security disability benefits policy can be divided into two eras, both of which featured growth in enrollment and program spending. During the first era, between 1935 and 1972, conservatives in Congress sought to limit federal power over the Southern political economy, which was premised on racial segregation and a steady supply of cheap African-American labor. This meant constraining liberal efforts to enact broad income-support guarantees for the nation's poor and disabled, programs that would lift the living standards of African Americans. By the late 1960s, the civil rights movement had brought down formal racial hierarchy in the South and weakened the power of conservative Democrats in Congress, and once disability benefits were created, lawmakers broadly supported expansion. During the second era, new ways of thinking about disability and social-welfare obligations raised challenges for the nation's disability policy. Rather than seeking an expanded social safety net, recently mobilized disability rights activists lobbied for civil rights protections that would open access to mainstream social institutions, including the workplace. The emphasis on work rather than welfare complemented conservative attempts to rein in social spending. Since 1972, lawmakers have sought to tighten eligibility for disability benefits while expanding job accommodations and work incentives, efforts that have largely failed to enhance employment among the disabled (this section relies heavily on Stone 1984; Berkowitz 1987; Quadagno 1988; Derthick 1990; Quadagno 2005; and Erkulwater 2006).

In the 1930s, lawmakers recognized the severe hardships endured by workers with impairments, but they were deeply divided over whether the federal government or the states should take primary responsibility for the disabled and whether aid should take the form of cash benefits. Lest these programs develop into income support programs for people with a vast array of disadvantages, lawmakers were willing to compensate only medical reasons for unemployment, not social ones. Yet they knew that drawing the line between medical and social handicaps would be exceedingly difficult. Thus, the Social Security Act of 1935 did not provide pensions for disabled workers. Instead, it provided matching grants to the states for programs that would offer cash assistance to senior citizens, persons with blindness, and single-parent families living in poverty. These programs—Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to Families with Dependent Children (AFDC)—left states in charge of aid to the poor and ameliorated the concerns of Southern Democrats seeking to safeguard local control over black labor.

Nevertheless, shortly after World War II, with the basic Old Age and Survivors Insurance (OASI) program in place, officials at the Social Security Administration (SSA) made extending coverage to disabled workers and their families a top priority. However, experience with private insurance and veterans' pensions had taught policy-makers that disability was an inherently expansive administrative category, particularly during economic downturns. When jobs were scarce, even for the fittest of workers, administrators and judges took pity on down-and-out workers and stretched narrow definitions of disability, thus converting benefits reserved for the severely disabled into general compensation programs for the unemployed. To assuage wary members of Congress, SSA officials decided to start small. In its recommendations for the 1950 amendments, the Social Security Advisory Council dropped plans for covering temporary impairments and instead proposed a definition of disability that would encompass only permanent and severe physical or mental conditions that could be verified by medical examination. The program, however, immediately became entangled in the battle over national health insurance. The American Medical Association (AMA), Republicans, and conservative Democrats opposed disability benefits, fearing that they represented the entering wedge for greater federal intrusion into health care. In the face of steep opposition, Congress voted instead to create Aid to the Permanently and Totally Disabled (APTD). Like OAA, AB, and AFDC, APTD matched state spending on public assistance programs for the disabled, but it left each state free to set its own benefit levels and write its own legal definitions of disability.

Although conservatives regarded APTD as sufficient, liberals viewed the program as only the beginning. For the next 6 years, SSA officials worked tirelessly to bring disability benefits to fruition through piecemeal initiatives. In 1952, they proposed allowing a worker to "freeze" wages at the onset of a disability and then, upon reaching retirement age, receive benefits based on predisability earnings rather than the reduced earnings brought about because of the disability. Two years later, liberals succeeded in getting the disability freeze enacted into law. To appease the AMA and its congressional allies, lawmakers hammered out a compromise, which stipulated that, although SSA field offices would take initial applications for the freeze, the actual examinations of disability status would be made by designated state agencies operating under guidance from the SSA. Private physicians, not government doctors, would provide the medical documentation that state disability examiners needed. Although he objected to cash benefits for disabled workers, President Dwight Eisenhower did not oppose the freeze, which was similar to provisions in many private disability insurance plans. Moreover, Secretary of Health, Education, and Welfare Oveta Culp Hobby and assistant secretary Roswell Perkins believed that the freeze could serve as a conduit for channeling workers into the growing number of state vocational rehabilitation programs (Derthick 1979; Berkowitz 1987).

As soon as they had secured the freeze, SSA officials girded for a showdown over cash benefits. The AMA, the Chamber of Commerce, the private insurance industry, and congressional conservatives in both parties remained staunch opponents. SSA officials, however, pitched cash benefits as an early retirement pension for older workers with impairments. They argued that, because of their advanced age, these workers would have a difficult time learning new skills or adapting to a new occupation, making permanent withdrawal from the workplace appropriate. Officials succeeded in mollifying private insurers, who were not interested in covering older workers and simply wanted to safeguard their market among younger workers. Labor unions threw their organizational might behind disability benefits, and in 1956, Disability Insurance eked through the Senate by only a single vote (Quadagno 2005). The final version of the program adopted the state-run process for determining disability that had been established in 1954, and limited eligibility to workers aged 50 and over with severe and permanent impairments. Yet the program's restrictiveness, so crucial to its passage, undercut the goal of linking Social Security to rehabilitation. Because older workers made poor candidates for rehabilitation, the SSA failed to develop a close working relationship with rehabilitative services, even after younger workers became eligible for benefits in 1960.

Once DI was established, it ceased to be controversial and soon underwent a period of rapid growth. Throughout the late 1950s and the 1960s, Congress repeatedly made the program more generous: extending benefits to the disabled children and survivors of qualified workers, dropping the requirement that a worker had to be 50 years old to qualify for benefits, reducing the waiting period for benefits from 6 months to 5, and allowing benefits for impairments that, although not permanent, were expected to last at least a year. In addition, disability benefits became a form of constituency politics, as lawmakers frequently questioned SSA officials about why it took so long for the agency to process claims and why seemingly disabled claimants were denied benefits.

In the 1960s, changes in federal–state relations upended prevailing assumptions about welfare policy and opened the door to further expansion of disability benefits. The civil rights movement weakened the power of Southern Democrats in Congress, and the migration of the African Americans to the North and Midwest, where public assistance programs were administered more liberally than in the South, contributed to steeply rising welfare costs. Long defenders of local control of public assistance, conservatives lost faith in the ability of the states to properly manage the matching grant programs (Quadagno 1988). In 1969, President Richard Nixon proposed transferring responsibility for the state programs to the federal government and creating nationally uniform benefit levels and eligibility criteria. The adult programs for the aged, blind, and disabled would be rolled into one federal cash benefit program called Supplemental Security Income, and AFDC would become the Family Assistance Plan, open to all poor families.

AFDC quickly became embroiled in a bitter debate over whether Congress should provide the able-bodied poor, many of whom were African American, a minimum level of income support, but since neither the aged nor disabled were expected to work, SSI was less controversial. In 1972, lawmakers added it to a landmark bill that substantially raised Social Security benefits, indexed them to inflation, and made disabled workers eligible for Medicare. SSI represented an historic expansion of federal aid to the poor, especially the mentally ill, who, up until this point had been cared for at state expense in public hospitals and asylums, and disabled children, who had previously qualified for state assistance programs only if they were blind or crippled. Nevertheless, SSI sailed through Congress precisely because lawmakers expected the program to serve primarily the aged poor rather than the disabled poor. They had hoped that creating a means-tested supplement to Social Security would provide an adequate pension for low-income retirees, and they simply extended that guarantee to low-income people with disabilities with little thought given to the fact that the disabled clientele that SSI would aid would be far different from the older workers the SSA was accustomed to serving. Many had worked little, if at all, prior to enrolling in SSI, and their barriers to gainful employment were as much social as they were medical in origin (Erkulwater 2006).

The 1972 amendments marked the beginning of turmoil for DI and SSI as conflicting pressures to expand eligibility but also promote employment buffeted the programs. Throughout the early 1970s, DI and SSI experienced rapid and unexpected growth. Congressional and SSA studies indicated several reasons for this, including high levels of unemployment; declining stigma associated with disability and dependence on public assistance; high benefit levels relative to wages; and a growing backlog in claims, which created pressure for examiners to adjudicate claims quickly and led to rushed and sloppy evaluations. In 1980, President Jimmy Carter and a Democratic Congress enacted a set of amendments to slow program growth. In addition to reducing and capping DI benefits for younger workers, the bill expanded work incentives—for example, by increasing the length of time during which a beneficiary could work but then return to the disability rolls should employment prove impossible to maintain. The most significant provision of the 1980 amendments, however, was its mandate for continuing disability reviews. To strengthen program integrity, the amendments called for the SSA to conduct a review of every disabled beneficiary's status at least once every three years, unless the beneficiary suffered from a permanent impairment. Prior to this, the SSA reviewed a beneficiary's medical status only if the agency expected his or her medical condition to improve or if the individual had returned to work.

When President Ronald Reagan entered office in 1981, his administration greatly accelerated the reviews, using them as a pretext for removing hundreds of thousands of beneficiaries from DI and SSI. Rushed and poorly implemented, the disability reviews created a political firestorm that emboldened antipoverty and disability advocates. They filed hundreds of lawsuits challenging the legality of the rules the SSA used to deny benefits, and SSA hearing officers and federal judges overturned thousands of denials. Members of Congress excoriated the reviews in more than two dozen hearings between 1982 and 1984. Critics charged that the SSA had secretly tightened the standards of disability, that it was terminating benefits despite little evidence that beneficiaries' medical conditions had improved, and that the criteria for assessing mental impairments were far too restrictive and out of touch with current medical practice. Above all, critics objected to the heartlessness of the enterprise, noting that many individuals who had lost benefits had been on the rolls for years before being cut from their primary form of income support with little warning and after only perfunctory reviews of their medical status.

What also made the disability reviews difficult for the Reagan administration to maintain was the fact that medicine was moving in the opposite direction, toward an expansive understanding of impairment. In 1980, the American Psychiatric Association (APA) amended its diagnostic manual to recognize more mental disorders and to include fuller descriptions of the behaviors and functional limitations associated with these disorders. Psychiatrists also adopted an expansive understanding of mental illness that treated behavior that departed from statistical or social norms as possible indicators of a disorder. Similarly, by the 1970s, pediatricians began treating learning and behavioral problems in children as medical impairments rather than "bad behavior." Medical professionals, put simply, came to accept something that SSA officials had long known—that the boundary between medical and social reasons for one's inability to work or otherwise function was blurry at best. Assessing an impairment could not be done in isolation from assessing the environment in which a person functioned and societal expectations about what constituted "normal" behavior and abilities (Erkulwater 2006).

The diagnostic revolutions in psychiatric and pediatric medicine coupled with widespread outrage over the reviews led to sweeping changes in the administrative rules determining disability, in turn greatly altering the face of the Social Security disability rolls. With the SSA's disability process in disarray, Congress passed and Reagan signed the 1984 Disability Benefits Reform Act. The law significantly liberalized the standards of disability by, among other things, requiring that the SSA prove an individual's medical condition had improved (which is difficult to do) before determining that he or she was no longer disabled, requiring that the SSA evaluate the combined effect of multiple impairments rather than automatically denying benefits when no single impairment was severe enough to meet the legal standard of disability, and compelling the agency to rewrite its rules governing the evaluation of mental disorders with input from mental health professionals and advocates (Berkowitz 1987; Derthick 1990; Erkulwater 2006).

In 1985, the SSA released revised rules for evaluating mental impairments in adults, and 6 years later, a revamped series of rules for childhood disabilities. Whereas in the past, disability examiners had placed a great deal of emphasis on tangible or objectively verifiable signs of an impairment—a missing limb or diseased heart, for instance—the new rules required examiners to conduct a thorough assessment of whether a claimant could actually find and keep a job. Examiners had to consider a person's history of employment, assessments of his or her functioning, and even the presence of symptoms, like pain or depression, that could prevent work even if they were not objectively verifiable. In sum, the SSA adopted disability criteria that recognized a broader number of medical conditions, included more exacting descriptions of these conditions, and took into account the functional impact of impairments, resulting in a more thorough but, also, more expansive interpretation of disability (Erkulwater 2006).

The reforms brought an end to the upheaval caused by the disability reviews, but they did not end the contentiousness between the SSA and antipoverty advocates. If anything, resolution of the reviews brought new challenges to the SSA. During the 1980s, advocates came to appreciate the fact that, as one of the few national programs providing cash support to the disadvantaged, DI and SSI were central to the economic well-being of low-income groups. Groups as diverse as Legal Services, the APA, the American Academy of Pediatrics, the Arc, the Children's Defense Fund, the Bazelon Center for Mental Health Law, the National Law Center on Homelessness and Poverty, and the National Senior Citizens Law Center supported expansion of disability benefits. Over the next decade, advocates challenged virtually every SSA rule in an effort to pry DI and SSI open to more of the disabled, and they found ready allies among federal judges, who came away from the disability reviews with little regard for the SSA.

No single case illustrates the power of litigation in making disability benefits more accessible than *Sullivan v. Zebley* (1990). Prior to *Zebley*, the SSA determined whether a child was disabled by looking only at the severity of the child's medical condition with little attention to the way in which the child's condition affected his or her functioning. The agency argued that this approach was necessitated by the fact that the standard of disability used for adults was inappropriate for children. That standard assessed whether an adult had the functional capacity to remain employed, yet it could not be applied to children because children did not engage in paid work. Advocates, however, asserted that the SSA's childhood disability standard did not comport with the way in which medical professionals assessed children, and the Supreme Court in *Zebley* agreed. In a 7-2 decision, it ordered the SSA to devise an evaluation that considered whether a child functioned in an "age-appropriate" manner across a range of activities, such as school, daily self-care, play, and social relationships—activities that the Court deemed the "work" of children. These revisions made SSI accessible to children with a range of developmental delays and learning, mood, and behavioral disorders and led to an explosion in the number of children in the program (Erkulwater 2006).

Yet at the same time that disability rolls were growing, the rise of the disability rights movement called into question the assumption that people with disabilities were incapable of work and, therefore, automatically entitled to publicly provided income support. In the late 1960s, activists influenced by the civil rights movement objected to the exclusion of the disabled from workplaces, schools, and public spaces, and they rejected as prejudicial the compassion and pity that able-bodied members of society felt toward the disabled. The reason people with disabilities did not work, activists argued, was not because they were inherently incapable of doing so, but because the able-bodied discriminated against them and erected barriers, architectural and social, to their participation in paid work. Unlike previous groups representing the disabled, these new activists were not interested in more money or more services for the disabled; instead, they demanded that people with disabilities be fully integrated into mainstream society as a matter of right (Scotch 2001).

The early 1990s featured conflicting pressures in disability policy. The disability rights movement culminated in the enactment of the Americans with Disabilities Act (ADA) in 1990. The law sought to increase the employment of the disabled by banning discrimination and mandating that employers make reasonable accommodations for their disabled employees. The ethos of disability rights spilled over into Social Security as well. Since 1980, Congress has enacted a number of initiatives to encourage beneficiaries to return to work, including trial work periods, extended eligibility for Medicare or Medicaid, and a disregard of earnings and disability-related work expenses. However, no matter how much Congress tinkered with disability benefits, lawmakers could neither appease disability rights activists nor convince large numbers of the disabled to trade welfare for work. To many activists, social-welfare programs like DI and SSI were inherently flawed because they were premised on the belief that people with disabilities could not be productive citizens. For many people with disabilities, however, the ADA and work incentives were not sufficient to maintain employment, and DI and SSI continued to expand despite the passage of the ADA.

By 1993, rapid growth engulfed both programs in bitter controversy. SSI in particular became an easy target for budget-cutters in both political parties following escalating costs and media claims that the program was rife with fraud and abuse. In 1996, Democratic President Bill Clinton and a Republican Congress agreed to a major welfare reform bill that curtailed eligibility for AFDC, renamed Temporary Assistance for Needy Families (TANF), but realized most of its cost savings through cuts in SSI and Medicaid. The bill overturned *Zebley* by tightening SSI's disability standard for children, removed alcohol or substance abuse as a qualifying disability for DI or SSI, and made legal immigrants ineligible for a range of safety-net programs.

Welfare reform, however, did not put an end to Congress' efforts to tighten Social Security disability benefits and encourage the disabled to work. In 1999, lawmakers authorized Ticket to Work (TTW), yet another effort to assist working-aged DI and SSI beneficiaries trying to re-enter the workplace. Under TTW, beneficiaries can choose from a network of service providers that offer vocational rehabilitation and on-going employment support. While making the transition to work, they can keep Medicare or Medicaid coverage for an extended period of time, and for the first 9 months, can keep all earnings in addition to disability benefits. Meanwhile, the SSA will suspend its periodic review of beneficiaries' medical status and resume payment of disability benefits should earnings ever fall below $1,000 a month over the next three years.

Nonetheless, these measures did little to boost employment among people with disabilities or arrest growth in the number of applications filed for DI and SSI benefits. Instead, the job accommodations and protections of the ADA benefited the most advantaged of the disabled. Compared to their counterparts who were not employed, individuals who worked despite their disabilities were more likely to hold a college degree and to work in positions offering private health-care coverage (Russell 2002; Findley and Sambamorthi 2004). Yet for the vast majority of people with disabilities, the employment rate and earnings fell in the 1990s, and poverty rates climbed, even during the latter half of the decade when the economy expanded and poverty rates among able-bodied working-aged people plummeted (Stapleton, Burkhauser, and Houtenville 2004).

The 2000s were marked by several years of slow job growth followed by the Great Recession of 2007–2009, which hurt all workers, especially those with low levels of education. Workers with disabilities, however, were devastated. Although highly educated workers with disabilities were more likely to be employed compared to their disabled counterparts with less education, educational attainment did not afford the same protection against job loss that it did for able-bodied workers. At every level of educational attainment, disabled workers were more likely than their counterparts without disabilities to suffer unemployment and long spells of joblessness. Once the recession ended, the disabled remained less likely to work or to look for work than the able-bodied, and when they did work, they earned less and were more likely to be underemployed—that is, working at low wages or part-time jobs, even when they desired full-time employment (Fogg, Harrington, and McMahon 2010; U.S. Census Bureau 2011). Between 2009 and 2010, compared to households without a working-aged adult with a disability, households of the disabled experienced steeper declines in real median income and sharper increases in poverty (U.S. Census Bureau 2011).

The weak job market exacerbated fiscal pressures on DI. Between 2000–2012, the number of applications filed for DI and SSI doubled from 2.7 million to over 5.5 million (SSA Office of the Chief Actuary, 2013; Table 69, SSA 2013a). Although the share of DI applications approved for benefits has dropped from 47 percent in 2000 to 35 percent today, because claimants file so many applications, the ratio of awards to workers has skyrocketed from 4.6 benefit awards per 1,000 workers in 2000 to 6.8 today (Table 6. C7, SSA 2013b). As a result, between 2005–2013, the SSA paid out more in benefits to disabled workers than it was taking in payroll-tax contributions, resulting in a predicted shortfall in the DI trust fund by 2016 (Board of Trustees 2013).

3 A PRIMER

DI and SSI are administratively complex programs that defy easy generalizations. Although the programs use nationally uniform rules, claimants are by no means treated uniformly. Furthermore, although SSI was intended to supplement DI, it has evolved into both a safety net for the most disadvantaged of the poor and transitional assistance for impaired workers trading paychecks for disability checks. Yet, because paid employment is the primary form of income support for disabled and nondisabled alike, neither program fully compensates for the economic adversities brought about by disablement.

3.1 Eligibility and Enrollment

DI's program for workers and SSI's program for adults use the same definition of disability and the same process for determining disability. According to the Social Security Act, in order to qualify for benefits, a person must be unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." Not only must the disability examiner decide that the claimant cannot return to his previous job, but he must also agree that the claimant cannot perform any other job given his age, education, and work experience. Because children do not engage in paid employment, the SSA uses a different standard for children applying to SSI. They must demonstrate "marked and severe functional limitations" that last at least a year. The widows, widowers, and adult children of covered workers can also qualify for DI if disabled, although the disability standards for widows and widowers are stricter than those for workers or SSI recipients.

In addition to meeting the disability standard, applicants for DI must also satisfy an earnings test, whereas applicants for SSI must meet an income or means test. The earnings test for DI examines both how recently and how long the applicant worked before filing for benefits. In general, individuals filing for DI must have worked at least half of their adult life before filing for benefits. During this time, claimants are required to make contributions, paid as payroll taxes, to the DI trust fund.

Because SSI is a program of last resort, claimants must show that they have inadequate income and assets and that they have applied for other assistance programs for which they might be eligible. To qualify, a claimant's monthly income must not exceed SSI's income limit, which is equal to twice the maximum monthly benefit. This income limit is adjusted with inflation over time, so that, in 2012, individuals wishing to enroll in SSI had to show an income of no more than $1,396 per month. The limit for couples was $2,096. Because SSI excludes some of a claimant's earnings when calculating income, a claimant can receive SSI even though his or her family income exceeds the federal poverty line.

The Social Security Act's definition of disability is a strict one. Using a different definition of disability, the Census Bureau estimates that 54.4 million individuals in the United States are disabled, and two-thirds of these suffer from an impairment severe enough to limit daily activities (Brault 2010). However, because the programs are restricted to people with severe disabilities and because they include the earnings test or means test, taken together, DI and SSI pay benefits to only 13.7 million people with disabilities. Of the nearly 9.4 million individuals DI covers, almost 9 in 10 are disabled workers, and the rest are the disabled widows, widowers, or adult children of covered workers. SSI, on the other hand, is a smaller program, enrolling 5.4 million adults and 1.4 million children with disabilities (Table 7.A1, SSA 2013b; Chart 12, Table 65, SSA 2012; Tables 3 and 17, SSA 2013a).

Even though the two programs share the same definition of disability, SSI recipients are not simply DI beneficiaries, only poorer; rather, they tend to suffer from different types of disabilities. The most common impairments among SSI recipients are intellectual disabilities (formerly called "mental retardation") and mental disorders, which afflict nearly three out of five recipients. By contrast, only one-third of DI workers qualify based on a mental impairment. Instead, the most common impairments are musculoskeletal disorders, including chronic pain and repetitive stress injuries (Table 35, SSA 2013a; Table 68, SSA 2012).

At any given point in time, the overlap between DI and SSI is small, but over time, the overlap is substantial because SSI is both a bridge between employment and public support and a major source of income support in its own right. Originally, lawmakers expected SSI to supplement low Social Security payments, but only 1.4 million individuals receive concurrent benefits. By contrast, roughly 4.5 million recipients rely on SSI as their sole source of income support (Table 3.C6.1, SSA 2013b). Nevertheless, SSI serves as a key resource as claimants move from the workplace to the disability rolls. Although few remain dual beneficiaries for an extended period of time, over any given 5-year period, up to one-quarter of disabled claimants receive both DI and SSI, often relying on

SSI and then transitioning entirely to DI once the 5-month waiting period for workers' benefits elapses (Rupp and Riley 2011).

3.2 Benefit Levels, Expenditures, and Financing

Both DI and SSI are budgetary entitlements, meaning that individuals who meet the programs' means-test or contribution requirements and disability standard are entitled to full benefits absent congressional changes to the rules of eligibility or the formula used to calculate payments. To finance DI, covered workers and their employers each pay a tax of 0.9 percent on a wage base. Adjusted for inflation each year, this wage base stood at $113,700 in 2013. The amount of benefits a worker receives corresponds to his or her past earnings. In 2012, monthly benefits for DI workers averaged $1,130, and the program paid out a total of $136.9 billion in benefits to workers and their disabled spouses and children (Tables 4.A4 and 5.A1.2, SSA 2013b).

Funded through general revenues, SSI is a smaller program. In 2012, disabled adults enrolled in SSI received an average of $536 per month, whereas children received a mean benefit of $621. Together, SSI's annual costs for disability benefits in 2012 were $44.1 billion (Tables 7.A1 and 7.A4, SSA 2013b). Because DI is self-financing, the need to keep predicted benefit payments in line with payroll-tax revenues limits the program's capacity for expansion. SSI, on the other hand, faces no such limit to its expansion, though rapid program growth invites congressional scrutiny.

3.3 The Administrative Structure

Early supporters of Social Security distinguished it from public assistance by pointing to its uniformity throughout the nation. Under public assistance, eligibility and benefit levels could and often did vary widely from one region to the next. Social Security, on the other hand, sought to treat beneficiaries the same, regardless of place of residence. Yet uniformity is more descriptive of Social Security's retirement pension than its disability programs, where there has always been a great deal of variation between states and levels of review.

A major source of disparity is the decentralization of the disability determination process. Although SSA field officers take the application for disability benefits, examiners for state agencies conduct the initial determination of disability. They also perform the continuing disability reviews, in which once every three years, the SSA re-examines the medical condition of beneficiaries to ensure that they are still disabled. Although the SSA pulls cases for review, state examiners decide whether the beneficiary's medical condition has improved enough for him or her to work. When making both their initial and review determinations, examiners rely heavily on the records provided by third-party treating physicians or, in some cases, consulting physicians hired to conduct independent assessments of a claimant's medical condition.

The SSA provides examiners with guidance, but wide differences between states remain. At first glance, these differences appear regional. State examiners in the Mississippi Delta and Appalachia regions consistently turn away a larger share of applicants than elsewhere. Yet these states also have high application rates, high incidences of functional limitations in the working-age population, and chronic underemployment and poverty. After controlling for the demographic, health, and economic characteristics of states, the Southern and Appalachian states are no longer distinctive, though state variations in disability outcomes persist (McCoy, Davis, and Hudson 1994; Strand 2002; Social Security Advisory Board 2006; Brault 2010).

The multilayer appeals process introduces additional fragmentation and variability. Two-thirds of beneficiaries enter the disability rolls at the state level. Unfavorable state decisions can be appealed to an administrative law judge (ALJ) in the SSA's Office of Disability Adjudication and Review. The ALJ's review is not bound by the findings of the state examiners, and by this stage, claimants generally secure legal representation. If the claimant is unhappy with the ALJ's decision, he or she can appeal the case to the SSA's Appeals Council, the final step in the administrative review process. Claimants who have exhausted administrative review can then appeal to the federal courts. At the initial state level, disability examiners award benefits to one-third of applicants, but on appeal, three-quarters of cases are awarded benefits. This provides denied claimants strong incentives to appeal initial denials, if they can afford to hire a lawyer and weather the protracted process. Yet fewer than half of all denied claimants appeal their decision beyond the state level. Thus, how successful claimants are often depends on how doggedly they pursue their cases (Coile 2003/2004; Social Security Advisory Board 2006; Tables 60 and 62, SSA 2011).

3.4 The Impact on Economic Well-Being

Disability is a pervasive contributor to poverty and insecurity. In 2010, 28 percent of working-aged individuals who were disabled lived below the poverty line, a rate that was more than twice that of the nondisabled. Half of all working-aged adults who live below the poverty line for at least a year suffer from a disability, whereas 2 out of every 5 families that are poor have a member with a disability. In 2010, the median income for households in which at least one working-aged member reported a health problem that limited functioning was only $25,550, compared to $58,736 for households in which no one suffered such restrictions (Fremstad 2009; U.S. Census 2011).

Because African Americans are vulnerable to disability and poverty, Social Security disability benefits are important forms of income support for them. Relative to whites, blacks are more likely to live below the poverty line, to be unemployed, to earn lower wages over their lifetime, and to suffer from poor health. Because DI benefits are based on past earnings, DI does not rectify disparities in income across racial groups. However, because their incidences of disability are higher and lifetime earnings are lower, blacks receive higher benefits relative to taxes than do whites, and they are overrepresented on the disability rolls. Although 13 percent of the working-aged population in 2010 was African American, blacks comprised 18 percent of DI enrollment. Similarly, although most SSI recipients are white, African Americans represent 28 percent of the adults and 46 percent of children enrolled in SSI (U.S. GAO 2003; Rupp et al. 2005/2006; Table 3. C7b, SSA 2013b).

DI and SSI do much to ameliorate the hardships associated with disability and poverty, but they do not meet the full measure of need. Without them, almost one-fifth of DI workers and half of adults and children enrolled in SSI would live below the poverty line. For half of all disabled workers, disability benefits comprise 75 percent or more of total personal income (Koenig and Rupp 2003/2004; Social Security Advisory Board 2006; Strand and Rupp 2007). However, maximum federal SSI payments equal only 75 percent of the poverty threshold for individuals and 90 percent for couples.

To makes ends meet, households with a disabled member must supplement disability payments with other sources of income, the most important of which is earnings from employment, and, consequently, poverty rates vary dramatically depending on family or household situation (Strand and Rupp 2007). Among households with a disabled member, earnings account for one-third to one-half of total income, but because families with two parents are better able to take advantage of employment opportunities than families with a single parent, only one-quarter of families receiving SSI that are headed by a couple live below the poverty line. Likewise, couple-headed families receiving SSI are over 3.5 times more likely to live 200 percent above the poverty line than single-parent families. By contrast, single-parent households are more likely to live in deep poverty (below 50 percent of the poverty line) and to remain poor even after taking into account disability payments because they are poorly positioned to take advantage of paid employment (Koenig and Rupp 2003/2004; Kearney, Grundmann, and Gallicchio 1994, 1995; Rupp et al. 2005/2006; DeCesaro and Hemmeter 2008).

Disability, therefore, is a disadvantage that DI and SSI mitigate but do not eliminate. Because earnings constitute the primary source of income for Americans regardless of their disability status, individuals who are disadvantaged in the labor market—because of their medical condition, their family situation, or some other reason—will face lower incomes than those who are not. Even after taking disability benefits into account, poverty rates for the disabled in the U.S. are higher than in Western Europe, Australia, and Canada, where income support guarantees are broader (Fremstad 2009).

4 CHANGE AND CHALLENGES

When lawmakers enacted DI in the 1950s, they expected the program to aid mostly workers with age-related infirmities, like heart disease and arthritis, or severe impairments in mobility. Yet today's beneficiary is a far cry from that which lawmakers envisioned; not only is he younger than disabled beneficiaries of the past, but he is also more likely to suffer from mental, behavioral, or musculoskeletal impairments that can be difficult to measure and verify. Although policy-makers have sought ways of integrating employment with income support, as the plights of disabled children and the able-bodied poor illustrate, meeting the contemporary challenges of disability policy requires thinking beyond disability benefits and disability rights.

4.1 Transitions to Adulthood for Disabled Children

Many childhood disorders are neither totally nor permanently disabling, and this is particularly the case with deficits in cognition, emotional control, or behavior—the most common childhood impairments. Indeed, with proper care, some impaired children will eventually "catch up" with their age peers or learn to adapt to their disorders. The least functionally impaired of disabled children might even go on to lead economically productive lives as adults (U.S. Surgeon General 1999; Erkulwater 2006). Adequately preparing disabled children for adulthood, however, requires that SSA administrators track children as they mature and offer support services to those who are capable of eventually moving from SSI to employment. Yet because the SSA has its hands full simply conducting initial determinations of disability in a timely manner, re-evaluation and referral to support services rarely occur once a child enrolls in SSI (Wen 2010).

Without follow-up and support, teenagers enrolled in SSI as young children face a rocky transition to adulthood. Many are reluctant to accept part-time work even though they are able because SSI benefits provide a crucial and reliable source of income for their families. But because the adult and children's standards of disability are not the same, growing up on SSI does not guarantee growing old on SSI. Out of every 5 children who qualify for SSI as minors, 2 do not qualify as adults at age 18. For children with emotional, learning, or behavioral disorders, the odds are even worse; 2 out of every 3 are rejected, even though little provision has been made to ensure that they are prepared for a life on their own. Although the SSA has tried to create programs that encourage teenagers on SSI to transition to work, few families know about the programs or make use of them. Consequently, many children who leave SSI as young adults have difficulty adjusting to life on their own. Although the majority find work, their incomes remain low, often lower than their SSI payments, and half never complete high school (Loprest and Wittenberg 2005; Davies, Rupp, and Wittenburg 2009; Hemmeter, Kauff, and Wittenburg 2009; Wen 2010).

4.2 Neither Jobs Nor Support

Since 1980, policy-makers have sought to increase employment among the disabled through financial incentives, trial work periods, and the legal right to workplace accommodations. They have also added a patchwork of transitional services, such as health care, rehabilitation, and case management. Still, in any given year, fewer than one percent of disabled beneficiaries ever return to work, much less earn enough to leave the Social Security disability rolls (Rich 2011). Nevertheless, snapshots of the disability rolls present a distorted picture of beneficaries' work efforts. Workers beset by a medical condition that interferes with employment wait, on average, 7 to 8 years before filing for disability benefits (Burkhauser, Butler, and Weathers 2001/2002). Once on the rolls, many remain committed to work. Among DI beneficiaries tracked for a decade after entering the rolls, one-third found employment at some point during the 10-year period. One in 5 worked while receiving benefits, and 7 percent earned enough to spend some time off the rolls (Lui and Stapleton 2010). Persuading Social Security disability beneficaries to return to work, however, is not nearly as daunting as helping them maintain employment. Although a significant number of beneficiaries can and do return to work, their employment rarely affords them a level of job security and economic well-being that allows them to forego disability benefits over the long run. In fact, among people with disabilities who already work, one-third are underemployed (Fogg, Harrington, and McMahon 2010).

At the same time that disability rights and work incentives have failed to provide remunerative employment to the disabled, recent reforms have scaled back the safety net and made citizens more vulnerable to economic dislocation with profound implications for disability benefits policy. In 1996, Congress greatly restricted benefits to low-income families with children by mandating that parents, even those with preschool children, work and by limiting families to TANF for only 2 years at any one spell and 5 years over an entire lifetime. By contrast, other than the possibility of a periodic medical re-evaluation, SSI has no behavioral requirements or time limits. Moreover, SSI benefits are generous when compared to cash payments under TANF. In half the states, the maximum TANF grant for a family of three does not come close to matching the average SSI grant to a single disabled child (Stapleton et al. 2001/2002; U.S. House of Representatives, Committee on Ways and Means 2009). As a result, efforts to tighten TANF have driven up applications for SSI given the similarity in the populations the two programs serve. Many low-income parents suffer from mental health problems or learning disorders or they have a child who does, and this is particularly true of TANF recipients who fail to transition successfully to work (Acs and Loprest 1999). Therefore, because of the porous boundaries between disability and ability, absent eliminating disability benefits outright, policymakers cannot dramatically reduce welfare spending overall without confronting head-on shortcomings in the labor market for disadvantaged workers (Nadel, Wamhoff, and Wiseman 2003/2004; Wamhoff and Wiseman 2005/2006).

Ultimately, the challenges that DI and SSI face grow out of policy-makers' inability to reconcile our conflicting attitudes toward need and work, social and personal responsibility. In an environment of uncertain job prospects and tenuous income support programs, DI and SSI have evolved into a shadow safety net for many Americans and their families. Although lawmakers have tried to facilitate the movement of the disabled into the workplace, disability rights and government services remain poorly coordinated with a steady supply of remunerative jobs. Addressing these policy challenges while remaining compassionate toward the disabled requires more than a mere tinkering with Social Security; it requires a wholesale rethinking of our obligations toward people with disabilities.

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