
Background

History of the Social Security Disability Insurance Program

When President Franklin D. Roosevelt signed the Social Security Act into law on August 14, 1935, the original program was designed to pay benefits only to retired workers aged 65 and older. The amendments of 1939 added two new categories of benefits: payments to the spouse and minor children of a retired worker (known as *dependents benefits*) and survivors benefits paid to the family of a deceased worker. That change transformed Social Security from a retirement program for individuals into a family based economic security program.

The Social Security Amendments of 1954 initiated the Disability Insurance (DI) program that provided the public with additional coverage against economic insecurity. Effective as of 1955, there was a disability “freeze” of workers’ Social Security records during years when they were unable to work. Although that measure offered no cash benefits, it did prevent such periods of disability from reducing or wiping out retirement and survivors benefits. This legislation outlined the work requirements, the definition of disability, the nature of the disability determinations, and the emphasis on rehabilitation, which are still fundamental to the disability program.

On August 1, 1956, as he signed new disability legislation, President Eisenhower said, “We will . . . endeavor to administer the disability [program] efficiently and effectively, [and] . . . to help rehabilitate the disabled so that they may return to useful employment I am hopeful that the new law . . . will advance the economic security of the American people.” These amendments provided cash benefits to disabled workers aged 50–64 (after a 6-month waiting period) and to adult children of retired, disabled, or deceased workers, if the children had been disabled before the age of 18.

Over the next 4 years, Congress broadened the scope of the program, providing benefits to disabled workers’ dependents in 1958 and permitting disabled workers under the age of 50 to qualify for benefits in 1960. In 1967, the act was further amended to provide benefits for disabled widows and widowers aged 50–64 at a reduced rate.

The Social Security Amendments of 1972 further enhanced the disability program by:

- reducing the waiting period from 6 months to 5;

- increasing from 18 to 22 the age before which a “childhood disability” must have begun;
- extending Medicare coverage to persons who had been receiving disability benefits for 24 consecutive months; and
- establishing the needs-based Supplemental Security Income (SSI) program to replace the Old-Age Assistance, Aid to the Blind, and Aid to Permanently and Totally Disabled programs. The SSI program, unlike the Social Security disability program, provided benefits to disabled children under the age of 18.

Throughout the 1970s, growth in the disability rolls was higher than expected as a result of increased applications. In addition, relatively few beneficiaries were being rehabilitated and returning to work. As a result, Congress enacted legislation in 1980 that:

- limited disability benefit levels,
- tightened administration of the Social Security and SSI disability programs by instituting a review of initial disability decisions and by establishing a periodic review of continuing disability requirements,
- enhanced rehabilitation and work incentive provisions, and
- withheld payment of benefits to incarcerated felons.

In response to concerns arising from the implementation of the 1980 provision regarding the continuing disability review process, Congress passed legislation in 1982 that ensured persons, appealing decisions on the cessation of their disability claim could:

- elect to have benefits and Medicare coverage continued pending review by an administrative law judge, and
- have an opportunity for a face-to-face evidentiary hearing at the reconsideration level of appeal.

Two provisions of the Social Security Amendments of 1983 affected the disability program:

- The age at which full retirement benefits are payable was gradually increased from 65 to 67 to restore financial soundness to the Old-Age, Survivors, and Disability Insurance (OASDI) programs. The increase in full retirement age, which began in 2000, means that disabled workers and widow(er)s may remain on the DI rolls for an additional 2 years before “converting” to age-based benefits. It is also likely that more of these
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older workers will apply for and become entitled to disability-based benefits because of this change.

- Benefits to disabled widow(er)s were improved by decreasing the benefit reduction for beneficiaries under the age of 60 and by continuing payments to certain disabled widow(er)s who remarried.

In 1984, Congress enacted a number of changes affecting the interpretation of disability, such as instituting a “medical improvement standard” in the continuing disability review process, revising the mental impairment listings, and considering the combined effect of all impairments when determining eligibility for benefits.

From 1984 through 1998, many relatively minor legislative changes were made in the Social Security disability program. Those changes provided additional Medicare protection for the disabled, made the definition of disability for disabled widow(er)s the same as that for disabled workers, prohibited eligibility for individuals whose drug addiction or alcoholism was a contributing factor to their impairment, and modified the provisions for a trial work period.

On December 17, 1999, President Clinton signed into law the Ticket to Work and Work Incentives Improvement Act. The purpose of that legislation is to improve the disability program’s work incentives by giving beneficiaries greater choice in seeking rehabilitation and employment services. The provisions of the act:

- create a Ticket to Work and Self-Sufficiency program that provides disabled beneficiaries with a voucher they may use to obtain vocational rehabilitation services, employment services, and other support services from an employment network of their choice;
- prohibit the Social Security Administration from initiating continuing disability reviews while the beneficiary is using a ticket;
- provide for expedited reinstatement of benefits for individuals whose prior entitlement to disability and health care benefits had been terminated as a result of earnings from work (those former beneficiaries may request reinstatement of benefits without filing a new application);
- establish a community-based work incentives planning and assistance program for the purpose of providing accurate information about work incentives to disabled beneficiaries;
- expand health care services by allowing the states to offer Medicaid buy-in for workers with disabilities even though they may no longer be eligible for

disability benefits under Social Security or SSI because their medical condition has improved; and

- allow people with disabilities who return to work to continue their premium-free Medicare Part A coverage for an additional 4½ years beyond the 4 years previously provided. (Medicare Part B can also continue if premiums are paid.)

Definition of Disability

The definition of disability under Social Security is different from that used by other disability programs. Social Security pays benefits only for total disability; it does not pay benefits for partial disability or for short-term disability.

To be eligible for benefits a person must:

- be insured for benefits,
- be younger than full retirement age,
- have filed an application for benefits, and
- have a Social Security–defined disability.

Meeting the insured requirement means that a person must have worked long enough—and recently enough—under Social Security. The number of work credits (quarters of coverage) a person needs to qualify for benefits depends on the individual’s age when he or she becomes disabled.

Section 223(d)(1) of the Social Security Act defines *disability* as an—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of *blindness* as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which the individual has previously engaged with some regularity and over a substantial period of time.

In most cases, a dollar amount is used to indicate whether a person is engaging in substantial gainful activity (SGA). For 2010, the SGA amount was \$1,000 per month for a nonblind individual and \$1,640 per month for a blind person. Effective January 2001, the SGA level is adjusted annually on the basis of the national average wage index.

A medically determinable *physical or mental impairment* is an impairment that results from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. An impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings.

Types of Benefits Available

The Social Security program pays benefits to disabled individuals and to certain dependents. Those benefits include the following:

1. Monthly cash benefits, after a 5-month waiting period, for a **disabled worker and family**. The worker and eligible family members continue to receive benefits, as long as the worker remains disabled, until the worker reaches full retirement age (at which time, the disabled-worker benefit converts to retired-worker benefits) or dies. (Eligible family members would become eligible for retirement- or survivor-based benefits.)

The spouse of a disabled worker is eligible for benefits if he or she is aged 62 or older or has in his or her care a child under the age of 16 or a disabled adult child who is entitled to benefits on the worker's earnings record. Unmarried children are entitled to benefits until they reach age 18, or until age 19 if they are a full-time elementary or secondary school student.

2. Monthly cash benefits, after a 5-month waiting period, for a **disabled widow(er) or a disabled surviving divorced spouse** who is aged 50 to full retirement age, referred to in this publication as *disabled widow(er)s*.
3. Monthly cash benefits payable to **disabled adult children** of disabled, retired, or deceased workers. Those children must be aged 18 or older and must have become disabled before the age of 22. The 5-month waiting period does not apply to disabled adult children.
4. **Medicare benefits**, which are available 2 years after the disabled worker, disabled widow(er), or disabled adult child becomes eligible for benefits.
5. **Vocational rehabilitation services**, which are available for disabled beneficiaries who could return to work if they were provided with some assistance.

Initial Disability Decision-Making Process

The disability decision-making process begins when an individual files an application for benefits at a

Social Security office. An employee in the office determines if the applicant meets the nonmedical requirements for benefits such as age, work credits, performance of SGA, and relationship to the insured worker. If those requirements are met, the application is sent to the Disability Determination Services (DDS) office in the state where the applicant resides. The DDS then decides whether an individual is disabled under Social Security law.

Disability examiners and medical staff in the DDS office use medical evidence from the applicant's doctors, hospitals, clinics, or institutions where the individual received treatment. Those medical sources are also asked for information about a person's ability to do work-related activities, such as walking, sitting, lifting, carrying, and remembering instructions.

The DDS may need more medical information before they can decide a person's case. If it is not available from the individual's current medical sources, they may ask the applicant to go to a special examination, called a *consultative examination*, that is paid for by the Social Security Administration (SSA).

A five-step sequential evaluation process is used to decide if a person is disabled. Those steps are as follows:

1. **Is the individual working?** If the person is working and earning more than the SGA amount, the person generally cannot be considered disabled. This decision is made by a Social Security employee. If the person is not working at the SGA level, the file goes to the DDS.
2. **Is the condition "severe"?** A condition must interfere with basic work-related activities for a claim to be considered. If it does not, the person is not found disabled. If it does, the DDS will go to the next step.
3. **Does the individual have an impairment that meets or equals one that is described in SSA's Listing of Impairments?** SSA maintains a list of impairments for 14 major body systems: musculoskeletal, special senses and speech, respiratory, cardiovascular, digestive, genitourinary, hemic and lymphatic, skin and subcutaneous tissue, endocrine, multiple body, neurological, mental, neoplastic, and immunologic. Those impairments are so severe that they automatically mean that a person is disabled. If the condition is not on the list, the DDS will have to decide if it is of equal severity to a listed impairment. If it is, the person is found disabled. If not, the DDS goes to the next step.

4. **Can the individual do the work he or she previously did?** If the person's condition is severe but not at the same or equal severity as an impairment on the list, then the DDS must determine whether it interferes with a person's ability to do his or her past work. If it does not, the claim will be denied. If it does, the DDS goes to the next step.

5. **Can the individual do any other type of work?** To determine an individual's ability to do other work, the DDS considers the person's medical conditions, age, education, work experience, and any transferable skills. If the DDS decides the person cannot do other work, the claim will be approved. If the DDS decides that the person can do other work, the claim will be denied.

A person is considered blind if his or her vision cannot be corrected to better than 20/200 in the better eye or if his or her visual field is 20 degrees or less, even with a corrective lens. A number of special rules apply to persons who are blind. Those rules recognize the impact of blindness on a person's ability to work. For example, the dollar amount used to determine whether a blind individual is engaging in SGA is higher than the limit for a sighted person.

Appeals Process

If an applicant's claim for disability benefits is denied, he or she has the right to appeal that decision. There are four levels of appeals: (1) reconsideration by the state DDS, (2) hearing by an administrative law judge (ALJ), (3) review by the Appeals Council, and (4) federal court review. At each level of appeal, claimants or their representative must file the request for appeal in writing within 60 days from the date of the notice of denial.

Generally, the reconsideration is the first step in the appeals process. The reconsideration is a case review and is similar to the initial determination except that the case is assigned to a different disability examiner and medical team at the DDS. Claimants are given the opportunity to present additional evidence, which is considered along with the evidence that was submitted during the initial determination.

If the claim is again denied, the individual may request a hearing before an ALJ. Usually the ALJ will hold a hearing, although the claimant may ask that his or her case be decided on the basis of the written record without a hearing. At the hearing, the claimant and witnesses testify under oath or affirmation, and the testimony is recorded verbatim. The ALJ, who is responsible for looking into all the issues, receives

documentary evidence as well as the testimony of witnesses. The ALJ will allow the claimant, the claimant's representative, or both to present arguments and examine witnesses.

The final step in the administrative appeals process is at the Appeals Council. If the claimant is dissatisfied with the hearing decision, he or she may request that the Appeals Council review the case. The council, made up of administrative appeals judges, may also, on its own motion, review a decision within 60 days of the ALJ's decision.

The Appeals Council considers the evidence of record, any additional evidence submitted by the claimant, and the ALJ's findings and conclusions. The council may grant, deny, or dismiss a request for review. If it agrees to review the case, the council may uphold, modify, or reverse the ALJ's action, or it may remand it to the ALJ so that he or she may hold another hearing and issue a new decision.

Claimants may file an action in a federal district court within 60 days after the date they receive notice of the Appeals Council's action. If the U.S. District Court reviews the case record and does not find in favor of the claimant, the claimant can continue with the appellate process to the U.S. Circuit Court of Appeals.

Benefit Calculations

In addition to meeting the strict medical definition of disability, an individual must also meet an insured-status requirement. To be eligible for disabled-worker benefits, a person must have worked long enough and recently enough under Social Security. A person can earn up to four work credits per year. The amount of earnings required for a credit increases each year as general wage levels rise.

The number of work credits a person needs for disability benefits depends on the individual's age when he or she becomes disabled. To be fully insured, the maximum number of credits a person needs is 40. To be currently insured, a person generally needs 20 credits earned in the last 10 years ending with the year he or she becomes disabled. However, younger workers may qualify with fewer credits.

Dependents of a disabled worker are eligible for benefits if the worker meets both the medical and insured-status requirements. Disabled widow(er)s and disabled adult children do not need to meet a work requirement themselves, but the worker on whose record they are filing must be insured.

To determine the amount of a person's monthly cash benefit, SSA uses the following four-step process:

1. Calculate each worker's average indexed monthly earnings (AIME). First, the worker's annual covered earnings after 1950 are indexed to reflect the general earnings level in the indexing year—the second calendar year before the year of eligibility (that is, the year a worker becomes disabled). Earnings in years after the indexing year are not indexed but instead are counted at their actual value.

The period used to calculate the AIME equals the number of full calendar years elapsing between age 21 and the year of first eligibility. The actual years used in the computation are the years of highest earnings minus dropout years equal to one-fifth of the number of elapsed years rounded to the next lower integer (to a maximum of 5 dropout years). However, the number of years of earnings used is at least 2. *Effective for initial entitlement after June 1980.*

Disabled workers who receive fewer than 3 dropout years under the one-fifth rule may be credited with additional dropout years based on child care, up to a total of 3 dropout years. (To receive this credit, a worker must have had no earnings in that year and must have been living with a child under age 3.) However, the number of years of earnings used is at least 2. *Effective for July 1981.*

The AIME is calculated as the sum of the highest year's earnings, divided by the number of months in the computation period.

2. Compute the primary insurance amount (PIA). The formula used to compute the PIA from the AIME is weighted to provide a higher PIA-to-AIME ratio for workers with low earnings. For workers who become disabled in 2010, the PIA is equal to the sum of:

90 percent of the first \$749 of AIME, plus
32 percent of the next \$3,768 of AIME, plus
15 percent of AIME over \$4,517.

When subsequent retirement benefits are computed at conversion to retired-worker benefits at the full retirement age (FRA), or at retirement for a worker who earlier recovered from a disability, the years of disability are disregarded from the PIA calculation. That preserves insured status and benefit level.

Alternative methods of computing the PIA apply to workers who have low earnings but a steady work history over most of their adult years and to workers who also receive a pension based on their own noncovered work.

3. Compute the family maximum (FMAX). Monthly benefits payable to the worker and family members or to the worker's survivors are limited to a maximum family benefit amount. The family maximum level for retired-worker families or survivors usually ranges from 150 percent to 188 percent of the worker's PIA. The maximum benefit for disabled-worker families ranges from the smaller of 85 percent of AIME (or 100 percent of the PIA, if larger) to about 150 percent of the PIA.

Beginning with the first year of eligibility, the PIA and FMAX are increased by cost-of-living adjustments.

4. Compute the person's monthly benefit amount (MBA). Disabled workers and persons retiring at the FRA are paid 100 percent of the PIA. The PIA is reduced for workers who retire between the age of 62 and the FRA. If a disabled worker receives reduced retirement benefits before disability entitlement, the disability benefit is reduced by the number of months for which he or she received reduced retirement benefits.

Dependents of retired or disabled workers may receive up to 50 percent of the PIA. Disabled adult children of deceased workers may receive up to 75 percent of the PIA.

Disabled widow(er)s aged 50–60 may receive up to 71.5 percent of the PIA. Disabled widow(er)s aged 60 to the FRA may receive up to 100 percent of the PIA, but benefits are reduced for age, with a maximum reduction of 28.5 percent.

All monthly benefits are limited by the family maximum, so dependents may not receive their full MBA.

Benefits Offset and Withheld

Disabled-worker and dependents' benefits may be offset if the disabled worker receives workers' compensation (WC) or other public disability benefits (PDB). The Social Security Amendments of 1965 require that benefits be reduced when the worker is also eligible for periodic or lump-sum WC/PDB payments, so that the combined amounts of the disabled worker's and family's Social Security benefits plus the WC/PDB payment do not exceed 80 percent of the worker's average current earnings. The combined

payments after reduction are never less than what the total Social Security benefits were before reduction. The reduction continues until the month the worker reaches age 65 or the month the WC/PDB payment stops, whichever comes first.

If a spouse or disabled widow(er) worked for a federal, state, or local government to which he or she did not pay Social Security taxes, the pension he or she receives from that agency may reduce his or her Social Security benefits. That provision is known as the *government pension offset*. The offset will reduce the amount of the Social Security benefit by two-thirds of the amount of the government pension.

The annual earnings test applies to nondisabled beneficiaries under the FRA. Benefits for those beneficiaries are withheld \$1 for every \$2 they earn above the annual earnings limit. In the calendar year a beneficiary attains the FRA, for months before the FRA, \$1 is withheld for every \$3 earned over the annual earnings limit for that age group. A retired worker's earnings will also affect his or her dependents' benefits, including those of disabled adult children. In addition, a spouse's earnings may affect benefits for his or her children. (How a disabled beneficiary's work affects his or her benefit is discussed in the next section.)

Other reasons for withholding benefits include spouses who no longer have an entitled child in their care, beneficiaries who are incarcerated, or beneficiaries whose whereabouts are unknown.

Work Incentives

Special rules make it possible for disabled beneficiaries to work and still receive monthly benefits and Medicare or Medicaid. Those rules are known as *work incentives*.

Disabled beneficiaries are encouraged to return to work by providing a trial work period (TWP) and an extended period of eligibility (EPE). During the TWP, earnings are allowed to exceed the SGA dollar amount for 9 months. During the 3-year EPE that follows the TWP, benefits are withheld only for those months in which earnings exceed the SGA amount. After the end of the EPE, monthly benefits are terminated when earnings exceed the SGA amount. Certain impairment-related expenses that a person needs to make in order to work may be deducted when counting earnings to determine whether the work is substantial. Even if cash benefits are withheld, Medicare and Medicaid coverage can continue.

The Ticket to Work and Work Incentives Improvement Act has further improved work incentives. That

law substantially expands work opportunities for people with disabilities. The provisions of the law become effective at different times in different parts of the country. The provisions below apply to Social Security and SSI.

- 1. Ticket to Work and Self-Sufficiency Program.** Starting in 2002, some Social Security and SSI disability beneficiaries received a "ticket" that they may use to obtain vocational rehabilitation and other employment-support services from an approved provider of their choice. The program is voluntary and will be phased in nationally over a 3-year period.
- 2. Expanded Availability of Health Care Services.** As of October 1, 2000, the law expands Medicaid and Medicare coverage to more people with disabilities who work. It extends Medicare Part A premium-free coverage for 93 months after the trial work period for most disabled beneficiaries who work.

In addition, states now have the option to expand Medicaid coverage to workers with disabilities using income and resource limits set by the states.
- 3. Expedited Benefits.** Effective January 1, 2001, if a person's Social Security or SSI disability benefits have ended because of earnings from work and if he or she becomes unable to work again within 60 months because of his or her medical condition, the person would be able to request reinstatement of benefits, including Medicare and Medicaid, without filing a new application.
- 4. Disability Reviews Postponed.** Effective January 1, 2001, an individual using a "ticket" does not need to undergo the regularly scheduled disability reviews. Effective January 1, 2002, people who have been receiving Social Security disability benefits for at least 24 months will not be asked to go through a disability review because of the work they are doing. However, regularly scheduled medical reviews could still be performed and benefits could be terminated if earnings were above the limits.
- 5. Work Incentives Outreach Program.** The law directs the Social Security Administration to establish a community-based work incentives planning and assistance program to disseminate accurate information about work incentives and to give beneficiaries more choice. SSA has established a program of cooperative agreements and contracts to provide benefits planning and assistance to all disabled beneficiaries, including information about the availability of protection and advocacy services.

6. **Protection and Advocacy.** The law authorizes SSA to make payments to protection and advocacy systems established in each state to provide information, advice, and legal services to disability beneficiaries.

More information about work incentives is available at <http://www.socialsecurity.gov/work>.

Benefit Termination

In general, benefits continue as long as a person remains disabled. However, under Social Security law, all disability cases must be reviewed from time to time to make sure that people receiving benefits continue to meet the disability requirements. Benefits continue unless there is strong proof that a person's impairment has medically improved and that he or she is able to return to work.

How often a case is reviewed depends on the severity of the impairment and the likelihood of improvement. The frequency can range from 6 months to 7 years. Here are general guidelines for reviews.

- **Improvement expected**—If medical improvement can be predicted when benefits start, the first review will be 6 to 18 months later.
- **Improvement possible**—If medical improvement is possible but cannot be predicted, the case will be reviewed about every 3 years.
- **Improvement not expected**—If medical improvement is not likely, the case will be reviewed about once every 5 to 7 years.

During a review, the disabled beneficiary is asked to provide information about any medical treatment he or she has received and any work he or she might have done. An evaluation team, which includes a disability examiner and a doctor, then requests the individual's medical records and carefully reviews his or

her file. If the team decides a person is still disabled, benefits will continue. If they decide that the person is no longer disabled, the individual can file an appeal if he or she disagrees with the determination. Otherwise, benefits stop 3 months after the beneficiary is notified that his or her disability ended.

Benefits for dependents continue as long as the disabled worker continues to be entitled to benefits. However, a person's benefits may be terminated for other reasons. The most common reasons to terminate benefits are the following:

- The beneficiary dies. If the deceased was the worker, eligible dependents may become entitled to survivors' benefits.
- The disabled worker or disabled widow(er) attains the FRA, and their benefit is automatically converted to retired-worker benefits or aged widow(er) benefits, respectively.
- The disabled beneficiary is no longer disabled because of medical recovery or successful reentry to the workforce.
- A spouse and worker divorce (with some exceptions).
- Certain divorced spouses remarry.
- A spouse no longer has a child under the age of 16 or a disabled child in his or her care.
- A child reaches age 18.
- A student reaches age 19 or is no longer attending elementary or secondary school full time.
- Dependent children marry.
- Dependents become entitled to another equal or larger benefit.

Benefits usually stop effective with the month the terminating event occurred.