NATIONAL CENTER FOR POLICY ANALYSIS

Not All Disabilities Are Alike: Implementing a Rating System for SSDI

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Despite today's workplace accommodations for the disabled, improved diagnoses and treatments, and less physically demanding jobs, the number of individuals receiving disability payments has increased dramatically over previous decades. Prior to 1990, the annual percentage of workers receiving benefits grew about half a percent per year.

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Executive Summary

Since 1990, the percentage of workers receiving Social Security Disability Insurance (SSDI) benefits has grown an average of 4.8 percent annually. As a result, the Disability Trust Fund, which is funded by 1.8 percentage points of the payroll tax (split evenly between workers and employers), is expected to be depleted by the end of 2016. As of December 2013:

- There were 10.2 million individual disabled workers, disabled widowers or disabled adult children receiving Social Security Disability.
- Disabled beneficiaries ages 18 to 64 were 4.8 percent of the total nonsenior adult population.
- The average beneficiary age was 53 years and the average monthly benefit was $1,146.

Unfortunately, despite these numbers, there is little political will for a complete overhaul of SSDI. Policymakers have proposed just a few reforms, mainly focused on efforts to combat fraud. But more could be done regarding how beneficiaries are paid and how to provide better work incentives.

Top Diagnoses for Beneficiaries. Musculoskeletal and connective tissue disorders are the largest diagnostic category for SSDI beneficiaries, accounting for 30.5 percent (32 percent of diagnoses for female workers, and 29 percent for males). Osteoarthritis is the most common form of musculoskeletal disease and the most common cause of disability in the general population, affecting 27 million people age 25 and older.

Mental disorders are the second leading diagnosis category among SSDI beneficiaries. Mental disorders include a variety of conditions ranging from mild to severe — everything from mood disorders to schizophrenic/psychotic disorders. Mood disorders are the most commonly diagnosed subcategory of mental disorders. These include major depression, dysthymia (low-grade depression for at least two years), bipolar disorder, mood disorders due to a medical condition or substance-induced mood disorders. With the exception

of bipolar disorders, most mood disorders will improve over time. But some beneficiaries improve enough over time to work to some degree, or were not critically disabled at the time they applied.

Both musculoskeletal and mental disorders are difficult to diagnose because, in most cases, there is no lab test to pinpoint a condition, and physicians must rely on gross physical evidence (such as swollen joints) to determine if it is present.

The prognoses for mental and musculoskeletal conditions are different. The majority of musculoskeletal diseases grow worse over time, even though treatments can stabilize symptoms; whereas most mental disorders, particularly mood disorders, can improve over time and in some instances, improve quickly.

But the Social Security Disability system is a one-size-fits-all program. Unlike the Veterans Disability system, there are no varying degrees of disability. Thus, money is wasted in a system that does not differentiate between a treatable condition and a progressive, degenerative disease. Although the system is supposed to get those who get better back to work, the program provides little follow-up and even less incentive. As a result, few people (less than 1 percent) ever go back to work, even if they are physically and mentally able.

Solution: Restructure the all-or-nothing payment system to reflect varying degrees of disability, as does the Veterans' Disability system. A lower level of benefit payments could be awarded to individuals who have a higher probability of improvement. Disability ratings could be instituted similar to the Veterans Disability system, with a few changes.

- During the initial application exam, a degree of disability would be established for the applicant, ranging from 10 percent disabled to 100 percent disabled.
- Payments would be established based on this rating; for instance, applicants with a 50 percent disability rating would receive half of the full monthly benefit.

Varying payments based on degree of disability may be the greatest cost saving measure that could be implemented by SSDI:

- Currently more than 1.3 million workers with mood disorders receive an average monthly benefit of $1,061.94 per month. If this payment were reduced by an average 25 percent, reflecting varying degrees of disability among this population, the SSDI program would save over $4.2 billion a year.
- More than 2.7 million workers with musculoskeletal disorders receive an average benefit of $1,224.78 per month. If this payment were reduced an average of 20 percent, reflecting varying degrees of disability among this population, the SSDI program would save over $8 billion a year.

Solution: Eliminate the "Ticket to Work" program and lift the maximum monthly income limit for work. The current SSDI system offers a voluntary "Ticket to Work" program in which beneficiaries can work for up to three years without losing their disability benefits. When the program began in 1999, the Congressional Budget Office estimated the program would generate savings beginning in fiscal year 2004, and that those savings would increase to $110 million annually by fiscal year 2009. However, the program had little effect on beneficiaries returning to work. The Office of the Inspector General determined that while the Ticket Program produced $16.6 million in savings in fiscal year 2005, it cost $18 million. Moreover, the OIG expected that cost to increase over time, as 2008 changes created greater financial incentives for employment networks to participate.

In exchange for a reduction in payments due to rating disability by degree, the monthly maximum limit on labor income ($1,090 in 2015) that disqualifies a beneficiary from receiving disability benefits could be eliminated. This step would reverse the SSDI program incentive that rewards receiving maximum benefits as long as possible while penalizing work. Allowing people to work, even if they are receiving a reduced benefit, would not only incentivize work, but would also add payroll tax revenue into the system that funds these beneficiaries in the first place.

Introduction

Heart disease is the leading cause of death in the United States, killing over 600,000 people in 2013. Deaths from cancer (584,881) and chronic lower respiratory diseases (149,205) followed behind.[1] Interestingly, these conditions — the leading causes of death in the United States — are far different from the conditions that render individuals unable to work thus qualifying for Social Security disability benefits. According to the Social Security Trustees Report, the Social Security Disability Insurance (SSDI) system cost over $122 billion in 2012.[2] As of December 2013, 10.2 million individuals were receiving Social Security Disability: 87.4 percent were disabled workers, 10.2 percent were disabled adult children and 2.5 percent were disabled widowers.[3]

Workers contribute to SSDI through their payroll taxes. However, benefits are also available to disabled children over the age of 18, if they are unmarried and one of their parents receives disability benefits. Parents who care for disabled children under the age of 18 are eligible for Supplemental Security Income (SSI), which provides payments for children who are disabled and not expected to work enough to earn regular disability benefits. Disability benefits for widows and widowers are available if the spouse was receiving disability benefits at the time of death, and the surviving spouse is 60 years or older.[4]

In 2013, 4.8 percent of the population ages 18 to 64 were disabled beneficiaries. The average beneficiary age was 53 years and the average monthly benefit was $1,146. Despite today's workplace accommodations for the disabled, improved diagnoses and treatments, and less physically demanding jobs, the number of individuals receiving disability payments has increased dramatically over previous decades. Demographic changes are at play here. Decades ago, disability recipients were predominantly men, but as women have entered the workforce and as they tend to file disability claims more often, they now comprise almost half of current beneficiaries. Additionally, with an aging population comes an increasing amount of disability among the workforce. Prior to 1990, the annual percentage of workers receiving benefits grew less than one-quarter of one percent per year. Due to demographic changes and relaxed criteria for receiving disability benefits, the percentage of workers receiving benefits has grown an average of 4.8 percent annually since 1990. [See Figure I.]

The Disability Trust Fund is expected to be depleted by the end of 2016. Unfortunately, despite these numbers, there is little political will for a complete overhaul of SSDI. Policymakers have proposed a few reforms, mainly focused on efforts to combat fraud in the system. Fraud is an issue with any government entitlement program. But in the case of the SSDI program, fraud detection measures do nothing to link the disabled individual with an appropriate diagnosis, effective and available treatments, and the goal of getting back to work, even in a limited capacity. To determine if fraud is rampant in the disability program, it is important to identify the most common disability diagnoses of beneficiaries, the efficacy of available

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Pamela Villarreal is an NCPA expert on retirement, economic growth and tax issues. Villarreal has written studies and analyses on specific economic and retirement topics such as minimum wage effects, the jobs market, returns on stock and bond investments, retirement account reforms and the NCPA's state tax calculator. She has authored and co-authored numerous publications on diverse topics such as capital gains taxes, reverse mortgages, Social Security disability and baby boomers' spending habits. One of her studies, "Wealth, Inheritance and the Estate Tax," was coauthored with noted economist Jagadeesh Gokhale.

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treatments and the prognosis for a beneficiary's future.

The Top Diagnoses for SSDI Beneficiaries

Musculoskeletal and connective tissue disorders are the largest diagnostic category for SSDI beneficiaries, accounting for 30.5 percent of diagnoses for all workers receiving benefits — 32 percent of diagnoses in female workers, and 29 percent in males. Publicly available SSDI data do not provide subcategories for these disorders. What are these conditions, how common are they in the general population, and are they treatable?

Musculoskeletal and Connective Tissue Disorders in the Social Security Disability Evaluation Process. The "bluebook," as it is often referred, is a diagnostic manual that assists physicians in making disability determinations. Social Security lists several different categories under which one could qualify for disability. However, the categories are vaguely based more on the ability to engage in gainful activity rather than medical causes. For instance, musculoskeletal impairments are divided into those that cause a major dysfunction of a joint, those involving major surgery of a weight bearing joint, spinal disorder, those that require amputation, those involving the fracture of an upper extremity, and soft tissue injuries.[5]

Musculoskeletal and Connective Tissue Disorders in Medicine. The diseases of musculoskeletal and connective tissue disorders are discussed below in order of occurrence in the general population. These are common diagnoses that could result in an applicant filing a Social Security Disability claim. [See the Table.]

Osteoarthritis is the most common form of musculoskeletal disease and the most common cause of disability in the general population, affecting 27 million people age 25 and older.[6] The condition manifests as pain associated with the gradual wearing of cartilage in the joints. Osteoarthritis occurs in females more than males and the incidence increases with age. One-third (34 percent) of adults over age 65 have the condition. Most individuals will have some degree of osteoarthritis in their lifetimes, but there are treatments and measures to reduce pain and pressure on the joints, such as anti-inflammatories, weight reduction and exercise.[7] Since the SSDI beneficiary population increases with age, it is highly likely that osteoarthritis is a common diagnosis for beneficiaries.

Carpal tunnel syndrome is chronic pain caused by a pinched nerve in the wrist. It is often the result of repetitive motion and is one of the top workplace injuries. About 3 percent of women and 2 percent of men will experience carpal tunnel syndrome in their lifetime, but its peak prevalence is in women over the age of 55.[8] Carpal tunnel syndrome can be treated with corticosteroids, splinting and, in severe cases, surgery.[9]

Sjögren's syndrome is an autoimmune disorder in which the white blood cells attack moisture-producing glands. It can take years to diagnose Sjögren's, but it is estimated to occur in 0.05 to 4.8 percent of the general population, most commonly in females, age 40 and over.[10] It is difficult to diagnose because its symptoms mimic other conditions.[11] Generally, without any further complications, Sjögren's syndrome can be successfully managed with treatments specifically designed for the areas of the body affected. For example, eye drops can be used to treat dry eyes.

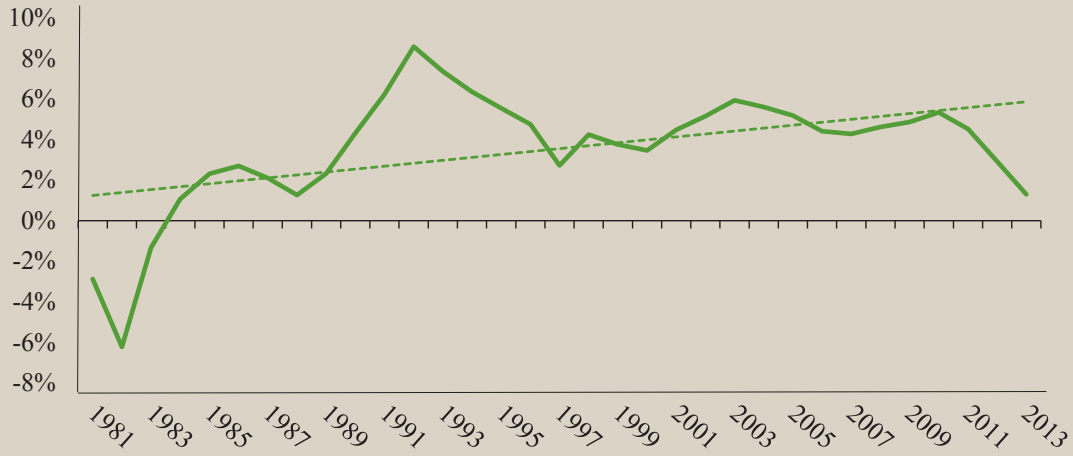
Select Musculoskeletal/Connective Tissue Disorders

Musculoskeletal/Connective Tissue Disorder	Percentage of Population Affected	Most Prevalent in
Osteoarthritis	9 percent	Adults over age 65
Carpal tunnel syndrome	5 percent	Females over age 55
Sjögren's syndrome	Up to 4.8 percent	Females age 40 and over
Fibromyalgia	1.6 percent	Adult females
Rheumatoid arthritis	0.6 percent	Females over age 50
Systemic lupus erythematosus	0.053 percent	Adult females
Ehler's Danlos syndrome	0.02 to 0.94 percent	All ages, male and female
Vasculitis	0.03 percent	All ages, male and female
Scleroderma	0.028 percent	Females, ages 30 to 50
Myositis	Negligible	African-American women over age 50
Mixed connective tissue disorder	0.001 to 0.009 percent	Adult females

Sources: Compiled by author from various sources: see footnotes.

Fibromyalgia is a disorder that causes pain at various points on the body and produces other symptoms such as fatigue, insomnia and mood changes. It affects about 1.6 percent of the general population (5 million people). Eighty to 90 percent of fibromyalgia patients are women. The cause of fibromyalgia is uncertain, but it is believed that symptoms may begin after surgery, physical trauma or psychological stress. Treatment for fibromyalgia includes exercise, relaxation techniques and non-narcotic pain relievers.[12]

Figure I
Growth of Disability Recipients, 1981-2013
(percent of workers)



Source: Author's calculations from the *2013 Annual Statistical Report on the Social Security Disability Insurance Program*.

Rheumatoid arthritis (RA) is a degenerative and chronic musculoskeletal/connective tissue disorder. It affects 0.6 percent of the population but is most common in females over the age of 50.[13] Complications from rheumatoid arthritis can result in osteoporosis, carpal tunnel syndrome, heart problems and lung disease.[14] There is no cure for RA, but it can be treated with such drugs as nonsteroidal anti-inflammatories and biologics. The long-term prognosis, however, is not favorable. Forty percent of patients have some degree of disability after 10 years.[15]

Systemic lupus erythematosus (often referred to as "lupus") affects 0.053 percent of the general population, most commonly females.[16] It is an autoimmune disease characterized by muscle pain, joint stiffness and rashes. Lupus is chronic, but symptoms can be treated with nonsteroidal anti-inflammatories, corticosteroids and/or immunosuppressive drugs. However, long-term complications may occur.[17]

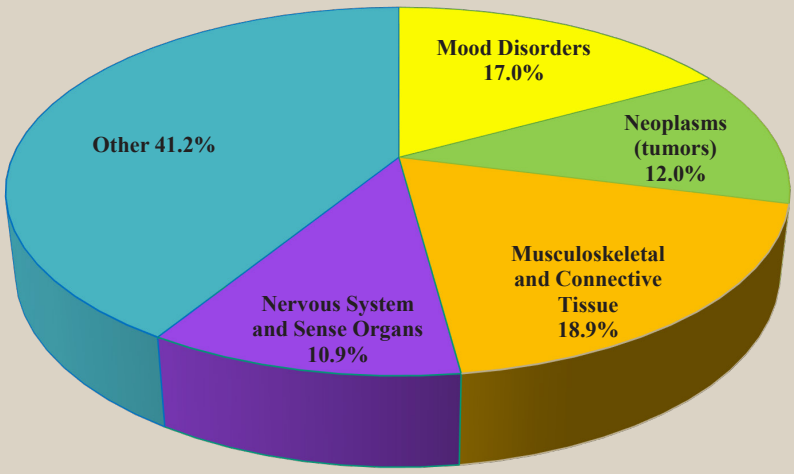
Ehler's Danlos Syndrome (EDS) affects 0.02 to 0.04 percent of the general population of all ages and both genders.[18] It is an inherited connective tissue disorder characterized by overly flexible joints and stretchy or fragile skin that bruises easily. EDS can also cause ruptured blood vessels and intestinal damage. There is no cure, but symptoms can be treated with pain medication, blood pressure medication and physical therapy.[19]

Vasculitis, inflammation of the blood vessels, affects 0.03 percent of the general population, and can affect anyone of either sex or any age.[20] (There are several types of vasculitis that are named according to where on the body they occur.) Treatments include corticosteroids and medications that suppress the immune system.[21]

Scleroderma is an overproduction of collagen in the body's tissues. It affects 0.028 percent of the general population and is most common in females, ages 30 to 50.[22] Scleroderma is characterized by tightening of the skin and hardening of connective tissues, but can also harm blood vessels, internal organs and the digestive tract. There is currently no drug that stops the progression of scleroderma, but different types of medications can help manage pain and symptoms.[23]

Myositis is an inflammation and degeneration of the muscles. Although rare, affecting only 10 per one million people a year, it occurs more often in women (particularly those over age 50) than men, and more often in African-Americans. The condition can be caused by other diseases, such as dermatomycosis, rheumatoid arthritis, scleroderma and lupus. It is also caused by viral infections or certain drugs and substances, such as statin drugs, alcohol and cocaine. Myositis may be temporary based on its origin; for instance, if it is caused by statin drugs, it will usually stop once the drugs are stopped. Chronic myositis can be treated with corticosteroids,

Figure II
Distribution of Benefits Withheld Due to Substantial Work, by Diagnostic Group, December 2013



Source: "Table 52: Disabled Workers, Distribution by Diagnostic Group," *2013 Annual Statistical Report on the Social Security Disability Insurance Program*.

RA medications and physical therapy.[24]

Mixed connective tissue disease is a combination of several diseases, primarily lupus, scleroderma and polymyositis. It affects about 0.001 to 0.009 percent of the general population, and is most common in adult females.[25]

Mental Disorders. Mental disorders are the second leading diagnosis among SSDI beneficiaries. Mental disorders include a variety of conditions ranging from mild to severe, including everything from mood disorders to schizophrenic/ psychotic disorders.

Mood disorders are the most commonly diagnosed subcategory of mental disorders among beneficiaries. These include major depression, dysthymia (low-grade depression for at least two years), bipolar disorder, mood disorders due to a medical condition, or substance-induced mood disorder. All of these disorders are characterized by such symptoms as feeling sad, hopeless or helpless for long periods of time, difficulty sleeping, thoughts of suicide, loss of interest in usual activities, appetite loss, decreased energy and/or physical pain.[26]

Females are twice as likely to experience mood disorders as males, and children whose parents have experienced mood disorders are also at a higher risk.

Manic depression, or bipolar disorder, which can stem from depression, affects about 2.6 percent of the population.[27] Bipolar disorder is characterized by depression with periods of euphoric highs, irritability, agitation, racing thoughts and difficulty concentrating.

Prognoses for Mood Disorders. Studies have found that those who experience "unipolar" mood disorders (not bipolar or manic depression) tend to improve over time with appropriate treatment. Psychiatrists Joseph Goldberg and Martin Harrow have conducted a number of longitudinal studies on the outcomes of patients with mood disorders. One study involved periodic follow-ups — at 2 years, 4.5 years, 7.5 years and 10 years — of bipolar depressed, unipolar depressed and psychotic unipolar depressed patients who were hospitalized at the beginning of the study period.[28] The follow-up treatments were at the discretion of the patients and their individual physicians. Thus, the efficacy of individual treatments was not examined. However, Goldberg and Harrow found that among bipolar patients:[29]

- One-quarter were rehospitalized in the year preceding a follow-up.
- They had more rehospitalizations and periods of work impairment than unipolar nonpsychotic patients.
- Generally, less than half had good overall outcomes at any point in time.

Patients experiencing nonpsychotic depression had better outcomes than the bipolar and unipolar psychotic depressed patients, particularly at 7.5-year and 10-year follow-ups:[30]

- After both 7.5 and 10 years, 63 percent of nonpsychotic unipolar depressed patients had good overall outcomes.
- Further, more than 80 percent of nonpsychotic unipolar depressed patients were functioning effectively in their primary work role for at least half the time in the year preceding their follow-ups.

Schizophrenia. This brain disorder affects about 1 percent of Americans and occurs equally in men and women. Symptoms are most likely to begin in the teenage years. These include hallucinations, delusions, hearing "voices" others do not hear, and experiencing hypersensitive sensations, such as feeling invisible "fingers" touching them. A person

may also experience less obvious cognitive symptoms, such as trouble paying attention, processing information and making decisions.[31]

Antipsychotic medications can be effective in treating schizophrenia, but the key to success is consistency. Patients sometimes find it difficult to continue taking medication once they feel better, and family members must often take responsibility for monitoring the patient.[32]

Organic mental disorders. These brain disorders are caused by outside factors, such as a traumatic brain injury, stroke, a degenerative disease, Parkinson's disease or exposure to toxic substances. Organic mental disorders can usually be detected by blood tests, a CT scan or an electroencephalogram.[33] Treatment depends on the condition that caused the disorder, and usually includes rehabilitation or medication. However, the prognosis is poor, as most tend to get worse over time.[34]

Other mental disorders affect disability recipients, such as — autism, developmental disorders and intellectual disabilities — but these disability beneficiaries are more likely to be family members of workers, because they will not typically have sustained a work history that would qualify them for Social Security Disability.[35] (Supplemental Security Income is a program within the Social Security system for those who will never be able to work, but is not addressed in this paper.)

How SSDI Treats Disability

As described above, two of the most common categories of disability are actually very different in terms of diagnosis and prognosis, yet have some things in common. Both musculoskeletal and mental disorders are difficult to diagnose because, in most cases, there is no lab test to pinpoint a condition, and physicians must rely on gross physical evidence (such as swollen joints) to determine if it is present.

For instance, a blood test that measures elevated inflammatory activity in the body (known as the SED rate) can indicate a variety of possible conditions, such as vasculitis or rheumatoid arthritis. And a brain scan cannot conclusively diagnose schizophrenia. Both of these categories of disability must rely a great deal on the symptoms experienced and described by the patient, as well as family history.

Psychiatrists use symptom validity tests (SVTs) to determine the accuracy or truthfulness of a claimant's self-reported symptoms, behavioral presentation and performance on neuropsychological measures.[36] SVTs are also used in Veterans Disability and private disability insurance determinations, and are highly regarded by medical professionals. However, the Social Security Administration doubts their reliability in determining a claimant's credibility and it prohibits their use.[37]

Mental and musculoskeletal conditions are different in terms of prognosis. The majority of musculoskeletal diseases will grow worse over time, even though treatments can stabilize symptoms; whereas most mental disorders, particularly mood disorders, can improve over time and in some instances, improve quickly.

But the Social Security Disability system is a one-size-fits-all program. Unlike the Veterans Disability system, there are no varying degrees of disability. Thus, money is wasted in a system that does not differentiate between a treatable condition and a progressive, degenerative disease. Although the system is supposed to get those who get better back to work, the program provides little follow-up and even less incentive. As a result, few people (less than 1 percent) ever go back to work, even if they are physically and mentally able to do so.[38]

Mood disorders are the most frequently diagnosed mental disorder. With the exception of bipolar disorders, most mood disorders will improve over time. And some beneficiaries improve enough to work to some degree, or were not completely disabled when they applied.

- In fact, in 2013, the benefits of 34,497 individuals were withheld due to substantial work activity. Mood disorders were one of the top two conditions prevalent in those who had benefits withheld (17 percent), second only to musculoskeletal disorders (18.9 percent). [See Figure II.]
- Furthermore, in 2013, 31,591 workers were terminated from disability benefits due to a successful return to work. Nearly 20 percent of those cases were mood disorders and another nearly 18 percent were musculoskeletal disorders. [See Figure III.]

How the Application Process Works. To qualify for disability, workers must have enough Social Security disability credits based on their time in the workforce. The minimum number of credits required increases with age from six credits at age 23 to 40 credits at age 62. Older workers must have earned most of

their credits within the recent past. A nondisabled individual can lose eligibility for the program after 10 years out of the labor market, and must work additional years to regain the necessary number of credits.[39]

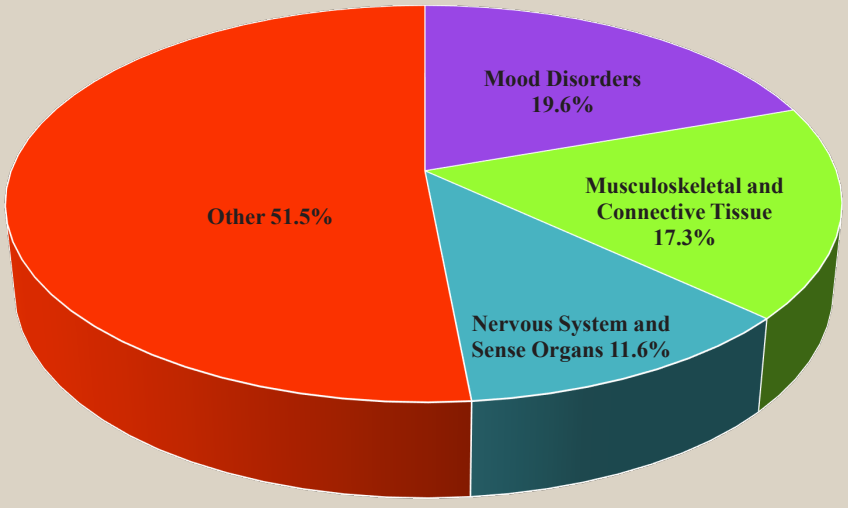
A claims examiner investigates each applicant's medical history and can require examination by an independent doctor chosen by the Social Security Administration. Once this process is completed, most claims are processed in three to five months, and payments begin the sixth month from the date the disability began.[40] If the initial claim is denied, an applicant can appeal the decision in writing within 60 days.[41]

Once benefits begin, the beneficiary's status will be reviewed periodically to determine the continuation of benefits:[42]

- If a beneficiary's condition is expected to be temporary, a review will be done after approximately six to 18 months.
- If improvement is possible, a beneficiary's case will be reviewed about every three years.
- If improvement is not expected, a beneficiary's case will be reviewed every five to seven years.

These continuing disability reviews (CDRs) are designed to combat program fraud and improper payments. Indeed, a report from the Social Security Administration's Office of the Inspector General found that every dollar spent on CDRs yields $9 in cost savings over 10 years. In 2014, however, the Office of the Inspector General found that between 2003 and 2008 CDRs declined 65 percent, likely due to the fact that during those years the federal government provided no dedicated funding for program integrity. Dedicated program integrity funding was restored in fiscal year 2013, but 1.3 million cases were still uncompleted by the end of that year.[43]

Figure III
Distribution of Benefit Terminations Due to Successful Return to Work, by Diagnostic Group, 2013



Source: "Table 53: Disabled Workers, Distribution by Diagnostic Group," *2013 Annual Statistical Report on the Social Security Disability Insurance Program.*

Even when cases are completed and the beneficiary's condition has improved, improper payments still occur, costing tens of millions of dollars.[44]

Implementing Reforms

Despite numerous other reports from the Inspector General detailing lack of follow-up on beneficiaries' disability status and improper payments, it remains to be seen whether the SSDI system will improve its "back end" functions. But a few solutions could be considered up front, during the approval process and subsequent follow-ups.

Restructure the all-or-nothing payment system to reflect varying degrees of disability, as does the Veterans' Disability system. Reasons for disability and treatments available to those suffering debilitating diseases have changed over the years. For instance, 30 years ago, neoplasms (tumors) were a significant cause of disability, affecting 16 percent of worker beneficiaries. Now they account for only three percent, thanks to early detection and improved treatments.[45]

Disability ratings could be instituted similar to the Veterans Disability system, with a few changes.

- During the initial application exam, a degree of disability would be established for the applicant, ranging from 10 percent disabled to 100 percent disabled.
- Payments would be established based on this rating; for instance, applicants with a 50 percent disability rating would receive half of the full monthly benefit they would receive if they were 100 percent disabled.

Varying payments based on degree of disability may be the greatest cost saving measure that could be implemented by SSDI:

- Currently more than 1.3 million workers with mood disorders receive an average monthly benefit of $1,061.94 per month. If this payment were reduced by an average 25 percent, reflecting varying degrees of disability among this population, the SSDI program would save over $4.2 billion a year.
- More than 2.7 million workers with musculoskeletal disorders receive an average benefit of $1,224.78 per month. If this payment were reduced an average of 20 percent, reflecting varying degrees of disability among this population, the SSDI program would save over $8 billion a year.

Prioritize Continuing Disability Reviews (CDRs). For conditions with the highest likelihood of improvement, a CDR would take place after one year, as is typically the case with the current system. Beneficiaries with conditions that become more progressive over time would be reexamined after five years, and again after five more years. After 10 years of disability, or by the time the beneficiary reaches age 55, the CDRs would stop, unless the beneficiary appeals his or her rating. This restructuring would alleviate the backlog of CDRs and give priority to those most likely to improve and spend more productive years in the workforce.

Those who have a permanent, irreversible disability, such as loss of limbs or paralysis, or have reached the advanced stages of a debilitating disease at the time of their initial application, would also be waived from future CDRs unless they choose to appeal their disability rating.

Eliminate the "Ticket to Work" program. The current SSDI system offers a voluntary "Ticket to Work" program, in which beneficiaries can work for up to three years without losing their disability benefits. The Social Security Administration provides funds to Employment Networks (EN) and State Vocational Rehabilitation Agencies (VRAs) that provide job training and assist beneficiaries in finding appropriate employment opportunities. When the program began in 1999, the Congressional Budget Office estimated it would generate savings beginning in fiscal year 2004, and that those savings would increase to $110 million annually by fiscal year 2009.[46] However, a report by the Inspector General found that the costs of funding ENs and VRAs outweighed the savings generated by participants gaining full time employment and leaving the disability rolls. The analysis compared 3,430 beneficiaries who participated in the Ticket Program to 1,513 of those who received VRA help outside of the Ticket Program and found:[47]

- A higher percentage of Ticket Program participants had some work activity between October 2004 and December 2006 (66 percent versus 52 percent).
- However, both groups' employment steadily declined over the two-year period.
- The percentage of Ticket Program participants who were employed in December 2006 was only slightly higher than nonprogram participants (69 percent versus 66 percent).
- Average annual earnings of Ticket Program participants in 2005 was actually lower than for non participants.

Generally the program had little effect on beneficiaries returning to work. The OIG also determined that while the Ticket Program produced $16.6 million in savings in fiscal year 2005, it cost $18 million. Moreover, the OIG expected that cost to increase, as 2008 changes created greater financial incentives for ENs to participate.

Instead, lift the maximum monthly income limit for work. In exchange for a reduction in payments due to rating disability by degree, the monthly maximum on labor income ($1,090 in 2015) that disqualifies a beneficiary from receiving disability benefits could be eliminated. This step would reverse the SSDI program incentive that rewards receiving maximum benefits as long as possible while penalizing work. Allowing people to work, even if they are receiving a reduced benefit, would not only incentivize work, but would also add payroll tax revenue into the system that funds these beneficiaries.

Conclusion

Incremental changes beginning now and continuing over time will slow the depletion of the trust fund and may be more palatable than several changes at once. The most significant change should be how disability is viewed and rated, as described in this paper. But other changes must be addressed, such as the beneficiary status of dependents and spouses, and the accuracy of determinations made by administrative law judges during the appeals processes. These will discussed in the future.

Notes

1. "Number of Deaths for Leading Causes of Death," Centers for Disease Control and Prevention, Deaths: Final Data for 2013, Table 10. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf.

2. "A Summary of the 2014 Annual Reports," Social Security and Medicare Trustees; available at http://www.ssa.gov/oact/trsum/.

3. "Annual Statistical Report on the Social Security Disability Insurance Program, 2013," available at http://www.ssa.gov/policy/docs/statcomps/di_asr/.

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5. " Disability Evaluation under Social Security," available at http://www.ssa.gov/disability/professionals/bluebook/.

6. "Arthritis-Related Statistics," Centers for Disease Control and Prevention. Available at http://www.cdc.gov/arthritis/data_statistics/arthritis_related_stats.htm.

7. Ibid.

8. "Carpal Tunnel Syndrome," University of Maryland Medical Center. Available at http://umm.edu/health/medical/reports/articles/carpal-tunnel-syndrome.

9. Ibid.

10. S.R. Pillemer, E.L. Matteson, L.T. Jacobsson et al., "Incidence of physician-diagnosed primary Sjögren syndrome in residents of Olmsted County, Minnesota," *Mayo Clinic Procedures*, 2001, Vol. 76, No. 6, pages 593–599.

11. "What is Sjögren's Syndrome?" Available at http://www.sjogrens.org/.

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