

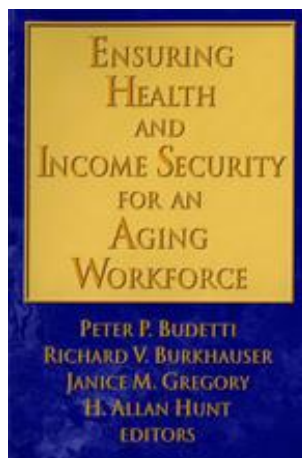
---

Upjohn Institute Press

---

## Getting Older in the 21<sup>st</sup> Century

Mark V. Nadel  
*Social Security Administration*



Chapter 5 (pp. 136-161) in:

**Ensuring Health and Income Security for an Aging Workforce**

Peter P. Budetti, Richard V. Burkhauser, Janice M. Gregory,  
and H. Allan Hunt, eds.

Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 2001

DOI: 10.17848/9780880994668.ch4

# Getting Older in the 21st Century

## The Risks and Consequences of Disability

Mark V. Nadel  
*Social Security Administration*

Among the fearful risks facing workers as they get older, disability looms large. As insurance salespeople never tire of telling us, for younger workers the risk of disability is greater than the risk of death. It is a risk that is somewhat mitigated in that some workers can start drawing pensions before they are in their mid sixties and nearly all workers have been able to draw Social Security early retirement benefits starting at age 62. Yet, until reaching the age where retirement income is available, workers confront an increased risk of disability as they age. In light of the gradual increase in the normal retirement age that began in January 2000 and concomitant diminution in early retirement benefits, the risk to older workers of becoming disabled is a particularly timely issue. We are concerned about two groups of older workers: those in what is commonly regarded as the latter years of “normal employment age” (ages 55 to 64) who will be affected by changes in the Early Retirement Age benefits and those 65 and older who will be affected by current and proposed changes in the normal retirement age.

This chapter has four objectives. The first is to examine older workers’ risk of disability, primarily the long-term disability that may limit or end employment for the rest of a worker’s life. The second is to examine the risk of loss of employment resulting from disability and the characteristics of workers that affect that employment risk. While impairment does not necessarily equate to a loss of employment, being able to overcome the impairment and work by no means guarantees that anyone will give the older worker a job. Moreover, even with the same impairment, different individuals have very different risks of losing employment or income. Third, I examine the systems of insurance coverage against those risks; who is insured, by whom, and how ade-

quately? Last, I consider the public policy implications of older workers' risk of disability, in particular the implications for proposals to raise the retirement age. In this chapter, the term *impairment* is used to mean diminished physical or mental health; *disability* refers to an impairment that results in loss of employment or serious reduction in income.

## THE RISK OF DISABILITY

As we get older, we confront a greater risk of becoming disabled. Almost one quarter of older Americans report that they have a significant disability that affects their ability to work. Data from the 1995 National Health Interview Survey (NHIS) show that 15.7 percent of individuals aged 55 to 64 reported that they were unable to work due to a disability. An additional 7 percent report that they are limited in their work activity by a disability. In contrast, 7.9 percent of the 45- to 54-year-old age group reported inability to work, but about the same proportion (6.5 percent) reported limitations in work.

It should be noted at the outset that these data, while the best available, should still be viewed with caution. The findings are based on self-reported assessments, and it is likely that some unknown number of respondents prefer to ascribe their lack of work to a disability than to the less socially acceptable reason that they just do not want to work any more. If such fudging overstates the true state of disability, there is also a countervailing trend. Almost one million 55- to 64-year-olds who report that they have no disability simultaneously report that they are unable to work due to health reasons. This may be due to some people having an acute but temporary problem, and it probably includes a number of mentally ill individuals.

We will soon have a much better assessment of the prevalence of health impairments in the population. The Social Security Administration (SSA) is embarking on an ambitious survey of disability status and functioning in the population that will provide an estimate of the number of people in the population who are severely disabled enough to qualify for Social Security Disability Insurance (SSDI) benefits.<sup>1</sup>

## Trends

The current prevalence of disability tells us just part of the story. Ideally, we would want to know what this portends for older workers in the future, and the best way to forecast the future is to examine recent trends in disability.

From the time that the 1983 amendments enacting changes in the normal retirement age were passed, there was concern that longer life spans did not necessarily translate into longer work life. An important article by Ernest Gruenberg advanced the argument that recent medical successes in postponing death only resulted in the prolongation of sickness (Gruenberg 1977). That concern was underscored by subsequent studies that pointed to evidence of deteriorating health and disability status among the older working-age population from the late 1960s through the 1970s. More recently, however, the data show a very different picture. Crimmins, Reynolds, and Saito (1999), using data from the National Health Interview Survey, analyzed trends in work ability and work limitations during the period 1982 to 1993 for the 50- to 69-year-old population. They found that in the later years of that period, both men and women older than the age of 61 are less likely to report inability to work. The size of the annual average decline in inability to work ranged from 40 to 70 percent for men and 50 to 70 percent for women. This improvement is also seen in older individuals.

Given the increase in the normal retirement age, disability trends for individuals older than 65 are also relevant. The trend toward better health is manifest for that group as well. For the 12 years between 1982 to 1994, analyses of the National Long Term Care Survey (NLTC) data have shown that the fraction of the 65- to 74-year-old population that is not chronically disabled grew by 2.6 percentage points, from 85.9 to 88.5 percent, and the fraction of the 75- to 84-year-olds not chronically disabled grew by 5.4 percentage points (Manton, Corder, and Stallard 1997). These findings support the idea that as the health and ability to work among older and younger retirement-age workers improve, increasing the age of full eligibility for Social Security will not be as detrimental to older workers as some have argued.

However, the effect of health status is more complex than a simple snapshot of point-in-time impairment would indicate. A recent analysis of the longitudinal Health and Retirement Survey found that it is not

just poor health, but rapid declines in health (“health shocks”) that explain retirement behavior. What we don’t know is whether the proportion of workers affected by the onset of such health shocks is also declining. Presumably, those who do retire early due to such health issues would be disproportionately affected by increasing the retirement age.

In summary, while becoming older increases the risk of disability, the situation for workers is better than it was. Living longer does not necessarily mean living sicker, and in the aggregate, the possibility of longer work lives is somewhat less constrained by health concerns than was true a generation ago (Bound et al. 1999).

### **International Perspectives**

The decline in disability in the United States has also been seen in other industrial countries. Waidmann and Manton (1998) reviewed studies from 10 industrial countries and found that these nations also recently experienced moderate to large declines in chronic disability in the elderly. For example, Canadian studies have shown there was a significant increase in life expectancy free of severe disability for both males and females at age 65 from 1986 to 1991. In Great Britain, analyses of Britain’s three General Household Surveys in 1976, 1981, and 1985 found an improvement over time in the expectation of life without disability in for 65- and 75-year-olds. Also, in Italy, the Netherlands, and for females in Switzerland, there were relative increases in disability-free life expectancy (DFLE) over the respective time periods.

The reasons behind the improvement are hinted at by findings in France, where disability-free life expectancy at birth increased significantly for both males and females from 1981 to 1991. For individuals 65 and older, DFLE also increased sizably in absolute and relative terms for both males and females. Robine, Mormniche, and Sermet (1998) assessed whether declines in disability were due to delayed onset of morbidity or improved management of potentially disabling conditions once they exist. The results showed that the prevalence of potentially disabling conditions rose significantly between 1980 and 1991. However, the propensity of those having these conditions to report themselves disabled fell (Robine, Mormniche, and Sermet 1998). These findings, Waidmann and Manton argued, suggest the possibility

that the treatment or management of diseases has improved or that rehabilitation rates have increased.

### **Trends and Projections in the SSDI Program**

As I discuss in more detail below, self-reported impairments are a far cry from qualifying for SSDI. Nonetheless, Social Security disability awards seem to reinforce the findings of the recent survey research. This can be seen by looking at the percentage of older workers who are awarded disability benefits at different time periods. In 1975, among 55- to 59-year-olds, the disability incidence rate (i.e., the proportion of workers in that age range who were determined to be disabled by Social Security) was 2.1 percent; by 1997, the percentage had declined to 1.4 percent. More notably, the incidence among workers aged 60–64 declined from 2.9 to 1.6 percent (Social Security Administration 1999). This decline may be due largely to the trend toward early retirement, but the administrative data do not reveal the extent to which older workers in declining health opt for early retirement in lieu of applying for DI benefits. However, an analysis of HRS data by Burkhauser, Couch, and Phillips (1996) found that the men who retired early (at age 62) do not significantly differ in the prevalence of health limitations from those who wait. While they caution that this does not mean that health is unimportant, the finding at least casts some doubt on the assumption that raising the retirement age will automatically cause a proportional response in DI applications.

While trends in self-reported impairments for older workers and DI award incidence rates show a slight decline, Social Security actuarial estimates project an increase in the proportion of the workforce on the rolls. This is not in contradiction to the improving health trends. Rather, it is a reflection of the greater trend of the aging of the population as the baby boom bulges through middle age. An increasing proportion of the population will be in the over-50 age range, with its higher disability incidence rates. The Social Security Actuary's intermediate projections of the disability insurance incidence rate in 2008 is 5.9 per thousand, compared with 4.7 per thousand in 1998. The estimate takes into account the increase in the normal retirement age, with its consequent incentive for workers over 62 to seek to get on the SSDI rolls.

## Who Gets Impaired and How?

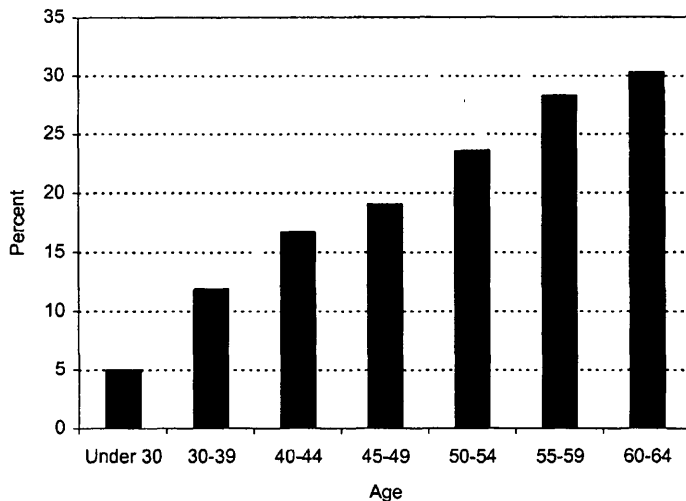
As we contemplate the possible effects of current and potential increases in retirement age, we can get a more complete understanding of the consequences by getting behind the aggregate figures and examining the disability status of different subgroups in the population. It is useful to consider the categories of disabilities affecting older workers and how disabilities are distributed across subgroups of older workers.

Not only are older workers more likely to be impaired, but the nature of the probable impairments also change over the lifespan. Figures 1, 2, and 3 show the prevalence of the three largest categories of disability among different age groups (Social Security Administration 1998, p. 219). Not surprisingly, the prevalence of musculoskeletal and circulatory disorders rise dramatically with age. Mental disorders do not necessarily decrease with age in the population. Rather, the decreasing proportion in that category for older workers reflects the growth in mental impairment SSDI allowances for younger age workers and the consequent larger numbers of younger workers in that category.

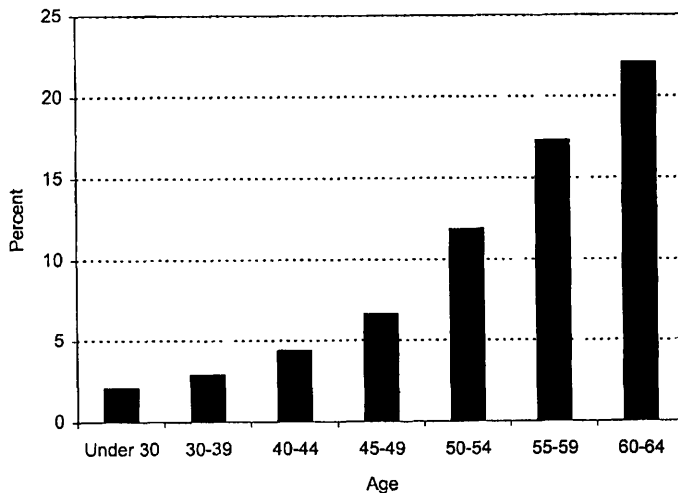
Age is not the only demographic characteristic for which disability varies. Numerous studies have documented differences in health status among racial and ethnic groups across the life cycle in the United States. For example, compared with whites, African Americans report higher rates of hypertension, diabetes, and arthritis, while Hispanics report higher rates of hypertension and diabetes and a lower rate of heart conditions (Kington and Smith 1997). Obviously, socioeconomic status must be considered in assessing the independent effect of race. In fact, Kington and Smith demonstrated that socioeconomic status plays a significant role in explaining racial and ethnic differences in the ability to function once a person has a chronic illness, but it plays a relatively minor role in explaining differences in the prevalence of chronic disease. This seems to suggest that lower socioeconomic status may lead to poorer outcomes once a disease develops because of such factors as reduced access to health care services.

Race and ethnicity are also related to employment. Crimmins, Reynolds, and Saito (1999) found that relative to non-Hispanic whites, African Americans are more than twice as likely to report inability to work. Even looking across people with the same education levels (i.e.,

**Figure 1 Distribution of SSDI Beneficiaries with Musculoskeletal System Diseases by Age**

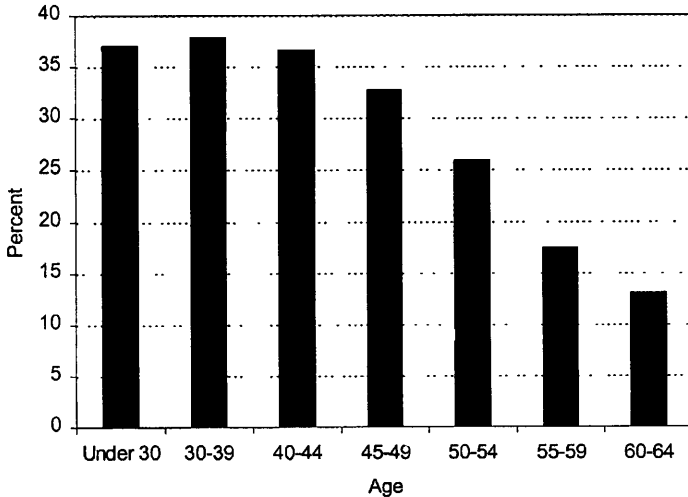


**Figure 2 Distribution of SSDI Beneficiaries with Circulatory System Diseases by Age**





**Figure 3 Distribution of SSDI Beneficiaries with Mental Disorders by Age**



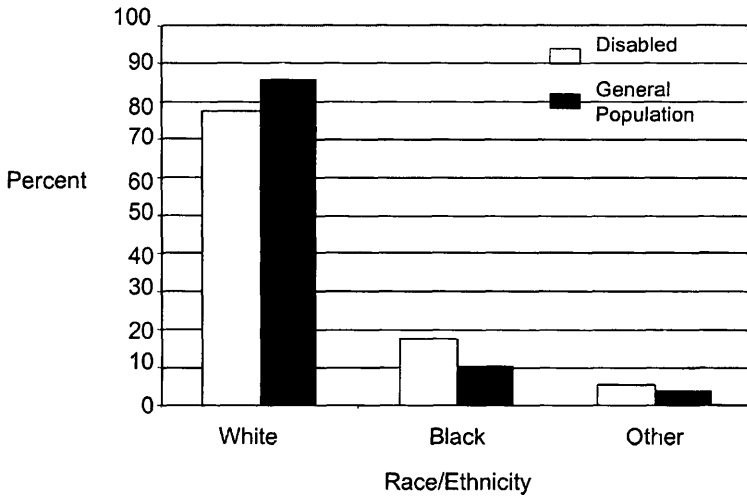
controlling for education), being African American increases the likelihood of being unable to work by about half. Similarly, Hispanics are about one and a half times more likely than non-Hispanic whites to have work disability; however, Hispanics' relative likelihood of being unable to work is about 25 percent less than that of non-Hispanic whites when education is controlled. For example, looking at the age group of particular interest, their logistic regression estimated that the probability of being unable to work among 62-year-old men with 10 years of education was 26.1 for African Americans, 18.4 for whites, and only 14.4 for Hispanics. The pattern is similar for women.

These data are also mirrored by the composition of SSDI rolls. As seen in Figure 4, African Americans are at higher risk of being severely enough disabled to qualify for SSDI.<sup>2</sup>

## **AGING AND THE EMPLOYMENT RISKS OF IMPAIRMENT**

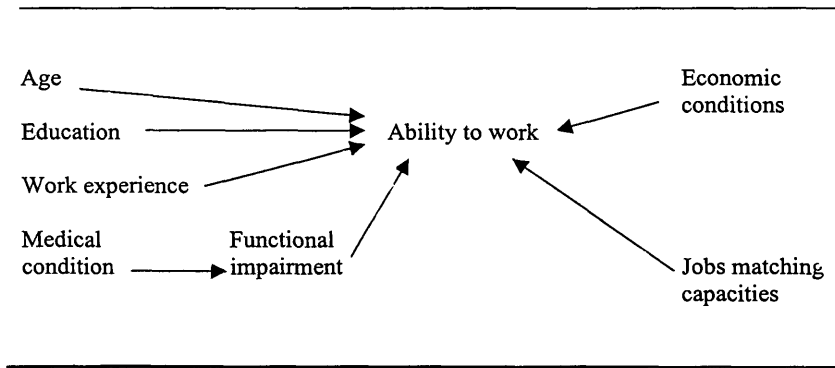
This section focuses on the economic risk of disability in general and the risk to older workers in particular. Age clearly has an effect on

**Figure 4 Race/Ethnic Representation of 55- to 57-Year-Olds in DI and General Populations**



SOURCE: Table 5.A1, *Social Security Bulletin, Annual Statistical Supplement 1998*, p. 185. Data for General Population: Table No. 22, *Resident Population, by Race and Single Years of Age, 1997*, U.S. Bureau of the Census.

gaining and sustaining employment. Not only are older workers more likely to get DI benefits, data from Social Security's New Beneficiary Survey show that, once on the rolls, older beneficiaries have a lower tendency to return to work; once working they have a higher tendency also to stop working (Hennessey 1997, p. 16). Age by itself, of course, is not the only factor limiting an individual's ability to work in the economy. Similarly, a medical impairment, by itself, does not necessarily limit an individual's ability to work in the economy. Rather, the ability to work is a function of individual factors and factors in the environment. Figure 5 presents a simple model of the process. The following discussion gets below the aggregate data on disability and focuses on factors that either mitigate or exacerbate the risk of loss of employment once impairment has occurred.

**Figure 5 Factors Affecting Employability**

SOURCE: Adapted from Curtis et al. (1998).

### **The Impact of Underlying Economic Conditions**

Whether a medical impairment becomes a cause of unemployment is affected substantially by economic factors. First, economic incentives play a critical role in the decisions of people with disabilities to participate in the labor force or to seek disability benefits. An individual's decision to apply for benefits is influenced by a variety of such factors. Examples of these factors might include the availability of potential sources of other income such as pensions or savings, the availability of health insurance and noncash benefits, and the costs associated with the application process (Stapleton et al. 1998).

Secondly, underlying economic conditions affect the economic risk of disability for workers who are already out of the labor force or who are laid off. Rupp and Stapleton (1995) summarized the results of numerous econometric studies estimating the effect of the business cycle on Disability Insurance (DI) applications, awards, and caseloads. The results varied in magnitude across these studies but remained consistent in direction. The authors reported strong results in two studies they conducted. The first study analyzed DI applications and awards using 1988–1992 data; the second looked at DI initial determinations

and initial allowance rates using 1988–1993 data. Stronger effects were found for applications. Specifically, they found that a 1-percentage-point increase in the unemployment rate resulted in a 4 percent growth in DI applications.

Similarly we would expect that disability insurance applications should fall when the economy rebounds from a recession. In fact, the DI application rate growth declined from a peak of 13.2 percent in 1991 to 2.7 percent in 1994, as the economy rebounded from the recession. These results suggest that the labor market affects the number of workers applying for SSDI, but note that this evidence covers only a relatively short period of time, and the DI application rate, just as the DI approval rate, is also affected by changes in SSA policy and implementation practices. Nonetheless, it seems reasonable to infer that workers with disabilities would be more likely to seek SSDI benefits when they have fewer alternatives in the economy.

Recent evidence indicates that the economic risk of disability does not occur only during economic downturns but is present even when the economy is robust. Burkhauser et al. (1999) evaluated how the 1990s business cycle impacted working-age disabled people. As expected, they were able to quantitatively demonstrate the disproportionately negative impact the downturns in the business cycle had on people with disabilities relative to those without disabilities. What is more disturbing, however, is that employment and labor earning of individuals with disabilities declined over the entire 1990 business cycle, although less so in recovery than in recession.

### **Mitigating Factors**

Although aging does increase the risk of disability, and the economy (expressed by the unemployment rate) can affect workers positively or negatively, there are a number of factors for the individual and for society that mitigate the economic risk of impairment for at least a segment of the workforce. For the individual, these factors might include employer accommodations, a supportive family, and good medical care. In the aggregate, two factors of particular importance are the changing nature of work and educational attainment.

### **The changing nature of work**

Whether a particular impairment results in loss of employment depends largely on the kind of work one is doing when disabled and the kind of jobs that are available. This relationship, in turn, depends on broader trends affecting the physical nature of work. The replacement of high-paying manufacturing jobs with relatively low-paying service sector jobs is seen by many as an important factor in DI application and award growth. Rupp and Stapleton (1995) suggested that in the short-run this trend may increase the DI application rate, as workers with disabilities who lose their manufacturing jobs may not find new work in the service sector and then apply for disability benefits. In the long run, however, it is thought the effect might be to reduce the number of applications, because service sector workers are less susceptible to disabling injuries and illnesses. Rupp and Stapleton suggested that these long-run effects may vary across different impairment groups. For example, workers with physical impairments would be less likely to require DI benefits, while those with mental impairments would be more likely to do so. If they are correct, another correlate of this difference is that as work requires greater cognitive skills, those with mental impairments will be less likely to retain or gain employment due to a lack of skill match. At the same time, those with physical impairments but lacking requisite cognitive skills for other reasons will also be less likely to be employed because of a decline in jobs requiring only physical exertion.

### **The importance of education**

It has become a cliché to report that both income and likelihood of employment are positively related to levels of education—but, like many clichés, it is true. The current economy requires higher-skilled workers, and while there is an undersupply of more-skilled workers, there is an oversupply of less-skilled workers (Bassi, Benson, and Cheney 1996). Accordingly, among the general population, the jobless rate is directly related to education. For example, the unemployment rate of men who were not high school graduates was 61 percent higher than those who were. Similarly, those whose education stopped at high school graduation had a jobless rate 26 percent higher than those who had been to college (Bureau of Labor Statistics 1998).

The data on the relationship between education, disability, and employment (while controlling for other factors) is more scant (Curtis et al. 1998). Nonetheless, there have been studies that point to the importance of education in allowing persons with disabilities to continue working. For example, two-thirds of the relative reduction in inability to work over the time period analyzed by Crimmins, Reynolds, and Saito (1999) was accounted for by the higher education level of the older age cohort in the most recent time period studied. Similarly, education level is a factor positively associated with those on DI going back to work (Hennessey and Muller 1995).

The good news here is that the educational level of the population has been rising. In 1969, 36 percent of the 35- to 45-year-old age cohort had less than a high school degree. In 1994, only 12 percent of this cohort had so limited an education. Similarly, the percentage of that age group having college degrees has doubled to 27 percent (Friedland and Summer 1999).

## **INSURANCE COVERAGE FOR THE RISK OF DISABILITY**

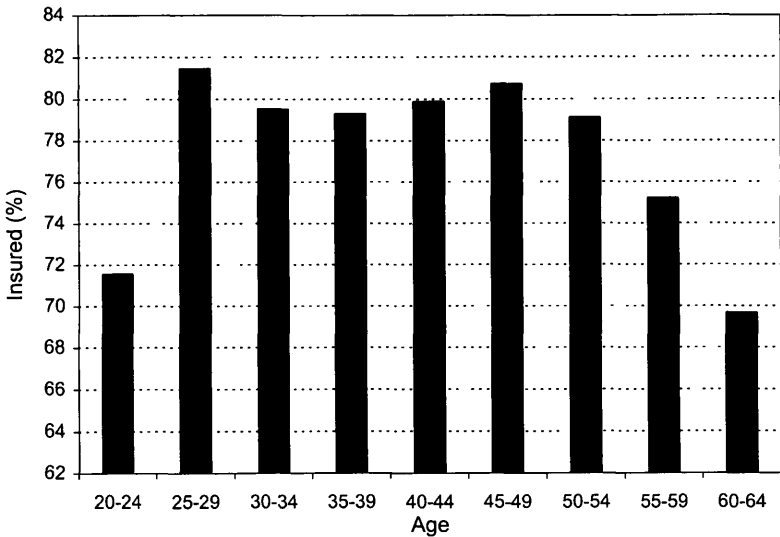
When the onset or worsening of an impairment results in the inability to work, workers may be covered by a combination of public and private benefit plans. Workers generally are covered by Social Security disability programs, workers compensation, and, to a much more limited extent, private disability insurance.

The first issue to raise in considering disability coverage is one of scope. Far fewer individuals receive any disability insurance income, public or private, than have self-reported work impairments. Using data from the 1994 National Health Interview Survey on Disability, Adler (1997) found that while 16.9 million working-age adults reported having a work disability, only 9.1 million received benefits from any disability program. Many of the respondents with self-reported disabilities may have only short-term disabilities or may be overstating their condition, but we simply do not yet know how many are in those categories and how many are have serious need for assistance but lack benefits.

### The Protection Offered by Social Security Disability Insurance

Old Age, Survivors, and Disability Insurance (OASDI) is the broadest protection available for workers who become disabled, and it is the only disability insurance that the vast majority of Americans have. In 1998, 133.4 million workers were insured for DI benefits. To be disability-insured, workers over age 31 must have worked 5 of the last 10 years immediately preceding their period of disability.<sup>3</sup> As of 1997, 80 percent of the working-age population was SSDI insured, but the smaller proportion of younger workers who are covered lower this percentage. As a result of the exclusion of some categories of workers (such as domestics and most government workers) from Social Security in the earlier years of the program, the percentage of covered workers also trails off slightly starting with the age 50–54 cohort (Figure 6). This is especially true for women, probably because they were disproportionately out of the labor force earlier in their lives or exempt as teachers (i.e., employees of local governments).

**Figure 6 Age Groups that Are SSDI Insured (estimated)**



SOURCE: *Social Security Bulletin, Annual Statistical Supplement, 1998*, p. 181.

While most workers are covered by Social Security, the extent to which the SSDI program actually provides benefits in case of serious impairment is limited by two factors: the criteria for receiving benefits and the amount of those benefits relative to previous earnings.

The criteria for being awarded SSDI benefits are very stringent. The law defines disability as the inability to engage in any “substantial gainful activity” by reason of any medically determinable physical or mental impairment(s) 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. Moreover, SSDI benefits generally do not begin until five months after the onset of the disability. Many more individuals apply for DI benefits than actually receive them. At latest count, approximately 49 percent of applicants are ultimately awarded benefits either initially or through the final administrative appeal.

Once awarded, the SSDI benefit amount, like retirement benefits, is related to earnings, but is also progressive. That is, the more you have earned, the more you get in benefits, but lower-wage workers receive an amount that represents a higher proportion of the predisability earnings than higher-wage workers. The benefits and replacement rate for a 50-year-old worker at different income levels is shown in Table 1. Note that individuals on SSDI may earn up to \$700 per month and not lose any benefits. Benefits are generally also paid to spouses when there is a dependent child and also to those children. In 1997, those benefits averaged \$178 to wives and \$129 to husbands. Children received an average of \$195 (\$292 if they were also disabled).

**Table 1 Earnings Replacement Rates for Steady Workers Entitled to SSDI (1998)<sup>a</sup>**

Variable	Earnings level				
	Low	Average	High	Maximum	
1997 Earnings (\$)	12,342	27,426	43,882	65,400	
Annual benefit <sup>b</sup> (\$)	7,060	11,629	15,446	17,920	
Replacement rate (%)	57.2	42.4	35.2	27.4	

<sup>a</sup> For a 50-year-old worker at four levels of covered earnings.

<sup>b</sup> Shown for illustrative purposes. Benefits are paid on a monthly basis.



## Accounting for Age

The connection between age and disability is inherent in the Social Security Disability program. The initial cash benefit program established in the Social Security Amendments of 1956 provided benefits only for disabled insured workers who were between the ages of 50 and 65. The House Ways and Means Committee Report on the legislation stated

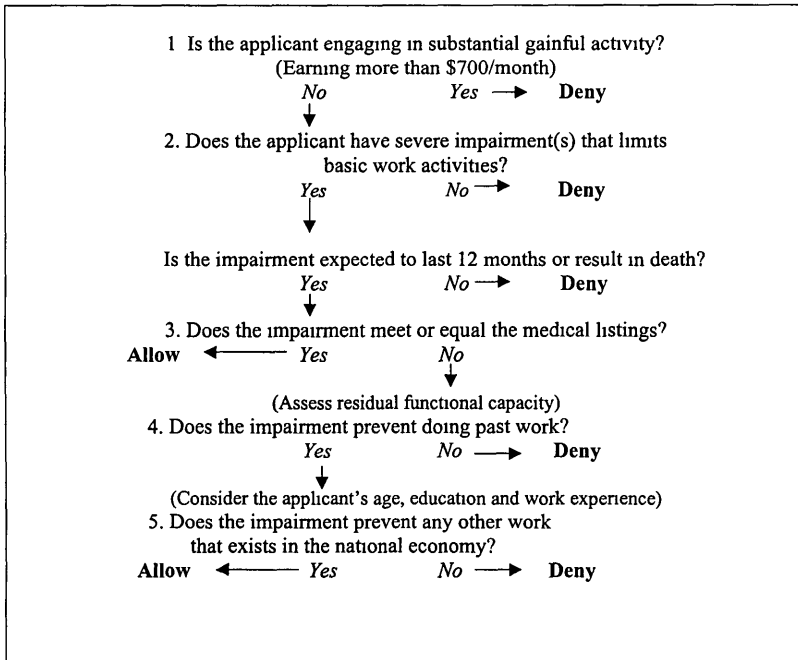
retirement protection for the 70 million workers under old-age and survivors insurance is incomplete because it does not now provide a lower retirement age for those who are demonstrably retired by reason of a permanent and total disability. We recommend the closing of this serious gap in the old-age and survivors insurance system by providing for the payment of retirement benefits at age 50 to those regular workers who are forced into premature retirement because of disability.

Thus, disability insurance was conceived of as a necessary early retirement program for older workers.

In 1960, Congress removed the minimum age requirement of 50 years for disability insurance beneficiaries. Nonetheless, the Social Security Administration considers age to be a significant factor in the disability decision process. It is not that age makes an individual more disabled; rather, the agency's assumption is that people in the latter stages of work life who have impairments are less likely to be able to adjust to new employment opportunities. To understand the place that age plays in disability determination, it is useful to review briefly how SSA determines that an individual is disabled for purposes of receiving SSDI. SSA uses a five-step sequential evaluation process (Figure 7).

It is at step five—determining whether there are other jobs the individual can perform—that age comes into account, as required by the Social Security Act. For younger persons (under age 50), SSA does not consider that age will seriously affect one's ability to adapt to a new work situation. Social Security regulations state that "if you are closely approaching advanced age (50–54) we will consider that your age, along with a severe impairment and limited work experience, may seriously affect your ability to adjust to a significant number of jobs in the national economy." "Advanced age" (55 or over) is that point

**Figure 7 Social Security Sequential Disability Decision-Making Process**



where SSA regards age as significantly affecting a person’s ability to perform substantial gainful activity.

Both the increasing numbers of workers in the older age ranges and the impact of the easing of standards for them in step five can be seen in the proportion of persons who successfully apply for DI benefits (Table 2).

**The Protection Offered by Supplemental Security Income**

As the name implies, the Supplemental Security Income (SSI) program supplements the coverage provided by SSDI. As a means-tested program, it does so in two ways. First, it provides disability benefits to individuals who are not covered by SSDI. For individuals who meet the low income and assets test, the sequential evaluation to determine whether they are disabled for Social Security purposes is the same as it

**Table 2 SSDI Awards and Applications by Age, 1997<sup>a</sup>**

Age range	Applications filed	Awards	Applications allowed (%)
30-39	209,355	70,735	34
40-49	283,343	116,438	41
50-59	320,861	195,883	61

SOURCE: Social Security Administration unpublished data.

<sup>a</sup> Both applications and awards are the total of first-time and reapplications.

is for SSDI. Secondly, even for individuals who are receiving SSDI but whose benefits are very low (currently below \$500 a month), SSI provides supplemental coverage with a total benefit somewhat higher than \$500 a month. Last year, 5.3 million persons received SSI on the basis of a disability.<sup>4</sup> Currently, out of 6.3 million SSDI beneficiaries, 1.6 million receive SSI as well. In addition to federal benefits, 44 states also provide additional benefits. Unlike SSDI, every dollar of earnings after the first \$65 a month results in a 50-cent reduction in SSI benefits.

### **The Increased Retirement Age**

In reviewing Social Security coverage for disability, we cannot look only at the DI and SSI programs. Medicare and retirement benefits must also be considered as part of the protection available to workers who become disabled.

Medicare is provided to persons who have received SSDI benefits for two years. While health insurance is obviously an important issue for any adult, it is particularly important for persons with disabilities because there is substantial evidence that they are at greater risk for additional health complications (Marge 1998). Individuals who get SSI benefits then get Medicaid immediately rather than having to wait for Medicare. Medicaid, ironically, can be more useful to these individuals because, unlike Medicare, it provides prescription drug coverage.

Social Security retirement benefits are also closely linked to workers' financial status if they become disabled. Workers on DI automatically transition to retirement benefits upon reaching 65 years of age,

but that retirement age is gradually increasing to 67. To the extent that individuals retire early due to poor health, the current increase in the normal retirement age and the eventual reduction in the amount of benefits from 80 to 70 percent of normal retirement for those workers who retire at 62 is an incentive for more workers to seek SSDI. The amount of SSDI benefits would be comparable to their normal retirement benefit. If they can get SSDI, they then convert at the normal retirement age to whatever their full Social Security retirement benefit would be and never suffer a reduction in benefits. GAO (1999) argued that while future increases in the retirement age would result in net trust fund savings, there would be some increase in disability insurance payments. However, for workers who were in poor health but could not meet the strict disability standards of SSDI, they would either have to continue to work until normal retirement age or accept a reduced retirement benefit. In short, the Social Security retirement age affects how workers mitigate the risk of disability as they age.

However, the relationship between health and retirement plans may not be as simple as is sometimes assumed. As noted above, HRS data indicate that the men who retired early (at age 62) do not significantly differ in the prevalence of health limitations from those who wait (Burkhauser, Couch, and Phillips 1996). The Congressional Budget Office (1999) also found that only 8 percent of men and 11 percent of women who took early retirement had non-Social Security income below the poverty line and a work-related disability. This may suggest that only a small proportion of early retirees are rendered extremely dependent on early Social Security benefits retirement by virtue of both disability and income.

### **Insuring against Workplace Injury—Workers Compensation**

While the Social Security Disability Insurance system covers workers with severe disabilities regardless of how they developed those disabilities, workers' compensation (WC) insurance is a nearly universal system to provide reimbursement of wages and expenses for workers who become disabled as a result of their job. WC will be discussed only briefly here.

Private insurance companies provide WC insurance, but it is not an entirely private system. Employers are generally required to provide

the insurance, but its existence also protects employers from legal liability. WC began in the early 1900s and now has separate programs for each of the 50 states and the District of Columbia. Since the basic goal of WC is to restore workers to their previous abilities, the programs strongly emphasize rehabilitation. WC is fully funded by employers. Benefits include a weekly amount until maximum medical improvement has been realized, with payments thereafter based on the degree of disability; medical care is also covered. Benefit payments, which include both cash payments and medical care, totaled \$42.4 billion in 1996.

### **Insuring against Disability—Private Plans**

While Social Security provides financial protection for workers who become severely disabled over the long term and workers compensation provides coverage for those who become injured or sick on the job, private disability insurance falls between these systems. It should be noted at the outset that private plans are not independent of Social Security; they developed in a climate that already included Social Security and other public benefits. The private plans assumed the existence of Social Security and generally are tailored to integrate with it, by offsetting their benefits by the amount of Social Security benefits. Private disability plans are broadly divided into two categories, short-term and long-term, but beyond that there is great variety and no standard terminology.

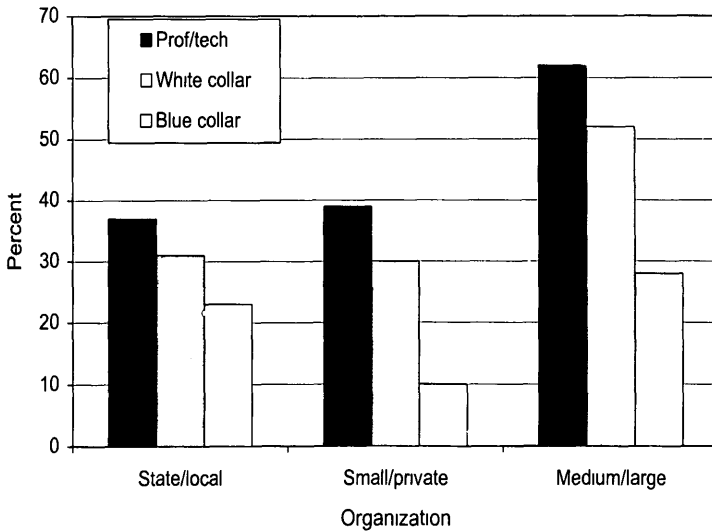
The definitions of disability within the types of plans vary to some extent, but they generally share major characteristics. Short-term plans typically cover impairments that are judged to prevent employees from engaging in their usual occupation. They generally pick up workers after sick pay is exhausted, although the plan may be in lieu of sick pay. Benefit periods generally range from 30 days to six months. Nearly all employees who end up getting short-term benefits return to work within two months. Others may, if they are covered, “graduate” to long-term disability coverage. Generally, long-term plans are more restrictive, particularly after the first two years. While they initially provide payments for employees unable to perform their usual occupation, after two years the definition usually requires the employee to be unable to perform any occupation. The earnings replacement rate of these long-

term plans is about 60 percent, up to a contractual maximum dollar amount. However, this generally includes any SSDI payments.

Private plans provide a useful measure of protection. The problem is that relatively few workers are covered. According to Bureau of Labor Statistics data, about 40 percent of full-time workers have short-term policies, and about one-third of workers have employer-provided long-term policies. As shown in Figure 8, workers in smaller firms are less likely to have long-term policies. Note that blue-collar workers in all categories of employers are the least likely to have long-term disability insurance. That is, workers in the most arduous occupations are least likely to be covered.

Individually purchased disability plans are also available, but we were unable to obtain data on participation rates for such plans. They are, however, mostly limited to highly compensated employees or self-employed individuals. These plans may replace up to 80 percent of earnings, though more typical replacement rates are 60–70 percent. Often these plans do not offset payments by the amount of Social Security benefits.

**Figure 8 Employees with Long-Term Disability Insurance**



SOURCE: Bureau of Labor Statistics 1997 Employee Benefits Survey.

As with individual and small-group health insurance, the disability income insurance market is heavily underwritten. The workers we are concerned about here, with their greater risk of disability, would likely be deemed uninsurable or face extremely high premium payments. Thus for most workers, especially most blue-collar and small-firm employees, Social Security is the only game in town.

The extent of coverage and the resulting economic risk of disability-related employment loss can be put in perspective by comparison with other countries, even though comparisons are inexact due to broader definitions of disability in other nations and the use of disability rolls to cover more general unemployment. First, a higher proportion of the working-age population is receiving disability insurance benefits in most European countries. Second, the economic well-being of men with disabilities in the United States is often not equal to their counterparts in those other countries. Burkhauser and Daly (1998) made this point by comparing the experience of U.S. and German men. Using cross-sectional data, they found that the average-income German who has a disability lives in a household which has an income that is virtually the same as that of the average German without a disability. In contrast, the income gap in the United States between those with and without disabilities is approximately 25 percent. Additionally, in Germany the pre-tax and transfer income (composed largely of own wage earnings) of men with disabilities is nearly 80 percent of that of men without disabilities, whereas in the United States the pre-tax and transfer income gap for men is almost 35 percent.

## **CONCLUSION AND POLICY ISSUES**

Older may be wiser, but it often is also weaker. For the individual, the story is mixed. While any given individual is far more likely to be impaired in the second half of work life than in the first, the good news is that that individual is likely to be somewhat healthier than his counterpart of 20 years ago. For the social insurance system, however, the improvements in health and functioning are still going to be trumped by increased number of people in their late fifties and early sixties. It

could have been worse, but demographic factors still present three key policy problems having to do with distributional issues.

The first problem is that health status is not randomly distributed in the population. Minorities and those with low educational levels are more likely to have impairments affecting their employment. Whatever the covariance and root causes of the unequal health status of minorities, under present trends, minorities will constitute a disproportionate number of those with health impairments at the same time that they are becoming a larger proportion of the general population.

The second problem is that the impact of disability on employment is concentrated. Those with higher educational status are both less likely to need to leave a job due to impairment and more likely to regain employment after losing it because of disability. This factor also reinforces the problem facing minority groups.

Finally, just as workers are admonished to have private pensions and savings in addition to Social Security (completing the famous three-legged stool), SSDI provides a benefit level that does not hold workers harmless in the event of disability. The replacement rate is less than 50 percent for most workers. However, while most people have at least short legs on their stool for retirement, a similar supplement to Social Security Disability Insurance is generally not available. We do not know the size of the assets of SSDI beneficiaries, but since their average income tends to be low, it is very unlikely that their savings are of much help when they become disabled. Similarly, private long-term disability insurance covers only about one-third of workers. Like employer-provided health insurance, it tends to be offered to workers who are already better off. In short, the health risk to the older population is not randomly distributed, and the consequences of impairment add additional risk to traditionally disadvantaged groups.

In addition to the aging baby boomers, the other contextual issue for assessing disability is the currently scheduled and potential increases in the retirement age. While we know that many people prefer to take Social Security retirement benefits at age 62, raising that age will not affect as high a proportion of workers with impairments as would have been true 20 years ago. Nonetheless, that trend will be scant comfort to those who seek to retire early for health reasons but whose impairments do not meet SSDI criteria. We are still learning more about their numbers and characteristics, but suffice it to say for



now that there will be groups that will be worse off if they must defer retirement beyond the current early retirement age or take further reductions in retirement benefits.

The current policy response to the increased prevalence of disability among older workers is to make it relatively easier for older workers to be awarded SSDI. To the extent that workers are required to work longer to receive retirement benefits, additional options may be considered. These would include modifying (i.e., easing) the sequential evaluation system for older workers, allowing a partial disability benefit for older workers, or lowering the Medicare eligibility age to reduce health costs for workers forced to retire on reduced benefits. These are all expensive propositions, but nonetheless, the impact on older workers in fragile health must be considered as we examine policy options to improve the solvency of the system.

## Notes

Mark V. Nadel is Associate Commissioner, Office of Disability and Income Assistance Policy, Social Security Administration. This paper was written with the assistance of Stephane Philogene. Howard Bradley also provided useful help. I appreciate comments from Jane Ross, Eli Donkar, Kalman Rupp, and Michael Marge. The views expressed in this paper are entirely my own and do not necessarily represent the position of the Social Security Administration.

1. The National Study of Health and Activity will do medical examinations and functional assessments and collect other data from a sample of 5,500 working-age individuals, most of whom will have been previously screened to get a sample of individuals with some degree of impairment. SSA disability examiners will determine whether individuals not now on the rolls would qualify for benefits on the basis of impairment.
2. The disability and survivors insurance features of Social Security are particularly important to blacks. While a smaller proportion of all black beneficiaries receive retirement benefits than do whites, a larger proportion of black beneficiaries receive DI benefits than do whites (25 percent for blacks compared to 12 percent for whites). See Hendley and Bilimoria (1999).
3. To be insured for DI, workers under age 65 must 1) be fully insured and 2) have recent covered earnings, as follows. Workers age 31 and over must have covered earnings in at least 20 of their last 40 quarters ending with the quarter in which the worker became disabled. Workers who become disabled before age 31 may meet an alternative to the 20/40 test: younger workers must have quarters of coverage equal to at least half of the quarters in the period between the quarter of attain-

ment of age 21 and the quarter of onset of disability. (Any odd number of quarters in that period is rounded off by one.) Even the youngest workers, however, must have a minimum of 6 quarters. Workers who meet statutory blindness requirements need only be fully insured and need not meet the second requirements for recent earnings.

4. SSI can also be paid, if the low income and asset test is met, to the aged (65+) and to children with disabilities

## References

- Adler, Michelle. 1997. *Analysis of the Disability Survey*. Department of Health and Human Services, ASPE Research Notes, Vol. 16.
- Bassi, Laurie, George Benson, and Scott Cheney. 1996. "The Top Ten Trends." *Training and Development*, Nov.
- Bound, John, Michael Schoenbaum, Todd Stinebrickner, and Timothy Waidmann. 1999. "The Dynamic Effects of Health on the Labor Force Transitions of Older Workers." *Labour Economics* 6: 179–202.
- Bureau of Labor Statistics. 1998. News release. Washington, D.C.: U.S. Department of Labor, <http://stats.bls.gov/news.release/hsgsec.t02.htm> (accessed December 1999).
- Burkhauser, Richard V., Kenneth A. Couch, and John W. Phillips. 1996. "Who Takes Early Social Security Benefits? The Economic and Health Characteristics of Early Beneficiaries." *The Gerontologist* 36(6): 789–799.
- Burkhauser, Richard V., Mary C. Daly, and Andrew J. Houtenville. 1999. "How Working-Age People with Disabilities Fared over the 1990s Business Cycle." Paper presented at the 1999 Association for Public Policy and Management Annual Research Conference held in Washington, D.C., November 4–6.
- Burkhauser, Richard V., and Mary C. Daly. 1998. "Disability and Work: The Experiences of American and German Men." *FRBSF Economic Review* 1998, no. 2: 17–29.
- Crimmins, Eileen M., Sandra L. Reynolds, and Yasuhiko Saito. 1999. "Trends in Health and Ability to Work among the Older Working-Age Population." *Journal of Gerontology* 54B(1): S31–S40.
- Curtis, Glenn, Robert Garian, Ihor Gawdiak, David Osborne, and Eric Solsten. 1998. *Vocational Factors in the Social Security Disability Decision Process: A Review of the Literature*. Library of Congress Federal Research Division, Washington, D.C., pp. 107–121.
- Friedland, Robert, and Laura Summer. 1999. *Demography Is Not Destiny*. Washington, D.C.: National Academy on an Aging Society, p. 30.

- General Accounting Office. 1999. *Social Security Reform: Implications of Raising the Retirement Age*. Report no. HEHS-99-112. Washington, D.C.: U.S. Government Printing Office
- Gruenberg, Ernest M. 1977. "The Failures of Success." *Milbank Memorial Fund Quarterly* 55(1):3-24.
- Hendley, Alexa, and Natasha Bilimoria. 1999. "Minorities and Social Security: An Analysis of Racial and Ethnic Differences in the Current Program." *Social Security Bulletin* 62(2): 59-64.
- Hennessey, John. 1997. "Factors Affecting the Work Efforts of Disabled-Worker Beneficiaries." *Social Security Bulletin*. 60(3): 3-20.
- Hennessey, John, and L. Scott Muller. 1995. "The Effect of Vocational Rehabilitation and Work Incentives on Helping the Disabled-Worker Beneficiary Back to Work." *Social Security Bulletin* 58(1): 15-28.
- Kington, Raynard S., and James P. Smith. 1997. Socioeconomic Status and Racial and Ethnic Differences in Functional Status Associated with Chronic Diseases. *American Journal of Public Health* 87(5): 805-810.
- Manton, Kenneth, Larry Corder, and Eric Stallard, 1997. "Chronic Disability Trends in Elderly United States Populations: 1982-1994." *Proceedings of the National Academy of Sciences* 94: 2593-2598.
- Marge, Michael. 1998. *Healthy People 2010 Disability Objectives: Private Sector and Consumer Perspectives*. Syracuse, New York: American Association on Health and Disability.
- Robine, J.M., P. Mormiche, and C. Sermet. 1998. "Examination of the Causes and Mechanisms of the Increase in Disability Free Life Expectancy." *Journal of Aging and Health* 10(2): 171-191.
- Rupp, Kalman, and David Stapleton. 1995. "Determinants of the Growth in the Social Security Administration's Disability Programs: An Overview." *Social Security Bulletin* 58(4): 43-70.
- Social Security Administration. 1998. *Social Security Bulletin*, Annual Statistical Supplement, 1998. Washington, D.C.: U.S. Government Printing Office.
- \_\_\_\_\_. 1999. *Social Security Disability Insurance Program Worker Experience*. Office of the Chief Actuary, SSA Publication no. 11-11543.
- Stapleton, David, Kevin Coleman, Kimberly Dietrich, Gina Livermore, and the Lewin Group, 1998. "Empirical Analyses of DI and SSI Application and Award Growth." In *Growth in Disability Benefits*, Kalman Rupp and David C. Stapleton, eds. Kalamazoo, Michigan: W.E. Upjohn Institute for Employment Research, pp. 31-79.
- U.S. Congressional Budget Office. 1999. *Raising the Earliest Eligibility Age for Social Security Benefits*. Washington, D.C.: U.S. Government Printing Office, p. 20.

- Waidmann, Timothy A., and Kenneth G. Manton. 1998. *International Evidence on Disability Trends among the Elderly*. Report prepared under contract DHHS-100-97-0010 for the Office of Disability and Long Term Care Policy. U.S. Department of Health and Human Services, Washington, D.C.
- Yelin, Edward. 1998. "Comments on Chapter 2," In *Growth in Disability Benefits*, Kalman Rupp and David C. Stapleton, eds. Kalamazoo, Michigan: W.E. Upjohn Institute for Employment Research, pp. 93–97.
- Yelin, Edward H., and Patricia P. Katz. 1994. "Labor Force Trends of Persons with and without Disabilities." *Monthly Labor Review* 117(10): 36–42.