



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

**Hearing before the
House Ways and Means Committee
Subcommittee on Social Security**

**How Disability Insurance Eligibility
Decisions Are Made**

March 20, 2012

**Testimony of
Lisa D. Ekman, JD, MSW
On Behalf of the Social Security Task Force
Consortium for Citizens with Disabilities**

ON BEHALF OF:

Association of University Centers on Disability
Bazelon Center for Mental Health Law
Community Legal Services
Corporation for Supportive Housing
Easter Seals
Health & Disability Advocates
National Alliance on Mental Illness
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TESTIMONY OF LISA D. EKMAN, JD, MSW, ON BEHALF OF THE SOCIAL SECURITY TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, thank you for the opportunity to provide testimony for this hearing on how Social Security Disability Insurance (SSDI) eligibility decisions are made.

I am a senior policy advisor for Health & Disability Advocates (HDA). HDA is a national policy and advocacy group headquartered in Chicago, Illinois. I also am a member of the Consortium for Citizens with Disabilities (CCD) Social Security Task Force. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program. I present this testimony on behalf of the undersigned members of the CCD Social Security Task Force.

The SSDI program provides vital and much-needed economic security and access to health care for individuals whose impairments are so severe that they preclude substantial, gainful work. This income support program is an integral component of our nation's safety net, reflecting the core American value of assisting those in need. We appreciate your interest in and attention to this critical program.

The Social Security Administration (SSA) requires adequate administrative resources to effectively administer the SSDI program and complete initial disability determinations in an accurate and timely manner. SSA's administrative budget (Limitation on Administrative Expenses or LAE) has been inadequate in recent years. We urge Congress to provide SSA with adequate resources to carry out all necessary program functions, especially to process initial claims, including hiring sufficient staff at the state Disability Determination Services (DDS) offices and in SSA's field offices.

We believe that the basic structure of the SSDI program is effective and should be preserved. Because the intent of the SSDI program is to replace wages and provide income support for individuals who do not have the capacity to engage in substantial gainful work, the current definition of disability is appropriate. The definition is strict, providing benefits only to individuals with the most significant impairments. And although more needs to be done to support SSDI beneficiaries to return to work to the extent that they are able, the vast majority of SSDI beneficiaries are not able to work beyond the substantial gainful activity level given the severity of their impairments and the likely course of their disabilities. Yet, the current definition provides sufficient flexibility to allow, encourage, and expand policies that can promote employment within the existing structure. While we support a number of Social Security and SSI program improvements, they do not depend on revising the definition of disability or changing the basic structure of the SSDI program.

In general, SSA does a good job of making disability determinations, given the complexity inherent in evaluating whether an individual with disabilities is entitled to SSDI benefits. There are areas, however, in which SSA can improve. We will outline some recommendations for improvement later in our testimony.

I. SSA Requires Adequate Resources to Effectively Administer the SSDI Program

Processing initial disability applications and completing initial disability determinations are resource intensive activities. Both require a significant amount of staff time to collect relevant information and fully develop the evidence required to make the correct determination. Unfortunately, SSA's LAE has not kept up with its increasing workload. This threatens SSA's ability to process disability applications in a timely manner.

As you know, for many years, SSA did not receive adequate funds to provide its mandated services, a key reason for the hearings backlog. Between FY 2000 and FY 2007, the resulting administrative funding shortfall was more than \$4 billion. The dramatic increase in the hearing level disability claims backlog coincided with this period of significant under-funding.

Congressional efforts to provide SSA with adequate funding for its administrative budget between 2008 and 2010 were encouraging. In FY 2008, the tide finally changed for the first time in a decade, when Congress appropriated \$148 million over the President's budget request. The FY 2009 appropriation provided SSA with more than \$700 million over the FY 2008 appropriation.

We were extremely grateful to Congress for recognizing SSA's need for adequate resources and including additional funds for SSA in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provided SSA with \$500 million to handle the unexpected surge in both retirement and disability applications due to the economic downturn. SSA also received badly needed funds to replace its aged National Computer Center. With the FY 2009 appropriation and the ARRA funding, SSA was able to hire thousands of new employees, including additional ALJs and hearing level support staff. This additional staff undoubtedly led to SSA's ability to make progress on the disability backlog at the hearing level.

The FY 2010 appropriation of \$11.45 billion for SSA's Limitation on Administrative Expenses (LAE), a 10 percent increase over the FY 2009 appropriation, continued to provide SSA with the resources it needed to meet its service delivery needs. Unfortunately, that trend did not continue and the current trend in funding threatens to undo all of the progress SSA made between 2008 and 2011. SSA has received virtually no increase in LAE since 2010. In FY 2011, SSA's appropriation was \$11.42 billion, a small decrease from the FY 2010 level. The FY 2012 appropriation has returned SSA's LAE to just slightly above the FY 2010 level at \$11.46 billion. This level of funding, however, is completely inadequate to keep up with SSA's workload.

As SSA's Deputy Commissioner Carolyn W. Colvin stated in her testimony for the previous hearing in this series on January 24, 2012:

Due to tight budgets in fiscal years (FY) 2011 and 2012, we have suspended or postponed lower priority activities so that we can continue to achieve our most important goals - eliminating the hearings backlog and focusing on program integrity work. Our available funding in FY 2012 is almost \$400 million less than what we operated with in FY 2010. At the same time, our fixed costs and our workloads continued to increase. We lost over 4,000 employees in FY 2011, and we expect to lose over 3,000 more employees this year that we cannot replace. We simply do not have enough staff to complete all of the work for which we are responsible....

The failure to provide SSA with adequate resources has had an impact on the ability of SSA to process disability applications and complete determinations in a timely manner, in both SSA field offices and state DDS offices. According to the SSA's Fiscal Year 2013 Budget Request, SSA had funding for 16,739 DDS employees in FY 2011.¹ That number fell to 14,825 in FY 2012 and, even under the President's FY 2013 budget request, it is expected to fall farther to 14,391 in FY 2013. That represents a 14% reduction in the number of DDS staff available to process disability applications in just the last two years.

At the same time, there has been a significant increase in the number of initial applications both for retirement and disability benefits. According to Steven Goss, Social Security's Chief Actuary, in his December testimony before this Subcommittee, this increase is driven by baby boomers entering their high disability years and the first wave becoming eligible to retire, the historic entry of women into the workforce in the 1960s and 1970s enabling them to qualify for Social Security disability benefits in larger numbers, and the recession. In FY 2011, SSA received 4.8 million retirement, survivor, and Medicare applications, and approximately 3.2 million initial disability claims—the highest number in SSA history. This trend of increased retirement applications is not likely to reverse itself anytime soon based on demographics and the aging of the baby boomers. Although the recent growth in initial disability applications is expected to level off, the number of initial disability claims is expected to remain high.

Assuming that the number of initial disability claims levels off but remains high, SSA predicts that both the number of pending disability claims and the processing time to complete them will increase.² The President requested an increase in funding for SSA's LAE to \$11.76 billion for FY 2013, a very slight increase of the FY 2012 LAE. Even if SSA receives the increase it has requested, SSA predicts that pending disability claims will increase to 861,000 in FY 2012 and to over 1.1 million in FY 2013. In addition, SSA predicts that the average number of days it will take to process initial disability claims will increase from 111 in FY 2012 to 137 in FY 2013, more than a 23% increase in one year. If SSA receives less than its FY 2013 budget request for LAE, it is likely that the pending claims and the disability processing time will only increase beyond the prediction.

Making disability determinations is a complex process and requires time to properly obtain and evaluate the evidence to make the correct decision regarding an applicant's claim. SSA field office and DDS personnel, who face increasing workloads due to both internal and external factors, might be unable to devote the resources and time needed to adequately process and evaluate disability applications. The failure to adequately develop the evidence can result in an incorrect initial decision, denying the claim for an eligible individual, thus increasing the likelihood of an appeal. For example, it might be determined that the applicant actually meets a medical listing when all of the evidence has been collected during an appeal. If the DDS personnel had been able to complete the development of the case record during the initial determination, the individual would have received benefits sooner and the cost and delay of an appeal might have been avoided.

Additional funding is required for SSA's LAE in order to reduce and eliminate the backlog at the DDS and hearing levels and to provide essential services to the public. While the current situation is dire, without adequate, ongoing appropriations to fund SSA, the forward progress recently made by the agency will deteriorate, leaving people with severe disabilities to wait years to receive the benefits to which they are entitled.

We strongly urge Congress to provide SSA with sufficient administrative funding so that there are enough personnel in both the SSA field offices and the DDSs to adequately process, develop, and determine disability claims in a timely manner. Additional funding is also needed to ensure that SSA is able to provide other critical services to the people with disabilities and to conduct program integrity activities.

II. The Current Definition of Disability Is Appropriate and Should Not Be Changed

The current definition of disability is appropriate and ensures that only those individuals with the most severe disabilities are eligible to receive benefits. The current definition is strict, requiring an individual to prove that he or she cannot maintain substantial gainful employment in the national economy. The end result is that the SSDI program provides benefits only to individuals with the most significant impairments. Many individuals receiving SSDI have made repeated attempts to work, often exacerbating their impairments, before finally turning to the program as a last resort for critical income support for themselves and their families.

The intent of the SSDI program is to provide wage replacement for workers who can no longer work at a substantial gainful level due to a physical or mental impairment. The statutory definition contained in 42 U.S.C. § 423 is:

(d)(1) The term “disability” means—

(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;

In 2012, SSA defines substantial gainful activity (SGA) as earning more than \$1010 per month for individuals with disabilities other than blindness and \$1,690 for individuals who are blind. Individuals who earn more than SGA (after the application of the SSDI work incentives) or who have disabilities likely to last less than 12 months are not entitled to receive SSDI benefits. Moreover, in evaluating whether an applicant is able to perform SGA, SSA considers not only the individual’s current job or occupation, it must by law examine all jobs in the national economy which that individual might be capable of performing, regardless of whether the individual would be hired or whether there is an actual job opening. This standard is very strict and most people who apply for benefits are denied because they cannot establish that they meet the statutory requirements. In 2010, for example, only 36% of those who applied were awarded benefits during the initial application process.³

Examining the characteristics of the people who receive benefits can assist in illustrating the appropriateness of the current definition of disability and attest to SSA’s effective application of that definition.

Beneficiaries Are Diverse and Significantly Impaired

The people who are approved for benefits have diverse disabilities. Beneficiaries include people with: late stage cancer, advanced heart disease, end-stage renal failure, intellectual disabilities, physical disabilities, endocrine disorders, pulmonary disorders, mental illness, individuals with visual impairments, and individuals who are deaf, just to give a few examples. However, just because an

individual is diagnosed with any of these impairments does not mean that he or she will be eligible for benefits. The one thing all SSDI beneficiaries have in common is that their impairments are severe enough to prevent them from performing substantial gainful activity.

Many beneficiaries are terminally ill when they apply. In fact, about one in five male SSDI beneficiaries and one in seven female SSDI beneficiaries die within the first five years of receiving benefits.⁴ Nearly 70% of SSDI beneficiaries in 2010 were age 50 or older and nearly 1 in 3 was age 60 or older.⁵ Forty-five out of one-hundred disabled workers receiving benefits qualified for benefits based on an age-related impairment, impairments which are likely to worsen rather than improve over time.

SSDI Benefits Are Modest and Many Beneficiaries Are Poor

It is also important to note that SSDI benefits only replace a percentage of the workers' previous earnings and, especially for low and moderate earners, are quite modest. The average monthly benefit in January 2012 for a SSDI program beneficiary was only \$1,110 per month, an annual income of just \$13,320.⁶ It is important to keep in mind, for comparison purposes, that a person working full-time, 40 hours per week, and earning at the federal minimum wage of \$7.25/hour, earns \$15,080 annually.⁷

SSDI benefits are so modest that they actually do not provide enough income to lift all beneficiaries out of poverty. In fact, nearly one-third of the people receiving SSDI live in households with total household income below 100% of the federal poverty level.⁸ People with work-limiting disabilities, despite the availability of SSDI, are 4.5 times more likely to live in chronic poverty than people without disabilities.⁹ Forty-seven percent of those living in poverty overall are people with disabilities and 65% of people living in long-term poverty are people with disabilities.¹⁰

III. The Disability Determination Process

Establishing eligibility for disability benefits is not a rubber-stamp process. Applicants must have a physical or mental impairment established by medical evidence provided by a physician.¹¹ Statements of symptoms alone are not sufficient.¹² Thus, the key to appropriate disability determinations is full and adequate development of the relevant evidence.

Individuals can file SSDI applications in person at a Social Security office, by telephone, or online. SSA obtains information about the individual's impairment(s) through the "Disability Report," Form SSA-3368. On the form, the individual lists impairments, treating sources and other sources of medical evidence. SSA also obtains signed consent forms, which include permission to contact any treating sources to obtain medical evidence, and any medical evidence that the individual has obtained. The package is then sent to the DDS to develop the disability claim. All requests for medical evidence necessary to evaluate the impairment are sent out by the DDS.

CCD supports initiatives to improve the process at the initial determination level so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Inadequate case development at the DDS level means that ALJs will need to spend more time reviewing cases prior to the hearing. This leads to longer processing times at the hearing level. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process.

A. New Screening Initiatives. We support SSA's efforts to accelerate decisions and develop new mechanisms for expedited eligibility throughout the application and review process for people whose conditions are the most severe and/or terminal. We encourage the use of ongoing screening as claimants obtain more documentation to support their applications. However, SSA must work to ensure that there is no negative inference drawn when a claim is not selected by the screening tool or allowed at that initial evaluation. There are two initiatives that appear to be working well, with SSA increasing the number of claims considered in these categories each fiscal year:

- **Quick Disability Determinations.** We have supported the Quick Disability Determination (QDD) process since it first began in SSA Region I states in August 2006 and was expanded nationwide by Commissioner Astrue in September 2007.¹³ The QDD process has the potential of providing a prompt disability decision to those claimants who have extremely severe impairments and readily available medical evidence. Since its inception, the vast majority of QDD cases have been decided favorably in less than 20 days, and sometimes in just a few days.

- **Compassionate Allowances.** This initiative allows SSA to create "an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both...." There are now 113 conditions on this list, published on SSA's website.¹⁴ These are conditions that clearly qualify under the disability standard based on objective medical information that can be obtained quickly. Unlike the QDD screening, which occurs only when an application is filed, screening for compassionate allowances can occur at any level of the administrative appeals process.

B. Improve development of evidence earlier in the process. We have a number of recommendations to ensure that disability claims are properly developed at the beginning of the process. Why are we so concerned about denials at the initial levels based on incomplete records? For a variety of reasons, many claimants denied at the initial level do not appeal to the reconsideration level, even though they may be as likely to be entitled to benefits as those who do appeal. We have long been concerned about claimants being discouraged from appealing denials and dropping out of the process.

While an imperfect measure of the appeal rate because the data is not longitudinal, an SSA chart for fiscal year 2011, "Fiscal Year 2011 Workload Data: Disability Decisions," does provide a very general idea about the difference in appeal rates after initial claim denials and after reconsideration denials. Far less than half of claimants whose initial claims are denied go on to request reconsideration (about 39%). In contrast, far more than 50% of claimants who receive reconsideration denials, if they proceed to that step, appeal to the ALJ hearing level.

Our specific recommendations for better development of evidence earlier in the process include the following:

- **SSA should provide more assistance to claimants at the application level.**

At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing the application, particularly in light of electronic filings, so that all impairments and sources of information are identified, including non-physician and other professional sources.

- **SSA should ensure that DDSs obtain necessary and relevant evidence.**

Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. However, DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating and examining doctors. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to DDS adjudicators. SSA has created some national forms to collect evidence, but they vary in quality. The situation is further complicated because some DDSs use their own forms, which also vary in quality. SSA should review its own national forms and DDS forms that are used to collect evidence, and set standards for state-specific forms to ensure higher quality.

- **SSA should increase reimbursement rates for providers.**

To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts. Increasing the reimbursement rate will undoubtedly improve provider response rates. It also will help to improve the medical expertise available to adjudicators for consultative examinations and for medical experts.

- **SSA should provide better explanations to medical providers.**

SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and they should ask providers for evidence relevant to the standard.

- **SSA should provide more training and guidance to adjudicators.**

Many reversals at the appeals levels are due to earlier erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as: weighing medical evidence, including treating source opinions; the role of non-physician evidence; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings. In 2006, SSA piloted using Pediatric Medical Units (PMUs) to provide specialized expertise for adjudicators who determine eligibility for disability benefits. Teams of interdisciplinary clinicians with specialized developmental and assessment expertise provided important support for state disability adjudicators. We support these types of efforts to help make disability decisions as efficiently and as early as possible in the process.

- **SSA should improve the quality of consultative examinations.**

Steps should be taken to improve the quality of the consultative examination (CE) process. The current low reimbursement rate is not sufficient to ensure the quality of consultative examinations (CEs) and undoubtedly is a factor regarding which doctors and psychologists are willing to conduct CEs for SSA. But this does not explain why claimants are referred to the wrong physician, given the disabling impairments. We hear far too many stories about inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's. This is wasted money for SSA and unhelpful to individuals, especially those with low incomes who do not have

complete medical records documenting their conditions and who need a high quality CE report to help establish their eligibility.

It is important to note that the regulations allow SSA to pay treating physicians to provide CEs, but they are rarely used in that capacity. It is likely that the low reimbursement rate contributes to non-use of treating physicians for CEs. SSA should explore ways to expand use of treating physicians to provide this information.

Also, to ensure that its funds are being used as effectively and appropriately as possible, SSA should provide more oversight of the CE process, which is conducted by the state agencies.

It appears that some DDSs refer cases for CEs rather than wait for medical documentation from the claimant's treating sources, both physicians and non-physician (if requested). A significant factor is likely the fact that DDSs operate under processing time standards against which SSA measures their performance. Claimants' representatives frequently report on the problems with obtaining medical evidence – requests are often given low priority given the busy nature of many medical offices; reimbursement rates are inadequate; and many offices lack medical records staff. The DDSs face these same challenges and when coupled with the regulatory time constraints, we believe that the DDSs are under pressure to cut short efforts to obtain medical information from treating sources.

What Statistical Analysis Can and Cannot Tell Us about the Disability Determination Process

The process of evaluating whether a person has a disability that is severe enough to qualify for DI is complex. No two people with a disability are truly alike, no matter how similar they might look on paper based on simple factors such as age, prior earnings level, primary diagnosis code, or geography. That is why disability evaluators use in-depth reviews of evidence from professionals who have actually treated and interacted, in person, with the applicant in order to make a disability determination. They must evaluate the severity of the disabling condition or conditions on a unique individual and compare this severity to the standard in the law, regulations, and SSA policy.

Statistical analysis that examines characteristics like the ones mentioned in the previous paragraph can be very useful in evaluating aspects of the overall SSDI program, like trends in the impairments for which people receive disability benefits, geographic disparities in disability prevalence, or the age or earnings profiles of new beneficiaries, for example. We do not believe, however, that even the most sophisticated statistical analysis can predict with any degree of accuracy whether an individual disability determination was correct or incorrect or whether a particular individual's impairment prevents the individual from working. Key factors in making the disability determination, such as the medical evidence presented, simply cannot be captured in statistics.

A recent working paper by the RAND Corporation entitled “Does Disability Insurance Receipt Discourage Work?”¹⁵ illustrates the danger in attempting to apply statistical analysis to evaluate the accuracy of the disability determination process. The statistical observations made by this working paper, which did not include a review of a single individual disability case or the medical evidence in any case, have been repeatedly misrepresented in making unfounded claims about SSDI adjudication and beneficiaries – such as the notion that one-quarter of current beneficiaries had their cases wrongly decided and are not eligible for benefits, and would be working if they did not receive SSDI. Such inferences are false and misinterpret what can be concluded from the working paper findings.¹⁶ The most the RAND authors' statistical analysis seems to be able to show is that 23 percent of

applications (not those whose applications are allowed benefits, or all those receiving SSDI benefits) have at least a chance, however small, of having a different outcome if another examiner had evaluated the claim. The RAND authors do not appear to estimate the actual probability or likelihood of having a different outcome. We believe it is quite low for a number of reasons, primarily because the large majority of examiners have fairly similar allowance and denial rates and it is likely a different evaluator would come to the same decision as the first.

That same RAND study finds very low levels of earnings (even among those denied benefits), which would suggest that many people with very serious barriers to work are denied benefits because they do not meet the strict legal standard. The working paper does not document poor decision making by DDS examiners, nor does it show that disabled individuals who do receive benefits could work instead and do not need them. Finally, the working paper could not attempt to determine whether any actual disability determinations were correct or not, because the researchers didn't have access to the kinds of detailed information used by an adjudicator to determine whether an individual applicant's condition met the severity standard in the law. Instead, it looked for statistical trends based on general indicators.

We caution against drawing any conclusions regarding the accuracy of the disability determination process or on the effect of SSDI benefit receipt on the work behavior of applicants based on a statistical analysis of administrative data. Although the current system could be improved in the ways we have previously outlined, it is fundamentally sound and the state DDSs are to be commended for the careful, thoughtful evaluation of evidence and application of the law which they use to award benefits.

Conclusion

The President's Budget Proposal for FY 2013 is the minimum needed to continue driving down disability backlogs, improve services to people with disabilities, increase efficiency, and keep pace with the rising demands of the American public. The speed and quality of SSA's disability process must continue to improve and should not be allowed to regress into the longer waiting periods of the recent past. These challenges can only be addressed if Congress and the Administration work together to ensure that Social Security continues to be the safety net it was designed to provide for people with disabilities and their families, as well as retirees and survivors of workers and retirees.

Thank you again for the opportunity to testify. CCD looks forward to continuing to work with the Subcommittee to protect this vital program for people with disabilities.

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National Multiple Sclerosis Society
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association

Endnotes

¹ <http://www.socialsecurity.gov/budget/2013BudgetOverview.pdf>

² <http://www.socialsecurity.gov/budget/2013BudgetOverview.pdf>

³ <http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2011/6c.html#table6.c7>

⁴ Gina Livermore, David Stapleton, and Henry Claypool, *Health Insurance and Health Care Access Before and After SSDI Entry*, page X, The Commonwealth Fund, May 2009.

⁵ Social Security Administration, *2010 Annual Statistical Supplement to the Social Security Bulletin*, February 2011, Table 5.D4, <http://www.socialsecurity.gov/policy/docs/statcomps/supplement/>

⁶ http://www.socialsecurity.gov/policy/docs/quickfacts/stat_snapshot/index.html?qs

⁷ See <http://www.dol.gov/dol/topic/wages/minimumwage.htm>,

⁸ Gina Livermore, et al., *Work Activity and Use of Employment Supports Under the Original Ticket to Work Regulations: Characteristics, Employment, and Sources of Support Among Working-Age SSI and DI Beneficiaries*, Final Report, April 2009, p. 8, http://www.ssa.gov/disabilityresearch/documents/TTW5_2_BeneChar.pdf

⁹ Gina A. Livermore and Peiyun She, *Long-term Poverty and Disability Among Working Age Adults*, Research Brief, August 2006, <http://digitalcommons.ilr.cornell.edu/edicollect/1226/>

¹⁰ Livermore and She, August 2006, <http://digitalcommons.ilr.cornell.edu/edicollect/1226/>

¹¹ 20 C.F.R. §§ 404.1508, 404.1513(a), 416.908, and 416.913(a). As specified in the regulations, certain other licensed professionals can establish the existence of specific impairments, e.g., licensed optometrists can establish visual disorders.

¹² 20 C.F.R. §§ 404.1508 and 416.908.

¹³ 20 C.F.R. §§ 404.1619 and 416.1019.

¹⁴ <http://www.ssa.gov/compassionateallowances/conditions.htm>

¹⁵ Maestas, Nicole, Kathleen J. Mullen and Alexander Strand. Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt. Santa Monica, CA: RAND Corporation, 2011. http://www.rand.org/pubs/working_papers/WR853-2.

¹⁶ See e.g. http://www.washingtonpost.com/opinions/the-dwindling-state-of-social-security/2011/10/31/gIQA8rzjM_story.html; Burkhauser and Daley: *Journal of Public Policy Analysis and Management*, 2012