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STATEMENT OF

PETER J. MCGOUGH, DIRECTOR

OFFICE OF PROGRAM PLANNING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ON

SOCIAL SECURITY ADMINISTRATION'S PROGRAM

FOR REVIEWING THE CONTINUING ELIGIBILITY

OF DISABLED PERSONS

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) efforts over the last two years in reexamining the continued eligibility of persons on the disability rolls. These reexaminations, mandated by the Social Security Disability Amendments of 1980 (Public Law 96-265), are referred to as Continuing Disability Investigations or CDIs.

Since March 1981, SSA has conducted CDIs on over 900,000 beneficiaries, and almost 400,000 have been terminated. The current termination rate at the initial decision level is 44 percent.

These reviews have been the subject of significant publicity and nationwide attention. Congressional concern has been intense through hearings, legislation, and other oversight activities. We have responded to many Congressional requests regarding these reviews over the last 18 months and have testified at several hearings.

SSA has taken several initiatives over the last year to improve the review process, and recently, the Secretary of HHS announced a major reform package to further improve the process for the mentally impaired as well as the physically impaired.

My testimony today will focus on two issues--the problems with adjudicating persons with mental impairments, and the issue of a possible medical improvement standard for all CDIs.

BACKGROUND--EVOLUTION OF EVENTS

In March 1981,[1] GAO reported to the Congress that SSA had not adequately followed up to verify that disability insurance beneficiaries remained disabled. The primary emphasis of this report was on problems with SSA's medical reexamination diary process, which at that time was SSA's only means of following up on beneficiaries on the rolls. We said that SSA was not establishing a reexamination diary on all beneficiaries who were expected to medically recover, and was not reexamining all beneficiaries who were diaried for a follow-up investigation. The report said that, based on a nationwide sample case review conducted in 1979 by SSA, as many as 20 percent of the persons on the disability rolls were not disabled. SSA conducted a follow-up study in 1980 and 1981 and found that 26 percent of the beneficiaries on the rolls during July/September 1980 were not disabled.

Congressional concern over SSA's medical reexaminations and other inadequate review procedures led to the enactment of Section 311 of the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabilities have not been determined to be permanent. SSA began the reviews in April 1981.

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[1]More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficaries," HRD-81-48, March 3, 1981.

Since our March 1981 report, our studies have focused on SSA's disability reexamination efforts and the high termination rate, which was in excess of 40 percent through 1981 and 1982. Part of this high termination rate included people who had recovered and others who perhaps should never have received disability benefits. We pointed out in previous testimony, however, that many individuals losing their benefits had been on the rolls several years, still had severe impairments, and had experienced little or no medical improvement. We concluded that many of the terminations were caused because of a changed adjudicative process and climate, and weaknesses in State agency medical development practices. These conclusions were especially applicable to SSA's mentally disabled and I would like to briefly summarize the results of our review of the process for adjudicating mental impairments.

PROBLEMS WITH ADJUDICATING MENTAL IMPAIRMENTS

Our review revealed several weaknesses in SSA's and the States' Disability Determination Services (DDSs) adjudicative policies and practices. Specific weaknesses we identified were:

(1) an overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities;

(2) inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

(3) inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

(4) insufficient psychiatric resources in most State DDSs.

These problems are discussed in more detail below. A more complete description of our findings and specific case illustrations are included in my testimony before the Senate Special Committee on Aging on April 7, 1983.

Overly Restrictive Interpretation of SSA'S Medical Criteria

SSA's regulations contain a set of medical evaluation criteria--referred to as the medical listings--describing impairments that are presumed to be severe enough to prevent an individual from working. If a person meets the criteria, he or she is awarded disability.

Mental impairments in the listings are categorized as: (1) chronic brain syndromes, (2) functional psychotic disorders, (3) functional nonpsychotic disorders, and (4) mental retardation. With the exception of mental retardation, the listings for mental impairments include an "A" part and a "B" part. For example, the listings for a schizophrenic (functional psychotic) disorder include part A--"manifested persistence of one or more of the following clinical signs: depression (or elation), agitation, psychomotor disturbances, hallucinations, or delusions...", and part B--"resulting persistence of marked restriction of daily activities and constriction of interest and seriously impaired ability to relate to other people". To be eligible for disability benefits, both part "A" and all of part "B" must be met.

Although the criteria for meeting the medical listings for mental impairments have not changed substantially since 1968,[2] it has become increasingly difficult for mentally-impaired individuals to meet the medical listings. As a result of our case reviews and discussions with examiners in 5 DDSs, the problem focuses principally on part B of the listings. Examiners were concluding that individuals did not meet part B based on very brief descriptions of the individuals' performing only rudimentary daily activities--such as watching television, visiting relatives, fixing basic meals, and doing basic shopping activities. Often little else positive was contained in the medical evidence.

Hard line taken by SSA

We asked examiners why they were accepting a few positive signs as support that the individuals did not have a "marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people" (as part B requires).

The examiners we interviewed told us it is difficult for them to determine when restriction of daily activities, constriction of interests, and inability to relate to other people are severe enough to meet the listings. The examiners also said SSA is taking a hard line in interpreting the criteria.

[2]The I.Q levels for mental retardation were changed in 1979 to "59 or less,' instead of "49 or less".

How the criteria are applied by SSA is of fundamental importance because cases are evaluated by SSA's quality assurance system, and State agencies look to case returns from SSA's Regional Office Disability Assessment Branches (DABs) as the clearest indicator of SSA's intent. State officials and examiners we spoke with unanimously perceive DAB returns over the past several years as intending to make it extremely difficult to meet the listings, and they have responded accordingly in their decisions. Several examiners told us that it only takes a few returns before you change the way you evaluate evidence.

We reviewed some of these case returns where the DDS had determined the individuals were very severely mentally impaired and were disabled, but the DAB returned the cases because the individuals had some daily activities, albeit extremely minimal ones. Our findings generally confirmed what the examiners had told us.

The following comment in a December 1981 letter to SSA's Chicago Regional Office from the DDS Director in Wisconsin addresses the impact of the DAB reviews in setting the adjudicative climate:

> "The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny. The rationales for these denials as promulgated by DAB reviewers, seems to be based on the most minimal possible understanding of mental impairments in terms of their effect on individuals, on the fluctuations involved in the behavior of those with

such impairments, and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capability of going out in the competitive world and obtaining and holding a job with the normal stresses, under supervision and with the necessity to be able to perform consistently."

We spoke to SSA's chief psychiatrist and two other SSA psychiatrists about our findings and about the difficulties in making medical assessments of an individual's daily activities (part B). They said to make a severity determination of a person's daily activities it is necessary to evaluate comprehensively the quality of the activity, how often it is done, whether independently or under supervision, with what degree of comprehension, and how appropriate the activity is. Other considerations should include whether the claimant is living independently or in a supervised/structured environment; or is on medication and the effects of it; and whether the claimant is in remission and the time spans between relapses.

Concerns raised about the restrictiveness of the listings' criteria

The American Psychiatric Association and others have commented to SSA, and have testified at Congressional hearings, that the criteria in the listings are overly restrictive, and have recommended changes is parts A and B of the listings. In 1982, the Chicago Regional Medical Advisor for SSA wrote that it is:

"practically impossible to meet the Listings ... for any individual whose thought processes

> are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization... In fact an individual may be commitable due to mental illness according to the State's Mental Health Codes and yet found capable of 'unskilled work' utilizing our disability standards..."

Virtually every examiner that we talked with echoed these observations. We were told that to meet the listings an individual had to be actively and continually manifesting clinical signs. Even claimants severely impaired, and currently or recently hospitalized, were found not disabled. Our group discussions with examiners produced comments to the effect that unless a claimant was "flat on his back in an institution," "comatose," or "in a catatonic state," he or she would not meet the listings.

Residual Functional Capacity and Vocational Characteristics Are Not Appropriately Considered

When an individual fails to meet the listings but the impairment still limits his or her ability to perform basic work functions, SSA's process to determine disability requires that an assessment be made of the individual's residual functional capacity (RFC). In mental impairments an RFC should consider such factors as, "capacity to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting." If the RFC assessment finds the individual incapable of doing his or her previous work, an assessment must

then be made of the individual's RFC and such vocational characteristics as age, education, and work skills to see if he or she can do other work in the national economy.

As difficult as it is to meet the criteria in the medical listings, the chances of a younger individual getting or sustaining benefits based on RFC and vocational factors is extremely slim. As we found in many of the cases we reviewed, when an individual does not meet the listings, SSA's guidance to the States resulted in a virtual presumption that he or she has the RFC to do basic work activities or unskilled work. We found little indication that thorough vocational assessments were being done.

We traced the evolution of this policy guidance back to April 1979 with SSA's publication of Informational Digest 79-32. The digest stated in part that "the capacity for unskilled work... in and of itself represents substantial work capability and would generally be sufficient to project a favorable vocational adjustment for claimants with solely mental impairments."

Several examiners told us that DAB and other quality assurance returns have given them a clear message to terminate benefits for younger workers who do not meet the medical listings.

In May 1982 the Mental Health Association of Minnesota filed a class action suit against SSA's policies regarding mental impairments in the Fourth Division Minnesota District

Court. The court concluded that,

> "...A new policy was developed by SSA beginning in early 1980 concerning eligibility for mentally impaired claimants. In accordance with that policy, SSA determined that persons whose mental impairment does not meet or equal the Listing of Impairments retain sufficient residual functional capacity to do at least unskilled work."

The court ruled in favor of the Association and said, in part, of SSA's policy that:

> "The policy ... is arbitrary, capricious, irrational, and an abuse of discretion.
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> "By use of this policy, the defendant has terminated the benefits of and denied new benefits to class members without proper assessment of the individuals' capacity to engage in substantial gainful activity."

As required by the court, the Commissioner, SSA, sent a memorandum to all Regional Commissioners on January 3, 1983, stating in effect that to presume a person who does not meet or equal the listings maintains the RFC to perform unskilled work is contrary to federal regulations. In addition, in March, and again in April 1983, SSA issued instructions to the DDSs dealing with mental impairments and their effects on individual work abilities. The instructions provide greater flexibility for determining the ability of a mentally disabled person to do work and may result in more accurate disability decisions. They do not change existing procedures, but are intended to make sure

the adjudicators clearly understand the existing procedures for evaluating the RFC assessments and considering the vocational factors in cases of mental impairments.

Inadequate Development and Use of Existing Medical Evidence

The Social Security Act requires that mental impairments causing disability be demonstrated by medically acceptable clinical techniques. When possible, all medical evidence should be obtained from existing sources, including treating physicians and institutions.

In many of the cases we reviewed, the existing medical evidence of record, including evidence already in the case file, had not, in our judgment, been appropriately considered. Rather, undue reliance was often given to purchased consultative examination (CE) reports, using them as the primary evidence on which decisions were based.

Examiners we spoke with at the five DDSs visited confirmed this. In our group discussions with examiners, they told us they order CEs automatically when they receive the case folders. They pointed out that it is almost a waste of time developing thorough longitudinal histories on a person who has some positive characteristics, which they interpret as not meeting the listings. They pointed out to us that if a medical/vocational allowance is warranted they would have to develop the claimant's negative characteristics fully, which is time-consuming, and in the end they feel the case would probably be

returned from the DAB because the person would be viewed as being able to do unskilled work. The examiners say they are then penalized on two counts--their backlogs increase and an error is charged against them.

Examiners also said that, because of production and processing time goals to adjudicate cases, they are reluctant to wait for or obtain all the historical data. They said it is much easier and faster to develop and justify a medical/vocational termination with a positive CE report.

The problem with over-relying on a CE report is that the CE physician rarely has the complete medical history to assess the patient, which can result in the physician relying on the individual's condition at that particular point in time and on the individual's description of his or her history and daily activities. The illness itself may prevent the claimant from accurately portraying such information. Also, if claimants want to appear normal, they may exaggerate their conditions or activities.

Examiners told us that SSA's policy of focusing on daily activities often leads to an over-reliance on CE examinations, which always describe claimants' daily activities. As we said earlier, because of SSA's restrictive interpretations of the medical listings, any positive daily activities that the claimant does are likely to result in a disability denial.

CE reports usually describe the daily activities as he or she "watches television," "visits relatives," "shops," "cooks

own meals," etc. Examiners, however, cannot assess the quality of a person's daily functioning and behavior from a simple description of activities.

In a discussion with the SSA psychiatrists, they confirmed that it is unlikely that a thorough psychiatric evaluation can be performed on an individual in a CE session without the individual's medical history, prior work history, workshop evaluations, and history of daily activities. These necessary elements are often lacking in CE reports, and are not being developed by the State examiners.

State Psychiatric Resources Are Severely Limited

Overall, we found that there is a shortage of in-house psychiatric medical staff available for advice within the SSA/State adjudicative system. Nationally, as of December 1982, four States and the District of Columbia had no in-house psychiatrists, and 36 others had, by SSA standards, a deficiency in the minimum psychiatric-hours required. SSA and State officials said the limited fee rates established by the States are significantly less than a competitive rate and thus, they cannot hire or contract with more psychiatrists.

In the five DDSs visited, three did not have any psychiatrists reviewing cases and two were significantly understaffed relative to SSA's psychiatric requirements. Because the process encompasses a medical (psychiatric) evaluation that is highly complex, we asked SSA's psychiatrists whether a lay person or a

non-psychiatric physician has the expertise to make such an assessment. They said examiners would not be technically qualified nor would most physicians of other medical specialties.

MEDICAL IMPROVEMENT REMAINS A MAJOR ISSUE

The second issue I want to discuss is an important policy question confronting SSA and the Congress. The issue is whether there should be a medical improvement requirement in order to terminate beneficiaries who are already on the disability rolls.

Since 1976 SSA has been determining continuing eligibility on the basis of whether a beneficiary's present medical condition meets the standards for disability at the time of review, regardless of whether the condition has improved, or whether the relevant criteria or its interpretation has changed since the beneficiary was awarded benefits. This policy also applied before 1969. Between 1969 and 1976, however, beneficiaries were generally not subject to benefit terminations if their medical conditions had not improved, unless the original awards were clearly erroneous.

In response to a March 7, 1983, request from Senators Levin and Cohen, of the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs, we began developing information relevant to the issue of having a medical improvement standard for CDIs. In particular, we looked at the situation that existed when SSA had a medical improvement standard (the "LaBonte principle") during 1969 to 1976, and the results of a 1981 SSA study designed to identify characteristics

of beneficiaries most likely to be terminated in the mandated CDI reviews. An assessment of medical improvement was part of this 21,500 SSA case study. Although we have not completed our work, we have discussed our work to date with the Senators' staff and they are aware that we are sharing our preliminary data today.

La Bonte Principle

From 1969 to 1976, SSA operated under the principle that termination from the disability rolls had to be based on evidence that demonstrated medical improvement; whereas before 1969 and since 1976, CDI cases had been treated as if they were initial applications, and medical improvement did not need to be shown.

Frances La Bonte was a claimant who had been initially denied disability, but was subsequently awarded after an appeal and a hearing by a hearing examiner (currently called ALJs). Subsequent to the award, a CDI was conducted. Because there was no change in the beneficiary's condition at the time of the medical reexamination, the benefits were continued. However, the State agency involved in the decision questioned the hearing examiner's award, and requested guidance from SSA.

In a March 13, 1969, memorandum to the State agency, the Assistant Director of SSA's Bureau of Disability Insurance said

> "...If, at the time of the initial decision, the inferences from the evidence reasonably supported a favorable decision, substantially similar evidence in a later continuing disability investigation should not be used to find current cessation based solely on different inferences. Unless current evidence at the time of the continuing disability investigation shows a material change in the claimant's situation, the period of disability established by the hearing examiner should administratively be held to be continuing. Material change in this context involves either medical improvement to a point consistent with substantial gainful work, or an actual return to substantial gainful activity."

In 1969, the La Bonte principle (named after the beneficiary) was informally adopted by SSA to avoid using the CDI process as a mechanism for overturning Bureau of Hearings and Appeals determinations with which claims examiners may disagree. The policy was formally incorporated in the operating manuals in December 1971, and provided that if the CDI reviewer determines a disability does not presently exist and medical improvement had not occurred since the previous determination, benefits were to continue or the case should be reopened under the rules of administrative finality.[3] In cases where the question of improvement could not be resolved, the disability determination was to be made on the basis of a current

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[3]Under the rules of adminstrative finality, a disability determination may be reopened and revised
--within 1 year for any reason,
--within 4 years for good cause, which is defined as a clerical error, an error on the face of the evidence (regardless of whether the determination was favorable to the claimant), and new material evidence, or
--at any time where the determination was procured by fraud or similar fault and for an error on the face of the evidence if the determination was unfavorable to the claimant.

assessment of the beneficiary's condition. Also, where the claimant's medical condition was unchanged, but his vocational competence improved significantly, a new evaluation in terms of his present work capacity was required.

It is difficult to determine what the effect of the La Bonte principle was on the CDI termination rates during its use because no statistics were developed as to what proportion of the continuances were due to the La Bonte principle versus regular findings of continuing disability. The overall termination rate for medical CDIs did sharply increase, however, after SSA discontinued using the La Bonte principle. In the year following its discontinuance (1977) the termination rate was 39 percent; whereas, the highest termination rate during the previous four years was 24 percent. In 1979 the termination rate reached a high of 48 percent.

The medical improvement requirement was dropped administratively in June 1976. SSA believed this would remedy the difficult decision of judging whether medical improvement occurred, assure equal treatment of all beneficiaries, reduce program and administrative costs, and remedy poor initial awards--including some ALJ decisions.

Redesign Study Results

To assess the potential significance of a medical improvement standard, we drew upon the results of a SSA study done during 1980-1981 which included information on how many beneficiaries on the rolls had medically improved. A purpose of

the study (the "Redesign" study) was, in preparation for the Congressionally mandated CDI reviews, to develop profiles of cases most likely to be ceased or continued and of disabilities that could be classified as permanent.

One of the characteristics developed was whether there was medical improvement between the initial award and the CDI. The study consisted of a sample of 21,521 beneficiaries awarded benefits between 1970 and 1978 who were still receiving benefits in January 1980 (projectable to about 60 percent of everyone on the rolls at that time). CDIs were done on each of these sampled cases during the study, and 6,923, or 32 percent were found to be ineligible and terminated. One-third (33 percent) of these terminations were determined to be beneficiaries who had not medically improved, 54 percent had medically improved, and in 13 percent medical improvement was undeterminable.

We further analyzed SSA's redesign cases to develop additional information on the reasons for the terminations where there was no medical improvement. We also developed information regarding beneficiaries who appealed their terminations to the ALJ level by matching automated files of all 6,923 terminated cases with SSA's Office of Hearings and Appeals files and with the SSA Master Beneficiary Records.

We believe the results of the redesign study are significant to the issue of the lack of a medical improvement

standard for the CDI reviews. We found that the primary contributing factors to the terminations of those without medical improvement were changes in adjudicative criteria and climate around 1979 including (1) the introduction of the vocational grid, (2) changes in certain criteria in the medical listings, (3) additional criteria for evaluating whether impairments were severe, and (4) a tightening of the use of "equalling the listings" as a basis for award or continuance[4]. These changes appeared to account for nearly all the terminations without medical improvement.

Beneficiaries who had been placed on the rolls by an appellate level were proportionately the hardest hit. Although initial disability awards by ALJs and the U.S. Courts accounted for only 12 percent of the 21,521 sampled redesign cases, they accounted for 20 percent of the terminations. Of the 2,303 termination cases where the beneficiaries' condition had not improved, initial awards by ALJs and U.S. Courts accounted for 31 percent.

Our analysis of the redesign study results indicated that about 47 percent of all redesign CDI terminations were back on the disability rolls by April 1983. Most of these were put back on by ALJs. ALJs made decisions on 49 percent of the terminations and 71 percent of these decisions were reversals.

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[4]For example, from 1970 to 1977, over 40 percent of the awards were for equalling the medical listings. Beginning in 1978 a precipitous drop in "equalling" occured from 32 percent to the current 8 percent of all awards. Coincidently, of the 1970 to 1978 period covered by the Redesign Study, the lowest termination rate of the Redesign cases occurred for awards made in 1978.

SUMMARY

In summary Mr. Chairman, we have identified weaknesses in the disability adjudication process, and our most recent work focused on the mentally ill. However, it is also important to point out that SSA has already moved forward with several actions to improve the adjudicative process generally and specifically for the mentally ill. The additional guidance sent to claims examiners points out the need for complete development of medical evidence, including more thorough assessments of daily activities. The guidance also points out the need for more thorough assessments of work capacity. These instructions, if properly reinforced and monitored through quality assurance activities, should lead to more accurate decisions. SSA has also increased its monitoring of the consultative examination process, including steps to help assure that consultative examination physicians are supplied with a complete medical history on the claimants.

The insufficiency of psychiatric resources cannot be solved quickly, however. It will likely remain a problem for some time. It is also very workload dependent. The more mental impairment cases there are to be adjudicated, the more serious the problem.

We continue to believe that the issue of a medical improvement standard should be addressed by the Congress, and if a standard is desired, the appropriate criteria should be specifically legislated.

We are continuing to study various aspects of the disability programs and will work closely with this Subcommittee as our work progresses.

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Mr. Chairman, that concludes my statement. We will be happy to answer any questions you or the Subcommittee members may have.