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SOCIAL SECURITY:

Employment and Health Status of

Social Security Denied Applicants

Statement of Joseph F. Delfico
Director, Income Security Issues
Human Resources Division

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Special Committee on Aging
United States Senate

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SUMMARY

Our 1987 survey found that about 58 percent of the social security disability applicants who were denied benefits in 1984 (and were still not receiving benefits as of 1987) were not working. Over two-thirds of these nonworking denied applicants reported that they had been out of work for at least 3 years, and 54 percent said they did not expect to ever work again.

The self-reported health status of the nonworking denied applicants resembled that of allowed applicants. For example, 80 percent of the nonworking denied and 78 percent of the allowed perceived their health as fair to poor, with about 44 percent of both groups saying that they were in poor health. Forty percent of the nonworking denied and 51 percent of the allowed said they had to depend on others for at least one personal care activity, such as dressing, eating, or getting in and out of bed.

These findings raise some questions about the accuracy of the social security disability criteria and determination process in judging an applicant's ability to work. We believe that the determinations of claimants' residual functional capacity (RFC) may be causing problems in disability adjudication. Our previous work has found them to be the major area of disagreement between the initial decisions made by state disability adjudicators and the appellate decisions by administrative law judges (ALJs). Disagreement over RFC was the principal cause for high reversal rates by ALJs for claimants aged 55 to 59 with certain impairments. For example, of claimants with back disorders aged 55 to 59 who had been awarded benefits by ALJs, we found that RFC was the basis for ALJ reversals in 86 percent of the cases.

The budgetary constraints imposed on the state disability determination services (DDSs) by the Social Security Administration (SSA) during the last few years may have adversely affected the quality of DDSs' disability decisions. From 1986 to 1989, there has been a 12-percent increase in cases processed and a 13-percent decrease in staff-years, and the trend is expected to continue. The DDSs' production increased from 168 cases per staff-year in 1986 to 214 cases in 1989. The production for fiscal years 1990 and 1991 are budgeted at 216 and 219 cases per staff-year. We noted that the pending caseloads (for initial cases) at the DDSs are growing and SSA's quality assurance (QA) figures have begun to show a decline in decisional quality, particularly for DDS denial decisions. The initial cases pending at the DDSs have increased 22 percent from June 1989, to June 1990. The QA error rate of DDS denial decisions increased from 4.3 percent in 1986 to 6.9 percent in 1989. About two-thirds of these error rates were for documentation errors. The relative increase in error rates appears to support concerns raised by DDS administrators about the impact of resource reductions on their case development.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the findings of our report on the health and financial status of denied social security disability applicants and to present some observations about the disability determination process.

At the request of this Committee and the House Subcommittee on Social Security, we conducted a study in 1987 to examine the employment, health, and financial status of social security disability insurance applicants, especially those who were denied benefits.[1] For this study, we contracted with the Bureau of the Census to conduct personal interviews of approximately 3,000 people nationwide. We collected a wide range of demographic, health, and economic data on both beneficiaries and denied applicants. We primarily studied applicants whose cases were adjudicated in 1984.

I will focus today on the survey's findings concerning denied applicants. I will also discuss the process of assessing disability applicants' capacity for work, which is one area of the disability determination process that does not appear to be working well. Finally, I will discuss our concerns, and those of

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[1]Social Security: Denied Applicants' Health and Financial Status Compared With Beneficiaries' (GAO/HRD-90-2, November, 1989)

state disability administrators, about recent budget cuts and staffing pressures.

OVER HALF OF DENIED APPLICANTS NOT WORKING

About 58 percent of the applicants who were denied benefits in 1984 (and were still not receiving benefits as of 1987) reported that they were not working. Of those not working, over two-thirds had been out of work for at least 3 years, and 54 percent said they did not expect to ever work again. Of those who were working, 71 percent said that because of their health, they were limited in the kind or amount of work they could do. Over 40 percent of those working said they earned less in 1986 than they did before applying for disability.

The denied applicants who were not working generally reported poor health. In fact, the self-reported health status of the nonworking denied applicants resembled that of allowed applicants. For example,

-- 80 percent of the nonworking denied and 78 percent of the allowed perceived their health as fair to poor, with about 44 percent of both groups saying that they were in poor health;

-- 40 percent of the nonworking denied and 51 percent of the allowed said that they had to depend on others for at least

one personal care activity, such as dressing, eating, or getting in and out of bed;

-- 71 percent of the nonworking denied and 76 percent of the allowed could be classified as having severe functional limitations.[2]

As you can see, the survey found that denied applicants' own assessment of their ability to work differed with the Social Security Administration's (SSA's) determinations that they could. This raises some questions about the accuracy of SSA's disability criteria and determination process in judging an applicant's ability to work.

We do not know, however, all the reasons why the nonworking denied applicants in our study were not employed or whether SSA's determinations were incorrect. There are several factors that may influence whether or not a denied applicant works. These include personal motivation and attitudes toward work as well as the availability of jobs in the economy. Also, many severely impaired people may perceive themselves unable to work, but will not meet the program's criteria for disability.

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[2]Using Census' measurement to classify the severity of functional limitation, we consider a person as having a severe limitation if he or she (1) cannot perform one or more of the essential activities of daily living (e.g., walking 2 to 3 blocks without resting or sitting for 2 hours) or (2) needs help of another person for any of the personal care items.

Social security disability is an all or nothing concept. Applicants are either allowed benefits based on total disability or they are not. The definition of disability is very strict. SSA regulations and rulings explain that to meet the social security criteria for disability, a person's impairment(s) must be of such severity that he or she is not only unable to do work previously done, but also cannot, considering age, education, and work experience, engage in any kind of substantial gainful activity that exists, in significant numbers, in the national economy. In making such a determination, it does not matter if (1) such work exists in the immediate area in which the person lives, (2) a specific job vacancy exists, or (3) the person would be hired if he or she applied for work.

Nonetheless, some denied applicants who participated in our survey may be unable to work. Many areas of the disability determination process are judgmental and subject to varying interpretations by adjudicators and physicians. One such area that may be causing problems in disability adjudication is the assessments of claimants' residual functional capacity (RFC).

RFC ASSESSMENTS DIFFER SIGNIFICANTLY BETWEEN LEVELS OF ADJUDICATION

Social security regulations define RFC as a medical assessment of what work activity a person can do despite his or her functional limitations. Our previous work has found these assessments to be the major area of disagreement between the initial decisions made by state disability adjudicators and the appellate decisions by administrative law judges (ALJs).

RFC assessments occur when adjudicators determine that claimants cannot be awarded benefits on medical considerations alone.[3] In such cases, and before considering vocational factors, adjudicators working with state agency physicians decide what capacity for work claimants have.

In assessing the RFC for individuals with physical limitations, an adjudicator[4] is to consider the claimant's ability to do physical activities, such as walking, standing, lifting, and

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[3]SSA has a list of impairments that are considered severe enough, in and of themselves, to prevent most people from doing any gainful activity. If the severity of a claimant's impairment(s) corresponds to that of an impairment in the list or is similar enough to be judged "equivalent," benefits are granted without further evaluation.

[4]SSA regulations specifically require that RFC determinations be made by state agency physicians. However, they are frequently made by adjudicators, with final approval by physicians. The HHS Office of Inspector General reported in 1989 that 75 percent of the state agencies they surveyed said that their physicians never or seldom prepare RFCs themselves.

carrying. For example, an RFC for medium work means that the person can do work that involves lifting no more than 50 pounds at a time with frequent lifting or carrying objects weighing up to 25 pounds. Similarly, an RFC for heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of 50 pounds.

In making the RFC determinations, state disability determination services (DDSs) generally do not ask treating physicians or consulting medical examiners[5] to make judgments of what claimants can do. The DDS adjudicators and physicians, without observing the claimants, make these judgments based on the medical evidence in the claimants' files.

ALJs, on the other hand, often consider DDSs' RFC judgments to be unrealistic. They hold hearings and conduct face-to-face interviews with claimants. At the hearing, they ask claimants questions about their work history, current activities, and perception of impairments, and generally form an opinion about a claimant's credibility. An ALJ may also use a medical advisor to render an opinion on the severity of the claimant's impairment and its impact on the claimant's capacity for work-related

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[5]Consulting medical examiners should not be confused with in-house DDS physicians. DDS physicians, with rare exceptions, do not examine or see claimants. They make their medical judgments based on evidence in case files. Consulting examiners are selected by DDSs to examine claimants and provide medical evidence when insufficient evidence is available from claimants' treating physicians.

activities. Medical advisors observe claimants at hearings and review medical evidence.

ALJs also often ask treating physicians and consulting examiners to provide their assessment (with rationales) about claimants' capacities for physical exertion (for example, how many pounds they can lift or carry). They then use this assessment to help them arrive at an RFC determination.

Differences in the DDSs' and ALJs' RFC determinations are one of the major reasons for high reversal rates by ALJs. For example, in a report we issued last year, Social Security: Selective Face-to-Face Interviews with Disability Claimants Could Reduce Appeals (GAO/HRD-89-22, April, 1989), we found that disagreement over RFC was the principal cause for high reversal rates by ALJs for claimants aged 55 to 59 with back disorders, heart conditions, lung disease, diabetes, or anxiety. For example, of cases involving claimants with back disorders aged 55 to 59 who had been awarded benefits by ALJs, RFC was the basis for ALJ reversals in 86 percent.

DDS assessments of applicants' RFCs were often much higher than those of ALJs. For example, in reviewing the RFCs in a sample of 242 cases where ALJs had awarded benefits following DDS denials, we found that while DDSs had determined that 54 percent of the claimants could do medium or heavy work, the cases, the ALJs

determined that less than 1 percent could do those levels of work. Similarly, while ALJs determined that 71 percent of those cases could do only sedentary work or less, the DDSs determined that only 1 percent of them were in those categories.

DDSs' practices in RFC determinations have been the subject of several lawsuits. For example, in a class action suit filed against the Tennessee DDS, a U.S. district court ruled that some of the DDS's RFC practices violated social security regulations. The DDS had been instructing its consulting physicians to refrain from making assessments of RFC and to exclude from their reports any comments on the claimants' abilities to walk, lift, etc. The court's order in 1986 and a judgment in 1987 require, in part, that adjudicators must request medical assessments from all treating and consulting physicians from whom they acquire any evidence.

We support efforts to better involve treating or consulting physicians in the determinations of claimants' RFC. Physicians who have observed and examined claimants should be in a better position to provide medical assessments of claimants' functional limitations (such as the capabilities to walk, lift, etc.).

We also believe that conducting face-to-face interviews of

selected categories of claimants at the reconsideration stage[6] could improve DDSs' RFC determinations. As stated in our report on selective face-to-face interviews, experiments with such interviews at the reconsideration stage by two DDSs suggest that the interviews appear to improve decisional quality at DDSs and resolve some cases that would otherwise become appeals to ALJs.

Closing the gap between the DDSs' and the ALJs' RFC determinations should result in more allowances at the initial level and fewer appeals and reversals at the ALJ level. This would relieve claimants of both the hardships of delays and the cost of attorney fees.

BUDGET LIMITATIONS MAY AFFECT THE QUALITY OF DECISIONS

Budgetary constraints imposed on the DDSs by SSA during the last few years may have adversely impacted on the quality of DDSs' disability decisions. DDS officials we contacted[7] during the last two weeks told us that, due to inadequate budgets and resulting productivity pressures, they had to alter some case development practices which they believe has affected their ability to adequately develop cases.

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[6]The reconsideration stage is the first level of appeal provided by the DDSs.

[7]We spoke to officials from eight DDSs about their own operations and those of other DDSs about which they had some insight. These officials included the President and seven other officers of the National Council of Disability Determination Directors.

For example, some DDS administrators said that they were not able to purchase some consultative examinations even in cases where the examinations were needed. They also said that because of increased workloads and time pressures, they reduced personal contacts with claimants in cases where it would improve case development. Some DDSs have reportedly been unable to handle all their workloads, resulting in a large backlog of cases awaiting initial decisions.

We expressed concerns about budget constraints on the disability program in 1987. We reported[8] then that budget cuts had resulted in DDSs doing less than the required number of continuing disability reviews, and that this was not cost effective. We also noted that while the 1984 disability amendments called for more extensive case development, the increasing pressures of doing more cases with fewer examiners and physician staff could lead examiners to take shortcuts, which could adversely affect the quality of decisions.

Since then the productivity pressures have increased further. From 1986 to 1989, there has been a 12-percent increase in cases processed and a 13-percent decrease in staff-years, and the trend is expected to continue. The DDSs processed over 2.2 million

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[8]Social Security: Effects of Budget Constraints on Disability Program (GAO/HRD-88-3, October, 1987)

cases in 1986 with 13,302 staff-years, or 168 cases per staff-year. In 1989, the DDSs processed almost 2.5 million cases with 11,634 staff-years, or 214 cases per staff-year. The production for fiscal years 1990 and 1991 are budgeted at 216 and 219 cases per staff-year, respectively. These levels are above those immediately preceding the 1984 amendments (200 in fiscal year 1982 and 205 in 1983), when the DDSs' workloads were extremely high and when the case development requirements were less extensive.

Pending caseloads (for initial cases) at the DDSs are growing. Initial cases pending at the DDSs have increased 22 percent from June 1989, to June 1990. Some DDSs, such as the one in Massachusetts, had over a 50-percent increase in pending initial cases during that period.

Increases in errors reported by SSA's quality assurance (QA) program appear to support concerns raised by some DDS administrators about the impact of resource reductions on their case development. The QA data show a marked decline in quality beginning in 1987. Those claimants who are denied benefits appear to be affected the most. The QA error rate of DDS initial allowance decisions increased from 2.4 percent for fiscal year 1986 to 3.1 percent for fiscal year 1989. The error rate of DDS denial decisions increased even more dramatically, from 4.3 to

6.9 percent during the same period. About two-thirds of these error rates were for documentation deficiencies.

This concludes my statement. I will be pleased to answer any questions you may have.