United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

For Release on Delivery
Expected at 9:00 a.m.
Thursday, August 3, 1995

SOCIAL SECURITY DISABILITY

Management Action and Program Redesign Needed to Address Long-Standing Problems

Statement of Jane L. Ross, Director,
Income Security Issues
Health, Education, and Human Services Division

GAO/T-HEHS-95-233

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to testify on issues related to the Social Security Administration's (SSA) management of the Disability Insurance (DI) and Supplemental Security Income (SSI) programs. These programs have grown rapidly with costs now approaching $60 billion a year in cash benefits to almost 10 million disabled beneficiaries. Moreover, the characteristics of the beneficiaries are changing; they are younger people with different types of impairments than in the past.

Today I would like to focus my remarks on three areas that require action to improve SSA's management of these programs and to make their design conform to a more contemporary concept of disability:

-- improving the timeliness and consistency of disability decisions,

-- helping more people reduce their dependence on cash benefits, and

-- ensuring that benefits are going only to those least able to work.

To develop this information, we relied on our previous work (see app., Related GAO Products), reviewed the work of other researchers and experts, and incorporated, where appropriate, data we have obtained as part of ongoing work we are conducting at your request.

In summary, our work shows that SSA has serious problems managing the disability programs on several separate but related fronts. First, the lengthy and complicated decision-making process results in untimely decisions, especially for those who appeal, and shows troubling signs of inconsistency, which compromise the integrity of the process. Second, SSA has a poor record of reviewing beneficiaries to determine whether they remain eligible for benefits and an even worse record of providing rehabilitation to help people move off the disability rolls and into employment. This reinforces the public perception that SSA pays disability benefits to people who may not qualify for them. Third, and related to the first two problems, SSA needs to make better decisions about work capacity to restore public confidence and better serve the beneficiaries.

Although the problems we cite are serious, both short-term and long-term solutions are available. SSA acknowledges and has plans to address some of the issues, but others have raised additional proposals that also warrant consideration. We believe that relatively quick action could be taken to reduce inconsistent decision-making, step up reviews of beneficiaries who may be able to return to work, and improve rehabilitation

outcomes. In some cases, SSA has the authority to take action; in others, decisionmakers may need to rethink the goals and objectives of DI and SSI. In particular, more deliberation may be necessary to better manage beneficiaries' entrance onto and exit from the rolls over the long run.

BACKGROUND

In 1994, 5.6 million disabled workers and their dependents received $38 billion in DI benefits, up from 3.9 million at the end of 1985--a 43-percent increase. Most of this growth occurred in the last 3 years when 1.1 million beneficiaries were added to the rolls. The SSI program has grown even more. Over the last decade, the number of disabled SSI recipients doubled, from 2.1 million to 4.2 million. They receive about $20 billion in benefits per year. In 1994, it cost SSA $2.7 billion to manage the disability claims process for these programs. These administrative costs account for more than half of SSA's total administrative budget but only about 3 and 7 percent of DI and SSI benefit payments, respectively.

The DI program was enacted in 1956 and provides monthly cash benefits and Medicare eligibility to severely disabled workers. SSI, on the other hand, was enacted in 1972 as a means-tested income assistance program for aged, blind, or disabled people. The Social Security Act defines disability as an inability to engage in substantial gainful activity by reason of a severe physical or mental impairment. The impairment must be medically determinable and expected to last at least a year or result in death. Both DI and SSI use the same criteria and procedures for determining whether the severity of an applicant's impairment qualifies him or her for disability benefits.

DI is funded through Federal Insurance Contributions Act (FICA) taxes, which are paid into the DI Trust Fund by employers and employees.[1] In contrast, SSI program costs are funded from general revenues, not the Trust Fund. Applicants for DI must have worked long enough and recently enough to be insured for disability benefits. Once found eligible for benefits, disabled workers continue to receive them until they return to work, reach full retirement age (when disability benefits convert to retirement benefits), die, or are found to have medically

---

[1]FICA payroll taxes are divided into the Disability Insurance Trust Fund, the Old Age and Survivors Insurance Trust Fund, and the Medicare Hospital Insurance Trust Fund. Because the DI Trust Fund was projected to be insolvent in 1995, last year the Congress reallocated payroll tax receipts to it from the Social Security Old Age and Survivors Trust Fund. This will result in a transfer of almost $500 billion by 2016, when the DI Trust Fund is again projected to be insolvent.

improved or regained their ability to work. SSI benefits are based on income rather than work history, but like DI, SSI terminates benefits to people who die, medically improve, or are able to return to work.

People can receive both DI and SSI benefits. If a beneficiary's DI benefit--based on work history--is less than the maximum SSI benefit, the DI benefit is supplemented with SSI. There are about 1.5 million of these concurrent beneficiaries, and they represent a growing percentage of the caseload.

Both DI and SSI are administered by SSA and state disability determination services (DDS). SSA field offices determine whether applicants meet the nonmedical criteria for eligibility, and DDSs make the initial determination of whether applicants meet the definition of disability. Applicants who are denied benefits at the DDS level may request a hearing before one of SSA's 1,011 administrative law judges (ALJ) and may subsequently pursue denials at this level in the federal courts.

Statute Requires Measures That Could Reduce Dependence on Cash Benefits

DI was originally established to extend Social Security old age and survivors assistance to workers who became too disabled to work. Although many of the early beneficiaries received disability payments until they retired, original legislation also promoted the rehabilitation of disabled beneficiaries. When the Congress enacted DI legislation, it recognized the great advances in rehabilitation techniques and the importance of rehabilitation efforts on behalf of disabled persons. DI legislation, and subsequently the SSI law, required that those who apply for disability benefits be promptly referred to vocational rehabilitation agencies for services to maximize the number of such individuals who could return to productive activity. In addition, current law requires SSA to suspend benefits to beneficiaries who fail to cooperate with rehabilitation efforts. In 1965, the Congress authorized payment of state costs for rehabilitation from the DI Trust Fund.

SSA is required by law to conduct continuing disability reviews (CDR) to determine which beneficiaries have recovered to the point that they no longer qualify for benefits. The law requires CDRs at least every 3 years on DI beneficiaries for whom medical improvement is expected or possible. SSA is also required by regulation to perform CDRs at least once every 7 years on beneficiaries for whom medical improvement is not expected. In addition, the Social Security Independence and Program Improvements Act of 1994 requires SSA to conduct CDRs on 100,000 SSI adults and on one-third of SSI children reaching age 18 in each of the years 1996, 1997, and 1998.

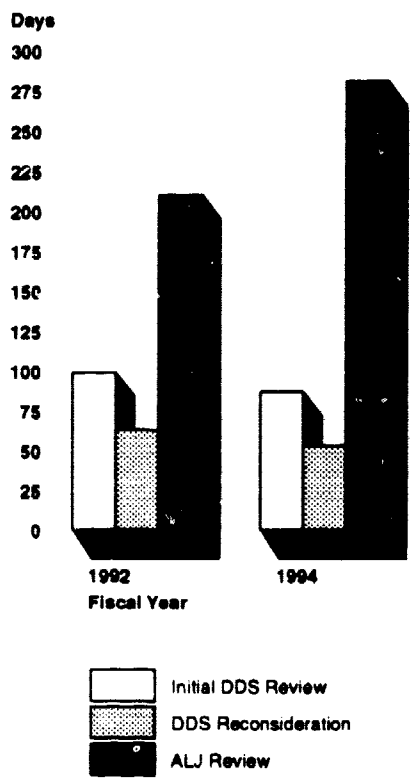
MAKING TIMELY AND CONSISTENT DISABILITY DECISIONS

Long waits for disability decisions and high reversal rates on appeal have been a subject of concern for many years. Currently, decision-making backlogs continue to grow and inconsistencies persist between initial decisions made by DDSs and those that are appealed to ALJs. SSA has attempted to address these problems in the past, and the agency and others have recent proposals directed at improving timeliness and reducing inconsistency.

Workload Pressures and Delays

Rising rates at which applications and appeals are being filed have caused tremendous workload pressures for the DDSs and ALJs. As we testified before you on May 23, 1995, backlogs and processing times at the ALJ level continue to grow. Between 1985 and 1994, the number of new appeals to ALJs more than doubled to 549,000, and the backlog of pending appeals more than quadrupled. As of March 1995, over 500,000 cases--or more than a year's worth of cases--were currently awaiting decision. As shown in figure 1, these large backlogs mean DI beneficiaries wait an average of 281 days for a final decision on appeal, which can result in hardship for claimants. From the first time they apply, some claimants may wait as long as 550 days for a decision.

Figure 1: Processing Times

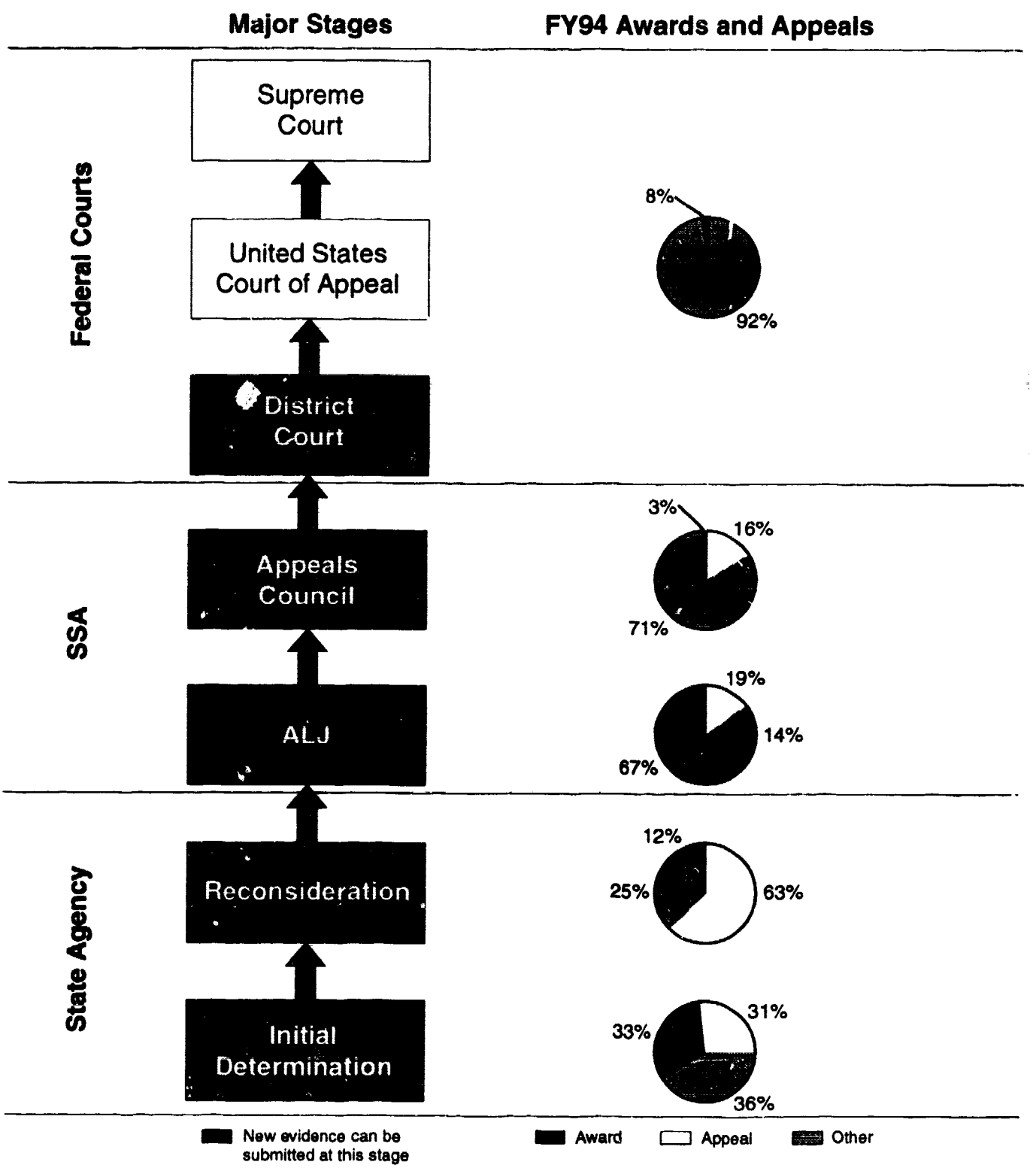


Current Process Is Long and Complicated

Figure 2 is an overview of the current decision-making process. As you can see, the process includes a multilayered administrative structure to handle appeals. The shaded boxes show that new evidence can be introduced at many points in the process, and the pie charts show that each decision level can lead to new awards, most notably at the ALJ level.[2]

[2]Other results can include denial, remand, or dismissal (for example, if a claimant fails to pursue the case).

Figure 2: The Decision-Making System and Results



For both DI and SSI, the disability determination process starts at the state DDS with the initial decision. An applicant whose claim is denied can ask to have the initial decision reconsidered. Reconsideration is conducted by different DDS personnel from those who made the initial determination; the criteria and process for determining disability, however, are the same.

Applicants whose claims are denied at the reconsideration level may request hearings before one of SSA's ALJs. About 70 percent of applicants are represented by attorneys at these hearings, and additional evidence may be submitted by medical and vocational experts as well as the applicant. Applicants whose claims are denied by ALJs can request a review by SSA's Appeals Council and then may pursue further appeals in the federal courts--first in the district courts[3] and the courts of appeal, and finally the Supreme Court.

The decision process is lengthy for those who appeal, but more than three-quarters of all awards are made by DDSs and less than one-quarter are made at the ALJ level or higher. In fiscal year 1994, DDSs awarded benefits to about 961,000 applicants in total, and ALJs awarded benefits to 264,000, while the courts awarded benefits to far fewer applicants.

Inconsistent Results Between DDSs and ALJs

SSA has had long-standing problems with consistency of its disability decisions. In 1994, ALJs allowed benefits in 75 percent of the disability cases they decided.[4] This high rate of awards to applicants denied at the DDS level raises concern about whether DDS and ALJ decisions are made on a consistent basis.

In part, this difference reflects the program's design. The ALJ does not explicitly consider and rule on the DDS's original decision. Instead, the ALJ makes a "fresh" decision based on the

---

[3]At the district court, the applicant can ask to submit new evidence for the record. If the court agrees that new evidence should be considered, it remands the case to SSA. The law provides that additional evidence may be taken before the agency on remand, but only on a showing that this is new material evidence and that there was good cause for the failure to incorporate the evidence at a prior proceeding.

[4]Approximately 11 percent of ALJ cases were dismissed before a decision was reached.

ALJ's own view of the evidence in the case.[5] In addition, the evidence considered by the ALJ can be very different from that considered by the DDS. A claimant has a right to introduce any new evidence to the ALJ, whether or not the claimant presented it to the DDS.

However, these differences do not fully explain the disparity between the two levels. Available research indicates that the two decision-making levels do not agree even when faced with the same evidence. In 1982, SSA published the results of a study that tested the consistency of DDS and ALJ decision-making.[6] As part of this study, the agency presented the same evidence to two different groups of decisionmakers--one representing the ALJ policy and procedures and the other representing the DDS policy and procedures.[7] The ALJ representatives concluded that 48 percent of the test cases should have resulted in awards, while the DDS representatives concluded that only 13 percent of the same cases should have been awards. The study concluded that "significant differences in decision results were produced when these different decision makers were presented with the same evidence on the same cases."

All the reasons for this disparity are not conclusively known, but some causes have been identified. The introduction of new evidence, for example including claimant allegations that their condition has worsened over time, and face-to-face contact at the ALJ level are two significant aspects of the current process that explain some of the disparity. Notably, SSA found that when an applicant appeared in person before a decisionmaker, there was a substantial effect on the final decision. Specifically, the 1982 study showed that evidence from the personal appearance increased the allowance rate by 17 percentage points. The results of a more recent SSA study published in 1994 suggest that disparities between DDS and ALJ decisions remain

---

[5]Technically, the ALJ's decisions are said to be de novo, or "afresh."

[6]Implementation of Section 304(g) of Public Law 96-265, Social Security Disability Amendments of 1980: Report to the Congress by the Secretary of Health and Human Services ("The Bellmon Report") Department of Health and Human Services, Social Security Administration (Jan. 1982).

[7]The evidence included all documentary evidence presented to the DDS, as well as all supplementary evidence presented to the ALJ, along with a transcript of the hearing before the ALJ. Neither group participating in the test knew what the ALJ had decided on the case.

there may be periods when they are capable of working. SSA has updated several of the listings to keep pace with advances in medicine but has not done a comprehensive evaluation of their validity.

Research also suggests that SSA's listings overestimate inability to work and are limited in distinguishing accurately between people who can and cannot work. For example, one study identified a sample of adults living in the community who had physical impairments that met or equaled the listings.[21] When their work histories were tracked, it was found that about 60 percent of men and 30 percent of women were employed 2 years after diagnosis. For adults under age 55, employment rates were even higher--over 80 percent for men and over 40 percent for women.[22]

More emphasis on functional rather than diagnostic measures is considered necessary to better assess work capacity. In its reengineering effort, SSA concluded that its methodology for making disability determinations under current law is excessively complex and does not permit the best assessment of a claimant's functional ability. Part of its reengineering effort is focused on simplifying its process and providing more standardized ways to assess medical impairment and resultant functional ability. Considerable research, however, will be needed to improve the measurement of applicants' ability to function. SSA is starting a study of disability in the general population (including the working population) that should provide some of this type of information.[23]

In addition, both the law and SSA policy generally allow benefits to be awarded to applicants whose impairments would not preclude work if they were to receive treatment.[24] In many

---

[21]Henry P. Brehm and Thomas V. Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

[22]Employment percentages exclude the 27 percent who died during the 2-year period.

[23]The study, called the Disability Exam Study, is also designed to determine the characteristics of and special accommodations made for people who continue to work and who would be considered disabled under alternative definitions of disability.

[24]The medical listings for cardiovascular disease and epilepsy require that the applicant's condition be assessed under the listings after the applicant has been under prescribed treatment for at least 3 months. However, applicants not under treatment

judgments, some level of continuing disparities would be expected. For example, about half the cases ALJs hear are musculoskeletal cases--frequently back injuries--and another 16 percent are mental impairment cases. Such cases often turn on pain, depression, fatigue, or other more subjective symptoms that could affect ability to function in the workplace.

Prior Efforts to Increase Timeliness and Consistency

SSA and the Congress have taken action in the past to increase the timeliness and consistency of disability decisions in the past. These efforts, which related to the appellate part of the process, have either been blocked by court action or substantially reduced because of workload pressures.

Three prior attempts to improve productivity and quality assurance reviews of ALJ decisions have been made. First, 1980 legislation required SSA to establish a process known as "own motion review" to oversee the quality of ALJ decisions. In some cases, this action leads to the ALJ's being overruled. However, the agency only reviews about one-half of 1 percent of ALJ allowances today, mainly because of workload pressures. Second, beginning in 1975, SSA embarked on several efforts to "target" for corrective action ALJs who had relatively high award rates or relatively low productivity. Decisions of ALJs with relatively high award rates would be subject to special review, and ALJs with low productivity would be reported for personnel actions.[12] ALJs sued to enjoin the productivity initiative, claiming it would interfere with the ALJs' decisional independence. SSA settled the suit and has not attempted major initiatives in this area again.[13] Third, in the late 1970s, a federal district court in Western Kentucky attempted to impose time limits on ALJ decisions. The court sought to require SSA to ensure that all cases would be scheduled for a hearing by an ALJ within 90 days after appeal. SSA stated that it lacked the resources to achieve this goal and also lacked the legal authority to pay benefits without an ALJ's favorable decision. As a result of the case, a 155-day time limit went into effect in Kentucky. However, no national time standard exists today.[14]

---

[12]The Administrative Procedures Act protects the independence of ALJs by limiting agency authority over certain personnel actions, such as promotions, reassignments, and transfers.

[13]Bono v. Social Security Administration, No. 77-0819-CV-W-4 (W.D.Mo., July 24, 1979).

[14]Blankenship v. Secretary of HEW, 587 F. 2nd 329 (6th cir. 1978).

In 1982, SSA established a pilot project in which it assigned staff to represent it in proceedings before the ALJs. SSA reasoned that since claimants with attorneys were frequently successful, it, too, should be represented.[15] However, SSA was forced to abandon this effort after the decision in Salling v. Bowen.[16] In his decision, the judge pointed out that the ALJ process was not designed by legislation to be an adversarial process and that changes in the law would be necessary if the process were to become adversarial.

New Proposals for Reforming the Appeals Process

We and many other experts have called for process changes to streamline the decision-making process, especially the appeals process. Recognizing the importance of making quicker and better decisions as early as possible, SSA has recently embarked on a long-range project to reengineer the disability decision-making process. Under reengineering, SSA plans for earlier face-to-face contact and better development of the record before the ALJ hearing. Central to this effort is the adjudication officer, a new focal point for prehearing activities such as identifying issues in dispute, assessing whether there is a need for additional evidence, and developing the record. SSA believes that this process will permit the ALJs to conduct more hearings and render prompter decisions. In addition, SSA plans to develop a single presentation of policies for all decisionmakers, including ALJs, to follow in determining disability. Other suggested reforms not included in SSA's reengineering plan are closing the record and changing the scope of the ALJ review.

Having claimants meet face-to-face with the decisionmaker earlier in the process has been proposed by both SSA and us to improve the process.[17] Generally, early dispute resolution is considered desirable to expedite the process by helping to ensure the earliest possible development of a complete record. An

---

[15]In 1994, approximately 71 percent of claimants had attorneys present at their hearings. Claimants with either attorneys or other representation were successful 71 percent of the time, while unrepresented claimants had only a 50-percent success rate. Some of this difference may indicate that claimants with weak cases have difficulty obtaining representation.

[16]Salling v. Bowen, 641 F.Supp. 1046 (W.D.Va. 1986).

[17]Plan for a New Disability Claim Process, Social Security Administration (Sept. 1994); and Social Security: Selective Face-to-Face Interviews With Disability Claimants Could Reduce Appeals (GAO/HRD-89-22, Apr. 20, 1989).

earlier face-to-face meeting, for example, can help target the collection and development of medical and other evidence necessary for making a correct decision more quickly. Providing an opportunity for earlier face-to-face contact may place heavier workload demands on the front end of the process, however, if applicants request this option.

Closing the record means that after some point early in the process the claimant would not be able to introduce new evidence to the case file. This would encourage the claimant to make sure that as much evidence as possible was presented as soon as possible. Today, SSA estimates that about 25 percent of ALJ allowances are based on new evidence not previously presented to the DDSs. With appropriate development of evidence earlier in the process, closing the record holds promise for tightening the focus of hearing decisions and avoiding the "do it over" aspect of the ALJ decision. In 1982, legislation was introduced that, if enacted, would have closed the record after the reconsideration stage of the process. The Grace Commission made a similar recommendation in 1983.

The Grace Commission also recommended limiting the scope of the ALJ review. Under this limited review, the ALJ would rule only on whether the DDS had complied with law and regulation when it made the original decision. This, in combination with a closed record, would most closely resemble a true appellate process and could considerably reduce the number of reversals made by ALJs. In fact, closing the record without narrowing the scope of ALJ review would not be likely to reduce their higher award rate unless ALJs were restricted in substituting their judgment for that of the DDS.

HELPING MORE BENEFICIARIES REDUCE THEIR DEPENDENCE ON CASH BENEFITS

Since 1992, we have been reporting that the characteristics of disability beneficiaries are changing and that beneficiaries leave the rolls less often.[18] For example, in 1985, the number of new entrants on the rolls was roughly equal to the number of people who left. Today, new entrants are roughly double the number of those departing.

Several factors have fueled this trend. First, people are being added to the rolls at a younger age--on average at about 48 years old. Second, those with mental impairments have come to represent higher percentages of the rolls and may stay on the rolls longer because, unlike many physical impairments, mental impairments generally do not shorten life expectancy.

---

[18]Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Rehabilitation Has Had Negligible Impact

SSA's lack of aggressive efforts to refer beneficiaries for rehabilitation services has been well documented for years. In addition to the lack of program emphasis on improving the work prospects of beneficiaries, leaving the rolls has been unattractive financially. Many beneficiaries might be unable to replace their cash benefits, health insurance, and other in-kind benefits with earnings and fringe benefits in the workplace.

In recent years, about 1 of every 500 DI beneficiaries has been terminated from the rolls because they return to work. SSA does not measure the number of SSI recipients terminated because they return to work, but its information indicates that very few do so. Today, SSA refers about 8 percent of new beneficiaries--almost 300,000 individuals--to state vocational rehabilitation agencies for appropriate services administered by the Department of Education's Rehabilitation Services Administration (RSA). These state agencies, however, only accept about 10 percent of SSA's referrals. SSA pays the cost of the rehabilitation for successfully rehabilitated DI beneficiaries from the DI Trust Fund and for successfully rehabilitated SSI recipients from general revenues. In 1994, SSA paid RSA about $64 million for rehabilitation services, or 0.11 percent of total benefits. Of the more than 7 million disabled beneficiaries on the rolls in 1994, only 5,653--less than one-tenth of 1 percent--were successfully rehabilitated at an average cost of about $11,300 per case.

Since state RSA offices are 80-percent federally funded, the practice of again paying additionally the entire cost of rehabilitating DI beneficiaries would seem to be a strong incentive to RSA offices to seek out more beneficiaries for rehabilitation. However, this incentive has not apparently achieved this purpose. Recently, the Department of Health and Human Services (HHS) Inspector General reported finding little evidence that the reimbursement system was inducing states to increase the number of SSA clients served. With few exceptions, states made no special efforts to enroll SSA beneficiaries in vocational rehabilitation programs and established no special rehabilitation programs for them.

Savings From CDRs Not Fully Realized

SSA is required to periodically review the medical eligibility of DI beneficiaries through CDRs. The frequency of these reviews is based on the beneficiary's age and impairment. The law requires beneficiaries for whom medical improvement is expected or possible to be reviewed at least once every 3 years.

SSA regulations require review of all permanently disabled cases at least once every 7 years.

Staff and budget limitations, combined with the dramatic increase in applications for disability benefits, have prevented DDSs from performing all the required examinations. For example, each year from 1991 through 1993, DDSs performed fewer than 74,000 CDRs, while as many as 490,000 CDRs come due each year. As a result, a CDR backlog now totaling about 1.5 million disabled worker cases has developed. The CDR backlog may increase because the agency is now required to conduct CDRs on 100,000 SSI adults in addition to reviewing one-third of SSI children reaching age 18 in each of the years 1996, 1997, and 1998. These new requirements--which will be absorbed within existing budgets--may further affect SSA's ability to reduce the DI backlog.

SSA is refining techniques to improve its CDR efficiency. It originally performed CDRs by referring all beneficiaries to state DDSs for medical review on the basis of fixed schedules. In May 1993, SSA started profiling beneficiaries on the basis of information in computerized databases about their characteristics. These profiles were intended to better predict the likelihood of medical improvement, and beneficiaries were referred for DDS review primarily when their profiles indicated that medical improvement would be likely.

In addition, SSA is currently studying what SSA and DDS resources might be required to eliminate the backlog over a 2-, 3-, or 4-year period, including the impact on SSA's ability to process initial claims and handle appeals at the ALJ level. As part of this effort, SSA is also studying the feasibility of contracting out part of its CDR activities to private organizations.

Conducting CDRs has profound implications for expenditures because of the combined effect of the surge in applications and the growing tendency of beneficiaries to remain on the rolls longer. If SSA were to perform CDRs on its backlog of 1.5 million disabled worker cases, it would obtain nearly all of its savings from eliminating about half of the backlog, which is made up of beneficiaries for whom medical improvement is expected or possible. The remainder of the backlog is permanently disabled cases; most of these beneficiaries are over 50 years old and about half have been on the rolls for 11 or more years. Taking all of this into account, however, the net savings could amount to about $1.7 billion for cash and medical benefits that would have been paid over the beneficiaries' average length of stay on the rolls. This figure is based on SSA's estimate that about 3 percent of the cases for whom medical improvement is expected or possible would be terminated. Each termination would cost an

average of $500 for performing the CDR, but would save an average $90,000 in lifetime DI and Medicare benefit costs.

Proposals to Reduce Dependence on Cash Benefits

Like the proposals to improve timeliness and consistency in the process of enrolling people in DI and SSI, proposals to improve the system's ability to remove people from the rolls have come from a number of sources. These proposals generally include time-limited benefits, private sector rehabilitation, faster access to rehabilitation, and more CDRs financed by a revolving fund. Some of these proposals would require legislative action.

Time-limited benefits are being discussed in the Congress and by researchers and other experts. Time limits are intended to set the expectation that disability benefits are to be considered temporary. This expectation is intended to encourage beneficiaries to take some responsibility, such as obtaining treatment and pursuing rehabilitation, to overcome their disabling conditions and return to productive employment. Generally, such proposals establish criteria for deciding which disability cases would be subject to the time limits.

In pursuing the time-limited approach, the CDR profiles might provide useful guidelines for deciding when to apply time limits and for what duration. Funding treatment and rehabilitation services could also help to facilitate recovery, maximize work prospects, and limit reapplications. In addition, establishing criteria for extending or terminating benefits at reapplication would need to be developed.

Private sector rehabilitation has been suggested as a way to increase the availability and effectiveness of rehabilitation efforts. SSA is testing such approaches under its Project Network initiative, which involves intensive outreach, liberalized work incentives, and case management. In addition to the evaluation of Project Network now under way, more needs to be done to assess the potential impact of a vigorous employment assistance program, particularly when integrated with other aspects of DI and SSI programs.

In 1976, we reported that most of the funding for rehabilitation had not achieved its intended effect, and in 1981, the Congress amended the Social Security Act to restrict funding for rehabilitation to cases in which the beneficiary returned to substantial gainful activity for 9 continuous months.[19] While the principle of paying only for rehabilitation successes remains

[19]These 9 months correspond to the trial work period allowed by work incentive provisions for DI beneficiaries.

a good one, better reimbursement mechanisms to tie rehabilitation funding to return-to-work outcomes need to be developed and tested, whether public or private agencies are the service providers. One proposal to address this problem would give private and nonprofit rehabilitation providers a long-term share of the savings that might accrue from a successful effort, especially if it yielded sustained results. For example, some disabilities, such as multiple sclerosis or certain mental impairments, cause intermittent impairment possibly necessitating renewed rehabilitation interventions and support during reoccurrences.

Faster access to rehabilitation is believed by many private sector experts to be a key to successful rehabilitation. But SSA refers beneficiaries at the same time it notifies them that they have been awarded benefits. At this point, the beneficiary has been through a lengthy determination process, especially if the case was appealed. Moreover the process requires an applicant to emphasize his or her incapacity. And, because the applicant is unlikely to work during the determination process, it is not unreasonable to expect that skills, motivation, and work habits will erode during this extended period, reducing the beneficiary's receptivity to rehabilitation. Although early referral is an important predictor of successful rehabilitation, overcoming the disability mindset fostered by the decision-making process will also be necessary to greatly improve rehabilitation outcomes.

Conducting more CDRs has been suggested in many of our reports.[20] Experience to date suggests that CDRs can be part of a well-balanced plan for reducing the number of people on the rolls, and new techniques--such as profiling--show promise to improve CDR efficiency. However, because of lack of funding, SSA continues to fall short of conducting all required CDRs. Also, even though the new profile process has increased its effectiveness and better targeted its limited resources, SSA is still making improvements to this process.

To provide additional funding for CDRs, proposals have been made to establish a special CDR budget account. Under one such proposal, an amount representing projected cost savings from performing CDRs in the previous year would be transferred to the CDR account annually to be used solely for additional CDRs. In

---

[20]Our most recent reports on CDRs are Social Security: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993); Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994); and Social Security: New Continuing Disability Review Process Could Be Enhanced (GAO/HEHS-94-118, June 27, 1994).

concept, such a fund would be similar to the Medical Care Cost Recovery Fund in the Department of Veterans Affairs (VA). The fund provides administrative support to obtain copayments from certain VA beneficiaries and payments from veterans' health insurers to cover care provided in VA hospitals. The VA fund is self-sustaining and provides almost $600 million in recovered revenue every year at a cost of about $100 million.

ENSURING THAT ONLY THOSE WHO CANNOT WORK GET BENEFITS

Ensuring that those receiving benefits are unable to work--permanently or for an extended period of time--is critical to protecting the taxpayers' dollars and to improving public confidence. This would also be consistent with society's shift toward recognizing the productive capacities of people with disabilities. Yet decisions about who is eligible for benefits and who is not are not easy and require a great deal of judgment in many cases. In part, the inherent subjectivity of these decisions accounts for some of the disparities between DDSs and ALJs. It also helps explain the complexities involved in targeting CDRs and rehabilitation to those most likely to leave the rolls.

Managing the Caseload Requires Refocusing From Disability to Work Capacity

In accordance with the Social Security Act, which requires that an applicant's work incapacity be based on the presence of medically determinable physical and mental impairments, SSA developed the Listing of Impairments (the listings) as part of its process for determining eligibility. The listings represent a consensus of medical experts about the signs, symptoms, and laboratory findings as well as some functional criteria, which, according to SSA, are severe enough to ordinarily prevent an individual from engaging in any gainful activity. Applicants who do not meet or equal the listings are further evaluated by nonmedical factors.

Medical impairments alone are poor predictors of work capacity, although they might have been better predictors decades ago in a largely manufacturing economy. In fact, about 65 percent of awards are based on the medical listings, yet people with identical impairments are working. For example, any person who has lost the use of both feet is qualified under current listings. Thus, any individual in a wheelchair could qualify for benefits, even though people in wheelchairs have proven capable of earning a living. Similarly, a person who might be capable of work, but only on a part-time basis, can be granted benefits. For example, under the listings, people with mental impairments who experience repeated episodes of deterioration can be eligible for disability benefits, although

there may be periods when they are capable of working. SSA has updated several of the listings to keep pace with advances in medicine but has not done a comprehensive evaluation of their validity.

Research also suggests that SSA's listings overestimate inability to work and are limited in distinguishing accurately between people who can and cannot work. For example, one study identified a sample of adults living in the community who had physical impairments that met or equaled the listings.[21] When their work histories were tracked, it was found that about 60 percent of men and 30 percent of women were employed 2 years after diagnosis. For adults under age 55, employment rates were even higher--over 80 percent for men and over 40 percent for women.[22]

More emphasis on functional rather than diagnostic measures is considered necessary to better assess work capacity. In its reengineering effort, SSA concluded that its methodology for making disability determinations under current law is excessively complex and does not permit the best assessment of a claimant's functional ability. Part of its reengineering effort is focused on simplifying its process and providing more standardized ways to assess medical impairment and resultant functional ability. Considerable research, however, will be needed to improve the measurement of applicants' ability to function. SSA is starting a study of disability in the general population (including the working population) that should provide some of this type of information.[23]

In addition, both the law and SSA policy generally allow benefits to be awarded to applicants whose impairments would not preclude work if they were to receive treatment.[24] In many

---

[21]Henry P. Brehm and Thomas V. Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

[22]Employment percentages exclude the 27 percent who died during the 2-year period.

[23]The study, called the Disability Exam Study, is also designed to determine the characteristics of and special accommodations made for people who continue to work and who would be considered disabled under alternative definitions of disability.

[24]The medical listings for cardiovascular disease and epilepsy require that the applicant's condition be assessed under the listings after the applicant has been under prescribed treatment for at least 3 months. However, applicants not under treatment

cases, providing treatment would be a lower cost alternative to DI and SSI if the applicant were able to work. Moreover, the current policy yields inequitable treatment of applicants with similar conditions. For instance, if an applicant is receiving treatment at the time of application, then the effect of the treatment on functioning is considered in the disability determination process, and benefits could be denied appropriately. However, if the applicant is not receiving treatment, the disability determination is made without considering whether treatment could improve the condition. In these cases, benefits could be awarded even if the applicant would not qualify for benefits if treated.

CONCLUDING OBSERVATIONS

Many long-standing problems need to be addressed to improve the administration and outcomes of SSA's disability programs. SSA has acknowledged many of its management problems regarding the timeliness and consistency of disability decisions and has plans to address some of them in its reengineering effort. It has paid little attention, however, to the rehabilitation components of the DI and SSI programs and lags behind in conducting enough CDRs because of budgetary limits.

It is imperative that SSA's decision-making process reach much quicker and more consistent disability decisions. This process--the core of SSA's disability programs--is an inherently difficult one that requires a significant level of judgment in many disability cases. Although the process may never be completely objective, it can be improved by paying more attention to making the best possible decision as early in the process as possible. For example, better case development at the initial level would help remedy this, and narrowing the scope of subsequent reviews would help reduce inconsistencies.

Conducting effective CDRs and determining whether and what type of rehabilitation is appropriate are complicated by the need to make difficult professional judgments about the work capacities of people with disabilities. Better ways to assess the relationship between impairments and functioning in the workplace will be crucial for effective interventions that can help beneficiaries reduce their dependence and keep them off the rolls in the first place. For example, assessing the work prospects of people with disabilities will require knowing about more than their medical impairments, which alone poorly predict work capacity. Moreover, since the DI and SSI programs were enacted decades ago, major changes have occurred in the expectations of society and people with disabilities themselves

---

can still be found eligible on a basis other than meeting the listings.

regarding work. More importantly, the potential to realize these expectations may be greater because of significant advances in medicine, such as new medications to control the symptoms of certain mental illnesses, and changes in technology, such as assistive devices that can be used to accommodate people with disabilities at work.

Many of the problems we have documented are rooted in poor program administration, but corrective actions in these areas alone are not enough to ensure that all those who can work do so. While it is crucial to act expeditiously on certain fronts--reducing inconsistency in decision-making, decreasing CDR backlogs, and improving rehabilitation, for instance--over the long run, decisionmakers may need to rethink the fundamental design of DI and SSI to minimize the dependence of people with disabilities on cash benefits.

- - - - -

Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or the other Subcommittee members may have.

For more information on this testimony, please call Cynthia Bascetta, Assistant Director, at (202) 512-7207. Other major contributors are David Fiske, Senior Evaluator; Carolina Morgan, Evaluator; William Hutchinson, Senior Evaluator; Daniel Schwimer, Attorney-Advisor; Ellen Habenicht, Evaluator; Barbara Bordelon, Senior Evaluator; Chris Crissman, Assistant Director; Annette Lozen, Evaluator; Ronald Vieregge, Senior Evaluator; and Susan Higgins, Senior Evaluator.

RELATED GAO PRODUCTS

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program (GAO/HEHS-95-137, July 7, 1995).

Disability Insurance: Broader Management Focus Needed to Better Control Caseload (GAO/T-HEHS-95-233, May 23, 1995).

Supplemental Security Income: Recipient Population Has Changed as Caseloads Have Burgeoned (GAO/T-HEHS-95-120, Mar. 27, 1995).

Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns (GAO/T-HEHS-95-67, Jan. 27, 1995).

Disability Benefits for Addicts (GAO/HEHS-94-178R, June 8, 1994).

Social Security: Most of Gender Difference Explained (GAO/HEHS-94-94, May 27, 1994).

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).

Vocational Rehabilitation: Evidence for Federal Program's Effectiveness is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993).

Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992).

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (GAO/HRD-92-56, Apr. 21, 1992).

Vocational Rehabilitation Program: Client Characteristics, Services Received, and Employment Outcomes (GAO/T-PEMD-92-3, Nov. 12, 1991).

Social Security Disability: Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991).

Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

Impact of Vocational Rehabilitation Services on the Social Security Disability Insurance Program (GAO/T-HRD-88-16, May 26, 1988).

(106504)