

GAO

Report to the Chairman, Subcommittee
on Social Security, Committee on Ways
and Means, House of Representatives

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SOCIAL SECURITY DISABILITY

Alternatives Would Boost Cost-Effectiveness of Continuing Disability Reviews





United States
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The Honorable Jim Bunning
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

In recent years, the Social Security Administration (SSA) has had difficulty ensuring that people receiving disability benefits under the Disability Insurance (DI) program are eligible for benefits. SSA is required by law to conduct periodic examinations, called continuing disability reviews (CDR), to determine whether a beneficiary has medically improved to the extent that the person is no longer considered disabled. SSA is also authorized to conduct CDRs on individuals receiving disability benefits under the Supplemental Security Income (SSI) program, and recent legislation requires CDRs for some who receive SSI benefits. Together, the programs pay about \$60 billion annually to 9 million disabled beneficiaries;¹ an additional 1.6 million nondisabled dependents of DI beneficiaries also receive benefits.

Programs of this magnitude require sound management to ensure that funds are being spent as the Congress intended and to achieve the most effective use of resources. Such management includes (1) monitoring the disability status of all beneficiaries to help ensure program integrity and (2) helping as many beneficiaries as possible to become self-sufficient by determining their vocational rehabilitation (VR) service needs and providing them assistance to enter or reenter the workforce. The amounts in cash and medical benefits that beneficiaries can receive by age 65 average about \$113,000 for SSI beneficiaries and about \$225,000 for DI beneficiaries.²

You asked us to provide information about the backlog of cases due for CDRs under the DI program. We were also asked by the Chairman, Senate Special Committee on Aging, to provide information on the CDR process and how to improve it. As agreed with your office, we are providing the same information to you and the Chairman, Senate Special Committee on

¹We use the term beneficiary to refer to any individual who receives either DI or SSI disability benefits, or both. About 1.1 million of the 9 million beneficiaries were concurrently enrolled in both programs.

²See Supplemental Security Income: Disability Program Vulnerable to Applicant Fraud When Middlemen Are Used (GAO/HEHS-95-116, Aug. 31, 1995) and Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Aging, in separate reports.³ Both reports also include information about cases scheduled for CDRs under the SSI program. Specifically, we are providing information on (1) the number and characteristics of individuals who are due for CDRs, (2) how SSA selects individuals for and conducts CDRs, (3) whether available resources are adequate for conducting required CDRs, and (4) what potential options exist for improving the CDR process. In addition, in our forthcoming report on SSA's review of SSI recipients' disability status, we will discuss SSA's strategy for meeting new legislative requirements for CDRs under the SSI program.

To develop this information, we interviewed SSA and state disability determination services officials and members of the National Academy of Social Insurance (NASI) disability policy panel. We analyzed extracts from the SSA Master Beneficiary Record (MBR) and Supplemental Security Income Record Description (SSIRD) databases and electronic files provided by the Office of Disability, which contained information on beneficiaries who were due or overdue for a CDR in fiscal year 1996. We also reviewed applicable laws and regulations and relevant SSA documents, including procedures, guidance, work plans, budgets, and CDR costs. We reviewed reports and papers by others, including the NASI disability policy panel and its members. Furthermore, we reviewed the process SSA uses in determining which beneficiaries should receive a CDR and the composition of the formulas that process uses to estimate the likelihood of benefit termination for beneficiaries. We also analyzed the electronic databases as provided to us by SSA officials but did not evaluate the validity of the databases or the SSA formulas used to estimate the likelihood of benefit termination. Our scope and methodology are discussed further in appendix I.

Results in Brief

About 4.3 million DI and SSI beneficiaries are due or overdue for CDRs in fiscal year 1996.⁴ Of those reviews, about 2.5 million are required by law; SSA has the authority but is not required to review another 1.8 million beneficiaries. The typical beneficiary awaiting a CDR is middle-aged, is disabled by mental illness, has been receiving benefits for at least 8 years, and is overdue for a CDR by at least 3 years.

³See *Social Security Disability: Improvements Needed to Continuing Disability Review Process* (GAO/HEHS-97-1, Oct. 16, 1996).

⁴Beneficiaries are "due" for a CDR if they are due in the current year; they are overdue if they were due for a CDR in a previous year.

Although many beneficiaries have limited potential for medical improvement because of severe disability or terminal illness, the CDR process provides SSA a means to ensure that only eligible people receive benefits.⁵ SSA typically performs CDRs on only a portion of those beneficiaries who the agency determines are cost-effective to review, as estimated by formulas SSA developed. SSA's process for selecting beneficiaries to receive CDRs, however, excludes approximately one-half of beneficiaries who are due or overdue for a CDR—those who fall in the middle group, between beneficiaries with the greatest and least likelihood of benefit termination—and its formulas are not useful for a majority of these beneficiaries. Recognizing that it needs to improve its selection process, SSA is developing plans to include more beneficiary groups and is making other process improvements to facilitate identifying beneficiaries who may no longer be disabled and should be removed from the disability rolls.

With funding that could exceed \$4 billion over 7 years (1996 through 2002, inclusive), SSA is developing a plan to eliminate the backlog of CDRs for workers under the age of 59 in the DI program and to conduct CDRs that have recently been required in the SSI program. To avoid continuing the backlog, from 1996 through 2002, SSA will need to conduct about twice as many CDRs as it has conducted over the past 20 years combined. SSA will likely face other challenges, including expanding the plan it is developing to accommodate the additional SSI CDRs required by recently enacted legislation and making the improvements to the CDR process that are necessary to fully implement the plan. SSA's plan to conduct CDRs on 8,182,300 beneficiaries in 7 years is ambitious. Furthermore, because SSA has not completed incorporating new CDR requirements into its plan, it is too early to tell whether authorized funding will be sufficient to conduct all required CDRs. However, even if SSA could meet these challenges and conduct these CDRs, it would still have to forgo conducting CDRs that are authorized but not required for SSI beneficiaries and CDRs for DI beneficiaries that SSA currently excludes from the CDR selection process.

The workload challenges that SSA may encounter between now and 2002 and limitations in the existing CDR process suggest a need to examine alternative means of conducting CDRs more cost-effectively. SSA estimates that only a very small percentage of beneficiaries leave the program as a

⁵SSA performs two types of CDRs: full medical CDRs and mailer CDRs. Full medical CDRs are labor-intensive reviews of beneficiaries' employment and disability status. Mailer CDRs are questionnaires through which the beneficiary provides medical care, health, and other information to SSA. Mailer CDRs enable SSA to do more CDRs without performing the costlier full medical CDRs on beneficiaries who have little likelihood of leaving the beneficiary rolls through medical improvement.

result of the current CDR process. Instead of requiring periodic CDRs on all beneficiaries, a more cost-effective approach that imposed less rigid requirements on who must be reviewed and how often might better serve SSA's needs. This would give SSA greater flexibility to concentrate its CDR efforts on beneficiaries with the greatest potential for medical improvement and subsequent benefit termination.

While ensuring that it performs CDRs cost-effectively, SSA must also ensure program integrity. With more flexible scheduling of CDRs, SSA would also need a process that both ensured that all groups of beneficiaries were subject to selection for a CDR and provided more frequent contacts with beneficiaries who were not selected. Although SSA would incur some administrative costs to implement an alternative process like this, the costs would likely be offset by a one-time net savings of over \$1.4 billion that would result from identifying ineligible beneficiaries and terminating their benefits when they failed to respond to SSA's CDR contacts. Furthermore, SSA might be able to use the CDR process to strengthen its return-to-work initiatives and help more beneficiaries move off disability by using CDR contacts to assess beneficiaries' work potential and help them obtain the services they need to enter or reenter the workforce.

Background

The DI and SSI programs are the two largest federal programs providing assistance to people with disabilities.⁶ DI is the nation's primary source of income replacement for workers with disabilities who have paid Social Security taxes and are entitled to benefits. The DI program also pays benefits to disabled dependents of disabled, retired, or deceased workers—disabled adult children and disabled widows and widowers. SSI provides assistance to disabled people who have a limited or no work history and whose income and resources are below specified amounts.⁷ State disability determination service (DDS) agencies, which are funded by SSA, decide whether individuals applying for DI or SSI benefits are disabled.

Federal laws specify those who must receive CDRs. The 1980 amendments to the Social Security Act require that SSA review at least every 3 years the

⁶The Social Security Act defines disability for adults in the DI and SSI programs as the inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last 12 months or longer. Individuals under age 18 are also covered under the SSI program if their physical or mental impairments are of comparable severity. In this report, the term disabled includes individuals classified as either blind or disabled.

⁷People over age 65 who are not disabled also receive SSI if their income and resources fall below specified amounts. However, the nondisabled elderly receiving SSI are not included in this report.

status of DI beneficiaries whose disabilities are not permanent to determine their continuing eligibility for benefits. The law does not specify the frequency of the required reviews for beneficiaries with permanent disabilities. The Social Security Independence and Program Improvements Act of 1994 requires that SSA conduct CDRs on one-third of the SSI beneficiaries who reach age 18 and a minimum of 100,000 additional SSI beneficiaries annually in fiscal years 1996 through 1998. The 1996 amendments to the Social Security Act require that SSA conduct CDRs (1) at least every 3 years for children under age 18 who are likely to improve or, at the option of the Commissioner, who are unlikely to improve and (2) on low-birth-weight babies within their first year of life. The 1996 legislation also requires disability eligibility redeterminations, instead of CDRs, for all 18-year-olds beginning on their 18th birthdays, using adult criteria for disability.⁸

State DDS agencies set the frequency of CDRs for each beneficiary according to his or her outlook for medical improvement, which is determined on the basis of impairment and age. Beneficiaries expected to improve medically, classified as “medical improvement expected” (MIE), are scheduled for review at 6- to 18-month intervals; beneficiaries classified as medical improvement possible (MIP) are scheduled for review at least once every 3 years; and those classified as medical improvement not expected (MINE) are scheduled for review once every 5 to 7 years.

For almost a decade, because of budget and staffing reductions and competing priorities, SSA has been unable to conduct all the DI CDRs required by the Social Security Act. Moreover, the agency has conducted relatively few elective SSI CDRs. (See tables III.1 and III.2 for numbers of previous CDRs conducted and CDR funding.) In 1996, the Congress authorized about \$3 billion for CDRs for fiscal years 1996 through 2002. In addition, SSA plans to earmark over \$1 billion in its administrative budget for CDRs during that same time period.

DI and SSI Beneficiaries Due for CDRs Have Similar Characteristics

The DI and SSI programs have about 4.3 million beneficiaries due or overdue for a CDR in fiscal year 1996. About 2.5 million of these reviews are required by law, including about 2.4 million DI CDRs and 118,000 SSI CDRs. SSA is authorized, but not required by law, to conduct the remaining CDRs.

⁸The 1996 legislation also repeals the provision on CDRs for 18-year-olds in the 1994 legislation and allows the disability eligibility redeterminations of 18-year-olds to count as required SSI CDRs.

As shown in table 1, about half of all beneficiaries are awaiting CDRs, the largest category of which is disabled workers receiving DI benefits.⁹

Table 1: Beneficiaries Due or Overdue for CDRs in 1996 Compared With Total Disability Beneficiaries, by Program

Beneficiary description	Number of beneficiaries due for CDRs in FY 1996	Total disability beneficiaries as of January 1996
Disability Insurance program (includes beneficiaries receiving DI and SSI benefits concurrently)		
Disabled workers	1,991,529	4,300,720
Disabled widows and widowers of workers	69,105	177,820
Disabled adult children of workers	292,715	847,320
Subtotal	2,353,349	5,325,860
Supplemental Security Income program		
Disabled adults	1,393,693 ^a	2,617,920
Disabled children	515,739 ^a	1,081,420
Subtotal	1,909,432 ^a	3,699,340
Total, DI and SSI programs	4,262,781	9,025,200

^aEstimates are based on a 15-percent sample.

Sources: GAO analysis of MBR and SSIRD extracts, records supplied by SSA's Office of Disability, and data supplied by SSA's Office of Systems Requirements.

SSA calculated a smaller number of CDRs due or overdue of about 1.4 million DI beneficiaries and 1.6 million SSI beneficiaries. It excluded from its calculation DI worker beneficiaries aged 59 and older, disabled widows and widowers and disabled adult children of DI worker beneficiaries, and SSI beneficiaries aged 59 and older. SSA officials acknowledged that CDRs are required for all of the DI beneficiaries it has excluded, but stated that, because of the backlog, the agency is focusing its attention on the portions of the CDR population that it estimates are more cost-effective to review.

In general, DI worker beneficiaries¹⁰ and adult SSI beneficiaries in the backlog have similar characteristics, and SSA estimates a low likelihood of benefit termination as a result of medical improvement. On average, workers receiving DI and adult SSI beneficiaries have been receiving

⁹Of those receiving DI benefits, about 20 percent have a benefit amount sufficiently low that they also receive some SSI benefits. These individuals are referred to as concurrent beneficiaries.

¹⁰We excluded disabled widows and widowers and disabled adult children of DI worker beneficiaries from our analysis because SSA could not supply us with reliable data that would allow us to locate needed MBR files for individuals in these groups.

benefits for over 9 years and their predominant disability is mental disorders. While both are middle-aged, the average SSI adult beneficiary is about 9 years younger than the average DI worker beneficiary. In addition, the average estimated likelihood of benefit termination for DI and SSI MIE and MIP beneficiaries under age 60 is less than 5 percent.¹¹ More data on DI and SSI characteristics are provided in tables IV.1 through IV.12.

Table 2: Selected Characteristics of DI and SSI Populations Due for a CDR

Characteristic	DI worker beneficiary	SSI beneficiary	
		Adult	Child
Average age in years	51	42	11
Predominant disability	Mental disorder	Mental disorder	Mental retardation
Average number of years receiving benefits	10	9	6
Average number of years CDR is overdue	3	3	2
Average (mean) estimated likelihood of benefit termination of MIEs and MIPs under age 60	4%	5%	Not applicable
Average (median) estimated likelihood of benefit termination of MIEs and MIPs under age 60	2%	2%	Not applicable

Sources: GAO analysis of MBR and SSIRD extracts, and records supplied by SSA's Office of Disability.

SSA Only Conducts CDRs on Beneficiaries It Considers Cost-Effective to Review

SSA uses two types of CDRs, a full medical CDR and a mailer CDR, to review beneficiaries' status. The full medical CDR process is labor-intensive and generally involves (1) one of 1,300 SSA field offices to determine whether the beneficiary is engaged in any substantial gainful activity (SGA)¹² and (2) one of 54 state DDS agencies to determine whether the beneficiary continues to be disabled, a step that frequently involves examination of the beneficiary by at least one medical doctor. Beginning in 1993, questionnaires—called mailer CDRs—replaced full medical CDRs for some beneficiaries to increase the cost-effectiveness of the CDR process.

¹¹SSA estimates the likelihood of benefit termination only for MIE and MIP beneficiaries under age 59. It does not estimate the likelihood of benefit termination for MINEs, beneficiaries aged 59 and older, SSI child beneficiaries, or adult disabled children or disabled widows and widowers of DI worker beneficiaries. However, when SSA provided data to us on workers receiving DI, it used a cutoff of under age 60 rather than under age 59 to define younger and older workers. Our analyses reflect that same definition for both DI and SSI data. SSA's more recent work has used age 59 as the cutoff between younger and older beneficiaries.

¹²SSA currently defines SGA as employment that produces eligible earnings of more than \$960 a month for blind individuals and \$500 a month for other disabled individuals.

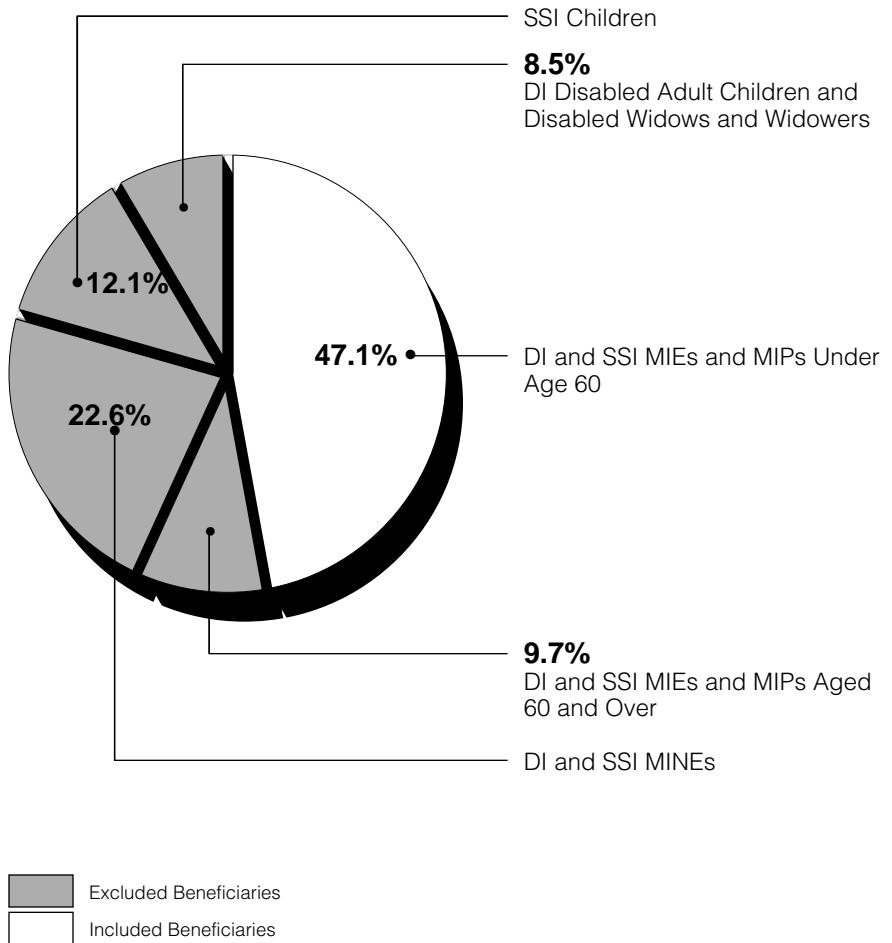
SSA also developed statistical formulas for estimating the likelihood of medical improvement and subsequent benefit termination based on computerized beneficiary information such as age, impairment, length of time on the disability rolls, and date of last CDR.¹³ For beneficiaries for whom application of the formulas indicates a relatively low likelihood of benefit termination, SSA uses a mailer CDR; when the formula application indicates a relatively high likelihood of benefit termination, SSA uses a full medical CDR. For those who receive mailer CDRs, SSA takes an additional step to determine whether responses to a mailer CDR, when combined with data used in the formulas, indicate that medical improvement may have occurred; in this small number of cases, the beneficiary is also given a full medical CDR. Individuals who have responded to a mailer CDR and are found to be still disabled are not referred for full medical CDRs, and SSA sets a future CDR date. Currently, SSA estimates that the average cost of a full medical CDR is about \$1,000, while the average cost of a mailer CDR is between about \$25 and \$50. (See app. II for more details on the steps in the CDR process.)

SSA Primarily Selects Beneficiaries for CDRs on the Basis of the Likelihood Their Benefits Will Be Terminated

SSA does not include in its selection process all DI and SSI beneficiaries. SSA limits its selection process to those beneficiary categories it considers cost-effective to review on the basis of their potential for medical improvement. Approximately one-half of the DI and SSI beneficiaries currently due for CDRs are included in SSA's process for estimating the likelihood of benefit termination through the use of statistical formulas; these estimates are the basis of selection for CDRs. Adult beneficiaries that SSA includes in its selection process are DI worker and SSI beneficiaries under age 59 who have been classified as MIES or MIPS. SSA currently excludes MINE beneficiaries, beneficiaries aged 59 and older, and disabled adult children and disabled widows and widowers of DI worker beneficiaries from its estimation process because it considers these categories not cost-effective to review. While SSA considers some SSI child beneficiaries cost-effective to review, children are currently selected for CDRs without the use of formulas to estimate the likelihood of benefit termination. (See fig. 1 and table III.4.)

¹³On the basis of the beneficiary's impairment type and recent work activity, if any, SSA decides which of 23 formulas to use. Also, when SSA uses the formulas on SSI beneficiaries, it does not use the variables on length of time since the last CDR and number of previous CDRs because relatively few SSI beneficiaries have undergone a CDR.

Figure 1: Distribution of DI and SSI Beneficiaries Due for CDRs in SSA’s Selection Process for Estimating the Likelihood of Benefit Termination

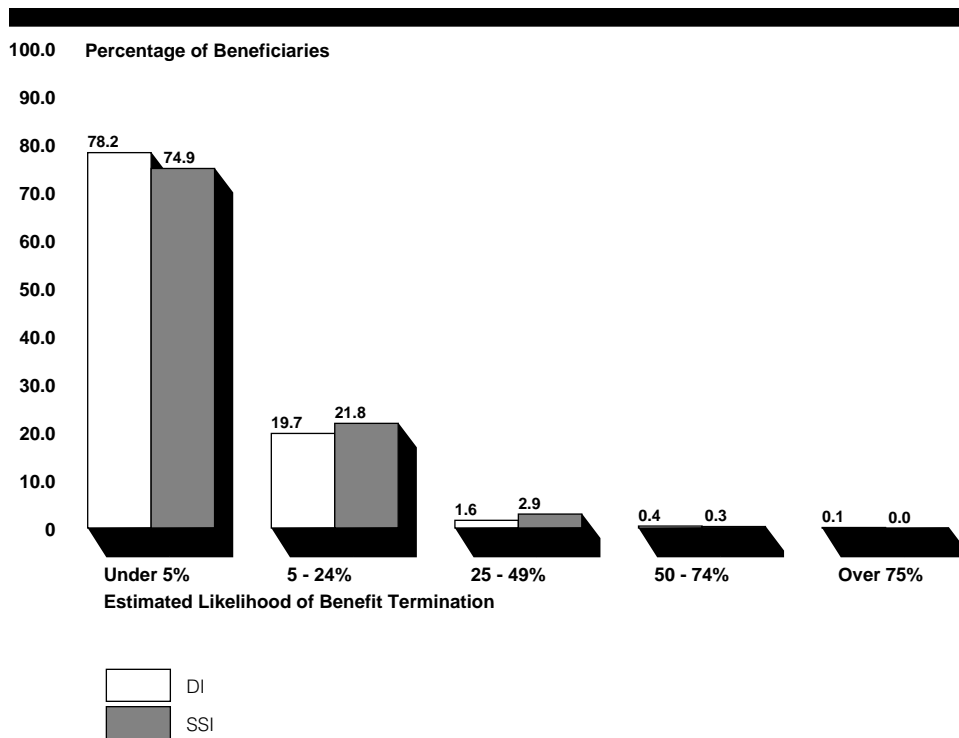


Sources: GAO analysis of MBR and SSIRD extracts, and reports supplied by SSA’s Office of Disability.

The development and use of formulas reflect SSA’s effort to make the CDR process more cost-effective by using the estimates to identify beneficiaries who should receive a mailer CDR and those who should receive a full medical CDR. However, SSA acknowledges that the formulas are not useful for estimating the likelihood of benefit termination for most beneficiaries in this process. The formulas are primarily useful for identifying beneficiaries who SSA estimates are most or least likely to have their

benefits terminated from a CDR. For individuals who fall in the middle category—which constitutes the majority of beneficiaries included in the estimation process—the formulas provide less accurate estimates, according to SSA. At this time, SSA does not select for CDRs any beneficiaries from this middle group because it is unable to determine whether a mailer or a full medical CDR is most appropriate for these beneficiaries. According to SSA, if it conducted mailer CDRs on the middle group, this would likely result in more beneficiaries being subsequently referred for full medical CDRs than the agency can accommodate in its budget. Similarly, if it conducted full medical CDRs on the middle group, it would be using a higher-cost process than SSA believes is necessary for some in this group. (See fig. 2 and table III.5.) Consequently, SSA selects a portion of the beneficiaries with the highest and lowest estimated likelihood of benefit termination for full medical and mailer CDRs, respectively.

Figure 2: Estimated Likelihood of Benefit Termination for DI and SSI Beneficiaries Included in SSA's Estimation Process for CDR Selection



Note: SSA estimates the likelihood of benefit termination for DI MIE and MIP worker beneficiaries under age 60 and SSI MIE and MIP adult beneficiaries under age 60 as part of its CDR selection process.

Sources: GAO analysis of MBR and SSIRD extracts, and records supplied by SSA's Office of Disability.

SSA has not developed statistical formulas to use in selecting SSI child and 18-year-old beneficiaries for CDRs. According to SSA, it selected low-birth-weight babies for CDRs of children for fiscal year 1996 because historically about 40 percent of this category have benefits terminated as a result of a CDR. Selecting low-birth-weight babies for CDRs is also consistent with CDR requirements that take effect in fiscal year 1997.

For 18-year-old SSI beneficiaries in fiscal year 1996, SSA selected a judgmental sample classified as either MIE or MIP who had characteristics associated with a high likelihood of benefit termination. For fiscal year

1996, all reviews of child and 18-year-old SSI beneficiaries are to be full medical CDRs.¹⁴

SSA Plans to Include More Beneficiary Categories and Make Other Selection Process Improvements to Better Identify the Nondisabled

Recognizing the need to improve the current process, SSA plans to expand and enhance its procedures for selecting beneficiaries for CDRs and conducting the reviews. Furthermore, SSA told us that these planned process improvements will limit the extent to which SSA can conduct the planned number of CDRs and reduce the CDR backlog.

SSA plans to include more beneficiary categories in its selection process by expanding the use of the statistical formulas for certain MINE-classified beneficiaries and children and enhancing the formulas. Beginning in fiscal year 1997, according to SSA, formulas will be used for those beneficiaries who are classified as MINES because they are older rather than because of their impairment. SSA also plans to develop formulas to use for children receiving SSI beginning in about fiscal year 1998. According to SSA, postponing the development of formulas for SSI child beneficiaries will allow the agency to integrate this process improvement with the knowledge it will gain about impairments that afflict children as a result of the new requirement to conduct CDRs for children in the SSI program beginning in fiscal year 1997.

SSA also plans to pursue two approaches for the collection of medical treatment information about beneficiaries. First, SSA plans to obtain Medicare and Medicaid data and integrate the data into the statistical formulas to increase the validity of the estimated likelihood of benefit termination. SSA expects that the additional information will allow it to better determine the appropriateness of either mailer or full medical CDR for beneficiaries with estimates of benefit termination in the middle range. Second, SSA plans to develop a new type of CDR that would be conducted by mail to obtain current information about a beneficiary's disability and treatment. Unlike the current mailer CDR, the new type of CDR would collect information directly from beneficiaries' physicians and other medical treating sources. This information will be combined with computerized beneficiary data to help identify the beneficiaries in the middle range who are most likely to be no longer disabled and therefore warrant full medical CDRs.

¹⁴Beginning in fiscal year 1997, as a result of the 1996 amendments to the Social Security Act, the disability eligibility status of all 18-years-olds will be redetermined on the basis of adult criteria.

Incorporating Additional Required CDRs Into Its Plan and Implementing Process Improvements Are Among the Challenges SSA Must Address

In the past year, new legislation has increased authorized funding for CDRs to about \$3 billion by 2002, but has also required CDRs for some SSI beneficiaries for whom the reviews were previously elective. Because SSA has not finished incorporating the new CDR requirements into its plans, it is too early to determine whether the authorized funding will be adequate for all required CDRs. However, exclusions from the estimates SSA used regarding the size of the backlog in fiscal year 1996, SSA's need to complete process improvements in order to conduct a greater number of CDRs, and other challenges all contribute to the uncertainty that SSA will be able to be current with required CDRs within 7 years.

CDR Funding Authorized in Two Laws and Earmarked in SSA Budget

Funding for CDRs from all sources could exceed \$4 billion by 2002. The bulk of the funding for CDRs is authorized by the Contract With America Advancement Act of 1996, which authorized about \$2.7 billion between 1996 and 2002. While the funding is primarily for DI CDRs, a portion can be used for SSI CDRs. Most recently, the 1996 amendments to the Social Security Act authorized a total of about \$250 million for SSI CDRs and medical eligibility redeterminations in fiscal years 1997 and 1998. For the first time in 1996, SSA designated \$200 million of its administrative budget to be used solely to conduct CDRs. By comparison, SSA spent almost \$69 million to conduct CDRs in fiscal year 1995. SSA expects to continue to earmark moneys in future budgets at the same level as fiscal year 1996. (See table III.2 for SSA's CDR spending in past years.)

SSA's Plan in Progress, Contains Weaknesses

SSA's plan to conduct CDRs on 8,182,300 beneficiaries between 1996 and 2002 is ambitious. The plan, as of August 1, 1996, called for SSA to conduct nearly twice as many CDRs as it has conducted over the past 20 years combined. If the plan is fully implemented, SSA will conduct the CDRs for DI worker beneficiaries under age 59, the beneficiary category the plan defines as constituting the DI backlog. In addition, it will conduct about 350,000 SSI CDRs required under the Social Security Independence and Program Improvements Act of 1994 and about 2 million additional elective SSI CDRs. (See table III.6 for the number of full medical and mailer CDRs SSA plans to conduct.) SSA's plan reflects increased authorizations from the Contract With America Advancement Act but does not yet account for the increased authorizations or increased CDRs and related work required by the 1996 amendments to the Social Security Act.

SSA's estimate of the size of the DI CDR backlog in fiscal year 1996 excludes about 848,000 beneficiaries, composed of disabled widows and widowers,

disabled adult children, and workers aged 59 and older. SSA officials acknowledge that CDRs are required for these beneficiaries, but SSA has excluded them from the plan because it focuses on those categories SSA considers more cost-effective to review. In addition, an SSA official said that a large number of beneficiaries in the excluded categories are expected to leave the program because either they will die or convert to retirement benefits before SSA can conduct their CDRs. However, SSA has not estimated the proportion of excluded categories who may leave the program, nor does it include in its plan beneficiaries in these categories who will come due for CDRs in fiscal years 1997 through 2002.

Process improvements are critical to SSA's ability to implement the portion of the plan that relies on the mailer CDR, a component whose use is planned to triple in fiscal year 1998. SSA's success with the mailer CDR will rely on yet-to-be-tried improvements. Although plans to expand the formulas to more beneficiary categories and collect medical treatment information appear promising, some improvements are in the earliest stages of development with only about 1 year available for completion. Thus, SSA will need to develop these initiatives more quickly than it did previous improvements. The integration of Medicare and Medicaid data into the formulas used to estimate the likelihood of benefit termination, and the development of a new type of CDR that collects information from physicians and other medical treating sources, are expected to allow SSA to begin conducting CDRs on beneficiaries with an estimated benefit termination in the middle range. SSA said that it currently is unable to determine whether the beneficiaries with estimates in the middle range should have a full medical CDR or a mailer CDR. Without that ability, SSA cannot determine the most cost-effective type of CDR to use, and its planned expansion of the use of the mailer CDR will be in jeopardy.

SSA faces a variety of other challenges to the implementation of its plan and the elimination of the backlog of required CDRs:

- First, SSA must incorporate into its workload SSI CDRs and disability eligibility redeterminations required by the 1996 amendments to the Social Security Act. These requirements include performing CDRs once every 3 years for children under 18 years old who are likely to medically improve and for all low-birth-weight babies by their first birthday. This law also requires SSA to conduct disability eligibility redeterminations on all child beneficiaries who turn 18 years old, within 1 year of their birthday, and for between 300,000 and 400,000 children who qualified for SSI under individualized functional assessments (IFA). These reviews of children

would take precedence over required CDRs and may shift resources away from other CDRs.¹⁵ The law also changes SSI eligibility for legal aliens who have not resided in this country for 5 years before receiving benefits, necessitating CDRs of the beneficiaries to determine continuing eligibility.

- Second, other recent legislation poses a competing priority. The law eliminates drug and alcohol abuse as a basis for receiving disability benefits; as a result, benefits will terminate for many of an estimated 196,000 DI and SSI beneficiaries whose primary impairments are drug abuse and/or alcoholism. SSA expects many of those terminated to reapply on the basis of other impairments, thus increasing SSA's workload of initial claims for benefits. Previous increases in initial claims adversely affected the number of CDRs conducted as resources were shifted away from that activity to process initial applications.
- Third, SSA's plan includes doing CDRs for many of the estimated 3.7 million SSI beneficiaries whose CDRs may be conducted at SSA's discretion. While conducting these discretionary SSI reviews may be warranted largely because relatively few SSI CDRs have been conducted in the past, it shifts resources away from conducting required DI reviews.
- Fourth, the daunting effort to gear up for the unprecedented CDR workload will include negotiations between SSA and 50 state DDS agencies to increase CDR workloads and DDS efforts to hire, train, and supervise additional staff.

Alternate Approaches Focus on CDRs' Cost-Effectiveness and Their Use in Helping Beneficiaries Move Off Disability

In the Contract With America Advancement Act, the Congress emphasized maximizing the combined savings from CDRs under the DI and SSI programs. SSA has been working to improve its ability to identify beneficiaries for whom conducting CDRs would be most cost-effective. Other alternatives exist, however, that would likely make CDRs more cost-effective and improve program integrity.

Revising Requirements Could Improve CDRs' Cost-Effectiveness

The current system of periodic CDRs for all beneficiaries, including those with virtually no potential for medical improvement, is a costly approach for identifying the approximately 5 percent of beneficiaries who medically improve to the point of being found ineligible for benefits. Furthermore, the frequency of CDRs is currently based on medical improvement classifications that do not clearly differentiate between those most and least likely to have their benefits terminated as a result of a CDR. Our analysis found that the estimated likelihood of benefit termination, as

¹⁵The IFA reviews would, however, be counted toward the total number of SSI CDRs required under the Contract With America Advancement Act.

determined by SSA's formulas, was very similar for beneficiaries classified as MIES and MIPS. Although millions of dollars are spent annually to conduct periodic CDRs, some beneficiaries, especially those in the DI program, have received benefits for years without having any contact with SSA regarding their disability or their ability to return to work despite continuing disability. An alternate approach could build on SSA's efforts to identify those beneficiaries whose CDRs are likely to be cost-effective and also increase contact with beneficiaries who remain in the program. Such an approach involves requiring (1) CDRs of beneficiaries with the greatest potential for medical improvement, (2) CDRs of a random sample from all other beneficiaries, and (3) regular contact with the remainder of the beneficiaries to increase program integrity.

Less rigid requirements regarding the frequency of CDRs are necessary if reviews are to be conducted primarily on those beneficiaries whose cases are cost-effective to review—that is, those beneficiaries with the greatest potential for medical improvement—and for SSA to still be in compliance with laws governing CDRs. According to SSA, one of the best indicators of whether beneficiaries will remain on disability rolls is whether they have previously undergone a CDR. If an initial CDR finds that the beneficiary continues to be medically eligible for disability benefits, subsequent CDRs may not be cost-effective or appropriate. Because few CDRs actually result in benefit terminations, periodic reviews, even at the maximum 3- and 7-year intervals currently used, may not be appropriate for certain beneficiaries if further reviews are not warranted after the initial CDR and at least several years on the disability rolls.

Conducting CDRs on a random sample of beneficiaries from among those whose cases are believed by SSA to be less cost-effective to review is consistent with a more cost-effective and flexible approach to scheduling CDRs. It also addresses a weakness in SSA's current process by ensuring overall program integrity. SSA's current process excludes some categories of beneficiaries from portions of the selection process. As a result, about one-half of all beneficiaries due for a CDR will go without oversight unless SSA changes its selection process. If periodic CDRs are not conducted for all beneficiaries, it is increasingly important to develop a strategy to ensure overall program integrity.

Contact with beneficiaries, in addition to the contact that occurs in the CDR process, can improve program integrity by reminding beneficiaries that their medical conditions are being monitored and serving as a deterrent to abuse by those no longer medically eligible for benefits. It could also

support SSA's process improvement efforts, particularly within the next year. We believe that a new type of brief mailed contact would, at a minimum, in the year it is implemented, allow SSA to contact a majority of beneficiaries with overdue CDRs to remind them of their responsibility to report medical improvements and to inquire about their interest in returning to work.¹⁶ By collecting CDR-related information as part of this new contact, it could also speed the development of SSA's planned improvements to the CDR process. For example, SSA could gather information on physicians and other treating sources seen by beneficiaries since their last CDR. Such information is needed to implement SSA's new medical treating source CDR.

SSA has not evaluated this three-pronged proposal for improving the CDR process, but in our discussions with agency officials, some provided comments on one aspect of it. In discussing additional, more frequent contact with beneficiaries in addition to that which occurs during a CDR, several officials raised the issue of the cost of such an initiative. Although some administrative funds would be used for this contact, it should result in significant savings because a considerable number of beneficiaries, on the basis of SSA's experience, can be expected to refuse repeatedly to provide requested information and, as a result, will have their benefits terminated after a prescribed due-process procedure is followed.¹⁷ According to SSA, those who fail to cooperate generally do so because they believe that they are no longer eligible for benefits. On the basis of SSA's experience with CDRs and financial eligibility redeterminations, we assumed that .71 percent of the DI beneficiaries and 1 percent of the SSI beneficiaries who were contacted would have their benefits terminated for noncooperation after all due-process procedures were followed. These termination rates represent an estimated one-time net federal savings of over \$1.4 billion from contacting beneficiaries in the CDR backlog, with DI savings accounting for about \$1.2 billion and SSI savings accounting for about \$230 million. If extended to all beneficiaries not receiving CDRs or financial eligibility redeterminations, the costs and subsequent savings

¹⁶In order to minimize the burden placed on beneficiaries to provide SSA with information, those who would be receiving financial eligibility redeterminations or who are selected for a CDR are excluded from the proposed contact. Currently, SSA does not have a system for coordinating the collection of CDR and financial eligibility redetermination information. If a system for providing coordination is developed, SSA may want to consider collecting the CDR-related information contained in the proposed mail contact at the same time that it collects information for financial eligibility redeterminations. SSA is currently exploring the potential for better coordinating CDRs and financial eligibility redeterminations. We discuss SSA's efforts to coordinate CDRs and financial eligibility redeterminations in our forthcoming report on SSA's review of SSI recipients' disability status.

¹⁷Although the savings would accrue to trust funds and the general fund, rather than to the agency's administrative operations, that is true as well for savings from CDRs.

from such a contact would likely be higher. See appendix I for a further discussion of our estimated savings.

Establishing Data-Based Criteria for Time-Limited Benefits May Be Difficult

Time-limiting disability benefits has been proposed as a way to reduce beneficiaries' dependence on cash benefits by removing them from the rolls after set periods of time. Time limits are intended to encourage beneficiaries to obtain treatment and pursue rehabilitation to overcome their disabling conditions and obtain productive employment. Proposals for time-limited benefits generally establish criteria for deciding which categories of beneficiaries would be subject to time limits and no longer subject to required CDRs.¹⁸ Some believe that such broad application of time limits could significantly reduce the number of people who would continue on the rolls indefinitely and eliminate the CDR backlog. However, others believe that it could create a large backlog of disability claims when those who are terminated because of the time limit reapply for benefits. Time limits are also thought to increase the number of people on the rolls because SSA and DDS staff may, in certain cases, be more likely to award benefits because of the limited payment period. Instead of subjecting all beneficiaries with nonpermanent impairments to time limits, some believe that time limits should be applied to certain subsets or categories of beneficiaries—those with impairments that are likely to improve with treatment or surgery. Such impairments include affective disorders, tuberculosis, certain fractures, and orthopedic impairments for which surgery can restore or improve function.

However, our analysis of the characteristics of those in the CDR backlog suggests that implementing time-limited benefits on the basis of either medical improvement classifications or specific impairments is not currently feasible. As explained earlier, on the basis of our analysis of available CDR population characteristics, there is little correlation between the MIE and MIP classifications and the estimated likelihood of benefit termination. Moreover, our analysis did not associate any specific impairment or other characteristic with a greater likelihood of benefit termination. Furthermore, SSA and the NASI disability policy panel concluded that the MIE, MIP, and MINE classifications do not accurately reflect the likelihood of medical improvement and subsequent benefit termination.

¹⁸See, for example, National Academy of Social Insurance, *Balancing Security and Opportunity: The Challenge of Disability Income Policy. Findings and Recommendations of the Disability Policy Panel* (Washington, D.C.: NASI, Jan. 25, 1996).

SSA Could Better Utilize the CDR Process to Encourage Return to Work

The CDR process has the potential to be used to further SSA's return-to-work initiatives, strengthening that effort and offering greater opportunity for beneficiaries to become self-sufficient despite their continuing disabilities. While the Social Security Act states that as many individuals as possible applying for benefits under the DI program should be rehabilitated into productive activity, only about 8 percent of DI and SSI beneficiaries are referred for vocational rehabilitation (VR) services.¹⁹ SSA generally does little during the CDR process to determine beneficiaries' VR needs and provide assistance to help beneficiaries become self-sufficient. Although in conducting full medical CDRs SSA obtains information from the beneficiary on VR services received since the initial application or last CDR, SSA and DDS staff are neither required nor instructed to assess beneficiaries' work potential, make beneficiaries aware of rehabilitation opportunities, or encourage them to seek VR services. When conducting mailer CDRs, SSA provides beneficiaries the opportunity to indicate an interest in VR services.

In our April 1996 report, we noted that medical advances and new technologies are creating more opportunities than ever for disabled people to work, and some beneficiaries who do not medically improve may nonetheless be able to engage in substantial gainful activity.²⁰ Yet, weaknesses in the design and implementation of DI and SSI program components have limited SSA's capacity to identify and assist in expanding beneficiaries' productive capacities. Beneficiaries receive little encouragement to use rehabilitation services. We recommended in that report that the Commissioner of Social Security take immediate action to place greater priority on return to work, including designing a more effective means to identify and expand beneficiaries' work capacities and better implementing existing return-to-work mechanisms.

Conclusions

Our analysis of the characteristics of beneficiaries awaiting DI and SSI CDRs supports SSA's conclusion that there is little likelihood a large proportion of beneficiaries will show sufficient medical improvement to no longer be disabled. Therefore, if SSA is to decrease long-term reliance on these

¹⁹DI and SSI applicants are to be promptly referred to state VR agencies for services intended to prepare them for work opportunities. SSA field office employees are required to inform applicants that they may be contacted by a state VR agency; employees are also expected to give written materials about VR services to anyone who inquires about disability benefits. However, according to SSA's guidelines, applicants should not be referred for VR services if they have terminal illnesses or severe or rapidly progressive impairments not responding to treatment. VR referrals are also subject to state policies that screen out applicants who are not considered reasonable candidates for rehabilitation.

²⁰SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS-96-62, Apr. 24, 1996).

programs as the primary source of income for the severely impaired, it will need to shift its emphasis. It must rely less on assessing medical improvement and more on return-to-work programs to better gauge the potential for self-sufficiency despite the lack of medical improvement.

SSA's plan to conduct repeated CDRs at regularly scheduled intervals may not be warranted for some beneficiaries, given the large number of beneficiaries with little likelihood of benefit termination and the emphasis on cost-effectiveness in the Contract With America Advancement Act. A more cost-effective approach might incorporate (1) a focus on conducting CDRs for beneficiaries with the greatest likelihood of benefit termination due to medical improvement, (2) conducting CDRs on a random sample of all other beneficiaries to correct a weakness in SSA's process, and (3) contact with beneficiaries not selected for a CDR or a financial eligibility redetermination to strengthen program integrity.

However, for this cost-effective approach to work, SSA needs to be able to accurately estimate the likelihood of benefit termination for all beneficiaries. Currently, our analysis shows that about one-half of all beneficiaries due or overdue for a CDR have been excluded from SSA's process that utilizes formulas to estimate the likelihood of benefit termination. Furthermore, for many beneficiaries, the formulas result in less accurate estimates. If SSA is to be current with CDRs by 2002, it will need to meet many challenges, including expanding the use of its mailer CDR. Because such an expansion is dependent upon SSA's ability to implement at least two of its planned process improvements, this raises further questions about SSA's ability to implement its plan.

Recommendations to the Commissioner of Social Security

We recommend that, to the extent SSA is authorized to act, the Commissioner of SSA replace the routine scheduling for CDRs of all who receive DI and SSI program benefits with a more cost-effective process that would (1) select for review beneficiaries with the greatest potential for medical improvement and subsequent benefit termination, (2) correct a weakness in SSA's CDR process by conducting CDRs on a random sample from all other beneficiaries, and (3) help ensure program integrity by instituting contact with beneficiaries not selected for CDRs. As part of this effort, the Commissioner should develop a legislative package to obtain the authority the agency needs to enact the new process for those portions of the DI and SSI populations that are subject to required CDRs.

To enable as many disabled individuals as possible to become self-sufficient, SSA should test the use of CDR contacts with beneficiaries to determine individuals' rehabilitation service needs and help them obtain the services and employment assistance they need to enter or reenter the workforce.

Agency Comments and Our Evaluation

In commenting on a draft of this report, SSA agreed to test the use of CDR contacts with beneficiaries to determine individuals' rehabilitation service needs and help them obtain the services and employment assistance they need to enter or reenter the workforce. SSA also agreed to begin to consider changing the current statutory requirements for CDRs as part of its effort to continually seek ways to maintain stewardship of the disability program in the most cost-effective manner. However, it disagreed with our recommendation on specific changes it should make to the CDR process. In particular, it disagreed with conducting CDRs on random samples of beneficiaries who are less cost-effective to review and with making more frequent contact with all beneficiaries. We continue to believe that ensuring program integrity requires that all beneficiaries have an opportunity to be selected for a CDR. In addition, we believe that efforts to monitor disability status will serve as a deterrent to abuse by those no longer medically eligible for benefits, and that maintaining periodic contacts with all beneficiaries is a sound management practice. SSA also made technical comments on our report, which we incorporated as appropriate. The full text of SSA's comments and our responses are contained in appendix V.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of the report until 7 days after the date of this letter. At that time, we will send copies to the Commissioner of Social Security. We will make copies available to others on request.

Please contact me at (202) 512-7215 if you or your staff have any questions about this report. Other GAO contacts and staff acknowledgments are listed in appendix VI.

Sincerely yours,

A handwritten signature in black ink that reads "Jane L. Ross". The signature is written in a cursive style with a large, stylized "R" at the end.

Jane L. Ross
Director, Income Security Issues

Contents

Letter		1
Appendix I Scope and Methodology	Number of Beneficiaries Due or Overdue for a CDR in Fiscal Year 1996 Analysis of Characteristics Savings Estimate for Proposed Contact With Beneficiaries in the CDR Backlog	28 28 29 30
Appendix II How SSA Conducts Continuing Disability Reviews	Full Medical Reviews Mailer CDRs	33 33 37
Appendix III Supplementary Data on CDRs		40
Appendix IV Tables on CDR Population Characteristics		44
Appendix V Comments From the Social Security Administration	GAO Comments	97 106
Appendix VI GAO Contacts and Staff Acknowledgments		108

Related GAO Products

112

Tables

Table 1: Beneficiaries Due or Overdue for CDRs in 1996 Compared With Total Disability Beneficiaries, by Program 6

Table 2: Selected Characteristics of DI and SSI Populations Due for a CDR 7

Table I.1: Initial and Final Record Counts for DI Workers Due or Overdue for a CDR in FY 1996 28

Table I.2: Initial and Final Population and Sample Sizes for SSI Beneficiaries Due or Overdue for a CDR in FY 1996 29

Table I.3: Estimated Costs and Savings of Mail Contact 32

Table III.1: Full Medical and Mailer CDRs Completed, FY 1988-95 40

Table III.2: Amount Spent by SSA on Full Medical and Mailer CDRs, FY 1992-95 40

Table III.3: DI and SSI CDRs Due in FY 1996, by Medical Improvement Classification 41

Table III.4: Distribution of DI and SSI Beneficiaries Due for CDRs Included in and Excluded From SSA's Selection Process for Estimating the Likelihood of Benefit Termination 42

Table III.5: Estimated Likelihood of Benefit Termination for DI and SSI Beneficiaries Included in SSA's Estimation Process for CDR Selection 42

Table III.6: CDRs SSA Plans to Conduct in FY 1996-2002 43

Table IV.1: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program and Medical Improvement Classification 44

Table IV.2: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program and Medical Improvement Classification, in Percentages 48

Table IV.3: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program, Age, and Medical Improvement Classification 52

Table IV.4: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program, Age, and Medical Improvement Classification, in Percentages 58

Table IV.5: Characteristics of Selected DI Workers Awaiting CDRs in FY 1996, by Program and Estimated Likelihood of Benefit Termination 64

Table IV.6: Characteristics of Selected DI Workers Awaiting CDRs in FY 1996, by Program and Estimated Likelihood of Benefit Termination, in Percentages 70

Table IV.7: Characteristics of Adult and Child SSI Recipients Awaiting CDRs in FY 1996, by Medical Improvement Classification	76
Table IV.8: Characteristics of Adult and Child SSI Recipients Awaiting CDRs in FY 1996, by Medical Improvement Classification, in Percentages	82
Table IV.9: Characteristics of SSI Recipients Awaiting CDRs in FY 1996, by Age and Medical Improvement Classification	87
Table IV.10: Characteristics of SSI Recipients Awaiting CDRs in FY 1996, by Age and Medical Improvement Classification, in Percentages	89
Table IV.11: Characteristics of Selected SSI Adults Awaiting CDRs in FY 1996, by Estimated Likelihood of Benefit Termination	92
Table IV.12: Characteristics of Selected SSI Adults Awaiting CDRs in FY 1996, by Estimated Likelihood of Benefit Termination, in Percentages	94

Figures

Figure 1: Distribution of DI and SSI Beneficiaries Due for CDRs in SSA's Selection Process for Estimating the Likelihood of Benefit Termination	9
Figure 2: Estimated Likelihood of Benefit Termination for DI and SSI Beneficiaries Included in SSA's Estimation Process for CDR Selection	11
Figure II.1: Eight-Step Evaluation Process for a Full Medical CDR	34
Figure II.2: SSA's Disability Update Report	38

Abbreviations

CDR	continuing disability review
DDS	disability determination service
DI	Disability Insurance
IFA	individualized functional assessment
MBR	Master Beneficiary Record
MI	medical improvement
MIE	medical improvement expected
MINE	medical improvement not expected
MIP	medical improvement possible
NASI	National Academy of Social Insurance
OD	Office of Disability
RFC	residual functional capacity
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income
SSIRD	Supplemental Security Income Record Description
VR	vocational rehabilitation

Scope and Methodology

This appendix provides additional details concerning our methodology. Information is included about databases used in estimating for the DI and SSI programs the number of beneficiaries due or overdue for a CDR in fiscal year 1996 and analyzing their characteristics. We also include information on our calculations of the potential one-time savings from our proposed mailed contact to collect CDR-related information from beneficiaries. We analyzed the electronic databases as provided to us by SSA officials but did not evaluate the validity of the databases or the SSA formulas used to estimate the likelihood of benefit termination. We did our review from September 1995 to August 1996 in accordance with generally accepted government auditing standards.

Number of Beneficiaries Due or Overdue for a CDR in Fiscal Year 1996

To determine the number of DI worker beneficiaries currently due or overdue for a CDR, we used SSA's Office of Disability's (OD) CDR database and the Master Beneficiary Record (MBR). OD's database contains information on all beneficiaries SSA has determined were due or overdue for a CDR in fiscal year 1996. We eliminated records for DI beneficiaries who were included in OD's database but whose MBR could not be found or who did not meet the definition of being due or overdue for a CDR in fiscal year 1996. The eliminated records primarily involved cases that were not due for a CDR until the next century and were incorrectly included in the backlog population. Table I.1 contains initial and final population sizes after adjustments.

Table I.1: Initial and Final Record Counts for DI Workers Due or Overdue for a CDR in FY 1996

	Number of records
Records received from OD	2,720,411
Records without an MBR match	52
Records that mature in the next century	728,830
Records used in the analysis	1,991,529

OD provided the number of disabled widows and widowers and disabled adult children in the backlog but did not supply other information about them.

To determine the number of SSI beneficiaries currently due or overdue for a CDR, we used OD's database that contains information on all SSI beneficiaries SSA has determined were due or overdue for a CDR in fiscal year 1996. We drew a random sample of 15 percent of these beneficiaries stratified by whether the (1) beneficiary was an adult or a child and (2) state disability determination services (DDS) had classified the

likelihood of medical improvement as expected (MIE), possible (MIP), or not expected (MINE). We eliminated from our sample beneficiaries whose CDR due dates were after fiscal year 1996 or who were over 65.²¹ On the basis of our sample data, we estimated the size of the population with these exclusions. Table I.2 contains initial population and sample sizes and final sizes after adjustments.

Table I.2: Initial and Final Population and Sample Sizes for SSI Beneficiaries Due or Overdue for a CDR in FY 1996

	Adult MIEs and MIPs ^a	Adult MINEs	Child MIEs	Child MIPs	Child MINEs	Total
Population provided by OD	998,671	641,697	114,464	348,516	92,167	2,185,515
15% random sample	148,300	96,253	17,170	52,275	13,825	327,823
CDR due date after FY 96	251	32,213	35	54	5,822	38,375
Over age 65	2,233	804	0	0	0	3,037
Final sample	145,816	63,236	17,135	52,221	8,003	286,411
Adjusted population	972,111	421,580	114,231	348,156	53,354	1,909,432

Note: Estimates based on a 15-percent sample.

^aFor 236 sample records, a MIE or MIP classification was not specified. When we analyzed records by MIE or MIP classification separately, we classified those records as MIPs.

Analysis of Characteristics

For the population of DI workers, we obtained information on characteristics from the MBR and OD's CDR database. From the MBR, we obtained information on age, gender, race, impairment, time receiving benefits, and time overdue for a CDR. Because information obtained from OD did not differentiate between MIE and MIP beneficiaries, we used MBR data to classify beneficiaries in the two categories.²² From OD's CDR database, we obtained information on (1) records for all those classified as MINE and (2) estimates of the likelihood of benefit termination for MIE and MIP beneficiaries, the only categories for which likelihood data were available. We did not analyze the characteristics of DI beneficiaries who are disabled widows and widowers and disabled adult children because we did not have sufficient information to identify them in the MBR.

²¹We excluded from our analysis SSI beneficiaries receiving disability benefits who are over 65 because SSA does not conduct CDRs on these beneficiaries. If CDRs were conducted and these beneficiaries were found to be no longer disabled, they would continue to qualify for SSI benefits on the basis of their age. At age 65, individuals receiving SSI disability benefits also become eligible for SSI age benefits. Such individuals can choose to continue receiving disability benefits or can switch to age benefits.

²²We classified as MIP 583 of the records for worker beneficiaries under the age of 60, because a MIE or MIP classification was not specified.

For the sample of SSI beneficiaries, we obtained information on characteristics from SSA's Supplemental Security Income Record Description (SSIRD) and OD's CDR database. From the SSIRD, we obtained information on age, gender, race, impairment, time receiving benefits, and time overdue for a CDR. We also used SSIRD data to classify adults into MIE and MIP categories. From OD's CDR database, we obtained information on (1) medical improvement classifications for all children and MINE adults; (2) records for all adults classified as MINE; and (3) estimates of the likelihood of benefit termination for adult MIE and MIP beneficiaries, the only categories for whom likelihood data were available.

Because we used a sample to estimate characteristics of the universe of SSI beneficiaries due or overdue for CDRs in fiscal year 1996, the reported estimates in tables IV.7 through IV.12 have sampling errors associated with them. Sampling error is variation that occurs by chance because a sample was used rather than the entire population. The size of the sampling error reflects the precision of the estimate—the smaller the sampling error, the more precise the estimate. The tables in appendix IV contain sampling errors for reported estimates calculated at the 95-percent confidence level. This means that the chances are about 95 out of 100 that the range defined by the estimate, plus or minus the sample error, contains the true percentage. With few exceptions, the sampling errors were less than 1 percentage point. This means that for most percentages, there is a 95-percent chance that the actual percentage falls within plus or minus 1 percentage point of the estimated percentage.

Savings Estimate for Proposed Contact With Beneficiaries in the CDR Backlog

Our estimate of a one-time savings associated with our recommendation to begin a process for more frequent contact with beneficiaries who are not selected for either a CDR or a financial eligibility redetermination during the year is based on the following SSA costs and savings estimates and assumptions. The number of DI beneficiaries who would be contacted by this initiative was estimated by subtracting the number of DI CDRs planned for fiscal year 1996 from the DI population due or overdue for CDRs as of fiscal year 1996. For the SSI program, the number of beneficiaries who would be contacted by this initiative was estimated by subtracting the estimated number of SSI beneficiaries who would receive either a financial eligibility redetermination or a CDR from the SSI population currently due or

overdue for CDRs as of fiscal year 1996.²³ We assumed that the percentage of beneficiaries who would fail to cooperate with this initiative would be the same as the most recent SSA estimates for DI CDRs and SSI financial eligibility redeterminations. We used savings estimates resulting from DI benefit terminations as provided by the Office of the Actuary. To estimate federal savings from SSI benefit terminations, we used estimates provided by SSA's Office of the Actuary and the Department of Health and Human Services' Health Care Financing Administration for adult beneficiaries, and offsetting cost estimates to account for the resultant increase in food stamps. Because these SSI beneficiaries would be contacted for financial eligibility redeterminations within the next 5 years, the SSI estimates we used reflect only 5 years of savings and offsetting food stamps. Because many DI beneficiaries who have been receiving benefits for years may never have been contacted for CDRs, the DI estimates we used reflect a lifetime of savings. As a proxy for the cost of the mailer, we used an SSA estimate of the cost of the current nonscannable mailer. Because this figure overestimates the cost of a scannable mail contact, it provides a conservative estimate, including some administrative and developmental costs.

²³In order to minimize the burden placed on beneficiaries to provide SSA with information, those who would be receiving financial eligibility redeterminations are excluded from the proposed mail contact. Currently, SSA does not have a system for coordinating the collection of CDR and financial eligibility redetermination information. If a system for providing coordination was developed, SSA might want to consider collecting the CDR-related information contained in the proposed mail contact at the same time that it collects information for financial eligibility redeterminations. SSA is currently exploring the potential for better coordinating CDRs and redeterminations. Our forthcoming report on SSA's review of SSI recipients' disability status contains a discussion of SSA's efforts to coordinate CDRs and financial eligibility determinations.

**Appendix I
Scope and Methodology**

Table I.3: Estimated Costs and Savings of Mail Contact

	DI program	SSI program
Calculation of number of beneficiaries expected to be dropped from the programs		
Beneficiaries due or overdue for CDRs in fiscal year 1996	2,353,349	1,909,432
Less: planned financial eligibility redeterminations for those who are not receiving a CDR	Not applicable	552,233
Less: planned CDRs	329,000	236,000
Beneficiaries not contacted during the year	2,024,349	1,121,199
Multiplied by: percentage of beneficiaries who fail to cooperate	.71%	1.00%
Total beneficiaries expected to be dropped from the program	14,373	11,212
Per-beneficiary savings and offsetting costs		
Gross savings to DI trust fund/SSI program	\$60,000	\$17,424
Gross savings to Medicare/federal portion of Medicaid	\$30,000	\$9,071
Less: offsetting costs of additional food stamps	Not applicable	\$3,100
Net savings per beneficiary dropped from the program	\$90,000	\$23,395
Total estimated savings to the federal government		
Net program savings (number of beneficiaries dropped multiplied by net savings per beneficiary)	\$1,293,570,000	\$262,304,740
Less: cost of sending scannable mailer (number of beneficiaries contacted at \$25)	\$50,608,725	\$28,029,975
Total estimated net savings from proposed initiative (combined total = \$1,477,236,040)	\$1,242,961,275	\$234,274,765

How SSA Conducts Continuing Disability Reviews

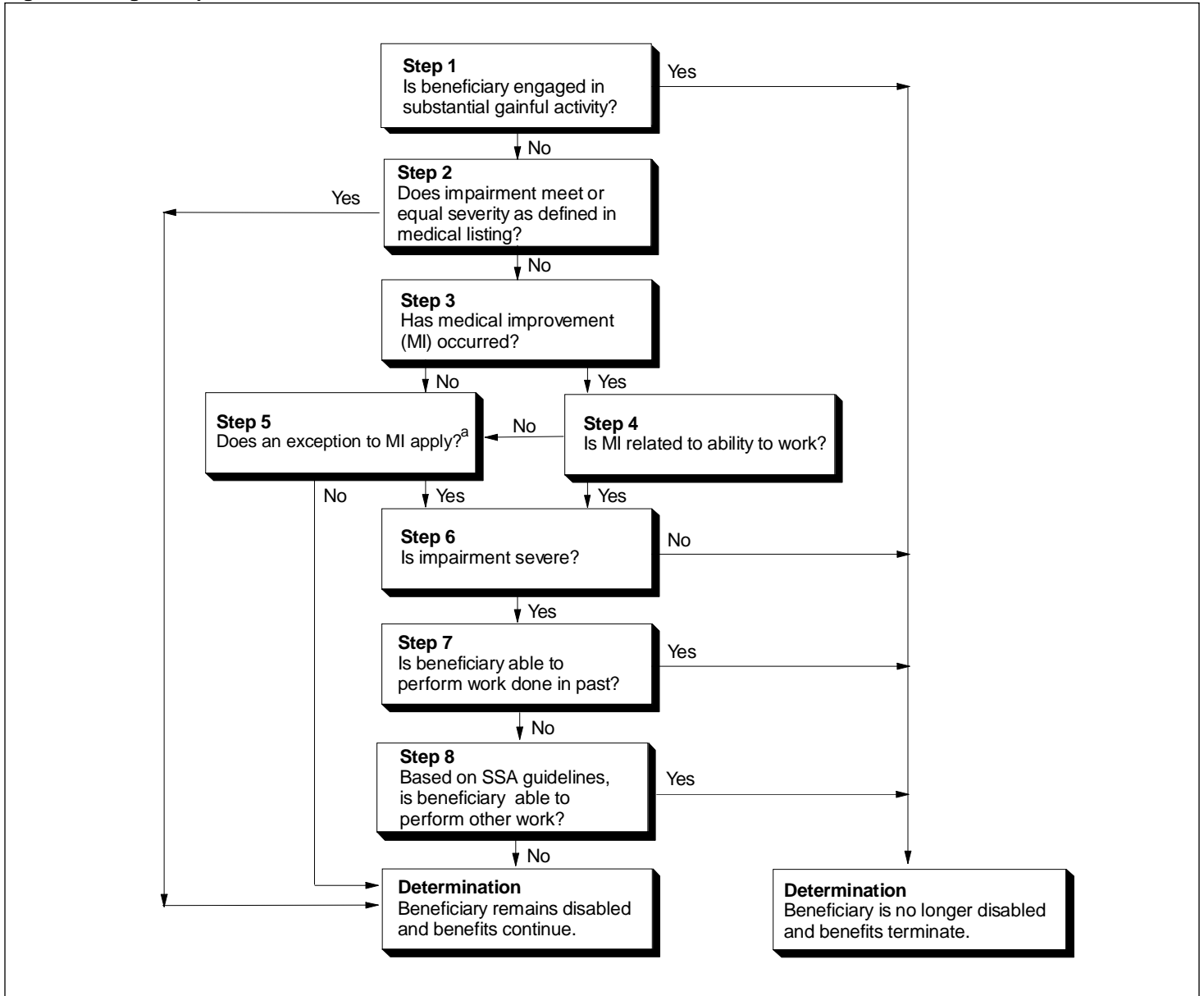
This appendix provides details on SSA's procedures for conducting CDRs. More specifically, we (1) outline the process for conducting full medical CDRs and (2) discuss SSA's use of mailer CDRs.

Full Medical Reviews

Generally, a full medical CDR is used to determine with certainty whether a beneficiary has medically improved to the point that the person is no longer disabled and should be removed from the disability rolls. The full medical CDR process is labor-intensive and generally involves (1) one of 1,300 SSA field offices to determine whether the beneficiary is engaged in any substantial gainful activity (SGA), and (2) one of 54 state DDS agencies to determine whether the beneficiary continues to be disabled, a step that frequently involves examination of the beneficiary by at least one medical doctor. A full medical CDR generally follows an eight-step evaluation process (see fig. II.1).

Appendix II
How SSA Conducts Continuing Disability
Reviews

Figure II.1: Eight-Step Evaluation Process for a Full Medical CDR



^aIf an exception to MI applies in which the initial determination was fraudulently obtained or the beneficiary does not cooperate with SSA, benefits are terminated.

Source: SSA program operations manual system.

At step one, the SSA field office determines whether the beneficiary is engaged in SGA. Field office staff contact the beneficiary, often through a face-to-face meeting, and obtain information on the person's condition, medical treating sources, and the effect of the impairment on the beneficiary's ability to perform SGA. This information describes any changes that have occurred since the initial application or most recent CDR and includes types of treatment received, medicines received, specialized tests or examinations, vocational rehabilitation services received, and any schools or training classes attended since the last medical determination. The SSA field office also obtains information on any work activities since the person became disabled, whether the condition continues to interfere with the ability to work, and whether the beneficiary has been released for work by the treating physician. Benefits are terminated for beneficiaries engaged in SGA, regardless of medical condition. A beneficiary found to be not working or working but earning less than SGA has his or her case forwarded to the state DDS office.

At step two, the DDS compares the beneficiary's condition with the Listing of Impairments developed by SSA. The listings contain over 150 categories of medical conditions that, according to SSA, are severe enough ordinarily to prevent a person from engaging in SGA. The DDS obtains medical evidence from the sources who treated the beneficiary during the 12 months prior to the CDR. If the medical evidence provided is insufficient for a disability decision, the DDS will arrange for a consultative examination by an independent doctor. A beneficiary whose impairment is cited in the listings or whose impairment is at least as severe as those impairments in the listings, and who is not engaged in SGA, is found to be still disabled.

At step three, a beneficiary whose impairment is not cited in the listings or whose impairment is less severe than those cited in the listings is evaluated further to determine whether there has been medical improvement (MI). MI is defined as any decrease in medical severity of the impairment(s) present at the time of the most recent medical determination. In deciding whether MI has occurred, the DDS considers changes in symptoms, signs, and/or laboratory findings and determines whether these changes reflect decreased medical severity of the impairment(s). If MI has not occurred, the DDS skips step four and proceeds to step five to consider whether any exceptions to MI apply.

At step four, for beneficiaries for whom MI has occurred, the DDS determines whether MI is related to the ability to work. MI relates to the

ability to work when there is an increase in a person's residual functional capacity (RFC) to do basic work activities compared with the person's RFC at the last medical determination. When MI does not relate to the ability to work, the DDS proceeds to step five. If MI relates to the ability to work, the DDS goes to step six.

At step five, the DDS determines whether exceptions to MI apply. Exceptions provide a way for SSA to find a beneficiary no longer disabled in certain limited situations even though there is no decrease in the severity of the impairment. There are two exceptions to MI. The first exception applies to certain situations in which the person can engage in SGA—for example, when substantial evidence shows that advances in medical or vocational therapy or technology have favorably affected the severity of a beneficiary's impairment or RFC to do basic work activities. The second exception can apply without regard to the person's ability to engage in SGA—for example, in situations in which the prior determination was fraudulently obtained or in which the beneficiary fails to cooperate with SSA in providing information or in having an examination. At any point in the eight-step evaluation process, if the second exception applies, benefits are terminated. If no exceptions apply, disability benefits are continued.

At step six, when either the first exception applies or MI is determined to be related to the ability to work, the DDS determines whether the beneficiary's current impairment is severe. According to SSA standards, a severe impairment is one that significantly limits a person's ability to do basic work activities, such as standing, walking, speaking, understanding and carrying out simple instructions, using judgment, responding appropriately to supervision, and dealing with change. If the DDS determines that the impairment is not severe, benefits are terminated.

At step seven, for beneficiaries with severe impairments, the DDS determines whether the beneficiary can still perform work he or she has done in the past. This determination is based on an assessment of the beneficiary's current RFC. If the person is found to be able to do past work, benefits are terminated.

At step eight, for beneficiaries found unable to perform work done in the past, the DDS determines whether the beneficiary can do other work that exists in the national economy. Using SSA guidelines, the DDS considers the person's age, education, vocational skills, and RFC to determine what other work, if any, the beneficiary can perform. Unless the DDS concludes that

the person can perform work that exists in the national economy, benefits are continued.

Mailer CDRs

Mailer CDRs enable SSA to conduct more CDRs without performing labor-intensive full medical reviews. The mailer CDR is a questionnaire through which a beneficiary provides information about health, medical care, work history, and training (see fig. II.2 for the questionnaire currently used).²⁴ Currently, SSA sends mailer CDRs to a portion of beneficiaries with the lowest estimated likelihood of benefit termination.

In conjunction with data on the beneficiaries' impairment, age, and other characteristics, SSA uses responses to mailer CDRs to help identify those beneficiaries most likely to have medically improved who thus should receive full medical reviews. For example, if the beneficiary indicates that his or her health is better, SSA will generally conduct a full medical CDR. In mental impairment cases, SSA may decide that a full medical CDR is unwarranted even if the beneficiary reports MI. If, however, the beneficiary indicates that his or her health is the same or worse, SSA then reviews the beneficiary's response to the next question on whether, within the last 2 years, a doctor has indicated that the person can return to work. On the basis of the beneficiary's responses to the CDR mailer and characteristics, SSA assesses the potential effects of any hospitalizations or surgeries on the beneficiary's health status and the importance of ongoing medical treatment or its absence to the beneficiary's health condition. If necessary, SSA will contact the beneficiary for additional information or clarification. If SSA's analysis indicates possible MI, the beneficiary is referred for a full medical CDR. Otherwise, the beneficiary is rescheduled for a future CDR.

²⁴In fiscal year 1996, SSA started using a scannable, machine-readable questionnaire form.

**Appendix II
How SSA Conducts Continuing Disability
Reviews**

Figure II.2: SSA's Disability Update Report

DATE: _____

Disability Update Report

Social Security Administration, P.O. Box 4550, Wilkes-Barre, PA 18767-4550

FORM APPROVED
OMB NO. 0960-0511

PAYEE'S NAME AND ADDRESS	REPORT PERIOD	
	From: _____	To The Present
	BENEFICIARY	
	TELEPHONE NUMBER	CLAIM NUMBER

Please be sure to use black ink or a #2 pencil to print your answers. Also, read the enclosed instructions before completing the form. Finally, remember that when answering the questions, the "REPORT PERIOD" for which we need information about you is from to the present.

1. a. During the report period, have you worked for someone or been self-employed? YES NO

b. If you answered "YES" to 1.a., please complete the information below.

	WORK BEGAN	WORK ENDED	MONTHLY EARNINGS
	Month Year	Month Year	Dollars Only, No Cents
Most Recent Work	1. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	2. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>
	3. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/>

2. Have you attended any school or work training program(s) during the report period? YES NO

3. During the report period . . . (please place an "X" in one box only):

<input type="checkbox"/> my doctor and I have not discussed whether I can work.	<input type="checkbox"/> my doctor told me I cannot work.	<input type="checkbox"/> my doctor told me I can work.
---	---	--

4. Place an "X" in **only** one box which best describes your health now as compared to the beginning date of the report period.

<input type="checkbox"/> BETTER	<input type="checkbox"/> SAME	<input type="checkbox"/> WORSE
---------------------------------	-------------------------------	--------------------------------

Form SSA-455-OCR-SM (10-95) Continued on the Reverse →

**Appendix II
How SSA Conducts Continuing Disability
Reviews**

5. a. Have you gone to a doctor or clinic for treatment during the report period? → YES NO

b. If you answered "YES" to 5.a., please list:

Most Recent Visit	Reason For Visit:	Month	Year
		<input type="checkbox"/>	<input type="checkbox"/>
1.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. a. Have you been hospitalized or had surgery during the report period? → YES NO


b. If you answered "YES" to 6.a., please list:

Most Recent	Reason For Hospitalization Or Surgery:	Month	Year
		<input type="checkbox"/>	<input type="checkbox"/>
1.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Would you be interested in receiving rehabilitation or other services that could help you get back to work? YES NO

REMARKS: If you use this space to further answer questions 1. through 7., place an "X" in the box to the right and print on the lines below.

I know that anyone who makes a false statement or representation of material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm that the above statements are true.

<p>SIGN HERE</p> 	<p>TODAY'S DATE</p> <p>Month Day Year</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
	<p>TELEPHONE NUMBER</p> <p>Area Code</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Form SSA-455-OCR-SM (10-95)

Supplementary Data on CDRs

Table III.1: Full Medical and Mailer CDRs Completed, FY 1988-95

Fiscal year	Full medical CDRs completed		Mailer CDRs completed without full medical reviews	Total
	For the DI program	For the SSI program		
1987	195,991	14,339		210,330
1988	321,246	32,573		353,819
1989	280,452	86,364		366,816
1990	155,586	39,500		195,086
1991	54,638	18,830		73,468
1992	58,430	14,715		73,145
1993	27,413	8,517	34,581	70,511
1994	72,852	10,743	31,007	114,602
1995	127,895	34,664	76,122	238,681

Note: DI program figures include CDRs completed on beneficiaries concurrently enrolled in both DI and SSI programs. SSA began counting mailer cases as CDRs in 1993. During the years shown, SSA conducted mailer CDRs only on beneficiaries in the DI program.

Sources: State agency operating reports for fiscal years 1987 to 1995 and SSA's OD reports on mailer CDRs for fiscal years 1993 to 1995.

Table III.2: Amount Spent by SSA on Full Medical and Mailer CDRs, FY 1992-95

Dollars in thousands	
Fiscal year	Amount spent
1992	\$30,027
1993	24,983
1994	39,409
1995	68,769

Source: SSA's Office of Budget.

**Appendix III
Supplementary Data on CDRs**

Table III.3: DI and SSI CDRs Due in FY 1996, by Medical Improvement Classification

Program/beneficiary type	Medical improvement classification				Total
	MIE	MIP	MINE	Not specified	
Disability Insurance program					
Disabled workers	162,525	1,286,525	542,479	0	1,991,529
Disabled widows and widowers of disabled workers	a	a	a	69,105	69,105
Disabled adult children of disabled workers	a	a	a	292,715	292,715
Subtotal	162,525	1,286,525	542,479	361,820	2,353,349
Supplemental Security Income program^b					
Disabled adults	186,727	785,383	421,580	0	1,393,693
Disabled children	114,231	348,156	53,354	0	515,739
Subtotal	300,958	1,133,539	474,934	0	1,909,432
Total, DI and SSI programs	463,483	2,420,064	1,017,413	361,820	4,262,781

^aNot available.

^bEstimates based on a 15-percent sample. Because of rounding during the estimation process, row entries may not sum to row totals.

Sources: GAO analysis of MBR and SSIRD extracts, records supplied by SSA's OD, and data supplied by SSA's Office of Systems Requirements.

**Appendix III
Supplementary Data on CDRs**

Table III.4: Distribution of DI and SSI Beneficiaries Due for CDRs Included in and Excluded From SSA's Selection Process for Estimating the Likelihood of Benefit Termination

	DI	SSI^a	Total
Total beneficiaries	2,353,349	1,909,432	4,262,781
Beneficiaries included in selection process			
MIEs under 60 years old	145,201	174,194	
MIPs under 60 years old	1,000,713	688,570	
Subtotal	1,145,914	862,764	2,008,678
Percentage of column total	48.7%	45.2%	47.1%
Beneficiaries excluded from selection process			
MIEs 60 years and over	17,324	12,533	
MIPs 60 years and over	285,812	96,814	
MINEs	542,479	421,580	
DI disabled widows and widowers	69,105		
DI adult disabled children	292,715		
SSI children		515,739	
Subtotal	1,207,435	1,046,666	2,254,101
Percentage of column total	51.3%	54.8%	52.9%

Note: The DI category includes concurrent beneficiaries who receive both DI and SSI.

^aEstimates based on a 15-percent sample.

Sources: GAO analysis of MBR and SSIRD extracts, and records supplied by SSA's OD.

Table III.5: Estimated Likelihood of Benefit Termination for DI and SSI Beneficiaries Included in SSA's Estimation Process for CDR Selection

Likelihood of benefit termination	Percentage by program	
	DI	SSI^a
Under 5%	78.2	74.9
5-24%	19.7	21.8
25-49%	1.6	2.9
50-74%	0.4	0.3
Over 74%	0.1	0.0
Total	100.0	100.0

Note: SSA estimates the likelihood of benefit termination only for DI MIE and MIP workers under age 60 and for SSI adult MIEs and MIPs under age 60.

^aColumn does not total 100% because of rounding.

Sources: GAO analysis of MBR and SSIRD extracts, and records supplied by SSA's OD.

**Appendix III
Supplementary Data on CDRs**

Table III.6: CDRs SSA Plans to Conduct in FY 1996-2002

Fiscal year	Mailer CDRs	Full medical CDRs	Total CDRs
1996	270,000	248,000	
1997	280,000	346,000	
1998	744,000	428,500	
1999	880,000	593,400	
2000	890,000	779,800	
2001	820,000	777,600	
2002	840,000	678,000	
Total	4,724,000	3,851,300	8,575,300^a

^aThe total number of CDRs exceeds the total number of beneficiaries receiving CDRs because 393,000 beneficiaries are estimated to receive both a mailer CDR and a full medical CDR.

Source: SSA's Office of Budget as of July 31, 1996.

Tables on CDR Population Characteristics

Table IV.1: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program and Medical Improvement Classification

	DI only			Total
	MIE	MIP ^a	MINE	
Total CDR population	131,312	1,056,913	449,214	1,637,439
Age in years				
Under 30	4,808	14,825	3,770	23,403
30-39	23,959	117,142	43,989	185,090
40-49	46,171	301,577	111,232	458,980
50-59	41,744	376,546	136,325	554,615
60 and over	14,630	246,823	153,898	415,351
Average age (mean)	48	52	53	52
Average age (median)	48	53	56	53
Diagnostic group				
Infectious and parasitic diseases	519	9,032	5,274	14,825
Neoplasms	3,300	17,938	3,874	25,112
Endocrine, nutritional, and metabolic diseases	7,071	64,186	10,219	81,476
Disorders of blood and blood-forming organs	337	2,143	500	2,980
Mental disorders, excluding mental retardation	58,584	349,273	82,225	490,082
Mental retardation	2,331	37,334	34,729	74,394
Neurological and sensory disorders	8,141	66,188	83,221	157,550
Circulatory disorders	7,689	108,010	65,372	181,071
Respiratory disorders	1,352	26,011	12,512	39,875
Digestive disorders	1,727	12,392	3,049	17,168
Genitourinary disorders	1,132	4,169	8,954	14,255
Skin and subcutaneous tissue disorders	322	3,197	560	4,079
Musculoskeletal disorders	26,194	264,520	47,600	338,314
Congenital anomalies	139	2,729	1,442	4,310
Injuries	9,693	48,056	28,863	86,612
Other	264	2,309	2,088	4,661
Not identified	2,517	39,426	58,732	100,675
Estimated likelihood of benefit termination				
Subpopulation with likelihood estimated ^b	115,893	801,034		916,927
Under 5%	81,190	631,794		712,984
5-24%	30,143	153,976		184,119
25-49%	3,467	10,745		14,212

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only				Total DI CDR population			
MIE	MIP^a	MINE	Total	MIE	MIP^a	MINE	Total
31,213	229,612	93,265	354,090	162,525	1,286,525	542,479	1,991,529
3,968	16,713	2,935	23,616	8,776	31,538	6,705	47,019
9,154	61,571	20,759	91,484	33,113	178,713	64,748	276,574
10,193	67,447	24,946	102,586	56,364	369,024	136,178	561,566
6,099	55,102	21,990	83,191	47,843	431,648	158,315	637,806
1,799	28,779	22,635	53,213	16,429	275,602	176,533	468,564
43	46	49	46	47	51	53	51
42	25	49	46	4	52	55	52
130	2,538	984	3,652	649	11,570	6,258	18,477
321	1,835	449	2,605	3,621	19,773	4,323	27,717
1,824	16,437	2,304	20,565	8,895	80,623	12,523	102,041
48	653	172	873	385	2,796	672	3,853
18,989	110,381	19,688	149,058	77,573	459,654	101,913	639,140
1,891	24,880	22,219	48,990	4,222	62,214	56,948	123,384
1,470	9,961	13,631	25,062	9,611	76,149	96,852	182,612
1,008	12,404	6,378	19,790	8,697	120,414	71,750	200,861
314	4,466	2,107	6,887	1,666	30,477	14,619	46,762
212	1,789	410	2,411	1,939	14,181	3,459	19,579
138	719	1,643	2,500	1,270	4,888	10,597	16,755
52	514	83	649	374	3,711	643	4,728
3,090	30,161	5,272	38,523	29,284	294,681	52,872	376,837
22	487	366	875	161	3,216	1,808	5,185
1,295	6,525	4,231	12,051	10,988	54,581	33,094	98,663
36	342	373	751	300	2,651	2,461	5,412
373	5,520	12,955	18,848	2,890	44,946	71,687	119,523
29,308	199,679		228,987	145,201	1,000,713		1,145,914
21,277	161,961		183,238	102,467	793,755		896,222
7,136	34,503		41,639	37,279	188,479		225,758
795	2,756		3,551	4,262	13,501		17,763

(continued)

Appendix IV
Tables on CDR Population Characteristics

	DI only			Total
	MIE	MIP ^a	MINE	
50-74%	875	3,143		4,018
75% and over	218	1,376		1,594
Average likelihood (mean)	6	4		4
Average likelihood (median)	3	2		2
Number of years receiving benefits				
Under 4	45,143	69,445	4,274	118,862
4-5	36,073	267,188	13,152	316,413
6-7	27,051	247,751	36,457	311,259
8-9	11,197	161,876	58,287	231,360
10 or over	11,848	310,653	337,044	659,545
Average years (mean)	6	9	15	10
Average years (median)	5	7	14	9
CDR maturity				
Maturing in FY 1996	29,588	250,529	86,972	367,089
Matured 1 year ago	26,972	171,807	75,736	274,515
Matured 2 years ago	19,761	167,043	53,946	240,750
Matured 3 years ago	16,234	129,197	33,212	178,643
Matured 4 years ago	14,721	112,659	41,388	168,768
Matured 5-10 years ago	21,651	168,196	124,085	313,932
Matured over 10 years ago	1,376	30,784	338	32,498
Not identified	1,009	26,698	33,537	61,244
Average years (mean)	3	3	3	3
Average years (median)	2	2	2	2
Gender				
Female	52,362	387,329	143,205	582,896
Male	78,907	669,275	305,865	1,054,047
Not identified	43	309	144	496
Race				
Black	20,542	180,617	76,872	278,031
White	102,617	836,377	357,118	1,296,112
Other	6,188	25,563	9,997	41,748
Not identified	1,965	14,356	5,227	21,548

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only				Total DI CDR population			
MIE	MIP ^a	MINE	Total	MIE	MIP ^a	MINE	Total
91	348		439	966	3,491		4,457
9	111		120	227	1,487		1,714
5	4		4	6	4		4
3	2		2	3	2		2
10,483	16,614	829	27,926	55,626	86,059	5,103	146,788
9,260	64,375	2,896	76,531	45,333	331,563	16,048	392,944
6,582	52,617	6,237	65,436	33,633	300,368	42,694	376,695
2,390	33,143	11,386	46,919	13,587	195,019	69,673	278,279
2,498	62,863	71,917	137,278	14,346	373,516	408,961	796,823
6	8	15	10	6	9	15	10
5	7	13	8	5	7	14	9
6,122	58,312	11,899	76,333	35,710	308,841	98,871	443,422
6,339	40,931	15,528	62,798	33,311	212,738	91,264	337,313
5,254	34,245	11,890	51,389	25,015	201,288	65,836	292,139
4,191	27,190	9,022	40,403	20,425	156,387	42,234	219,046
3,690	25,227	7,865	36,782	18,411	137,886	49,253	205,550
5,008	32,465	13,580	51,053	26,659	200,661	137,665	364,985
297	3,585	23,397	27,279	1,673	34,369	23,735	59,777
312	7,657	84	8,053	1,321	34,355	33,621	69,297
3	3	3	3	3	3	3	3
3	2	3	2	2	2	2	2
16,931	121,270	40,532	178,733	69,293	508,599	183,737	761,629
14,280	108,320	52,722	175,322	93,187	777,595	358,587	1,229,369
2	22	11	35	45	331	155	531
7,364	58,438	25,754	91,556	27,906	239,055	102,626	369,587
21,281	157,559	63,178	242,018	123,898	993,936	420,296	1,538,130
2,001	9,375	3,113	14,489	8,189	34,938	13,110	56,237
567	4,240	1,220	6,027	2,532	18,596	6,447	27,575

^aWe classified 583 of the records for worker beneficiaries under the age of 60 as MIP because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIE and MIP workers aged 60 and over or for MINE workers. Therefore, the total number with an estimated likelihood of benefit termination is less than the total for the column.

Source: GAO analysis of MBR records and files supplied by OD.

Appendix IV
Tables on CDR Population Characteristics

Table IV.2: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program and Medical Improvement Classification, in Percentages

	DI only			Total
	MIE	MIP ^a	MINE	
Total CDR population	131,312	1,056,913	449,214	1,637,439
Age in years				
Under 30	4	1	1	1
30-39	18	11	10	11
40-49	35	29	25	28
50-59	32	36	30	34
60 and over	11	23	34	25
Average age (mean)	48	52	53	52
Average age (median)	48	53	56	53
Diagnostic group				
Infectious and parasitic diseases	0	1	1	1
Neoplasms	3	2	1	2
Endocrine, nutritional, and metabolic diseases	5	6	2	5
Disorders of blood and blood-forming organs	0	0	0	0
Mental disorders, excluding mental retardation	45	33	18	30
Mental retardation	2	4	8	5
Neurological and sensory disorders	6	6	19	10
Circulatory disorders	6	10	15	11
Respiratory disorders	1	2	3	2
Digestive disorders	1	1	1	1
Genitourinary disorders	1	0	2	1
Skin and subcutaneous tissue disorders	0	0	0	0
Musculoskeletal disorders	20	25	11	21
Congenital anomalies	0	0	0	0
Injuries	7	5	6	5
Other	0	0	0	0
Not identified	2	4	13	6
Estimated likelihood of benefit termination				
Subpopulation with likelihood estimated ^b	115,893	801,034		916,927
Under 5%	70	79		78
5-24%	26	19		20
25-49%	3	1		2

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only				Total DI CDR population			
MIE	MIP^a	MINE	Total	MIE	MIP^a	MINE	Total
31,213	229,612	93,265	354,090	162,525	1,286,525	542,479	1,991,529
13	7	3	7	5	2	1	2
29	27	22	26	20	14	12	14
33	29	27	29	35	29	25	28
20	24	24	23	29	34	29	32
6	13	24	15	10	21	33	24
43	46	49	46	47	51	53	51
42	25	49	46	47	52	55	52
0	1	1	1	0	1	1	1
1	1	0	1	2	2	1	1
6	7	2	6	5	6	2	5
0	0	0	0	0	0	0	0
61	48	21	42	48	36	19	32
6	11	24	14	3	5	10	6
5	4	15	7	6	6	18	9
3	5	7	6	5	9	13	10
1	2	2	2	1	2	3	2
1	1	0	1	1	1	1	1
0	0	2	1	1	0	2	1
0	0	0	0	0	0	0	0
10	13	6	11	18	23	10	19
0	0	0	0	0	0	0	0
4	3	5	3	7	4	6	5
0	0	0	0	0	0	0	0
1	2	14	5	2	3	13	6
29,308	199,679		228,987	145,201	1,000,713		1,145,914
73	81		80	71	79		78
24	17		18	26	19		20
3	1		2	3	1		2

(continued)

Appendix IV
Tables on CDR Population Characteristics

	DI only			Total
	MIE	MIP ^a	MINE	
50-74%	1	0		0
75% and over	0	0		0
Average likelihood (mean)	6	4		4
Average likelihood (median)	3	2		2
Number of years receiving benefits				
Under 4	34	7	1	7
4-5	27	25	3	19
6-7	21	23	8	19
8-9	9	15	13	14
10 and over	9	29	75	40
Average years (mean)	6	9	15	10
Average years (median)	5	7	14	9
CDR maturity				
Maturing in FY 1996	23	24	19	22
Matured 1 year ago	21	16	17	17
Matured 2 years ago	15	16	12	15
Matured 3 years ago	12	12	7	11
Matured 4 years ago	11	11	9	10
Matured 5-10 years ago	16	16	28	19
Matured over 10 years ago	1	3	0	2
Not identified	1	3	7	4
Average years (mean)	3	3	3	3
Average years (median)	2	2	2	2
Gender				
Female	40	37	32	36
Male	60	63	68	64
Not identified	0	0	0	0
Race				
Black	16	17	17	17
White	78	79	79	79
Other	5	2	2	3
Not identified	1	1	1	1

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only				Total DI CDR population			
MIE	MIP ^a	MINE	Total	MIE	MIP ^a	MINE	Total
0	0		0	1	0		0
0	0		0	0	0		0
5	4		4	6	4		4
3	2		2	3	2		2
<hr/>							
34	7	1	8	34	7	1	7
30	28	3	22	28	26	3	20
21	23	7	18	21	23	8	19
8	14	12	13	8	15	13	14
8	27	77	39	9	29	75	40
6	8	15	10	6	9	15	10
5	7	13	8	5	7	14	9
<hr/>							
20	25	13	22	22	24	18	22
20	18	17	18	20	17	17	17
17	15	13	15	15	16	12	15
13	12	10	11	13	12	8	11
12	11	8	10	11	11	9	10
16	14	15	14	16	16	25	18
1	2	25	8	1	3	4	3
1	3	0	2	1	3	6	3
3	3	3	3	3	3	3	3
3	2	3	2	2	2	2	2
<hr/>							
54	53	43	50	43	40	34	38
46	47	57	50	57	60	66	62
0	0	0	0	0	0	0	0
<hr/>							
24	25	28	26	17	19	19	19
68	69	68	68	76	77	77	77
6	4	3	4	5	3	2	3
2	2	1	2	2	1	1	1

^aWe classified 583 of the records for worker beneficiaries under the age of 60 as MIP because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIE and MIP workers aged 60 and over or for MINE workers. Therefore, the total number with an estimated likelihood of benefit termination is less than the total for the column.

Source: GAO analysis of MBR records and files supplied by OD.

**Appendix IV
Tables on CDR Population Characteristics**

Table IV.3: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program, Age, and Medical Improvement Classification

	DI only								Concurrent			
	Workers under 60 years old				Workers 60 years and older				Workers under 60 years old			
	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total
Total CDR population	115,893	801,034	290,066	1,206,993	15,419	255,879	159,148	430,446	29,308	199,679	69,856	298,843
Age in years												
Under 30	4,808	14,824	3,770	23,402					3,968	16,713	2,934	23,615
30-39	23,958	117,142	43,989	185,089					9,154	61,571	20,759	91,484
40-49	46,171	301,574	111,231	458,976					10,193	67,446	24,945	102,584
50-59	40,956	367,494	131,076	539,526					5,993	53,949	21,218	81,160
60 and over					15,419	255,879	159,148	430,446				
Average age (mean)	46	48	48	48	62	63	63	63	41	43	45	43
Average age (median)	47	49	49	49	62	63	63	63	41	43	44	43
Diagnostic group												
Infectious and parasitic diseases	443	7,357	3,727	11,527	76	1,675	1,547	3,298	119	2,324	787	3,230
Neoplasms	2,543	9,808	2,510	14,861	757	8,130	1,364	10,251	268	1,209	314	1,791
Endocrine, nutritional, and metabolic diseases	6,168	49,022	5,520	60,710	903	15,164	4,699	20,766	1,649	13,709	1,224	16,582
Disorders of blood and blood-forming organs	299	1,751	359	2,409	38	392	141	571	44	610	153	807
Mental disorders, excluding mental retardation	54,637	315,621	54,666	424,924	3,947	33,652	27,559	65,158	18,298	105,013	14,731	138,042
Mental retardation	2,217	34,312	28,952	65,481	114	3,022	5,777	8,913	1,847	23,648	18,869	44,364
Neurological and sensory disorders	7,218	52,614	62,944	122,776	923	13,574	20,277	34,774	1,358	8,707	11,393	21,458
Circulatory disorders	6,118	61,356	29,201	96,675	1,571	46,654	36,171	84,396	868	8,148	3,346	12,362
Respiratory disorders	1,088	14,884	4,584	20,556	264	11,127	7,928	19,319	280	3,096	948	4,324
Digestive disorders	1,339	8,898	1,795	12,032	388	3,494	1,254	5,136	189	1,390	273	1,852
Genitourinary disorders	979	3,096	7,340	11,415	153	1,073	1,614	2,840	120	588	1,463	2,171
Skin and subcutaneous tissue disorders	254	2,451	258	2,963	68	746	302	1,116	45	407	42	494
Musculoskeletal disorders	22,437	178,711	20,212	221,360	3,757	85,809	27,388	116,954	2,737	21,561	2,394	26,692

**Appendix IV
Tables on CDR Population Characteristics**

only				Total DI CDR population							
Workers 60 years and older				Workers under 60 years old				Workers 60 years and older			
MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total
1,905	29,933	23,409	55,247	145,201	1,000,713	359,922	1,505,836	17,324	285,812	182,557	485,693
				8,776	31,537	6,704	47,017				
				33,112	178,713	64,748	276,573				
				56,364	369,020	136,176	561,560				
				46,949	421,443	152,294	620,686				
1,905	29,933	23,409	55,247					17,324	285,812	182,557	485,693
62	63	63	63	45	47	48	47	62	63	63	63
62	63	63	63	46	48	48	48	62	63	63	63
11	214	197	422	562	9,681	4,514	14,757	87	1,889	1,744	3,720
53	626	135	814	2,811	11,017	2,824	16,652	810	8,756	1,499	11,065
175	2,728	1,080	3,983	7,817	62,731	6,744	77,292	1,078	17,892	5,779	24,749
4	43	19	66	343	2,361	512	3,216	42	435	160	637
691	5,368	4,957	11,016	72,935	420,634	69,397	562,966	4,638	39,020	32,516	76,174
44	1,232	3,350	4,626	4,064	57,960	47,821	109,845	158	4,254	9,127	13,539
112	1,254	2,238	3,604	8,576	61,321	74,337	144,234	1,035	14,828	22,515	38,378
140	4,256	3,032	7,428	6,986	69,504	32,547	109,037	1,711	50,910	39,203	91,824
34	1,370	1,159	2,563	1,368	17,980	5,532	24,880	298	12,497	9,087	21,882
23	399	137	559	1,528	10,288	2,068	13,884	411	3,893	1,391	5,695
18	131	180	329	1,099	3,684	8,803	13,586	171	1,204	1,794	3,169
7	107	41	155	299	2,858	300	3,457	75	853	343	1,271
353	8,600	2,878	11,831	25,174	200,272	22,606	248,052	4,110	94,409	30,266	128,785

(continued)

**Appendix IV
Tables on CDR Population Characteristics**

	DI only								Concurrent			
	Workers under 60 years old				Workers 60 years and older				Workers under 60 years old			
	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total
Congenital anomalies	116	2,037	1,036	3,189	23	692	406	1,121	21	422	304	747
Injuries	8,209	35,865	22,431	66,505	1,484	12,191	6,432	20,107	1,190	5,300	3,649	10,139
Other	211	1,761	1,696	3,668	53	548	392	993	29	292	317	638
Not identified	1,617	21,490	42,835	65,942	900	17,936	15,897	34,733	246	3,255	9,649	13,150
Estimated likelihood of benefit termination												
Subpopulation with likelihood estimated ^b	115,893	801,034		916,927					29,308	199,679		228,987
Under 5%	81,190	631,794		712,984					21,277	161,961		183,238
5-24%	30,143	153,976		184,119					7,136	34,503		41,639
25-49%	3,467	10,745		14,212					795	2,756		3,551
50-74%	875	3,143		4,018					91	348		439
75% and over	218	1,376		1,594					9	111		120
Average likelihood (mean)	6	4		4					5	4		4
Average likelihood (median)	3	2		2					3	2		2
Number of years receiving benefits												
Under 4	42,591	61,444	3,945	107,980	2,552	8,001	329	10,882	10,241	15,842	803	26,886
4-5	32,865	213,672	12,603	259,140	3,208	53,516	549	57,273	8,857	58,706	2,824	70,387
6-7	22,678	172,225	28,991	223,894	4,373	75,526	7,466	87,365	6,033	43,767	5,630	55,430
8-9	9,021	110,751	39,125	158,897	2,176	51,125	19,162	72,463	2,100	27,000	9,351	38,451
10 and over	8,738	242,942	205,402	457,082	3,110	67,711	131,642	202,463	2,077	54,364	51,248	107,689
Average years (mean)	6	9	14	10	8	9	16	12	6	8	14	9
Average years (median)	5	7	13	8	7	8	14	10	5	7	13	8
CDR maturity												
Maturing in FY 1996	28,232	229,520	46,426	304,178	1,356	21,009	40,546	62,911	6,001	56,384	6,654	69,039
Matured 1 year ago	25,439	144,394	36,609	206,442	1,533	27,413	39,127	68,073	6,189	37,981	10,224	54,394
Matured 2 years ago	18,080	109,412	29,161	156,653	1,681	57,631	24,785	84,097	5,063	28,065	8,757	41,885
Matured 3 years ago	14,152	86,222	23,129	123,503	2,082	42,975	10,083	55,140	3,931	21,943	7,473	33,347
Matured 4 years ago	11,876	79,177	30,404	121,457	2,845	33,482	10,984	47,311	3,339	20,772	6,182	30,293
Matured 5-10 years ago	16,271	109,485	90,694	216,450	5,380	58,711	33,391	97,482	4,274	24,894	7,105	36,273
Matured over 10 years ago	872	16,381	250	17,503	504	14,403	88	14,995	202	1,993	23,386	25,581
Not identified	971	26,443	33,393	60,807	38	255	144	437	309	7,647	75	8,031

**Appendix IV
Tables on CDR Population Characteristics**

only				Total DI CDR population							
Workers 60 years and older				Workers under 60 years old				Workers 60 years and older			
MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total
1	65	62	128	137	2,459	1,340	3,936	24	757	468	1,249
105	1,225	582	1,912	9,399	41,165	26,080	76,644	1,589	13,416	7,014	22,019
7	50	56	113	240	2,053	2,013	4,306	60	598	448	1,106
127	2,265	3,306	5,698	1,863	24,745	52,484	79,092	1,027	20,201	19,203	40,431
				145,201	1,000,713		1,145,914				
				102,467	793,755		896,222				
				37,279	188,479		225,758				
				4,262	13,501		17,763				
				966	3,491		4,457				
				227	1,487		1,714				
				6	4		4				
				3	2		2				
242	772	26	1,040	52,832	77,286	4,748	134,866	2,794	8,773	355	11,922
403	5,669	72	6,144	41,722	272,378	15,427	329,527	3,611	59,185	621	63,417
549	8,850	607	10,006	28,711	215,992	34,621	279,324	4,922	84,376	8,073	97,371
290	6,143	2,035	8,468	11,121	137,751	48,476	197,348	2,466	57,268	21,197	80,931
421	8,499	20,669	29,589	10,815	297,306	256,650	564,771	3,531	76,210	152,311	232,052
8	10	17	13	6	9	14	10	8	9	16	12
7	8	15	10	5	7	13	8	7	8	14	10
121	1,928	5,245	7,294	34,233	285,904	53,080	373,217	1,477	22,937	45,791	70,205
150	2,950	5,304	8,404	31,628	182,375	46,833	260,836	1,683	30,363	44,431	76,477
191	6,180	3,133	9,504	23,143	137,477	37,918	198,538	1,872	63,811	27,918	93,601
260	5,247	1,549	7,056	18,083	108,165	30,602	156,850	2,342	48,222	11,632	62,196
351	4,455	1,683	6,489	15,215	99,949	36,586	151,750	3,196	37,937	12,667	53,800
734	7,571	6,475	14,780	20,545	134,379	97,799	252,723	6,114	66,282	39,866	112,262
95	1,592	11	1,698	1,074	18,374	23,636	43,084	599	15,995	99	16,693
3	10	9	22	1,280	34,090	33,468	68,838	41	265	153	459

(continued)

**Appendix IV
Tables on CDR Population Characteristics**

	DI only								Concurrent			
	Workers under 60 years old				Workers 60 years and older				Workers under 60 years old			
	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total
Average years (mean)	3	3	3	3	4	4	3	4	3	2	3	3
Average years (median)	2	2	3	2	4	3	2	3	2	2	3	2
Gender												
Female	46,191	293,484	89,899	429,574	6,171	93,845	53,306	153,322	15,607	101,170	27,584	144,361
Male	69,659	507,241	200,025	776,925	9,248	162,034	105,840	277,122	13,699	98,487	42,261	154,447
Not identified	43	309	142	494	0	0	2	2	2	22	11	35
Race												
Black	18,488	142,242	51,997	212,727	2,054	38,375	24,875	65,304	6,922	49,998	18,373	75,293
White	89,741	624,288	226,042	940,071	12,876	212,089	131,076	356,041	19,955	137,657	47,879	205,491
Other	5,767	21,130	7,294	34,191	421	4,433	2,703	7,557	1,875	7,970	2,489	12,334
Not identified	1,897	13,374	4,733	20,004	68	982	494	1,544	556	4,054	1,115	5,725

**Appendix IV
Tables on CDR Population Characteristics**

only				Total DI CDR population							
Workers 60 years and older				Workers under 60 years old				Workers 60 years and older			
MIE	MIP	MINE	Total	MIE	MIP^a	MINE	Total	MIE	MIP	MINE	Total
5	4	3	4	3	3	3	3	4	4	3	4
5	4	2	3	2	2	3	2	4	3	2	3
1,324	20,100	12,948	34,372	61,798	394,654	117,483	573,935	7,495	113,945	66,254	187,694
581	9,833	10,461	20,875	83,358	605,728	242,286	931,372	9,829	171,867	116,301	297,997
0	0	0	0	45	331	153	529	0	0	2	2
442	8,440	7,381	16,263	25,410	192,240	70,370	288,020	2,496	46,815	32,256	81,567
1,326	19,902	15,299	36,527	109,696	761,945	273,921	1,145,562	14,202	231,991	146,375	392,568
126	1,405	624	2,155	7,642	29,100	9,783	46,525	547	5,838	3,327	9,712
11	186	105	302	2,453	17,428	5,848	25,729	79	1,168	599	1,846

^aWe classified 583 of the records for worker beneficiaries under the age of 60 as MIP because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIE and MIP workers aged 60 and over or for MINE workers. Therefore, the total number with an estimated likelihood of benefit termination is less than the total for the column.

Source: GAO analysis of MBR records and files supplied by OD.

**Appendix IV
Tables on CDR Population Characteristics**

Table IV.4: Characteristics of DI Workers Awaiting CDRs in FY 1996, by Program, Age, and Medical Improvement Classification, in Percentages

	DI only								Concurrent			
	Workers under 60 years old				Workers 60 years and older				Workers under 60 years old			
	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total
Total CDR population	115,893	801,034	290,066	1,206,993	15,419	255,879	159,148	430,446	29,308	199,679	69,856	298,843
Age in years												
Under 30	4	2	1	2					14	8	4	8
30-39	21	15	15	15					31	31	30	31
40-49	40	38	38	38					35	34	36	34
50-59	35	46	45	45					20	27	30	27
60 and over					100	100	100	100				
Average age (mean)	46	48	48	48	62	63	63	63	41	43	45	43
Average age (median)	47	49	49	49	62	63	63	63	41	43	44	43
Diagnostic group												
Infectious and parasitic diseases	0	1	1	1	0	1	1	1	0	1	1	1
Neoplasms	2	1	1	1	5	3	1	2	1	1	0	1
Endocrine, nutritional, and metabolic diseases	5	6	2	5	6	6	3	5	6	7	2	6
Disorders of blood and blood-forming organs	0	0	0	0	0	0	0	0	0	0	0	0
Mental disorders, excluding mental retardation	47	39	19	35	26	13	17	15	62	53	21	46
Mental retardation	2	4	10	5	1	1	4	2	6	12	27	15
Neurological and sensory disorders	6	7	22	10	6	5	13	8	5	4	16	7
Circulatory disorders	5	8	10	8	10	18	23	20	3	4	5	4
Respiratory disorders	1	2	2	2	2	4	5	4	1	2	1	1
Digestive disorders	1	1	1	1	3	1	1	1	1	1	0	1
Genitourinary disorders	1	0	3	1	1	0	1	1	0	0	2	1
Skin and subcutaneous tissue disorders	0	0	0	0	0	0	0	0	0	0	0	0
Musculoskeletal disorders	19	22	7	18	24	34	17	27	9	11	3	9

**Appendix IV
Tables on CDR Population Characteristics**

only				Total DI CDR population							
Workers 60 years and older				Workers under 60 years old				Workers 60 years and older			
MIE	MIP	MINE	Total	MIE	MIP^a	MINE	Total	MIE	MIP	MINE	Total
1,905	29,933	23,409	55,247	145,201	1,000,713	359,922	1,505,836	17,324	285,812	182,557	485,693
				6	3	2	3				
				23	18	18	18				
				39	37	38	37				
				32	42	42	41				
100	100	100	100					100	100	100	100
62	63	63	63	45	47	48	47	62	63	63	63
62	63	63	63	46	48	48	48	62	63	63	63
1	1	1	1	0	1	1	1	1	1	1	1
3	2	1	1	2	1	1	1	5	3	1	2
9	9	5	7	5	6	2	5	6	6	3	5
0	0	0	0	0	0	0	0	0	0	0	0
36	18	21	20	50	42	19	37	27	14	18	16
2	4	14	8	3	6	13	7	1	1	5	3
6	4	10	7	6	6	21	10	6	5	12	8
7	14	13	13	5	7	9	7	10	18	21	19
2	5	5	5	1	2	2	2	2	4	5	5
1	1	1	1	1	1	1	1	2	1	1	1
1	0	1	1	1	0	2	1	1	0	1	1
0	0	0	0	0	0	0	0	0	0	0	0
19	29	12	21	17	20	6	16	24	33	17	27

(continued)

**Appendix IV
Tables on CDR Population Characteristics**

	DI only								Concurrent			
	Workers under 60 years old				Workers 60 years and older				Workers under 60 years old			
	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total
Congenital anomalies	0	0	0	0	0	0	0	0	0	0	0	0
Injuries	7	4	8	6	10	5	4	5	4	3	5	3
Other	0	0	1	0	0	0	0	0	0	0	0	0
Not identified	1	3	15	5	6	7	10	8	1	2	14	4
Estimated likelihood of benefit termination												
Subpopulation with likelihood estimated ^b	115,893	801,034		916,927					29,308	199,679		228,987
Under 5%	70	79		78					73	81		80
5-24%	26	20		20					24	17		18
25-49%	3	1		2					3	1		2
50-74%	1	0		0					0	0		0
75% and over	0	0		0					0	0		0
Average likelihood (mean)	6	4		4					5	4		4
Average likelihood (median)	3	2		2					3	2		2
Number of years receiving benefits												
Under 4	37	8	1	9	17	3	0	3	35	8	1	9
4-5	28	27	4	21	21	21	0	13	30	29	4	24
6-7	20	22	10	19	28	30	5	20	21	22	8	19
8-9	8	14	13	13	14	20	12	17	7	14	13	13
10 and over	8	30	71	38	20	26	83	47	7	27	73	36
Average years (mean)	6	9	14	10	8	9	16	12	6	8	14	9
Average years (median)	5	7	13	8	7	8	14	10	5	7	13	8
CDR maturity												
Maturing in FY 1996	24	29	16	25	9	8	25	15	20	28	10	23
Matured 1 year ago	22	18	13	17	10	11	25	16	21	19	15	18
Matured 2 years ago	16	14	10	13	11	23	16	20	17	14	13	14
Matured 3 years ago	12	11	8	10	14	17	6	13	13	11	11	11
Matured 4 years ago	10	10	10	10	18	13	7	11	11	10	9	10
Matured 5-10 years ago	14	14	31	18	35	23	21	23	15	12	10	12
Matured over 10 years ago	1	2	0	1	3	6	0	3	1	1	33	9
Not identified	1	3	12	5	0	0	0	0	1	4	0	3

**Appendix IV
Tables on CDR Population Characteristics**

only				Total DI CDR population							
Workers 60 years and older				Workers under 60 years old				Workers 60 years and older			
MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total
0	0	0	0	0	0	0	0	0	0	0	0
6	4	2	3	6	4	7	5	9	5	4	5
0	0	0	0	0	0	1	0	0	0	0	0
7	8	14	10	1	2	15	5	6	7	11	8
				145,201	1,000,713			1,145,914			
				71	79			78			
				26	19			20			
				3	1			2			
				1	0			0			
				0	0			0			
				6	4			4			
				3	2			2			
13	3	0	2	36	8	1	9	16	3	0	2
21	19	0	11	29	27	4	22	21	21	0	13
29	30	3	18	20	22	10	19	28	30	4	20
15	21	9	15	8	14	13	13	14	20	12	17
22	28	88	54	7	30	71	38	20	27	83	48
8	10	17	13	6	9	14	10	8	9	16	12
7	8	15	10	5	7	13	8	7	8	14	10
6	6	22	13	24	29	15	25	9	8	25	14
8	10	23	15	22	18	13	17	10	11	24	16
10	21	13	17	16	14	11	13	11	22	15	19
14	18	7	13	12	11	9	10	14	17	6	13
18	15	7	12	10	10	10	10	18	13	7	11
39	25	28	27	14	13	27	17	35	23	22	23
5	5	0	3	1	2	7	3	3	6	0	3
0	0	0	0	1	3	9	5	0	0	0	0

(continued)

**Appendix IV
Tables on CDR Population Characteristics**

	DI only								Concurrent			
	Workers under 60 years old				Workers 60 years and older				Workers under 60 years old			
	MIE	MIP ^a	MINE	Total	MIE	MIP	MINE	Total	MIE	MIP ^a	MINE	Total
Average years (mean)	3	3	3	3	4	4	3	4	3	2	3	3
Average years (median)	2	2	3	2	4	3	2	3	2	2	3	2
Gender												
Female	40	37	31	36	40	37	33	36	53	51	39	48
Male	60	63	69	64	60	63	67	64	47	49	60	52
Not identified	0	0	0	0	0	0	0	0	0	0	0	0
Race												
Black	16	18	18	18	13	15	16	15	24	25	26	25
White	77	78	78	78	84	83	82	83	68	69	69	69
Other	5	3	3	3	3	2	2	2	6	4	4	4
Not identified	2	2	2	2	0	0	0	0	2	2	2	2

**Appendix IV
Tables on CDR Population Characteristics**

only				Total DI CDR population							
Workers 60 years and older				Workers under 60 years old				Workers 60 years and older			
MIE	MIP	MINE	Total	MIE	MIP^a	MINE	Total	MIE	MIP	MINE	Total
5	4	3	4	3	3	3	3	4	4	3	4
5	4	2	3	2	2	3	2	4	3	2	3
70	67	55	62	43	39	33	38	43	40	36	39
30	33	45	38	57	61	67	62	57	60	64	61
0	0	0	0	0	0	0	0	0	0	0	0
23	28	32	29	17	19	20	19	14	16	18	17
70	66	65	66	76	76	76	76	82	81	80	81
7	5	3	4	5	3	3	3	3	2	2	2
1	1	0	1	2	2	2	2	0	0	0	0

^aWe classified 583 of the records for worker beneficiaries under the age of 60 as MIP because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIE and MIP workers aged 60 and over or for MINE workers. Therefore, the total number with an estimated likelihood of benefit termination is less than the total for the column.

Source: GAO analysis of MBR records and files supplied by OD.

Appendix IV
Tables on CDR Population Characteristics

Table IV.5: Characteristics of Selected DI Workers Awaiting CDRs in FY 1996, by Program and Estimated Likelihood of Benefit Termination

	DI only					Total
	Under 5%	5-24%	25-49%	50-74%	75% and over	
Total CDR population	712,984	184,119	14,212	4,018	1,594	916,927
Age in years						
Under 30	7,454	8,422	2,838	807	111	19,632
30-39	83,842	49,140	6,001	1,712	405	141,100
40-49	253,996	87,794	4,061	1,185	709	347,745
50-59	367,690	38,763	1,312	314	369	408,450
Average age (mean)	49	44	38	38	44	48
Average age (median)	50	44	37	37	44	49
Diagnostic group						
Infectious and parasitic diseases	5,573	1,969	224	30	4	7,800
Neoplasms	2,236	7,640	1,884	572	19	12,351
Endocrine, nutritional, and metabolic diseases	40,717	12,921	932	452	168	55,190
Disorders of blood and blood-forming organs	1,053	574	347	75	1	2,050
Mental disorders, excluding mental retardation	309,753	57,793	2,545	133	34	370,258
Mental retardation	31,802	4,673	44	2	8	36,529
Neurological and sensory disorders	49,530	10,224	63	9	6	59,832
Circulatory disorders	61,967	5,330	172	2	3	67,474
Respiratory disorders	12,225	3,697	49	1	0	15,972
Digestive disorders	5,454	4,230	507	45	1	10,237
Genitourinary disorders	1,469	1,758	658	184	6	4,075
Skin and subcutaneous tissue disorders	1,479	1,030	159	33	4	2,705
Musculoskeletal disorders	160,550	38,406	1,835	323	34	201,148

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only						Total DI CDR population					
Under 5%	5-24%	25-49%	50-74%	75% and over	Total	Under 5%	5-24%	25-49%	50-74%	75% and over	Total
183,238	41,639	3,551	439	120	228,987	896,222	225,758	17,763	4,457	1,714	1,145,914
13,930	4,854	1,662	231	4	20,681	21,384	13,276	4,500	1,038	115	40,313
53,473	15,667	1,383	154	48	70,725	137,315	64,807	7,384	1,866	453	211,825
60,086	17,033	432	38	50	77,639	314,082	104,827	4,493	1,223	759	425,384
55,749	4,085	74	16	18	59,942	423,441	42,848	1,386	330	387	468,392
44	40	32	32	42	43	48	43	37	37	43	47
44	40	30	30	42	43	49	43	35	36	44	48
1,821	568	51	3	0	2,443	7,394	2,537	275	33	4	10,243
295	874	269	38	1	1,477	2,531	8,514	2,153	610	20	13,828
12,081	2,757	391	109	20	15,358	52,798	15,678	1,323	561	188	70,548
290	186	148	30	0	654	1,343	760	495	105	1	2,704
103,244	18,694	1,313	59	1	123,311	412,997	76,487	3,858	192	35	493,569
24,276	1,179	29	5	6	25,495	56,078	5,852	73	7	14	62,024
7,706	2,337	19	2	1	10,065	57,236	12,561	82	11	7	69,897
7,951	1,057	7	0	1	9,016	69,918	6,387	179	2	4	76,490
2,523	846	7	0	0	3,376	14,748	4,543	56	1	0	19,348
791	735	51	1	1	1,579	6,245	4,965	558	46	2	11,816
361	275	67	5	0	708	1,830	2,033	725	189	6	4,783
222	173	51	6	0	452	1,701	1,203	210	39	4	3,157
17,586	6,515	181	16	0	24,298	178,136	44,921	2,016	339	34	225,446

(continued)

Appendix IV
Tables on CDR Population Characteristics

	DI only					Total
	Under 5%	5-24%	25-49%	50-74%	75% and over	
Congenital anomalies	1,473	580	92	8	0	2,153
Injuries	21,047	17,754	3,349	1,701	223	44,074
Other	1,038	775	91	47	21	1,972
Not identified	5,618	14,765	1,261	401	1,062	23,107
Medical improvement classification						
MIE	81,190	30,143	3,467	875	218	115,893
MIP ^a	631,794	153,976	10,745	3,143	1,376	801,034
Number of years receiving benefits						
Under 4	73,606	27,288	3,015	119	7	104,035
4-5	184,112	56,437	4,560	1,317	111	246,537
6-7	153,725	37,126	2,722	1,153	177	194,903
8-9	95,327	22,324	1,385	593	143	119,772
10 and over	206,214	40,944	2,530	836	1,156	251,680
Average years (mean)	9	8	7	8	15	9
Average years (median)	7	6	6	7	15	7
CDR maturity						
Maturing in FY 1996	177,757	71,236	6,708	1,478	573	257,752
Matured 1 year ago	128,560	36,706	3,000	1,146	421	169,833
Matured 2 years ago	104,796	20,502	1,410	540	244	127,492
Matured 3 years ago	85,918	13,350	727	270	109	100,374
Matured 4 years ago	79,316	11,065	454	169	49	91,053
Matured 5-10 years ago	107,890	17,032	573	173	88	125,756
Matured over 10 years ago	14,193	2,932	87	20	21	17,253
Not identified	14,554	11,296	1,253	222	89	27,414
Average years (mean)	3	2	1	2	2	3
Average years (median)	2	1	1	1	1	2
Gender						
Female	265,359	67,835	4,839	1,144	498	339,675

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only						Total DI CDR population					
Under 5%	5-24%	25-49%	50-74%	75% and over	Total	Under 5%	5-24%	25-49%	50-74% and over	75% and over	Total
256	153	31	3	0	443	1,729	733	123	11	0	2,596
2,959	2,928	529	74	0	6,490	24,006	20,682	3,878	1,775	223	50,564
147	137	29	5	3	321	1,185	912	120	52	24	2,293
729	2,225	378	83	86	3,501	6,347	16,990	1,639	484	1,148	26,608
21,277	7,136	795	91	9	29,308	102,467	37,279	4,262	966	227	145,201
161,961	34,503	2,756	348	111	199,679	793,755	188,479	13,501	3,491	1,487	1,000,713
19,277	5,826	951	29	0	26,083	92,883	33,114	3,966	148	7	130,118
51,789	14,326	1,290	155	3	67,563	235,901	70,763	5,850	1,472	114	314,100
39,920	9,225	549	102	4	49,800	193,645	46,351	3,271	1,255	181	244,703
23,918	4,872	247	55	8	29,100	119,245	27,196	1,632	648	151	148,872
48,334	7,390	514	98	105	56,441	254,548	48,334	3,044	934	1,261	308,121
8	7	7	8	15	8	9	8	7	8	15	8
7	6	5	6	15	7	7	6	6	7	15	7
45,056	15,273	1,858	151	47	62,385	222,813	86,509	8,566	1,629	620	320,137
35,135	8,423	490	98	24	44,170	163,695	45,129	3,490	1,244	445	214,003
27,674	5,075	286	67	26	33,128	132,470	25,577	1,696	607	270	160,620
22,191	3,489	170	18	6	25,874	108,109	16,839	897	288	115	126,248
21,109	2,879	96	24	3	24,111	100,425	13,944	550	193	52	115,164
25,498	3,534	117	18	1	29,168	133,388	20,566	690	191	89	154,924
1,880	292	12	9	2	2,195	16,073	3,224	99	29	23	19,448
4,695	2,674	522	54	11	7,956	19,249	13,970	1,775	276	100	35,370
3	2	1	2	1	3	3	2	1	2	2	3
2	1	0	1	1	2	2	1	1	1	1	3
95,894	19,278	1,400	161	44	116,777	361,253	87,113	6,239	1,305	542	456,452

(continued)

Appendix IV
Tables on CDR Population Characteristics

	DI only					Total
	Under 5%	5-24%	25-49%	50-74%	75% and over	
Male	447,301	116,261	9,368	2,874	1,096	576,900
Not identified	324	23	5	0	0	352
Race						
Black	126,316	30,891	2,650	633	240	160,730
White	555,908	142,990	10,696	3,157	1,278	714,029
Other	19,723	6,479	516	130	49	26,897
Not identified	11,037	3,759	350	98	27	15,271

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only						Total DI CDR population					
Under 5%	5-24%	25-49%	50-74%	75% and over	Total	Under 5%	5-24%	25-49%	50-74% and over	75% and over	Total
87,320	22,361	2,151	278	76	112,186	534,621	138,622	11,519	3,152	1,172	689,086
24	0	0	0	0	24	348	23	5	0	0	376
45,745	10,157	884	111	23	56,920	172,061	41,048	3,534	744	263	217,650
126,267	28,544	2,422	291	88	157,612	682,175	171,534	13,118	3,448	1,366	871,641
7,601	2,058	152	26	8	9,845	27,324	8,537	668	156	57	36,742
3,625	880	93	11	1	4,610	14,662	4,639	443	109	28	19,881

Note: SSA does not estimate the likelihood of benefit termination for MIE and MIP workers aged 60 and over or for MINE workers.

^aWe classified 583 of the records for worker beneficiaries under the age of 60 as MIP because a MIE or MIP classification was not specified.

Source: GAO analysis of MBR records and files supplied by OD.

Appendix IV
Tables on CDR Population Characteristics

Table IV.6: Characteristics of Selected DI Workers Awaiting CDRs in FY 1996, by Program and Estimated Likelihood of Benefit Termination, in Percentages

	DI only					Total
	Under 5 %	5-24%	25-49%	50-74%	75% and over	
Total CDR population	712,984	184,119	14,212	4,018	1,594	916,927
Age in years						
Under 30	1	5	20	20	7	2
30-39	12	27	42	43	25	15
40-49	36	48	29	29	44	38
50-59	52	21	9	8	23	45
60 and over	0	0	0	0	0	0
Average age (mean)	49	44	38	38	44	48
Average age (median)	50	44	37	37	44	49
Diagnostic group						
Infectious and parasitic diseases	1	1	2	1	0	1
Neoplasms	0	4	13	14	1	1
Endocrine, nutritional, and metabolic diseases	6	7	7	11	11	6
Disorders of blood and blood-forming organs	0	0	2	2	0	0
Mental disorders, excluding mental retardation	43	31	18	3	2	40
Mental retardation	4	3	0	0	1	4
Neurological and sensory disorders	7	6	0	0	0	7
Circulatory disorders	9	3	1	0	0	7
Respiratory disorders	2	2	0	0	0	2
Digestive disorders	1	2	4	1	0	1
Genitourinary disorders	0	1	5	5	0	0
Skin and subcutaneous tissue disorders	0	1	1	1	0	0

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only						Total DI CDR population					
Under 5%	5-24%	25-49%	50-74%	75% and over	Total	Under 5%	5-24%	25-49%	50-74%	75% and over	Total
183,238	41,639	3,551	439	120	228,987	896,222	225,758	17,763	4,457	1,714	1,145,914
8	12	47	53	3	9	2	6	25	23	7	4
29	38	39	35	40	31	15	29	42	42	26	18
33	41	12	9	42	34	35	46	25	27	44	37
30	10	2	4	15	26	47	19	8	7	23	41
0	0	0	0	0	0	0	0	0	0	0	0
44	40	32	32	42	43	48	43	37	37	43	47
44	40	30	30	42	43	49	43	35	36	44	48
1	1	1	1	0	1	1	1	2	1	0	1
0	2	8	9	1	1	0	4	12	14	1	1
7	7	11	25	17	7	6	7	7	13	11	6
0	0	4	7	0	0	0	0	3	2	0	0
56	45	37	13	1	54	46	34	22	4	2	43
13	3	1	1	5	11	6	3	0	0	1	5
4	6	1	0	1	4	6	6	0	0	0	6
4	3	0	0	1	4	8	3	1	0	0	7
1	2	0	0	0	1	2	2	0	0	0	2
0	2	1	0	1	1	1	2	3	1	0	1
0	1	2	1	0	0	0	1	4	4	0	0
0	0	1	1	0	0	0	1	1	1	0	0

(continued)

Appendix IV
Tables on CDR Population Characteristics

	DI only					Total
	Under 5 %	5-24%	25-49%	50-74%	75% and over	
Musculoskeletal disorders	23	21	13	8	2	22
Congenital anomalies	0	0	1	0	0	0
Injuries	3	10	24	42	14	5
Other	0	0	1	1	1	0
Not identified	1	8	9	10	67	3
Medical improvement classification						
MIE	11	16	24	22	14	13
MIP ^a	89	84	76	78	86	87
Number of years receiving benefits						
Under 4	10	15	21	3	0	11
4-5	26	31	32	33	7	27
6-7	22	20	19	29	11	21
8-9	13	12	10	15	9	13
10 and over	29	22	18	21	73	27
Average years (mean)	9	8	7	8	15	9
Average years (median)	7	6	6	7	15	7
CDR maturity						
Maturing in FY 1996	25	39	47	37	36	28
Matured 1 year ago	18	20	21	29	26	19
Matured 2 years ago	15	11	10	13	15	14
Matured 3 years ago	12	7	5	7	7	11
Matured 4 years ago	11	6	3	4	3	10
Matured 5-10 years ago	15	9	4	4	6	14
Matured over 10 years ago	2	2	1	0	1	2
Not identified	2	6	9	6	6	3
Average years (mean)	3	2	1	2	2	3
Average years (median)	2	1	1	1	1	2

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only						Total DI CDR population					
Under 5%	5-24%	25-49%	50-74%	75% and over	Total	Under 5%	5-24%	25-49%	50-74%	75% and over	Total
10	16	5	4	0	11	20	20	11	8	2	20
0	0	1	1	0	0	0	0	1	0	0	0
2	7	15	17	0	3	3	9	22	40	13	4
0	0	1	1	3	0	0	0	1	1	1	0
0	5	11	19	72	2	1	8	9	11	67	2
12	17	22	21	8	13	11	17	24	22	13	13
88	83	78	79	92	87	89	83	76	78	87	87
11	14	27	7	0	11	10	15	22	3	0	11
28	34	36	35	3	30	26	31	33	33	7	27
22	22	15	23	3	22	22	21	18	28	11	21
13	12	7	13	7	13	13	12	9	15	9	13
26	18	14	22	88	25	28	21	17	21	74	27
8	7	7	8	15	8	9	8	7	8	15	8
7	6	5	6	15	7	7	6	6	7	15	7
25	37	52	34	39	27	25	38	48	37	36	28
19	20	14	22	20	19	18	20	20	28	26	19
15	12	8	15	22	14	15	11	10	14	16	14
12	8	5	4	5	11	12	7	5	6	7	11
12	7	3	5	3	11	11	6	3	4	3	10
14	8	3	4	1	13	15	9	4	4	5	14
1	1	0	2	2	1	2	1	1	1	1	2
3	6	15	12	9	3	2	6	10	6	6	3
3	2	1	2	1	3	3	2	1	2	2	3
2	1	0	1	1	2	2	1	1	1	1	3

(continued)

Appendix IV
Tables on CDR Population Characteristics

	DI only					Total
	Under 5 %	5-24%	25-49%	50-74%	75% and over	
Gender						
Female	37	37	34	28	31	37
Male	63	63	66	72	69	63
Not identified	0	0	0	0	0	0
Race						
Black	18	17	19	16	15	18
White	78	78	75	79	80	78
Other	3	4	4	3	3	3
Not identified	2	2	2	2	2	2

**Appendix IV
Tables on CDR Population Characteristics**

Concurrent only						Total DI CDR population					
Under 5%	5-24%	25-49%	50-74%	75% and over	Total	Under 5%	5-24%	25-49%	50-74%	75% and over	Total
52	46	39	37	37	51	40	39	35	29	32	40
48	54	61	63	63	49	60	61	65	71	68	60
0	0	0	0	0	0	0	0	0	0	0	0
25	24	25	25	19	25	19	18	20	17	15	19
69	69	68	66	73	69	76	76	74	77	80	76
4	5	4	6	7	4	3	4	4	4	3	3
2	2	3	3	1	2	2	2	2	2	2	2

Note: SSA does not estimate the likelihood of benefit termination for MIE and MIP workers aged 60 and over or for MINE workers.

^aWe classified 583 of the records for worker beneficiaries under the age of 60 as MIP because a MIE or MIP classification was not specified.

Source: GAO analysis of MBR records and files supplied by OD.

Appendix IV
Tables on CDR Population Characteristics

Table IV.7: Characteristics of Adult and Child SSI Recipients Awaiting CDRs in FY 1996, by Medical Improvement Classification

	Adults			Total
	MIE	MIP ^a	MINE	
Total estimated CDR population	186,727	785,383	421,580	1,393,693
Age in years				
Under 5				
5-9				
10-14				
15-17				
18-21	10,207	40,654	12,087	62,947
22-29	27,453	105,454	108,435	241,342
30-39	46,280	164,034	120,282	330,596
40-49	53,187	197,821	72,595	323,603
50-59	37,067	180,501	69,194	286,763
60 and over	12,533	96,814	38,987	148,335
Not identified	0	107	0	107
Average age (mean)	42	44	40	42
Average age (median)	42	44	37	42
Diagnostic group				
Infectious and parasitic diseases	913	9,600	2,653	13,167
Neoplasms	2,680	8,780	1,467	12,927
Endocrine, nutritional, and metabolic diseases	11,067	53,700	5,660	70,427
Disorders of blood and blood-forming organs	553	3,833	773	5,160
Mental disorders, excluding mental retardation	99,960	323,121	46,987	470,071
Mental retardation	22,760	132,627	104,895	260,282
Neurological and sensory disorders	9,340	30,313	36,627	76,281
Circulatory disorders	3,593	33,860	13,420	50,874
Respiratory disorders	2,467	12,867	5,547	20,880
Digestive disorders	1,860	6,387	847	9,093
Genitourinary disorders	800	2,973	4,113	7,887
Skin and subcutaneous tissue disorders	507	1,340	207	2,053
Musculoskeletal disorders	9,753	57,247	6,947	73,947
Congenital anomalies	380	2,747	2,613	5,740
Injuries	8,347	15,400	7,153	30,900
Other	720	2,260	840	3,820

**Appendix IV
Tables on CDR Population Characteristics**

Children				Total SSI CDR population			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
114,231	348,156	53,354	515,739	300,958	1,133,539	474,934	1,909,432
32,053	11,994	1,460	45,508	32,053	11,994	1,460	45,507
33,426	108,452	10,780	152,657	33,426	108,449	10,780	152,655
33,106	153,767	25,327	212,199	33,106	153,763	25,327	212,196
6,140	30,401	6,013	42,554	6,140	30,401	6,013	42,554
9,506	43,535	9,760	62,802	19,713	84,188	21,847	125,748
				27,453	105,455	108,435	241,343
				46,280	164,036	120,282	330,598
				53,186	197,823	72,594	323,604
				37,066	180,503	69,194	286,764
				12,533	96,815	38,987	148,335
				0	113	13	127
9	12	13	11	29	34	37	34
9	12	13	12	30	35	34	34
153	1,053	213	1,420	1,067	10,654	2,867	14,587
5,453	3,020	747	9,220	8,133	11,800	2,213	22,147
11,180	25,394	2,027	38,601	22,247	79,095	7,687	109,028
1,220	6,820	640	8,680	1,773	10,654	1,413	13,840
22,133	69,070	4,507	95,709	122,093	392,193	51,494	565,781
22,873	143,427	14,367	180,664	45,633	276,051	119,262	440,946
10,213	44,895	12,307	67,415	19,553	75,208	48,934	143,695
1,600	2,507	473	4,580	5,193	36,367	13,894	55,454
6,193	8,754	953	15,900	8,660	21,620	6,500	36,780
833	1,127	220	2,180	2,693	7,513	1,067	11,273
527	1,053	153	1,733	1,327	4,027	4,267	9,620
180	333	60	573	687	1,673	267	2,627
2,093	4,034	540	6,667	11,847	61,281	7,487	80,614
5,993	14,461	4,080	24,534	6,373	17,207	6,693	30,274
987	1,880	420	3,287	9,333	17,280	7,573	34,187
21,893	17,681	3,373	42,948	22,613	19,940	4,213	46,767

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults			Total
	MIE	MIP ^a	MINE	
Not identified	11,027	88,327	180,830	280,183
Estimated likelihood of benefit termination				
Subpopulation with likelihood estimated ^b	174,194	688,570		862,764
Under 5%	121,301	525,322		646,623
5-24%	45,760	142,307		188,067
25-49%	6,507	18,813		25,320
50-74%	500	1,927		2,427
75% and over	127	200		327
Average likelihood (mean)	5	4		5
Average likelihood (median)	2	2		2
Number of years receiving benefits				
Under 4	43,020	79,400	9,127	131,548
4-5	38,087	260,368	28,494	326,950
6-7	29,967	182,847	44,834	257,649
8-9	28,247	106,847	67,068	202,162
10 and over	47,407	155,821	272,058	475,284
Not identified	0	100	0	100
Average years (mean)	7	7	13	9
Average years (median)	7	6	12	8
CDR maturity				
Due in FY 1996	18,153	157,761	64,161	240,075
Due 1 year ago	26,767	153,301	55,321	235,389
Due 2 years ago	38,214	123,534	54,108	215,855
Due 3 years ago	16,927	97,854	52,314	167,095
Due 4 years ago	15,167	87,994	51,247	154,408
Due 5-10 years ago	53,920	135,367	122,475	311,763
Due over 10 years ago	9,327	14,207	12,247	35,780
Not identified	8,253	15,367	9,707	33,327
Average years (mean)	4	3	4	3
Average years (median)	3	2	4	3
Gender				
Female	103,000	448,095	226,637	777,734
Male	83,720	337,135	194,943	615,799
Not identified	7	153	0	160
Race				
Black	50,307	231,928	103,868	386,103
White	87,520	353,742	219,037	660,299

Appendix IV
Tables on CDR Population Characteristics

	Adults			Total
	MIE	MIP^a	MINE	
Other	24,367	88,740	39,734	152,841
Not identified	24,533	110,974	58,941	194,448

Appendix IV
Tables on CDR Population Characteristics

Children				Total SSI CDR population			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
12,646	42,429	7,520	62,595	37,013	131,169	47,254	215,436
31,393	53,142	6,640	91,176	55,926	164,116	65,581	285,624

Note: Estimates are based on a 15-percent sample. The largest percentage sampling error in the column at the 95-percent confidence level is provided in the corresponding column in table IV.8. Because of rounding during the estimation process, row entries may not sum to row totals.

^aWe classified 236 sample records for adult beneficiaries as MIPs because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIEs and MIPs aged 60 and over. Therefore, the total number with an estimated likelihood of benefit termination is less than the total number for the column. Furthermore, SSA does not estimate the likelihood of benefit termination for children or MINEs.

Source: GAO analysis of SSIRD records and files supplied by OD.

Appendix IV
Tables on CDR Population Characteristics

Table IV.8: Characteristics of Adult and Child SSI Recipients Awaiting CDRs in FY 1996, by Medical Improvement Classification, in Percentages

	Adults			Total
	MIE	MIP ^a	MINE	
Total estimated CDR population	186,727	785,383	421,580	1,393,693
Largest sampling error in column at the 95-percent confidence level	0.6	0.3	0.4	0.2
Age in years				
Under 5				
5-9				
10-14				
15-17				
18-21	5	5	3	5
22-29	15	13	26	17
30-39	25	21	29	24
40-49	28	25	17	23
50-59	20	23	16	21
60 and over	7	12	9	11
Average age (mean)	42	44	40	42
Average age (median)	42	44	37	42
Diagnostic group				
Infectious and parasitic diseases	0	1	1	1
Neoplasms	1	1	0	1
Endocrine, nutritional, and metabolic diseases	6	7	1	5
Disorders of blood and blood-forming organs	0	0	0	0
Mental disorders, excluding mental retardation	54	41	11	34
Mental retardation	12	17	25	19
Neurological and sensory disorders	5	4	9	5
Circulatory disorders	2	4	3	4
Respiratory disorders	1	2	1	1
Digestive disorders	1	1	0	1
Genitourinary disorders	0	0	1	1
Skin and subcutaneous tissue disorders	0	0	0	0
Musculoskeletal disorders	5	7	2	5
Congenital anomalies	0	0	1	0

**Appendix IV
Tables on CDR Population Characteristics**

Children				Total SSI CDR population			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
114,231	348,156	53,354	515,739	300,958	1,133,539	474,934	1,909,432
0.7	0.4	1.1	0.3	0.5	0.2	0.4	0.2
28	3	3	9	11	1	0	2
29	31	20	30	11	10	2	8
29	44	47	41	11	14	5	11
5	9	11	8	2	3	1	2
8	13	18	12	7	7	5	7
				9	9	23	13
				15	14	25	17
				18	17	15	17
				12	16	15	15
				4	9	8	8
9	12	13	11	29	34	37	34
9	12	13	11	30	35	34	34
0	0	0	0	0	1	1	1
5	1	1	2	3	1	0	1
10	7	4	7	7	7	2	6
1	2	1	2	1	1	0	1
19	20	8	19	41	35	11	30
20	41	27	35	15	24	25	23
9	13	23	13	6	7	10	8
1	1	1	1	2	3	3	3
5	3	2	3	3	2	1	2
1	0	0	0	1	1	0	1
0	0	0	0	0	0	1	1
0	0	0	0	0	0	0	0
2	1	1	1	4	5	2	4
5	4	8	5	2	2	1	2

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults			Total
	MIE	MIP ^a	MINE	
Injuries	4	2	2	2
Other	0	0	0	0
Not identified	6	11	43	20
Estimated likelihood of benefit termination				
Subpopulation with likelihood estimated ^b	174,194	688,570		862,764
Under 5%	70	76		75
5-24%	26	21		22
25-49%	4	3		3
50-74%	0	0		0
75% and over	0	0		0
Average likelihood (mean)	5	4		5
Average likelihood (median)	2	2		2
Number of years receiving benefits				
Under 4	23	10	2	9
4-5	20	33	7	23
6-7	16	23	11	18
8-9	15	14	16	15
10 and over	25	20	65	34
Average years (mean)	7	7	13	9
Average years (median)	7	6	12	8
CDR maturity				
Due in FY 1996	10	20	15	17
Due 1 year ago	14	20	13	17
Due 2 years ago	20	16	13	15
Due 3 years ago	9	12	12	12
Due 4 years ago	8	11	12	11
Due 5-10 years ago	29	17	29	22
Due over 10 years ago	5	2	3	3
Not identified	4	2	2	2
Average years (mean)	4	3	4	3
Average years (median)	3	2	4	3
Gender				
Female	55	57	54	56
Male	45	43	46	44
Race				
Black	27	30	25	28
White	47	45	52	47

**Appendix IV
Tables on CDR Population Characteristics**

Children				Total SSI CDR population			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
1	1	1	1	3	2	2	2
19	5	6	8	8	2	1	2
1	1	16	2	4	8	40	15
52	23	5	27	34	14	2	14
22	45	18	37	21	37	8	27
9	17	18	16	13	22	12	18
8	7	18	8	13	12	16	13
8	8	41	11	19	16	62	28
5	6	9	6	6	7	12	8
4	5	9	5	5	6	11	6
21	37	12	31	14	25	15	21
26	27	13	26	19	22	13	19
18	15	13	15	19	15	13	15
9	7	11	8	9	11	12	11
6	5	10	6	7	9	12	10
15	6	31	11	24	14	29	19
2	1	6	1	4	1	3	2
4	1	4	2	4	2	3	2
3	2	4	2	3	3	4	3
2	1	4	2	4	2	4	2
38	36	41	37	49	51	52	51
62	64	59	63	51	49	48	49
28	37	27	34	27	32	25	29
33	35	47	36	42	42	51	44

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults			Total
	MIE	MIP^a	MINE	
Other	13	11	9	11
Not identified	13	14	14	14

Appendix IV
Tables on CDR Population Characteristics

Children				Total SSI CDR population			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
11	12	14	12	12	12	10	11
27	15	12	18	19	14	14	15

Note: Estimates are based on a 15-percent sample. The largest percentage sampling error at the 95-percent confidence level is near the top of each column. Because of rounding during the estimation process, row entries may not sum to row totals.

^bWe classified 236 of the sample records for adult beneficiaries as MIPs because a MIE or MIP classification was not specified.

^cSSA does not estimate the likelihood of benefit termination for MIEs and MIPs aged 60 and over. Therefore, the total with an estimated likelihood of benefit termination is less than the total number for the column. Furthermore, SSA does not estimate the likelihood of benefit termination for children or MINEs.

Source: GAO analysis of SSIRD records and files supplied by OD.

Table IV.9: Characteristics of SSI Recipients Awaiting CDRs in FY 1996, by Age and Medical Improvement Classification

	Adults under 60 years old			Adults 60 years and older		
	MIE	MIP ^a	MINE	MIE	MIP	MINE
Total estimated CDR population	174,194	688,570	382,593	12,533	96,814	38,987
Age in years						
18-21	10,207	40,654	12,087			
22-29	27,453	105,454	108,435			
30-39	46,280	164,034	120,282			
40-49	53,187	197,821	72,595			
50-59	37,067	180,501	69,194			
60 and over				12,533	96,814	38,987
Average age (mean)	40	41	37	62	63	62
Average age (median)	41	42	35	62	63	62
Diagnostic group						
Infectious and parasitic diseases	847	8,653	2,460	67	947	193
Neoplasms	2,453	7,107	1,313	227	1,673	153
Endocrine, nutritional, and metabolic diseases	9,833	45,140	4,640	1,233	8,560	1,020
Disorders of blood and blood-forming organs	553	3,733	753	0	100	20
Mental disorders, excluding mental retardation	94,647	301,488	42,414	5,313	21,633	4,573
Mental retardation	22,247	128,134	101,128	513	4,493	3,767

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults under 60 years old			Adults 60 years and older		
	MIE	MIP ^a	MINE	MIE	MIP	MINE
Neurological and sensory disorders	8,540	26,900	34,354	800	3,413	2,273
Circulatory disorders	2,993	20,073	9,000	600	13,787	4,420
Respiratory disorders	2,067	8,353	3,440	400	4,513	2,107
Digestive disorders	1,740	5,433	707	120	953	140
Genitourinary disorders	753	2,653	3,807	47	320	307
Skin and subcutaneous tissue disorders	460	1,187	173	47	153	33
Musculoskeletal disorders	8,453	37,793	4,727	1,300	19,453	2,220
Congenital anomalies	373	2,607	2,593	7	140	20
Injuries	7,793	12,553	6,627	553	2,847	527
Other	633	1,993	773	87	267	67
Not identified	9,807	74,767	163,683	1,220	13,560	17,147
Estimated likelihood of benefit termination						
Subpopulation with likelihood estimated ^b	174,194	688,570				
Under 5%	121,301	525,322				
5-24%	45,760	142,307				
25-49%	6,507	18,813				
50-74%	500	1,927				
75% and over	127	200				
Average likelihood (mean)	5	4				
Average likelihood (median)	2	2				
Number of years receiving benefits						
Under 4	42,034	75,714	7,560	987	3,687	1,567
4-5	36,360	234,588	24,287	1,727	25,780	4,207
6-7	27,393	154,134	39,041	2,573	28,713	5,793
8-9	25,560	89,000	59,721	2,687	17,847	7,347
10 and over	42,847	135,034	251,984	4,560	20,787	20,074
Not identified	0	100	0	0	0	0
Average years (mean)	7	7	13	9	8	11
Average years (median)	7	6	12	9	7	10
CDR maturity						
Due in FY 1996	17,600	148,047	57,868	553	9,713	6,293
Due 1 year ago	26,027	139,927	49,147	740	13,373	6,173
Due 2 years ago	35,573	105,040	48,747	2,640	18,493	5,360
Due 3 years ago	15,953	82,587	47,467	973	15,267	4,847
Due 4 years ago	14,067	74,474	47,581	1,100	13,520	3,667

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults under 60 years old			Adults 60 years and older		
	MIE	MIP ^a	MINE	MIE	MIP	MINE
Due 5-10 years ago	49,014	111,974	111,935	4,907	23,393	10,540
Due over 10 years ago	8,400	11,913	11,167	927	2,293	1,080
Not identified	7,560	14,607	8,680	693	760	1,027
Average years (mean)	4	3	4	5	4	4
Average years (median)	3	2	4	5	3	3
Gender						
Female	94,640	381,842	202,063	8,360	66,254	24,574
Male	79,547	306,588	180,530	4,173	30,547	14,414
Not identified	7	140	0	0	13	0
Race						
Black	47,754	206,994	95,715	2,553	24,933	8,153
White	81,780	312,475	201,290	5,740	41,267	17,747
Other	22,500	75,400	34,647	1,867	13,340	5,087
Not identified	22,160	93,700	50,941	2,373	17,273	8,000

Note: Estimates are based on a 15-percent sample. The largest percentage sampling error in the column at the 95-percent confidence level is provided in the corresponding column in table IV.10. Because of rounding during the estimation process, row entries may not sum to row totals.

^aWe classified 236 sample records for adult beneficiaries as MIPs because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIEs and MIPs aged 60 and over or for MINEs. Therefore, the total number with an estimated likelihood of benefit termination is less than the total number for the column.

Source: GAO analysis of SSIRD records and files supplied by OD.

Table IV.10: Characteristics of SSI Recipients Awaiting CDRs in FY 1996, by Age and Medical Improvement Classification, in Percentages

	Adults under 60 years old			Adults 60 years and older		
	MIE	MIP ^a	MINE	MIE	MIP	MINE
Total estimated CDR population	174,194	688,570	382,593	12,533	96,814	38,987
Largest sampling error in column at the 95-percent confidence level	0.6	0.3	0.4	2.3	0.8	1.3
Age in years						
18-21	6	6	3			
22-29	16	15	28			
30-39	27	24	31			
40-49	31	29	19			
50-59	21	26	18			

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults under 60 years old			Adults 60 years and older		
	MIE	MIP ^a	MINE	MIE	MIP	MINE
60 and over				100	100	100
Average age (mean)	40	41	37	62	63	63
Average age (median)	41	42	35	62	63	63
Diagnostic group						
Infectious and parasitic diseases	0	1	1	1	1	0
Neoplasms	1	1	0	2	2	0
Endocrine, nutritional, and metabolic diseases	6	7	1	10	9	3
Disorders of blood and blood-forming organs	0	1	0	0	0	0
Mental disorders, excluding mental retardation	54	44	11	42	22	12
Mental retardation	13	19	26	4	5	10
Neurological and sensory disorders	5	4	9	6	4	6
Circulatory disorders	2	3	2	5	14	11
Respiratory disorders	1	1	1	3	5	5
Digestive disorders	1	1	0	1	1	0
Genitourinary disorders	0	0	1	0	0	1
Skin and subcutaneous tissue disorders	0	0	0	0	0	0
Musculoskeletal disorders	5	5	1	10	20	6
Congenital anomalies	0	0	1	0	0	0
Injuries	4	2	2	4	3	1
Other	0	0	0	1	0	0
Not identified	6	11	43	10	14	44
Estimated likelihood of benefit termination						
Subpopulation with likelihood estimated ^b	174,194	688,570				
Under 5%	70	76				
5-24%	26	21				
25-49%	4	3				
50-74%	0	0				
75% and over	0	0				
Average likelihood (mean)	5	4				
Average likelihood (median)	2	2				

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Adults under 60 years old			Adults 60 years and older		
	MIE	MIP ^a	MINE	MIE	MIP	MINE
Number of years receiving benefits						
Under 4	24	11	2	8	4	4
4-5	21	34	6	14	27	11
6-7	16	22	10	21	30	15
8-9	15	13	16	21	18	19
10 and over	25	20	66	36	21	51
Not identified	0	0	0	0	0	0
Average years (mean)	7	7	13	9	8	11
Average years (median)	7	6	12	9	7	10
CDR maturity						
Due in FY 1996	10	22	15	4	10	16
Due 1 year ago	15	20	13	6	14	16
Due 2 years ago	20	15	13	21	19	14
Due 3 years ago	9	12	12	8	16	12
Due 4 years ago	8	11	12	9	14	9
Due 5-10 years ago	28	16	29	39	24	27
Due over 10 years ago	5	2	3	7	2	3
Not identified	4	2	2	6	1	3
Average years (mean)	4	3	4	5	4	4
Average years (median)	3	2	4	5	3	3
Gender						
Female	54	55	53	67	68	63
Male	46	45	47	33	32	37
Not identified	0	0	0	0	0	0
Race						
Black	27	30	25	20	26	21
White	47	45	53	46	43	46
Other	13	11	9	15	14	13
Not identified	13	14	13	19	18	21

Note: Estimates are based on a 15-percent sample. The largest percentage sampling error at the 95-percent confidence level is provided near the top of each column. Because of rounding during the estimation process, row entries may not sum to row totals.

^aWe classified 236 sample records for adult beneficiaries as MIPs because a MIE or MIP classification was not specified.

^bSSA does not estimate the likelihood of benefit termination for MIEs and MIPs aged 60 and over or for MINEs. Therefore, the total number with an estimated likelihood of benefit termination is less than the total number for the column.

Source: GAO analysis of SSIRD records and files supplied by OD.

Appendix IV
Tables on CDR Population Characteristics

Table IV.11: Characteristics of Selected SSI Adults Awaiting CDRs in FY 1996, by Estimated Likelihood of Benefit Termination

	Under 5%	5-24%	25-49%	50-74%	Over 74%	Total
Total estimated CDR population ^a	646,623	188,067	25,320	2,427	327	862,764
Age in years						
18-21	49,287	580	820	160	13	50,860
22-29	96,360	21,933	13,033	1,513	67	132,907
30-39	126,461	74,167	8,920	613	153	210,314
40-49	170,501	77,974	2,327	140	67	251,008
50-59	203,914	13,407	220	0	27	217,568
Not identified	100	7	0	0	0	107
Average age (mean)	42	39	30	29	36	41
Average age (median)	43	40	29	28	33	41
Diagnostic group						
Infectious and parasitic diseases	5,873	2,973	593	53	7	9,500
Neoplasms	3,240	4,967	1,240	107	7	9,560
Endocrine, nutritional, and metabolic diseases	43,034	10,360	1,393	187	0	54,974
Disorders of blood and blood-forming organs	1,833	1,253	920	280	0	4,287
Mental disorders, excluding mental retardation	316,801	71,020	7,987	253	73	396,135
Mental retardation	146,587	2,913	680	187	13	150,381
Neurological and sensory disorders	23,220	11,993	187	40	0	35,440
Circulatory disorders	19,687	3,273	93	7	7	23,067
Respiratory disorders	6,987	3,227	207	0	0	10,420
Digestive disorders	2,060	4,853	253	7	0	7,173
Genitourinary disorders	1,480	1,553	300	67	7	3,407
Skin and subcutaneous tissue disorders	493	753	313	87	0	1,647
Musculoskeletal disorders	27,867	16,860	1,440	60	20	46,247
Congenital anomalies	1,667	813	360	127	13	2,980
Injuries	7,813	10,373	2,120	40	0	20,347

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Under 5%	5-24%	25-49%	50-74%	Over 74%	Total
Other	1,367	927	300	13	20	2,627
Not identified	36,613	39,954	6,933	913	160	84,574
Medical improvement classification						
MIE	121,301	45,760	6,507	500	127	174,194
MIP ^b	525,322	142,307	18,813	1,927	200	688,570
Number of years receiving benefits						
Under 4	78,180	34,267	4,980	307	13	117,747
4-5	198,728	64,007	7,520	687	7	270,948
6-7	138,507	37,880	4,660	473	7	181,527
8-9	86,547	22,960	4,320	667	67	114,561
10 and over	144,561	28,953	3,840	293	233	177,881
Not identified	100	0	0	0	0	0
Average years (mean)	8	7	7	7	13	7
Average years (median)	7	6	6	7	12	6
CDR maturity						
Due in FY 1996	121,387	38,627	5,073	533	27	165,647
Due 1 year ago	120,921	39,220	5,393	400	20	165,954
Due 2 years ago	105,494	30,847	3,880	340	53	140,614
Due 3 years ago	74,967	20,933	2,367	253	20	98,540
Due 4 years ago	70,800	15,620	1,947	153	20	88,540
Due 5-10 years ago	123,941	31,280	5,040	567	160	160,987
Due over 10 years ago	15,887	3,860	507	40	20	20,313
Not identified	13,227	7,680	1,113	140	7	22,167
Average years (mean)	3	3	3	3	5	3
Average years (median)	3	2	2	2	6	2
Gender						
Female	362,282	100,560	12,280	1,167	193	476,482
Male	284,208	87,500	13,033	1,260	133	386,135
Not identified	133	7	7	0	0	147
Race						
Black	191,208	55,607	7,173	667	93	254,748
White	293,021	86,387	13,333	1,340	173	394,255
Other	72,307	22,340	2,940	300	13	97,900
Not identified	90,087	23,733	1,873	120	47	115,861

(Table notes on next page)

Appendix IV
Tables on CDR Population Characteristics

Note: Estimates are based on a 15-percent sample. The largest percentage sampling error in the column at the 95-percent confidence level is provided in the corresponding column in table IV.12. Because of rounding during the estimation process, row entries may not sum to row totals.

^aSSA does not estimate the likelihood of benefit termination for MIEs and MIPs aged 60 and over or for MINEs.

^bWe classified 236 sample records for adult beneficiaries as MIPs because a MIE or MIP classification was not specified.

Source: GAO analysis of SSIRD records and files supplied by OD.

Table IV.12: Characteristics of Selected SSI Adults Awaiting CDRs in FY 1996, by Estimated Likelihood of Benefit Termination, in Percentages

	Under 5%	5-24%	25-49%	50-74%	Over 74%	Total
Total estimated CDR population ^a	646,623	188,067	25,320	2,427	327	862,764
Largest sampling error in column at the 95-percent confidence level	0.3	0.6	1.6	5.1	14.0	0.3
Age in years						
18-21	8	0	3	7	4	6
22-29	15	12	51	62	20	15
30-39	20	39	35	25	47	24
40-49	26	41	9	6	20	29
50-59	32	7	1	0	8	25
Not identified	0	0	0	0	0	0
Average age (mean)	42	39	30	29	36	41
Average age (median)	43	40	29	28	33	41
Diagnostic group						
Infectious and parasitic diseases	1	2	2	2	2	1
Neoplasms	1	3	5	4	2	1
Endocrine, nutritional, and metabolic diseases	7	6	6	8	0	6
Disorders of blood and blood-forming organs	0	1	4	12	0	0
Mental disorders, excluding mental retardation	49	38	32	10	22	46
Mental retardation	23	2	3	8	4	17
Neurological and sensory disorders	4	6	1	2	0	4

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Under 5%	5-24%	25-49%	50-74%	Over 74%	Total
Circulatory disorders	3	2	0	0	2	3
Respiratory disorders	1	2	1	0	0	1
Digestive disorders	0	3	1	0	0	1
Genitourinary disorders	0	1	1	3	2	0
Skin and subcutaneous tissue disorders	0	0	1	4	0	0
Musculoskeletal disorders	4	9	6	2	6	5
Congenital anomalies	0	0	1	5	4	0
Injuries	1	6	8	2	0	2
Other	0	0	1	1	6	0
Not identified	6	21	27	38	49	10
Medical improvement classification						
MIE	19	24	26	21	39	20
MIP ^b	81	76	74	79	61	80
Number of years receiving benefits						
Under 4	12	18	20	13	4	14
4-5	31	34	30	28	2	31
6-7	21	20	18	20	2	21
8-9	13	12	17	27	20	13
10 and over	22	15	15	12	71	21
Not identified	0	0	0	0	0	0
Average years (mean)	8	7	7	7	13	7
Average years (median)	7	6	6	7	12	6
CDR maturity						
Due in FY 1996	19	21	20	22	8	19
Due 1 year ago	19	21	21	16	6	19
Due 2 years ago	16	16	15	14	16	16
Due 3 years ago	12	11	9	10	6	11
Due 4 years ago	11	8	8	6	6	10
Due 5-10 years ago	19	17	20	23	49	19
Due over 10 years ago	2	2	2	2	6	2
Not identified	2	4	4	6	2	3

(continued)

Appendix IV
Tables on CDR Population Characteristics

	Under 5%	5-24%	25-49%	50-74%	Over 74%	Total
Average years (mean)	3	3	3	3	5	3
Average years (median)	3	2	2	2	6	2
Gender						
Female	56	53	49	48	59	55
Male	44	47	51	52	41	45
Not identified	0	0	0	0	0	0
Race						
Black	30	30	28	27	29	30
White	45	46	53	55	53	46
Other	11	12	12	12	4	11
Not identified	14	13	7	5	14	13

Note: Estimates are based on a 15-percent sample. The largest percentage sampling error at the 95-percent confidence level is provided near the top of each column. Because of rounding during the estimation process, row entries may not sum to row totals.

^aSSA does not estimate the likelihood of benefit termination for MIEs and MIPs aged 60 and over or for MINEs.

^bWe classified 236 sample records for adult beneficiaries as MIPs because a MIE or MIP classification was not specified.

Source: GAO analysis of SSIRD records and files supplied by OD.

Comments From the Social Security Administration

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



SOCIAL SECURITY

Office of the Commissioner

September 23, 1996

Ms. Jane L. Ross
Director, Income Security Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Ross:

Thank you for the opportunity to comment on the draft report, "Social Security Disability: Alternative Approaches Would Increase Cost Effectiveness of Continuing Disability Reviews" (GAO/HEHS-96-202).

As always, we appreciate the time and effort of the General Accounting Office (GAO) in conducting this review. SSA is very aware of the Agency's proactive role in guiding the disability program into the twenty-first century, and we welcome GAO's input in these efforts. It has been a major concern of SSA's that, beginning in the late 1980's, the Agency was unable to remain current in processing the continuing disability review (CDR) workload due to budget and staffing reductions and historically high workloads. Recently enacted legislation has provided the Agency with the ability to schedule additional CDRs. To enhance the Agency's ability to meet these challenges, SSA has redesigned and continues to improve its CDR process.

Although we do not concur with all of the report recommendations, we agree that SSA should continually seek ways to improve stewardship of the disability program in the most cost-effective manner. We believe that this report presents us with an opportunity to begin the process to consider changing the current statutory requirements for CDRs. Under the existing requirements, we believe the Agency's redesigned CDR strategy will result in reliable, cost-effective monitoring of all disabled beneficiaries on the Social Security Disability Insurance and Supplemental Security Income rolls, although the Agency is open to exploring and evaluating the ideas presented by the GAO in this report.

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

**Appendix V
Comments From the Social Security
Administration**

2

Enclosed are our specific comments on the report. If you have any questions, please call me or have your staff contact Sandy Miller at (410) 965-0372.

Sincerely,

Shirley S. Chater
Shirley S. Chater
Commissioner
of Social Security

Enclosures

Appendix V
Comments From the Social Security
Administration

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION (SSA) ON THE
GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT, "SOCIAL SECURITY
DISABILITY: ALTERNATIVE APPROACHES WOULD INCREASE COST
EFFECTIVENESS OF CONTINUING DISABILITY REVIEWS" (GAO/HEHS-96-202)

We appreciate the time and effort of GAO in conducting this review of the SSA disability program's continuing disability review (CDR) process. SSA is very aware of the Agency's proactive role in guiding the disability program into the twenty-first century. We welcome input that will help us in these efforts and find that the report provides some valuable information. We believe that this report presents us with an opportunity to begin the process to consider changing the current statutory requirements for CDRs. However, while we appreciate GAO's efforts, we are unable to concur with all of the report recommendations.

SSA is required to conduct periodic CDRs for people receiving benefits under the Social Security disability insurance (SSDI) program to determine whether a beneficiary has medically improved to the extent that the person is no longer considered disabled. It has been a major concern of SSA's that, beginning in the late 1980's, the Agency was unable to remain current in processing the CDR workload due to budget and staffing reductions and historically high workloads. Under recently enacted legislation, in addition to existing SSDI CDR workloads, SSA will now conduct CDRs for certain groups of beneficiaries receiving disability benefits under the Supplemental Security Income (SSI) program for whom the reviews were previously elective.

To enhance the Agency's ability to meet these challenges, SSA has redesigned and continues to improve its CDR process. We believe that the Agency's strategy for developing this CDR process is sound and will achieve the desired result of reliable, cost-effective monitoring of all disabled beneficiaries on the SSDI and SSI rolls. Our plans call for eliminating the backlog of SSDI CDRs within 7 years and for conducting the required SSI CDRs as well. Under this redesigned process, and with the additional funding currently in place, we fully expect to achieve these goals. Some major improvements that have resulted from the new process so far include:

- o Separate accounting controls have been established to ensure that administrative dollars allocated for the processing of CDRs are not redirected to other workloads;
- o CDR workload monitoring has been enhanced by the creation of the SSI CDR automated case control file, which is generated in central office for workload monitoring by the field offices;

**Appendix V
Comments From the Social Security
Administration**

2

- o Automated optical scanning and electronic evaluation of CDR mailers have been implemented; and
- o Procedures for expanding and enhancing CDR selection continue to be refined; e.g., integrating Medicare and Medicaid data into the statistical formulas.

The following comments specifically address the report recommendations. In addition, we have already provided technical comments under separate cover.

GAO Recommendation

To the extent SSA is authorized to act, the Commissioner of SSA should replace the routine scheduling of all who receive program benefits for DI and SSI CDRs with a more cost-effective process that would:

- (1) Select for review beneficiaries with the greatest potential for medical improvement and subsequent benefit termination;
- (2) Correct a weakness in SSA's CDR process by reviewing a random sample of other beneficiaries; and
- (3) Help ensure program integrity by instituting contact with beneficiaries not selected for CDRs.

As part of this effort, the Commissioner should develop a legislative package to obtain the authority the Agency needs to enact the new process for those portions of the DI and SSI populations that are subject to routinely scheduled CDRs.

SSA Comment

Although we do not concur with GAO's specific recommendations, we agree that SSA should continually seek ways to maintain stewardship of the disability program in the most cost-effective manner. To that end, we will begin to consider which legislative changes, if any, will produce such a result. The data obtained from experience with the CDR mailer/profiling process will help

See comment 1.

**Appendix V
Comments From the Social Security
Administration**

3

guide us to that goal. However, under the current statutory requirements, we believe the Agency's redesigned CDR strategy will result in reliable, cost-effective monitoring of all disabled beneficiaries on the SSDI and SSI rolls. We believe the following description of SSA's strategy will provide a needed context for our evaluation of GAO's recommended actions.

SSA's statistical profiles that predict the likelihood of medical improvement are based on CDRs that were processed in 1989 and 1990. The CDRs processed were for SSDI disabled workers whose cases had been diaried as medical improvement expected (MIE) and medical improvement possible (MIP), since those CDRs offered the most potential for savings and were required by law. Accordingly, in 1993 SSA was able to initiate an improved CDR process predicated on statistical profiles that focused on SSDI disabled workers. The profiles identified cases that have such a low likelihood of medical improvement that conducting medical reviews of these cases is not cost effective. Individuals in these low-profile categories received a mailer questionnaire that inquired into the individuals' current medical status and work activity. Use of mailer questionnaires reduced the burden on disabled individuals whose medical conditions were not likely to have improved, while permitting SSA to double the cost effectiveness of its CDR process. Although in the aggregate, cases in the low-profile category are not cost effective to medically develop, instances of medical improvement reported in response to mailers have been cost effective to develop.

In addition to identifying cohorts of cases that are not cost effective to medically develop, the statistical profiles rank the likelihood of medical improvement for all other cases. SSA has released for full medical development those cases with the highest likelihood of medical improvement. As the profile rankings move from highest to lowest, the cost effectiveness of medical development decreases. Cases ranked in the middle do not offer as high a return on investment as those cases most likely to involve medical improvement.

The report characterizes the statistical profile process as "not useful" and "less accurate" for cases that rank in the middle. This is not accurate. The reality is that, without profiles, there would be no "middle" cases. Although SSA is exploring process improvements that would increase the cost effectiveness of conducting CDRs on these "middle" profile CDRs, as a group, middle profile cases are currently cost effective to medically develop.

See comment 2.

**Appendix V
Comments From the Social Security
Administration**

4

Further improvements in statistical profiles may identify additional cases in the middle cohort that are not cost effective to medically develop. (The original 8 formulae used in 1993 have already been expanded to 16 formulae and then 23.) The potential for further refinements, however, does not suggest a lack of usefulness for the current formulae.

Using a 5,000 case validation study, the SSDI MIE and MIP profiles have been extended to SSI adult MIE and MIP cases. This subsequent application of SSDI profiles to SSI adult cases was possible due to the similarity of impairments among these cases.

SSA is now evaluating the applicability of MIE and MIP profiles to cases categorized as having permanent impairments, those diaried as medical improvement not expected (MINE). In those situations in which the beneficiary's age is the determining factor making medical improvement not expected, the profiles appear to be effective. However, where the impairment is the determining factor in precluding medical improvement (e.g., cases involving amputations and severe mental deficiencies), the profiles do not appear to be effective since these cases are not represented in the MIE and MIP base files from which profiles were developed. Despite these limitations, the profiles appear to be capable of isolating many cases that are, and are not, cost effective to medically develop among MINE diaries.

See comment 3.

Study cases have been released to validate the usefulness of existing profiles with MINE cases. SSA has not excluded these cases from selection, as suggested in the report. Rather, the Agency is proceeding steadily and cautiously in expanding the use of profiles to ensure that all cases warranting a medical review receive one, and that cohorts of cases that are not released for medical review are not cost effective to medically develop. To this end, SSA has continued integrity samples to validate the predictive value of its CDR formulae, as well as a series of validation studies to support expansion of these profiles.

Study cases have also been employed to identify childhood cases with the greatest likelihood of medical improvement. Until a sufficient number and range of childhood CDRs have been conducted, the selection of childhood CDRs will be determined by study data results. Our experience has been that childhood cases selected in this way prove to be highly cost effective to medically develop.

**Appendix V
Comments From the Social Security
Administration**

5

See comment 4.

Regarding random sampling of other beneficiaries, beyond its ongoing quality assurance reviews, SSA does not support random sampling that is not a part of its overall strategy to improve the effectiveness of the CDR process. As processing capacity becomes available to perform CDRs on cohorts of cases not now being released in volume; e.g., the middle profile cases and the MINE cases, controlled studies will be initiated and the volume of these less cost-effective CDRs will be increased. SSA's goal is to develop efficient processes that maximize the cessation rate on cases that are medically developed and minimize the possibility of error on cases that are not selected for medical development. In this way, SSA expects to achieve much greater return and significantly less loss in terms of overlooked cessations than would be possible through random sampling.

See comment 5.

The recommended action that SSA release large numbers of mailer questionnaires and defer evaluating the information provided by beneficiaries seems inefficient and ill conceived. It would be inconsistent with the objective of SSA's CDR process to devise a process that is predicated on the likelihood that some beneficiaries may not respond and thus have benefits suspended, that obtains information from beneficiaries and then defers that information, and that does not constitute a CDR. Moreover, we are able to efficiently evaluate large volumes of CDR mailers by using optical scanning and electronic evaluation of responses.

See comment 6.

A further concern with using a mass mailer is that nonresponse rates cited by GAO do not account for workloads that could result from reestablished eligibility of beneficiaries who are terminated for nonresponse. GAO also assumes that the mass mailing could be done as an automated process without significant administrative costs. GAO's estimate does not take into account the cost of inquiries, due process procedures and reinstatement actions. Fallout from an automated process could result in significant administrative costs resulting in SSA having to defer processing other disability work in order to handle the new workload.

GAO Recommendation

To enable as many disabled individuals as possible to become self-sufficient, SSA should test the use of CDR contacts with beneficiaries to determine individuals' rehabilitation service needs and help them obtain the services and employment assistance they need to enter or reenter the work force.

**Appendix V
Comments From the Social Security
Administration**

6

SSA Comment

We agree that approaching beneficiaries about the availability and advantages of rehabilitation and return-to-work services at the same time we perform a CDR could improve the chances for successful return-to-work efforts, and we concur that a test of this idea should be performed.

SSA has stated, in response to other recent GAO reports on return-to-work activities, that the Agency recognizes the need to better identify beneficiaries with rehabilitation potential, increase the numbers of beneficiaries who receive rehabilitation and return-to-work services and help more beneficiaries become self-reliant and independent of disability benefits. We continue to work within SSA to develop viable policy options for achieving this end, including an agenda for research grants and contracts to conduct demonstrations that would assist in that effort. We would plan to test your recommended approach as a component of this overall effort.

As also stated in comments to the earlier GAO reports, SSA needs the cooperation and assistance of our Federal and private sector partners if an efficient and comprehensive return-to-work strategy is to be developed for DI and SSI disability beneficiaries. For the last several months, we have been talking with other Federal agencies with responsibilities for the rehabilitation and employment of persons with disabilities in America. We have reached agreement with key Federal sponsors of these programs that the rehabilitation community, in general, needs to be better educated in the unique characteristics and circumstances of SSA's disabled beneficiaries and in the work incentives available to beneficiaries who are ready and able to work in spite of continuing impairments. We are developing the first in a planned series of interagency agreements with these Federal partners to strengthen the understanding of, and participation in, return-to-work efforts for disability beneficiaries among other Federal, State, and private entities.

Other Comments

Page 19, second paragraph

The report discusses the "...uncertainty that SSA will be able to be current with required CDRs within 7 years." With the additional funding currently in place, SSA fully expects to achieve its goal of eliminating the CDR backlog over the next 7 years. We agree with GAO that SSA faces considerable challenges in accomplishing this, but we disagree with GAO's assessment that our ability to do so is uncertain.

Now on p. 13.

See comment 7.

**Appendix V
Comments From the Social Security
Administration**

Now on p. 19.

See comment 8.

Pages 31 and 32

The report states that "SSA generally does little during the CDR process to determine beneficiaries' VR needs..." and that "...staff are neither required nor instructed ... to make beneficiaries aware of rehabilitation opportunities..." While it is true that specific VR needs are not determined by SSA, field office personnel are instructed to make beneficiaries aware of rehabilitation services when appropriate, and each full medical CDR is screened for possible referral for VR services.

The following are GAO's comments on the Social Security Administration's letter dated September 23, 1996.

GAO Comments

1. When SSA considers legislative changes that would make the CDR process more cost-effective, we believe that it must reassess the requirements of the existing schedule for conducting CDRs. According to SSA officials, if an initial CDR finds that a beneficiary is still disabled, subsequent CDRs are likely to result in the same conclusion. We question whether additional CDRs for that beneficiary are appropriate or cost-effective. Similarly, predictive formulas for DI worker beneficiaries allow SSA to determine those workers most likely to medically improve. Other groups not now included in the selection process may yield additional groups that are cost-effective to review.
2. While we recognize that the use of the formulas established the cases that fall into the "middle group," SSA officials told us that SSA does not know which type of CDR—full medical or mailer—is more appropriate for those beneficiaries. SSA has at least two efforts under way to improve its ability to determine which type of CDR would be the more cost-effective.
3. We agree that SSA is currently testing the feasibility of expanding the use of formulas to the MINES, and the report states that such an effort is under way.
4. While cost-effectiveness is an important aspect of the CDR process, we also believe that to ensure program integrity, all beneficiaries should have some likelihood of selection for a CDR. Such a program weakness is particularly troubling given that SSA has been unable to conduct all required CDRs for almost a decade and it estimates that the backlog will not be eliminated for another 7 years.
5. Our recommendation provides a comprehensive approach to program management that focuses on cost-effectiveness, program integrity, and increased contact with beneficiaries. Increased beneficiary contact is valuable to remind beneficiaries that their disability status is being monitored and that they are responsible for reporting medical improvement. We believe that such a contact also offers an additional opportunity for SSA to further its program improvement efforts. For example, it could be used to identify medical treating sources that should receive the medical treating source mailer currently under development.

6. We believe that ongoing periodic contact with beneficiaries is essential to a well managed program and should be done even if such an activity is considered a program operating cost. However, in estimating the costs of increased contact with beneficiaries, we considered a number of factors, including administrative and other costs. Because SSA could not provide us with estimates for these costs, we used the cost of the CDR mailer process to approximate the costs. The cost of the mailer reflects a more expensive manual process; thus we believe that it overstates the true cost of a scannable mail contact. In addition, because of the significant cost savings likely to result from the termination of benefits for individuals who do not respond—a net federal savings of over \$1.4 billion—we believe that there is sufficient latitude to cover the cost of such an initiative.

7. Given the challenges that SSA faces, we continue to believe that its ability to eliminate the backlog of all required CDRs is uncertain. It may be possible for SSA to conduct the number of CDRs in its plan. However, the plan excludes about 848,000 required CDRs that are currently due or overdue. In addition, it does not include new CDRs and disability eligibility redeterminations required by the 1996 amendments to the Social Security Act, which take precedence over other required CDRs. Additional challenges are cited in our report.

8. We are pleased that SSA agrees with our recommendation to integrate return-to-work initiatives and the CDR process and that SSA has efforts under way to elicit the assistance of federal and private sector partners in the development of a return-to-work strategy. In our report, we acknowledge that field office employees play a limited role in providing information on VR opportunities to beneficiaries when they apply, but we also note that these staff take VR-related actions during a full medical CDR, and that state VR agencies have a role in limiting candidates for rehabilitation.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to those named above, the following persons made important contributions to this report: Susan E. Arnold, Senior Evaluator; Christopher C. Crissman, Assistant Director; Julian M. Fogle, Senior Evaluator; Elizabeth A. Olivarez, Evaluator; Susan K. Riggio, Evaluator; Vanessa R. Taylor, Senior Evaluator (Computer Science); and Ann T. Walker, Evaluator (Database Manager).

Appendix VI
GAO Contacts and Staff Acknowledgments

Appendix VI
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GAO Contacts and Staff Acknowledgments

Related GAO Products

Supplemental Security Income: Some Recipients Transfer Valuable Resources to Qualify for Benefits (GAO/HEHS-96-79, Apr. 30, 1996).

SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS-96-62, Apr. 24, 1996).

PASS Program: SSA Work Incentives for Disabled Beneficiaries Poorly Managed (GAO/HEHS-96-51, Feb. 28, 1996).

SSA's Rehabilitation Programs (GAO/HEHS-95-253R, Sept. 7, 1995).

Supplemental Security Income: Disability Program Vulnerable to Applicant Fraud When Middlemen Are Used (GAO/HEHS-95-116, Aug. 31, 1995).

Social Security Disability: Management Action and Program Redesign Needed to Address Long-Standing Problems (GAO/T-HEHS-95-233, Aug. 3, 1995).

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-95-164, 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).

Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

Social Security: New Continuing Disability Review Process Could Be Enhanced (GAO/HEHS-94-118, June 27, 1994).

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

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