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SUPPLEMENTAL SECURITY INCOME

SSA Is Taking Steps to Review Recipients' Disability Status

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The Honorable E. Clay Shaw
Chairman, Subcommittee on Human Resources
The Honorable Nancy L. Johnson
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

In recent years, the Congress has been concerned that ineligible individuals may be receiving disability benefits under the Supplemental Security Income (SSI) program, which provides benefits to low-income disabled and blind[1] individuals. These concerns stem, in part, from frequent allegations of fraud, waste, and abuse in the program. For example, we recently confirmed allegations that some ineligible non-English-speaking applicants were illegally obtaining benefits through the use of middlemen, who provide translation and/or other services for a fee to help individuals apply for benefits.[2] Concerns about the program also stem from sharp increases in the number of SSI recipients in recent years. From 1990 to 1996, the population of disabled SSI recipients increased by over 40 percent, from about 3.4 million to nearly 4.8 million.

To help ensure that only eligible individuals are receiving SSI benefits, the Social Security Independence and Program Improvements Act of 1994 required that the Social Security Administration (SSA) review the disability status of a minimum number of SSI recipients. In August 1996, the Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which amended the Social Security Act to require SSA to conduct continuing disability reviews (CDR) within the first year of life on all low-birth-weight babies receiving SSI benefits and at least once every 3 years on all other SSI recipients under age 18 for whom medical improvement is likely. The 1996 legislation repealed the requirement that SSA conduct CDRs on one-third of SSI recipients attaining age 18 in each of fiscal years 1997 and 1998 and replaced it with the requirement that, starting on the date of the legislation's enactment, SSA redetermine medical eligibility on the basis of adult criteria for all recipients within 1 year of their 18th birthdays.

[1]In this report, the term "disabled" includes recipients classified as either blind or disabled under the SSI program. People over the age of 65 who are not disabled also receive SSI if they meet the same resource and income requirements that apply to the disabled. Because this report is concerned with CDRs of disabled recipients, we did not include the aged in our analyses.

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

To assist in your oversight of the SSI program, you asked us to examine SSA's strategy for conducting the legally required CDRs on SSI recipients. In response, we addressed the following questions:

- What steps is SSA taking to conduct legally required SSI CDRs in fiscal years 1996 through 1998;
- what resources has SSA committed to meeting this requirement and what additional resources, if any, are needed;
- how does SSA select recipients for SSI CDRs;
- what are the potential benefits of conducting CDRs on the SSI population; and
- what potential options exist for improving the CDR process?

In companion reports, we discussed SSA's general strategy for conducting CDRs, which are also required under the Disability Insurance (DI) program.[3] The DI program provides disability benefits to individuals who have enough work experience to be insured under Social Security.

To address these questions, we (1) interviewed federal and state officials; (2) reviewed relevant laws, regulations, policies, procedures, and reports; and (3) reviewed SSA data on CDR work plans, budgets, costs, savings, and previously conducted CDRs. Furthermore, we reviewed the process SSA uses in selecting recipients for CDRs and the composition of the formulas used to estimate the likelihood of benefit termination for that process. We estimated savings from benefit terminations after CDRs using assumptions provided by SSA; the Health Care Financing Administration (HCFA), which administers the Medicaid program; and the Congressional Budget Office. In addition, to characterize the population of SSI recipients currently due or overdue for CDRs, we analyzed SSA data from the Supplemental Security Income Record Description (SSIRD) for a 15-percent sample of the SSI disabled population due or overdue for CDRs on the basis of SSA's current system for scheduling CDRs. We used SSIRD data as provided and did not evaluate its accuracy or the validity of SSA formulas used in the selection process. (App. I contains more details on our scope and methodology.)

Results in Brief

For fiscal year 1996, SSA planned to conduct required CDRs on about 118,000 SSI recipients—one-third of SSI recipients attaining 18 years of age and 100,000 recipients in other age groups. SSA also planned to conduct other CDRs that were not legally required on over 100,000 additional SSI

[3]Social Security Disability: Improvements Needed to Continuing Disability Review Process (GAO/HEHS-97-1, Oct. 16, 1996) and Social Security Disability: Alternatives Would Boost Cost-Effectiveness of Continuing Disability Reviews (GAO/HEHS-97-2, Oct. 16, 1996).

recipients. As of June 1996, SSA was on schedule, having completed about 60 percent of the required CDRs. SSA is currently revising its SSI CDR plans to meet the new legislative requirements enacted in August 1996. Although the Congress and SSA took steps to provide over $4 billion for CDRs in fiscal years 1996 through 2002, legally required DI CDRs, which include a large backlog, and other competing priorities may make it difficult for SSA to conduct all required SSI CDRs after fiscal year 1996.

In fiscal year 1996, SSA limited its selection for CDRs to a portion of SSI recipients it considers cost-effective to review. In general, these include recipients for whom medical improvement is either expected or possible, who make up about one-half of all SSI recipients due or overdue for CDRs. Although SSA estimates that conducting CDRs will result in removing only about 5 percent of SSI recipients from the rolls, without CDRs, the number of ineligible recipients would likely increase over time. Moreover, SSA estimates that conducting CDRs on SSI adult recipients for whom medical improvement is expected or possible results in about $3 in federal program savings for every $1 spent conducting CDRs.

In our companion reports, we identified two options that would enable SSA to further enhance its CDR process. First, we recommended that SSA (1) establish less rigid requirements, to the extent it has the authority, on who is scheduled for CDRs and how often; (2) ensure that it makes contact with all recipients; and (3) develop a legislative proposal to obtain the authority needed to extend this new process to all recipients. These actions would give SSA greater flexibility than the current CDR scheduling system to concentrate its efforts on recipients with the greatest potential for medical improvement and subsequent benefit termination. Second, we recommended that, to more efficiently use CDR resources and strengthen its return-to-work initiatives, SSA should test the use of its contacts during CDRs to also determine recipients' vocational rehabilitation service needs and provide them with the support and assistance they need to enter or reenter the workforce.

Background

The SSI program provides financial assistance to disabled people whose income and resources are below specified amounts. As of January 1996, about 2.6 million adults and 1.1 million children were receiving SSI disability benefits and an additional 1.1 million adults were receiving both SSI and DI benefits.[4] Most SSI recipients qualify for Medicaid coverage, and

[4]SSI recipients can also qualify for disability benefits under the DI program if they have enough work experience to be insured under Social Security.

48 states and the District of Columbia also supplement federal SSI payments with state SSI benefits. In 1995, SSI disability recipients received a total of about $21 billion in federal SSI benefits and $2.6 billion in SSI state supplements.

Reviewing recipients' disability status, especially those most likely to improve, is an important component of good program management. Even though the SSI program was created to provide benefits to people who are severely disabled or terminally ill,[5] some people do improve through treatment, surgery, or the passing of time. Amidst concerns about fraud, waste, and abuse in the SSI program, the Congress passed the Social Security Independence and Program Improvements Act of 1994, which required SSA to conduct CDRs on one-third of SSI recipients attaining age 18 and another 100,000 recipients in each of fiscal years 1996 through 1998.

The 1996 amendments to the Social Security Act required that SSA conduct CDRs on all low-birth-weight babies within their first year of life and at least once every 3 years on all children under age 18 whose conditions are likely to improve. The amendments single out low-birth-weight babies because historically a relatively high percentage of these babies, about 40 percent, have had their benefits terminated after CDRs. The 1996 amendments replaced the requirement that SSA conduct CDRs on one-third of recipients attaining age 18 with the requirement that SSA redetermine disability eligibility using adult criteria for all recipients attaining age 18.[6] These redeterminations differ from CDRs in that SSA bases decisions for disability eligibility redeterminations on whether recipients meet eligibility requirements; for CDRs, SSA bases eligibility decisions on whether recipients' impairments have improved since the last determination. Since these disability eligibility redeterminations can be counted as CDRs on SSI recipients, this report examines SSA's plans to conduct both of these types of reviews. In addition, this report focuses on CDRs of SSI-only recipients because provisions in the 1994 and 1996 laws apply only to recipients who are receiving disability benefits solely under the SSI program, and not under both the SSI and DI programs. Legislation has required CDRs of DI beneficiaries, including those also receiving SSI benefits, since 1980.

[5]The Social Security Act defines disability as the inability to engage in substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment expected to last for a continuous period of at least 12 months or result in death. SGA is defined as earnings of more than $960 a month for blind individuals and $500 a month for other disabled individuals. Children qualify for benefits if they have impairments of comparable severity.

[6]For most recipients, SSA starts basing disability decisions on adult rather than child criteria at age 18.

The number of SSI CDRs required by the 1994 and 1996 legislation represent large increases over the number conducted in previous years. In fact, the number of CDRs required in fiscal year 1996 alone exceeds the total of all SSI CDRs conducted in fiscal years 1991 through 1995 (see table II.1). According to SSA, it conducted few CDRs of SSI recipients in those years because the agency had limited resources and no legal requirement existed. However, because SSA had the authority to conduct SSI CDRs, SSA continued to schedule SSI recipients for CDRs and, as a result, about 1.9 million SSI adults and children are now due or overdue for CDRs. Tables II.2 through II.4 present selected characteristics, including age, impairment, and length of time receiving benefits, for the SSI population who were due or overdue for CDRs in fiscal year 1996.

SSA administers the SSI program with the help of state agencies, called disability determination services (DDS). DDSs make disability determinations for SSA, process initial applications, assess recipients' potential for medical improvement, and set due dates for and conduct CDRs. DDSs determine when recipients will be due for CDRs on the basis of their potential for medical improvement. On the basis of recipients' impairments and ages, DDS officials classify individuals into one of three categories: medical improvement expected (MIE), medical improvement possible (MIP), or medical improvement not expected (MINE). Individuals are then scheduled for CDRs at 6- to 18-month intervals if classified as MIE, at least once every 3 years if classified as MIP, and once every 5 to 7 years if classified as MINE.

In recent years, given limited resources for conducting CDRs and the large backlog of 2.4 million DI CDRs due or overdue, SSA developed new processes in an effort to conduct CDRs in a more cost-effective manner. SSA developed a mailer CDR process to obtain self-reported information on current medical conditions, treatments received, and work activities as a low-cost alternative to full medical CDRs. The full medical CDR process is labor-intensive and generally involves (1) 1 of 1,300 SSA field offices that determines whether disabled recipients continue to meet the financial eligibility requirement regarding income and resources and (2) 1 of 54 state DDSs that determines whether recipients continue to be disabled, which frequently involves medical exams by at least one doctor. The average cost of a full medical CDR is about $1,000, while the average cost of the mailer CDR is between about $25 and $50.

In addition, on the basis of the outcomes of previously conducted CDRs on DI beneficiaries, SSA developed statistical formulas to estimate the

likelihood of benefit termination as a result of CDRs using recipient characteristics, such as age, impairment, length of time on disability rolls, and previous CDR activity. SSA sends mailer CDRs to a portion of individuals who it estimates, on the basis of its formulas, have the lowest likelihood of benefit termination. Cases selected for mailer CDRs are later sent to DDSs for full medical CDRs only if responses to the mail questionnaire and information used in the formulas to estimate the likelihood of benefit termination warrant a more comprehensive review.

SSA Plans to Conduct Required SSI CDRs and Test the Use of the Mailer CDR

For fiscal year 1996, SSA planned to conduct full medical CDRs for the legally required SSI CDRs and to test the mailer CDR process on over 100,000 additional SSI recipients. Table 1 presents, for fiscal year 1996, the number of CDRs SSA specified in planning documents and the number SSA had initiated and DDSs had completed as of June 1996. As of June, DDSs had completed about 60 percent of the required reviews in each category.

Table 1: Number of SSI CDRs Planned in FY 1996 and Initiated and Completed as of June 1996

Category	Planned CDRs	Initiated CDRs	Completed/returned CDRs as of June 1996
Legally required CDRs			
Full medical—18-year-olds	Between 16,000 and 18,000	18,000[a]	10,500
Full medical—other age groups	100,000	109,800[a]	64,000
Additional CDRs			
Mailer	119,400	107,900[b]	53,000
Total CDRs	**Between 235,400 and 237,400**	**235,700**	**127,500**

Note: Because of updating, the numbers reported in this table differ somewhat from planned CDRs contained in SSA's 7-year plan for fiscal years 1996 through 2002.

[a]Full medical CDRs sent to SSA field offices.

[b]Mailer CDRs sent to SSI recipients. SSA revised its initial plans and sent out mailer CDRs to 107,900 SSI recipients in fiscal year 1996.

SSA is currently modifying its CDR plan for fiscal years 1997 through 2002, which were developed before the enactment of new SSI CDR requirements under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Under the new requirements, SSA must conduct at least 150,000 SSI CDRs in each of fiscal years 1997 and 1998, which includes

disability eligibility redeterminations on 18-year-olds.[7] Prior to the new requirements, SSA's CDR plan specified more SSI CDRs in fiscal year 1997, but fewer than 150,000 SSI CDRs in fiscal year 1998. Estimates of the minimum number of SSI CDRs that will be required in later years were not available at the time our fieldwork was completed. However, SSA's plan called for dramatic increases in the number of SSI CDRs in fiscal years 1999 through 2002, ranging from 367,000 to 625,000 per year.

Resources Appear Sufficient for Required SSI CDRs, but Competing Priorities Pose Challenges

SSA plans to use CDR funds to conduct the legally required SSI CDRs and disability eligibility redeterminations in fiscal years 1996 through 2002. In fiscal year 1996, SSA for the first time set aside regular administrative funds for CDRs, and the Congress took steps to increase funding for CDRs. SSA set aside $200 million for both SSI and DI CDRs and plans to continue that level of funding at least through fiscal year 2002. In addition, the Contract With America Advancement Act of 1996 established a new funding mechanism[8] for CDRs and authorized up to an additional $2.7 billion for SSI and DI CDRs through fiscal year 2002. This was about $1 billion less than the amount SSA had requested from the Congress and believed would be sufficient, along with regular administrative funds, to conduct CDRs on all SSI recipients who were due or overdue for review and all required DI CDRs through fiscal year 2002. The 1996 amendments to the Social Security Act subsequently authorized an additional $250 million for SSI CDRs and disability eligibility redeterminations[9] in fiscal years 1997 and 1998. Combined, regular administrative funding for CDRs and the new budget authority could total over $4 billion in fiscal years 1996 through 2002.

Competing priorities, such as conducting legally required DI CDRs, which include an enormous backlog of reviews, may pose challenges to conducting all required SSI CDRs in fiscal years 1997 through 2002. Furthermore, the same DDS staff who conduct SSI CDRs also conduct DI CDRs

[7]SSA has determined that newly required CDRs on low-birth-weight babies and children under age 18 whose impairments are likely to improve may count toward the 100,000 CDRs required under the Social Security Independence and Program Improvements Act of 1994.

[8]The legislation authorizes funding for 7 years for CDRs from the Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

[9]In addition to CDRs and disability eligibility redeterminations on 18-year-old recipients, these funds can also be used for disability eligibility redeterminations of between 300,000 and 400,000 child recipients who qualified for SSI under individualized functional assessments (IFA). The 1996 amendments discontinued IFAs and required SSA within 1 year to redetermine the disability eligibility of all recipients who had qualified as a result of IFAs. Prior to the 1996 amendments, children with severe impairments who did not qualify for disability benefits based solely on their impairments received IFAs to determine whether they would qualify on the basis of their impairments and their inabilities to engage in age-appropriate activities.

and process initial applications and other reviews of disability eligibility required by law. Although SSA has estimated that funds are sufficient to conduct all required SSI and DI[10] CDRs in fiscal years 1996 through 2002, in our companion reports we question whether CDR funds are sufficient to meet those CDR goals. To the extent that CDR funds are not sufficient to conduct all required SSI and DI reviews, SSI CDRs may be scaled back, since SSA generally considers them to be less cost-effective than DI CDRs. Only SSI CDRs were scaled back when SSA received less CDR funding for fiscal years 1996 through 2002 than it had requested from the Congress.

Also, according to SSA, the ability to conduct CDRs is always vulnerable to unexpected increases in initial applications and disability eligibility redeterminations. In fact, both of the 1996 laws require work in these areas that may compete with CDRs for DDS staff. First, SSA currently estimates that, because the Contract With America Advancement Act eliminated drug and alcohol abuse as a basis for receiving disability benefits, benefits will be terminated for some of the 196,000 SSI recipients and DI beneficiaries whose primary impairments were drug abuse and/or alcoholism. SSA expects many of those terminated to reapply on the basis of other impairments. Second, in fiscal years 1997 and 1998, the 1996 amendments to the Social Security Act require SSA to redetermine the disability eligibility of between 300,000 and 400,000 children currently receiving SSI benefits. Although these disability eligibility redeterminations can count toward the required 100,000 SSI CDRs in those years, the law gives them precedence over required CDRs on other children. SSA is currently evaluating the impact of this and other required work on its ability to conduct CDRs.

SSA Uses Different Approaches to Select Adult, Child, and 18-Year-Old Recipients for SSI CDRs

In fiscal year 1996, SSA only conducted SSI CDRs on a portion of recipients it considered to be cost-effective to review. In general, these included MIEs or MIPs, who make up about one-half of all SSI recipients due or overdue for CDRs. For SSI adult recipients, SSA selected from among those who were classified as MIE or MIP and under the age of 59 in that year. SSA's 1996 fiscal year plan called for conducting about 100,000 full medical CDRs and 107,900 mailer CDRs of adult MIE and MIP SSI recipients. For children, SSA limited its selection to low-birth-weight babies, who totaled about 7,200. According to SSA, it did not select other children in anticipation of the requirement to conduct disability eligibility redeterminations on between

[10]SSA plans to conduct required CDRs on all DI worker beneficiaries under age 59 but currently excludes from its plan required CDRs on three categories of DI beneficiaries: workers aged 59 and over, and disabled widows and widowers and disabled adult children of disabled, retired, or deceased DI worker beneficiaries.

300,000 and 400,000 children receiving SSI. Among 18-year-old SSI recipients, SSA selected 18,000 MIE and MIP recipients, which is about one-third of SSI recipients attaining age 18.

For adult and 18-year-old recipients, SSA used different approaches to select recipients for CDRs. To select adult recipients, SSA used formulas developed for DI beneficiaries to estimate the likelihood of benefits being terminated as a result of a CDR. As is currently done under the DI program, SSA then selected a portion of those with the highest and lowest estimated likelihood of benefit termination for full medical and mailer CDRs, respectively. SSA did not select recipients in the middle range, which contains the majority of recipients included in the estimation process, because in this range, the formulas are less helpful in identifying recipients who are more likely to have their benefits terminated as a result of a CDR and, therefore, to warrant a full medical CDR. SSA has only developed formulas for use in selecting adult recipients. Among 18-year-old recipients, SSA selected a judgmental sample of those it believed would be most likely to have their benefits terminated as a result of a CDR based on some of the characteristics used to select adult cases for CDRs, such as impairment type and length of time receiving SSI.

SSA tested the validity of using the DI formulas to estimate the likelihood of benefit termination for adult SSI recipients in its 1995 study of SSI CDRs and its analysis of SSI and DI population characteristics. The SSI and DI programs are subject to the same eligibility requirements, and SSA's 1995 study of 5,000 adult SSI CDRs found that the formulas differentiated between cases most and least likely to result in benefit terminations about equally well for both disability populations. Since relatively few SSI recipients have ever undergone a CDR, SSA did not use length of time since the last CDR and the number of previous CDRs, which are variables normally included in the DI formulas, when estimating the likelihood of benefit termination for SSI recipients.

In fiscal years 1997 and 1998, required disability eligibility redeterminations on children will count toward the requirement to conduct at least 100,000 SSI CDRs in each year. In addition, SSA will be required to conduct CDRs annually on (1) low-birth-weight babies and (2) other children under age 18 at least once every 3 years starting on the date of enactment of the 1996 amendments. In fiscal years 1997 and 1998, therefore, CDRs on children could dominate SSI CDRs. SSA plans to continue to develop and modify the formulas and SSI selection process as it learns more about conducting CDRs on this population. SSA's current plans for

broad CDR process improvements include expanding the use of the formulas to children and certain recipients classified as MINEs in order to select individuals for full medical and mailer CDRs from these recipient categories on the basis of their estimated likelihood of benefit termination. SSA also plans to (1) develop a new type of mailer CDR for gathering information on recipients' medical conditions directly from their physicians and other treating sources and (2) obtain Medicaid data and integrate the data into the statistical formulas to increase the validity of the estimated likelihood of benefit termination. These latter improvements would allow SSA to better predict which recipients in the middle range of estimated likelihood of benefit termination are more likely to have their benefits terminated as a result of a CDR and, therefore, to warrant full medical CDRs. (We discuss these plans further in app. III.)

SSI CDRs Are Cost-Effective for Certain Categories of Recipients

Reviewing recipients' disability status, especially those most likely to improve, is one component of a well-managed program. Few recipients voluntarily report medical improvement and leave the rolls. SSA currently estimates that CDRs will remove only about 5 percent of SSI recipients from the rolls in the long run.[11] However, if the CDR process was not in place, recipients' continuing disability eligibility would be uncertain and the number of ineligible recipients would likely increase over time. On the basis of SSA's estimate that 5 percent of SSI recipients would have their benefits terminated as a result of CDRs, we estimate that about 95,000 of the approximately 1.9 million SSI recipients currently due or overdue for CDRs are no longer medically eligible for benefits. In fiscal year 1996 alone, these recipients would have received about $481 million in federal SSI benefits and about $418 million in federal and state Medicaid benefits.

SSI CDRs on some categories of recipients appear to be cost-effective. Benefit terminations result in SSI and Medicaid savings at both the federal and state levels (see app. IV for information on savings). SSA calculates cost-effectiveness for various recipient categories by comparing (1) the estimated present value of benefit savings due to benefit terminations resulting from CDRs on a category with (2) the estimated total costs of conducting CDRs for that category. Because SSA has little experience conducting SSI CDRs, SSA cautions that estimates of savings resulting from SSI terminations are somewhat tentative.

[11]Because SSA has little experience conducting CDRs on the SSI population, SSA cautions that any estimates of the percentage of SSI recipients who would have their benefits terminated after a CDR are tentative.

SSA estimates that CDRs on adults SSA has classified as MIE or MIP save about $3 in federal SSI and Medicaid benefits for every $1 spent conducting CDRs on those categories. State savings increase this ratio to $4 saved for every $1 spent. SSI CDRs on low-birth-weight babies are more cost-effective than CDRs on adults—saving about $14 in program benefits for every $1 spent conducting CDRs; however, these children constitute less than 1 percent of the SSI disabled population. SSA estimates that, in general, CDRs on recipients classified as MINE are not cost-effective, and, at best, break even.

Options Exist for Making CDRs More Cost-Effective and Using CDRs to Help Recipients Move Off Disability

Increased SSI CDR activity comes at a time when both the Congress and SSA have sought a CDR strategy that is more cost-effective. In the Contract With America Advancement Act, the Congress emphasized maximizing the combined savings from CDRs under the SSI and DI programs. SSA has been working to improve its ability to identify recipients for whom conducting CDRs is cost-effective.

Options exist for making SSI CDRs more cost-effective and helping SSA meet the challenge of conducting all required CDRs. In companion reports, we identified two options for improving the CDR process—one that could make CDRs more cost-effective and one that would strengthen return-to-work efforts. In addition to these options, to increase service to the public and more efficiently use resources, SSA is exploring coordinating CDRs with redeterminations of recipients' financial eligibility.

Revising Requirements Can Improve CDRs' Cost-Effectiveness

In our companion reports, one option we proposed for improving the CDR process was for SSA to adopt less rigid requirements for scheduling CDRs in order to shift the emphasis from periodic reviews to a system that is more cost-effective. The current system, in which periodic CDRs are scheduled for all SSI recipients, including those with virtually no potential for medical improvement, is a costly approach to identifying the approximately 5 percent of recipients who are likely to have improved to the point of being found ineligible for benefits. Furthermore, the frequency of CDRs is currently based on medical improvement classifications that do little to identify those most likely to have their benefits terminated as a result of a CDR. We found that the estimated likelihood of benefit termination was very similar for recipients classified as MIE and MIP. In addition, although millions of dollars are spent annually to conduct periodic CDRs, some individuals, especially DI beneficiaries for whom SSA is not conducting CDRs, have received benefits for years without having any contact with SSA

regarding their disability or their ability to return to work despite continuing disability.

We recommended in these reports a three-pronged approach to increasing the cost-effectiveness of CDRs while maintaining program integrity. Specifically, we recommended that SSA replace the routine scheduling of CDRs with a new process that, if extended by the Congress to all recipients, would (1) be cost-effective by selecting for review individuals with the greatest potential for medical improvement and subsequent benefit termination, (2) correct a weakness in SSA's current CDR process by reviewing a random sample of all other recipients, and (3) improve program integrity by instituting contact with those not selected for CDRs or financial eligibility redeterminations.[12] As part of this effort, we also recommended that the Commissioner of Social Security develop a legislative package to obtain the authority the agency needs to enact this new process for those portions of the SSI and DI populations that are subject to routinely scheduled CDRs.

Less rigid requirements regarding the frequency of CDRs are necessary if CDRs are to be conducted primarily on those recipients whose cases are most cost-effective to review—that is, those recipients with the greatest potential for medical improvement. But to maintain program integrity, SSA must keep abreast of the potential for medical improvement of all recipients. Currently, SSA excludes MINE recipients and those aged 59 and older from the selection process altogether. We believe this weakness in the current process could be addressed by conducting CDRs on a random sample of recipients in these or other categories that SSA decides in the future are less cost-effective to review.

Instituting periodic contact with recipients who are not chosen for CDRs or financial eligibility redeterminations can help protect program integrity by reminding recipients that their medical conditions are being monitored and serving as a deterrent to abuse by those no longer medically eligible for benefits. More specifically, we believe that a new type of brief mailed contact would, at a minimum, allow SSA to contact a majority of recipients with overdue CDRs in the year it is implemented to remind them of their responsibility to report medical improvements. SSA could also use such contact to gather information to support ongoing or planned initiatives, such as SSA's return-to-work initiatives or planned improvements to the CDR process.

[12]In order to minimize the burden placed on recipients to provide SSA with information, those who would receive financial eligibility redeterminations are excluded from the proposed contact.

Some SSA officials expressed concern about the cost of this new type of mailed contact with recipients. Although some administrative funds would be used for the contact that might have been used for CDRs or other activities, the contact should result in significant program savings because of the considerable number of recipients who, on the basis of SSA's experience, can be expected to refuse repeatedly to provide the requested information and, as a result, have their benefits terminated after a prescribed due-process procedure is followed. On the basis of SSA's experience with CDRs and financial eligibility redeterminations, we assume that about 1 percent of the SSI recipients who were contacted would have their benefits terminated for noncooperation. This benefit termination rate represents a onetime net federal savings of about $230 million from contacting SSI recipients due or overdue for CDRs in fiscal year 1996. (See app. II for a further discussion of estimated savings.)

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

Another option we proposed for improving the use of CDR-related resources was to support return-to-work efforts by better using the CDR process to assess recipients' work potential, even if there is no medical improvement, and encouraging recipients to obtain vocational rehabilitation (VR) services. With medical advances and new technologies creating more opportunities for disabled people to work, some recipients who do not medically improve may nonetheless be able to engage in substantial gainful activity. In an April 1996 report, we recommended 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 recipients' work capacities and better implementing existing return-to-work mechanisms.[13]

In our companion reports, we recommended that SSA use CDR contacts to identify recipients' productive capacities, inform them about VR services, and encourage them to work. Currently, through contacts during the CDR process, SSA generally provides little support and assistance to help recipients become self-sufficient. When conducting full medical CDRs, SSA obtains information on VR services received since the initial application or last CDR. However, SSA and DDS staff are neither required nor instructed to assess recipients' work potential, make recipients aware of rehabilitation services, or encourage them to seek VR services. SSA provides limited encouragement through mailer CDRs by asking respondents to indicate whether they are interested in rehabilitation or other services that could

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

help them obtain work. Those respondents who indicate an interest and appear to be reasonable candidates[14] for rehabilitation are to be referred to state VR agencies. However, on average, only about 8 percent of all SSI recipients and DI beneficiaries are referred for VR services.

SSA Is Exploring More Coordination Between CDRs and Financial Eligibility Redeterminations

SSA is exploring the potential for better coordinating SSI CDRs with redeterminations of recipients' financial eligibility. Each year, SSA reviews the income, resources, and living arrangements of about 2 million SSI recipients to ensure that they still meet SSI's financial eligibility requirements. Because staff involved in conducting CDRs and financial eligibility redeterminations either are located in the same place or are the same, SSA is hoping to expand coordination to conserve its resources and provide better service to the public. Currently, the only coordination that takes place is on the part of SSA's field office staff, who are instructed when conducting a CDR to gather financial eligibility redetermination information if the recipient is also due for such a redetermination.

In exploring opportunities for coordination, SSA will have to resolve procedural issues that, in the past, served as obstacles to pursuing greater coordination. Over the past 10 years, interest in coordinating the two activities has been thwarted by (1) different schedules for conducting CDRs and financial eligibility redeterminations throughout the year and (2) the lack of compatible databases for SSA field office staff to determine who is scheduled for both CDRs and financial eligibility redeterminations. SSA believes that increased numbers of SSI CDRs and large demands on staff resources will serve as added incentives to overcoming these and other potential obstacles.

Conclusions

Congressional action in 1994 prompted an increase in SSI CDR activity that should help SSA identify and remove more ineligible recipients from the program. In 1996, the Congress further increased the number of required CDRs and disability eligibility redeterminations and also increased funding that SSA can use to conduct SSI CDRs in the future. However, SSA will likely face challenges from competing priorities for staff resources, including required DI CDRs.

[14]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 limited by restrictive state policies that screen out applicants who are not considered reasonable candidates for rehabilitation.

Because of increases in the required number of SSI CDRs; the large backlog of required DI CDRs; and the Contract With America Advancement Act, which emphasizes cost-effectiveness, we identified in companion reports two options that could make the CDR process more cost-effective. We recommended that a more cost-effective approach for determining who receives CDRs may be to (1) review recipients 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 all other recipients, and (3) ensure program integrity by instituting contact with recipients not selected for CDRs or financial eligibility reviews. However, for this approach to be cost-effective, SSA needs to be able to accurately estimate the likelihood of benefit termination for all recipients, which it can now only do for portions of those recipients classified as MIE or MIP. Furthermore, using CDR contacts to assess recipients' potential for and promote VR services and coordinating CDRs with financial eligibility redeterminations could increase the efficient use of CDR resources.

Agency Comments and Our Evaluation

In commenting on our draft report, SSA generally agreed with our conclusions regarding its progress in conducting SSI CDRs and stated that this report, along with the companion reports, provided valuable information that would be helpful to the agency in achieving its CDR goals in the future. The agency agreed that SSA should continually seek ways to maintain stewardship of the disability program in the most cost-effective manner and begin to consider which legislative changes, if any, will produce such a result. The agency also stated that it would (1) test using CDR contacts to assess recipients' potential for and promote VR services and (2) continue to explore options for coordinating CDRs with financial eligibility redeterminations. We also received technical comments from SSA, which we incorporated where appropriate. SSA's comments are reprinted in appendix V.

As agreed with your office, we will send copies of this report to the Commissioner of Social Security. We will also 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.

Jane L. Ross
Director, Income Security Issues

Contents

Tables

Abbreviations

AFDC	Aid to Families With Dependent Children
CDR	continuing disability review
DDS	disability determination service
DI	Disability Insurance
HCFA	Health Care Financing Administration
IFA	individualized functional assessment
MIE	medical improvement expected
MINE	medical improvement not expected
MIP	medical improvement possible
OD	Office of Disability
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. This information includes the databases and sample used in analyzing characteristics of SSI recipients due or overdue for CDRs in fiscal year 1996. Also included is information on our estimates of (1) savings resulting from benefit terminations after CDRs and (2) onetime savings from our proposed new type of mailed contact. We used Supplemental Security Income Record Description (SSIRD) data as provided and did not evaluate the data's accuracy. We did our work between September 1995 and August 1996 in accordance with generally accepted government auditing standards.

Database and Sample Used to Analyze Characteristics of SSI Recipients Due or Overdue for CDRs

To determine the number of SSI recipients currently due or overdue for CDRs, we used the SSA Office of Disability's (OD) CDR database. This database contained records on all recipients SSA had determined were due or overdue for a CDR in fiscal year 1996. For purposes of our analyses, we took a random sample of 15 percent of those recipients stratified by whether the (1) recipient was an adult or a child and (2) DDSs had classified as medical improvement expected (MIE), possible (MIP), or not expected (MINE). We eliminated from our sample recipients whose CDR due dates were after fiscal year 1996 or who were over age 65.[15] On the basis of our sample data, we estimated the size of the population with these exclusions. Table I.1 contains initial population and sample sizes and final sizes after adjustments.

Table I.1: Initial and Final Population and Sample Sizes for SSI Recipients Due or Overdue for CDRs in FY 1996

	Adult		Child			
	MIEs and MIPs	MINEs	MIEs	MIPs	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
Age over 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

[15]We excluded from our analysis recipients receiving disability benefits who are over age 65. If CDRs were conducted and these recipients 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 aged benefits. Such individuals can choose to continue receiving disability benefits or switch to aged benefits.

For the final sample, we obtained information on characteristics from SSA's SSIRD and OD's CDR database. From the SSIRD, we obtained information on age, gender, race, impairment, length of time receiving benefits, and length of time overdue for a CDR. Because information obtained from OD did not always differentiate between adult MIE and MIP recipients, we used SSIRD data to classify adults into the two categories.[16] From OD's CDR database, we obtained information on (1) medical improvement classifications for all children and for adults classified as MINE and (2) estimates of the likelihood of benefit termination for adult MIE and MIP recipients, the only recipient categories for whom likelihood of benefit termination estimates were available.

Because we used a sample to estimate characteristics of the universe of recipients due or overdue for CDRs in fiscal year 1996, the reported estimates in tables II.2 through II.4 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. In appendix II, the tables in which we report recipients' characteristics 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 sampling 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 of the estimated percentage.

Estimates of Savings Resulting From Benefits Being Terminated After CDRs

We obtained information from a variety of sources to estimate the present value of savings to federal and state governments resulting from benefits being terminated after CDRs. The present value of savings is the current value, in constant 1996 dollars, of benefits that would have been paid over a recipient's lifetime had benefits not been terminated. Appendix IV contains our estimates of the present value of savings resulting from SSI CDRs.

[16]We classified as MIE any beneficiary clearly identified as such; we classified all other recipients in OD's MIE/MIP category as MIPs—this includes 236 of the total records in our sample.

To calculate savings, we (1) obtained estimates of federal and state SSI and Medicaid savings and (2) calculated increased benefits that would be paid by other programs after SSI benefits had been terminated. From SSA, we obtained an estimate of the present value of federal SSI savings and a formula[17] for estimating the present value of state SSI supplement savings. From the Health Care Financing Administration we obtained estimates of the present value of federal and state Medicaid savings.

To calculate offsetting costs from benefits paid by other programs, we used assumptions provided by the Congressional Budget Office regarding increased benefits under the Food Stamp and Aid to Families With Dependent Children (AFDC) programs that former SSI recipients would receive once they no longer qualified for SSI benefits. In calculating increases in Food Stamp program benefits, we assumed that (1) about 50 percent of SSI recipients terminated as a result of a CDR would be receiving food stamps and (2) without SSI benefits, which count as income when determining Food Stamp benefit levels, Food Stamp benefits would increase by about one-third of recipients' former SSI benefit levels. In calculating offsetting AFDC costs, we assumed that about 50 percent of children who were terminated from the SSI program would be eligible for AFDC and that, on average, families' AFDC benefits would increase by $70 per month, the marginal per-child AFDC cost.

Savings Estimate for Proposed Contact With Recipients Due or Overdue for CDRs

The new type of brief mailed contact proposed in the companion reports would result in program savings because we expect a considerable number of recipients to repeatedly refuse to provide requested information and, as a result, have their benefits terminated.[18] As a condition of receiving benefits, recipients are required to respond to reasonable requests for information. When recipients do not respond, SSA first attempts to contact recipients to determine their reasons for nonresponse. If a recipient refuses to cooperate, SSA then follows procedures to ensure due process in terminating benefits.

In calculating savings, we estimated the (1) number of recipients who would be contacted and the percentage who would fail to cooperate, (2) savings per termination, and (3) cost per contact. Table I.2 presents these estimates and summarizes assumptions used in making the

[17]According to SSA, the present value of state SSI supplement savings equals the average monthly state supplement times 75. This means that, for every $1 of average monthly state SSI supplement, states save $75.

[18]See Social Security Disability: Improvements Needed to Continuing Disability Review Process (GAO/HEHS-97-1, Oct. 16, 1996) and Social Security Disability: Alternatives Would Boost Cost-Effectiveness of Continuing Disability Reviews (GAO/HEHS-97-2, Oct. 16, 1996).

estimations. As the table shows, of the approximately 1.9 million recipients who are currently due or overdue for a CDR, we propose that SSA contact the approximately 1,121,000 recipients who we estimate would not be scheduled for either a CDR or a financial eligibility redetermination in that year. We estimated that the number of recipients scheduled for a CDR would be about 236,000 recipients, the number planned for fiscal year 1996. According to SSA, about one-third of SSI recipients receive financial eligibility redeterminations annually, and we estimated that about 552,200 disabled SSI recipients would be scheduled for such redeterminations in fiscal year 1996.

Table I.2: Estimated Costs and Savings of Proposed Mailed Contact

	Number or dollar amount
Estimated number of recipients terminated as a result of mailed contact	
Recipients due or overdue for CDR in FY 1996	1,909,432
Recipients not receiving a CDR or financial eligibility redetermination and who would receive mailed contact	1,121,199
Recipients receiving mailed contact who would fail to cooperate (at a noncooperation rate of .01)	11,212
Estimated savings per termination	
SSI and Medicaid savings	$26,495
Food Stamp benefits increase that would offset savings	$3,100
Net savings per beneficiary terminated	$23,395
Estimated total savings to the federal government	
Savings	$262,304,740
Total cost for initial mailed contact (at $25 per contact)	$28,029,975
Program savings less costs	$234,274,765

On the basis of SSA's experience with mailer CDRs and financial eligibility redeterminations, about 1 percent of the recipients who received the mailed contact would have their benefits terminated for continual noncooperation. We estimated that the mailed contact would be responsible for only the first 5 years of savings resulting from terminating SSI recipients' benefits because of failure to cooperate. We used 5 years for our period of savings because, given SSA's system for scheduling financial eligibility redeterminations, all SSI recipients would have been contacted at least once within 5 years of the mailed contact. To estimate savings, we used SSA and Health Care Financing Administration estimates of the present value of SSI and Medicaid savings, respectively, that would be

realized each year after benefits were terminated as a result of a CDR (see app. IV).

We assigned a cost for the initial mailed contact of $25, the lower range of SSA's estimate for the cost of the current mailer CDR. Because this figure overestimates the costs of the scannable mailed contact, it provides a conservative estimate, including some administrative and developmental costs.

Additional Data on SSI CDRs

Table II.1: Number of CDRs Conducted on Individuals Receiving Both DI and SSI, and SSI Only, FY 1988-95

	Benefits		
Fiscal year	**DI and SSI**	**SSI only**	**Total**
1988	48,345	32,573	80,918
1989	42,675	86,364	129,039
1990	21,286	39,500	60,786
1991	8,297	18,830	27,127
1992	10,202	14,715	24,917
1993	5,335	8,517	13,852
1994	15,445	10,743	26,188
1995	25,408	34,664	60,072
Total	**176,993**	**245,906**	**422,899**

Source: SSA state agency operating reports.

Table II.2: Characteristics of Adult, Child, and 18-Year-Old SSI Recipients Due or Overdue for CDRs in FY 1996, in Percentages

	Adults	Children	18-year-olds	Total
Total estimated CDR population	1,393,693	478,598	37,141	1,909,432
Largest sampling error in column at the 95-percent confidence level	1.1	0.4	1.3	0.2
Age in years				
Under 5		10		2
5-9		32		8
10-14		44		11
15-17		9		2
18-21	5	5	100	7
22-29	17			13
30-39	24			17
40-49	23			17
50-59	21			15
60 and over	11			8
Average age (mean)	42	11	18	34
Average age (median)	42	11	18	34
Diagnostic group				
Infectious and parasitic diseases	1	0	0	1
Neoplasms	1	2	1	1
Endocrine, nutritional, and metabolic diseases	5	8	5	6
Disorders of blood and blood-forming organs	0	2	1	1

(continued)

	Adults	Children	18-year-olds	Total
Mental disorders, excluding mental retardation	34	18	24	30
Mental retardation	19	34	48	23
Neurological and sensory disorders	5	13	8	8
Circulatory disorders	4	1	0	3
Respiratory disorders	1	3	1	2
Digestive disorders	1	0	0	1
Genitourinary disorders	1	0	0	1
Skin and subcutaneous tissue disorders	0	0	0	0
Musculoskeletal disorders	5	1	1	4
Congenital anomalies	0	5	1	2
Injuries	2	1	1	2
Other	0	9	1	2
Not identified	20	2	6	15
Medical improvement classification				
MIE	13	23	15	16
MIP[a]	56	67	69	59
MINE	30	10	16	25
Estimated likelihood of benefit termination				
Subpopulation with likelihood estimated	862,764[b]	[c]	[c]	[c]
Under 5%	75	[c]	[c]	[c]
5-24%	22	[c]	[c]	[c]
25-49%	3	[c]	[c]	[c]
50-74%	0	[c]	[c]	[c]
75% and over	0	[c]	[c]	[c]
Average likelihood (mean)	5	[c]	[c]	[c]
Average likelihood (median)	2	[c]	[c]	[c]
Number of years receiving benefits				
Under 4	9	28	16	14
4-5	23	37	33	27
6-7	18	16	15	18
8-9	15	8	10	13
10 and over	34	10	25	28
Average years (mean)	9	6	8	8
Average years (median)	8	5	6	6
CDR maturity				
Due in FY 1996	17	31	25	21

(continued)

	Adults	Children	18-year-olds	Total
Due 1 year ago	17	26	25	19
Due 2 years ago	15	15	15	15
Due 3 years ago	12	8	8	11
Due 4 years ago	11	6	7	10
Due 5-10 years ago	22	10	16	19
Due over 10 years ago	3	1	3	2
Not identified	2	2	1	2
Average years (mean)	3	2	3	3
Average years (median)	3	2	2	2
Gender				
Female	56	37	37	51
Male	44	63	63	49
Race				
Black	28	34	39	29
White	47	35	44	44
Other	11	12	10	11
Not identified	14	18	7	15

Note: Estimates are based on a 15-percent sample. For the percentages in each column, the second row contains the largest sampling error at the 95-percent confidence level. Because of rounding during the estimation process, row entries may not sum to row totals.

[a]We classified 236 of the sample records for adult recipients as MIPs because a MIE or MIP classification was not specified.

[b]The total number with an estimated likelihood of benefit termination is less than the total number for the column because SSA provided estimates of the likelihood of benefit termination only for MIEs and MIPs aged 59 and under. This includes recipients 1 year older than the current cutoff SSA uses when selecting recipients for CDRs. SSA currently limits its CDR selection to recipients under age 59. Furthermore, SSA does not estimate the likelihood of benefit termination for children or MINEs.

[c]SSA does not estimate the likelihood of benefit termination for children.

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

Table II.3: Characteristics of SSI Adult and Child Recipients Due or Overdue for CDRs in FY 1996, by Medical Improvement Classification, in Percentages

	Adults			
	MIE	MIP[b]	MINE	Total
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

Children[a]				Total			
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

(continued)

	Adults			
	MIE	MIP[b]	MINE	Total
Musculoskeletal disorders	5	7	2	5
Congenital anomalies	0	0	1	0
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	174,194	688,570		862,764[c]
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

Children[a]				Total			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
2	1	1	1	4	5	2	4
5	4	8	5	2	2	1	2
1	1	1	1	3	2	2	2
19	5	6	8	8	2	1	2
1	1	16	2	4	8	40	15
d	d	d	d				
d	d	d	d				
d	d	d	d				
d	d	d	d				
d	d	d	d				
d	d	d	d				
d	d	d	d				
d	d	d	d				
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

(continued)

	Adults			
	MIE	MIP[b]	MINE	Total
Male	45	43	46	44
Race				
Black	27	30	25	28
White	47	45	52	47
Other	13	11	9	11
Not identified	13	14	14	14

Children[a]				Total			
MIE	MIP	MINE	Total	MIE	MIP	MINE	Total
62	64	59	63	51	49	48	49
28	37	27	34	27	32	25	29
33	35	47	36	42	42	51	44
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. For the percentages in each column, the second row contains the largest sampling error at the 95-percent confidence level. Because of rounding during the estimation process, row entries may not sum to row totals.

[a]Includes 18-year-olds.

[b]We classified 236 of the sample records for adult recipients as MIPs because a MIE or MIP classification was not specified.

[c]The total number with an estimated likelihood of benefit termination is less than the total number for the column because SSA provided estimates of the likelihood of benefit termination only for MIEs and MIPs aged 59 and under. This includes recipients 1 year older than the current cutoff SSA uses when selecting recipients for CDRs. SSA currently limits its CDR selection to recipients under age 59. Furthermore, SSA does not estimate the likelihood of benefit termination for children or MINEs.

[d]SSA does not estimate the likelihood of benefit termination for children.

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

Table II.4: Characteristics of Selected SSI Adults Due or Overdue for CDRs in FY 1996, by Estimated Likelihood of Benefit Termination, in Percentages

	Under 5%	5-24%	25-49%	50-74%	75% and over	Total estimated CDR population	Largest sampling error in row at the 95-percent confidence level
Total	646,623	188,067	25,320	2,427	327	862,764	
Age in years							
18-21	97	1	2	0	0	50,860	0.4
22-29	73	17	10	1	0	132,907	0.6
30-39	60	35	4	0	0	210,314	0.5
40-49	68	31	1	0	0	251,008	0.5
50-59	94	6	0	0	0	217,568	0.3
Not identified	94	6	0	0	0	107	11.9
Average age (mean)	42	39	30	29	36	41	
Average age (median)	43	40	29	28	33	41	

(continued)

	Under 5%	5-24%	25-49%	50-74%	75% and over	Total estimated CDR population	Largest sampling error in row at the 95-percent confidence level
Diagnostic group							
Infectious and parasitic diseases	62	31	6	1	0	9,500	3
Neoplasms	34	52	13	1	0	9,560	3
Endocrine, nutritional, and metabolic diseases	78	19	3	0	0	54,974	1
Disorders of blood and blood-forming organs	43	29	21	7	0	4,287	4
Mental disorders, excluding mental retardation	80	18	2	0	0	396,135	0
Mental retardation	97	2	0	0	0	150,381	0
Neurological and sensory disorders	66	34	1	0	0	35,440	1
Circulatory disorders	85	14	0	0	0	23,067	1
Respiratory disorders	67	31	2	0	0	10,420	2
Digestive disorders	29	68	4	0	0	7,173	3
Genitourinary disorders	43	46	9	2	0	3,407	4
Skin and subcutaneous tissue disorders	30	46	19	5	0	1,647	6
Musculoskeletal disorders	60	36	3	0	0	46,247	1
Congenital anomalies	56	27	12	4	0	2,980	5
Injuries	38	51	10	0	0	20,347	2
Other	52	35	11	1	1	2,627	5
Not identified	43	47	8	1	0	84,574	1
Medical improvement classification							
MIE	70	26	4	0	0	174,194	1
MIP	76	21	3	0	0	688,570	0
Number of years receiving benefits							
Under 4	66	29	4	0	0	117,747	0.7
4-5	73	24	3	0	0	270,948	0.4
6-7	76	21	3	0	0	181,527	0.5
8-9	76	20	4	1	0	114,561	0.6

(continued)

	Under 5%	5-24%	25-49%	50-74%	75% and over	Total estimated CDR population	Largest sampling error in row at the 95-percent confidence level
10 and over	81	16	2	0	0	177,881	0.5
Average years (mean)	8	7	7	7	13	7	
Average years (median)	7	6	6	7	12	6	
CDR maturity							
Due in FY 1996	73	23	3	0	0	165,647	0.6
Due 1 year ago	73	24	3	0	0	165,954	0.6
Due 2 years ago	75	22	3	0	0	140,614	0.6
Due 3 years ago	76	21	2	0	0	98,540	0.7
Due 4 years ago	80	18	2	0	0	88,540	0.7
Due 5-10 years ago	77	19	3	0	0	160,987	0.5
Due over 10 years ago	78	19	2	0	0	20,313	1.5
Not identified	60	35	5	1	0	22,167	1.7
Average years (mean)	3	3	3	3	5	3	
Average years (median)	3	2	2	2	6	2	
Gender							
Female	76	21	3	0	0	476,482	0.3
Male	74	23	3	0	0	386,135	0.4
Not identified	91	5	5	0	0	147	12.0
Race							
Black	75	22	3	0	0	254,748	0.4
White	74	22	3	0	0	394,255	0.4
Other	74	23	3	0	0	97,900	0.7
Not identified	78	20	2	0	0	115,861	0.6

Notes: Estimates are based on a 15-percent sample. For the percentages in each row, the last column contains the largest sampling error at the 95-percent confidence level. Because of rounding during the estimation process, row entries may not sum to row totals.

Data in this table include recipients 1 year older than the current cutoff SSA uses when selecting recipients for CDRs because SSA provided estimates of the likelihood of benefit termination for MIEs and MIPs aged 59 and under. SSA currently limits its CDR selection to recipients under 59. 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.

SSA Plans for CDR Process Improvements

SSA plans to expand and enhance its procedures for selecting SSI recipients and DI beneficiaries for CDRs and conducting the reviews. More specifically, SSA plans to (1) expand the use of formulas for estimating the likelihood of benefit termination to children and certain recipients classified as MINE and (2) obtain medical treatment information about recipients and integrate the data into the process for selecting recipients for CDRs.

SSA plans to expand the use of statistical formulas for estimating the likelihood of benefit termination to children and a portion of both the SSI recipients and DI beneficiaries classified as MINE. To develop the formulas to estimate the likelihood of benefit terminations for child SSI recipients, SSA plans to conduct reviews of children by selecting cases from across the range of impairments. According to SSA, this process expansion is not expected to begin until about fiscal year 1998 because of new legislation eliminating the individualized functional assessment (IFA) component of disability eligibility criteria for child recipients. An SSA official explained that the agency is close to validating the use of the formulas for MINEs and plans to begin conducting CDRs on this group in fiscal year 1997. Included in this process expansion will be MINEs who are classified as such because they are older rather than because of their impairment. SSA believes that these age-classified MINEs may be cost-effective to review because some of them may have improved medically to the extent that they are no longer disabled. At this time, SSA does not have any plans to include the MINEs who are classified as such because they are believed to have permanent disabilities.

SSA also plans to pursue two approaches for the collection of medical treatment information about recipients. First, SSA has plans to develop a new type of low-cost mailer CDR to be sent to recipients' physicians and other treating sources. At this time, SSA only selects individuals for CDRs from among the groups with the highest and lowest estimated likelihood of benefit termination for full medical and mailer CDRs, respectively. SSA officials explained that they do not conduct CDRs on SSI recipients or DI beneficiaries with likelihood of benefit termination estimates in the middle range because they believe the formulas do not adequately distinguish between these individuals for purposes of determining who in this group should receive full medical CDRs. 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 would be cost-effective. 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. SSA believes the new mailer CDR to physicians and other treating sources would provide information about medical conditions and treatments received that would help SSA to determine who in the middle group has a likelihood of benefit termination warranting a full medical CDR.

Second, SSA plans to obtain 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 also allow it to better identify the appropriateness of a mailer or full medical CDR for recipients with estimates of the likelihood of benefit termination in the middle range. Given that the majority of SSI recipients and DI beneficiaries for whom likelihood of benefit termination is estimated fall into the middle range of estimates, these CDR process enhancements are particularly critical to SSA's ability to meet its CDR goals over the next 7 years.

Federal and State Savings Resulting From SSI CDRs

Our calculations of present value savings are based on estimates provided by SSA and the Health Care Financing Administration and assumptions provided by the Congressional Budget Office on offsetting Food Stamp and AFDC costs. For SSI CDRs, savings result from SSI and Medicaid benefits being terminated for recipients who no longer meet the program's definition of disability. Table IV.1 contains the present value of federal savings per CDR termination. As the table indicates, the present value of savings to the federal government per CDR termination is, for adults, $42,000 and for children, $33,000. This means, for example, that for every adult for whom a CDR results in a termination, the federal government could expect to save, on average, $42,000 (in constant 1996 dollars) that it would have paid over the recipient's lifetime had benefits not been terminated.

The savings for children are less than those for adults, primarily because, even after being terminated from the SSI program, a majority of children would continue to qualify for Medicaid benefits on the basis of their families' economic status or their participation in AFDC. As the table shows, these estimates also take into account offsetting costs resulting from increases in AFDC and Food Stamp benefits that some former SSI recipients would receive once they no longer qualified for SSI.

Table IV.1: Present Value of Federal Savings From SSI CDRs

Program	Adults	Children
Savings		
SSI	$31,500	$33,000
Medicaid	16,000	7,000
Total	47,500	40,000
Offsets		
Food Stamp	5,500	6,000
AFDC	[a]	1,000
Total	5,500	7,000
Net savings	**$42,000**	**$33,000**

[a]Not applicable.

Sources: SSA's Office of the Actuary, Health Care Financing Administration's Office of the Actuary, and Congressional Budget Office's Human Resources Cost Estimate Unit.

Because many states pay SSI state supplements and all states share in Medicaid, SSI CDRs also result in states realizing SSI and Medicaid savings.[19]

[19]In 1995, over 2 million disabled individuals received state SSI supplements.

Because benefit levels vary across states, the present value of savings also varies. Table IV.2 shows, for the five states with the largest total state supplement payments in fiscal year 1994, a range of over $10,000 in the present value of SSI supplement savings. States' savings also vary because the size of their recipient populations differ. Table IV.2 shows the wide variation in potential state savings based on (1) the number of disabled individuals currently receiving state SSI supplements and due and overdue for CDRs and (2) SSA's current estimates of a 5-percent benefit termination rate. The present value of state Medicaid savings would average about $11,100 for adults and $4,800 for children.

Table IV.2: Present Value of SSI State Supplement Savings and Potential Total Savings in Five States

State	Fiscal year 1994 total supplements paid (in millions)	Present value of SSI state savings per termination	Number of recipients due or overdue for CDRs in March 1996	Present value of potential SSI state savings[a] (in millions)
California	$963.0	$13,100	235,500	$154.5
New York	260.5	5,100	164,000	41.8
Wisconsin	100.3	6,300	51,100	16.1
Massachusetts	74.9	5,800	41,100	12.0
Pennsylvania	71.6	2,800	80,700	11.5

[a]Assumes that CDRs would result in benefit terminations for 5 percent of recipients due or overdue for CDRs.

Sources: SSA's Office of the Actuary and Office of Research, Evaluation, and Statistics.

Comments From the Social Security Administration

SOCIAL SECURITY
Office of the Commissioner

September 27, 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, "Supplemental Security Income: Social Security Administration Taking Steps to Review Recipients' Disability Status" (GAO/HEHS-96-185).

We are pleased that the report notes the Social Security Administration's (SSA) progress in completing required Supplemental Security Income (SSI) continuing disability reviews (CDR). We are on schedule in completing SSI CDRs required by 1994 legislation, and we are currently revising our plans to accommodate 1996 legislation that calls for additional SSI reviews.

To enhance the agency's ability to meet its Social Security disability insurance (SSDI) and SSI CDR challenges, SSA has redesigned and continues to improve its CDR process. We plan to eliminate the backlog of SSDI CDRs within 7 years and conduct the required number of SSI reviews as well. Under the redesigned process, and with the additional funding currently in place, we fully expect to achieve these goals.

Enclosed are our specific comments on the report. In addition, we have already provided technical comments under separate cover. If you have any questions, please call me or have your staff contact Sandy Miller at (410) 965-0372.

Sincerely,

Shirley S. Chater
Commissioner
of Social Security

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION (SSA) ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT, "SUPPLEMENTAL SECURITY INCOME: SOCIAL SECURITY ADMINISTRATION TAKING STEPS TO REVIEW RECIPIENTS' DISABILITY STATUS (GAO/HEHS-96-185)

We appreciate the opportunity to comment on this General Accounting Office (GAO) draft report, a companion to two earlier GAO draft reports "Social Security Disability: Improvements Needed to Continuing Disability Review Process" (GAO/HEHS-96-186), and "Social Security Disability: Alternative Approaches Would Increase Cost Effectiveness of Continuing Disability Reviews" (GAO/HEHS-96-202). The earlier reports focused on the SSA's disability program's continuing disability review (CDR) process under title II of the Social Security Act, whereas this report is directed to Supplemental Security Income (SSI) program CDRs. These reports provide valuable information that will be helpful to the agency in achieving its CDR goals.

Prior to recent legislation, scheduling CDRs for SSI recipients was not required by statute. However, the Social Security Independence and Program Improvements Act of 1994 sets requirements for SSA's review of the disability status of SSI recipients. In addition, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires SSA to conduct CDRs within the first year of life on all low birth weight babies receiving SSI benefits and at least once every three years on all other SSI recipients under age 18 for whom medical improvement is likely.

We are pleased that the report makes significant note of SSA's progress in completing required SSI CDR reviews on schedule for fiscal year 1996. As stated in the report, SSA is on schedule in completing SSI CDRs required by the 1994 legislation and is currently revising its SSI CDR plans to accommodate the 1996 legislation.

To enhance the agency's ability to meet its Social Security disability insurance (SSDI) and SSI CDR challenges, SSA has redesigned and continues to improve its CDR process. As we stated in our comments to the earlier reports, we believe that the agency's strategy for developing this process is sound and will achieve the desired result of reliable, cost-effective monitoring of all disabled beneficiaries on the SSDI and SSI rolls. A detailed description of our CDR strategy was included in our comments to the earlier reports.

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:

- Separate accounting controls have been established to ensure that administrative dollars allocated for the processing of CDRs are not redirected to other workloads;
- 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;
- Automated optical scanning and electronic evaluation of CDR mailers have been implemented; and
- Procedures for expanding and enhancing CDR selection continue to be refined; e.g., integrating Medicare and Medicaid data into the statistical formulas.

While the report makes no recommendations, it refers to recommendations on the overall CDR process that were made in the earlier reports. Recommended actions included using a three-pronged approach to replace routine CDR scheduling of all who receive DI and SSI benefits to achieve greater cost-effectiveness and utilizing CDR contacts to assess recipients' potential for, and to promote, vocational rehabilitation (VR) services. The current report also endorses better coordinating of CDRs with financial eligibility reviews for more efficient use of CDR resources.

We agreed that SSA should continually seek ways to maintain stewardship of the disability program in the most cost-effective manner. To that end, SSA will begin to consider which legislative changes, if any, will produce such a result. Under current statutory requirements, however, we believe, as stated above, that the agency's redesigned CDR strategy will result in reliable, cost-effective monitoring of all disabled beneficiaries on the SSDI and SSI rolls.

We also agreed that CDR contacts are a good opportunity for approaching beneficiaries about the availability and advantages of rehabilitation and return-to-work services, and we concur that a test of this idea should be performed. Our CDR mailer provides beneficiaries the opportunity to indicate an interest in VR services, and each full medical review is screened for possible referral for VR services. SSA recognizes the need to better identify beneficiaries with rehabilitation potential, and we continue to work to develop viable policy options for

achieving this. We would plan to test your recommended approach as a component of this overall effort. We also agree that coordinating CDRs with financial eligibility reviews is an efficient use of resources, and we continue to explore options for improving this process.

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: Chris C. Crissman, Assistant Director; Kerry Gail Dunn, Senior Evaluator; Julian M. Fogle, Senior Evaluator; Ann Lee, Senior Evaluator; Elizabeth A. Olivarez, Evaluator; Susan K. Riggio, Evaluator; and Ann T. Walker, Evaluator (Database Manager).

Related GAO Products

Social Security Disability: Alternatives Would Boost Cost-Effectiveness of Continuing Disability Reviews (GAO/HEHS-97-2, Oct. 16, 1996).

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

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

Supplemental Security Income: Disability Program Vulnerable to 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/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).

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).

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