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SOCIAL SECURITY:
Reforms in the Disability
Determination and Appeals Process

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

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

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SUMMARY

Evidence from the Social Security Administration's (SSA's) quality assurance reviews show a decline over the last few years in the quality of state disability decisions, particularly those decisions to deny benefits. Such a decline has accompanied significant increases in workload for the state disability determination services (DDSs). These factors may also have contributed to an increase in the number of benefit awards made on appeal.

The success (or allowance) rate for those claimants that appeal to administrative law judges (ALJs) has risen in the last several years to about 63 percent. This high rate naturally raises questions about the accuracy of the earlier decisions, and calls for explanations of why ALJs allow so many of the claimants who were denied earlier.

While many factors have been found to contribute to the high ALJ allowance rate, a significant factor and a difference between the ALJ decision process and that of the DDSs is the face-to-face appearance of the claimant. At hearings, ALJs ask claimants questions about their work history, current activities, and perception of impairments. We believe that conducting face-to-face interviews of some claimants at the initial or reconsideration (first of several appeal levels) stage could improve DDS determinations.

A broad structural change to offer all or most claimants a face-to-face meeting with adjudicators at the initial decision level may be quite costly. We question whether face-to-face meetings are desirable for those cases where an allowance decision is likely based on a file review. Limiting such meetings, for example, to those cases where a denial decision is likely or to resolve differences in medical conclusions, would appear to save substantial administrative costs.

H.R. 1799 provides for the elimination of the reconsideration level of appeal. If this bill is enacted, and the necessary resources are provided, social security claimants would receive more timely decisions on appeal. However, in our view, there are a number of unanswered questions about: (1) the resulting appeal rates of denied disability claimants, and the related impact on ALJ workloads; and (2) the costs to SSA and related resource implications for the state DDSs.

The elimination of reconsideration will likely increase the workload for ALJs. As many as 180,000 additional cases could be expected to go to ALJs each year, which would add between $100 and $200 million in new administrative costs per year. Some of the additional cost due to increased ALJ workloads could be offset by savings from eliminating the earlier case reviews at the reconsideration level, many of which are reviewed again by ALJs.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss efforts to improve the initial decision making on social security disability claims, and to explore reasons why many claims are only allowed after hearings by administrative law judges (ALJs). Specifically, my remarks will address concerns we have about disability case processing accuracy and timeliness, and the impact budget constraints placed on the state disability determination services (DDSs) in recent years may have had on these measures. I will also discuss concerns we have about the DDSs' inability to meet all disability workload needs including continuing disability reviews (CDRs)[1].

Also, I will comment on two key provisions of H.R. 1799, the Disability Appeals Process Reform Act of 1991. These two provisions, providing for face-to-face interviews at the initial decision level and the elimination of reconsideration[2] as a level of appeal, are designed to improve decision making and to streamline the appeals process.

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[1]CDRs are done to assess whether individuals on the disability rolls have medically improved enough to work. A provision in the Social Security Disability Amendments of 1980 requires SSA to review, at least every 3 years, beneficiaries whose conditions are not considered permanent.

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

The Social Security Administration's (SSA's) quality assurance (QA) reviews show a decline over the last few years in the quality or accuracy of state disability decisions, particularly those decisions to deny benefits. Such a decline has accompanied significant increases in workload and production for the DDSs.

The increases in errors reported by SSA's QA program appear to support concerns raised by some DDS administrators over the last few years about the impact of resource reductions on their case development. These factors may also have contributed to an increase in the number of benefit awards made on appeal. ALJs are allowing[3] about 63 percent of the claims that are appealed to them. This has grown steadily from about 50 percent during 1985 and 1986.

INDICATIONS OF DETERIORATING QUALITY OF INITIAL DECISIONS

There has been a marked decline in quality beginning in 1987. Those claimants who are initially denied benefits appear to be affected the most. The QA error rate of DDS initial allowance decisions went from 2.4 percent for fiscal year 1986 to 3.1 percent for fiscal year 1989; then it improved slightly to 2.9

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[3]Often the rate of allowances by ALJs is referred to as a "reversal" rate. SSA, however, prefers to call this an allowance rate because often the situation in a given disability claim has changed since the initial decision.

percent for fiscal year 1990. The error rate of DDS denial decisions increased more dramatically, from 4.3 to 7.0 percent during the same period. About two-thirds of the recorded errors were for documentation deficiencies.

Beginning in 1987, we cautioned against placing budget constraints on the disability program. We reported[4] to this subcommittee then that budget cuts had resulted in DDSs doing less than the required number of CDRs, and that this was not cost effective. We also noted that while the 1984 disability amendments called for more extensive case development, the increasing pressures of doing more cases with fewer examiner and physician staff could lead examiners to take shortcuts, which could adversely affect the quality of decisions.

From 1986 to 1990, there has been a 10-percent increase in disability cases processed, with a 16-percent decrease in staff-years at the DDSs. Pending caseloads (for initial decisions) at the DDSs are growing, resulting in longer processing times for decisions. Initial cases pending at the DDSs have increased 37 percent from March 1990 to March 1991. The situation is not expected to get better. SSA's budget justifications project that by the end of fiscal year 1992, 703,000 initial claims (about 20 weeks of work) may be pending in the DDSs, an increase of more

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

than 80 percent from the 384,900 claims pending at the end of fiscal year 1990.

Many claimants denied at the initial level have to wait until they present their case before an ALJ to be allowed benefits. As noted earlier, the success (or allowance) rate for those claimants that appeal to this level is about 63 percent. This high rate raises questions about the accuracy of the earlier decisions, and calls for explanations of why ALJs allow so many of the claimants who were denied earlier.

ALJ DECISIONS AIDED BY FACE-TO-FACE CONTACT

ALJs have historically had high allowance rates. Concerns over the high rates have led to several studies[5] of the ALJ process. While many factors have been found to contribute to the high ALJ allowance rate, a significant factor and a difference between the ALJ decision process and that of the DDSs is the face-to-face appearance of the claimant. At hearings, ALJs ask claimants

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[5]One such study was done by SSA in 1981. The study (referred to as the Bellmon Study) of 3,600 ALJ decisions sought to determine, among other factors, the effect of face-to-face interviews of claimants at hearings. The study concluded that the in-person appearances of the claimants contributed significantly to the high allowance rates. Other identified factors were (1) distinct differences in the adjudicatory standards and procedures followed by ALJs and DDSs, and (2) the introduction of new evidence (often identifying that medical conditions had worsened) following the DDS decisions.

questions about their work history, current activities, and perception of impairments, and generally form an opinion about a claimant's credibility. An ALJ may also use a medical advisor to render an opinion on the severity of the claimant's impairment and its impact on the claimant's capacity for work-related activities. Medical advisors observe claimants at hearings and review medical evidence.

Another reason for the high ALJ allowance rate is that DDSs and ALJs tend to conclude differently about what work-related functions claimants are able to do on a sustained basis, despite their impairments. This "residual functional capacity" (or RFC)[6] is a key element in the determination of disability. Our previous work found these assessments to be the major area of disagreement between the DDS adjudicators and the ALJs. In a report[7] we issued to this subcommittee 2 years ago, we found that disagreement over RFC was the principal cause for high allowance rates by ALJs for claimants aged 55 to 59 with back disorders, heart conditions, lung disease, diabetes, or anxiety. For example, of cases involving claimants with back disorders aged 55 to 59 who had been awarded benefits by ALJs, RFC was the basis for ALJ allowances in 86 percent.

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[6]See Appendix I for a definition of RFC, and a brief description of its applications.

[7]Social Security: Selective Face-to-Face Interviews with Disability Claimants Could Reduce Appeals (GAO/HRD-89-22, April, 1989)

DDS assessments of claimants' RFCs were often much higher than those of ALJs. For example, in reviewing the RFCs in a sample of 242 cases where ALJs had awarded benefits following DDS denials, we found that while DDSs had determined that 54 percent of the claimants could do medium or heavy work, the ALJs determined that less than 1 percent could do such work. Similarly, while ALJs determined that 71 percent of the claimants could do only sedentary work or less, the DDSs concluded that only 1 percent of them were so limited.

In making RFC determinations, ALJs generally seek more information from treating physicians or consulting medical examiners[8] on claimants' abilities to perform basic work activities than do the DDS adjudicators. The DDS staff, without observing the claimants, tend to rely more on their own judgments of the functional limitations of the claimants' impairments.

We support efforts to better involve treating or consulting physicians in the determinations of claimants' RFC. Physicians who have observed and examined claimants should be in a better

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

position to provide medical assessments of claimants' functional limitations (such as the capabilities to walk, lift, etc.).

SELECTIVE FACE-TO-FACE INTERVIEWS APPEAR DESIRABLE

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

A larger scale application of face-to-face interviews at the DDS level may have merit. We are awaiting, as I am sure this subcommittee is, for the final results of SSA's experiments with such interviews during its Personal Appearance Demonstration (PAD) project[9]. The HHS Office of Inspector General (OIG) issued an interim report on its initial evaluation on January 18, 1990. Early results indicate that claimants and disability examiners

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[9]The Social Security Benefits Reform Act of 1984 required the conduct of demonstration projects in which claimants were offered the opportunity for a personal meeting with the decision maker prior to an unfavorable disability determination. The demonstrations were conducted in 10 states between March, 1986 and January, 1988.

thought the personal interviews improved the decision process and the claimants' understanding of the process. Apparently, however, the interviews did not discourage denied claimants from further appeals. The OIG reported that 68 percent of the claimants who were denied benefits after their interview said they planned to appeal the decision.

Offering all or most claimants a face-to-face meeting with adjudicators at the initial decision level may be quite costly. The OIG reported that DDS examiners spent up to 8 hours more per case under PAD than under the current process. In addition to increased costs, DDS management suggested to the OIG that full implementation would require major changes in the operation and orientation of the DDSs, and present problems with respect to staffing and arranging for the interviews.

H.R. 1799 provides for all claimants to be offered an opportunity for a face-to-face interview at the initial decision level. We question whether face-to-face meetings are necessary for those cases where an allowance decision is likely based on a file review. Limiting such meetings, for example, to those cases where a denial decision is likely, would appear to save substantial administrative costs. Another option is for DDSs to offer personal interviews to claimants when the DDS examiners (including physicians) know that their conclusions about the severity of the claimant's medical problems are in contradiction

to those of treating sources. This would appear to offer a timely opportunity to better resolve a known conflict, and possibly save the claimant from having to appeal to an ALJ. The DDSs, perhaps, should also be given the flexibility to offer such in-person contact in any case where the staff believe it would significantly aid decision making.

RECENT EFFORTS BY SSA TO IMPROVE INITIAL DECISIONS

SSA recognizes the possible benefits of earlier face-to-face contact. This and other process changes are being examined by the Office of Disability at the request last year of the Commissioner. From the internal memorandums and discussion papers we have seen, it appears that the Commissioner is committed to improving the disability adjudication process, with particular emphasis on improving initial decisions.

We are not aware of any recent decisions to experiment with or implement specific changes to the current process. However, we can report that a group of DDS administrators and SSA staff was recently tasked with identifying ways to improve the process and that they have developed a number of options to pursue. These options include using state disability examiners or federal disability specialists rather than district office claims representatives to handle initial claims intake. Unlike current

claims representatives, federal disability specialists would be specially trained in disability adjudication similar to DDS examiners. Other options include various means of providing face-to-face interviews at the initial decision level.

STREAMLINING APPEALS THROUGH ELIMINATION OF RECONSIDERATION

The current process takes too long for claimants who appeal state decisions, and we support efforts to shorten this time. H.R. 1799 provides for the elimination of the reconsideration stage of appeal. If this bill is enacted, and the necessary resources are provided, social security claimants would receive more timely decisions on appeal.

However, in our view, there are a number of unanswered questions about: (1) the resulting appeal rates of denied disability claimants, and the related impact on ALJ workloads; and (2) the costs to SSA and related resource implications for the state DDSs.

The elimination of reconsideration will likely increase the workload for ALJs. We estimate that as many as 180,000 additional cases could be expected to go to ALJs each year, which would add between $100 and $200 million in new administrative costs. Some of the additional cost due to increased ALJ

workloads could be offset by savings from eliminating the earlier case reviews at the reconsideration level, many of which are reviewed again by ALJs. However, estimating these savings is difficult.

BUDGET CONSTRAINTS LIMITING CDR WORKLOADS

We testified before this subcommittee on October 6, 1987, regarding the effects of budget constraints on SSA's disability programs. We pointed out that because of reductions in DDS staffing, SSA limited the numbers of CDRs it expected DDSs to process.

Many CDRs are still not being done, and a backlog is growing. As a result, savings to the Disability Insurance Trust Fund are being lost because thousands of beneficiaries are being unjustifiably continued in payment status.

Generally, there are three types of disability workloads processed by DDSs--initial applications for benefits, requests for reconsideration reviews, and CDRs. Initial applications and reconsiderations are considered priority and "nondiscretionary." SSA considers CDRs "discretionary", although they are legally mandated to be done.

The DDSs were only able to process 195,000 CDRs in fiscal year 1990, of which about 59,000 were medical improvement expected[10] cases. Current DDS activity reports show only about 22,000 CDRs completed (6,000 were medical improvement expected cases) during the first 6 months of this fiscal year.

Recent SSA data suggest that there are over 350,000 medical improvement expected cases for which scheduled review dates are past due. Also, new cases "come due" with scheduled review dates at the rate of about 21,000 a month, or 250,000 a year. These workload estimates do not include other types of CDRs also legally mandated to be done.

These cases should be reviewed. Termination rates for medical improvement expected cases have been about 10 to 12 percent in recent years. Recent projections from SSA's Office of the Actuary show a return of about $4.00 for every $1.00 spent reviewing medical improvement expected CDR cases. Also, using SSA data, we estimate a loss to the Trust Fund of about $4 to $5

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[10]Medical improvement expected cases are those cases for which DDSs schedule a review date at the time of initial award, based on an expectation that the beneficiaries' impairment(s) may improve. The review is scheduled to see if, in fact, the beneficiary has medically improved sufficiently to be able to work. Reviews of these cases generally produce a higher rate of termination than other categories of CDRs.

million per year in unnecessary benefit payments for every 10,000 medical improvement expected cases not reviewed.[11]

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

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[11]In 1987, we estimated losses to the Trust Fund to be about $8 to $9 million per year in unnecessary benefit payments for every 10,000 medical improvement expected cases that were not reviewed. We based this calculation on projections from SSA's Office of the Actuary, which assumed at that time a cessation (or termination) rate of 20 percent. The SSA projections also allowed for reversals of some cessation decisions following appeals. As noted above, DDSs have only achieved cessation rates of around 10 to 12 percent in recent years for these types of cases.

RESIDUAL FUNCTIONAL CAPACITY DETERMINATIONS

Social security regulations define "residual functional capacity" (RFC) as a medical assessment of what work activity a person can do despite his or her functional limitations. RFC assessments occur when adjudicators determine that claimants cannot be awarded benefits on medical considerations alone.[12] In such cases, and before considering vocational factors, adjudicators working with state agency physicians decide what capacity for work claimants have.

In assessing the RFC for individuals with physical limitations, an adjudicator[13] is to consider the claimant's ability to do physical activities, such as walking, standing, lifting, and carrying. For example, an RFC for medium work means that the person can do work that involves lifting no more than 50 pounds at a time with frequent lifting or carrying objects weighing up

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

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

to 25 pounds. Similarly, an RFC for heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of 50 pounds.