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Report to the Chairman, Committee on Finance, U.S. Senate

October 2006

SOCIAL SECURITY DISABILITY PROGRAMS

Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently

GAO-07-8

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-07-8, a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

The Social Security Act requires that the Social Security Administration (SSA) find an improvement in a beneficiary's medical condition in order to remove him or her from either the Disability Insurance (DI) or Supplemental Security Income (SSI) programs. GAO was asked to (1) examine the proportion of beneficiaries who have improved medically and (2) determine if factors associated with the standard pose challenges for SSA when determining whether beneficiaries continue to be eligible for benefits. To answer these questions, GAO surveyed all 55 Disability Determination Services (DDS) directors, interviewed SSA officials, and reviewed pertinent SSA data.

What GAO Recommends

GAO is making a recommendation to SSA to clarify guidance regarding the degree of medical improvement required to meet the standard, the use of exceptions, and the presumption of disability for assessing medical improvement when conducting CDRs.

While generally agreeing with the value of additional guidance, SSA expressed reservations about the need for further guidance on the exceptions. GAO continues to see such a need since 7 of the 11 disability examiners we spoke with were uncertain regarding when to apply the exceptions.

www.gao.gov/cgi-bin/getrpt?GAO-07-8.

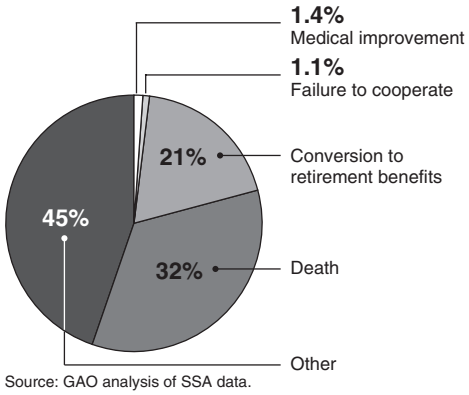
To view the full product, click on the link above. To view results of GAO's survey of DDS directors, click: www.gao.gov/cgi-bin/getrpt?rptno=GAO-07-4sp. For more information, contact Robert E. Robertson (202) 512-7215 or robertsonr@gao.gov.

What GAO Found

Each year, about 13,800 beneficiaries, or 1.4 percent of all the people who left the disability programs between fiscal years 1999 and 2005, did so because SSA found that they had improved medically. More beneficiaries leave because they convert to regular retirement benefits, die, or for other reasons—including having earnings above program limits. In addition, while continuing disability reviews (CDR) are SSA's most comprehensive tool for determining whether a recipient continues to have a disability, on average, 2.8 percent of beneficiaries were found to have improved medically and to be able to work following a CDR during this 7-year period.

Several factors associated with the medical improvement standard (the standard) pose challenges for SSA when assessing whether beneficiaries continue to be eligible for benefits. First, limitations in SSA guidance may result in inconsistent application of the standard. For example, SSA does not clearly define the degree of improvement needed to meet the standard, and the DDS directors GAO surveyed reported that they use different thresholds to assess if medical improvement has occurred. Second, contrary to existing policy, disability examiners in a majority of the DDSs are incorrectly conducting CDRs with the presumption that a beneficiary has a disability rather than with a "neutral" perspective. Other challenges associated with the standard include inadequate documentation of evidence as well as the judgmental nature of medical improvement determinations. All these factors have implications for the consistency of CDR decisions. However, due to data limitations, GAO was unable to determine the extent to which these problems affect decisions to continue or discontinue benefits.

Average Percentage of All Beneficiaries Who Were Removed from the DI and SSI Programs by Category (Fiscal Years 1999 to 2005)



Source: GAO analysis of SSA data.

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Abbreviations

ALJ	administrative law judge
DDS	Disability Determination Services
DI	Disability Insurance
CDR	Continuing Disability Review
CPD	comparison point decision
POMS	Program Operations Manual System
RFC	residual functional capacity
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

October 3, 2006

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

In fiscal year 2005, the Social Security Administration (SSA) paid about $126 billion to approximately 12.8 million beneficiaries under the Disability Insurance (DI) and Supplemental Security Income (SSI) programs. These disability programs provide income support and in most cases, access to medical care for people unable to work due to physical or mental impairments, or both. In recent years, both programs have grown and are poised to grow even faster as the baby boom generation enters its disability-prone years. For example, SSA expects that by 2010 the number of DI beneficiaries and their eligible family members will increase by more than one-third over 2001 levels.

SSA is required to conduct periodic continuing disability reviews (CDR) to ensure that only eligible people continue to receive benefits. These reviews assess whether individuals are still eligible for benefits based on their current medical condition and ability to work, among other criteria.[1] When SSA was conducting these reviews in the early 1980s, there were concerns that some beneficiaries were being arbitrarily removed from the programs. In response, Congress passed the Social Security Disability Benefits Reform Act of 1984[2] (the act), which among other things established a medical improvement standard (the standard). Under this standard, unless certain exceptions apply, SSA must find improvement in a beneficiary's medical condition and that the individual is able to work in order to discontinue benefits.[3] If SSA determines that the standard has

[1] In addition to medical CDRs, SSA also conducts "work CDRs" where it assesses if an individual's earnings exceeded program limits. Our analysis only looked at medical CDRs. It did not include work CDRs.

[2] Pub. L. No. 98-460 (1984).

[3] For this report, we refer to "medical improvement" and individuals who have "improved medically" as a finding that meets the requirements of the medical improvement standard (improvement in a beneficiary's medical condition that is related to the ability to work).

been met in the course of conducting a CDR, the beneficiary may continue to receive benefits until the individual receives another CDR (which potentially could result in a discontinuation of benefits), dies, or transitions into Social Security retirement benefits.

Since the standard has been implemented, some observers have suggested that certain factors associated with the standard may lead SSA to continue benefits for some individuals who might otherwise be able to work. Given this observation and the continued growth in the DI and SSI programs, the Senate Committee on Finance asked us to (1) examine the proportion of beneficiaries who are removed from the disability programs because they have improved medically and (2) determine if factors associated with the standard pose challenges when determining whether beneficiaries continue to be eligible for benefits.

To address these questions, we reviewed the act, regulations, and SSA guidance and processes for evaluating whether beneficiaries continue to be eligible for benefits. We examined SSA data on CDR outcomes for a 7-year period (fiscal years 1999 to 2005). We looked only at DI and SSI adult beneficiaries.[4] We verified the statistical data on CDR outcomes, interviewed knowledgeable officials about the data, and determined that the data were sufficiently reliable for the purposes of our review. Furthermore, we conducted a national survey of all 55 Disability Determination Services (DDS) directors and received 54 completed responses to achieve a response rate of 98 percent. In addition, we interviewed various SSA officials, disability experts, and disability advocacy groups regarding the standard. We also conducted site visits in three states (Massachusetts, Texas, and California). We selected these states based on several criteria, including number of disability beneficiaries, proportion of CDRs that result in a discontinuation of benefits, and geographic dispersion, among other criteria. During these visits, we conducted in-depth interviews with 80 selected SSA officials, including DDS directors, CDR supervisors, disability examiners,[5] and

[4] For the purposes of our study, we only assessed DI and SSI adult beneficiaries who received a full medical CDR. We did not include children or the "age 18 re-determinations" in our analysis since there are differences between the medical CDR sequential evaluation processes for adults and children. Also, we only assessed the outcome of the full medical CDRs.

[5] During our site visits, we met with 11 CDR supervisors and disability examiners who the DDS directors selected as the most knowledgeable in their office about the CDR process and the medical improvement standard.

medical specialists. We also interviewed regional office disability officials, regional Office of Disability Adjudication and Review officials, administrative law judges, and regional Office of Quality Performance officials and examiners. Moreover, we reviewed selected CDR cases to obtain examples of how the standard may impact decisions to continue or discontinue benefits. In addition, we consulted with outside groups including the Social Security Advisory Board and disability advocacy groups. We conducted our work from October 2005 through June 2006 in accordance with generally accepted government auditing standards. Appendix I discusses our scope and methodology in more detail. The survey and a tabulation of the results can be viewed at http://www.gao.gov/cgi-bin/getrpt?rptno=GAO-07-4sp.

Results In Brief

On average, each year about 13,800 beneficiaries, or 1.4 percent of all the people who left the disability programs between fiscal years 1999 and 2005, were removed because SSA found that they had improved medically. More beneficiaries leave the programs because they die or convert to regular retirement benefits. Moreover, while CDRs are the agency's most comprehensive tool for determining whether a recipient continues to have a disability, on average, about 2.8 percent of beneficiaries who undergo a CDR leave the DI and SSI programs due to medical improvement. For example, in fiscal year 2005, SSA conducted about 333,000 medical CDRs and discontinued disability benefits for about 10,300 recipients for medical improvement.

Our review suggests that several factors associated with the standard pose challenges for SSA's ability to assess whether beneficiaries continue to be eligible for benefits. First, limitations in SSA guidance may result in inconsistent application of the standard. For example, we found that SSA does not clearly define the degree of improvement needed to meet the standard, and the directors we surveyed reported using different thresholds to show medical improvement. From our survey, 17 DDS directors reported that a large or very large increase in a recipient's ability to perform basic work activities is required to show medical improvement, while 24 reported that a moderate increase is required. In addition, while the act does provide for certain exceptions to medical improvement that could result in additional individuals having their benefits discontinued following a CDR, most of the disability examiners whom we spoke with on our site visits (7 of the 11 examiners) told us that they were uncertain about when to apply the exceptions. Second, incorrect application of one element of the standard by a majority of DDSs—CDRs should be conducted on a neutral basis, without a presumption that an individual

continues to have a disability—may make it difficult to determine if beneficiaries have improved medically. Finally, we found that other factors, such as inadequate documentation of evidence and the judgmental nature of the decision process concerning what constitutes medical improvement may make it difficult for SSA to determine whether a beneficiary remains eligible for benefits. These problems have implications for the consistency and fairness of SSA's medical improvement decision-making process. However, due to data limitations, we were unable to determine the extent to which these problems actually affect decisions to continue or discontinue benefits.

We are recommending that the Commissioner of Social Security clarify policies for assessing medical improvement. Areas that could benefit from improved clarity in guidance include what degree of improvement is needed to meet the standard, when the use of exceptions is appropriate, as well as clarification for DDSs about presumption of disability when conducting CDRs.

SSA generally agreed with our recommendation but expressed reservations about the need for further guidance on the proper use of the exceptions to medical improvement. SSA believed that its implementation of the statutory exceptions is appropriate and that its instructions are consistent with the intent of the law. We revised the report to more clearly highlight that the need for further guidance stems from our discussions with disability examiners, most of whom expressed uncertainty regarding the application of the exceptions.

Background

The Social Security Administration (SSA) administers two programs under the Social Security Act that provide benefits to people with disabilities: (1) Disability Insurance (DI) and (2) Supplemental Security Income (SSI).[6] Established in 1956, DI is an insurance program that provides benefits to workers who become unable to work because of a long-term disability. Workers who have paid into the Social Security Trust Fund are insured under this program. At the end of calendar year 2005, the DI program served about 8.3 million workers with disabilities, their spouses, and dependent children and paid out about $85 billion in cash benefits throughout the year. Once found entitled, individuals continue to receive

[6] Some disability recipients receive both DI and SSI benefits because of the low level of their income and resources.

benefits until they either die, return to work and earn more than allowed by program rules, are found to have improved medically and are able to work, or reach regular retirement age[7] (when disability benefits convert to retirement benefits).

SSI serves people with disabilities on the basis of need, regardless of whether they have paid into the Social Security Trust Fund. Created in 1972, SSI is an income assistance program that provides cash benefits for disabled, blind, or aged people who have low income and limited resources. At the end of calendar year 2005, the SSI program served about 6.8 million people and paid about $36 billion in federal cash benefits throughout the year.[8] These cash benefits are paid from general tax revenues. SSI benefits generally can be discontinued for the same reasons as DI benefits, although SSI benefits also may be discontinued if a person no longer meets SSI income and resource requirements. Unlike the DI program, SSI benefits can continue even after the person reaches full retirement age.

The Social Security Act's definition of disability for adults is the same under both programs. A person's physical or mental impairment must (1) have lasted or be expected to last at least 1 year or to result in death and (2) prevent or be expected to prevent him or her from being able to engage in substantial gainful activity (SGA) for that period of time. People are generally considered to be engaged in SGA if they earn above a certain dollar level. For 2006, SSA considers countable earnings above $860 a month to be SGA for an individual who is not blind and $1,450 a month for an individual who is blind.

History of the Medical Improvement Standard and the Current Continuing Disability Review Process

Prior to 1980, some studies indicated that many beneficiaries of the disability programs no longer had a disability and could work. To ensure that only eligible beneficiaries remained in the programs, Congress passed a law requiring SSA to conduct continuing disability reviews (CDR) beginning in January 1982. State Disability Determination Services (DDS) examiners began conducting medical CDRs under the same criteria used

[7] Beginning at age 62, workers receiving DI benefits may elect to receive retirement benefits in lieu of disability benefits.

[8] Of these beneficiaries, about 5.7 million were blind or had a disability and received about $31.8 billion in benefits. About 1.1 million beneficiaries did not have a disability, but were aged and received about $4.1 billion in benefits.

to evaluate initial disability claims. In 1981 and 1982, about 45 percent of those individuals who received a CDR had their benefits discontinued.[9] There was no statutory requirement for SSA to show that a beneficiary had improved medically in order to remove him or her from the programs. Disability advocacy groups and others became concerned that some beneficiaries were being inappropriately removed from the disability programs, and by 1984 SSA placed a moratorium on all CDRs.

To address concerns that some beneficiaries were being inappropriately removed from the programs, Congress enacted the Social Security Disability Benefits Reform Act of 1984. The act included a provision requiring SSA to find substantial evidence demonstrating medical improvement before ceasing a recipient's benefits (the medical improvement standard). SSA resumed CDRs in January 1986 using this standard, which is among the first steps of the CDR evaluation process.[10] The standard has the following two elements that need to be met

- **Is there improvement in a beneficiary's medical condition?** The regulations implementing the act define improvement as any decrease in the medical severity of the beneficiary's impairment(s) since the last time SSA reviewed his or her disability, based on changes in symptoms, signs, or laboratory findings.

- **Is this improvement related to the ability to work?** Improvement related to the ability to work is evaluated two different ways, depending on whether the comparison point decision (CPD) was based

[9] SSA officials noted that the discontinuation rate in the early 1980s may not have been representative of the results of the CDR process before the implementation of the medical improvement standard. SSA officials stated that in response to reports that suggested that many individuals who did not have a disability were receiving benefits, an aggressive effort was initiated in 1981 to remove individuals from the DI program whose impairments were not severe enough to entitle them to benefits. The agency reported that this effort focused on beneficiaries who were deemed at the time most likely to be determined not to have a disability and led to a large, temporary increase in the number of DI program discontinuances in the early to mid-1980s.

[10] Before disability examiners assess if a beneficiary has improved medically, they first assess if the beneficiary is working at the level of SGA. If beneficiaries are working at or above the SGA level, then benefits are discontinued. If not, then the CDR process proceeds to the second step.

on: (1) meeting or equaling a prior disability listing[11] or (2) a residual functional capacity (RFC) assessment.[12]

- Meeting or equaling the prior listing: In this case, a disability examiner will determine if the beneficiary's same impairment(s) still meets or equals the prior listing. A disability examiner compares the beneficiary's condition with the list of impairments in effect at the time he or she was first awarded disability benefits.[13] If the impairment(s) meets or equals the prior listing, then benefits are continued. If not, then the examiner proceeds with the CDR evaluation.

- Residual functional capacity assessment: In this case, a disability examiner compares the beneficiary's previous functional capacity to the current functional capacity for the same impairment. If functional capacity for basic work activities has improved, then the examiner finds that the medical improvement is related to the ability to work and proceeds with the CDR evaluation.

The act allows SSA to discontinue benefits even when the beneficiary has not improved medically if one of the specific "exceptions" to medical improvement applies[14]

- the person benefits from advances in medical or vocational therapy or technology,
- the person has undergone a vocational therapy program that could help him or her work,

[11] SSA maintains a list of impairments that, by definition, are so severe that they are disabling.

[12] The assessment of a beneficiary's actual ability to work comes later in the CDR process (steps 7 and 8). See appendix II for a more detailed description of the CDR process.

[13] At this step of the evaluation, a disability examiner considers only the listings that were met (or equaled) the last time the beneficiary was evaluated, not all of the listings that existed at the time of the last review.

[14] In addition to the Group I exceptions listed above, benefits may also be discontinued if a DI beneficiary is engaging in substantial gainful activity. The act also provides for other situations (called Group II exceptions) where SSA can discontinue either DI or SSI benefits. Group II exceptions are: (a) the prior determination or decision was fraudulently obtained, (b) the beneficiary does not cooperate with SSA, (c) SSA is unable to locate the beneficiary, and (d) the beneficiary fails to follow prescribed treatment which would be expected to restore his or her ability to do SGA. For Group II exceptions, SSA discontinues benefits immediately without further development.

- new or improved diagnostic techniques or evaluations reveal that the impairment is less disabling than originally thought, or
- the prior decision was in error.

In order to be removed from the disability programs for one of the exceptions, disability examiners must also show that the individual has the ability to engage in SGA.

SSA does not conduct CDRs on all beneficiaries each year. At the time beneficiaries enter the DI or SSI programs, DDSs determine when they will be due for CDRs based on their likely potential for medical improvement. Based on SSA regulations, DDSs classify beneficiaries into one of three medical improvement categories

- medical improvement expected—CDR generally once every 6 to 18 months;
- medical improvement possible—CDR once every 3 years; or
- medical improvement not expected—CDR once every 5 to 7 years.

SSA has also developed a method, called profiling, to determine the most cost-effective method of conducting a CDR. SSA applies statistical formulas that use data on beneficiary characteristics—such as age, impairment type, length of time on disability programs, previous CDR activity, and reported earnings—to predict the likelihood of medical improvement and, therefore, of benefit discontinuation. SSA assigns a "score" to beneficiaries indicating whether there is a high, medium, or low likelihood of medical improvement. In general, beneficiaries with a high score are referred for full medical CDRs. Beneficiaries with lower scores are, at least initially, sent a questionnaire, known as a "mailer."[15] Full medical CDRs involve an in-depth examination of a beneficiary's medical and possibly his or her vocational status. This may include a review of the recipient's case file, physical and psychological condition, and medical evidence by a disability examiner and physician. Unlike full medical CDRs, CDR mailers consist of a short list of questions asking beneficiaries to self-report information on their medical condition, treatments, and work activities. Appendix II describes the medical CDR evaluation process in detail.

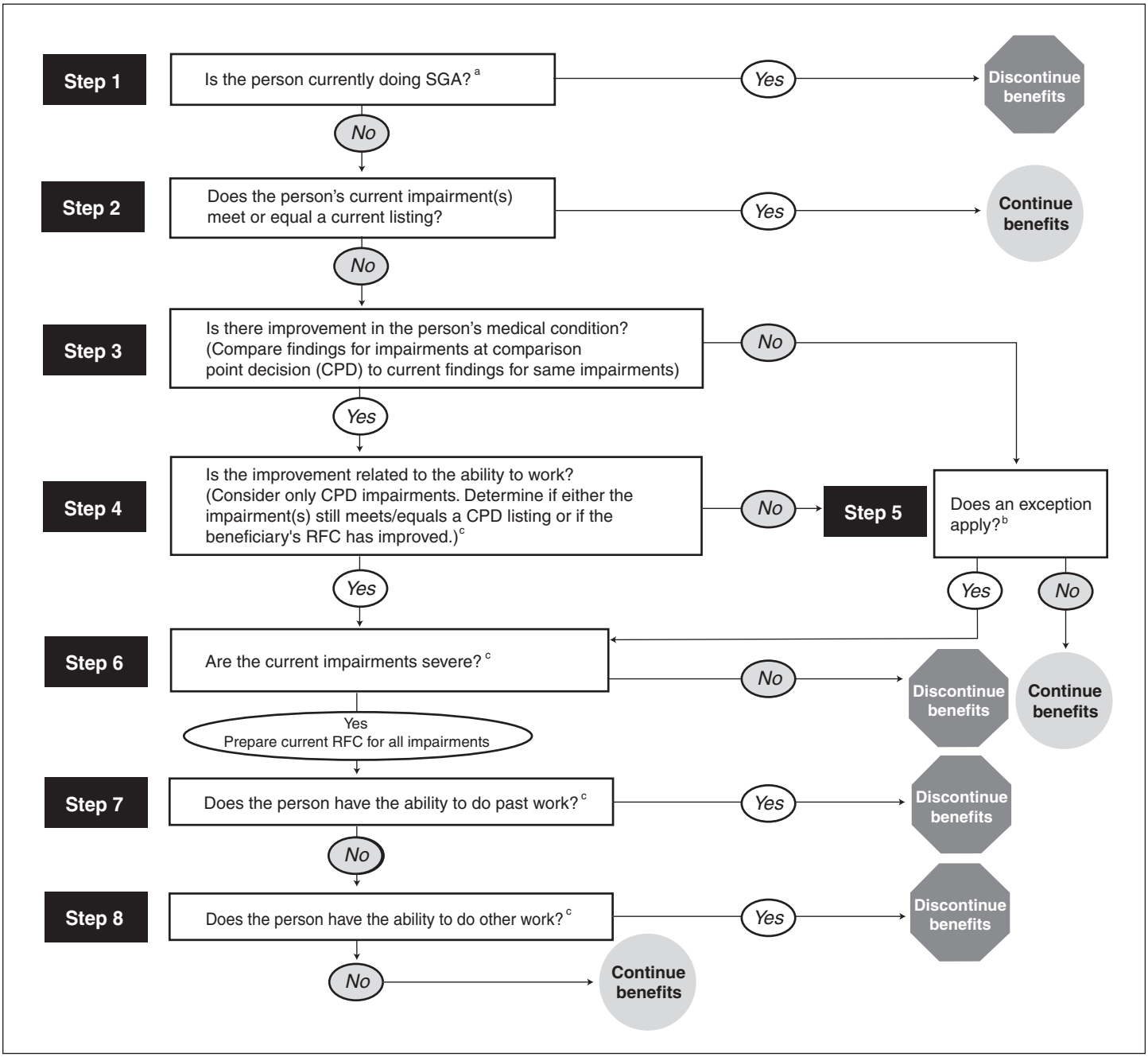
[15] If beneficiaries' responses to a mailer indicate possible improvement in medical condition or vocational status, SSA may refer these individuals for a full medical review. However, in most cases, SSA decides that a full medical review is not warranted and that benefits should be continued.

SSA will find that disability has ended and discontinue benefits[16] if it determines that medical improvement related to the ability to work has occurred or that one of the exceptions applies, and the person's impairments are not severe or the person can do past work or other work. If SSA determines that medical improvement has not occurred and that none of the exceptions apply, then benefits are continued[17] (see fig. 1).

[16] Beneficiaries may elect to have benefits continued while they appeal the decision that their disability has ended.

[17] SSA also conducts work CDRs where it may remove a beneficiary from the disability programs if their earnings exceed SGA.

Figure 1: Current Medical CDR Evaluation Process



Source: GAO and SSA.

[a]For SSI beneficiaries, SGA is not considered and the CDR evaluation process is started at Step 2. Instructions for SGA considerations differ for beneficiaries covered by certain work incentive programs.

[b]If a group II exception applies, discontinue benefits immediately without a medical determination.

[c]Consider age and time on the disability programs.

If SSA finds that the individual no longer has a disability and discontinues benefits following a CDR, the individual has the right to appeal the CDR decision, first to another reviewer for a reconsideration, second to an administrative law judge, then to the Appeals Council, and finally to federal courts. At the hearing before the administrative law judge (ALJ), the ALJ reviews the file, including any additional evidence submitted after the DDS determination and may hear testimony from the individual as well as medical and vocational experts.

SSA's Office of Quality Performance conducts quality reviews of disability determination outcomes. To conduct these quality reviews, SSA selects a random sample of cases each month from all final CDR decisions, stratifying the selection of cases by state and outcome (cases where benefits are continued and discontinued). Then, a quality examiner reviews the case to ensure it adheres to SSA guidance, including a review of the DDS decision, the documentation of that decision, and the evidence contained in the case. During these reviews, physicians[18] evaluate the evidence to ensure that the decision adheres to the medical improvement standard. In fiscal year 2005, SSA's Office of Quality Performance reported nationwide accuracy rates for cases where CDR benefits were continued and discontinued of 95 percent and 93 percent respectively. The combined accuracy rate for all CDRs was about 95 percent.

[18] A psychologist may evaluate the evidence if the individual has a psychological impairment.

Few Beneficiaries Are Removed from the Disability Programs Because They Are Found to Have Improved Medically

We found that on average, about 1.4 percent of all individuals who left the programs between fiscal years 1999 and 2005 were removed for medical improvement. More beneficiaries leave the disability programs because they either die or convert to social security retirement benefits. In addition, while full medical CDRs are the agency's most comprehensive tool for determining whether a beneficiary continues to have a disability, about 2.8 percent of those who receive these CDRs are found to no longer have a disability under the medical improvement standard.

Few Beneficiaries Are Removed from the Programs Due to Medical Improvement

Between fiscal years 1999 and 2005, annually, an average of 13,800[19] people—or about 1.4 percent of all individuals who left the disability programs—were removed because SSA found that they had improved medically.[20] More people leave the programs when they die, convert to full retirement benefits,[21] or leave for other reasons. For example, between fiscal years 1999 and 2005, each year an average of about 311,000[22] recipients (about 32 percent of all recipients who were removed from the disability programs) died, and about 209,000 (about 21 percent) converted from DI benefits to retirement benefits. In addition, each year about 444,000 beneficiaries (about 45 percent) were removed from the disability programs for other reasons. These include about 54,000 DI beneficiaries who SSA determined had earnings in excess of SGA, about 11,000 DI beneficiaries who either converted to old-age retirement benefits prior to reaching the full retirement age[23] or were found to be erroneously eligible

[19] For the purposes of our study, we only assessed DI and SSI adult beneficiaries who received full medical CDRs. We did not include children or the "age 18 re-determinations" in our analysis since there are differences between the medical CDR sequential evaluation processes for adults and children. Also, we only assessed the outcome of the full medical CDRs. We did not assess the outcome of the CDR mailers or CDRs of beneficiaries' earnings and work activity—referred to as work CDRs.

[20] The 13,800 people who were removed from the disability programs for medical improvement as a result of receiving a CDR represent about 0.1 percent of all adult DI and SSI disability beneficiaries. Of these 13,800 recipients, about 9,260 were DI recipients and about 4,580 were SSI recipients.

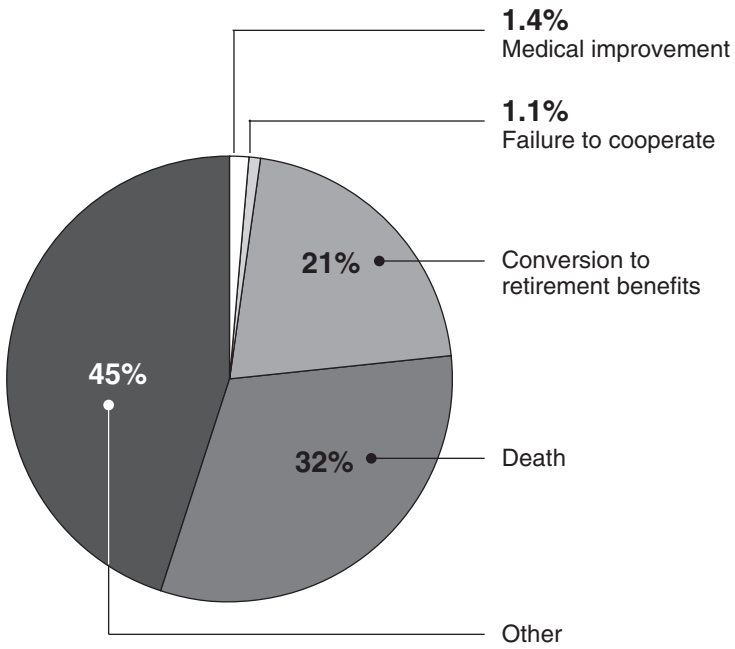
[21] SSA converts DI beneficiaries to retirement benefits when they attain full retirement age.

[22] The 311,000 recipients who died consisted of about 180,000 DI recipients and about 131,000 SSI recipients.

[23] Beginning at age 62, workers receiving DI benefits may elect to receive retirement benefits in lieu of disability benefits. Although most beneficiaries receiving DI benefits elect to receive their disability benefits until full retirement age—at which time disability benefits convert to benefits paid from the Old-Age and Survivors Insurance program—some choose to switch earlier.

for benefits, and about 379,000 SSI beneficiaries who were removed from the SSI program for all reasons other than death and medical improvement (including earnings and resources above the limit allowed by program guidelines) (see fig. 2).

Figure 2: Average Percentage of All Beneficiaries Who Were Removed from the DI and SSI Programs by Category (Fiscal Years 1999 to 2005)



Source: GAO analysis of SSA data.

Note: While the combined DI and SSI programs in figure 2 illustrate the reasons why beneficiaries are removed from the DI and SSI programs, there are some differences between these two programs. For the same time period, for the DI program, about 2 percent of all recipients who were removed from the DI program improved medically; about 45 percent converted from disability benefits to retirement benefits; about 39 percent died; about 12 percent had earnings in excess of SGA; and about 2 percent left for other reasons. For the SSI program, about 1 percent of all recipients who were removed from the SSI program improved medically; about 25 percent died; and about 74 percent left for other reasons.

During fiscal years 1999 to 2005, the proportion of all beneficiaries who were removed from the programs in each of the above categories remained fairly consistent. For example, during this period, the proportion of individuals removed from the disability programs in a fiscal year for medical improvement ranged from 1.0 percent to 1.7 percent; the proportion of individuals who died ranged from 31.1 percent to 33.0 percent; and the proportion of individuals who converted from disability benefits to retirement benefits ranged from 19.7 percent to 22.7 percent.

Few Beneficiaries Who Receive Full Medical Continuing Disability Reviews Are Removed from the Programs Each Year

SSA data show that few beneficiaries who receive medical CDRs are removed from the disability programs. Full medical CDRs are the agency's primary tool to determine whether a beneficiary has improved medically. Between fiscal years 1999 and 2005, the number of full medical CDRs conducted ranged from a high of 608,000 in 2001 to a low of 333,000 in 2005 (see fig. 3).[24] Between fiscal years 1999 and 2005, an average of about 26,000 individuals each year (about 5.3 percent) were removed from the disability programs as a result of receiving a medical CDR. Some of the officials we interviewed stated that the medical improvement standard may artificially limit the percentage of recipients who are found to have improved medically. However, we were unable to identify any empirical data regarding the impact of the standard on the percentage of recipients who have their benefits discontinued, or what a "proper" discontinuation rate should be.

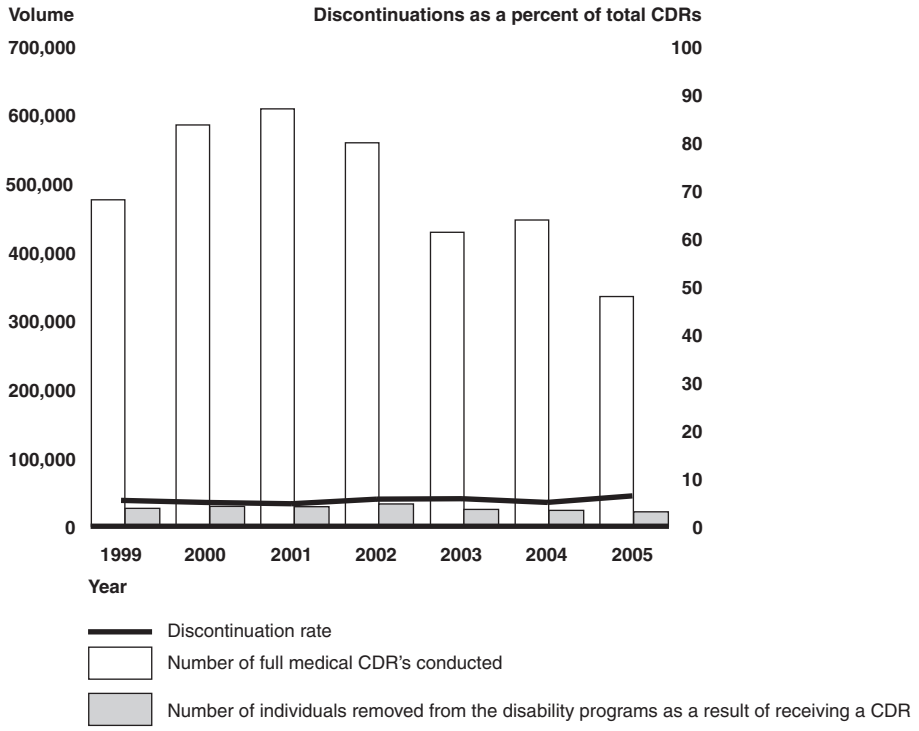
While the number of CDRs conducted between fiscal years 1999 and 2005 fluctuated,[25] the percentage of beneficiaries removed from the programs remained fairly constant.[26] For example, in fiscal years 1999, 2002, and 2004, the percentage of recipients who were removed from the disability programs as a result of receiving a CDR was 5.4 percent, 5.6 percent, and 5 percent respectively. In addition to medical improvement, SSA also removes beneficiaries for failing to cooperate during a CDR. For example, a beneficiary may fail to appear for scheduled meetings with disability examiners or physicians and thus may have their benefits discontinued. Of the individuals removed from the programs as a result of receiving a CDR between fiscal years 1999 and 2005, an average of about 13,800 individuals (or 2.8 percent of all CDRs conducted between fiscal years 1999 and 2005) were removed annually because SSA determined that they had improved medically, while an average of about 10,300 individuals (or about 2.1 percent) were removed each year for failure to cooperate.

[24] For fiscal years 2000 to 2004, in addition to the full medical CDRs, SSA also conducted an average of about 834,000 CDR mailers annually, ranging from a high of 960,000 mailers in 2000 to a low of 692,000 mailers in 2003.

[25] In the late 1990s Congress appropriated special funds for SSA to alleviate backlogs of CDRs. These special funds began in fiscal year 1996 and expired at the end of fiscal year 2002. Because of this special funding, the number of full medical CDRs conducted by SSA increased.

[26] We did not determine why the discontinuation rate remained consistent considering the change in the number of CDRs conducted.

Figure 3: Number of Full Medical CDRs Conducted and Resulting Benefit Discontinuations (Fiscal Years 1999 to 2005)



Source: GAO analysis of SSA Data.

Several Factors Challenge SSA's Ability to Assess Whether Beneficiaries Continue to Be Eligible for Benefits

Our review suggests that several factors associated with the standard pose challenges for SSA's ability to assess whether beneficiaries continue to be eligible for benefits. First, limitations in SSA guidance may result in inconsistent application of the standard. For example, we found that SSA does not clearly define the degree of improvement needed to meet the standard, and the DDS directors we surveyed reported using different thresholds to show medical improvement. As a result of this apparent limitation in SSA guidance, disability examiners may incorrectly decide to continue or discontinue benefits. In addition, while the act provides for certain exceptions that could result in additional individuals having their benefits discontinued following a CDR, most of the disability examiners we spoke with told us that they were uncertain about when to apply the exceptions. Second, we found that most DDSs are incorrectly conducting CDRs with the presumption that a beneficiary has a disability. Finally, other factors, such as inadequate documentation of evidence and the

judgmental nature of the decision process for assessing medical improvement may make it more difficult to determine whether a beneficiary remains eligible for benefits. However, due to data limitations, we were unable to determine the extent to which these challenges impact decisions to continue or discontinue benefits during a CDR.

Limitations in SSA Guidance for Applying the Medical Improvement Standard May Result in Inconsistent Disability Decisions

Our work shows that SSA does not clearly define the degree of improvement needed for examiners to determine if a beneficiary has improved medically. Many disability examiners and DDS officials told us that they were unsure about the degree of improvement required to meet the standard, and some said this confusion stems from unclear SSA guidance. In particular, SSA guidance instructs examiners to disregard "minor" changes in a beneficiary's condition.[27] However, this guidance does not adequately describe what constitutes a minor change. When we asked SSA officials to clarify their understanding of what constitutes a minor change, they told us that only changes that would not affect a beneficiary's ability to work should be considered minor. However, this explanation of minor changes is not included in the agency's guidance. As a result, some DDSs may be inconsistently defining what constitutes a minor change. For example, five DDS directors told us that they define minor changes to include those that may actually improve functioning or allow the beneficiary to work. In doing so, our review suggests that some DDSs may be inconsistently applying the standard as to what constitutes medical improvement. However, DDS directors differed on the extent to which the guidance to disregard minor changes impacts CDRs. Of the 52 DDS directors who answered a question in our survey on "minor" changes, 21 reported that the practice of disregarding minor changes is not an impediment to making a disability determination, while 31 reported that it is an impediment.[28]

Similarly, we found that SSA guidance may not provide DDS examiners with sufficient detail to determine whether improvements in beneficiaries' medical conditions are related to their ability to work. At this step of the CDR process, examiners look for changes in a beneficiary's ability to

[27] See SSA Program Operations Manual System (POMS) section DI 28010.015.

[28] While we received 54 completed surveys, not every director responded to every question. In presenting our results, we only included the directors who answered a particular question with a value on our response scale. If a director answered "no basis to judge," we did not count that response.

perform basic work activities since the last review, such as lifting heavy objects or standing or sitting for periods of time.[29] The guidance instructs examiners to ensure a "reasonable relationship" between the amount of improvement and the increase in the ability to perform basic work activities.[30] However, the guidance does not require a specific amount of increase in functioning. The DDS directors we surveyed reported that they interpret this guidance differently. Specifically, 17 of 49 directors reported that a large or very large increase in a recipient's ability to do basic work activities is required; 24 reported that a moderate increase is required; and 8 reported that a minor or any increase at all is required. Furthermore, two DDS directors in our survey inaccurately noted that the standard requires that a beneficiary's improvement be great enough so that it actually enables the individual to work.[31] One of these directors commented that because SSA guidance on this aspect of the standard is open to broad interpretation, it is difficult to document improvement to the extent the individual is able to work. As a result, some DDSs may be inconsistently applying this aspect of the standard that could potentially impact decisions to continue or discontinue benefits. However, we were unable to determine how much of an impact clarification of this guidance would have on CDR outcomes.

The disability advocates we spoke with differed in their views on the clarity of SSA guidance on medical improvement. While some stated that it is clear and adequate, others stated that the guidance on assessing medical improvement in psychological impairments and determining if improvement is related to the ability to work is confusing and unclear. One advocate stated that current SSA policies contribute to some recipients remaining in the disability programs despite their ability to work.

We also found that while the act provides for exceptions to medical improvement that could result in additional individuals having their benefits discontinued as a result of receiving a CDR, most of the disability examiners whom we spoke with on our site visits told us that they were

[29] At this step (step 4 of the CDR evaluation process), the assessment of working at the level of SGA is not considered. SGA is evaluated in the first step of the CDR evaluation process. See appendix II for a detailed description of the CDR process.

[30] See POMS section DI 28015.320.

[31] The assessment of a beneficiary's actual ability to work comes later in the CDR process (steps 7 and 8). See appendix II for a more detailed description of the CDR process.

uncertain about when to apply the exceptions.[32] SSA policies allow for various exceptions, including when the prior decision was in error or when persons benefit from education or training programs that could help the individuals work. However, we found that while the examiners and ALJs routinely assess whether a beneficiary has improved medically, they do not routinely assess whether or not each of the exceptions applies to the case. Moreover, many of the DDS officials and examiners we interviewed told us that the guidelines for using the error exception are written in a way that precludes its use, except in the most extreme situations.[33]

SSA officials explained that the exceptions were written to intentionally limit their use in order to prevent examiners from circumventing the standard, and that their infrequent use is appropriate. In addition, SSA explained that when it issued the final rules governing the medical improvement standard, it intended the exceptions to be true "exceptions"—not to be routinely applied (including the error exception). The agency also noted that a broader application of the error exception could lead to a substitution of judgment by an adjudicator for the original finding of disability in instances where a person's medical condition had not substantially improved. Some disability advocates we spoke with also noted that the narrow interpretation of the error exception is appropriate because it prevents substitution of judgment and arbitrary discontinuations.

A Majority of DDSs Incorrectly Apply SSA Guidelines Stating That CDRs Should Be Conducted Neutrally, without a Presumption of Disability

According to our survey, a majority of DDSs incorrectly presume that a beneficiary continues to have a disability when conducting CDRs, which may make it more difficult for examiners to determine if a beneficiary has improved medically. This is contrary to the act as well as SSA regulations and policy, which require that CDR decisions be made on a "neutral basis." SSA defines neutral basis as a review that neither presumes that a beneficiary (1) is still disabled because he or she was previously found disabled and (2) is no longer disabled because he or she was selected for a CDR. Under a neutral review, it is assumed that beneficiaries had a

[32] During our site visits, we met with 11 CDR supervisors and disability examiners who the DDS directors selected as the most knowledgeable in their office about the CDR process and the medical improvement standard. Seven of these 11 individuals stated that they were uncertain about when to apply the exceptions to medical improvement.

[33] The error exception applies when an error was evident in the prior decision.

disability at the time of the prior decision, but it is not assumed they still have a disability at the time of a CDR. However, in survey responses, 31 DDS directors responded that in practice, CDRs are conducted with the presumption that a beneficiary continues to have a disability.[34] When asked to explain this response, directors cited various factors that likely contribute to the presumption of disability during a CDR. Thirteen directors commented that the individuals are already receiving disability benefits, and as a result, the directors assume that the beneficiary continues to have a disability. Some of these directors also noted that they make this presumption because the beneficiary was found disabled when initially awarded benefits, and examiners must show medical improvement to remove them from the programs.

Since a majority of DDSs are conducting CDRs with a presumption that beneficiaries have a disability, those DDSs may be setting a higher bar than required by the standard for these reviews. Moreover, by requiring more evidence of medical improvement than is necessary under the standard, it may be harder to assess whether a recipient no longer has a disability and is able to work. Because 31 directors reported that examiners conduct CDRs with the presumption that beneficiaries continue to have a disability, a significant number of beneficiaries may be evaluated under this higher standard, and some may have their benefits erroneously continued. While these problems raise concerns about the consistency of decisions when determining if medical improvement has occurred, the ultimate impact of presuming that an individual has a disability on CDR decisions is unknown because we were unable to empirically test how the presumption of a disability impacts CDR decisions to continue or discontinue benefits.

Other Factors May Make Assessing Medical Improvement Difficult

Inadequate documentation of evidence and the judgmental nature of the process for assessing medical improvement are two additional factors that make it challenging to assess medical improvement. The standard establishes the prior decision as the starting point for conducting a CDR and requires examiners to find evidence of medical improvement since this last decision. Some DDS directors reported that it may be difficult to assess medical improvement in cases where the prior disability decision was based on incomplete or poorly documented evidence. For example, in

[34] Of the 48 DDS directors who responded to this question, 17 indicated that CDR decisions are made on a neutral basis.

one of the CDR cases we reviewed, a beneficiary had his benefits continued following the CDR because the rationale for the prior disability decision was vague, according to the examiner who reviewed the case with us. This beneficiary was originally awarded benefits on appeal based on recurrent stomach problems and depression. When the case was selected for a CDR, the case file included a general description of the beneficiary's medical condition, but lacked sufficient evidence to determine if medical improvement had occurred since the initial decision, according to the examiner. As a result, medical improvement could not be shown and benefits were continued. While many examiners and officials we interviewed agreed that it is difficult to show medical improvement in cases that lack adequate documentation, they differed in their opinions about how frequently this occurs. Of the directors who answered our survey question on insufficient documentation, 33 responded that they encounter cases with insufficient documentation infrequently or very infrequently, and 17 responded that such cases occurred more often.[35]

Survey respondents also differed in their opinions about the types of cases that more typically lack adequate documentation, but 15 directors commented that cases decided on appeal were the most likely to lack adequate documentation. One possible explanation for this may be streamlined processes at the appeals level. For example, one ALJ we interviewed noted that, in an effort to process cases in a timely manner, ALJs sometimes issue quick decisions in which most of the evidence is on tapes that are not transcribed or placed in the beneficiary's case file. In such instances, it is unlikely that the DDS examiner would have complete information for conducting a CDR and determining if medical improvement had taken place. Furthermore, several officials told us that guidance instructs ALJs to include enough information in their decisions so that the decisions will be legally sufficient. However, the guidance does not specifically instruct ALJs to include all of the evidence that will be needed to assess medical improvement at a future CDR. However, in recent regulations to implement changes to its disability determination process, SSA is taking steps that may help to address the problem of incomplete documentation for future CDRs. Specifically, SSA is

[35] We asked directors to exclude cases missing the entire case file (i.e. lost folders) in their responses to this survey question. We asked the directors a separate question regarding how frequently or infrequently they encounter cases where the entire case file is missing. Although SSA has established a new electronic system to process initial claims, it has yet to expand this new process to CDRs. As a result, CDRs are still being conducted in a paper environment.

developing requirements for training examiners to ensure they understand the information needed to make accurate and adequately documented decisions, has adopted guides for decision writing at the appeals level, and is in the process of developing guides for use at the DDS level.

In addition to the challenges associated with problems of inadequate documentation, many examiners also told us that the judgmental nature of the decision process concerning what constitutes an improvement can make it difficult to assess medical improvement. One examiner may determine that a beneficiary has improved medically and discontinue benefits, while another examiner may determine that medical improvement has not been shown and will continue the individual's benefits. For example, in one of the CDR cases that we reviewed, the examiner conducting the initial CDR determined that medical improvement was shown and discontinued the individual's benefits. The recipient was initially awarded disability benefits for a back injury with limited range of motion in the recipient's back. When the CDR was conducted, the examiner evaluated all of the relevant evidence and concluded that the individual's range of motion had improved. The examiner also noted that the individual's allegations of pain did not correlate with the findings from both the physical exam and the laboratory findings. As a result, the examiner concluded that medical improvement had occurred. On appeal to reconsideration 6 months later, a different DDS examiner conducted a review using the same medical evidence as the original examiner, but determined that medical improvement had not occurred, and continued benefits. The examiner conducting the appeal concluded that the beneficiary continued to experience pain consistent with the back condition, and thus medical improvement was not shown. However, we had no basis for determining which decision was correct.

The amount of judgment involved in the decision-making process increases when the process involves certain types of impairments that are difficult to assess. More specifically, assessing medical improvement may be more difficult in cases that involve certain types of psychological impairments, such as depression, than cases with physical impairments, such as amputations. In elaborating on their survey responses, 17 directors commented that assessing medical improvement is more difficult in cases with psychological impairments because evidence of these impairments is generally more subjective than evidence of many physical impairments. In addition, six directors commented that evaluations of psychological impairments tend to rely more heavily on assessment of functionality. According to some of these officials, an assessment of functionality is more subjective because it relies more on the beneficiaries' account of

their own conditions than on laboratory findings. Furthermore, some officials reported that the severity of psychological impairments can fluctuate over time, making it difficult to assess whether improvement has taken place. Two directors commented that determining whether there is medical improvement for some types of psychological impairments can also be complicated because medical experts' opinions can vary. One of these directors commented that the evidence to support psychological impairments, such as evaluations for depression, rely less on laboratory findings and more on clinical judgment. In contrast, certain tests for physical impairments tend to be less open to interpretation. For example, one director commented that X-rays of joint deterioration can generally be interpreted consistently among radiologists. The potential difficulty of assessing medical improvement in beneficiaries whose disability is based on certain types of psychological impairments is especially relevant, given that the proportion of all individuals in the disability programs whose disability is based on a psychological impairment has grown in recent years.

Conclusions

SSA is responsible for assuring that individuals who truly have a disability that prevents them from being able to work continue to receive benefits. At the same time, SSA has a stewardship responsibility to identify those beneficiaries who have improved medically and are no longer eligible for benefits. The medical improvement standard is intended to help SSA accomplish both of these responsibilities. However, several factors associated with the standard pose challenges for ensuring that the standard is implemented in a consistent and fair manner. Specifically, potential limitations in SSA guidance regarding the degree of improvement needed to meet the standard as well as a lack of clarity with respect to the appropriate use of the exceptions to medical improvement may make it difficult to assess if medical improvement has occurred. Clear guidance is especially important in view of the judgmental nature of the disability determination process. Additionally, while SSA guidelines regarding the presumption of disability during CDRs tend to be generally clear, incorrect application of these guidelines by several DDSs suggests that the outcomes of CDRs could be affected and may result in benefit continuation for some individuals who might otherwise been found to have improved medically. Other factors, including inadequate documentation of evidence, are more difficult to address in the short term. However, SSA is taking actions intended to address some of these problems.

Recommendation

To ensure that SSA is able to consistently assess whether DI and SSI beneficiaries have improved medically, we recommend that the Commissioner of Social Security clarify guidance for assessing medical improvement when conducting CDRs. More specifically, SSA should clarify guidance concerning (1) what degree of improvement is required to meet the standard and (2) when the use of exceptions to medical improvement is appropriate. SSA should also work with DDSs to ensure that CDRs are conducted on a neutral basis, without a presumption that beneficiaries continue to have a disability.

Agency Comments and Our Evaluation

We obtained written comments on a draft of this report from the Commissioner of the Social Security Administration (SSA). The agency generally agreed with our recommendation, but expressed reservations about the need for further guidance on the use of exceptions. More specifically, SSA believed that its implementation of the statutory exceptions to medical improvement is appropriate and that its instructions are consistent with the intent of the law. As such, SSA was concerned about language in the draft report that characterized SSA's guidance as discouraging and limiting the use of the exceptions. After considering these comments, we revised the report to include additional information on (1) examiners' confusion on the use of the exceptions when conducting CDRs and (2) SSA's rationale for its current exception guidance. Having made these changes, we continue to believe that additional guidance in this area is warranted if only, as the report notes, because most of the disability examiners whom we spoke with told us that they were uncertain about when to apply the exceptions. Moreover, while answering a survey question on the exceptions to medical improvement, 4 DDS directors commented that more guidance regarding the use of the exceptions is needed.

SSA generally agreed with the need for clarifying guidance concerning the degree of improvement required to meet the medical improvement standard. However, the agency believed that the report was unclear with regard to whether this part of the recommendation applied only to guidance for determining if there has been any medical improvement, or also to the guidance for determining if any medical improvement is related to the ability to work. As stated in the draft report, our discussion of medical improvement encompasses both elements (improvement in a beneficiary's medical condition and its relation to the ability to work). However, we did further clarify this throughout the entire report to minimize any confusion on this matter. Additionally, SSA indicated that clarification of this guidance would probably have little noticeable impact

on the number of cases in which SSA finds that a disability has ended. As our report notes, we cannot quantify the impact that clearer guidance would have on the discontinuation of benefits. Even so, we continue to believe that it is important for DDSs to consistently apply this aspect of the medical improvement standard and that, towards that end, additional guidance would be useful.

SSA agreed with the need for further training to ensure that CDRs be conducted on a neutral basis. However, it believed that more adjudicator training in this area would likely have little impact on discontinuing benefits. We cannot predict the impact additional guidance and training would have on continuing or discontinuing benefits. However, as the report points out, there are large numbers of DDS directors who are incorrectly applying the neutrality standard and, in our view, would benefit from additional guidance in this area.

Beyond commenting on our recommendation, SSA suggested that we provide additional context for some of the statistical information presented in our discussion of the proportion of beneficiaries removed from the disability programs each year. For example, SSA commented that the disability discontinuation rates in the early 1980s may not have been representative of the discontinuation rates prior to the implementation of the medical improvement standard due to special targeted initiatives aimed at removing individuals from the DI program who no longer had a disability. We revised the report to take into account these suggestions.

The Commissioner's comments have been reproduced in appendix III. SSA also provided additional technical comments, which have been incorporated in the report as appropriate.

Unless you publicly announce its contents earlier, we plan no further distribution until 30 days after the date of this report. At that time, we will make copies available to other parties upon request. In addition, the report will be available at no charge on GAO's Web site at http//:www.gao.gov. This report does not contain all the results from the survey. The survey and a more complete tabulation of the results can be viewed at http://www.gao.gov/cgi-bin/getrpt?rptno=GAO-07-4sp.

If you or your staff have questions concerning this report, please contact me at (202) 512-7215. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. See appendix IV for a listing of major contributors to this report.

Robert E. Robertson,
Director, Education, Workforce,
and Income Security Issues

Appendix I: Scope and Methodology

This appendix provides additional details about our analysis of the medical improvement standard (the standard), including challenges the standard poses for the Social Security Administration (SSA) when conducting medical continuing disability reviews (CDR). To meet the objectives of this review, we reviewed prior studies by GAO, SSA, SSA's Inspector General, Congressional Research Service, and external organizations related to the disability determination process and CDRs. We also reviewed the Social Security Disability Benefits Reform Act of 1984, regulations, and SSA policies and processes for assessing whether beneficiaries continue to be eligible for benefits. In addition, we analyzed SSA data on CDR outcomes over a 7-year period for fiscal years 1999 to 2005 as well as reports identifying the number of beneficiaries who leave the disability programs and the reasons why they leave. For the purposes of our study, we only assessed DI and SSI adult beneficiaries who left the programs as a result of receiving a full medical CDR. We did not include children or "age 18 re-determinations" in our analysis since there are differences between the medical CDR sequential evaluation processes for adults and children. We also did not assess the outcome of CDR mailers or work CDRs. We verified the statistical data on CDR outcomes for internal logic, consistency, and reasonableness. We determined that the data were sufficiently reliable for the purposes of our review. We also met with knowledgeable SSA officials to further document the reliability of these data.

We interviewed 34 officials from SSA's central offices (including officials from the Office of the Chief Actuary, the Office of Quality Performance, the Office of General Counsel, the Office of Research and Evaluation Statistics, the Office of Disability Programs, the Office of Disability Adjudication and Review, and the Office of Program Development and Research) to discuss the disability programs and the CDR process.

We conducted a national Web-based survey of all 55 Disability Determination Services (DDS) directors in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, the Western Pacific Islands, and the federal DDS. DDSs are the agencies responsible for conducting periodic CDRs to determine if beneficiaries' medical conditions have improved and if they are able to work. We received 54 completed surveys for a response rate of 98 percent. The purpose of this survey was to assess the extent to which the standard impacts outcomes of CDRs and determine if the standard poses any special challenges for SSA when determining whether beneficiaries continue to be eligible for benefits. We asked the directors about particular elements of the standard and how these elements, alone or in combination with other factors, impact CDR

outcomes. We also asked them how SSA guidance on implementing the standard affects CDR outcomes. We determined that the survey data are sufficiently reliable. Because this was not a sample survey, there are no sampling errors. However, the practical difficulties of conducting any survey may introduce errors, commonly referred to as nonsampling errors. For example, difficulties in how a particular question is interpreted, in the sources of information that are available to respondents, or in how the data are entered into a database or were analyzed, can introduce unwanted variability into the survey results. We took steps in the development of the questionnaire, the data collection, and the data analysis to minimize these nonsampling errors. For example, social science survey specialists designed the questionnaire in collaboration with GAO staff with subject matter expertise. Then, the draft questionnaire was pretested with a number of state officials to ensure that the questions were relevant, clearly stated, and easy to comprehend. The questionnaire was also reviewed by an additional GAO survey specialist. When the data were analyzed, a second, independent analyst checked all computer programs. Since this was a Web-based survey, respondents entered their answers directly into the electronic questionnaire. This eliminated the need to have the data keyed into a database thus removing an additional source of error. We conducted three pretests of this survey with DDS directors in three different states. We modified the survey to take their comments into account. We also provided SSA with a copy of the survey and incorporated its technical comments into the final version. This report does not contain all the results from the survey. The survey and a more complete tabulation of the results can be viewed at http://www.gao.gov/cgi-bin/getrpt?rptno=GAO-07-4sp.

To augment information from our state survey, we conducted independent audit work in three states (California, Massachusetts, and Texas) to examine how SSA policies and procedures are carried out in the field. We selected locations for field visits based on the following criteria: (1) geographic dispersion; (2) states with large numbers of CDRs conducted; (3) states with CDR discontinuation rates above, below, and at the national average; (4) states with varying DDS structures (i.e., centralized and decentralized); and (5) states with large numbers of Disability Insurance (DI) beneficiaries and large DI expenditures. In each state, we visited a DDS office, the SSA regional office, the regional Office of Quality Performance, and the regional Office of Disability Adjudication and Review (formerly known as the Office of Hearings and Appeals). In total, we conducted in-depth interviews with 80 SSA and DDS managers and line staff responsible for conducting medical CDRs, including DDS directors,

CDR supervisors and examiners, medical consultants, and administrative law judges.[36]

During our meetings with SSA and DDS officials, we documented management and staff views on the challenges associated with applying the medical improvement standard. In particular, we documented management and staff views on (1) the impact of the standard on CDR outcomes, (2) the effectiveness of SSA policies and procedures for applying the standard, and (3) the degree to which factors external to the standard create challenges when determining if a beneficiary has improved medically and is able to work. To further assess how the standard is applied in practice, we took a nonprobability sample of 12 CDR case files from the DDSs in California and Texas. We asked CDR supervisors to provide several cases that were (1) discontinued for medical improvement, (2) continued because the beneficiary was clearly disabled, and (3) ambiguous cases where it was difficult to apply the standard and determine if benefits should be continued or discontinued. These case files serve to illustrate the difficulties examiners face when determining if a beneficiary has improved medically and is able to work.

In addition, we interviewed seven disability policy experts from national disability research and advocacy organizations to obtain their input on the impact of the standard on the disability programs and any challenges it poses when assessing individuals' continued eligibility for benefits. We spoke with individuals affiliated with the following organizations

- American Association of People with Disabilities,
- Center for Health Services Research and Policy at George Washington University,
- Center for the Study and Advancement of Disability Policy,
- Consortium for Citizens with Disabilities,
- Disability Law Center,
- Disability Policy Collaboration,
- National Organization of Social Security Claimants' Representatives, and
- National Organization on Disability.

[36] During our site visits, we met with 11 CDR supervisors and disability examiners who the DDS directors selected as the most knowledgeable in their office about the CDR process and the medical improvement standard.

Finally, we spoke with representatives from the National Association of Disability Examiners, the National Council of Disability Determination Directors, and the Social Security Advisory Board. We spoke with these disability experts about the effect of the standard on CDR outcomes and any challenges it presents when conducting CDRs. We conducted our work from October 2005 through June 2006 in accordance with generally accepted government auditing standards.

Appendix II: The Continuing Disability Review Evaluation Process

In the *first step* of the CDR evaluation process for adult beneficiaries, an SSA field office representative determines if the beneficiary is working at the level of substantial gainful activity (SGA). A beneficiary who is found to be not working or working but earning less than the SGA level (minus allowable exclusions) has his or her case forwarded to the state Disability Determination Services (DDS).[37]

The *second step* is to determine if the individual's current impairment(s) is included on the current list of disabilities that SSA maintains. The list describes impairments that, by definition, are so severe that they are disabling. If the individual's current impairment(s) does meet or equal a current listing, then the DDS continues the individual's benefits and does not continue with the evaluation process. If the individual's current impairment(s) does not meet or equal a current listing, then the DDS proceeds to step three in the evaluation process.

The *third step* is to determine if improvement in the individual's medical condition has occurred. This improvement is any decrease in the medical severity of the impairment(s) that was present at the time of the most recent favorable medical decision (i.e., the initial decision to award disability benefits or the most recent CDR continuance—usually referred to as the comparison point decision, or CPD). At this step, the DDS examiner compares the current signs, symptoms, and laboratory findings associated with the beneficiary's impairment(s) to those recorded from the last review. If improvement has not occurred, the disability examiner skips to the fifth step in the evaluation. If improvement has occurred, the disability examiner proceeds to next step, the fourth step.

The *fourth step* is to determine if the improvement found in step three is related to the ability to work. Improvement related to the ability to work is evaluated two different ways, depending on whether the CPD was based on: (1) meeting or equaling a prior listing or (2) a residual functional capacity (RFC) assessment:

- Meeting or equaling the prior listing: In this case, the disability examiner will determine if the beneficiary's same impairment(s) still meets or equals the prior listing. Unlike step two, the examiner compares the beneficiary's condition with the list of impairments in

[37] For SSI beneficiaries, do not consider SGA but skip to the second step in the CDR evaluation.

effect at the time he or she was first awarded disability benefits.[38] If the impairment(s) no longer meets or equals the prior listing, then the examiner finds that the improvement is related to the ability to work and proceeds to step six of the evaluation process. If the impairment(s) meets or equals a prior listing, then benefits are continued.

- Residual functional capacity assessment: In this case, the disability examiner compares the beneficiary's previous functional capacity to the current functional capacity for the same impairment. If functional capacity for basic work activities has improved, then the examiner finds that the improvement is related to the ability to work and proceeds to step six of the evaluation process. If the current assessment does not show improvement, then the disability examiner proceeds to step five.

The *fifth step* is to determine whether an exception to medical improvement applies. The law provides for certain limited situations when the DDS may discontinue a recipient's benefits even though medical improvement has not occurred. The specific group I exceptions are (a) the individual is the beneficiary of advances in medical or vocational therapy or technology (related to the ability to work), (b) evidence shows that the individual has undergone vocational therapy (related to the ability to work), (c) evidence shows that, based on new or improved diagnostic or evaluative techniques, the individual's impairment(s) is not as disabling as it was considered at the time of the CPD, and (d) evidence shows that any prior determination or decision was in error. If an exception applies, the examiner continues through to step six of the evaluation process.[39] If an exception does not apply, benefits are continued.

The *sixth step* is to determine if the current impairments are severe. At this step, the examiner considers all of the beneficiary's impairments—

[38] At this step of the evaluation, a disability examiner considers only the listings that were met (or equaled) the last time the beneficiary was evaluated, not all of the listings that existed at the time of the last review.

[39] In addition to Group I exceptions, the law provides for additional situations (called Group II exceptions) to show that that disability discontinues. Group II exceptions are: (a) the individual's prior determination or decision was fraudulently obtained, (b) the individual does not cooperate with SSA, (c) SSA is unable to find the individual, and (d) the individual fails to follow prescribed treatment that would be expected to restore his or her ability to do SGA. In these situations, SSA discontinues benefits immediately without further development. SSA does not determine if medical improvement has occurred or if the individual is able to do SGA.

those present at the previous decision as well as any new impairments found in the current review. If the DDS determines that the beneficiary's current impairment(s) is not severe, benefits are discontinued without further development. If it is determined that the impairment(s) is severe, then the examiner considers the impact of the beneficiary's impairment(s) on his or her ability to function. This consideration will result in a current residual functional capacity (RFC) assessment that shows the beneficiary's ability to do basic work activities and the evaluation continues to the seventh step.

The *seventh step* is to determine whether the beneficiary has the capacity to do the work that he or she did before having a disability. If the beneficiary has the ability to do past work, then benefits are discontinued. If the beneficiary does not have the ability to do work he or she has done in the past, the evaluation continues to the eighth step.

The *eighth step* is to determine if the beneficiary has the ability to do other work. At this step, the disability examiner considers the complete vocational profile (the beneficiary's age, education, and past relevant work experience) together with the beneficiary's RFC to determine if he or she has the ability to do other work. If the beneficiary has the ability to do other work, disability benefits are discontinued. If he or she does not have the ability to do other work, benefits are continued.

Appendix III: Comments from the Social Security Administration

SOCIAL SECURITY
The Commissioner

September 8, 2006

Mr. Robert E. Robertson
Director, Education, Workforce
and Income Security Issues
U.S. Government Accountability Office
Room 5-T-57
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Robertson:

Thank you for the opportunity to review and comment on the draft report "SOCIAL SECURITY DISABILITY PROGRAMS - Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently" (GAO-07-8). Our comments on the report are enclosed.

If you have any questions, please have your staff contact Candace Skurnik, Director, Audit Management and Liaison Staff at (410) 965-4636.

Sincerely,

Jo Anne B. Barnhart

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS ON THE GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT, "DISABILITY PROGRAMS: CLEARER GUIDANCE COULD HELP SSA APPLY THE MEDICAL IMPROVEMENT REVIEW STANDARD MORE CONSISTENTLY" (GAO-07-08)

Thank you for sharing the draft report with us for comment.

We agree with GAO that our medical improvement review standard (MIRS) regulatory framework, and present-day application of such framework, protects beneficiaries' rights. We also agree with GAO that we should provide refresher training on MIRS to ensure consistent adjudication in all MIRS cases.

We appreciate that the draft report does not make specific recommendations about what GAO believes to be the appropriate degree of medical improvement necessary to meet the standard or how we should provide clarification of the rules for deciding medical improvement. As we indicate in several of our more detailed comments below, there is an inherent degree of judgment in these determinations, as well as virtually limitless variations in case facts, such that it may not be possible to quantify a more specific standard that would be meaningful and helpful. We also note that GAO gathered survey opinions that might suggest lowering the threshold for showing medical improvement; we believe that requiring evidence of only de minimis or minor medical improvement would arguably circumvent and be contrary to the intent and spirit of the MIRS statutory provision.

Our more detailed comments follow.

GAO was asked (1) to examine the proportion of beneficiaries who are removed from the disability programs because they have medically improved and (2) to determine if factors associated with the standard pose challenges when determining whether beneficiaries continue to be eligible for benefits. With regard to the second request, GAO concluded that:

- Limitations in SSA guidance for assessing medical improvement may result in inconsistent application of the standard.
- SSA guidance regarding the exceptions to the medical improvement review standard (MIRS) tends to limit their use and may result in benefits continuing for some individuals who may be able to work.
- There is an incorrect application of one element of the standard, specifically that continuing disability reviews (CDRs) should be conducted on a neutral basis and without a presumption that an individual continues to be disabled.
- Decisions whether disability ends are limited by inadequate documentation of evidence and the judgmental nature of the decision process concerning what constitutes medical improvement.

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We address each of these issues in turn, after first commenting on some of the statistical data included in the draft report.

1. The proportion of beneficiaries who are removed from the disability programs because they have medically improved and other data in the draft report

The draft report (on page 5) provides data for the 1981-82 period, when about 45 percent of CDRs resulted in termination, which can be contrasted with the data provided for the 1999-2005 period (on pages 1 and 2), when only 2.8 percent of beneficiaries who received a CDR were terminated. Presumably, this comparison is intended to illustrate the dramatic effect of the change to the MIRS in 1985 as a result of the 1984 legislation enacted by Congress. However, the 1981-82 period is not representative of the results of the CDR process before the MIRS standard was introduced. In response to the 1980 Social Security amendments and reports that suggested there were many non-disabled persons receiving disability benefits, an aggressive effort was initiated in 1981 to remove beneficiaries from the DI program whose impairments were not severe enough to entitle them to benefits. This effort focused on beneficiaries who were deemed at the time most likely to be determined not disabled and led to a temporary large increase in the number of DI program terminations in the early to mid-1980's. We suggest that GAO use a period prior to 1981 for a more appropriate comparison of the effects of the two approaches to evaluating continuing disability.

Also, the pie chart on page 12 of the draft report shows that 19 percent of terminations are due to conversion to retirement benefits and 45 percent are due to "other" reasons. However, about 44 percent of DI terminations are due to retirement conversion and less than 5 percent are for "other" reasons, while there is no retirement conversion in the SSI program and the most prominent reason for SSI terminations is excess income, which accounts for about 60 percent of all terminations. We believe that using one pie chart for both programs may be misleading and mask program differences. Therefore, we suggest that the report include a separate pie chart for each program.

2. Limitations in SSA guidance for assessing medical improvement may result in inconsistent application of the standard

The draft report actually seems to make two related recommendations in this regard, although only one of them is presented consistently. The draft report correctly notes that under the Act we may find that an adult's disability has ended only if the evidence establishes both that there has been medical improvement and that any medical improvement is "related to the ability to work." Under our regulations, these are separate inquiries, but the draft report does not consistently state whether GAO is recommending that we clarify both policies or just the policy for determining if there has been medical improvement. However, we were impressed by the extent and variety of opinions GAO was able to gather from our Disability Determination Services, Administrative Law Judges, and others within the agency who use and interpret our instructions and it is clear

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to us that we should do some training to clarify how adjudicators should address these issues.

Nevertheless, the implication in the draft that any such clarification will have a noticeable, if not significant, impact on the number of cases in which we find that disability has ended is probably not well founded. For example, even if we were to "clarify" that a relatively small change in a sign, symptom, or laboratory finding would be sufficient to show that there was medical improvement it would be very unlikely that such a small change would be shown to be "related to the ability to work" at the next step of the MIRS sequential evaluation process or result in a finding that the individual has again become able to work. Therefore, unless they are using very high thresholds for determining whether there is medical improvement, the fact that some DDSs report that they use relatively higher thresholds than others[1] is unlikely to make a significant difference in the number of their determinations that disability has ended.[2]

3. SSA guidance regarding the exceptions to the medical improvement review standard tends to limit their use and may result in benefits continuing for some individuals who may be able to work

The purpose of GAO's recommendation that we provide training on the appropriate use of the exceptions was not clear to us. The body of the draft report suggests that SSA guidance "appears to discourage and limit the use of the exceptions," especially the exception that allows a subsequent adjudicator to determine that a prior adjudicator's finding of disability (or continuing disability) was in error.[3] The draft reports anecdotal

[1] We noted on page 16 of the draft the statement that, "Specifically, 17 of 49 [DDS] directors reported that a large or very large increase in a recipient's ability to do basic work activities is required; 24 reported that a moderate increase is required; and 8 reported that a minor or any increase at all is required." However, since at least one of the terms ("moderate") used in the question was itself vague, it is not clear what standard the DDS administrators had in mind when they answered the question, nor do we believe that it would be especially helpful to add such terms to our instructions; for example, we do not believe it would be significantly better to require that there must be a "moderate" improvement in a sign, symptom, or laboratory finding to show medical improvement instead of more than "minor." It would be difficult, if not impossible, to quantify "the degree of improvement required to meet the standard" (draft, page 22) in every case. Also, please see the technical comments that follow these comments. It appears that the survey question may have improperly conflated the policy of "medical improvement" with consideration of the ability to do work-related activities.

[2] In this regard, we note on page 15 of the draft the statement, "Of the 52 DDS directors who answered a question in our survey on 'minor' changes, 21 reported that the practice of disregarding minor changes is not an impediment to making a disability determination, while 31 reported that it is an impediment." The draft draws no inferences from this statement, but we must point out that our policy not to consider "minor" changes appears to be consistent with the Act's requirement that there be "substantial evidence" demonstrating not only that there has been "any medical improvement" but that the improvement must be related to the ability to work. While a requirement for more than a minor change in the individual's medical condition might be an "impediment" to a subsequent reviewer's ability to cease entitlement, we believe that such a requirement is consistent with legislative history of the 1984 amendments indicating disapproval of termination for individuals "whose medical condition has not changed substantially since they were allowed."

[3] Draft pp. 16-17. For the recommendation, see pp. 21-22.

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information from adjudicators who may have expressed concerns that they were unable to change prior favorable decisions in as many cases as they might have liked.

The draft does not provide a GAO opinion about this finding, nor does it indicate that GAO found any evidence that the exceptions are being misapplied or not used in situations in which they should be used. Therefore, it was not clear what GAO is suggesting we should train about, and we suggest that the report explain why GAO believes we should provide such training; for example, whether GAO believes that we should broaden our interpretation of the error exception and allow adjudicators to make findings of decisional error more often or encourage them to consider whether prior decisions were in error more often than they do now.

We believe that our implementation of the statutory exceptions to medical improvement is appropriate and that our instructions are consistent with the intent of the law. We recommend that, in presenting this issue in the final report, GAO discuss not only the anecdotal and opinion information they gathered but the legislative history of the exception provisions and SSA's statements about those provisions in the preamble to the publication of the original MIRS regulations in 1985.[4] In the preamble to the final rules, we explained in essence that we did intend the exceptions to be true "exceptions"--that is, not to be applied routinely--including our reasons for limiting the "error" exception in the manner that GAO found and our adjudicators reported. A broader application of the error exception could lead to a substitution of judgment by an adjudicator for the original finding of disability when the person's "medical condition has not changed substantially." This quote from the 1984 legislative history indicates disapproval of termination for individuals whose medical condition had not changed substantially since the time they were awarded benefits.

4. There is an incorrect application of one element of the standard, specifically that continuing disability reviews (CDRs) should be conducted on a neutral basis and without a presumption that an individual continues to be disabled

Based on GAO's findings regarding adjudicator knowledge and application of this provision of the statute and our regulations, we agree that training is needed and will provide it. However, we would also like to comment that the implication in the draft report that better, more consistent adjudicator understanding of this provision would result in more cessations is unlikely. We believe that the major reasons for the provision in the statute were to address the climate of the times: the perception that the Agency had gone too far in the early 1980's in terminating beneficiaries, perhaps based on a presumption of non-disability, and court decisions of the time that held that there was a continuing presumption of disability on the other. The conference report for the legislation (98-1039, September 19, 1984) explained:

> The conference agreement attempts to strike a balance between the concern that a medical improvement standard could be interpreted to grant claimants a presumption of eligibility, which might make it extremely difficult to remove

[4] See 50 FR 50118, 50120 and 50123.

ineligible individuals from the benefit rolls, and the concern that the absence of an explicit standard of review or some alternative standard could be interpreted to imply a presumption of ineligibility or to allow arbitrary termination decisions, which might lead to many individuals being improperly removed from the rolls.

These issues are best addressed by ensuring that the MIRS sequential evaluation process is correctly followed. However, we agree with the draft that determinations of continuing disability, like determinations of initial entitlement, are often inherently subjective so we agree that it is appropriate that we take steps to ensure that adjudicators approach these cases neutrally, as required by the statue and our regulations.

5. Decisions that disability ends are limited by inadequate documentation of evidence and the judgmental nature of the decision process concerning what constitutes medical improvement

We appreciate the recognition in the draft report that we are taking steps to improve the quality of our case development and decisions. The report also correctly recognizes that the determinations in many of these cases are inherently subjective. It appears that there is no additional recommendation in the report regarding these issues.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

The following team members made key contributions to this report: Kelly Agnese; Jeremy D. Cox; Susan E.M. Etzel; Stuart M. Kaufman; Luann M. Moy; George H. Quinn, Jr.; Daniel A. Schwimer; Salvatore F. Sorbello; Wayne T. Turowski; Vanessa R. Taylor; and Rachael C. Valliere.

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