



Testimony Before the Subcommittee on Energy
Policy, Health Care, and Entitlements,
Committee on Oversight and Government
Reform, House of Representatives

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SOCIAL SECURITY DISABILITY PROGRAMS

SSA Could Take Steps to Improve Its Assessment of Continued Eligibility

Statement of Daniel Bertoni, Director
Education, Workforce, and Income Security Issues

GAO Highlights

Highlights of [GAO-14-492T](#), testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

SSA administers DI and SSI, two disability programs that provided \$189 billion in cash benefits to eligible adults and children in 2012. Both the numbers of DI and SSI recipients, as well as program costs, have grown in recent years and are poised to grow further in the future. Both the initial determination of an individual's medical eligibility at the time of application and CDRs after benefits have been granted are key to ensuring the integrity of these programs. CDRs also provide a check on program growth in a time of constrained federal resources. Since 1984, federal law has generally required SSA to find substantial evidence demonstrating medical improvement during a CDR before ceasing a recipient's benefits—known as the medical improvement standard.

In this statement, GAO describes (1) SSA's efforts to monitor DI and SSI beneficiaries' continued eligibility, and (2) factors associated with the medical improvement standard that affect these efforts. This testimony is primarily based on GAO products related to these issues from 2006 and 2012. GAO also updated selected information related to SSA's CDR backlog, budget requests, and guidance for assessing medical improvement as of 2014.

What GAO Recommends

GAO is not making any new recommendations at this time.

View [GAO-14-492T](#). For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov.

April 2014

SOCIAL SECURITY DISABILITY PROGRAMS

SSA Could Take Steps to Improve Its Assessment of Continued Eligibility

What GAO Found

The Social Security Administration (SSA) reported in January 2014 that it is behind schedule in assessing the continued eligibility of recipients in its two disability programs, Disability Insurance (DI) and Supplemental Security Income (SSI), and has accumulated a backlog of 1.3 million continuing disability reviews (CDRs). From fiscal years 2000 to 2011, the numbers of adult and child CDRs conducted fell about 70 percent. Children make up about one fifth of all SSI recipients, and GAO reported in 2012 that many of their CDRs were overdue. For example, more than 24,000 CDRs for children with mental impairments were overdue by 6 or more years, including over 6,000 CDRs for children who were expected to medically improve within 6 to 18 months of their initial determination. GAO also identified several cases which exceeded their scheduled review date by 13 years or more. When CDRs are not conducted as scheduled, the potential for improper payments increases as some recipients receive benefits for which they are no longer eligible. In September 2011, SSA's Office of the Inspector General estimated that SSA had paid about \$1.4 billion in SSI benefits to children who should have not received them. SSA attributes delays in performing CDRs to resource limitations and other factors; SSA also generally gives lower priority to conducting CDRs for children receiving SSI. In 2012, GAO recommended that SSA eliminate the existing CDR backlog for children with impairments who are likely to improve, and regularly conduct reviews for this group. While SSA generally agreed with GAO's recommendation, the CDR backlog remains.

During CDRs, disability recipients that SSA determines to have improved medically may be removed from the program; however, several factors may hinder SSA's ability to make this determination. In 2006, GAO reported that 1.4 percent of people who left the disability programs did so because SSA found that they had improved medically. At that time, GAO identified several factors that hindered SSA's ability to assess whether DI and SSI recipients met the medical improvement standard. These included: (1) limitations in SSA guidance for applying the standard; (2) inadequate documentation of prior disability determinations; (3) failure to abide with the requirement that CDR decisions be made on a neutral basis—without a presumption that the recipient remained disabled; and (4) the judgmental nature of the process for assessing medical improvement. Since 2006, SSA has taken some steps to address these issues; however, the agency has not fully clarified policies for assessing medical improvement, as GAO recommended.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to discuss our prior work on the Social Security Administration's (SSA) efforts to assess Disability Insurance (DI) and Supplemental Security Income (SSI) recipients' continued medical eligibility for benefits. In 2012, these disability programs provided \$189 billion in cash benefits to 10.9 million DI recipients and 8 million SSI recipients, including adults and children. Both the numbers of DI and SSI recipients, as well as program costs, have grown in recent years, and both are poised to grow further in the future because of economic and population changes. Federal law, as well as SSA's regulations and guidance, prescribe policies and procedures intended to ensure that only those eligible to receive benefits do so. Both the initial determination of an individual's medical eligibility at the time of application and assessments conducted after benefits have been granted are key to ensuring the integrity of these programs. Assessments of continued eligibility provide an important check on program growth by removing ineligible recipients from the rolls, even while new applicants are added. If these reviews are not conducted in sufficient numbers, the agency will continue to struggle to contain growth in benefit payments, placing added burden on already strained federal resources. Over the years, the Congress has taken actions to add requirements related to SSA's review of recipients' continued medical eligibility for benefits. For example, beginning in 1982, federal law required SSA to conduct certain continuing disability reviews (CDRs) for this purpose, and since 1984, federal law has generally required SSA to find substantial evidence demonstrating medical improvement before ceasing a recipient's benefits—known as the medical improvement standard.

My remarks today are based on our prior work that found several factors hindered SSA's efforts to assess disability program recipients' continued medical eligibility for benefits. I will discuss (1) SSA's efforts to monitor DI and SSI recipients' continued eligibility, and (2) factors associated with the medical improvement standard that affect these efforts. This information was drawn primarily from two reports we issued in 2006 and 2012, as well as a review of SSA's current related data we performed in March and April 2014. Specifically, we updated selected information related to SSA's CDR backlog, budget requests, and guidance for

assessing medical improvement as of 2014.¹ For our prior reports, we reviewed relevant federal law, regulations, and guidance; interviewed SSA officials; and also relied on a variety of additional methodologies. For example, for our 2006 report on the medical improvement standard,² we surveyed all 55 state directors responsible for disability determination services (DDS), and for our 2012 report on children receiving SSI benefits,³ we conducted site visits to 9 SSA field offices and 11 state DDS offices and reviewed SSA's data on CDRs conducted from fiscal years 2000 to 2011. We conducted our work in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

SSA administers two disability programs that provide monthly cash benefits to eligible individuals: DI, enacted in 1956, and SSI, enacted in 1972. DI provides monthly cash benefits to eligible workers unable to work because of a long-term disability and who have paid into the Social Security Trust Fund, whereas SSI provides monthly cash benefits to people with disabilities on the basis of need, regardless of whether they have paid into the Social Security Trust Fund. In order to be eligible for DI or SSI benefits based on a disability, an individual must meet the definition of disability for these programs—that is, they must have a medically determinable physical or mental impairment that (1) prevents

¹Beyond this review, we did not update our analyses from our prior reports.

²GAO, *Social Security Disability Programs: Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently*, [GAO-07-8](#) (Washington, D.C.: October 3, 2006).

³GAO, *Supplemental Security Income: Better Management Oversight Needed for Children's Benefits*, [GAO-12-497](#) (Washington, D.C.: June 26, 2012).

the individual from engaging in any substantial gainful activity and (2) has lasted or is expected to last at least 1 year or result in death.⁴

The disability determination process is the same for DI and SSI applicants. An SSA field office determines that an applicant has met SSA's nonmedical eligibility requirements for disability benefits,⁵ and then the applicant's claim is sent to the state DDS for an initial review of the claimant's medical eligibility.⁶ After assembling all medical and vocational information for the claim, a DDS examiner, in consultation with appropriate medical staff, determines whether the claimant meets the requirements of the law for having a disability. Claimants who are dissatisfied with the initial DDS determination may choose to pursue several levels of appeal, including: a "reconsideration" of the claim, conducted by DDS personnel who were not involved in the original decision; a hearing before an administrative law judge (ALJ); and a review of the claim by the Appeals Council, which is comprised of administrative appeals judges and appeals officers. Final SSA decisions are also subject to review in federal district court.

If SSA determines that an individual is disabled, the agency is required to conduct periodic CDRs to ensure that only recipients who remain disabled continue to receive benefits.⁷ These reviews assess whether individuals are still eligible for benefits based on several criteria, including their current medical condition and ability to work.⁸ DDS staff generally

⁴42 U.S.C. §§ 423(d)(1)(A) and 1382c(a)(3)(A). Substantial gainful activity is generally work activity involving significant physical or mental activities that is done for pay or profit, whether or not a profit is realized. 20 C.F.R. §§ 404.1572 and 416.972. In 2012, the substantial gainful activity threshold was \$1,690 per month for blind recipients and \$1,010 per month for individuals with other disabilities.

⁵For example, field office staff are to ensure that an SSI applicant meets income and resource requirements and determine if a DI applicant has a sufficient work history.

⁶Although SSA is responsible for administering these programs, the law allows for initial determinations of disability to be made by state agencies, known as DDS offices. See 42 U.S.C. § 421(a)(1). The work performed at DDS offices is federally funded and is carried out in accordance with applicable federal laws, as well as SSA regulations, policies, and guidelines.

⁷SSA's regulations pertaining to CDRs for DI and SSI can be found at 20 C.F.R. §§ 404.1589 and 416.989, respectively.

⁸In addition to medical CDRs, SSA also conducts "work CDRs" in which it assesses if an individual's earnings exceeded program limits. This testimony focuses on medical CDRs.

establish the timeframe for when SSA should conduct a CDR on the basis of the expected likelihood of a recipient's medical improvement. However, SSA also uses a profiling model to score and prioritize CDRs if funding is not available to conduct all scheduled CDRs.

In response to prior concerns that some recipients were being arbitrarily removed from the disability programs via the CDR process, Congress passed the Social Security Disability Benefits Reform Act of 1984,⁹ which, among other things, established a medical improvement standard. Under this standard, SSA may only discontinue benefits for an individual if it finds substantial evidence demonstrating both that a beneficiary's medical condition has improved¹⁰ and that the individual is able to engage in substantial gainful activity.¹¹ If SSA determines that these conditions have not been met in the course of conducting a CDR, the recipient may continue to receive benefits until the individual receives a subsequent CDR (which potentially could result in a discontinuation of benefits), dies, or transitions to Social Security retirement benefits.

⁹Pub. L. No. 98-460 § 2, 98 Stat. 1794.

¹⁰The regulations implementing the act define improvement as any decrease in the medical severity of the recipient's impairment(s) since the last time SSA reviewed his or her disability, based on improvements in symptoms, signs, or laboratory findings.

¹¹42 U.S.C. §§ 423(f)(1) and 1382c(a)(4)(A)(i). The medical improvement standard for individuals under the age of 18 who receive SSI benefits is different. See 42 U.S.C. § 1382c(a)(4)(B). The law also identifies certain other limited circumstances under which benefits may be discontinued, besides the medical improvement standard. See 42 U.S.C. § 423(f) and § 1382c(a)(4)(A) and (C).

SSA Has a Backlog of More Than 1 Million DI and SSI Benefit Eligibility Reviews

SSA reported in January 2014 that it is behind schedule in assessing the continued eligibility of DI and SSI recipients and has accumulated a backlog of 1.3 million CDRs. In recent years, SSA has cited resource limitations and a greater emphasis on processing initial claims and requests for hearings appeals as reasons for the decrease in the number of CDRs conducted. From fiscal years 2000 to 2011, the number of adult CDRs fell from more than 580,000 to about 180,000 (69 percent)¹² and the number of childhood CDRs fell from more than 150,000 to about 45,000 (70 percent), according to our analysis of SSA data (see fig. 1).¹³ More specifically, CDRs for children under age 18 with mental impairments—a group that comprises a growing majority of all child SSI recipients—declined from more than 84,000 to about 16,000 (an 80 percent decrease).

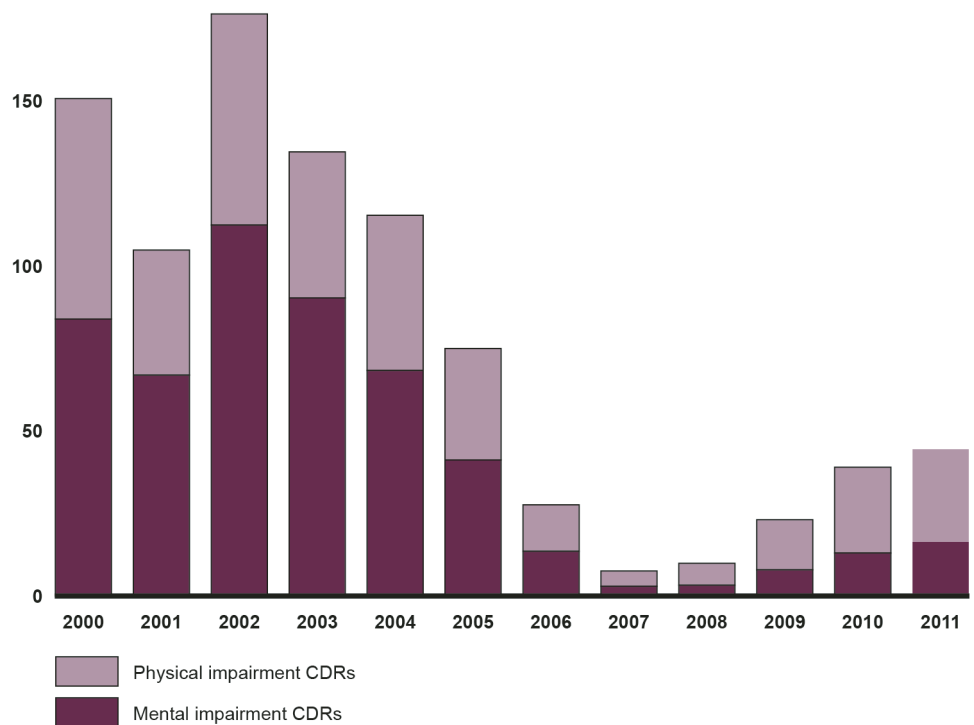
¹²In general, DDS staff consider the likelihood of a recipient's medical improvement when establishing the timeframe for when SSA should conduct a CDR. Improvement categories and general time frames used are (1) "medical improvement expected," 6 to 18 months; (2) "medical improvement possible," 3 years; and (3) "medical improvement not expected," 5 to 7 years. For adults receiving SSI, SSA conducts CDRs using two methods: (1) SSA headquarters sends some cases to the DDS for a full medical review, and (2) SSA mails a questionnaire to other recipients and reviews their responses to determine continued eligibility. At this time, SSA does not use the mailer process for SSI child recipients. For comparability in the number of CDRs for adults and children, the CDR data in this section apply to full medical reviews only.

¹³With respect to children receiving SSI benefits, under Title XVI of the Social Security Act, SSA is generally required to (1) conduct a CDR at least every 3 years on all child recipients under age 18 whose impairments are likely to improve (or, at the Commissioner's option, recipients whose impairments are unlikely to improve) (42 U.S.C. § 1382c(a)(3)(H)(ii)(I)); (2) conduct a CDR within 12 months after the birth of a child who was granted benefits in part because of low birth weight (42 U.S.C. § 1382c(a)(3)(H)(iv)); and (3) redetermine, within 1 year of the individual's 18th birthday (or whenever the Commissioner determines the individual is subject to a redetermination), the eligibility of any individual who was eligible for SSI childhood payments in the month before attaining age 18, by applying the criteria used in determining initial eligibility for adults (42 U.S.C. § 1382c(a)(3)(H)(iii)). For children under the age of 18—except for the initial CDR for low birth weight babies—DDS offices are directed by SSA policy to determine when recipients will be due for CDRs on the basis of their potential for medical improvement, and select and schedule a review date—otherwise known as a "diary date"—for each recipient's CDR.

Figure 1: Number of Childhood CDRs Conducted for SSI Recipients under Age 18, by Primary Impairment, Fiscal Years 2000 through 2011

CDRs (in thousands)

200



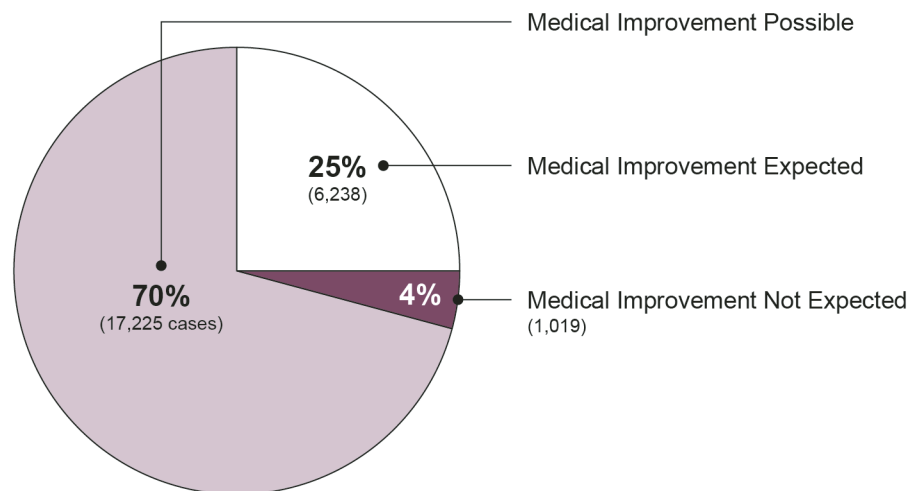
Source: GAO analysis of Social Security Administration data from the Continuing Disability Review (CDR) Waterfall Files.

Children make up about one fifth of all SSI recipients, and we reported in 2012 that a large proportion of their CDRs were overdue. For example, CDRs for about one half of all child recipients with mental impairments (435,000) were overdue, according to our analysis of SSA data in 2012.¹⁴ Of these recipients, about 344,000 (79 percent) had exceeded the scheduled date by at least a year, with about 205,000 (47 percent) exceeding their date by 3 years, and about 24,000 (6 percent) exceeding the scheduled date by 6 years. We also identified several cases which

¹⁴A total of about 861,000 child recipients with mental impairments were receiving SSI benefits as of December 2011.

exceeded their scheduled date by 13 years or more. Of the 24,000 childhood CDRs pending 6 years or more, we found that about 70 percent (over 17,000) were for children who had been categorized as “medical improvement possible” at initial determination, while 25 percent (over 6,000) of these pending CDRs were for those children deemed medically expected to improve within 6 to 18 months of their initial determination (see fig. 2). Of these cases, we identified nine recipients who were expected to medically improve, but whose CDR had been pending for 13 years or more. Reviews of children who are expected to medically improve are more productive than reviews of children who are not expected to medically improve because they have a greater likelihood of benefit cessation and thus yield higher cost savings over time.

Figure 2: Childhood CDRs Pending for at Least 6 Years, by Anticipated Medical Improvement Category, for Children with Mental Impairments



Source: GAO analysis of Social Security Administration data from the Continuing Disability Review (CDR) Waterfall Files.

Note: Percentages do not equal 100 percent due to rounding.

When CDRs are not conducted as scheduled, the potential for improper payments may increase as some recipients can receive benefits for which they are no longer eligible. In September 2011, SSA’s Office of the Inspector General estimated that SSA had paid about \$1.4 billion in SSI benefits to approximately 513,000 recipients under age 18 who should

have not received them—some of whom were pending reviews for 5 or more years.¹⁵ The Inspector General estimated that SSA will continue to make improper payments of approximately \$461.6 million annually until these reviews are completed. Furthermore, in its May 2012 CDR report, SSA estimated a program savings of \$9.30 for every \$1 invested in conducting CDRs and projected that those CDRs conducted for adult DI and SSI recipients and for child SSI recipients combined in fiscal year 2010 would have saved federal programs the present value of estimated lifetime benefits of \$3.5 billion.¹⁶

For several reasons, SSA has placed a higher priority on conducting CDRs for DI recipients, although children's SSI benefits are more likely to be ceased after review. According to SSA officials, when CDR funding is less than what is needed to conduct all CDRs at the scheduled intervals, the agency has historically given priority to performing reviews considered to be the most cost-effective, as well as staying current with DI CDRs and performing two specific statutorily required SSI reviews.¹⁷ SSA officials told us that it is more cost effective to conduct adult DI CDRs than childhood SSI CDRs, because ceasing benefits for a young adult DI recipient may potentially represent decades of saved benefits. For SSI, statutorily required age 18 redeterminations are cost effective for the

¹⁵The SSA Inspector General estimated that SSA did not complete 79 percent of childhood CDRs and 10 percent of age 18 redeterminations on the basis of the results of 275 cases of physical and mental impairments they reviewed. To estimate the amount of SSI payments made because SSA had not completed a timely childhood CDR, the Inspector General calculated the amount of SSI payments made between the 1-year anniversary of the scheduled CDR date and the earlier of the month of cessation or April 2011 (the date the Inspector General reviewed the cases).

¹⁶This represents the combined savings to the SSI, DI, Medicare, and Medicaid programs from CDRs conducted for the SSI and DI programs, from cessations and terminations due to failure to cooperate with a CDR in fiscal year 2010. The estimate includes savings to Medicare and Medicaid, as in some cases eligibility for SSI and SSDI confers eligibility for certain Medicare or Medicaid benefits, as well. SSA noted that the savings-to-cost ratio for fiscal year 2010 represents a significant drop from the average ratio for fiscal years 1996 through 2009 of \$10.60 to \$1, attributing the drop largely to the Medicaid estimates, which now reflect the effects of a Patient Protection and Affordable Care Act provision that allows most disabled SSI recipients terminated due to a CDR to retain their Medicaid coverage beginning January 1, 2014. *Annual Report of Continuing Disability Reviews, Fiscal Year 2010*.

¹⁷In particular, SSA officials identified the following two reviews: age 18 redeterminations, which are required within 1 year after a child turns age 18, and reviews required within 12 months after birth for recipients whose low birth weight was a contributing factor material to the determination of their disability. 42 U.S.C. § 1382c(a)(3)(H)(iii) and (iv), respectively.

same reason. Additionally, because DI benefit payments are, on average, almost twice as much as SSI childhood payments, CDRs of adult DI cases generally produce greater lifetime savings, according to SSA officials. However, SSA reported that it ceased about 12 percent of all adult DI claims that received a CDR. In comparison, our analysis of SSA's data showed that 32 percent of child SSI claims that received a CDR were ceased in fiscal year 2011. For example, of those childhood CDRs conducted for children under age 18 with mental impairments, SSA ceased benefits for about 28 percent on average in fiscal year 2011, with personality disorders and speech and language delay having the highest cessation rates, 39 and 38 percent, respectively.¹⁸ Despite these high cessation rates, SSA and state DDS officials have acknowledged that the agency has not conducted reviews for child recipients in a timely manner, and in some cases, they have not conducted childhood CDRs prior to a child's age 18 redetermination.

In our 2012 report, we recommended that SSA eliminate the existing CDR backlog of cases for children with impairments who are likely to improve and, on an ongoing basis, conduct CDRs at least every 3 years for all children with impairments who are likely to improve, as resources are made available for these purposes. SSA generally agreed that it should complete more CDRs for SSI children but emphasized that it is constrained by limited funding and competing DI and SSI workloads. Moving forward, one of the major objectives in SSA's Fiscal Year 2013-2016 Strategic Plan¹⁹ is to "increase efforts to accurately pay benefits," and the Plan indicates that SSA intends to conduct more CDRs, as funding is available. In addition, as part of the President's fiscal year 2014 budget request, SSA asked for \$1.227 billion to create a new Program Integrity Administrative Expenses account that the agency says would

¹⁸The cessation rates cited in this paragraph reflect "initial cessations," meaning that the agency concluded at the end of the CDR that the claimant involved no longer met the eligibility standards to continue receiving benefits, and therefore started the process to cease benefits. Claimants may subsequently avail themselves of an appeals process, which can result in a reversal of the initial cessation.

¹⁹SSA, *Strategic Plan: Security Value for America, Fiscal Years 2013-2016* (Feb. 2012).

establish a more reliable stream of mandatory program integrity funding.²⁰ While additional funding may help address the CDR backlog, we continue to have concerns about the agency's ability to manage limited funds in a manner that adequately balances its public service priorities with its stewardship responsibility. Because SSA has noted that it considers SSI childhood CDRs to be a lower priority than other CDRs, it is unclear whether the agency will use new increases in funding to review children most likely to medically improve—reviews that could yield a high return on investment.

Several Factors Associated with the Medical Improvement Standard Have Challenged the Assessment of Recipients' Continued Eligibility

During CDRs, disability recipients that SSA determines have improved medically may cease receiving benefits; however, several factors may hinder SSA's ability to make this determination. In 2006,²¹ our analysis of SSA data showed that 1.4 percent of all the people who left DI and SSI between fiscal years 1999 and 2005 did so because SSA found that they had improved medically; however, more recipients left for other reasons, including conversion to regular Social Security retirement benefits or death. At that time, we identified a number of factors that challenged SSA's ability to assess DI and SSI recipients using the medical improvement standard.²²

- *Guidance limitations*—Limitations in the SSA guidance then in effect for applying the medical improvement standard may have resulted in inconsistent disability decisions. Specifically, in 2006, SSA guidance on CDRs instructed examiners to disregard "minor" changes in a recipient's condition without defining what constituted a minor change.

²⁰This proposal was also included in the President's fiscal year 2015 budget request. According to a statement by Acting Commissioner Carolyn Colvin, the Program Integrity Administrative Expenses account, as proposed, would be separate, and in addition to, SSA's Limitation on Administrative Expenses account. Under the proposal, the funds would be available for 2 years, providing SSA with the flexibility to hire and train staff to support the processing of more program integrity work. See Carolyn W. Colvin, Acting Commissioner, SSA, *Statement for the Record*, testimony before Subcommittee on Social Security, Committee on Ways and Means, United States House of Representatives, January 16, 2014.

²¹See GAO, *Social Security Disability Programs: Clearer Guidance Could Help SSA Apply the Medical Improvement Standard More Consistently*, [GAO-07-8](#) (Washington, D.C.: October 3, 2006).

²²As previously noted, beyond our review of currently available data, we did not update our 2006 analyses.

In addition, when assessing whether improvements in recipients' medical conditions were related to their ability to work, the SSA guidance instructed examiners to ensure a "reasonable relationship" between the amount of improvement and the increase in the ability to perform basic work activities. However, at that time, the guidance did not require a specific amount of increase in functioning to better guide examiners in their decision making.

- *Inadequate documentation*—If a prior disability determination was inadequately documented, it can be challenging for the disability examiner to demonstrate medical improvement in a CDR. Because the prior decision is the starting point for conducting a CDR and examiners are required to find evidence of medical improvement since that last decision in order to cease benefits, inadequate documentation of evidence in prior decisions may make it difficult to assess medical improvement. In our 2006 survey, some DDS directors commented that cases decided on appeal were the most likely to lack adequate documentation. Several officials reported that guidance in effect at that time instructed ALJs to include enough information to make their decisions legally sufficient, but there was no specific instruction to include all of the evidence that would be needed to assess medical improvement as part of a future CDR.
- *Presumed disability*—According to our 2006 survey,²³ a majority of DDSs incorrectly presumed that a recipient had a disability when the CDR was being conducted, which may have made it more difficult for examiners to determine if a recipient had improved medically. We reported that this practice is contrary to the law as well as SSA

²³We 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. 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 medical improvement standard impacts outcomes of CDRs and determine if the standard poses any special challenges for SSA when determining whether recipients continue to be eligible for benefits. The results of this survey are available in GAO-07-4SP, *Social Security Disability Programs: Survey of Disability Determination Services Directors*, an E-supplement to [GAO-07-8](#).

regulations and policy, which require that CDR decisions be made on a “neutral basis.”²⁴

- *Reliance on judgment*—The judgmental nature of the process for assessing medical improvement likely hinders its reliability. For example, one examiner may determine that a recipient 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.²⁵ Furthermore, we previously found that the amount of judgment involved in the decision-making process increases when the process involves certain types of impairments, such as psychological impairments, which are more difficult to assess than other impairments, such as physical impairments.

These issues have implications for the consistency and fairness of SSA’s medical improvement decision-making process, and in 2006, we recommended that SSA clarify policies for assessing medical improvement. Since then, SSA has taken some steps that may help address the issues we raised but has not fully implemented the actions we recommended. In 2009, SSA began implementing an electronic claims analysis tool for use during initial disability determinations to (a) document a disability adjudicator’s detailed analysis and rationale for either allowing or denying a claim, and (b) ensure that all relevant SSA policies are considered during the disability adjudication process. In

²⁴At the time our 2006 report was issued, SSA defined neutral basis as a review that neither presumes that a recipient (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. See also 42 U.S.C. § 423(f), 42 U.S.C. § 1382c(a)(4), 20 C.F.R. § 404.1594(b)(6), and 20 C.F.R. §§ 416.994(b)(1)(vi) and 416.994a(a)(2).

²⁵In one of the CDR cases that we reviewed for our 2006 report, 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 recipient 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.

addition, SSA reported in February 2013 that it was developing a tool to help hearing offices standardize and document the hearing decision process and outcome. However, SSA's guidance for assessing medical improvement may continue to present challenges when applying the standard. As of April 2014, the guidance does not provide any specific measures for what constitutes a "minor" change in medical improvement,²⁶ and it instructs examiners to exercise judgment in deciding how much of a change justifies an increase in the ability to work.²⁷

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

Contacts and Acknowledgments

If you or your staff have any questions about this testimony, 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 statement. GAO staff who made key contributions to this testimony include James Bennett, Holly Dye, Rachel Frisk, Isabella Johnson, Kristen Jones, Sheila McCoy, and Walter Vance.

²⁶See SSA Program Operations Manual System (POMS) section DI 28010.015. The standards state that "although the decrease in severity may be of any quantity or degree, we will disregard minor changes in your signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that your disability has ended."

²⁷See POMS section DI 28015.320.

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Dan Bertoni

Daniel Bertoni is Director for disability issues with the U.S. Government Accountability Office. Mr. Bertoni began his career with GAO in 1989 and over the course of his career, has overseen numerous management and program integrity reviews at SSA, VA, DOD, and other federal agencies. He has also developed an extensive body of work on the many challenges facing federal disability programs, which GAO designated high-risk in 2003. Mr. Bertoni holds a Masters degree in Political Science and is a member of the National Academy of Social Insurance (NASI).