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Prepared by the Staff of the

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

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A. Introduction

The Social Security Administration is charged with the administration of two national disability programs: the disability insurance program (DI) and the supplemental security income program (SSI). The disability insurance program provides benefits in amounts related to a disabled worker's former wage levels in covered employment. Funding is provided through the social security payroll tax, a portion of which is allocated to a separate disability insurance trust fund. The SSI program provides cash assistance benefits to the needy blind and disabled, many of whom do not have recent attachment to the labor force. The benefit amount is based on the amount of other income available to the individual. Unlike DI benefits, the SSI benefits are funded through appropriations from general revenues.

B. Disability Insurance

The disability insurance (DI) program established by title II of the Social Security Act provides monthly benefits averaging $320 to some 2.9 million disabled workers. Benefits are also payable under the program to approximately 2 million dependent spouses and children of these disabled workers. For a disabled-worker *family*, monthly benefits average $639. The maximum benefit which could be paid to a worker who becomes disabled in 1979 is $552 for a disabled worker alone or $967 for a disabled worker family.

Although the original Social Security Act of 1935 did not include provision for a disability insurance program, there was early concern with the problem of loss of earnings due to disability. In the 1940's the Social Security Board in its annual reports generally supported the addition of some kind of disability program to the social security system. The 1948 Report of the Advisory Council on Social Security to the Finance Committee recommended the establishment of a disability program. The report further specified that coverage should be provided only in the case of disabilities which were medically demonstrable by objective tests, and that there should be a 6-month waiting period. The report envisaged requiring substantial and recent attachment to the social security system as a basis for qualifying for benefits. Disabled beneficiaries would be transferred to the retirement system upon reaching age 65, and they would be protected from reductions in their retirement benefits by eliminating periods of disability in computing the amount of the retirement benefit.

The Congress had various proposals for a disability program under its active consideration in the next few years. Finally, in the Social Security Amendments of 1954, the Congress included a provision for a disability "freeze" which would allow disabled workers to protect their ultimate retirement benefits against the effects of non-earning years, becoming effective in July 1955. The amendments provided

that the determination of who was disabled would be made by State agencies under contract with the Federal Government. It was expected that the agency used would ordinarily be the State vocational rehabilitation agency.

The 1956 amendments established the Disability Insurance Trust Fund and provided for the payment of benefits to disabled workers (but not to their dependents) starting in July 1957. Benefits were limited to workers aged 50 or over who had recent and substantial attachment to the social security program. The disability had to be severe enough to prevent the individual from engaging in any substantial employment and to be of "long-continued and indefinite duration." For eligible individuals, benefits were payable only after a full 6-month waiting period. (If an individual became disabled on January 15, the waiting period would be February through July. The first check, for the month of August, would be payable at the beginning of September.)

The disability benefit formula was essentially the same as the formula for retirement benefits, under which the benefit amount is determined according to the worker's lifetime average earnings (excluding in this case years of disability in computing the average). Since the benefits were at this time limited to workers age 50 or over, their general wage-histories could be expected to be comparable to retired workers. For this reason, there was no compelling reason to develop a new method of determining benefits.

The 1956 amendments also provided for the payment of benefits to disabled children age 18 and over who were dependents of retired workers or survivors of deceased workers (provided that the disability began before the child reached age 18).

The Secretary of Health, Education, and Welfare was given the authority to reverse cases that had been *allowed* by the State agencies which made the original determinations. The basic purpose of this provision was to protect the trust fund from being forced to pay benefits in cases that should not have been allowed in the first instance, and to promote more uniform administration of the program among the States.

Subsequent amendments added provisions for benefits to dependent spouses and children of disabled workers (1958) and eased the requirements related to prior work under social security (1958 and 1960). Also in 1960, the limitation of benefits to workers aged 50 or over was eliminated. The lowering of the age of eligibility had a significant impact on how the benefit computation formula operated. Since benefits are based on lifetime average earnings (excluding years of disability), benefits for workers who became disabled at a young age would be based on a very small number of years of earnings (as few as 2). This can lead to quite different results from the situation of a retired worker whose earnings are averaged over a relatively large number of years. However, no change in the disability benefit formula was made.

Certain provisions in the 1960 amendments were aimed at encouraging beneficiaries to return to employment. They provided for a nine-month period of "trial work," during which the disabled individual could have earnings without having his benefits terminated. They also eliminated the 6-month waiting period for benefits if a worker applied for disability a second time after failing in his attempt to return to work.

In 1965, the definition requiring that a disability be of "long-continued and indefinite duration" was changed to permit benefits for disabilities expected to last at least 12 months. Benefits for disabled widows were added in 1967. In 1972, the 6-month waiting period (established in 1956) was reduced to 5 months.

As the program grew, the Congress began expressing considerable concern over the increased allocations to the disability trust fund which had been required to meet actuarial deficiencies. The Finance Committee, in its report on the 1967 Social Security Amendments, commented:

> The committee recognizes and shares the concern expressed by the Committee on Ways and Means regarding the way this disability definition has been interpreted by the courts and the effects their interpretations have had and might have in the future on the administration of the disability program by the Social Security Administration. * * * The studies of the Committee on Ways and Means indicate that over the past few years the rising cost of the disability insurance program is related, along with other factors, to the way in which the definition of disability has been interpreted. The committee therefore includes in its bill more precise guidelines that are to be used in determining the degree of disability which must exist in order to qualify for disability insurance benefits.

The 1967 amendments were intended to emphasize the role of medical factors in the determination of disability. Since the beginning of the program, the Social Security Administration had been operating under guidelines that allowed consideration of certain vocational factors. However, these were being interpreted in varying ways, and there was believed to be a need to write into the law additional language which would define vocational factors in such a way that they could be interpreted and applied on a more uniform basis. The new language specified that an individual could be determined to be disabled only if his impairments were of such severity that he "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work."

The committee report discussed this provision further:

> The original provision was designed to provide disability insurance benefits to workers who are so severely disabled that they are unable to engage in any substantial gainful activity. The bill would provide that such an individual would be disabled only if it is shown that he has a severe medically determinable physical or mental impairment or impairments; that if, despite his impairment or impairments, an individual still can do his previous work, he is not under a disability; and that if, considering the severity of his impairment together with his age, education, and experience, he has the ability to engage in some other type of substantial gainful work that exists in the national economy even though he can no longer do his previous work, he also is not under a disability regardless of whether or not such work exists in the general area in which he lives or whether he would be hired to do such work. It is not intended, however, that a type of job which exists only in very limited numbers or in relatively few geographic locations would be considered as existing in the national economy. While such factors as whether the work he could do exists in his local area, or whether there are job openings, or whether he would or would not actually be hired may be pertinent in relation to other forms of protection, they may not be used as a basis for finding an individual to be disabled under this definition. It is, and has been, the intent of the statute to provide a definition of disability which can be applied with uniformity and consistency throughout the Nation, without regard to where a particular individual may reside, to local hiring practices or employer preferences, or to the state of the local or national economy.

Over the years, several amendments were adopted easing certain requirements of the disability program in the case of blind individuals. The level of earnings above which an individual is considered not disabled is substantially higher for blind persons than for those with other disabilities. No recency of employment test is applied in determining eligibility for the blind. For blind persons age 55 or over, eligibility is based on their ability to work at their usual occupation rather than on their ability to work at any job.

C. Supplemental Security Income

The Social Security Act as originally written in 1935 did not provide for disability protection under either the insurance (trust fund) title or under the public assistance titles. (A public assistance program limited to the needy blind was, however, a part of the 1935 act.) In 1950 a public assistance program for the "totally and permanently disabled" was added to the Social Security Act. Under the public assistance programs for the blind and disabled, basic eligibility standards and assistance levels were determined by each State, and program administration was carried out by the States (or by local governments under overall State supervision). State expenditures for the program were funded by the States with Federal matching from general revenue appropriations according to formulas specified in the Federal statute.

In 1972, Congress repealed the public assistance programs for the blind and disabled (along with the similar program for the aged) and established a new federally administered program called Supplemental Security Income (SSI). Under the new program (which became effective at the start of 1974), a basic Federal income support level is established for each aged, blind, and disabled person. Eligibility is determined and benefits are paid by the Social Security Administration. States may supplement the basic Federal income support levels, and these State supplementary benefits may be administered either by the States or by the Social Security Administration on behalf of the States.

At the present time, the SSI program provides a monthly minimum Federal income support level of $208.20 for a disabled individual and $312.30 for a disabled couple. These amounts are increased automatically for cost of living changes. State supplementation levels vary widely from State to State and within States according to different living arrangements of recipients. (See table 1.)

The disability part of the SSI program follows generally the definition and administrative processes applicable to the disability insurance program. To be eligible, an individual must be sufficiently disabled to permit a finding that he will be unable to engage in any substantial work activity for at least a period of 1 year from the time he became disabled.

TABLE 1.—INCOME GUARANTEE LEVEL FOR DISABLED PERSONS IN INDEPENDENT LIVING ARRANGEMENTS

State (administration of optional supplement)	Monthly income guarantee level	
	Individual	Couple
Alabama (State)	$208.20	$312.30
Alaska (State)	335.00	502.00
Arizona (State)	208.20	312.30
Arkansas (None)	208.20	312.30
California (Federal)	356.00	660.00
Colorado (State)	221.00	442.00
Connecticut (State)	297.00	372.00
Delaware (Federal)	208.20	312.30
District of Columbia (Federal)	223.20	342.30
Florida (State)	208.20	312.30
Georgia (State)	208.20	312.30
Hawaii (Federal)	223.40	336.50
Idaho (State)	262.00	373.00
Illinois (State)	[1] 208.20	[1] 312.30
Indiana (State)	208.20	312.30
Iowa (Federal)	208.20	312.20
Kansas (None)	208.20	312.30
Kentucky (State)	208.20	312.30
Louisiana (None)	208.20	312.30
Maine (Federal)	218.20	327.30
Maryland (State)	208.20	312.30
Massachusetts (Federal)	324.45	494.30
Michigan (Federal)	242.29	363.44
Minnesota (State)	242.00	358.00
Mississippi (None)	208.20	312.30
Missouri (State)	208.20	312.30
Montana (Federal)	208.20	312.30
Nebraska (State)	295.00	406.00
Nevada (Federal)	208.20	312.30
New Hampshire (State)	237.00	332.00
New Jersey (Federal)	231.00	324.00
New Mexico (State)	208.20	312.30
New York (Federal)	271.41	391.78
North Carolina (State)	208.20	312.30
North Dakota (State)	208.20	312.30

TABLE 1.—INCOME GUARANTEE LEVEL FOR DISABLED PERSONS IN INDEPENDENT LIVING ARRANGEMENTS—Continued

State (administration of optional supplement)	Monthly income guarantee level	
	Individual	Couple
Ohio (None)	$208.20	$312.30
Oklahoma (State)	287.20	470.30
Oregon (State)	220.20	322.30
Pennsylvania (Federal)	240.60	361.00
Rhode Island (Federal)	244.99	381.73
South Carolina (State)	208.20	312.30
South Dakota (State)	223.20	327.30
Tennessee (None)	208.20	312.30
Texas (None)	208.20	312.30
Utah (State)	218.20	332.30
Vermont (Federal)	247.00	[2] 384.00
Virginia (State)	208.20	312.30
Washington (Federal)	253.30	[2] 361.40
West Virginia (None)	208.20	312.30
Wisconsin (Federal)	294.40	451.50
Wyoming (State)	228.20	352.30

[1] State supplements in some cases but budgets each case individually regardless of living arrangements.

[2] State has two optional supplementation levels. This represents the higher amount payable to recipients in the State.

Note: "None" indicates no optional State supplementation. Where optional supplementation is indicated but the Federal levels of $208.20 and $312.30 are shown, the State optional supplementation does not apply in the case of individuals or couples in independent living arrangements. Mandatory supplementation may apply for certain individuals who were previously on State programs in effect prior to January 1974. Optional State supplementation may also apply for other living arrangements.

Source: HEW (data as of Oct. 1, 1979).

II. The Definition of Disability

A. What the Law Requires

The Social Security Act definition requires that in order to qualify for disability benefits an individual must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted, or is expected to last, at least 12 months, or is expected to result in death. The determination must be made on the basis of medically acceptable clinical and laboratory diagnostic techniques.

As indicated in the earlier discussion of the legislative development of the disability insurance program, the definition of disability has been somewhat modified and clarified over the years, the most recent major amendments being those in 1967 which, as described earlier, attempted to emphasize the role of medical factors by defining strictly in the law when and how vocational factors were to be applied. The 1972 amendments which established the supplemental security income program provided for the use of this same definition.

The definition in title II of the Social Security Act reads as follows:

> Sec. 223 * * *
> (d)(1) The term "disability" means—
> (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or
> (B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.
> (2) For purposes of paragraph (1)(A)—
> (A) an individual (except a widow, surviving divorced wife, or widower for purposes of section 202 (e) or (f)) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the pre-

ceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) A widow, surviving divorced wife, or widower shall not be determined to be under a disability (for purposes of section 202 (e) or (f)), unless his or her physical or mental impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled.

(5) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

The title XVI definition reads as follows:

SEC. 1614. (a) * * *

(3)(A) An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence

(with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(C) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(D) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria, except for purposes of paragraph (4), shall be found not to be disabled.

Essentially, the only differences in the laws are (1) under the SSI program the test of substantial gainful activity applies only to the "disabled." There is a separate definition of "blindness" to which the test of SGA does not apply; (2) the SSI program has no provision relating to eligibility of widows or widowers; (3) the SSI program has no requirement stipulating that the individual must furnish evidence of disability as required by the Secretary (in fact, the Secretary exercises authority to purchase needed medical evidence for SSI applicants); and (4) the SSI program provides for disability benefits for children under age 18. (The disability insurance program does not exclude children. However, eligibility requires at least a 1½-year work history.)

Thus, persons applying for benefits must generally meet the same definition of disability under both programs. Furthermore, the SSI statute specifically provides for following the same administrative procedures as are used for the title II program.

B. The Determination Process

The social security definition of disability is considered to be a strict definition, which only the most severely disabled can meet. However, the statute is not specific in describing how the definition is to be applied in individual cases. The State agencies are directed in how the definition is to be applied by detailed Federal regulations. These regulations were recently amended, effective February 26, 1979, to include specific rules on the application of the vocational factors which had been provided in statute in 1967, but for which the Social Security Administration had prior to this year issued only administrative guides.

The determination of disability may be based on medical considerations alone, or on medical considerations and vocational factors. In making the determination, the disability adjudicator is required to look at all the pertinent facts of a particular case, and must follow a sequential evaluation process. Current work activity, severity of impairment, and vocational factors are assessed in that order. The regulations set out the steps, and state that when a determination can be made at any step, evaluation under a subsequent step is unnecessary.

(1) The first question to be asked is whether the individual is currently engaging in substantial gainful activity (SGA). Under present administrative practice, if an individual is actually earning more than $280 per month he is considered to be engaging in substantial gainful activity. Earnings below $180 a month are generally regarded as not constituting SGA. Earnings between these two amounts must be evaluated. If it is determined that the individual is actually engaging in SGA, a finding is made that the individual is not disabled, without any consideration of either medical or vocational factors.

(2) If an individual is not actually engaging in SGA, the second step is to look at whether the individual has a severe impairment. Under the regulations, if an individual is found not to have any impairment which significantly limits his physical or mental capacity to perform basic work-related functions, a finding must be made that there is not a severe impairment and that the individual is not disabled. Vocational factors are not to be considered in such cases.

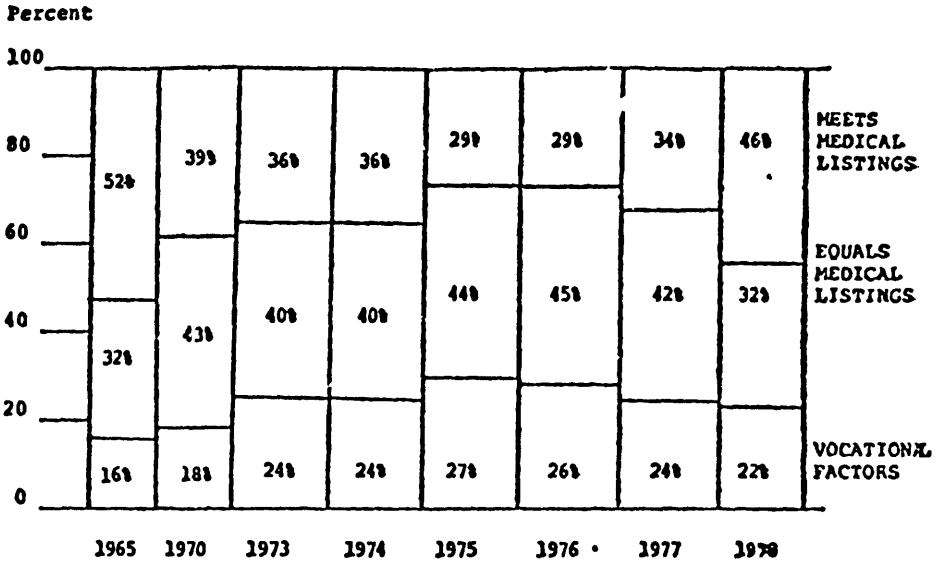
(3) If the individual is found to have a severe impairment, the next step is to determine whether the impairment meets or equals the medical listings which have been developed by the Social Security Administration for use in determining whether a condition constitutes a disability. If the impairment meets the duration requirement and is included in the medical listings, or is determined to be medically the equivalent of a listed impairment, a finding of disability must be made without consideration of vocational factors.

(4) In cases where a finding of "disability" or "no disability" cannot be made based on the substantial gainful activity test or on medical considerations alone, but the individual does have a severe impairment, the individual's residual functional capacity and the physical and mental demands of his past relevant work must be evaluated. If the impairment does not prevent the individual from meeting the demands of past relevant work, there must be a finding that the individual is not disabled.

(5) The final step is consideration of whether the individual's impairment prevents other work. If the individual cannot perform any past relevant work because of a severe impairment, but he is able to meet the physical and mental demands of a significant number of jobs (in one or more occupations) in the national economy, and the individual has the vocational capabilities (considering age, education and prior work experience) to make an adjustment to work different from that which he has performed in the past, it must be determined that the individual is not disabled. If these conditions are not met, there must be a determination of disability.

The basis for disability allowances has undergone change over the years. As the accompanying chart shows, in 1965 only 16 percent of title II disabled worker allowances involved consideration of vocational factors. This increased to 27 percent in 1975. However, in the succeeding years the trend has reversed, and in 1978 only 22 percent of allowances involved vocational factors. These figures appear to be consistent with a generally perceived trend in the last few years toward greater reliance on medical evidence in determining allowances and denials.

Basis for disability allowances, fiscal years 1965, 1970, and 1978–78



It is important, however, to look beyond the national statistics and to examine what individual States are doing in order to understand how complex and variable the determination process is. For example, although on a national basis about 22 percent of disabled worker allowances involved vocational factors, in California about 35 percent of allowances involved vocational factors, while in New Jersey only 14 percent involved vocational factors. This kind of variation among States also persists in the other categories of allowances—meeting and equaling the medical listings. The State reporting the highest percentage of cases as *meeting* the medical listings was North Dakota—68 percent. The lowest State was New Jersey—26 percent. The variation reported by States for the category of *equaling* the listings was even greater. New Jersey reported that 60 percent of its allowances were on the basis of equaling the listings; Michigan reported only 7 percent of allowances were made on this basis.

With respect to initial State agency denials, in fiscal year 1978 21 percent of disabled worker denials were on the basis of inadequate duration of the impairment, 32 percent on the basis of lack of severity ("slight impairment"), 25 percent on the basis of ability to perform usual work, 15 percent on the basis of ability to perform other work, 0.5 percent on the basis of engaging in substantial gainful activity, and 6 percent on the basis of failure to cooperate or follow required procedures. These percentages have also undergone change in recent years. Perhaps most startling are the figures for denials on the basis of slight impairment—up from about 8 percent in 1975 to 32 percent in 1978 and increasing to 36 percent in the last 6 months of calendar year 1978. This change appears to have resulted from the efforts by the Social Security Administration to give the States more detailed guidance in determining (under the sequential process described above) whether an individual has a "severe impairment," or whether his case should be denied without further analysis because his impairment does not meet the required degree of severity—i.e., is a "slight impairment." The States now have available to them lists of impairments which, when occurring alone, or in combination with other

impairments, are automatically considered slight. These impairments would not necessarily have been routinely considered slight in past years. (This development is discussed more fully in the section "Explanations Given for Changes in the Growth Pattern.")

State agency statistics reveal, however, that States are apparently still interpreting regulations and guidelines in varying ways. Although the percentage of cases denied on the basis of "slight impairment" nationwide stands at 32 percent, the percentage for individual States ranges from a high of 54 percent in Michigan to a low of 10 percent in Delaware for fiscal year 1978. The table below shows the variation among the States in the reasons for denial.

TABLE 2.—INITIAL STATE AGENCY TITLE II DETERMINATIONS, DISABLED WORKER CLAIMS, BY BASIS FOR DENIAL, FISCAL YEAR 1978

[In percent]

	Duration	Slight impairment	Able to perform usual work	Able to perform other work	Engaging in SGA	Failure to—			Other codes	Fiscal year 1978 total denials
						Cooperate	Appear for exam	Follow treatment		
All regions	21	32	25	15	0	4	2	0	1	509,626
REGION I										
Total	25	26	28	14	0	5	1	0	1	24,318
Connecticut	33	33	13	12	1	6	1	.....	1	5,956
Maine	22	16	37	20	0	4	0	.....	1	2,385
Massachusetts	22	26	30	12	0	6	2	0	1	11,604
New Hampshire	25	20	37	11	0	5	1	0	1	1,459
Rhode Island	18	24	35	17	0	3	1	0	1	1,837
Vermont	20	15	42	22	0	0	0	.....	1	1,077
REGION II										
Total	14	43	20	14	0	5	2	0	1	68,515
New Jersey	18	48	18	6	1	6	2	0	1	14,234
New York	16	34	23	17	0	6	3	0	1	42,744
Puerto Rico	4	66	13	14	0	1	1	0	0	11,488
Virgin Islands	18	33	16	10	6	2	6	.....	8	49

REGION III										
Total.....	12	20	40	21	0	3	2	0	1	49,712
Delaware.....	20	10	43	21	1	3	2	.....	1	949
District of Columbia...	9	31	29	16	0	8	6	.....	1	1,870
Maryland.....	10	23	40	20	0	4	2	.....	1	8,730
Pennsylvania.....	12	16	42	24	0	3	2	0	1	22,620
Virginia.....	12	28	35	18	0	3	2	0	1	10,397
West Virginia.....	14	13	44	21	1	4	2	.....	1	5,146
REGION IV										
Total.....	23	36	22	13	0	3	2	0	1	106,988
Alabama.....	27	34	20	14	0	2	2	0	1	11,965
Florida.....	21	22	34	16	0	4	2	0	1	24,546
Georgia.....	23	43	16	12	0	2	2	0	1	16,732
Kentucky.....	28	39	16	12	0	2	1	.....	1	9,511
Mississippi.....	20	39	25	10	0	3	2	0	0	8,137
North Carolina.....	26	48	13	8	0	2	2	.....	1	14,567
South Carolina.....	23	34	27	10	0	3	1	0	1	8,513
Tennessee.....	18	37	20	18	0	2	3	.....	1	13,017
REGION V										
Total.....	20	46	14	11	1	5	2	0	1	93,854
Illinois.....	25	53	4	6	0	9	2	0	1	27,024
Indiana.....	25	41	18	8	1	4	2	0	1	10,218
Michigan.....	17	54	9	12	0	6	1	0	1	23,128
Minnesota.....	26	21	32	17	1	2	1	.....	0	5,607
Ohio.....	15	48	19	13	1	3	1	0	1	20,428
Wisconsin.....	17	18	40	22	1	1	1	.....	0	7,449

TABLE 2.—INITIAL STATE AGENCY TITLE II DETERMINATIONS, DISABLED WORKER CLAIMS, BY BASIS FOR DENIAL, FISCAL YEAR 1978—Continued

[In percent]

	Duration	Slight impairment	Able to perform usual work	Able to perform other work	Engaging in SGA	Failure to—			Other codes	Fiscal year 1978 total denials
						Cooperate	Appear for exam	Follow treatment		
REGION VI										
Total	32	21	28	13	0	4	2	0	1	56,372
Arkansas	28	27	21	19	0	3	2	.....	1	7,371
Louisiana	30	19	30	16	0	3	2	0	0	12,263
New Mexico	31	23	19	18	1	5	1	0	1	3,084
Oklahoma	21	14	46	14	0	1	2	.....	1	6,879
Texas	38	21	25	9	0	5	1	.....	1	26,775
REGION VII										
Total	23	27	26	17	1	3	2	0	1	20,359
Iowa	26	13	30	24	1	4	1	.....	1	4,238
Kansas	23	25	31	12	1	3	3	0	1	3,334
Missouri	21	35	23	14	0	3	2	0	1	10,698
Nebraska	23	25	26	21	2	2	2	.....	1	2,089

REGION VIII										
Total	25	27	26	14	1	3	2	0	1	10,315
Colorado	29	30	17	14	1	4	4	0	1	4,658
Montana	21	19	35	18	1	3	2	0	1	1,652
North Dakota	18	33	33	11	2	1	0	.....	1	977
South Dakota	17	26	39	13	1	0	2	0	1	1,039
Utah	24	16	37	17	0	4	2	.....	1	1,331
Wyoming	29	41	16	8	0	4	1	.....	1	658
REGION IX										
Total	22	21	30	18	0	4	2	0	1	63,016
Arizona	23	34	29	9	0	3	1	.....	1	4,780
California	22	20	31	20	0	4	2	0	1	54,922
Guam	20	52	12	5	.....	5	5	.....	2	60
Hawaii	28	23	28	14	0	3	2	.....	1	1,478
Nevada	37	39	6	5	1	10	1	.....	2	1,776
REGION X										
Total	19	15	42	18	0	4	1	.....	1	16,177
Alaska	18	33	19	22	1	5	2	.....	0	557
Idaho	37	23	16	14	1	6	2	.....	1	1,677
Oregon	14	12	45	23	0	3	1	.....	1	5,993
Washington	18	14	46	15	0	5	1	.....	1	7,950

Source: Data provided by the Social Security Administration.

C. Meaning of Substantial Gainful Activity (SGA)

At the heart of the disability definition is the test—"Is the individual able to engage in any substantial gainful activity?" If the answer is in the affirmative, the individual cannot be determined to be disabled. The term "substantial gainful activity" is not defined in the statute. Rather, the Secretary of Health, Education, and Welfare is required by regulations to prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. These criteria have been expressed in regulations in the form of dollar amounts of earnings above which an individual would be presumed to be engaged in substantial gainful activity, and therefore not disabled for purposes of the social security definition. As the Acting Commissioner of Social Security, Don Wortman, stated to the Subcommittee on Public Assistance of the Finance Committee in testimony in September 1978, "* * * the levels at which the SGA is set is a fundamental part of the definition of who is, or who is not, disabled for purposes of these programs." Mr. Wortman further observed that "At earnings of $500 or more a month, the concept of 'substantial gainful activity' as one test of disability becomes almost meaningless as a means of distinguishing the disabled from the nondisabled. In a society in which many nondisabled people earn only that much or less, it would be difficult to determine whether low earnings are a result of an impairment or of economic and social factors unrelated to physical or mental impairments."

The SGA level was $100 a month in 1958, increased to $125 in 1966, $140 in 1968, $200 in 1974, $230 in 1976, $240 in 1977, $260 in 1978, and $280 a month in 1979. At the present time the administration is proposing to provide by regulation for automatic increases in the future which would be made on the basis of the rate of the increase in average taxable wages reported for the first calendar quarter of each year.

There have been proposals to increase substantially the amount to be used in establishing substantial gainful activity, on the grounds that the current level acts as a work disincentive. However, in response to a question posed by the Public Assistance Subcommittee at the hearing referred to earlier, the Social Security Administration responded that "raising the SGA level does not appear to give disabled beneficiaries an incentive to work * * * . The earnings of most disabled beneficiaries are considerably below the SGA level and * * * studies show no appreciable increases in earnings as the SGA earnings levels have increased."

Subsequent to the comment by the Department a special study, "Effect of Substantial Gainful Activity Level on Disabled Beneficiary Work Patterns," appeared in the March 1979 Social Security Bulletin. The research findings reported in the study show that increases in the substantial gainful activity level in 1966, 1968 and 1974 were not

followed by incremental increases in beneficiary earnings. The authors of the study draw the following implications from their findings:

> The SGA level serves as the administrative measure of work productivity. In conjunction with the medical severity criteria, it controls eligibility for the program. *Raising the SGA level would increase program costs by enlarging the size of the eligible population and by reducing the number of persons whose benefits could be terminated. The program-flow analysis suggests that the key to controlling program growth is in the allowance process and the eligibility criteria.* (Emphasis added.)
>
> Much less control over terminations is possible. Recovery for work is sharply limited by the original eligibility requirements—that is, severe and chronic illness that drastically affects earning capacity. Benefit terminations caused by recovery, either medical recovery or sustained employment above the SGA level, are minuscule compared with the number of beneficiaries coming on the rolls. There seems to be some room for improvement in the recovery rates of working beneficiaries. Any expectation of substantially reducing the program's size by means of work incentives, however, is placed in sobering perspective by the very low rate of benefit terminations for recovery among those who had sustained work while still beneficiaries.

It has been proposed that the SGA level be increased substantially for SSI, the needs-tested program, but not for title II disability insurance. The Social Security Administration has commented on some of the problems which this kind of proposal raises:

> Because SGA is an integral part of the definition of disability in both social security and SSI statutes, substantial differences in the meaning of SGA between the two programs obviously would create a multitude of problems.
>
> The public's understanding of SGA would be seriously affected if there were substantial differences in SGA between the social security and SSI programs. This would be particularly true where a person files claims for both benefits simultaneously and is found disabled under one program but not under the other.

(Hearing before the Subcommittee on Public Assistance of the Committee on Finance on H.R. 10848 and H.R. 12972 "Supplemental Security Income Disability Program," September 1978, p. 82.)

D. Medical Criteria Used in Determining Disability

Ever since the beginning of the disability insurance program in 1955, the Social Security Administration has had a list of medical impairments with sets of signs, symptoms and laboratory findings

which, if present in a person applying for disability benefits, are sufficient to justify a finding that he or she is disabled, unless there is evidence to the contrary. These criteria are known as the listing of impairments.

The listing includes medical conditions frequently found in people who file for disability benefits. It describes, for each of the 13 major body systems, impairments that are severe enough to prevent a person from engaging in substantial gainful activity and which may be expected to result in death or which have lasted or can be expected to last for a continuous period of not less than 12 months.

Effective March 27, 1979, the Social Security Administration issued new regulations updating the earlier listing which had been issued in 1968 and had in recent years been criticized as in serious need of review. Since 1968 the only new medical regulations issued by SSA were those needed to implement the childhood disability provisions of the SSI program. These were effective in March 1977.

Some of the criticisms that had been leveled at the 1968 listing, and specifically pointed out by the General Accounting Office in reports in August 1976 and August 1978, included a lack of specificity, and a failure to take into consideration advances in medical technology. The GAO also commented that State agency officials complained that the listings were sometimes too time consuming or costly to implement. For example, certain criteria required laboratory tests which were no longer commonly used in the medical community or which required equipment which was not readily available.

The Social Security Administration spent several years updating the medical listing. In publishing the new listing in the Federal Register, SSA maintained that the revisions reflected advances in the medical treatment of some conditions and in the methods of evaluating certain impairments. Although it is still too early for the new listing to be evaluated, State agencies appear generally to believe that the up-dating will result in better and more reasonable findings, insofar as they will reflect—at least for a period of time—a more current state of medical diagnostic practices.

The table which follows indicates the general nature of the body systems which are covered by the medical listing. Interestingly, table 3 would also seem to show that there are rather significant differences in the basis for awards between the title II and title XVI programs. More than 30 percent of the awards to title II disabled workers in 1975 (the latest year for which comparable data are available) were made on the basis of diseases of the circulatory system (heart). Only about 21 percent of SSI adults were awarded benefits on this basis. For SSI adults, by far the largest category of awards was on the basis of mental disorders—nearly 31 percent, compared with 11 percent under title II. Table 3 also shows a significantly larger percentage of title II benefits awarded on the basis of diseases of the musculoskeletal system—about 19 percent under title II as compared with about 13 percent under title XVI.

TABLE 3.—COMPARISON OF TITLE II DISABLED WORKER AWARDS AND TITLE XVI BLIND AND DISABLED ADULT AWARDS, BY DIAGNOSTIC GROUP, 1975

[In percent]

Diagnostic group	Title II	Title XVI
Infective and parasitic diseases	1.3	1.6
Neoplasms (cancer)	10.0	5.4
Endocrine, nutritional, and metabolic diseases	4.0	5.0
Mental disorders	11.2	[1] 30.7
Diseases of the nervous system and sense organs	6.8	10.0
Diseases of the circulatory system	30.2	20.7
Diseases of the respiratory system	6.6	4.7
Diseases of the digestive system	3.0	2.1
Diseases of the musculoskeletal system	18.7	12.7
Accidents, poisonings, and violence	5.4	3.9
Other	2.8	3.1
Total	100.0	100.0

[1] Includes mental retardation—13.1 percent.

Source: Data provided by the Social Security Administration.

III. The Disability Determination Process

A. General Description

The disability claims process is long and complex, if pursued through each possible level of appeal. It is identical for applicants of both title II and title XVI. Briefly, an applicant files his claim at a local social security office. The information taken at the social security office is sent on to a State disability agency, which determines on the basis of this and any new evidence it may require, whether the person meets the definition of disability. If the claim is denied, it is reconsidered by the State agency, upon request of the claimant. A claim which is denied at the reconsideration level may, upon appeal, receive a hearing by an administrative law judge. There is an additional level of administrative appeal to the Social Security Administration's Appeals Council. And, finally, if still dissatisfied a claimant may appeal the decision in a Federal district court. Thus, the question of whether an individual meets the definition of disability may go through five different steps, including four levels of appeal.

Other title II and title XVI claims (Old Age and Survivors Insurance and SSI claims on the basis of age) follow the same steps, excluding, of course, the State agency determination of disability. However, most claims that proceed through the appeals system involve the issue of disability. Therefore, whenever the claims and appeals process is criticized on the basis of quality of decisions, complexity of system, and length of process, it is ordinarily a disability case that is involved.

In recent years, of course, the system has had to handle a vastly larger caseload than was the case in the early years of the program. In 1962, for example, there were about 440,000 title II disabled worker applications received in social security district offices. In 1978, there were about 1.2 million title II cases, and more than 1 million title XVI disability and blindness applications. It is easy to understand that the system may have had difficulty in adjusting to a change of this magnitude.

The following description provides in somewhat greater detail how the process now works, the problems that have developed, and some recommendations for change.

DISABILITY ADJUDICATION PROCESS

[Calendar year 1978]

Level of decision	Number of decisions [1]	Allowances	Denials	Reversal rate
Initial decisions, total (including district office).	1,190,000	357,000	[2] 833,000	(70% denial rate)[2]
Initial decisions made by State agencies.....	905,000	357,000	548,000	(61% denial rate)
Reconsiderations.....	228,600	45,600	183,000	20%.
ALJ hearings.....	87,800	44,800	43,000	51%.
Appeals council.....	21,600	900	20,700	4%.
Federal courts.....	4,900	[3] 1,600	3,300	33%.[4]

[1] Includes all title II disability decisions—disabled worker, disabled widow(er)s and adults disabled in childhood.

[2] Includes all denials, made both by Social Security district offices and State disability agencies. 285,000 of these denials are technical denials (involving primarily lack of insured status) and do not require a determination of disability by a State agency.

[3] Includes 1,260 remands and 340 court allowances.

[4] Includes remands from Federal courts.

Source: Data provided by the Social Security Administration.

B. The Role of the District Office

If an individual wants to file a claim for disability under either the title II or title XVI program he must apply at his local social security district office. There are more than 1,300 district offices (including branch offices) throughout the United States, and they handle more than 6 million claims for benefits under the old-age, survivors and disability insurance and the supplemental security income programs each year. Overall, about 35 percent of the applications are filed by persons who claim to be disabled.

The manager of a district office has considerable latitude about how to organize the operations of his staff. Recently, however, SSA has required offices, unless they are too small to make this feasible, to develop specialists among their claims representatives to become expert in either the title II or title XVI program. In general, it is envisaged that persons applying for both programs would go first to a title II claims specialist, who would develop the information needed to process a title II claim, including the individual's insured status. If it appeared that the individual was also eligible for title XVI, he would be sent on next to a title XVI specialist, who would develop the income and resources information necessary to substantiate a title XVI application. In such cases, the information related to the disability aspects of the case would be taken by the title II specialist.

If the case were clearly identified as a title XVI case, it would be referred first to a title XVI claims specialist, who would develop both the income and resources information and the disability-related information needed to process the case.

The Social Security Administration does not intend that there be specialists designated to handle disability cases, although it is clear that in some offices, especially larger offices, there will be incentives to encourage individual claims representatives to specialize on an informal basis. Disability cases are generally significantly more complex than other cases, and it requires both skill and patience to conduct a disability interview sufficiently thorough to obtain the kinds of information necessary to develop the case. Because of the skill required, there have been recommendations by some that specialization of personnel within the district office should include specialization in disability. The Social Security Administration has not concurred with this proposal.

During the interview, it is the responsibility of the claims representative to obtain relevant medical and work history from the applicant and to see that the required forms are completed. The way in which this responsibility is handled varies from office to office, and with the circumstances of the individual. In some offices where it is believed that most applicants are capable of filling in the forms themselves, the claims representative may play a relatively passive role of reviewing briefly the form after it is completed. In other offices, the process involves a lengthy interview. In any case, the quality and completeness of the information that is obtained is extremely important in the further processing of the case. On the basis of the interview, the claims representative may determine that the individual is engaging in substantial gainful activity, in which case the individual will be denied without having his case considered further.

C. The Role of the State Agency

1. THE FEDERAL-STATE RELATIONSHIP

Although both the DI and SSI programs are considered Federal programs and their benefits are financed at the Federal level, the crucial benefit eligibility decision is made not by a Federal agency, but by 54 State agencies. These State agencies operate under contract with the Social Security Administration, an arrangement which goes back to the original disability insurance amendments, the disability "freeze" amendments of 1954.

The Congress decided that the determination of eligibility for the disability freeze could most logically be performed by State vocational rehabilitation agencies, which would facilitate and insure referral of disabled individuals for vocational rehabilitation services. The relationship provided in the law was a contractual one, with State agencies being reimbursed for their administrative expenditures from the disability insurance trust fund.

When the legislation was amended in 1956 to authorize payment of disability benefits, the same Federal-State arrangement was maintained. At the same time the Secretary of Health, Education, and Welfare was given the authority to reverse the State agencies' determinations that workers were qualified for benefits, in order to protect the trust fund from excessive costs and to promote more uniform decisions throughout the country. The Secretary was not authorized by the statute to allow claims which the State agency denied or to broaden State agency allowances (e.g., by finding an earlier date of first eligibility).

This Federal-State arrangement is unique among government programs, and differs from Federal-State grant-in-aid programs in that there is no need for specific State implementing legislation. However, State laws and practices control most aspects of administration, and the personnel involved are State employees who are controlled by various departments of the State government. The State agencies make determinations of disability on the basis of standards and regulations provided by the Social Security Administration. The costs of making the determinations and other aspects of related operations are paid wholly from the disability trust fund in the case of the disability insurance program, and from general revenues in the case of the supplemental security income program. No State funds are involved.

According to HEW statistics, an estimated 9,571 non-Federal man-years were expended by State agencies in fiscal year 1979. About 2.3 million claims were processed, at an overall cost of about $308 million. The major component of the cost was, of course, payroll costs, amounting to about $165 million. Purchase of medical evidence in the form of consultative examinations cost the Federal Government an estimated $84 million.

The question of the viability of the Federal-State contractual arrangement has been raised numerous times throughout the history of the program by various individuals and organizations that have studied the disability program. In an early study of the program, the Harrison Subcommittee of the House Ways and Means Committee heard conflicting testimony on whether the use of State vocational

rehabilitation agencies in making the basic disability determination should be continued or whether an alternative arrangement should be established.

In 1975 the Social Security Subcommittee of the House Ways and Means Committee conducted a survey of State disability determination services posing the question of whether the agencies believed the original reasons for maintaining the relationship with State vocational rehabilitation agencies were still valid. The responses showed that 24 State agencies believed that the original reasons for having the State agencies under the vocational rehabilitation agencies were no longer valid, and 23 believed that they were still valid.

The issue of the Federal-State relationship has been explored by the General Accounting Office in recent studies, resulting in two reports: "The Social Security Administration Should Provide More Management and Leadership in Determining Who Is Eligible for Disability Benefits," dated August 17, 1976, and "A Plan for Improving the Disability Determination Process by Bringing It Under Complete Federal Management Should Be Developed," issued August 31, 1978.

In the 1978 report the GAO stated:

> Under the existing Federal/State arrangement, the Social Security Administration cannot exercise direct managerial control of the activities of the State agencies. This circumstance, together with Social Security's failure to correct other weaknesses in the disability determination process, provides no assurance that a reasonable degree of uniformity and efficiency will be achieved in these ever-growing, very expensive programs.

The report points out that in the years 1967 to 1976, only 20,000 workers were reported as rehabilitated and terminated from the disability insurance rolls. During this time the disabled workers on the rolls increased by 1 million.

The report concludes that because very few beneficiaries have been rehabilitated and removed from the rolls as a result of efforts by State vocational rehabilitation agencies, the original reason for having the Federal-State relationship is no longer completely valid.

The GAO states in the 1978 report that it believes the present Federal-State relationship is an impediment to improving the administration of the programs because of (1) unanswered questions about the effectiveness and efficiency in the Federal-State relationship that have existed for almost 20 years; (2) questionable need for the process to be closely alined with the State vocational rehabilitation activities; (3) inability of the principals to remedy contractual defects, such as clearly defining their responsibilities; and (4) need for the Social Security Administration to have more effective management and control over the disability programs.

The final conclusion of the GAO report is that "the Secretary of HEW should develop, for consideration by the Congress, a plan for strengthening the disability determination process by bringing it under complete Federal management so that the Social Security Administration can achieve the control needed to properly manage the disability programs."

In July 1977, prior to the issuance of the second GAO report, the Social Security Administration developed and submitted to the States a new contractual agreement which it hoped would strengthen the administrative role of the Social Security Administration and result in improved and more uniform State operations. At this time 21 States have signed the new agreement, with the others continuing to express concern about the increased Federal control which is part of the new agreement.

Some of the general areas of concern of the non-signing States include provisions which require the Secretary to issue standards and requirements for conformity, provide the Secretary with the right to access to State agency premises, give the Secretary the authority to establish position descriptions and be consulted about personnel standards, and require the Secretary's approval of the State agency facilities, location of offices, and organizational structure.

Thus, at the present time, the disability program is operating under two different State agreements. In addition, the States now have the power to terminate their agreements with the Social Security Administration, which holds out the possibility that the Federal Government—SSA—could find itself in the position of having to establish a new Federal organization to serve the disabled population should a State decide to withdraw from its contract. One State, Wisconsin, filed and then withdrew a termination notice last year.

One response to this situation is to propose that the disability determination process be completely federalized, with the Social Security Administration acting as the administering agency. As noted above, this was advocated in a 1978 report by the GAO. However, there is little consensus on this approach at the present time. Proponents of federalization argue that it would result in additional flexibility in allocation of resources and would have the effect of providing greater uniformity in the treatment of disability applications and in all other aspects of the program. On the other hand, critics of this approach point out that such a move would require adding substantially to the number of Federal employees (there are now about 9,500 State agency employees), at a time when there are significant pressures to contain the Federal bureaucracy. They also argue that there could be considerable disruption in claims processing, experienced personnel could be lost in the process, and costs of administration could ultimately be increased. Even with Federal administration, it is argued, there could still be significant variations if there were not an emphasis on greater specificity of rules and in the application of the rules.

The Ways and Means Committee Report on H.R. 3236, the proposed Disability Insurance Amendments of 1979, discusses the need for an alternative to the present Federal-State arrangement. The report states:

> In the last several years, GAO and others have criticized the lack of uniformity and the quality of disability decisions made by the various State agencies. It must be recognized that, while the Federal-State determination system generally works reasonably well (many State agencies do an excellent job), significant improvements in Federal management and control over State performance are necessary to ensure uni-

> form treatment of all claimants and to improve the quality of decision making under the Nation's largest Federal disability program.

As is described more fully in the section dealing with current legislative proposals, the Ways and Means bill, following the recommendation of the Administration, provides for the elimination of the current system of negotiated agreements between the Federal Government and the States. The bill would give the Secretary the authority to establish through regulations the procedures and performance standards for the State disability determination programs. The regulations might specify, for example, administrative structure, the physical location of and relationship among agency staff units, performance criteria, fiscal control procedures, and other rules applicable to State agencies which would be designed to assure equity and uniformity in State agency disability determinations.

As the report describes, States would have the option of administering the program in compliance with these standards or of turning over administration to the Federal Government. States that decide to administer the program must comply with standards set by the Secretary, subject to termination by the Secretary if the State substantially fails to comply with the regulations and written guidelines.

The report concludes:

> Your committee believes that this new Federal administrative authority will both improve the quality of determinations and ensure that claimants throughout the Nation will be judged under the same uniform standards and procedures, while preserving the basic Federal-State structure.

2. FUNCTIONS OF THE STATE AGENCY

The role played by the State agencies in the disability determination process can be broken down into three very basic functions. Using criteria established by the Social Security Administration, (1) they make the initial determination as to whether an individual is disabled, (2) they reconsider initial decisions if the claimant believes he has been wrongfully denied, and (3) they conduct continuing disability investigations (CDI's) to determine whether individuals should remain on the disability rolls.

Initial Decisions.—The agency's initial decision as to whether an individual meets the criteria for disability is of crucial importance to the entire process. Although a significant percentage of those denied continue through the adjudication process by appeal, the vast majority of cases are determined at the initial decision level. This decision is made on the basis of a review of the individual's case file, which has been received from the district office. Ordinarily there is no personal interview with the applicant on the part of the State personnel who decide the claim. However, the agency frequently may contact the individual if further medical or vocational information is needed. If medical evidence is insufficient and can be obtained no other way, the agency may request that the individual undergo a consultative medical examination, which is paid for by the agency.

When all the evidence considered necessary to make a decision has been gathered, the case is determined by a State disability examiner, in consultation with a State agency physician and, if necessary, a

vocational specialist. The decision in all cases must be signed by the physician, although it has been claimed by the General Accounting Office, among others, that this is sometimes a purely formal requirement, and that there is sometimes little physician involvement in the decision.

Once the decision has been made as to whether the individual is disabled, and if he has been determined to meet other requirements for eligibility (such as insured status for DI, or the income and assets test for SSI), a letter is sent to the claimant informing him whether he has been found eligible for benefits. The form letter now being sent to claimants has been criticized as being seriously inadequate, in that it does not include the basis for the disability decision. This, according to critics, results in confusing the claimant, and sometimes encouraging him to ask for a reconsideration of his case unnecessarily simply because he does not understand the basis for denial. Both the SSI and DI bills which have passed the House this year (H.R. 3464 and H.R. 3236) have for this reason included a requirement that decision notices include in each case a statement setting forth a citation and discussion of the pertinent law and regulation, a list of the evidence of record and summary of the evidence, and the Secretary's determination and the reasons upon which it is based. On the other hand, questions have been raised concerning the amount of additional paperwork and administrative cost such a change might involve.

Reconsiderations.—Under the law, if a claimant who has been denied requests reconsideration of his case within 60 days of notification, the State agency must undertake a reconsideration of his case. This is performed by a reviewer who was not involved in the initial decision. The individual's case record is open to corrections or additions, and may be supplemented or updated to reflect the applicant's current condition.

In recent years there appears to be a strong trend toward the sustaining by the State agency of its own initial decision. Whether this is due to some of the administrative improvements and more precise guidelines that have been issued to direct State agency procedures is difficult to say for sure. It seems at least reasonable to suspect that the more detailed medical evidence which is now required, and the heavier reliance on purchase of consultative examinations, may be resulting in greater confidence in the initial decision by those who are assigned to reconsider a case. The State agency reversal rate for title II disabled worker reconsiderations dropped from about 33 percent in calendar year 1975 to about 18 percent in the first quarter of 1979. For title XVI, the percent of reversals dropped from about 27 percent in the last quarter of calendar year 1975 to 16 percent in the first quarter of 1979. (See tables 4 and 5.)

TABLE 4.—DISABLED WORKER RECONSIDERATIONS, FILING RATES [1] AND REVERSAL RATES ON INITIAL DENIALS

Calendar years	Total State and non-State					State agency decisions only				
		Reconsiderations					Reconsiderations			
		Total decisions		Reversals			Total decisions		Reversals	
	Initial denials	Number	Percent of denials [1]	Number	Percent of total	Initial denials	Number	Percent of denials [1]	Number	Percent of total
1973	562,053	156,933	27.9	59,371	37.8	375,219	155,960	41.6	58,813	37.7
1974	712,431	200,484	28.1	64,325	32.1	469,976	197,490	42.0	62,449	31.6
1975	744,554	222,237	29.8	72,948	32.8	498,836	218,570	43.8	70,947	32.5
1976	706,937	203,313	28.8	59,610	29.3	485,641	196,822	40.5	56,575	28.7
1977	804,796	240,292	29.9	51,881	21.6	537,766	237,438	44.2	50,408	21.2
1978	780,415	212,382	27.2	42,484	20.0	483,356	210,515	43.6	41,412	19.7
January to March 1979	211,844	61,553	29.1	10,974	17.8	140,219	61,075	43.5	10,717	17.5

[1] Filing rates are computed as the percent ratio of reconsideration determinations in a specified period to initial denials in the same period. The rates, therefore, are only approximate since some reconsiderations relate to denials made in an earlier period.

Source: Social Security Administration.

TABLE 5.—STATE REPORTED RECONSIDERATIONS, FILING RATES[1] AND REVERSAL RATES IN TITLE XVI DISABILITY AND BLINDNESS CLAIMS

Calendar years	Initial denials	Reconsideration determinations: Total affirmed and reversed: Number	Reconsideration determinations: Total affirmed and reversed: Percent of denials[1]	Reconsideration determinations: Reversals: Number	Reconsideration determinations: Reversals: Percent of denials
October to December 1975...[2]	126,619	[2] 42,900	33.9	[2] 11,380	26.5
1976	456,128	152,827	33.5	36,956	24.2
1977	484,987	162,207	33.4	31,791	19.6
1978	513,759	164,482	32.0	27,248	16.6
January to March 1979	138,552	45,984	33.2	7,319	15.9

[1] Filing rates are computed as the percent ratio of reconsideration determinations in a specified period to denials reported in the same period. The rates, therefore, are only approximate since some reconsiderations relate to denials made in an earlier period.
[2] Part of October is estimated since this type of data did not begin to be collected until the middle of October 1975.

Source: State Agency Operations Reports, Social Security Administration.

Continuing Disability Determinations.—The State agency not only has the function of deciding who comes on the disability rolls. It must also make determinations as to whether individuals stay on the rolls.

There is, however, no requirement for periodic redetermination of disability for all or even a sizable proportion of persons who are receiving disability benefits. The Social Security Claims Manual instructs State agencies on certain kinds of cases that are to be selected for investigation of continuing entitlement to disability benefits by means of a medical examination diary procedure. The agencies are cautioned that most allowed cases involve chronic, static, or progressive impairments subject to little or no medical improvement. In others, even though some improvement may be expected, "the likelihood of finding objective medical evidence of 'recovery' has been shown by case experience to be so remote as not to justify establishing a medical reexamination diary." In general, according to the claims manual, cases are to be "diaried" for medical reexamination only if the impairment is one of 13 specifically listed impairments. The diary categories include tuberculosis, functional psychotic disorders where onset occurred within the two preceding years, functional nonpsychotic disorders, active rheumatoid arthritis without deformity, cases in which corrective surgery is contemplated, obesity, fractures without severe functional loss or deformity, infections, peripheral neuropathies, sarcoidosis without severe organ damage, probability of progressive neoplastic disease but there is no definitive diagnosis, neoplastic disease which has been treated and incapacitating residuals exist but improvement of the residuals is probable, and epilepsy.

The high degree of selectivity used in selecting cases for medical reexamination is illustrated by the following statistics for title II. In 1977, there were about 2.7 million disabled workers in current pay status. The number of continuing disability investigations (CDIs) in that year for disabled workers was only about 165,000.

It is clear from the procedures followed and from program statistics that disabled individuals frequently remain on the disability rolls for extended periods without any reexamination of their medical condition. Unless there is a voluntary report of recovery or rehabilitation, or there is a report of work activity or earnings, an individual will generally continue indefinitely to receive benefits without any followup on his situation.

The Social Security Administration has recognized the issue raised by this failure to conduct reexaminations of persons who have been on the disability rolls for an extended period and is now conducting an ongoing sample study of DI and SSI disability cases which have never been subjected to a medical continuing disability investigation. The purposes of the study, according to SSA, are to gather information on changes that may be needed in the medical reexam criteria and to determine the extent to which disability beneficiaries may be erroneously on the rolls.

The House-passed disability insurance bill, H.R. 3236, provides that unless the disability adjudicator in the State agency makes a finding that the individual is under a disability which is permanent, there will be a review of the status of disabled beneficiaries at least once every three years. According to the committee report, this review is not intended to supplant the existing reviews of eligibility that are already being conducted such as the current "dairy" procedures. The finding of whether a condition is permanent, however, is not now a requirement of the claims process; consequently, there is little evidence to indicate the degree of change which would be brought about by the 3-year reexamination requirement of the House-passed bill. The determination that a condition is permanent is subject to a wide range of interpretation. Thus the number of new continuing disability investigations that actually would be brought about by the procedure is open to question.

3. THE WORKLOAD OF THE STATE AGENCY

Since 1970, the cost of State agency program administration has increased manyfold, from $48.6 million in that year, to an estimated $311 million in 1979. These funds have supported the activities of State agency employees who numbered only 2,600 in 1970, reached a high of 10.3 million in 1974 (the first year of implementation of the Supplemental Security Income program), and are estimated at about 9,600 in 1979.

Why this extraordinary growth? As far as costs are concerned, of course, inflation is a factor. But there is no question that in past years the State agencies have also been required to handle a vastly expanded workload. Recent statistics indicate that this growth may be leveling off. In 1970, for example, there were only about 600,000 title II initial disabled worker claims that were either allowed or denied by the State agencies. This number climbed to about 1 million in 1975, declining to about 845,000 in 1978. Beginning in 1974, the State agencies also were required to make disability determinations under the title XVI program. In 1978 these also numbered close to 800,000, showing a decline from earlier years.

The number of reconsideration determinations made by the State agencies has also risen over this same period of time. In 1970 there were only 91,000 reconsideration decisions involving disabled workers under title II. This grew to 237,000 in 1977, but also shows a recent decline, to 211,000 in 1978. The number of title XVI reconsideration determinations has grown steadily since the first year of that program, reaching a peak of about 165,000 in 1978.

These figures do not, of course, give the entire picture. The State agencies have additional, although considerably smaller, workloads to handle with respect to cases involving widows and children. In the early 1970's there was also a heavy workload of Black Lung determinations.

Statistics indicate clearly that the emphasis on handling cases that were coming on the rolls was not matched by an emphasis on examination of individuals already on the rolls. Continuing disability investigations of disabled workers, for example, actually declined between 1970 and 1974, although there has been some increase since the 1974 low point. In 1970 there were 163,000 disabled worker CDI determinations. This dropped to 123,000 in 1974, and stood at 165,000 in 1977.

4. PROCESSING TIMES AND THE QUALITY OF DECISIONS

Statistics would seem to indicate that as the State agencies were confronted with the very heavy workload increase in the first half of the 1970's, and particularly after the implementation of the SSI program, their response was to speed up the processing of cases. There is no question that in the minds of many administrators at both the Federal (SSA) and State agency levels the priority was to be speed. Significant backlogs were accumulating at various places and various stages of the claims process, and it was considered important to expedite the process. As is discussed more fully in other parts of this report, many feel that the result was a decline in the quality of decisions which were being made.

For title II, mean processing time for initial applications in the State agencies dropped from 42 days in December 1973 to 36 days in December 1975. For title XVI, mean processing time decreased from 44 days in December 1974 to 40 days in December 1975.

In the case of both programs, however, there has been a recent increase in State agency mean processing time. Most observers attribute this increase to a tightening up of the disability determination process by the State agencies in response to direct and indirect pressures from the Social Security Administration. It is perceived that there is a renewed emphasis emanating from SSA to improve the quality of decisions and to lower error rates. Thus, for title II, the State agency mean processing time has increased from 36 days in December 1975, to 45 days in November 1978. For title XVI, the mean processing time increased from 40 to 57 days for those same periods of time.

(Processing time appears to have been consistently shorter in the State agencies for title II cases than for title XVI. One explanation that has been given for this is that title II cases often have more complete and readily accessible medical documentation. There is less need to purchase new medical examinations and await necessary medical evidence.)

This increase in recent periods does not mean that the Social Security Administration has de-emphasized the desirability of speedy processing. On the contrary, it has set continually stricter processing goals which it uses to measure State agency performance. The goal in November 1978 for mean processing time for title II cases was 36 days. Using that measure, only four States met the goal, although several more were quite close. Sixteen States met the median processing goal of 33 days.

It is important to remember that national processing figures hide the very great discrepancies that exist among the States. For example, in November 1978 the New York State agency took (as a mean) 70 days to process a title II claim, while the Florida agency took only 29 days. In that same month the District of Columbia took nearly 87 days to process a title XVI case, New York took 80 days, and Maine took 35 days.

[See tables 6 and 7 for State-by-State data.]

TABLE 6.—STATE AGENCY INITIAL TITLE II CASE PROCESSING TIME, NOVEMBER 1978

	Cases	(Goal-36) Mean	(Goal-33) Median	Percentage of cases completed by— 30 days	60 days	90 days
United States	67,994	45.3	38	41.5	74.3	91.6
Boston	3,285	44.0	34	42.4	74.5	92.1
Connecticut	768	48.4	38	40.6	71.2	89.9
Maine	317	31.0	25	57.5	85.6	98.7
Massachusetts	1,580	43.5	36	41.5	73.8	92.8
New Hampshire	212	50.4	35	44.5	74.0	89.4
Rhode Island	275	42.0	36	40.9	80.2	93.0
Vermont	133	51.9	46	27.9	61.7	83.8
New York	9,243	62.6	53	26.9	57.7	79.9
New Jersey	2,058	47.3	38	39.5	71.5	89.0
New York	6,058	70.3	62	21.1	49.3	73.8
Puerto Rico	1,117	50.0	46	30.4	70.9	91.4
Philadelphia	7,739	51.4	42	37.4	64.8	84.3
Delaware	162	53.4	45	32.3	59.0	80.7
District of Columbia	169	66.5	49	34.4	58.1	81.4
Maryland	1,282	46.2	38	40.8	69.9	88.5
Pennsylvania	4,043	55.6	47	34.5	59.1	79.7
Virginia	1,370	45.1	37	42.7	74.7	91.9
West Virginia	713	45.5	37	38.9	72.0	89.6
Atlanta	13,840	38.0	30	51.1	83.2	95.8
Alabama	1,540	40.9	35	43.7	77.0	94.9
Florida	3,237	29.4	24	67.5	92.5	98.2
Georgia	1,949	38.1	30	50.3	84.2	96.5
Kentucky	1,284	43.3	39	47.9	78.7	94.3
Mississippi	1,007	47.5	42	37.1	70.8	92.3
North Carolina	2,006	36.3	29	51.7	85.7	97.0
South Carolina	1,228	42.2	38	41.4	75.1	92.7
Tennessee	1,589	40.4	35	43.6	82.5	95.4

TABLE 6.—STATE AGENCY INITIAL TITLE II CASE PROCESSING TIME, NOVEMBER 1978—Continued

	Cases	(Goal-36) Mean	(Goal-33) Median	Percentage of cases completed by— 30 days	60 days	90 days
Chicago	13,168	44.7	39	36.7	75.4	93.3
Illinois	3,495	43.7	36	37.6	77.0	93.3
Indiana	1,450	54.6	43	31.2	66.2	86.5
Michigan	3,146	38.5	35	43.0	81.9	96.6
Minnesota	805	40.4	35	42.5	79.4	95.2
Ohio	3,152	49.9	45	29.8	68.2	91.5
Wisconsin	1,120	40.6	36	37.6	80.3	96.3
Dallas	6,505	44.0	37	41.5	76.1	94.2
Arkansas	838	36.3	28	54.6	85.7	97.4
Louisiana	1,275	36.6	29	51.9	82.8	95.8
New Mexico	283	40.4	36	46.9	83.3	98.1
Oklahoma	781	55.1	54	29.6	68.2	91.7
Texas	3,328	46.3	44	52.5	76.2	94.4
Kansas City	3,093	41.0	34	45.8	76.7	93.4
Iowa	700	47.3	39	39.0	71.4	90.6
Kansas	458	40.8	31	48.7	75.3	92.7
Missouri	1,558	38.2	32	48.6	79.9	94.7
Nebraska	377	40.9	34	42.1	74.9	94.8
Denver	1,308	39.6	35	45.2	76.8	93.6
Colorado	610	39.7	36	41.7	75.9	92.6
Montana	181	37.9	28	53.2	84.3	96.3
North Dakota	129	41.4	35	45.5	72.0	93.2
South Dakota	115	40.4	30	50.5	83.5	99.0
Utah	212	40.0	29	50.8	75.1	93.4
Wyoming	61	42.9	39	32.6	68.5	88.8
San Francisco	7,876	38.9	32	47.7	80.5	96.3
Arizona	598	46.4	45	32.7	73.0	93.4
California	6,976	37.9	31	49.3	81.4	96.8
Hawaii	152	48.8	38	39.9	73.1	88.5
Nevada	149	44.3	39	43.9	78.5	94.9
Seattle	1,937	37.3	30	50.9	80.7	95.1
Alaska	35	54.4	33	47.3	73.6	91.2
Idaho	203	35.0	30	45.9	76.0	97.0
Oregon	641	34.0	27	55.8	84.7	97.4
Washington	1,058	39.1	31	48.7	79.3	93.5

Source: Social Security Administration.

TABLE 7.—STATE AGENCY INITIAL SSI CASE PROCESSING TIME,[1] ALL CASES, NOVEMBER 1978

	Cases	Mean	Percentage of cases completed by—		
			30 days	60 days	90 days
United States	55,435	57.2	24.6	62.0	85.5
Boston	2,643	55.9	27.0	64.1	87.4
Connecticut	498	63.2	16.5	56.0	82.7
Maine	232	35.1	46.6	84.5	97.8
Massachusetts	1,475	57.3	27.9	63.6	87.3
New Hampshire	115	52.9	30.4	63.5	89.6
Rhode Island	200	53.8	20.0	65.5	90.0
Vermont	123	54.7	30.1	61.8	82.1
New York	7,693	76.3	12.7	40.3	69.3
New Jersey	1,530	61.6	21.9	55.9	81.8
New York	6,163	80.0	10.4	36.5	66.2
Philadelphia	5,789	66.8	21.2	51.4	76.5
Delaware	113	70.9	19.5	50.4	72.6
District of Columbia	366	86.6	7.1	26.5	60.4
Maryland	918	60.2	25.6	58.0	83.1
Pennsylvania	2,778	72.7	19.5	46.2	70.9
Virginia	1,031	55.2	25.7	63.1	86.1
West Virginia	583	56.3	24.2	61.2	86.6
Atlanta	12,467	52.7	30.1	72.4	92.3
Alabama	1,578	49.6	29.8	68.2	90.4
Florida	2,538	45.5	32.1	77.5	93.8
Georgia	1,889	49.0	31.2	72.3	93.3
Kentucky	1,127	54.7	24.6	63.0	89.7
Mississippi	1,093	54.4	25.4	64.9	89.4
North Carolina	1,618	44.3	33.6	79.0	94.6
South Carolina	1,110	48.2	32.5	69.5	90.9
Tennessee	1,514	47.6	27.5	76.2	93.3
Chicago	8,751	56.8	21.6	64.5	87.4
Illinois	2,880	56.1	22.3	66.7	87.4
Indiana	788	67.8	18.1	54.4	76.8
Michigan	1,734	52.7	25.8	71.5	92.6
Minnesota	365	50.3	28.2	67.4	90.7
Ohio	2,214	59.2	18.6	57.9	85.0
Wisconsin	770	53.4	19.2	67.7	92.1

See footnote at end of table, p. 37.

TABLE 7.—STATE AGENCY INITIAL SSI CASE PROCESSING TIME,[1] ALL CASES, NOVEMBER 1978—Continued

	Cases	Mean	Percentage of cases completed by—		
			30 days	60 days	90 days
Dallas	6,695	52.5	28.2	64.0	88.5
Arkansas	749	41.8	38.7	80.0	95.5
Louisiana	1,873	47.0	32.0	73.9	92.7
New Mexico	350	52.7	26.3	63.4	88.0
Oklahoma	622	66.3	14.5	41.3	81.7
Texas	3,101	55.7	26.4	58.8	85.7
Kansas City	2,148	48.5	33.8	72.3	90.5
Iowa	417	53.5	28.8	67.1	87.1
Kansas	327	55.1	28.1	63.9	87.8
Missouri	1,197	44.4	37.3	77.1	93.0
Nebraska	207	52.3	32.9	67.6	87.4
Denver	976	51.0	28.8	69.2	88.9
Colorado	522	53.6	24.7	66.3	88.7
Montana	139	44.9	38.1	74.1	91.4
North Dakota	74	52.6	25.7	66.2	85.1
South Dakota	83	44.7	38.6	79.5	90.4
Utah	133	50.8	33.1	71.4	87.2
Wyoming	25	49.6	16.0	68.0	96.0
San Francisco	7,096	52.6	26.3	65.0	90.4
Arizona	341	57.2	14.7	60.1	88.3
California	6,481	52.2	27.3	65.4	90.7
Guam	16	49.3	18.8	62.5	93.8
Hawaii	122	59.2	12.3	58.2	86.1
Nevada	136	56.6	20.6	63.2	83.1
Seattle	1,177	56.4	28.3	66.4	87.0
Alaska	34	62.2	17.6	58.8	76.5
Idaho	157	47.9	29.9	70.1	93.6
Oregon	388	57.6	28.6	66.2	84.8
Washington	598	57.5	28.3	65.9	87.3

[1] Measures elapsed time from date of release to the DO through the date the disability decision is posted in the SSR.

Source: Social Security Administration.

Again using data for November 1978, it can be seen that nationally about 42 percent of title II cases were processed within 30 days, 74 percent within 60 days, and 92 percent within 90 days.

In addition to being criticized on the basis of processing times, State agencies have also been facing growing criticism in recent years for what many believe is inadequate quality in their decision-making. One of the major criticisms that has been made is that there is not uniformity of decisions and that different State agencies have been making decisions using different criteria. The assumption, thus, is that it is easier (or more difficult) to meet the disability definition depending on where you live.

As can be seen from the table that follows, State allowance rates vary substantially. In fiscal year 1978 initial disabled worker allowances ranged from 53.1 percent in New Jersey to 22.2 percent in Alabama.

TABLE 8.—INITIAL DISABLED WORKER ALLOWANCES AS PERCENT OF INITIAL DISABLED WORKER DETERMINATIONS—HIGH AND LOW STATES

Calendar Year 1976

High third		*Low third*	
State:	*Rate*	State:	*Rate*
New Jersey	57.4	Alabama	35.4
Connecticut	54.8	New Mexico	35.7
Minnesota	54.2	Virginia	36.6
Pennsylvania	54.0	Arkansas	36.7
Rhode Island	53.9	Kentucky	37.4
Iowa	51.9	Wyoming	37.8
Ohio	51.7	Nevada	38.6
Wisconsin	51.5	Texas	38.6
Vermont	51.1	West Virginia	41.2
Nebraska	50.7	Puerto Rico	41.2
Kansas	49.8	New Hampshire	41.4
Utah	49.7	Mississippi	41.5
Indiana	49.4	Oregon	41.5
New York	49.2	Florida	41.7
South Dakota	49.1	Oklahoma	41.9
Maine	48.8	Illinois	42.1
Delaware	48.5	Louisiana	42.1

Calendar year 1977

High third		*Low third*	
State:	*Rate*	State:	*Rate*
New Jersey	52.9	Alabama	26.2
Nebraska	50.9	New Mexico	26.3
New York	50.7	Maryland	29.9
Wisconsin	49.6	Michigan	31.8
Rhode Island	48.8	California	33.5
Kansas	48.2	Mississippi	33.5
Iowa	47.4	Louisiana	33.6
Utah	46.9	Washington	34.0
Ohio	45.9	Oregon	34.7
Vermont	45.8	Alaska	34.8
Massachusetts	45.3	Arkansas	34.9
Missouri	44.6	Oklahoma	35.2
Pennsylvania	44.0	Kentucky	35.8
Colorado	43.9	Hawaii	35.9
Maine	43.6	North Dakota	36.5
South Dakota	43.2	South Carolina	36.6
Connecticut	43.1	Illinois	36.8

Fiscal Year 1978

High third		*Low third*	
State:	*Rate*	State:	*Rate*
New Jersey	53.1	Alabama	22.2
Nebraska	52.1	New Mexico	22.4
Kansas	49.0	Louisiana	30.6
Wisconsin	48.6	Connecticut	32.4
Utah	48.4	Maryland	32.6
Iowa	47.9	Alaska	32.7
Delaware	47.6	Mississippi	34.1
Colorado	47.5	Arkansas	34.3
Vermont	46.5	Puerto Rico	35.2
Ohio	46.0	New York	35.3
South Dakota	45.7	Washington	35.3
Missouri	45.3	Michigan	35.4
Massachusetts	44.0	California	35.4
Maine	43.9	Idaho	35.8
North Carolina	43.6	Oregon	35.8
Nevada	43.6	Tennessee	36.0
Montana	43.3	New Hampshire	36.8
		Wyoming	36.8

Source: Social Security Administration.

In this connection, it should be recalled that until 1972 the Social Security Administration reviewed a majority of State allowances before they were actually made, thus providing preadjudicative review in most cases. As the result of pressures to reduce costs and staff levels, as well as to meet the pressures of a growing workload, SSA moved to a sample review procedure which involved only 5 percent of allowances. Moreover, these reviews have been made on a post-adjudicative basis, that is, after the claimant has already been awarded his disability benefit.

Faced with mounting criticism of the decisionmaking process and rapidly growing disability rolls, SSA has in the last few years been trying to strengthen its quality review system. The quality assurance program now places the primary burden for quality of decisions at the State agency level. States must review a sample of their caseloads on an on-going basis, and the percentage of cases to be reviewed by them is set by the Social Security Administration. This "first-tier" review is supplemented by Federal "second-tier" and "third-tier" reviews which are aimed at producing a sample review system for both titles II and XVI that will produce greater uniformity of decisionmaking nationwide.

As part of the quality review process, SSA has established a system which it calls special postadjudicative review (SPAR) for both title II and title XVI cases. Using a sample of cases, SPAR measures State agency decisions on the basis of three categories of deficiencies: (1) clear decisional error, a case in which a clear error, within a limited group of review situations, exists, and, without further development, the reviewer can say that the decision made was incontrovertibly wrong; (2) other decisional error, a case in which a significant decisional deficiency clearly supported by the evidence, exists outside the limited review situations constituting clear decisional errors; and (3) documentation deficiency, a case in which a deficiency in medical documentation inhibits or prevents review of the decision.

While the new review system represents an improvement in the review process, an argument can be made that some of the SPAR measurement and review procedures used by SSA are faulty and need to be improved and that there are important kinds of errors that may not be recorded in the review system. One concern is that the small postadjudicative sample review system now in use may not result in the high degree of uniformity of decisionmaking that should be maintained in a national program.

The following table shows that, using the limited SPAR measurement system, State agencies do, indeed, appear to vary significantly in their ability to meet SSA-established error rate goals. The table provides cumulative SPAR accuracy rates for the 12-month period October 1977–September 1978, by rank of State for title II only. (SSA has set 90 percent as par).

TABLE 9.—SOCIAL SECURITY CENTRAL OFFICE REVIEW OF TITLE II INITIAL DISABILITY DETERMINATIONS, OCTOBER 1977 TO SEPTEMBER 1978

[Cumulative SPAR accuracy rates]

State Agency [1]	Returns	Accuracy rate
National	2,997	88.5
Connecticut	28	95.6
Iowa	33	95.0
Alaska	15	94.5
Massachusetts	43	94.2
North Dakota	26	94.2
Rhode Island	43	94.2
Wyoming	16	93.8
Nebraska	41	93.7
Vermont	32	93.6
Oregon	42	93.5
Washington	37	93.5
Montana	29	93.2
Florida	42	93.1
Idaho	35	93.0
South Dakota	39	92.9
Minnesota	45	92.6
Maine	43	92.5
Michigan	68	92.4
Wisconsin	46	92.3
New Hampshire	58	92.1
Hawaii	45	92.0
Utah	51	91.7
Arizona	62	91.6
Nevada	43	91.5
North Carolina	48	91.5
District of Columbia	33	90.9
Maryland	76	90.8
Virginia	51	90.7
Kansas	59	90.5
New Mexico	52	90.5
Tennessee	48	90.5
Missouri	63	90.1
Arkansas	9	[2] 90.0
Delaware	40	89.5
West Virginia	58	89.2

See footnotes at end of table, p. 43.

TABLE 9.—SOCIAL SECURITY CENTRAL OFFICE REVIEW OF TITLE II INITIAL DISABILITY DETERMINATIONS, OCTOBER 1977 TO SEPTEMBER 1978—Continued

[Cumulative SPAR accuracy rates]

State Agency [1]	Returns	Accuracy rate
South Carolina	55	89.1
Alabama	62	89.0
Colorado	62	88.9
Puerto Rico	96	88.1
Georgia	60	87.9
Kentucky	60	87.8
Ohio	77	87.5
Oklahoma	80	87.4
Texas	88	87.2
California	137	87.0
Mississippi	87	86.0
Illinois	79	85.2
New Jersey	107	85.2
Louisiana	97	85.1
Indiana	95	84.9
Pennsylvania	94	84.9
New York	162	83.1

[1] Ranked from high to low based on 12-month accuracy rates.
[2] Accuracy par for SPAR is 90.0 percent.

Source: Social Security Administration.

There has been growing pressure on SSA to move again toward increased Federal review of cases on a preadjudicative basis.

The House-passed bill, H.R. 3236, provides for what amounts to a gradual return to prior practice, requiring SSA to phase in a preadjudicative review system for title II cases equaling 15 percent in 1980, 35 percent in 1981, and 65 percent in 1982 and years thereafter. (H.R. 3464, the House-passed bill relating to SSI disability, does not include any similar review provision for SSI cases.)

Although increased Federal review may increase processing time as well as require a significant increase in Federal manpower, it is argued that the procedure will improve the quality and uniformity of decision-making and will also result in substantial long-term savings to the trust fund. SSA estimates that in 1984 the House provision will add $17 million in administrative costs, decrease benefit payments by $198 million, for a net savings of $181 million (—.06 of payroll in long-range estimates).

In material submitted to the House Subcommittee on Social Security this last spring, it was stated by SSA that it intended to begin a 70 percent preadjudicative review in 1981, although it also indicated that this percentage might be modified based on experience. (In

October 9, 1979, testimony before the Committee on Finance, the Commissioner of Social Security recommended a modification to H.R. 3236 under which increased Federal review would be phased-in over a 5-year period, reaching a 65-percent level in 1985.)

D. Disability Hearings

1. DESCRIPTION OF THE HEARING PROCESS

If an individual is dissatisfied with the reconsidered determination that has been made by the State agency, he may request a hearing. The request must be filed within 60 days of receipt of notice of the reconsideration determination.

The Office of Hearings and Appeals (OHA)—formerly known as the Bureau of Hearings and Appeals—within the Social Security Administration is responsible for holding disability hearings. Hearings are held by an administrative law judge who is assigned by OHA to handle the case. There are now approximately 650 ALJ's handling title II and XVI cases throughout the country. The hearing is generally a claimant's first face-to-face meeting with the individual who is deciding his claim. State agency decisions, as indicated earlier, are ordinarily made on the basis only of what is in the claimant's file. At a hearing, however, the individual may present his own case in person, or he may have someone to represent him. The procedure is nonadversarial, and the judge is free to take new evidence, and to call upon expert witnesses concerning the claimant's medical condition and his vocational capabilities.

The hearings held by the administrative law judges are subject to the Administrative Procedure Act of 1946. The Social Security Act with its provisions for hearings predates the APA. It has been argued in the past that social security hearings should be exempt from the APA. However, the Supreme Court commented in the 1971 case of *Richardson* v. *Perales:*

> We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act.

The staff of the House Social Security Subcommittee, in a committee print entitled "Background Material on Social Security Hearings and Appeals," published September 17, 1975, noted:

> Encouraged by the Supreme Court decision to avoid taking a position on whether the APA applies and other Supreme Court decisions in recent years which have given more weight to administrative ramifications of hearing requirements, some commentators have stated that the APA should not be applied to social security cases. These recent Supreme Court cases are somewhat at odds with earlier cases such as *Wong Yang Sung.* In that case Justice Jackson refused to accord weight to the argument that an APA hearing would cause the Government inconvenience and added expense, stating "of course it will, as it will to nearly every agency to which it is applied. But the power of the purse belongs to

> Congress which has determined that the price for greater fairness is not too high." *Wong Yang Sung* v. *McGrath* (1950) 339 U.S. 33.
>
> Others, who are not so certain that their position can be sustained on legal grounds, believe that wise public policy may call for the exemption of the growing number of social welfare cases from APA coverage. Opposed to this view are those who believe APA hearing safeguards are as necessary for adjudication of individual program rights as they are for corporations affected by regulatory agency action. (pp. 3 and 4.)

What does APA coverage mean and how does it affect the right to and nature of the hearing? The Social Security Subcommittee print points out that there is a large body of case law seeking to answer these questions. The Supreme Court has held in a series of cases that the due process clause of the Constitution protects an individual from final denial of a substantial benefit without opportunity for a hearing. (*Flemming* v. *Nestor, 1960; Goldberg* v. *Kelly,* 1960). Moreover, these cases and others have spelled out the procedural components of the hearings which must be present to meet due process requirements, including adequate notice, access to evidence, right to cross examination, and right to counsel and written finding and reasons for decision. Due process also requires that the person who takes evidence and makes the decision be impartial, that the trier of fact may not be prosecutor in the same matter, and that he may not have been involved in the matter previously as an agency staff person. These also are requirements of the APA. But the APA goes beyond this. It is in the area of the qualification of the hearing officer and his relationship to the agency adjudicating the claim that the APA imposes requirements which are unique.

Currently, an ALJ must have seven years of "qualifying experience," must consent to having confidential questionnaires sent to employers, supervisors, law partners, judges, co-counsel and opposing counsel in cases in which he has participated; must demonstrate writing ability by preparing a sample opinion, and must participate in an oral interview by a board composed of an official of the Civil Service Commission, a practicing attorney from the American Bar Association and an ALJ.

The APA was designed to insure the independence of the ALJ from the agency in which he operates by placing his pay, promotion, and tenure under the Civil Service Commission, rather than under the agency whose cases he decides.

2. HEARING ISSUES

For a number of years there have been serious complaints about the social security hearing process, primarily because of its slowness. More recently, there have also been complaints about the quality of decision-making.

The hearings workload has increased considerably since 1970. In that year, only about 43,000 hearing requests were received. Black Lung cases, as well as growing social security disability cases, swelled this number to about 104,000 by 1972. In 1977 there were about 194,000 requests, and in 1978, about 196,000. The number grew to

nearly 207,000 in the first three quarters of fiscal year 1979. As can be seen in the following table, the number of cases processed has increased steadily. The number of cases pending at the end of the year also generally showed increases over the time period, until fiscal year 1978, when the ALJ backlog of pending cases decreased significantly. Data for the first three quarters of fiscal year 1979, however, indicate that the number of pending cases is resuming its upward climb, reflecting the upsurge in the number of hearing requests. (According to the Office of Hearings and Appeals, ALJ productivity has remained steady in recent months, with an average of 27 case dispositions per month.)

TABLE 10.—REQUESTS FOR HEARINGS—RECEIPTS, PROCESSED, AND PENDING TOTAL CASES (END OF YEAR)

Fiscal years	Receipts	Processed	Pending
1970	42,573	38,480	13,747
1972	103,691	61,030	63,534
1974	121,504	80,783	77,233
1975	154,962	121,026	111,169
1976 (15 mo)	203,106	229,359	84,916
1977	193,657	186,822	91,751
1978	196,428	215,445	74,747
1979 (to Sept. 1)	206,686	193,464	87,969

Source: Social Security Administration.

Processing time for hearings does appear to have been improving in recent years. In material submitted to the House Social Security Subcommittee in hearings in February and March, 1979, SSA stated: "Within the limits of available resources to accommodate climbing caseloads, the Social Security Administration had to take vigorous steps to reduce the backlog of pending cases and to shorten overall processing time. Increasing emphasis was inevitably placed on ALJ productivity. This emphasis has dramatically improved the timeliness of the hearings and appeals process by: Cutting the processing time for an appeal in half, from an average of 316 days in 1975 to a current average of 157 days; reducing the average ALJ work backlog from a high of 12.7 months in 1974 to 4 months today." (p. 241.)

The reference above to increased emphasis on ALJ productivity raises a serious issue in itself. The Bureau of Hearings and Appeals undertook a number of efforts to "increase ALJ productivity," many of which proved to be highly controversial with the ALJs themselves. Such moves as establishing case processing goals and trying to influence staffing patterns in individual ALJ operations prompted charges

by many of the judges that their independence was being undermined and that such moves would or could affect adversely the quality of their decisions.

The ALJ decision-making process still remains highly individualized. The ALJs develop and decide cases in very different ways. They differ markedly in the way they use support staff. Some ALJs write their own decisions, while some delegate this function to a hearing assistant, or others to a staff attorney. Some ALJs play a major role in developing cases while others rely on support staff to do this. Some rely heavily on the use of medical consultative examinations, while some make less use of this possible source of additional evidence. ALJs also vary in the use they make of the expertise of vocational specialists.

Production rates for ALJs also vary considerably, as can be seen in the following table. About 14 percent of ALJs processed fewer than 250 cases a year in fiscal year 1978; 37 percent processed more than 350.

TABLE 11.—ALJ PRODUCTION RATES—FISCAL YEAR 1978 [1]

Total cases processed	Number of ALJ's	Percent of ALJ's
0 to 100 cases	2	0.3
101 to 200 cases	24	3.9
201 to 250 cases	59	9.6
251 to 300 cases	120	19.6
301 to 350 cases	180	29.4
351 cases and above	228	37.2
Total	613	100.0

[1] Includes only those ALJ's who were on duty the entire fiscal year.

Source: Social Security Administration.

ALJs have frequently been criticized not only for their variations in productivity, but also for their variations in reversal rates. A person who requests a hearing may be assigned to what have been referred to as either "easy" or "hanging" judges. In the period January—March 1979, 33 percent of ALJs awarded claims to from zero to 46 percent of the disabled workers whose cases they decided, 46 percent of ALJs awarded claims to from 46 to 65 percent, and 21 percent of ALJs awarded claims to from 65 to 100 percent. Overall, the percentage of hearings that result in a reversal (an allowance of benefits) has been increasing. In fiscal year 1969 the title II disability reversal rate was 39 percent. It increased to 46 percent in 1973, and by 1978 had actually increased to more than half, or 52 percent of all cases. The SSI hearing reversal rate has increased from 42 percent in fiscal year 1975 to 47 percent in 1978. (See tables 12, 13, and 14.)

TABLE 12.—PROCESSING OF REQUESTS FOR HEARING:[1] TITLE II DISABILITY ONLY[2]

Fiscal year	Affirmed	Reversed	Dismissed	Total
1969	14,524	[3] 11,035	2,389	27,948
1970	15,898	14,668	3,179	33,745
1971	18,528	17,187	3,827	39,542
1972	21,313	20,411	4,404	46,128
1973	24,740	25,653	5,509	55,902
1974	25,110	27,677	5,391	58,178
1975	27,657	32,911	6,449	67,017
1976	34,814	38,064	9,934	82,812
Transition quarter	11,727	12,400	3,423	27,550
1977	38,094	46,341	10,926	95,361
1978	39,852	[4] 54,372	9,657	103,881

[1] Includes terminations.
[2] Does not include title II cases filed concurrently with title XVI.
[3] 39 percent.
[4] 52 percent.

Source: Social Security Administration.

TABLE 13.—PROCESSING OF REQUESTS FOR HEARING,[1] TITLE XVI DISABILITY AND BLIND

Fiscal year	Affirmed	Reversed	Dismissed	Total
1974[2]	53	33	35	121
1975	4,917	[3] 5,218	2,193	12,328
1976	13,094	14,895	5,318	33,307
Transition quarter	3,779	3,922	1,395	9,096
1977	14,428	16,317	5,395	36,140
1978	18,460	[4] 21,492	6,195	46,147

[1] Includes terminations.
[2] Includes title XVI cases filed concurrently with title II.
[3] 42 percent.
[4] 47 percent.

Source: Social Security Administration.

TABLE 14.—REQUESTS FOR HEARING,[1] CONCURRENT TITLE II/ TITLE XVI DISABILITY AND BLIND

Fiscal year	Affirmed	Reversed	Dismissed	Total
1975	3,099	[2]4,334	1,027	8,460
1976	12,623	13,820	3,997	30,440
Transition quarter	4,705	4,964	1,367	11,036
1977	18,706	21,149	5,546	45,401
1978	22,195	[3]26,331	5,772	54,298

[1] Includes terminations.
[2] 51 percent.
[3] 48 percent.

Source: Social Security Administration.

The cost of the hearing procedure to the individual in terms of time and energy expended may be very great. The cost to the system is also great, amounting to $597 for each case brought to a hearing in fiscal year 1978. There is reason, therefore, for considering ways in which this step of the adjudicatory process can be improved.

One alternative would be eliminating the ALJ hearing altogether, relying instead on a stronger decisionmaking and hearing structure at the earlier stages of determination. The Administration, although agreeing that the ALJ hearing should be maintained, has stated that it intends to study administrative changes which will result in a face-to-face meeting between the claimant and the individual who decides his case at the reconsideration level. This step, it is hoped, will contribute toward a lowering of the number of cases which are appealed to the ALJ level. The Administration has also indicated that it would like to use Social Security Administration personnel to present and defend the Government's case in a hearing before an ALJ. This, according to the Administration, will ensure a better developed case and permit the ALJ to serve in a more purely judicial role. Critics of this approach cite its cost and the fact that if the Government is represented, then provision should be made in all cases for the claimant also to be provided with legal defense—with a considerable increase in costs.

The Social Security Administration has already conducted a study of using face-to-face interviews at the reconsideration level. The experiment began in 1975 and was called the Reconsideration Interview Study (RIS). It involved 16 State agencies and applied to about 30 percent of each State's reconsideration cases.

In an April 1977 staff report, "Current Legislative Issues in the Social Security Disability Insurance Program," prepared by David Koitz who at that time was with the Office of the HEW Assistant Secretary for Management and Budget, a number of questions are raised about this approach, and the question of possible increased costs is mentioned specifically (pp. 80–81).

The report states:

> While on the surface, it may appear that the RIS procedure is a desirable improvement in handling contested decisions, it has some questionable features. The idea is to have the State agency make the reversal where it can so that the case does not have to go to a formal hearing. What we wind up with is better documentation of the case, but it is not clear as to whether or not we get a better decision. The disability examiner has been told to reverse the initial denial where he can—and if he cannot do it based on the documented evidence he has been given and telephone contacts he has made with the claimant, he is to bring the claimant in for a face-to-face discussion. The effect of the face-to-face interview is uncertain. Is the disability examiner really getting a better picture of the claimant's condition, or does he simply become more sympathetic with the claimant? Is he possibly intimidated by the confrontation? We do not know the answers.
>
> What we do know, however, is that the RIS procedure results in a greater number of allowances—it costs more money. The study indicated that the overall allowance rate for the test group was 2 percent higher than the control group (in which normal reconsideration procedures were used). The following table shows what this means at each appellate level:

DI AND SSI ALLOWANCES

[Projected on fiscal year 1977 workloads]

	Control group		Test group	
	DI and concurrent	SSI	DI and concurrent	SSI
Initial	648,400	234,450	648,400	234,450
Reconsideration	84,100	20,500	131,700	31,500
Hearing	57,200	11,500	26,200	5,300
Total	789,700	266,450	806,300	271,250

Increases: DI and concurrent=16,600 (+2 percent); SSI=4,800 (+1.8 percent).

With benefit payments under the DI program now approaching $11 billion a year, if the RIS procedure were fully implemented, it would increase DI benefit costs by more than $200 million a year in today's dollars—more than $1 billion during its first 5 years. In the SSI program, today's cost would be about $60 million a year.

Given the potential costs and the fact that while the RIS procedure generally renders a quicker decision on contested cases, we are not sure what the effect is on the quality of the decisions that are made, it seems questionable that full implementation of the procedure would be a desirable next step.

Responding to criticisms of the slowness of decisionmaking at this stage as well as at other stages of the process, and a growing number of Federal Court decisions mandating that an administrative decision be rendered within a specific time frame (frequently within a 90 day period) the House-passed bill includes a provision which requires the Secretary to submit to the Congress a report recommending the establishment of time limits on decisions on benefit claims. This report is to specifically recommend the maximum periods of time within which all administrative decisions should be made, taking into consideration both the need for expeditious processing of claims and the need for thorough consideration and accurate determinations of such claims. The report must deal with hearing decisions, as well as with initial, reconsideration and appeals council decisions.

There have also been other changes and recommendations for changes in the system. For example, it is suggested that a strong peer review system, and stronger training programs, could produce substantial improvements.

One study of the system, "The Social Security Administration Hearing System," prepared by the Center for Administrative Justice, October 1977, observes:

> Our general conclusion . . . is that the more dramatic proposals for reform of the system are inadvisable, either because they are not directed at real problems, because they would be on balance dysfunctional or because their effects are unknown. While the problems that have been identified by others do in various degrees infect the BHA system, we do not find the problems to be so overwhelming that an entirely new system is required. Moreover, we are convinced that significant reforms of which we suggest a substantial number, must be very carefully analyzed before they are implemented. There are very few reforms that will improve all dimensions of the process at once. Every change requires a tradeoff among relevant values.

(Reprinted in "Disability Adjudication Structure," Committee Print of the House Subcommittee on Social Security, January 29, 1978, see p. 47.)

E. Role of the Appeals Council and the District Court

1. APPEALS COUNCIL

If an individual is still dissatisfied with the disposition of his case after a hearing before or dismissal by an administrative law judge, he may request a review of his case by the Appeals Council of the Office of Hearings and Appeals. As with the request for a hearing, the request for a review by the Appeals Council must be made within 60 days of receipt of notice of the hearing determination.

The Appeals Council has fourteen members who handle cases according to their assigned geographic areas of the country. As are the reviews before the administrative law judge at the hearing level stage, the Appeals Council review is "de novo", whereunder any new evidence, not previously presented by the claimant, may be submitted for consideration along with the existing file. For the most part, these reviews are a "paper review" of the case, and thus do not involve a face-to-face presentation of the facts as is done at the hearing stage.

The existence of the Appeals Council is based on the following section of the Social Security Acts which states:

Sec. 221—

> (c) The Secretary may on his own motion review a determination, made by a State agency pursuant to an agreement under this section, that an individual is under a disability (as defined in section 216(i) or 223(d)) and, as a result of such review, may determine that such individual is not under a disability (as so defined) or that such disability began on a day later than that determined by such agency, or that such disability ceased on a day earlier than that determined by such agency.

In the regulations, the function of the Appeals Council is further described as a review of the determination made at the hearing stage, either "on its [the Appeals Council] own motion or on request for review", where:

> (1) There appears to be an abuse of discretion by the presiding officer; (2) There is an error of law; (3) The presiding officer's action, findings, or conclusions are not supported by substantial evidence; or (4) There is a broad policy or procedural issue which may affect the general public interest. * * * Where new and material evidence is submitted with the request for review, the entire record will be evaluated and review will be granted where the Appeals Council finds that the presiding officer's action, findings, or conclusion is contrary to the weight of the evidence currently of record. CFR § 404.947(a).

Presently, the cases reviewed by the Appeals Council are predominantly ones in which the claimant is seeking a reversal. The "own motion" review process that had traditionally been a major function of the Council, whereby cases not brought to the Council by a claimant were also subject to review, was for the most part abandoned in 1975 because of the pressure of a mounting caseload within the Bureau.

At the time this decision to down-grade own motion review was made, considerable concern was expressed over the effect this change might have on the quality of the decisionmaking process. This concern remains today. At the present time there is a quality control system in effect for administrative law judges. However, it is regarded by many as not sufficiently effective to assure uniform quality of decisions at the ALJ level, or to serve as a reliable mechanism to correct errors. As noted earlier, the ALJ operation is a highly independent one, and the wide variance in reversal rates would tend to support the conclusion that greater review of this step in the process may be needed.

The staff of the House Social Security Subcommittee commented in its "Survey and Issue Paper on the Social Security Administrative Law Judges," printed in 1975 that "The staff is also concerned with the failure of the Appeals Council to review ALJ's and hearing examiner allowances of benefits for possible error even though it realizes that recent actions in effectuating unreviewed decisions have been done with the idea of reducing processing time. . . . The staff

believes that the review of hearing officers decisions should be greatly expanded. . . ."

In concert with this recommendation, the Center for Administrative Justice concluded from its review (referred to earlier) that the own motion process should be reinstituted. In its report the Center states:

> * * * increased own-motion review of grants involves costs in the form of delay and uncertainty, even for claimants who are ultimately awarded benefits. Nevertheless, our conclusion is that these costs are worth bearing, at least in cases identified as likely to be error-prone. Moreover, if a class of cases in which benefits are granted by the ALJ can be identified as likely to have an unusually high incidence of errors, then the costs of own-motion review to the class of claimants who are subjected to delay and then granted benefits will be relatively modest because the class will be small.
>
> A remand or reversal in an appealed case is also a clearly acceptable form of supervisory control over the ALJ (although some ALJs reject even this position). Memoranda or conferences with particular ALJs whose cases reveal problems may, however, be viewed as attempts to undermine the independence of the ALJ corps (pp. 119–120).

In his testimony before the Subcommittee on Social Security of the Committee on Ways and Means on March 9, 1979, Commissioner Ross announced that the Agency intended to establish a new Appeals Board which would encompass the own motion review function. He stated:

> We will establish an SSA Review Board to review appeals by claimants, as the present Appeals Council does, and to review ALJ allowances on its own motion. It will ensure fair and consistent treatment for all claimants.

This new appeals body has not been formally announced in the Federal Register and the restoration of own motion review has not yet been put into effect.

With respect to own motion review, the Administration in its draft disability bill this year also proposed expanding the legislative authority of the Secretary to review denials as well as allowances.

In recent years the Appeals Council has adopted the practice that if additional evidence is required in a case, the Council will remand the case to the ALJ for receipt of additional evidence and rehearing. There has been growing consensus that it is desirable to remand cases back to the ALJs where the taking of additional evidence is required. In 1975 Social Security Commissioner James B. Cardwell testified at a Ways and Means Subcommittee hearing that SSA was considering "closing the record and having any Appeals Council review limited to the record established at the hearing; where the record was inadequate, the case would be remanded to the presiding officer."

The Administration's bill this year incorporated the proposal for closing the record at the ALJ level, thus eliminating the fourth *de novo* review at the Appeals Council level. The House bill also includes this provision.

2. FEDERAL COURT

Review of a case by the Appeals Council of the Office of Hearings and Appeals is the final recourse a claimant has within the administrative review process of the Social Security Administration if he is dissatisfied with the disposition of his case. However, increasingly reversal of the Agency's final decision is being pursued in a U.S. district court.

The number of appeals filed with Federal district courts has grown dramatically in the last decade. As is the situation of the workload of the Office of Hearings and Appeals, the vast majority of the court cases involve disability. Between 1955 and 1970, the number of disability appeals filed with Federal district courts totaled slightly under 10,000 cases for the entire period. Currently, there are approximately 15,000 DI and SSI-disability cases pending in the Federal court system. The following table shows the growth in the court case workload since 1970.

Fiscal year:	*Court filings— All SSA programs* [1]
1970	1,531
1975	5,052
1976	9,158
1977	9,114
1978	8,349

[1] Excludes cases currently remanded back to SSA by the courts. Approximately 5% of the cases are not related to disability. While filings appear to have declined in 1978, the number of cases pending continues to rise in 1979.

The volume of these cases in the courts and the continued growth of the backlog of cases pending have prompted proposals for establishment of a Disability Court as well as other proposals which would constrict the existing role of the Federal courts. Former Chairman of the Subcommittee on Social Security of the Ways and Means Committee, James Burke, proposed establishment of a Disability Court that would largely follow the pattern of the Tax Court in structure. Others, however, would address the ever-increasing activity of the courts by further restricting the court's function.

The statutory base underpinning the scope of judicial review of determinations made by the Agency is found in section 205(g) of the Social Security Act:

> The Court shall have power to enter, upon the pleadings, and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a hearing. The findings of the Secretary as to any fact, *if supported by substantial evidence*, shall be conclusive, * * * (emphasis supplied)

In theory, the "substantial evidence rule" imposed on the courts contrasts the review at that level with those conducted within the administrative process of the Social Security Administration in which cases are reviewed "de novo." Complaints have long been made by the Social Security Administration and others that the courts have frequently by-passed the substantial evidence rule by substituting their judgment of the facts for those of Agency adjudicators. In 1960, the

Harrison Subcommittee of the Ways and Means Committee reviewed this complaint and took the following position in its report:

> The jurisdiction of a court to review a determination of the Secretary is limited to a review of the record made before the Secretary. It is not a trial de novo but is limited to a consideration of the pleadings and the transcript of the proceedings at the hearing. The court has no power to hold a hearing and determine the merits of the claim because the statute makes it clear that the determination of claims is solely a function of the Secretary.

And as recently as 1977, the report of the Center for Administrative Justice raised concerns about the role of the Federal court, stating that in its review the Center could:

> find little, if any, contribution to accuracy and consistency resulting from judicial review. Judicially imposed requirements have certainly added to the administrative costs of the system. Nevertheless, we are dissuaded from a recommendation of outright abolition of judicial review because of the contribution that review makes to the political legitimation of the system (p. XXIV).

Short of abolishing judicial review, proposals have emerged to further restrict the role of the courts. The Administration's bill proposes, as part of its overall sets of reforms to the administrative process for disability, to limit judicial review in disability cases to questions of constitutionality and statutory interpretation. Commissioner Ross in his testimony on March 9, 1979 before the Subcommittee on Social Security of the Ways and Means Committee stated:

> If decisions are the product of the careful adjudicatory process I have described, claimants will be adequately protected by being able to take questions of law to the courts. In a system producing hundreds of thousands of decisions a year, it is essential to place responsibility for accurate factual determinations at the administrative level. This change will also have the desirable side effect of substantially reducing a major burden on the Federal courts—currently approaching 10,000 new OASDI and SSI cases a year, with a backlog of approximately 14,500 disability-related claims.

In addition to concern about the growth of the courts' workloads and adherence to the substantial evidence rule, concern has been expressed about the Secretary's authority, on his own motion, to remand a case back to an ALJ prior to filing his answer in a court case.

Some critics, including the Harrison subcommittee in 1960, have suggested that such absolute discretion gave the Secretary potential authority to remand cases back so that they could be strengthened to sustain court scrutiny. Others have suggested that such a device also may have the tendency to lead to laxity in appeals council review in that it will give them another look at the case if the claimant decides to go to court.

Similarly, under existing law the court itself, on its own motion or on motion of the claimant, has discretionary authority "for good

cause" to remand the case back to the ALJ. It would appear that, although many of these court remands are justified, some remands are undertaken because the judge disagrees with the outcome of the case even though he would have to sustain it under the "substantial evidence rule." Moreover, the number of these court remands seems to be increasing.

The House-passed bill, H.R. 3236, would eliminate the provision in present law which requires that cases which have been appealed to the district court be remanded by the court to the Secretary upon motion by the Secretary. Instead, remand requested by the Secretary would be discretionary with the court, and only on motions of the Secretary where "good cause" was shown. The bill would continue the provision of present law which gives the court discretionary authority to remand cases to the Secretary, but adds the requirement that remand for the purpose of taking new evidence be limited to cases in which there is a showing that there is new evidence which is material and that there was good cause for failure to incorporate it into the record in a prior proceeding.

IV. The Disability Benefit Formulas

Although the disability insurance program and the supplemental security income program share common definitions of disability and a common administrative structure, they utilize completely different methods of determining the amount of benefits payable. The disability insurance program is intended to be a wage-replacement system, and the benefit level for each individual is determined by applying a formula to the wages that he earned which were subject to social security taxes. The amount and source of other income available after disability is irrelevant to the determination of benefit amounts. (Earned income, however, may be relevant to the question of whether the individual continues to be disabled. Also, income in the form of workmen's compensation may cause a benefit reduction under a special provision intended to prevent duplication of benefits.)

The supplemental security income program provides benefits on an income guarantee basis under which the benefit payment is determined by subtracting the individual's other income from an income support amount which is established for all individuals in the same category. In practice, however, there are many different income support levels because of provisions for not counting certain types and amounts of income and differential rules for single individuals and couples and for different categories of recipients. These differences exist to some extent under the basic Federal program but to an even greater extent are present in the State supplementary programs.

A. Supplemental Security Income

As of July 1979, the SSI program provides a basic Federal income support level of $208.20 per month for a single individual and $312.30 per month for a couple. These are the Federal benefit amounts which would be payable to an individual or couple receiving SSI if that individual (or couple) had no other income. In many States, somewhat higher total amounts are payable because of the addition of a supplementary payment in an amount determined and financed by the State. States may (and many do) set varying supplemental levels for SSI recipients according to category (aged, blind, disabled), living arrangements (independent, boarding home, etc.) and geographic area. The income support levels as of October 1, 1979 for individuals and couples in independent living arrangements are shown in table 1 which appears earlier in this document.

When the SSI program was enacted in 1972, the basic Federal income support levels were set at $130 per month for a single individual and $195 for a couple. Subsequent legislation increased these amounts and provided for automatic increases tied to the Consumer Price Index under the same formula as applies to social security benefits. (The income support levels are raised each July by the percentage increase of the CPI for the January–March quarter of the year in question over the CPI for the January–March quarter of the

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preceeding year.) States are required to make corresponding increases in the State income support levels. However, since this requirement could result in an increase in State costs because of caseload growth associated with the higher levels, States are considered to be in compliance if they continue the aggregate level of State spending which was in effect prior to the increase in Federal benefits.

The income support level applicable to a given individual represents the payment which would be made to him if he had no other income. If the individual does have other income, the payment is reduced but not on a strict dollar-for-dollar basis. The first $20 per month of other income is simply not counted. Other income causes a dollar-for-dollar reduction if it is unearned income (such as social security or veterans compensation or rental income). Other income which results from the recipient's employment or self-employment ("earned income") is counted as follows: The first $65 per month of such income is not counted at all. Benefits are then reduced by 50 percent of earnings above the $20 and $65 flat "disregard" amounts.

The following example illustrates how the actual benefit is determined.

Federal income support level	$208.20
State supplementary addition	[1] 50.00
Amount payable to individual with no other income	258.20
Other income:	
Social security	150.00
Earnings	100.00
Gross other income	250.00
Disregards:	
$20 of any income	20.00
$65 earned income	65.00
50 percent of earnings above $65	17.50
Total not counted	102.50
Total "countable" income	147.50
Actual benefit payable	110.70

[1] Hypothetical amount; actual State supplements vary widely from State to State.

In the example above, the SSI program in effect supports the income of the particular individual described at a level of $360.70 as compared with the $258.20 income support level for an individual with no other income. Even higher levels are possible up to the "breakeven" point which is the amount of income at which the benefit level is reduced exactly to zero. Breakeven points vary from individual to individual because of the differences which exist in the basic income support levels and because the reductions from the basic income support level vary according to the particular combination of earned and unearned income. In the case of an individual who would be eligible for $258.20 if he had no other income (as in the example above), the breakeven point (if all income was "earned" income) would be $601.40 or about $7,200 per year.

These provisions for determining benefit amount and counting or not counting other income are common to all three categories of SSI recipients: aged, blind, and disabled. Since eligibility for SSI disability requires a sufficiently severe disability to indicate inability to

engage in any substantial work activity, the theoretical breakeven point under the above described rules for determining benefit amounts is largely hypothetical in the case of disabled recipients since a much lower level of earnings would generally be sufficient to establish that they no longer meet the definition of disability. In such instance, the higher breakeven point is mainly important for determining whether and to what extent benefits would be payable during the individual's 9-month trial work period.

In addition to the general SSI provisions for determining the amount of benefits, there are special provisions applicable only to the disabled and special provisions applicable only to the blind. For the disabled, in addition to not counting the first $65 of monthly earnings plus half of earnings above that amount, additional amounts of earnings are not counted if they are earned in accord with a plan for achieving self-support which has been approved by the Secretary. A similar additional exclusion is provided for blind individuals, and the blind are also allowed an exclusion of earnings equal to any work expenses they may have.

B. Disability Insurance

Unlike the income guarantee approach of SSI, the social security disability insurance program determines the amount of benefits payable by looking at the individual's previous earnings rather than his current income. The basic theory underlying the formula for determining benefit amounts is the same for social security retirement benefits as for social security disability benefits. A basic benefit level is arrived at by applying a formula to the average earnings the individual had over the course of a period of years which approximates the number of years in which he could reasonably have been expected to be in the workforce. For a retired worker, this period is equal to the number of years between the ages of 21 and 62. For a disabled worker, the number of years of earnings to be averaged ends with the year before he became disabled. In either case, the resulting averaging period is reduced by 5. This permits the worker to drop out that many "low years" in which because of unemployment, illness, or other reason he may have had little or no earnings. (Because social security coverage was greatly expanded in the 1950s, workers now retiring and older disabled workers have their earnings averaged from 1951 rather than from age 22. The 5-year dropout provision was also originally included to accommodate workers in jobs which were not covered until the mid–1950s. Otherwise, even with a 1951 starting date, they would have necessarily had their average lowered by the inclusion of several years of zero earnings under social security.)

For both retired and disabled workers, the basic benefit amount determined by applying the formula to the average earnings may be increased if the worker has a dependent spouse or children. Benefits for the spouse are payable if the spouse is over age 62 or if the spouse is caring for minor or disabled children. Benefits for children are payable if they are under age 18 or are disabled (as a result of a disability which existed in childhood) or if they are full-time students over age 18 but under age 22. The combined benefit for the worker and all dependents is limited by a family maximum provision to no more than 150 to 188 percent of the worker's benefit alone.

Although the same general rules apply to determining benefits for disabled individuals and their dependents as to determining benefits for retired workers and their dependents, the application of these rules leads to somewhat different results. In general, benefit levels are apt to be higher for disabled workers because of the smaller number of years over which earnings must be averaged. This is particularly true for younger disabled workers for whom as few as two years may be used in determining the average earnings to which the benefit formula will be applied. For example, in the case of a worker who is disabled at age 29, the number of years used to determine his benefit is equal to the 7 years between the year in which he reached age 21 and the year in which he became disabled less the 5 drop-out years. His benefit is based on his earnings in those two years in which he had his highest earnings.

Because earnings levels in the economy tend to increase from year to year, the advantage to the younger disabled worker of having his earnings averaged over a very few high years is magnified since the older worker is forced to include years when earnings levels were lower. Prior to the 1977 amendments, this problem was particularly severe since earnings were averaged at their actual values. The 1977 amendments lessened but did not eliminate this advantage by providing for the indexing of earnings to compensate for the impact of changing wage levels in the economy. Younger workers continue to have a substantial advantage both because statutory increases in the amount of annual earnings subject to social security have been much greater in recent years than in earlier years and because individual wage patterns differ widely from average wage patterns. As a result, an individual whose benefits are based on the average of his earnings over his two, three, or four highest years of earnings is likely to have a significantly higher benefit than an older worker who must average his highest ten or twenty or more years of earnings.

The benefits payable to disabled workers cover a broad range from a minimum of $122 monthly to a maximum (for a worker who became disabled in 1978) of about $730. The average benefit for all disabled workers in June 1979 was $320 per month. The average total family payment for disabled workers with dependents was $639 per month.

The benefit amounts payable under the social security disability insurance program have increased very greatly over the past decade. In part, these increases simply reflect the percentage increases in social security benefit levels resulting from legislation and from the automatic cost-of-living increase provisions instituted by the 1972 amendments. Wage growth in the economy also contributes to increased benefits since social security benefit amounts are determined by applying the benefit formula to an individual's average wages under social security. As indicated above, the impact of wage growth over the past several years has tended to be reflected in disability benefit increases more than in retirement benefit increases. The rate of growth in disability benefits as compared to retirement benefits is shown in the table below.

TABLE 15.—INCREASES IN BENEFITS AWARDED TO RETIRED AND DISABLED WORKERS, 1969 to 1978

Year	Retirement awards			Disability awards		
		Percentage			Percentage	
	Average amount	Over 1969	Over prior year	Average amount	Over 1969	Over prior year
1969	$106			$118		
1970	124	17	17	140	19	19
1971	138	30	11	157	33	12
1972 [1]	169	59	22	193	64	23
1973	170	60	1	197	67	2
1974 [2]	192	81	13	217	84	10
1975 [2]	214	102	11	243	106	12
1976 [2]	234	121	9	271	130	12
1977 [2]	255	141	9	295	150	9
1978 [2]	278	162	9	328	178	11

[1] September-December average.
[2] June-December average.

Source: Social Security Bulletin.

As indicated in the table, the differential between average monthly benefits awarded to disabled workers over the average monthly benefits awarded to retired workers has grown from $12 ten years ago to $50. In absolute terms, the average disability award has increased from $118 to $328 over this same ten year period. This is a 178 percent increase. During the same period of time, the cost of living (as measured by the Consumer Price Index) rose by about 80 percent. A part of this rapid growth in disability benefit levels is attributable to the over-indexing aspects of the automatic increase provisions enacted in 1972. Under the revised benefit formula adopted in the 1977 Amendments, initial benefit levels will continue to increase at a rate in excess of the inflation rate but to a lesser extent than under the prior law.

One of the reasons which has been advanced to explain the rapid growth in the disability program in recent years is that the increased benefit levels have made it more likely that any given individual will become and remain a beneficiary. When benefit levels were very low, an individual with a disability might find it economically advantageous to continue working even though his impairment limited his earnings to quite low levels. Similarly, an individual who became a recipient had a potential for significantly increasing his family income by participating in a program of rehabilitation. The higher benefit levels now prevailing in the program substantially reduce the extent to which a disabled person would find it advantageous to remain in or return to employment. For example, the average family benefit for a disabled worker with dependents now exceeds by some 20 percent the earnings which he could expect to obtain by becoming sufficiently rehabilitated to qualify for a minimum wage job.

While it is possible to draw a general conclusion that increased benefit levels appear to have contributed to the rapid growth of the program, there is no simple rule of thumb for determining the optimum benefit level which balances the desire for reasonable adequacy against the desire to maintain a reasonable incentive for continued employment or rehabilitation. Examination of this problem, however, has resulted in considerable analysis of the relationship between the initial benefit level and prior earnings on the theory that benefits should not replace so large a percentage of predisability earnings as to make the receipt of benefits from a financial standpoint nearly as desirable as, or even more desirable than the continuation of employment. Again there is no sure rule as to what level of benefits mark the dividing line above which the receipt of benefits becomes more attractive financially than continued employment. Clearly, this line falls somewhere below a level of 100 percent of prior earnings. However, the judgment of just how far below is complicated by several factors. Disability benefits are tax-free and are also free of various other costs an individual would probably incur in working. The availability of medicare for those who have been on the disability rolls for at least two years is also a factor in weighing the relative advantages of working or not working.

Another problem is the determination of an appropriate base against which to measure the concept of predisability earnings. The simplest and most frequently used base is the average indexed earnings on which benefits are based (a period of earning consisting of from 2 years for the youngest disabled workers to 23 years for the oldest disabled workers).

However, other periods of earnings are sometimes used, such as the 5 or 10 year period immediately preceding the year in which the disabling condition occurred or, as another illustration, the highest 3 or highest 5 years of earnings within an earnings record. The choice of the period of earnings to be used to determine how much of an individual's previous earnings are replaced by disability benefits is significant because different indicators of earnings replacement will result from using different approaches of measuring predisability earnings.

The following table, which is based on a sample of approximately 10,000 DI awards made in 1976, shows the replacement rates resulting from those awards under two illustrative approaches of measuring replacement rates. The first approach encompasses the period of earnings used to compute average indexed monthly earnings (AIME) as the base to which benefits are compared. The second approach uses the highest-five years of indexed earnings during the 10-year period immediately preceding the onset of the disabling condition.

TABLE 16.—DI REPLACEMENT RATES COMPUTED FROM 2 DIFFERENT MEASURES OF PREDISABILITY EARNINGS

Replacement rates[2] (1979 PIA) levels	Awards at each level of earnings replacement[1]			
	Using AIME		Using high 5 years of indexed earnings in last 10	
	Number of cases	Percent of total	Number of cases	Percent of total
Under 30 percent	0	0	268	3
30 to 39 percent	79	1	2,930	31
40 to 49 percent	3,669	38	2,168	23
50 to 59 percent	1,456	15	1,184	12
60 to 69 percent	947	10	1,353	14
70 to 79 percent	1,215	13	771	8
80 to 89 percent	1,477	15	526	5
90 to 99 percent	181	2	148	2
100 percent and over	561	6	237	2
Total sample	9,585	100	9,585	100
Average replacement rate (percent)	58		49	

[1] These awards include both individual and family benefits where applicable. The actual awards were made before a "decoupled" system was put into effect. However, the awards were recomputed for sample purposes as if a decoupled system existed to give some sense of the longer-range direction of DI replacement rates.

[2] Represents replacement of gross earnings.

As table 16 shows, the average replacement rate of the awards in the sample is higher when the longer period of earnings, AIME, is used. Similarly, the percentage of awards with relatively high replacement rates is greater when AIME is used.

Nonetheless, both approaches to measuring replacement—i.e., either long or recent periods of a worker's earnings history—show that there are a substantial number of DI awards which by themselves result in replacement rates in excess of predisability earnings. Using 80 percent of gross predisability earnings as a proxy for predisability disposable earnings, approximately 23 percent of the awards in the sample were above that level using AIME as the base period for measurement, and approximately 10 percent of the awards in the sample were above that level using the high-5 years of indexed earnings during the 10-year period prior to the onset of disability as the base period for measurement. Approximately two-thirds of these cases involved the payment of dependents benefits in addition to those of the worker.

The following tables show the prevalence of high replacement rates; using as a measure of that situation, the payment of benefits repre-

senting replacement of 80 percent of AIME or of the high-5 years of indexed earnings in the 10-year period immediately prior to onset for DI awards to (1) individuals alone (disabled workers without families) and to (2) disabled workers with eligible dependents:

TABLE 17.—PERCENTAGE DISTRIBUTION OF AWARDS TO DISABLED WORKERS WITHOUT DEPENDENTS WHICH RESULT IN REPLACEMENT RATES OF 80 PERCENT OR MORE, BY PIA LEVEL[1]

[In percent]

Primary insurance amount (1979 levels)	Using as base period for measurement— AIME	High-5 years in last 10
Minimum PIA	39	44
$122 to $150	17	10
$150 to $200	44	23
$200 to $250	0	12
$250 to $300	0	5
$300 to $350	0	5
Total	100	[2] 100

TABLE 18.—PERCENTAGE DISTRIBUTION OF AWARDS TO DISABLED WORKERS WITH DEPENDENTS WHICH RESULT IN REPLACEMENT RATES OF 80 PERCENT OR MORE, BY PIA LEVEL[1]

[In percent]

Primary insurance amount (1979 levels)	Using as base period for measurement—[1] AIME	High-5 years in last 10
Minimum PIA	3	4
$122 to $150	2	3
$150 to $200	16	18
$200 to $250	20	19
$250 to $300	23	24
$300 to $350	23	24
$350 to $400	12	8
Total	100	100

[1] Represents replacement of gross earnings.
[2] Column does not add due to rounding.

Note: The PIA should not be confused with the actual monthly benefit amount received by the worker and his family. In many instances, the actual monthly benefit amount is substantially higher. It is used here simply to show the incidence of high replacement rates within the relative scale of benefits.

As the preceding two tables show, high replacement rates for workers with no dependents tend to exist at the lower (and more heavily weighted) end of the benefits spectrum. For workers with dependents, the incidence of high replacement rates is more evenly spread among all benefit classes.

The SSA sample also shows that DI awards made to younger workers tend to result in higher replacement rates than those of older disabled workers, which reflects the effect of the shorter averaging period used to determine the younger workers' benefits. The following tables show the distribution of replacement rates by the ages of the disabled workers in the sample.

TABLE 19.—DISTRIBUTION OF DI REPLACEMENT RATES BY AGE GROUP OF DISABLED WORKERS

	Total		Replacement rate brackets using high-5 years of earnings in last 10 as base period for measurement [1] (percent)									Average replacement rate (percent)
	Number of cases	Percent	Under 30	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 to 99	100 and over	
Age at onset:												
Under 20....	64	100	0	0	3	20	11	14	23	6	22	72
20 to 24.....	574	100	0	2	23	21	17	10	15	2	9	60
25 to 29.....	698	100	0	4	31	19	12	9	19	2	4	59
30 to 34.....	652	100	0	16	25	11	14	21	11	1	1	57
35 to 39.....	714	100	0	17	16	9	25	19	8	3	3	59
40 to 44.....	889	100	2	24	19	12	24	10	5	2	3	54
45 to 49.....	1,232	100	5	30	20	13	18	6	3	2	2	49
50 to 54.....	1,699	100	4	37	23	12	13	5	2	1	2	47
55 to 59.....	1,965	100	4	44	25	10	9	4	2	1	1	44
60 to 64.....	1,098	100	5	53	22	11	6	2	1	1	1	41
Total.....	9,585											49

[1] Based on 1979 P1A levels.

Note: 9,585 cases in sample, including workers both with and without dependents.

	Total		Replacement rate brackets using AIME as base period for measurement [1] (percent)									Average replacement rate (percent)
	Number of cases	Percent	Under 30	30 to 39	40 to 49	50 to 59	60 to 69	70 to 79	80 to 89	90 to 99	100 and over	
Age at onset:												
Under 20....	64	100	0	0	3	20	10	14	23	6	22	72
20 to 24.....	574	100	0	2	23	21	17	10	15	2	9	60
25 to 29.....	698	100	0	4	31	19	12	9	19	2	4	59
30 to 34.....	652	100	0	4	26	13	11	13	26	3	4	63
35 to 39.....	714	100	0	1	22	10	9	17	28	4	9	68
40 to 44.....	889	100	0	0	24	14	8	19	24	3	8	66
45 to 49.....	1,232	100	0	0	31	15	9	17	18	3	8	62
50 to 54.....	1,699	100	0	0	40	16	9	14	13	2	6	57
55 to 59.....	1,965	100	0	0	52	16	9	10	8	1	4	52
60 to 64.....	1,098	100	0	0	64	12	9	6	5	1	2	49
Total.....	9,565											58

[1] Based on 1979 P1A levels.

Note: 9,585 cases in sample, including workers both with and without dependents.

While it is difficult to measure the aggregate effect high earnings replacement has had in either attracting disabled workers who are still engaged in employment to apply for DI benefits, or in discouraging DI beneficiaries with the potential to return to productive employment from attempting to do so, the percentage of awards in the sample where earnings replacement is high is of significant enough concern if only brought up within the context of whether or not a program which has as its principal purpose the replacement of lost earnings should ever provide benefits which completely supplant predisability earnings.

In his report to the Committee on Ways and Means in 1976, John Miller, a consulting actuary to the committee, stated that:

> disability income dollars are, in general, much more valuable and have much more purchasing power than earned dollars. The DI benefits are fully tax exempt, as are insured benefits except for employer provided benefits in excess of $100 per week. For a worker with a spouse and a child, paying an average State income tax, 50 percent of salary in the form of disability benefits may well equal 65 percent or more of gross earnings after tax. In addition, the disabled individual is relieved of many expenses incidental to employment such as travel, lunches, special clothing, union or professional dues and the like.
>
> It is a cause for deep concern that gross ratios of 0.600 or more apply to all young childless workers at median or lower salaries and to nearly all workers with a spouse and minor child for earnings up to the earnings base. In other words, all workers entitled to maximum family benefits are overinsured except older workers whose earnings approach the earnings base, middle-aged workers who earn not more than the earnings base, and young workers except those earning substantially more than the earnings base.
>
> Although these excessive replacement ratios have not been in effect long enough to have been fully reflected in the disability experience, overly liberal benefits may have played some part in the 47 percent increase, between 1968 and 1974, in the average rate of becoming disabled. Other than the indexing provisions, statutory changes during this period could have had no great effect. There is no evidence that the health of the nation has deteriorated. Rising unemployment has clearly been a factor, but the increasing attractiveness of the benefits must also be an important influence.

(U.S. Congress, House, Subcommittee on Social Security of the Committee on Ways and Means, *Report of Consultants on Actuarial and Definitional Aspects of Social Security Disability Insurance*, 94th Congress, 2d Session, 1976.)

It is also important to note that it is not correct to assume that a typical disabled worker family is dependent entirely or almost entirely on social security benefits. The following table prepared by the Congressional Budget Office shows the various other sources of income of disabled beneficiaries with children:

TABLE 20.—FAMILY INCOME FROM VARIOUS SOURCES IN 1975 AND OTHER CHARACTERISTICS OF DISABLED MALE SOCIAL SECURITY BENEFICIARIES WITH DEPENDENT CHILDREN [1]

Source of family income	Own benefit less than $3,000			Own benefit $3,000 or more		
	Percent with income from source	Average income from source for— Those with such income	Average recipient	Percent with income from source	Average income from source for— Those with such income	Average recipient
Social security	100.0	$2,584	$2,584	100.0	$5,356	$5,356
SSI	27.0	1,111	300	10.3	882	91
Public assistance	29.2	1,753	512	13.8	1,727	238
Veterans' benefits	17.2	1,945	335	21.4	3,374	722
Workmen's compensation	8.3	4,170	346	7.3	2,358	172
Property income	23.8	480	114	34.3	1,038	356
Public or private pension	11.1	3,035	337	19.3	3,705	715
Earnings	73.4	6,168	4,527	66.7	5,897	3,921
Other	5.2	1,172	61	10.8	1,846	199
Total family income			9,380			11,947
Food stamps	34.5			20.6		
Average years of school completed by disabled worker	8			10		

[1] Refers to men 21 to 62 yr of age in March 1976, who reported a disability limiting work activity and receipt of social security benefits in 1975.

Source: Based on *Survey of Income and Education*, U.S. Bureau of the Census.

The situation where social security DI benefits are the sole source of income to a disabled worker and his family may be the case in individual instances, but on the average disabled worker families tend to have other sources of income in significant amounts. Disabled workers in families with children derive on average only about 40 percent of their total cash income from social security benefits. The combined impact of high social security disability insurance replacement rates and substantial other sources of family income is to insulate disabled worker families, as a group, from any major reduction in income as a result of their disability. The following table shows an analysis of this result by the Congressional Budget Office indicating that very few worker families have more than a 10 percent reduction in disposable income as a result of disability.

TABLE 21.—ANNUAL DISPOSABLE INCOME OF DISABLED WORKER BENEFICIARY FAMILIES BEFORE AND AFTER DISABILITY, BY SEX OF DISABLED WORKER (PROJECTED TO 1980)

	Percentage distribution of DI families	Predisability disposable income [1]	Postdisability disposable income [2]	Ratio: Postdisability disposable income to predisability disposable income
Families where spouse has earnings:				
Men	37	$14,493	$15,407	1.06
Under 40	6	13,035	14,141	1.08
40 to 54	19	15,112	15,936	1.05
55 to 64	12	14,386	15,148	1.05
Women	17	17,196	18,509	1.08
Under 40	7	17,151	18,768	1.09
40 to 54	7	18,147	19,400	1.07
55 to 64	3	(3)	(3)	(3)
Families where spouse does not have earnings:				
Men	37	10,822	10,293	.95
Under 40	6	9,768	10,392	1.06
40 to 54	20	11,221	10,427	.93
55 to 64	11	10,938	10,049	.92
Women	9	6,938	7,260	1.05
Under 40	2	(3)	(3)	(3)
40 to 54	5	6,493	6,650	1.02
55 to 64	2	(3)	(3)	(3)
Total	100			

[1] Includes estimated earnings of worker and spouse, property income and transfer payments. Taxable income adjusted for estimated taxes and 6 percent of earned income is deducted for work expenses.

[2] Includes estimated earnings of spouse, property income, social security benefits and transfer payment. Taxable income is adjusted for taxes and 6 percent of earned income is deducted for work expenses.

[3] Sample size too small for reliable estimate.

Source: Estimates based on matched tape of CPS, social security records and longitudinal earnings records.

It should also be observed, however, from some of the previous tables that while DI benefits frequently result in relatively high replacement rates, there are numerous situations where the earnings replacement resulting from DI benefits is low. As the CBO analysis suggests, this does not mean necessarily that once the disabled worker joins the benefit rolls his income is cut substantially from what it was while he was working, but only that the DI benefit by itself frequently results in only modest replacement of a disabled worker's predisability earnings. Using AIME as the base against which earnings replacement is measured, 39 percent of the awards in the SSA sample resulted in replacement rates of less than 50 percent. Using the high-5 in the last 10, 56 percent of the awards resulted in replacement rates of less than 50 percent.

As might be expected, this situation was most prevalent in the higher benefit brackets. However, when using recent earnings as the base for measurement (i.e. high-5 in last 10) a substantial number of awards resulting in low replacement rates were shown to be in the lower benefit brackets. The following table shows the distribution of awards resulting in replacement rates of 50 percent or less by the PIA level of the workers involved.

TABLE 22.—AWARDS RESULTING IN DI REPLACEMENT RATES OF 50 PERCENT OR LESS BY PIA LEVEL

[In percent]

Primary insurance amount (1979 levels)	Using as base period for measurement—	
	AIME	High-5 years in last 10
Minimum PIA	0	1
$122 to $150	0	1
$150 to $200	0	9
$200 to $250	0	12
$250 to $300	6	13
$300 to $350	25	15
$350 to $400	25	17
$400 to $450	44	31
$450 to $500	(1)	(1)
Total	100	[2] 100

[1] Less than 0.5 percent.
[2] Column does not add due to rounding.

Note: The PIA should not be confused with the actual monthly benefit amount received by the worker and his family. In many instances, the actual monthly benefit amount is substantially higher. It is used here simply to show the incidence of low replacement rates within the relative scale of benefits. Derived from samples of 9,585 cases, including workers both with and without dependents.

V. Rehabilitation of the Disabled

A. Criteria for Selection for Vocational Rehabilitation

As noted earlier, the fact that State vocational rehabilitation agencies could provide access to the kinds of services the disabled would need in order to be rehabilitated was a basic consideration in Congress' decision that disability determinations should be conducted by units of the State vocational rehabilitation services. The 1965 social security amendments gave the Department of Health, Education, and Welfare the authority to use certain social security trust funds to reimburse State vocational rehabilitation agencies for the cost of services provided to disability insurance beneficiaries. The amendments required the Secretary of HEW to develop criteria for selecting individuals to receive rehabilitation services under the beneficiary rehabilitation program. The criteria were to be based on the savings which would accrue to the trust funds as a result of rehabilitating the maximum number of individuals into productive activity. If the State rehabilitation agency certifies that a beneficiary meets these criteria, the cost of the rehabilitation services is borne by the trust funds.

The Department has developed four criteria for selecting beneficiaries to receive services financed from the trust fund. These are:

1. The disabling physical or mental impairment is not so rapidly progressive as to outrun the effect of vocational rehabilitation services or to preclude restoration of the beneficiary to productive activity.
2. The disability without the services planned is expected to remain at a level of severity resulting in the continuing payment of disability benefits.
3. A reasonable expectation exists that providing such services will result in restoring the individual to productive activity.
4. The predictable period of productive work is long enough that the benefits which would be saved and the contributions which would be paid to the trust funds from future earnings would offset the costs of planned services.

The title XVI legislation enacted in 1972 authorized the referral of blind and disabled recipients under the SSI program for rehabilitation services provided by State vocational rehabilitation programs. The legislation also authorized the use of general revenues to reimburse the State agencies for the cost of services provided to SSI recipients. Both the House and Senate reports on the SSI legislation state:

> Many blind and disabled individuals want to work and, if the opportunity for rehabilitation for suitable work were available to them they could become self-supporting.

In developing the SSI-vocational rehabilitation program, the Department of HEW followed the pattern of the disability beneficiary rehabilitation program for title II beneficiaries. Regulations implementing the program state that its purpose is:

> * * * to enable the maximum number of recipients to increase their employment capacity to the extent that * * * full-time employment, part-time employment, or

> self-employment wherein the nature of the work activity performed, the earnings received, or both, or the capacity to engage in such employment or self-employment, can reasonably be expected to result in termination of eligibility for supplemental security income payments, or at least a substantial reduction of such payments * * *.

In keeping with this statement of purpose, the SSI program uses the same four criteria for selecting individuals to receive reimbursed services as are used for selecting individuals under the DI program. Beneficiaries under both programs who do not meet these criteria are, of course, eligible to be considered for services under the basic State vocational rehabilitation program.

B. Administration of the Program

After the 1965 amendments, the Department of HEW divided responsibility for managing the beneficiary rehabilitation program between the Social Security Administration and the Rehabilitation Services Administration (RSA). The 1966 program memorandum of responsibilities gives SSA the responsibility for developing basic program policies, overall program planning and evaluation, recommending legislative changes, and requesting the funds to operate the program. The Rehabilitation Services Administration is assigned the responsibility of providing direction and guidance to the State rehabilitation agencies, promulgating regulations, and developing funding requests. Both agencies are jointly responsible for establishing performance standards, reviewing program information, and making on-site reviews of State rehabilitation agencies. Responsibilities for the SSI-vocational rehabilitation program have generally followed the same lines as those agreed upon for the beneficiary rehabilitation program.

The General Accounting Office has criticized the two agencies for failing to coordinate their activities and thus provide for stronger program management. In its June 6, 1979 report, "Rehabilitating Blind and Disabled Supplemental Security Income Recipients: Federal Role Needs Assessing," the GAO says:

> Although RSA and SSA share responsibility for administering the SSI–VR program, the two agencies have not coordinated their management objectives and, as a result, have not developed an appropriate information system needed for successful program management. (p. 9)

C. Kind of Services Provided

After an individual is selected to receive services, the State vocational rehabilitation agency develops an individual plan which includes counseling, restoration, training and placement services necessary to attain the goal of the plan. The goal for DI and SSI beneficiaries is competitive employment. However, under the broader basic State rehabilitation program the goal may be homemaking, sheltered employment, or unpaid family work.

DI and SSI recipients are eligible for the same range of services available to other vocational rehabilitation clients.

The most frequent type of handicaps reported by DI beneficiaries who receive vocational rehabilitation services are orthopedic handicaps. Forty-five percent of DI clients report this type of handicap. Thirteen percent report mental illness, and 11 percent report visual impairment. SSI recipients who receive services report 25 percent orthopedic handicaps, 23 percent mental retardation, and 17 percent mental illness.

According to data in the fiscal year 1978 "Annual Report to the President and the Congress on Federal Activities Related to the Administration of the Rehabilitation Act of 1973, as amended," both DI and SSI clients require a longer period of rehabilitation than the average rehabilitation client. Both DI and SSI recipients are reported as requiring 19 to 24 months of rehabilitation services to meet their vocational objectives. This compares with 13 to 18 months required for the average rehabilitation client.

The annual report referred to above makes a number of other observations about DI and SSI beneficiaries. It observes that because DI beneficiaries generally have a recent work history and were employed prior to the onset of disability, they require on the average less training and maintenance services than do SSI recipients. Restorative services are used more frequently by DI beneficiaries than by SSI beneficiaries. The reason given for this is that DI beneficiaries generally suffer illness or injury a short time prior to being accepted for vocational rehabilitation services and thus are in greater need of the surgical and therapeutic services available in the vocational rehabilitation program. Because their handicaps often began during childhood, it is alleged, SSI recipients are more likely to have received restorative services prior to entry into the vocational rehabilitation program. SSI recipients generally require more training and more personal and vocational adjustment services than DI beneficiaries because they often do not have a history of work, and because a larger proportion are mentally retarded.

The 1978 report indicates that the average monthly earnings of all clients rehabilitated range from $320 to $390 at the time of rehabilitation closure. DI beneficiaries have earnings that are generally comparable to this average. This is not true for SSI recipients, who report lower earnings—$240 to $316 a month.

D. Program Effectiveness

In 1965 the Congress was assured by the Department of HEW that the money spent on rehabilitation services would result in savings to the disability insurance trust fund. The allocation of trust funds was based on an amount necessary to pay for the cost of vocational rehabilitation services, with a maximum not to exceed a fixed percentage of the prior year's total disability payments. The limit was originally set at 1 percent. Given reassurance in 1972 by the Department that the trust fund was in fact realizing savings due to the money being spent on rehabilitation, the Congress increased the authorization for use of trust fund money to 1.25 percent for fiscal year 1973 and to 1.5 percent for 1974 and years thereafter. The 1972 SSI legislation also authorized use of general revenues to fund rehabilitation services for SSI recipients.

Funding for both DI and SSI beneficiaries is set at 100 percent Federal funding. Under the basic vocational rehabilitation program, there is 80 percent Federal funding. States must make up the remainder.

In recent years the degree of the cost effectiveness of the vocational rehabilitation expenditures in behalf of disabled beneficiaries has been questioned. In 1970 the Department reported a savings of $1.60 for every $1 spent. In 1972 HEW issued a report to the Finance Committee which claimed that the program was saving $1.93 for every $1 spent. In June 1974 HEW reported savings of $2.50 for every $1 spent. However, a study done by SSA's Office of Research and Statistics raised some questions about the cost/benefit data that had been developed and about the effectiveness of the expenditures made. The report covered the period from 1967 to 1974. In summary, it showed that about 40 percent of the persons who were "rehabilitated" with trust fund money actually left the benefit rolls, and about 10 percent returned after relapses. It further showed that the benefit-cost ratio had consistently exceeded 1.00 during the first eight years of the program. However, the study raised some doubt about the program's most recent experience.[1]

> The growth in the number of rehabilitated beneficaries in recent years, however, is not comparable with the growth in the amount available for reimbursement from the trust funds. Further, the actual number of disabled beneficaries leaving the social security rolls because of more medical improvement or return to substantial gainful activity has not risen in recent years, in spite of the trust fund program and liberalization of the social security definition of disability to include more conditions likely to improve in time.

It also showed an apparent decline in benefit-cost ratios which began in 1970:

	Ratio of savings to expenditures	
	In year	Cumulative through year
1966	.....	.....
1967	0.43	0.41
1968	1.73	1.20
1969	3.80	2.19
1970	3.72	2.65
1971	3.03	2.74
1972	2.75	2.74
1973	1.65	2.49

[1](Ralph Treitel, "Effect of Financing Disabled Beneficiary Rehabilitation," *Social Security Bulletin*, November, 1975.)

Similarly, a report by the GAO in 1976 criticized the way the earlier estimates submitted to the Congress by HEW had been developed, and maintained that its study showed a much lower cost-benefit ratio, with a saving of $1.15 for each $1 spent. The report states:

> GAO believes the savings HEW attributed to the program were considerably overstated, that the program was operating close to the break-even point, and that there could be a downward trend in the savings computation.

Elaborating on its criticism of the beneficiary rehabilitation program, the GAO commented further:

> Also, the program's resources have been directed, in part, toward serving temporarily disabled beneficiaries who did not meet eligibility criteria. These beneficiaries might have met the less stringent criteria of the basic State vocational rehabilitation program for which the Federal share of costs is 80 percent. As a result, some potentially eligible beneficiaries may not have had the opportunity to receive vocational rehabilitation services.

A more fundamental concern, however, than the size of the cost/benefit ratio is one raised in a 1976 Ways and Means staff document. It pointed out the relatively small number of DI disabled workers who had been terminated from the benefit roll in aggregate as the result of rehabilitation services. The report states:

> Although the amount of trust funds available for beneficiary rehabilitation has increased from about $15 million in 1967 to almost $100 million in 1976, the bottom line—terminations due to rehabilitation—has been disappointing. Cumulatively over these 9 years, only 20,000 disabled workers who have been rehabilitated have been terminated from the rolls. This was during a period of time when the number of disabled workers on the rolls was increasing from 1.5 to 2.5 million.

In its June 1979 report on the SSI vocational rehabilitation program the GAO also commented on the cost effectiveness of that program, showing even more negative findings than it had reported for DI in 1976. The 1979 report showed that in 13 of the 14 State rehabilitation agencies included in the GAO review, the Federal funds spent on the SSI–VR program for the first 2½ years "greatly exceeded the savings in SSI payments for the cases reported to SSA as rehabilitations during that period."

Statistics appearing in the 1978 "Annual Report on Federal Activities Related to the Administration of the Rehabilitation Act of 1973, as amended," referred to earlier, also raise questions about the effectiveness of the vocational rehabilitation program in bringing about benefit terminations in DI and SSI.

The following chart shows the numbers of DI and SSI recipients who were reported in various service categories during fiscal year 1978 (and whose services were funded under titles II and XVI). Because individuals may remain in one category for longer than 1 year, this presentation cannot be viewed as a progression of the same individual through the service system. For example, individuals are

served for approximately 2 years, and at least 1 year must elapse from rehabilitation to termination. Persons may be terminated for a considerable period of time before re-entering the rolls as recidivists. However, the chart can provide an indication of the relative numbers of individuals who are progressing through the rehabilitation system and achieving economic independence.

			SGA rehabilitations [3]		DI and SSI		
	Served [1]	Rehabilitated [2]	Percent	Number	Terminations [4]	Recidivists [5]	Other [6]
DI	94,979	12,268	83.0	10,182	6,363	669	378
SSI	55,218	6,994	80.5	5,630	1,049	1,314	457
Total vocational rehabilitation program	1,167,991	294,396	NA	NA	NA	NA	NA

[1] "Served" refers to persons participating in a vocational rehabilitation program.
[2] "Rehabilitated" means that the employment objective has been met and maintained for 2 months and that the rehabilitation file was closed.
[3] "SGA rehabilitations" designates persons rehabilitated who achieved earnings at the time of rehabilitation equal to the level of "substantial gainful activity." This SGA level is the amount which disqualifies an individual from further benefits payments under DI and SSI. Currently, substantial gainful activity is determined to be earnings of $280 per month.
[4] "Terminations" refers to persons who cease receiving DI and SSI benefits following rehabilitation.
[5] "Recidivists" are the individuals who were terminated from the benefit rolls during fiscal year 1978 or before and then reentered benefit status during fiscal year 1978.
[6] "Other" refers to rehabilitated persons who terminated benefits during fiscal year 1978 for reasons not related to rehabilitation. Such reasons might include death, retirement, or other reasons not related to medical recovery or earnings.

Although 10,182 DI beneficiaries were rehabilitated with earnings at the level of substantial gainful activity, only 62 percent of that number were terminated from the benefit rolls. This indicates that 38 percent of the beneficiaries who might have been expected to terminate benefits did not. Benefits are terminated 3 months after the end of the 9-month trial work period if substantial gainful activity is maintained. It appears, therefore, that many DI beneficiaries did not maintain earnings for a sufficient period of time to terminate benefits. During fiscal year 1978, the number of persons who re-entered the benefit rolls due to employment failure was 11 percent of the number who terminated.

Only 19 percent of the number of SSI recipients who were rehabilitated at the level of substantial gainful activity successfully terminated benefits. In addition, the number of recidivists exceeded the number of SSI recipients terminated. (Some of the recidivists were terminated prior to fiscal year 1978 which accounts for the fact that recidivists exceeded terminations.)

Table 23 shows total funding for vocational rehabilitation programs on a State-by-State basis for fiscal year 1978.

TABLE 23.—FEDERAL OUTLAYS FOR VOCATIONAL REHABILITATION, BY STATE, FISCAL YEAR 1978

[In millions of dollars]

State	Basic State grant program (sec. 110)	Disability insurance (DI) trust fund program	Supplemental security income (SSI)	Innovation and expansion (sec. 120)
Alabama	18,545	2,396	1,252	304
Alaska	2,009	183	137	50
Arizona	8,677	956	540	187
Arkansas	10,729	1,681	795	133
California	58,429	11,150	9,037	1,641
Colorado	8,441	909	577	216
Connecticut	7,189	999	354	240
Delaware	2,035	257	170	51
District of Columbia	5,560	242	316	55
Florida	29,514	4,181	1,652	647
Georgia	21,551	2,930	1,327	414
Hawaii	2,367	237	146	66
Idaho	3,427	433	350	69
Illinois	27,983	3,216	1,854	863
Indiana	14,567	1,802	473	351
Iowa	9,216	889	325	30
Kansas	7,376	655	382	121
Kentucky	16,234	2,008	637	263
Louisiana	18,516	1,776	968	319
Maine	4,400	396	162	4
Maryland	11,736	1,400	963	347
Massachusetts	18,573	2,025	1,971	490
Michigan	26,270	3,691	2,165	709
Minnesota	13,629	1,431	917	335
Mississippi	13,730	1,761	1,131	200
Missouri	16,999	1,868	627	369
Montana	2,957	324	204	58
Nebraska	5,121	559	355	120
Nevada	2,037	289	159	50
New Hampshire	3,283	329	113	63
New Jersey	18,376	2,677	1,286	567
New Mexico	5,786	554	401	98
New York	48,880	8,382	3,695	1,544
North Carolina	25,062	2,812	1,430	422
North Dakota	2,472	221	247	55

TABLE 23.—FEDERAL OUTLAYS FOR VOCATIONAL REHABILITATION, BY STATE, FISCAL YEAR 1978—Continued

[In millions of dollars]

State	Basic State grant program (sec. 110)	Disability insurance (DI) trust fund program	Supplemental security income (SSI)	Innovation and expansion (sec. 120)
Ohio	36,284	4,759	1,944	833
Oklahoma	11,812	1,194	664	210
Oregon	8,308	1,247	645	174
Pennsylvania	40,921	6,433	2,640	940
Rhode Island	3,299	428	236	72
South Carolina	14,245	1,458	580	129
South Dakota	2,868	237	137	53
Tennessee	19,395	2,194	858	324
Texas	47,898	5,171	2,387	1,045
Utah	5,695	280	157	93
Vermont	2,176	240	149	54
Virginia	17,927	2,433	1,196	424
Washington	11,079	1,802	2,022	274
West Virginia	8,747	1,271	354	154
Wisconsin	17,196	1,900	657	357
Wyoming	2,000	160	125	50
Guam	742	15	0	50
Puerto Rico	17,000	1,000	0	229
Trust territories	400	0	0	50
Virgin Islands	557	30	0	35
Grand total	760,225	97,871	51,869	17,001

Source: Department of Health, Education, and Welfare.

E. Requirement to Accept Rehabilitation Services

Both titles II and XVI include provisions that beneficiaries who refuse rehabilitation services without good cause shall have their benefits withheld. As the programs are operated, it is the responsibility of the rehabilitation agency to report a refusal of services to the appropriate social security district office for followup action. If the refusal persists, there is supposed to be a finding of whether there was "good cause" for refusal, a determination which is made by disability examiners in the regional offices.

This requirement has been enforced very infrequently. In its May 1976 report the GAO stated that it had been told by SSA officials that nationally only one beneficiary's benefits were being withheld at that time. In January 1977 SSA began a new computerized VR information system, one purpose of which was to identify title II and title XVI beneficiaries who refuse to cooperate with vocational rehabilitation.

Nationally in 1977 there were over 20,000 reports of refusal to cooperate made by VR to SSA. The majority of these involved a re-referral to VR following a district office interview with the claimant. As an example of how the requirement actually resulted in penalties, during 1977 80 individuals were found not to have "good cause" and their benefits were either put in suspense status (title XVI) or deduction status (title II).

F. Program of Services for Children

When the supplemental security income program was first enacted it included a provision requiring the Secretary of HEW to make provision for referral of all disabled individuals "to the appropriate State agency administering the State plan for vocational rehabilitation services approved under the Vocational Rehabilitation Act." The provision for vocational rehabilitation services was basically designed for adults who could be expected to enter or reenter the work force. Because of its general inappropriateness for disabled children, there was in the early years of the SSI program virtually no use of this provision for referral of children to services in any State.

The Congress amended the law in 1976 to provide for a 3-year special services program designed to meet the needs of children for referral to agencies where they could have access to services appropriate to their needs. In its justification of the new legislation, the Finance Committee stated in its report:

> The committee believes that there are substantial arguments to support the establishment of a formal referral procedure. Many disabled children have conditions which can be improved through proper medical and rehabilitative services, especially if the conditions are treated early in life. The referral of children who have been determined to be disabled could thus be of very great immediate and long-term benefit to the children and families who receive appropriate services. In addition, the procedure could be expected to result in long-range savings for the SSI program, in that some children, at least, would have their conditions satisfactorily treated and would move off the disability rolls instead of receiving payments for their entire lifetime. The referral of disabled children by the Social Security Administration would also serve as a casefinding tool for community agencies serving disabled children and assist them in focusing their services in behalf of these children. Many communities have the capability to help disabled and handicapped children, but are not always able to identify those with the greatest need. (Rept. 94–1265, pp. 25–26)

As enacted, the law requires the referral by the Social Security Administration of children under age 16 to the State agency which administers the State crippled children's services program, or to another agency which the Governor determines is capable of administering the State plan in a more efficient and effective manner than the crippled children's agency.

State plans must be approved by the Secretary of HEW under regulations that (1) assure appropriate counseling for disabled children and their families, (2) provide for the establishment of an individual service plan for children and prompt referral to appropriate medical, education and social services, (3) provide for monitoring to assure adherence to each individual service plan, and (4) provide for disabled children age 6 and under and for children who have never attended public school and who require preparation to take advantage of public educational services of medical, social, developmental, and rehabilitative services in cases where such services reasonably promise to enhance the child's ability to benefit from subsequent education or training, or otherwise to enhance his opportunities for self-sufficiency or self-support as an adult.

State plans must provide for an identifiable unit within the administering agency to be responsible for the administration of the plan. Plans also have to provide for coordination with other agencies serving disabled children.

The law authorized $30 million for each of fiscal years 1977, 1978, and 1979. The funds are distributed on the basis of the proportion of children under age 7 in each State.

Final regulations for the services program were not published in the Federal Register until April 18, 1979. However, the program did get underway in most States prior to that time, operating under interim guidelines. At the present time, all except one State (Wisconsin) has had its plan approved by the Secretary. According to HEW, about $10 million was claimed by the States for use in this program in fiscal year 1978. About $20 million is expected to be spent in 1979.

Unless there is extending legislation, the program will terminate September 30, 1979. On September 27, 1979 the committee approved an amendment to H.R. 3434 providing for a 3-year extension of the program.

The following table shows the State allocation of funds for the program for fiscal year 1979.

TABLE 24.—ALLOCATIONS OF FUNDS UNDER THE SERVICES PROGRAM FOR SSI DISABLED CHILDREN, BY STATE, FISCAL YEAR 1979

States	Children under age 7	Allotment of funds
Total	22,097,899	$30,000,000
Region I:		
Connecticut	263,513	357,600
Maine	108,017	146,700
Massachusetts	505,574	686,400
New Hampshire	82,078	111,300
Rhode Island	83,666	113,700
Vermont	48,860	66,300
Region II:		
New Jersey	665,208	903,000
New York	1,680,483	2,281,500
Region III:		
Delaware	59,474	80,700
District of Columbia	89,742	121,800
Maryland	372,822	506,100
Pennsylvania	1,078,254	1,463,700
Virginia	497,034	674,700
West Virginia	193,286	262,500
Region IV:		
Alabama	407,836	553,800
Florida	775,176	1,052,400
Georgia	580,813	788,400
Kentucky	381,137	517,500
Mississippi	301,948	409,800
North Carolina	588,036	798,300
South Carolina	330,843	449,100
Tennessee	448,621	609,000
Region V:		
Illinois	1,175,494	1,596,000
Indiana	577,305	783,600
Michigan	964,638	1,309,500
Minnesota	390,302	529,800
Ohio	1,118,524	1,518,600
Wisconsin	450,263	611,400

TABLE 24.—ALLOCATIONS OF FUNDS UNDER THE SERVICES PROGRAM FOR SSI DISABLED CHILDREN, BY STATE, FISCAL YEAR 1979—Continued

States	Children under age 7	Allotment of funds
Region VI:		
Arkansas	234,588	$318,600
Louisiana	461,961	627,300
New Mexico	145,238	197,100
Oklahoma	290,258	394,200
Texas	1,495,750	2,030,700
Region VII:		
Iowa	281,729	382,500
Kansas	226,223	307,200
Missouri	482,037	654,300
Nebraska	162,243	220,200
Region VIII:		
Colorado	278,709	378,300
Montana	81,820	111,000
North Dakota	70,333	95,400
South Dakota	75,169	102,000
Utah	203,411	276,300
Wyoming	44,170	60,000
Region IX:		
Arizona	275,313	373,800
California	2,160,909	2,933,700
Hawaii	106,665	144,900
Nevada	64,170	87,000
Region X:		
Alaska	52,188	70,800
Idaho	105,318	143,100
Oregon	230,926	313,500
Washington	349,824	474,900

Source: Department of Health, Education, and Welfare.

VI. Financing Disability Insurance

A. History of Underfinancing

Underfinancing of disability insurance has been a phenomenon of the program almost since its inception. The 1961 and 1962 Board of Trustees of the social security programs reported a long-range actuarial deficiency for DI of 0.06 percent of taxable payroll. Although slightly beyond the acceptable margin of variation for long-range estimates, this level was considered at that time as being close to actuarial balance. However, in 1962 annual deficits began to appear. Expenditures exceeded revenues by $69 million in that year and rose to a difference of nearly $440 million in 1965. The 1963, 1964 and 1965 reports of the trustees showed a long-range deficit of 0.14 percent of taxable payroll. The 1964 report suggested that the DI Trust Fund would be exhausted by 1971. In all three reports—1963 through 1965—the trustees recommended that a higher allocation of the overall tax be given to the DI program.

Congress enacted a higher allocation to DI in 1965. While an annual deficit did not reappear in the program until 1975, the trustees continued to show long range actuarial shortfalls for the program in the intervening period. For instance, less than two years after the higher allocation had been enacted, the trustees in their report in February 1967 showed once again a long-range actuarial deficit of 0.15 percent of taxable payroll. Congress, again in 1967, provided a higher tax allocation to the program.

Since that time Congress has repeatedly addressed projections of higher costs of the program by increasing its tax allocation. A 1974 report of the staff of the Ways and Means Committee commented on this traditional approach to the financing shortfalls as follows:

> In the past, actuarial deficiencies have been eliminated by increased allocation of payroll tax receipts to the disability insurance system. Higher allocations were effectuated in 1965, 1967, and, to a smaller degree, in the two social security bills which were enacted in 1972. The last such action was taken in Public Law 93–233 which was approved on December 31, 1973. The 1974 trustees' report suggests reallocation of income among the three trust funds (OASI, DI, and HI) as a possible solution to the short-range financing problems of the social security program. The staff recommends that no further action of this nature be taken—which, to some degree, avoids facing the problems in the disability insurance program—until the committee receives an adequate explanation of the adverse experience which is taking place in the system.
>
> The long-range actuarial deficit of nearly 3 percent of payroll in the social security program announced in the trustees' report is a clear indication that the practice of increasing the allocation of funds to the disability insurance

> Trust Fund cannot be indulged in the future as it has been in the past. Prior to 1972 there was a built-in "safety" factor in the "level earnings" assumption that was used in estimating the long-range cost of the social security program. The use of the level earnings assumption generated actuarial surpluses as earnings levels rose and they had been used, among other things, to make up for adverse disability experience. However, under the "dynamic earnings" assumption adopted in 1972 this cushion no longer exists.[1]

The long-range projected deficit for both social security programs (OASI and DI combined) mentioned in the Ways and Means Committee staff report grew from 2.98 percent of taxable payroll in the 1974 trustees' report to 8.20 percent of taxable payroll in the 1977 trustees' report. The portion of the deficit attributable to DI in the 1974 report was 0.40 percent of taxable payroll; by 1977 the trustees were projecting a deficit for DI of 2.14 percent of taxable payroll—reflecting an average revenue shortfall over the 75-year actuarial measuring period of almost 60 percent of the cost of the DI program.

While the higher tax allocations to the DI program and the decoupling provisions enacted with the 1977 Social Security Amendments substantially improved the financial outlook for the program, the official estimates at the time of passage still showed a long-range actuarial deficiency for DI of 0.38 percent of taxable payroll. Nonetheless, the threat of immediate insolvency was removed. An annual deficit of $2.5 billion was projected for calendar year 1977, but annual surpluses beginning in 1978 were projected to occur at least through the remainder of the century.

As reported by an actuarial consultant to the House Committee on Ways and Means:

> The 1977 Act substantially strengthened the financing of the DI system by providing more income. This was done essentially by reallocating a greater proportion of the OASDI–HI tax rate to DI and by increasing the maximum taxable earnings bases for 1979–81 more by ad hoc changes than would have occurred under the automatic-adjustment provision. In addition, the financial status of the DI system was helped somewhat by the lower benefit level for future beneficiaries that occurs because of the decoupling procedures. [Source: Robert J. Myers, in a Report to the Ways and Means Committee: "Actuarial Analysis of Operation of Disability Insurance System under Social Security Program," published Feb. 1, 1979, WMCP 96–5.]

The following table shows estimates of the financial condition of the DI trust fund, prior to and following enactment of the 1977 amendments, made shortly after enactment. The second table which follows shows the alteration made to the tax schedule with those amendments.

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[1] U.S. Congress, House, Committee on Ways and Means, *Committee Staff Report on the Disability Insurance Program*, 93rd Congress, 2d session, 1974, p. 4.

TABLE 25.—ESTIMATED OPERATIONS OF THE DI TRUST FUND DURING CALENDAR YEARS 1977–87 UNDER PRESENT AND PRIOR LAW

[Dollar amounts in billions]

	Income		Outgo		Net increase in funds		Funds at end of year		Funds at beginning of year as a percentage of outgo during year	
	Prior law	Present law (1977 amendments)	Prior law	Present law (1977 amendments)	Prior law	Present law (1977 amendments)	Prior law	Present law (1977 amendments)	Prior law	Present law (1977 amendments
Calendar year:										
1977	$9.6	$9.6	$12.0	$12.0	—$2.4	—$2.4	$3.3	$3.3	48	48
1978	10.9	13.8	13.6	13.7	—2.8	.2	.5	3.5	24	24
1979 [1]	11.8	15.7	15.3	15.3	—3.5	.4	—3.0	3.9	3	23
1980 [1]	12.8	17.6	17.4	17.1	—4.6	.5	—7.6	4.4	([2])	23
1981 [1]	14.6	21.1	19.5	19.0	—4.9	2.1	—12.5	6.5	([2])	23
1982 [1]	15.5	23.0	21.7	20.9	—6.2	2.1	—18.7	8.6	([2])	31
1983 [1]	16.2	24.7	24.1	22.9	—8.0	1.8	—26.6	10.4	([2])	38
1984 [1]	16.8	26.5	26.8	25.2	—10.0	1.3	—36.6	11.6	([2])	41
1985 [1]	17.3	32.1	29.8	27.7	—12.4	4.5	—49.1	16.1	([2])	42
1986 [1]	19.3	34.9	33.0	30.3	—13.6	4.6	—62.7	20.8	([2])	53
1987 [1]	20.0	37.4	36.4	33.1	—16.4	4.3	—79.1	25.1	([2])	63

[1] Because it is estimated that the DI trust fund would have been exhausted in 1979 under prior law, the figures for 1979–87 under prior law are theoretical.

[2] Fund exhausted in 1979.

Note: The above estimates are based on the intermediate set of assumptions shown in the 1977 trustees report.

TABLE 26.—TAX RATES FOR THE SOCIAL SECURITY TRUST FUNDS

[In percent]

Calendar year	Prior law					Present law (1977 amendments)				
	OASI[1]	DI[2]	OASDI	HI[3]	Total	OASI[1]	DI[2]	OASDI	HI[3]	Total
EMPLOYERS AND EMPLOYEES, EACH										
1977	4.375	0.575	4.95	0.90	5.85	4.375	0.575	4.95	0.90	5.85
1978	4.350	.600	4.95	1.10	6.05	4.275	.775	5.05	1.00	6.05
1979–80	4.350	.600	4.95	1.10	6.05	4.330	.750	5.08	1.05	6.13
1981	4.300	.650	4.95	1.35	6.30	4.525	.825	5.35	1.30	6.65
1982–84	4.300	.650	4.95	1.35	6.30	4.575	.825	5.40	1.30	6.70
1985	4.300	.650	4.95	1.35	6.30	4.750	.950	5.70	1.35	7.05
1986–89	4.250	.700	4.95	1.50	6.45	4.750	.950	5.70	1.45	7.15
1990–2010	4.250	.700	4.95	1.50	6.45	5.100	1.100	6.20	1.45	7.65
2011 and later	5.100	.850	5.95	1.50	7.45	5.100	1.100	6.20	1.45	7.65
SELF-EMPLOYED PERSONS										
1977	6.185	0.815	7.0	0.90	7.9	6.1850	0.8150	7.0	0.90	7.9
1978	6.150	.850	7.0	1.10	8.1	6.0100	1.0900	7.1	1.00	8.1
1979–80	6.150	.850	7.0	1.10	8.1	6.0100	1.0400	7.05	1.05	8.1
1981	6.080	.920	7.0	1.35	8.35	6.7625	1.2375	8.00	1.30	9.3
1982–84	6.080	.920	7.0	1.35	8.35	6.8125	1.2375	8.05	1.30	9.35
1985	6.080	.920	7.0	1.35	8.35	7.1250	1.4250	8.55	1.35	9.90
1986–89	6.010	.990	7.0	1.5	8.5	7.1250	1.4250	8.55	1.45	10.00
1990–2010	6.010	.990	7.0	1.5	8.5	7.6500	1.6500	9.30	1.45	10.75
2011 and later	6.000	1.000	7.0	1.5	8.5	7.6500	1.6500	9.30	1.45	10.75

[1] Old-age and survivors insurance.
[2] Disability insurance.
[3] Hospital insurance (part A of medicare).

Source: Social Security Administration.

B. Recent Trustees' Forecasts—1978 and 1979

The 1978 trustees' report issued just six months after enactment of the 1977 Amendments showed a substantial improvement in the long-range financial condition of the DI program. Although still projecting a long-range deficiency, the report showed an actuarial imbalance for DI of only 0.14 percent of taxable payroll in contrast to the imbalance of 0.38 percent of taxable payroll estimated in December, 1977.

The 1978 report states:

> Large decreases in the estimated cost of the disability insurance program in both the medium-range and long-range were due to changes in assumptions regarding disability incidences and terminations. Both incidence and termination rates have been changed to reflect more recent experience. In addition, lower incidence rates are projected due to the decreased attractiveness of disability benefits, because of the generally lower benefits available under the new decoupled benefit calculation procedure.

The more recent experience referred to showed that DI awards had dropped off slightly in 1976 and 1977, from the high of nearly 600,000 awards to disabled-workers made in 1975, and that termination rates had increased. Nonetheless, recognizing the propensity of past trustees to underestimate the costs of the program, the 1978 trustees' report continued to forecast a substantial upward trend in the size of the program. The report states:

> Although the disability award rate during 1977 remained level as compared with 1976, a generally upward trend in incidence rates, as experienced over the past decade, was assumed to continue. Age-sex specific incidence rates were assumed to increase over the period 1978–97 to a level about 25 percent higher than that estimated for 1977, and to remain at that level thereafter.

The 1979 trustees' report issued in April 1979 once again showed improvement, under the report's central set of economic and demographic assumptions, in the long-range financial condition of the program over the prior year's forecast. For the first time since 1970, the trustees projected a long-range actuarial surplus for DI, amounting to .21 percent of taxable payroll. As did the 1978 forecast, the current report attributes the improvement in the long-range condition of the program to recent experience more favorable to the program. Awards to disabled workers dropped from a level of about 569,000 in 1977 to 457,000 in 1978.

However, while forecasting a considerably lower rate of growth, the trustees again were reluctant to project a long-term leveling off of the program. The report states:

> Although disability awards declined by over 20 percent in 1978, age-sex specific incidence rates were assumed to increase over the period 1979–1998 to about 10 percent higher than the average for 1977–1978, and to remain constant thereafter. This represents a gradual return to 1976–1977 experience.

> . . . this reduction in the incidence of disability was not anticipated and its causes are not very clear, so it is uncertain whether the trend will continue in the future. Thus, the higher DI trust fund levels projected in this report (as compared to last year's report) are contingent on the realization of the lower incidence rates assumed in this year's report.

Under these assumptions the DI benefit roll is projected to rise from a level of about 4.9 million beneficiaries in 1979 to 7.8 million in the year 2000.

C. Unfavorable Recent Economic Forecasts

Reports of the trustees in recent years have made projections of the financial soundness of the social security programs using three different sets of economic and demographic assumptions. These assumptions, referred to as optimistic, intermediate and pessimistic, are intended to give a picture of the financial condition of the program under a range of potential circumstances which could arise in the future. Traditionally for purposes of a general discussion of the financial condition of the programs and for pricing proposed legislative and policy changes, the intermediate or, as they sometimes are referred to, the central set of assumptions are used.

While the current forecasts under the optimistic and central sets of assumptions show that both the OASI and DI programs are adequately financed in the short run, the pessimistic assumptions show that at least the OASI program could run into financial difficulty beginning as soon as 1983 or 1984. Reserves in the OASI trust fund would fall to an extremely low level by the end of 1983. DI reserves appear to be adequate even under these conditions. The trustees caution—

> that although a positive balance is projected for the OASI trust fund at the end of each year through 1983, under the pessimistic assumptions, the assets at the end of 1983 would not be large enough to cover the entire amount of benefits that are payable at the beginning of the following month. This kind of cash-flow problem becomes imminent if, at any time, the trust fund falls to less than about 9 percent of the following 12 months of disbursements. Under the pessimistic assumptions, the OASI trust fund would begin to experience cash-flow difficulties early in 1983. The cash-flow problems would arise because almost all of the benefits for a given month are payable, generally, on the third day of the following month, while contribution income is received more or less uniformly throughout the month, on a daily basis. For example, the benefits for December 1983—estimated to be about $12½ billion under alternative III (the pessimistic assumption)—are payable on January 3, 1984, before any significant amount of income can be added to the fund's estimated assets of $8.3 billion on December 31, 1983 . . .

They point out further that a "severe or prolonged economic downturn" could lead to this pessimistic forecast for the program.

While the trustees' report is only a few months old, recent economic forecasts of the Administration, the Congressional Budget Committees, and a number of other forecasters indicate that the economy

is not moving in line with the central set of trustees' report assumptions. Generally, these forecasts are now more pessimistic and indicate that a recession has begun coupled with a continuing high rate of inflation. For social security, this means higher than anticipated outgo, with increases in revenues which do not keep pace with the additional outgo.

1. Administration "midsession" forecast:

The Administration's recent economic forecast, which accompanied its "midsession" report to the Congress on the budget, indicates a higher rate of inflation and higher unemployment than reflected in both its January budget submittal and the trustees' report intermediate assumptions.

This forecast falls between the trustees' intermediate assumptions and the pessimistic ones, but closer to the pessimistic ones. OASI reserve balances fall to 10 percent of one year's outgo by 1984 under the midsession assumptions, as compared to 5 percent under the trustees' pessimistic assumptions.

Either level is considered to be too low for cash-flow purposes. Balances in the DI trust fund, on the other hand, are more than adequate under both economic scenarios.

TABLE 27.—OASDI TRUST FUND RESERVES BALANCES

[As a percent of 1 year's outgo]

	Trustees' intermediate		Trustees' pessimistic		Midsession	
	OASI	DI	OASI	DI	OASI	DI
1979.....	30	29	30	29	29	29
1980.....	24	35	23	34	23	33
1981.....	19	42	16	39	17	40
1982.....	17	60	12	53	13	55
1983.....	18	81	8	68	12	73
1984.....	18	101	5	83	10	91

Source: Social Security Administration.

2. CBO economic update and tentative House and Senate Budget Committee forecasts:

The Congressional Budget Office also prepared a midyear economic update for 1979 and 1980, indicating an even more pessimistic trend than the Administration's forecast, not only through 1980, but for a number of subsequent years as well.

In a July 31, 1979 letter to the committee, the director of CBO states that estimates prepared by CBO for the House and Senate Budget Committees show that under their respective assumptions, the balance in the OASI trust fund would fall between 5.4 percent of fiscal year 1984 outgo (House version) and 7.7 percent of fiscal year 1984 outgo (Senate version). Once again, both would represent precariously low OASI trust fund reserve levels. The DI trust fund would have fiscal year 1984 reserves in the range of 55 percent to 60 percent of outgo.

3. Cautionary notes by the Trustees and Director of CBO:

Because of the possibility that economic conditions might move in the direction of that pessimistic forecast, in their 1979 report the trustees recommended that—

> . . . no reduction be made in the scheduled revenues of Old Age and Survivors Insurance and Disability Insurance trust funds without making provisions for offsetting reductions in expenditures or alternative financing arrangements," and that "it might be advisable to examine the need for flexibility to reallocate funds between the two trust funds in the short term.

The Director of CBO similarly suggested that "steps may have to be taken to ensure the solvency of the OASI trust fund," a number of which might alter the financing of DI.

The following four tables compare these adverse economic forecasts and show the impact they would have on the OASI and DI programs:

TABLE 28.—COMPARISON OF ECONOMIC ASSUMPTIONS OF THE SENATE BUDGET COMMITTEE, HOUSE BUDGET COMMITTEE, ADMINISTRATION'S MID-SESSION PATH, AND THE 1979 TRUSTEES' PESSIMISTIC PATH FOR CALENDAR YEARS 1979-1984

	1979	1980	1981	1982	1983	1984
Unemployment rate (average for year):						
Senate Budget Committee	6.2	7.3	7.0	6.3	5.7	5.3
House Budget Committee	6.2	7.3	7.1	6.9	6.6	6.3
Trustees' pessimistic path	6.3	8.2	7.4	6.9	6.4	6.0
Administration's mid-session path	6.1	6.8	6.5	6.1	5.8	5.6
Percentage growth in real GNP:						
Senate Budget Committee	1.8	1.0	3.8	5.3	4.3	3.9
House Budget Committee	1.8	1.0	3.5	4.0	4.0	4.0
Trustees' pessimistic path	2.3	−1.1	5.4	4.1	4.0	3.7
Administration's mid-session path	1.7	1.0	3.4	3.7	3.5	3.5
Percentage growth in CPI:						
Senate Budget Committee	10.6	9.3	8.4	7.6	7.5	7.5
House Budget Committee	10.6	9.3	8.6	7.8	7.1	6.8
Trustees' pessimistic path	10.3	8.9	7.3	6.3	6.0	6.0
Administration's mid-session path	10.7	8.6	7.5	6.6	6.2	5.6
June social security benefit increase:						
Senate Budget Committee	9.9	10.3	8.8	7.7	7.5	7.4
House Budget Committee	9.9	10.3	8.9	8.1	7.3	6.5
Trustees' pessimistic path	9.8	9.8	7.9	6.5	6.0	6.0
Administration's mid-session path	9.9	9.7	8.2	6.7	6.4	5.8

Source: CBO.

TABLE 29.—COMPARISON OF COMBINED OASDI OUTLAYS, BUDGET AUTHORITY, AND TRUST FUND BALANCES AT END OF YEAR UNDER ALTERNATIVE ECONOMIC ASSUMPTIONS AND ESTIMATING METHODOLOGIES

[In billions of dollars, by fiscal year]

	1979	1980	1981	1982	1983	1984
OUTLAYS						
CBO estimates:						
Senate Budget Committee assumptions	104.5	120.1	138.3	157.4	173.6	191.3
House Budget Committee assumptions	104.5	120.1	138.3	157.6	174.4	192.0
Administration's estimates:						
Trustees' pessimistic assumptions	104.1	118.9	135.0	150.8	165.7	181.4
Administration's mid-session estimate	104.4	118.9	134.6	150.1	165.1	180.7
INCOME						
CBO estimates:						
Senate Budget Committee assumptions	102.0	116.8	133.8	156.7	177.4	199.1
House Budget Committee assumptions	102.0	116.8	133.8	156.0	174.7	194.5
Administration's estimates:						
Trustees' pessimistic assumptions	102.5	116.4	133.1	151.8	167.3	183.2
Administration's mid-session estimate	101.8	117.8	134.2	154.0	170.6	187.2
TRUST FUND BALANCE AT END OF YEAR						
CBO estimates:						
Senate Budget Committee assumptions	32.9	29.7	25.3	24.6	28.3	36.2
House Budget Committee assumptions	32.9	29.7	25.1	23.5	23.8	26.2
Administration's estimates:						
Trustees' pessimistic assumptions	33.8	31.4	29.4	30.5	32.0	33.9
Administration's mid-session estimate	32.8	31.7	31.3	35.2	40.8	47.4
TRUST FUND BALANCE AT END OF PREVIOUS YEAR AS PERCENT OF OUTLAYS						
CBO estimates:						
Senate Budget Committee assumptions	33.9	27.4	21.5	16.1	14.2	14.8
House Budget Committee assumptions	33.9	27.4	21.5	15.9	13.5	12.4
Administration's estimates:						
Trustees' pessimistic assumptions	34.0	28.4	23.3	19.5	18.4	17.6
Administration's mid-session estimate	33.9	27.6	23.6	20.9	21.3	22.6

Source: CBO.

TABLE 30.—COMPARISON OF OLD AGE AND SURVIVORS INSURANCE OUTLAYS, BUDGET AUTHORITY, AND TRUST FUND BALANCES AT END OF YEAR UNDER ALTERNATIVE ECONOMIC ASSUMPTIONS AND ESTIMATING METHODOLOGIES

[In billions of dollars, by fiscal year]

	1979	1980	1981	1982	1983	1984
OUTLAYS						
CBO estimates:						
Senate Budget Committee assumptions	90.5	104.0	119.8	135.5	149.7	164.8
House Budget Committee assumptions	90.5	104.0	119.8	135.7	150.4	165.3
Administration's estimates:						
Trustees' pessimistic assumptions	90.1	103.1	117.3	131.2	144.2	157.7
Administration's mid-session estimate	90.3	103.2	116.9	130.5	143.7	157.3
INCOME						
CBO estimates:						
Senate Budget Committee assumptions	86.7	99.4	113.1	132.2	149.6	167.7
House Budget Committee assumptions	86.7	99.4	113.1	131.7	147.3	163.8
Administration's estimates:						
Trustees' pessimistic assumptions	87.2	99.1	112.5	128.0	140.8	153.9
Administration's mid-session estimate	86.6	100.3	113.5	129.8	143.6	157.3
TRUST FUND BALANCE AT END OF YEAR						
CBO estimates:						
Senate Budget Committee assumptions	27.2	22.7	16.1	12.8	12.7	15.7
House Budget Committee Assumptions	27.2	22.7	16.0	12.0	8.9	7.4
Administration's estimates:						
Trustees' pessimistic assumptions	28.1	24.2	19.4	16.2	12.8	9.0
Administration's mid-session estimate	27.2	24.4	20.9	20.2	20.2	20.2
TRUST FUND BALANCE AT END OF PREVIOUS YEAR AS PERCENT OF OUTLAYS						
CBO estimates:						
Senate Budget Committee assumptions	34.3	26.2	18.9	11.9	8.6	7.7
House Budget Committee assumptions	34.3	26.2	18.9	11.8	8.0	5.4
Administration's estimates:						
Trustees' pessimistic assumptions	34.4	27.3	20.6	14.8	11.2	8.1
Administration's mid-session estimate	34.3	26.4	20.9	16.0	14.1	12.8

Source: CBO.

TABLE 31.—COMPARISON OF DISABILITY INSURANCE (DI) OUTLAYS, BUDGET AUTHORITY, AND TRUST FUND BALANCES AT END OF YEAR UNDER ALTERNATIVE ECONOMIC ASSUMPTIONS AND ESTIMATING METHODOLOGIES

[In billions of dollars, by fiscal year]

	1979	1980	1981	1982	1983	1984
OUTLAYS						
CBO estimates:						
Senate Budget Committee assumptions	14.0	16.1	18.5	21.9	23.9	26.5
House Budget Committee assumptions	14.0	16.1	18.5	21.9	24.0	26.7
Administration's estimates:						
Trustees' pessimistic assumptions	14.0	15.8	17.7	19.6	21.5	23.7
Administration's mid-session estimate	14.0	15.8	17.7	19.5	21.4	23.4
INCOME						
CBO estimates:						
Senate Budget Committee assumptions	15.3	17.4	20.7	24.5	27.8	31.4
House Budget Committee assumptions	15.3	17.4	20.7	24.3	27.4	30.7
Administration's estimates:						
Trustees' pessimistic assumptions	15.3	17.3	20.6	23.8	26.5	29.3
Administration's mid-session estimate	15.2	17.5	20.8	24.2	27.0	29.9
TRUST FUND BALANCE AT END OF YEAR						
CBO estimates:						
Senate Budget Committee assumptions	5.7	7.0	9.2	11.8	15.6	20.5
House Budget Committee assumptions	5.7	7.0	9.1	11.5	14.9	18.8
Administration's estimates:						
Trustees' pessimistic assumptions	5.7	7.2	10.0	14.3	19.2	24.9
Administration's mid-session estimate	5.5	7.3	10.4	15.0	20.6	27.1
TRUST FUND BALANCE AT END OF PREVIOUS YEAR AS PERCENT OF OUTLAYS						
CBO estimates:						
Senate Budget Committee assumptions	31.4	35.4	37.8	42.0	49.4	58.9
House Budget Committee assumptions	31.4	35.4	37.8	41.6	47.9	55.8
Administration's estimates:						
Trustees' pessimistic assumptions	31.4	36.1	40.7	51.0	66.5	81.0
Administration's mid-session estimate	31.4	34.8	41.2	53.3	70.0	88.0

Source: CBO.

VII. Costs and Caseloads of the Disability Programs

A. Development of the Programs

As table 32 shows, the Nation's basic cash disability programs have changed dramatically in the last decade both in benefit cost and in caseload. As can also be seen, there has been a major impact on administrative costs, and on the number of individuals employed by the State disability agencies to make disability determinations. Costs of cash benefits grew from about $3.7 billion in 1970, to nearly $18 billion in 1979.

Nor do these figures tell the whole story. There are also major benefit expenditures for disabled persons under the medicare and medicaid programs. Since July 1, 1973, persons who are entitled to disability benefits under the Social Security Act for at least 24 consecutive months become eligible to apply for medicare part A (hospital insurance) benefits beginning with the 25th month of entitlement and also to enroll in the part B (supplementary medical insurance) program. According to estimates for fiscal year 1979, about 700,000 persons will receive reimbursed services under part A during the year at a cost of $2.4 billion. About 1.7 million persons will receive reimbursed services under part B at a cost of $1.4 billion. With respect to the medicaid program, for which most SSI recipients are automatically eligible, statistics for fiscal year 1976 show that about 2.7 million disabled recipients received $3.5 billion in benefits (about 25 percent of total medicaid payments).

TABLE 32.—SOCIAL SECURITY DISABILITY PROGRAMS

Fiscal year	Beneficiaries (millions) (December each year)		Benefits paid (billions)			State agency program administration	
	Title II	Title XVI	DI trust fund	SSI federally administered	Total	Cost (millions)	Employees (thousands)
1970	2.7	[1] 1.0	$2.8	[2] $0.9	$3.7	$48.6	2.6
1971	2.9	[1] 1.1	3.4	[2] 1.1	4.5	63.4	3.2
1972	3.3	[1] 1.2	4.0	[2] 1.3	5.3	68.2	4.4
1973	3.6	[1] 1.4	5.2	[2] 1.5	6.7	80.4	6.3
1974	3.9	1.7	6.2	[2] 1.8	8.0	146.8	10.3
1975	4.4	2.0	7.6	3.0	10.6	206.8	10.1
1976	4.6	2.1	9.2	3.4	12.6	228.3	9.3
1977	4.9	2.2	11.1	3.7	14.8	254.2	9.4
1978	4.9	2.2	12.3	4.1	16.4	278.0	9.6
1979 (est.)	4.9	2.3	13.6	4.3	17.9	311.0	9.6

[1] The SSI program began Jan. 1, 1974. Numbers for prior years represent the number of blind and disabled recipients under the former Federal-State programs of aid to the aged, blind, and disabled.

[2] Combined Federal and State expenditures for benefits paid to blind and disabled recipients under the former Federal-State programs of aid to the aged, blind, and disabled. Figure for fiscal year 1974 combines the expenditures under both programs.

1. DISABILITY INSURANCE

The disability insurance program has grown in caseload size and costs well beyond what was originally estimated. In part, the growth of the program reflects legislative changes which have expanded coverage and benefits. Much of the growth, however, must be ascribed to other causes such as *de facto* liberalizations as a result of court decisions, weaknesses in administration, and greater than anticipated incentives to become or remain dependent upon benefits.

At the time the disability insurance program was enacted in 1956, its long-range cost was estimated to be 0.42 percent of taxable payroll. The "high cost" short-range estimate indicated that benefit outlays would reach a level of $1.3 billion by 1975. Under the 1979 social security trustees' report, the long-range cost of the program is now estimated to be 1.92 percent of taxable payroll. Benefit payments for 1975 totalled $7.6 billion, and benefit payments for 1979 are expected to total approximately $14 billion. (Note: at present payroll levels, 1 percent of taxable payroll is roughly $10 billion.)

Table 34 shows the changes in the estimated costs of the program over the years since it was first enacted. Many of the cost increases in the earlier years are attributable to changes in the law broadening eligibility. The last major change of this type was enacted in 1967. The reductions in long-range costs after 1977 are partly a result of the new benefit computation for all social security benefits adopted in the 1977 amendments and of the increase in the tax base under those amendments. (An increased tax base has the effect of "lowering" the cost of the program as a percent of taxable payroll even if the actual costs of the program in absolute terms remain unchanged.) The 1978 reduction in long-range costs reflects an actuarial assumption based on a somewhat lower award rate in the past year or two.

There are now about 2.9 million disabled workers receiving DI benefits, increased from 1.9 million in 1969. This represents a 107 percent increase over a 10-year period during which there was no major legislative expansion of eligibility requirements. Currently, in addition to the disabled workers who are receiving benefits, there are benefits being paid to about 2 million dependents of disabled workers. (See table 33 for the number of benefits by type of beneficiary in each State.)

TABLE 33.—OASDHI CASH BENEFITS

[Number of monthly benefits in current-payment status, by type of beneficiary and by State, at end of June 1978]

State [1]	Total	Retired workers [2]	Disabled workers [3]	Wives and husbands [4] of—		Children [5] of—			Widowed mothers and fathers [6]	Widows and widowers [7]	Parents [7]	Persons with special age-72 benefits
				Retired workers	Disabled workers	Retired workers	Deceased workers	Disabled workers				
Total	34,067,797	17,923,874	2,857,843	2,941,839	491,352	662,080	2,799,492	1,511,543	569,192	4,147,505	17,742	145,335
Alabama	615,337	274,014	58,610	56,372	11,818	17,659	64,874	34,148	13,920	81,862	621	1,439
Alaska	18,973	7,953	1,460	993	273	852	4,442	1,064	709	1,197	12	18
Arizona	375,863	205,227	31,718	34,566	5,853	7,655	31,573	16,820	6,115	35,153	176	1,007
Arkansas	427,365	203,305	44,164	42,801	9,050	10,761	31,575	26,131	6,407	51,154	239	1,778
California	3,065,496	1,676,896	291,546	247,490	40,284	56,856	234,812	131,659	44,108	326,720	938	14,187
Colorado	314,998	166,690	24,174	30,118	4,121	5,141	28,189	12,452	5,375	37,101	82	1,555
Connecticut	455,115	273,258	30,771	32,221	4,014	6,487	32,473	12,942	6,616	53,556	167	2,610
Delaware	81,633	43,585	6,739	5,878	976	1,407	7,947	3,363	1,570	9,845	28	295
District of Columbia	89,042	48,408	8,055	4,805	613	1,667	10,433	2,830	1,881	9,721	59	569
Florida	1,859,607	1,105,027	139,670	173,156	22,313	26,887	107,859	61,862	22,077	194,028	573	6,155
Georgia	734,200	333,080	86,296	50,561	14,425	14,782	82,945	47,340	16,575	84,546	592	3,058
Hawaii	102,953	54,853	6,693	9,208	1,057	7,376	9,257	3,603	1,941	8,435	74	450
Idaho	122,864	67,814	9,030	12,164	1,568	2,385	10,021	4,642	1,735	13,021	26	458
Illinois	1,594,772	882,122	110,622	129,298	15,439	25,355	139,771	51,956	26,935	204,439	794	7,981
Indiana	793,795	426,509	61,593	67,373	10,131	12,870	65,291	32,869	12,678	101,339	283	2,859
Iowa	482,046	269,754	27,744	53,951	4,500	7,066	30,083	12,689	5,768	66,672	95	3,724
Kansas	356,15_	209,108	20,521	38,963	3,080	5,382	23,401	9,496	4,217	49,139	87	2,757
Kentucky	582,470	262,455	55,570	58,591	14,035	13,226	50,362	37,302	11,297	77,431	363	1,838
Louisiana	568,944	227,680	59,362	53,274	14,464	13,880	62,845	43,534	13,841	77,027	325	2,712
Maine	190,877	105,734	14,885	15,715	2,876	3,213	13,495	8,688	2,755	22,710	74	732
Maryland	502,251	268,189	39,037	37,204	5,235	8,335	50,496	16,751	9,892	64,085	289	2,738
Massachusetts	894,721	528,358	61,561	63,847	9,467	12,044	63,335	28,620	13,700	109,162	320	4,287
Michigan	1,316,999	667,692	115,690	114,284	19,429	23,699	117,797	61,222	23,187	169,098	556	4,345
Minnesota	599,767	340,603	32,643	63,557	5,343	11,831	41,844	16,289	7,895	75,429	131	4,202
Mississippi	417,726	181,735	43,425	35,832	8,631	14,472	45,368	28,885	9,002	48,832	364	1,180
Missouri	840,158	457,278	65,438	76,923	11,152	13,909	60,773	33,639	11,918	105,298	259	3,571
Montana	114,225	60,251	8,611	10,767	1,540	2,363	10,278	4,650	1,788	13,317	41	619
Nebraska	248,112	142,411	12,859	27,299	2,008	3,520	16,462	6,147	2,964	32,359	57	2,026
Nevada	80,587	44,780	7,971	5,098	1,111	1,307	8,114	3,424	1,493	7,051	18	220
New Hampshire	133,503	81,090	8,989	9,428	1,411	1,913	9,528	4,427	1,882	14,117	26	692

New Jersey	1,116,429	627,594	93,755	78,410	13,376	15,344	85,425	42,111	18,497	137,070	558	4,289
New Mexico	162,882	73,812	14,447	15,353	3,852	4,818	18,611	11,435	3,995	15,852	149	558
New York	2,837,044	1,601,350	236,823	198,014	35,983	46,717	210,467	114,856	43,061	335,158	1,338	13,277
North Carolina	846,938	415,521	87,409	62,786	13,831	16,444	87,935	41,897	17,737	99,671	682	3,025
North Dakota	101,517	54,513	4,969	13,089	973	2,471	7,349	2,679	1,380	13,402	30	662
Ohio	1,580,052	793,524	134,786	146,346	23,286	25,074	130,707	70,437	26,771	222,000	591	6,530
Oklahoma	469,551	241,873	39,869	48,363	7,184	7,823	33,242	21,079	6,486	61,554	193	1,885
Oregon	389,256	227,210	30,931	33,187	4,830	6,228	25,963	13,696	4,591	41,054	84	1,482
Pennsylvania	1,989,240	1,070,588	160,558	174,289	25,502	27,480	140,850	66,767	31,690	281,770	1,038	8,708
Rhode Island	161,951	97,091	13,417	9,966	1,844	1,954	10,394	5,634	2,242	18,559	57	793
South Carolina	422,000	192,561	48,465	26,739	7,934	8,724	52,560	25,054	11,057	47,034	388	1,484
South Dakota	116,565	63,407	6,338	13,657	1,145	2,336	8,475	3,133	1,576	15,596	20	884
Tennessee	705,111	334,846	71,994	64,274	13,399	15,229	61,416	38,972	13,002	88,461	564	2,954
Texas	1,739,311	848,716	134,944	177,315	26,361	39,727	165,883	79,416	34,676	224,657	1,051	6,565
Utah	138,238	75,558	8,924	13,545	1,626	2,762	13,353	4,904	2,306	14,841	29	390
Vermont	77,860	42,723	6,066	6,542	1,127	1,283	5,716	3,385	1,169	9,416	29	404
Virginia	680,538	335,210	63,051	54,531	11,611	13,149	66,608	33,115	13,675	85,646	514	3,428
Washington	547,495	312,086	42,665	46,898	6,399	9,118	39,991	19,718	6,669	61,383	130	2,438
West Virginia	354,773	146,469	39,348	35,212	10,495	8,748	28,559	25,126	6,933	52,349	286	1,248
Wisconsin	740,366	419,655	47,866	70,331	7,870	13,330	51,121	24,814	9,609	91,589	167	4,014
Wyoming	47,410	26,629	2,798	4,333	411	842	4,545	1,348	775	5,384	18	227
Other areas												
American Samoa	2,036	349	100	184	56	391	545	228	127	51	5	0
Guam	2,654	679	160	221	46	248	825	191	182	97	5	0
Puerto Rico	536,205	164,746	73,426	48,757	22,976	38,898	49,468	93,705	10,943	32,229	1,037	20
Virgin Islands	6,851	2,990	433	532	77	520	1,280	364	232	409	14	0
Abroad	304,974	138,315	8,854	37,228	2,881	18,122	32,543	8,029	9,569	48,329	1,096	8

[1] Beneficiary by State of residence.
[2] Aged 62 and over.
[3] Under age 65.
[4] Includes wife beneficiaries aged 62 and over, nondivorced and divorced, and those under age 65 with entitled children in their care.
[5] Includes disabled persons aged 18 and over whose disability began before age 22 and entitled full-time students aged 18 to 21.
[6] Includes surviving divorced mothers and fathers with entitled children in their care.
[7] Aged 60 and over for widows, widowers, and surviving divorced wives, and aged 62 and over for parents. Also includes disabled widows, widowers, and surviving divorced wives aged 50 to 59.

Source: Social Security Bulletin, March 1979/vol. 42, No. 3.

TABLE 34.—GROWTH IN ESTIMATED COST OF DI PROGRAM

Year of estimate	Estimated cost		
	Long-range (as percent of payroll)	Short-range [1] (millions)	1980 projection (millions)
1956	0.42	$379	([2])
1958	.49	492	$1,380
1960	.56	864	1,550
1965	.67	1,827	2,211
1967	.95	2,068	3,351
1973	1.54	6,295	NA
1975	2.97	9,640	NA
1976	3.51	12,715	16,197
1977	3.68	14,822	16,817
1978	2.26	16,532	16,532
1979	1.92	17,212	15,600

[1] Short-range represents intermediate estimate of cost for second year after the year of estimate.

[2] No 1980 projection made; 1975 costs were projected to be $949,000,000.

NA—not available.

Source: Estimates prepared by the Office of the Actuary of the Social Security Administration in connection with legislation (1956–67) or as a part of annual trustees' reports (1973–79). Short-range costs shown in this table are benefit payments only.

The following table shows the number of awards by calendar year over the last decade. The number of disabled worker awards in the last 5 years has been about 2.7 million. Through the 1968–78 period the annual number of awards rose from an average of about 340,000 for 1968–70 to a peak of 592,000 in 1975. Following 1975, there was no longer a steady upward trend. Instead, the number of awards in 1976–77 was about 5 percent lower than in 1975. The 1978 decrease was even sharper, to a level about 23 percent below that of 1975.

TABLE 35.—DISABLED-WORKER BENEFIT AWARDS, 1968-78

	Number of awards	Awards per 1,000 insured workers
Calendar year:		
1968	323,514	4.8
1969	344,741	4.9
1970	350,384	4.8
1971	415,897	5.6
1972	456,562	6.0
1973	491,955	6.3
1974	535,977	6.7
1975	592,049	7.1
1976	551,740	6.5
1977	569,035	6.6
1978	457,451	5.2

Source: Prepared by Robert J. Myers, consultant to the Committee on Finance

Following the rapid increases in the number of applications for title II worker disability in the first half of the 1970's, there has been a distinct leveling off, even a decrease, in the number applying. The decrease, however, has not been as significant as the decrease in the number of awards. In the same period referred to above, 1975–78, title II disabled worker applications decreased by about 8 percent. The most recent statistics available for 1979, however, show that for the first 5 months of this year the number of applications has been slightly higher than for the corresponding period in 1978.

TABLE 36.—TITLE II DISABLED WORKER APPLICATIONS RECEIVED IN DISTRICT OFFICES, 1970 THROUGH 1978[1]

[In thousands]

1970	868.7
1971	943.0
1972	947.5
1973	1,067.5
1974	1,331.2
1975	1,284.7
1976	1,256.3
1977	1,235.5
1978	1,184.8
January–May 1978	485.6
January–May 1979	489.0

[1] Calendar year.

Source: Social Security Administration.

TABLE 37.—DISABLED WORKER APPLICATIONS: RECEIPTS IN DISTRICT OFFICES BY QUARTER BY CALENDAR YEAR

	Jan.-Mar.	Apr.-June	July-Sept.	Oct.-Dec.	CY total
1970:					
Number	199,300	221,400	231,500	216,400	868,700
% of preceding qtr	112	111	105	93	
% of same pd yr ago	110	119	128	122	120
1971:					
Number	234,000	[1] 243,400	233,500	213,100	[2] 924,000
% of preceding qtr	108	104	96	91	
% of same pd yr ago	117	110	101	98	106
1972:					
Number	240,700	237,000	241,700	228,100	947,500
% of preceding qtr	113	98	102	94	
% of same pd yr ago	103	97	104	107	103
1973:					
Number	268,400	267,000	273,200	258,800	1,067,500
% of preceding qtr	118	99	102	95	
% of same pd yr ago	112	113	113	113	113
1974:					
Number	361,300	343,600	321,600	304,700	1,331,200
% of preceding qtr	140	95	94	95	
% of same pd yr ago	135	129	118	118	125
1975:					
Number	326,600	331,000	326,500	300,600	1,284,700
% of preceding qtr	107	101	99	92	
% of same pd yr ago	90	96	102	99	96
1976:					
Number	305,700	[1] 311,600	322,000	294,000	[1] 1,233,300
% of preceding qtr	102	102	104	91	
% of same pd yr ago	94	94	99	98	96
1977:					
Number	322,000	319,300	317,300	277,400	1,236,000
% of preceding qtr	110	99	99	87	
% of same pd yr ago	105	103	99	94	100
1978:					
Number	294,200	306,600	306,000	279,100	[2] 1,185,900
% of preceding qtr	106	104	100	91	
% of same pd yr ago	91	96	96	101	96
1979:					
Number	299,300	306,830	.....	.....	.....
% of preceding qtr	107	103	.....	.....	.....
% of same pd yr ago	102	100	.....	.....	.....

[1] 53d week omitted: 1971—19,000 applications; 1976—23,000 applications.
[2] The difference between this number and the number shown in the preceding table is due to differences in rounding.

Source: Social Security Administration.

2. SUPPLEMENTAL SECURITY INCOME

When the Congress was considering the enactment of the supplemental security income legislation in 1972, the estimates it had before it did not accurately portray the future nature of the caseload and costs of the program. Nor was there any testimony that indicated how the implementation of the program might affect the administrative capacity of the Social Security Administration, and, most particularly, the capacity of the disability adjudication structure.

Most of the discussion leading up to congressional passage of SSI centered on serving the aged population. Congress accepted estimates of the Administration indicating that the SSI population would continue to be composed largely of the aged. The Administration esti-

mated that, by the end of fiscal year 1975, there would be almost two aged beneficiaries for every disabled beneficiary. While it was foreseen that the number of persons receiving disability benefits would grow under the new program, it was expected that the number of aged beneficiaries would grow even more.

The Administration's early estimates on the number of persons who would qualify for disability payments under the SSI program appear to have been developed somewhat haphazardly. It apparently relied primarily on the Survey of the Disabled conducted by the Department of Health, Education, and Welfare in 1966. Looking to the future, the Administration estimated that the annual growth rate for SSI disability would be 2 percent, as compared to Administration estimates of 5-percent caseload growth under the then existing law projected into the future.

Even the higher projection for existing law did not seem to take into account what had actually been happening under the program of aid to the permanently and totally disabled. In the period December 1968 through December 1971 the disability rolls increased from 702,000 to 1,068,000—an increase of 52 percent.

In its budget justification for 1974, the first year of the SSI program, the Administration estimated that by June 1974 there would be 3.1 million aged on the rolls, and 1.7 million disabled. In June 1974 there were actually 2.1 million aged and 1.5 million disabled on the rolls. The Administration also estimated at that time that by June 1975 there would be 3.8 million aged and 1.8 million disabled. The figure for the disabled turned out to be accurate—there were 1.8 million disabled persons receiving benefits in June 1975, but the figure for the aged was only 2.3 million. Moreover, the overall estimate for the disabled was realized even though the estimate for disabled children of 250,000 was still less than one-third realized.

In calendar years 1974 and 1975, the first 2 years of the SSI program, the disability caseload increased substantially, from about 1.3 million individuals in January 1974 to about 2 million 2 years later. Since that time the actual number of persons receiving payments on the basis of disability has appeared to be stabilizing.

However, the SSI program is nonetheless becoming a program that is increasingly dominated by the disability aspects. Out of the 4.2 million persons receiving SSI benefits, 2.2 million came onto the rolls as the result of being determined to be disabled. (319,000 of these individuals have now reached age 65, but are still listed by SSA as being disabled. See table 37 for a State-by-State listing of recipients.)

Perhaps most indicative of the predominance of disability issues in the program are the figures showing numbers of applicants for benefits. About 80 percent of all applications are now being made on the basis of disability. This has been the case since 1976. In addition, about two-thirds of all awards made in recent years have been made to persons determined to be disabled. (See table 40.) Program expenditures also reflect the numbers and relatively higher average SSI payments of the disabled SSI population. About 60 percent of all SSI expenditures now go to persons who have been determined disabled. (See table 41.)

At the present time, more than 1 million, or nearly half of all disability applications received in social security district offices, are applications for SSI benefits. In 1974, the first full year of the SSI program, there were fewer than 800,000 applications, compared with

1.3 million title II applications. Over the 5½ years of the SSI program, SSI disability applications have increased steadily as a percentage of all disability applications. Persons working with the disability programs generally are agreed that the establishment of the SSI disability program, acting as a kind of out-reach mechanism, had the result of increasing the number of applications for title II disability.

TABLE 38.—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED, [Number of persons receiving federally administered payments, by reason for eligibility and State, March 1979]

State	Total	Aged	Blind	Disabled
Total[1]	4,229,782	1,956,318	77,475	2 195,989
Alabama[2]	140,182	84,301	1,914	53,967
Alaska[2]	3,205	1,278	68	1,859
Arizona[2]	29,264	12,318	530	16,416
Arkansas	82,489	47,879	1,574	33,036
California	701,724	319,032	17,284	365,408
Colorado[2]	32,927	15,322	362	17,243
Connecticut[2]	23,496	7,991	313	15,192
Delaware	7,195	2,753	185	4,257
District of Columbia	14,908	4,293	197	10,418
Florida	169,271	86,696	2,579	79,996
Georgia	158,406	77,482	2,943	77,981
Hawaii	10,147	5,189	146	4,812
Idaho[2]	7,601	2,968	93	4,540
Illinois[2]	125,997	38,501	1,697	85,799
Indiana[2]	41,579	16,672	1,068	23,839
Iowa	26,557	12,250	1,081	13,226
Kansas	21,621	9,161	322	12,138
Kentucky[2]	95,667	46,909	2,034	46,724
Louisiana	143,097	73,544	2,182	67,371
Maine	22,782	10,921	286	11,575
Maryland	48,599	17,046	574	30,979
Massachusetts	131,641	73,735	4,977	52,929
Michigan	118,214	42,397	1,729	74,088
Minnesota[2]	34,191	14,479	644	19,068
Mississippi	115,947	67,313	1,828	46,806
Missouri[2]	89,169	46,509	1,502	41,158
Montana	7,340	2,679	140	4,521
Nebraska[2]	14,144	6,212	243	7,689
Nevada	6,444	3,518	406	2,520
New Hampshire[2]	5,455	2,319	132	3,004

TABLE 38.—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED [Number of persons receiving federally administered payments, by reason for eligibility and State, March 1979]—Continued

State	Total	Aged	Blind	Disabled
New Jersey	84,617	33,452	1,021	50,144
New Mexico [2]	25,717	11,104	441	14,172
New York	377,901	147,302	3,970	226,629
North Carolina [2]	143,548	68,300	3,330	71,918
North Dakota [2]	6,862	3,701	65	3,096
Ohio	123,832	40,268	2,313	81,251
Oklahoma [2]	72,657	39,161	1,064	32,432
Oregon [2]	23,016	8,113	536	14,367
Pennsylvania	170,207	63,345	3,620	103,242
Rhode Island	15,506	6,361	184	8,961
South Carolina [2]	84,287	40,934	1,884	41,469
South Dakota	8,377	4,240	132	4,005
Tennessee	133,899	66,807	1,876	65,216
Texas [3]	269,678	160,271	4,126	105,281
Utah [3]	8,084	2,651	162	5,271
Vermont	9,083	3,947	120	5,016
Virginia [2]	80,461	37,604	1,419	41,438
Washington	48,541	16,992	546	31,003
West Virginia [2]	42,703	15,802	626	26,275
Wisconsin	68,883	32,987	958	34,938
Wyoming [2]	2,023	928	26	1,069
Unknown	57	17	.....	40
Other areas:				
Northern Mariana Islands [3]	584	364	23	197

[1] Includes persons with Federal SSI payments and/or federally administered State supplementation, unless otherwise indicated.

[2] Data for Federal SSI payments only. State has State-administered supplementation.

[3] Data for Federal SSI payments only; State supplementary payments not made.

Source: Social Security Administration.

TABLE 39.—SSI APPLICATIONS, BY CATEGORY, 1974–78

Calendar year	Total	Aged	Blind and disabled	Blind and disabled as a percent of total
1974	2,296,400	926,900	1,369,500	60
1975	1,498,400	377,400	1,121,000	75
1976	1,258,100	254,400	1,003,700	80
1977	1,298,400	258,500	1,039,900	80
1978	1,304,300	257,900	1,046,400	80

. Source: Data provided by the Social Security Administration.

TABLE 40.—NUMBER OF PERSONS INITIALLY AWARDED SSI PAYMENTS [1]

Year	Total SSI awards	Disabled	Disability as percent of total
1974	890,768	387,007	43
1975	702,147	436,490	62
1976	542,355	365,822	67
1977	557,570	362,067	65
1978	532,447	348,848	66

[1] Federally administered payments.

Source: Data provided by the Social Security Administration.

TABLE 41.—SSI BENEFIT EXPENDITURES [1]

Calendar year	Total	Disability [2]	Disability as percent of total
1974	$5,096,813	$2,556,988	50
1975	5,716,072	3,072,317	54
1976	5,900,215	3,345,778	57
1977	6,134,085	3,628,060	59
1978	6,371,638	3,881,531	61

[1] Federally administered payments.

[2] SSI program record-keeping maintains individuals on the rolls as disabled after they have reached age 65. In 1978 about $300,000 was paid to disabled individuals in this category.

Source: Data provided by the Social Security Administration.

B. Causes for Growth

As the preceding discussion shows, the experts have had very great difficulty estimating how the disability programs would develop, and they have frequently been wrong. They have found it equally difficult to pinpoint the reasons for growth in the disability programs, partic-

ularly in the disability insurance program. The growth that took place, primarily in the first half of the 1970's, would seem to have leveled off. But there is still no consensus on exactly why it happened, the weight to be given to various factors, or even on whether the period of rapid growth is over.

1. INCREASES IN DISABILITY INCIDENCE RATES

The table below shows standardized disability incidence rates under the disability insurance program for the period 1968–75. As can be seen, the rates show an almost steadily increasing trend from 1968, although appearing to level off in 1973–75.

TABLE 42.—STANDARDIZED DISABILITY INCIDENCE RATES UNDER DI, 1968–75

[Rates per 1,000 insured]

(Reprinted from "Actuarial Analysis of Operation of Disability Insurance System Under Social Security Program," by Robert J. Myers, appearing in a committee print of the Subcommittee on Social Security of the House Ways and Means Committee on "Actuarial Condition of Disability Insurance, 1978," Feb. 1, 1979, p. 7).

	Standardized rate [1]	Percentage increase over 1968
Year:		
1968	4.46	.....
1969	4.29	−4
1970	4.77	+7
1971	5.25	+18
1972	6.00	+35
1973	7.20	+61
1974	7.14	+60
1975	6.85	+54

[1] Overall incidence rate based on age-sex distribution of persons insured for disability benefits as of Jan. 1, 1975 (as shown in table 50, "Statistical Supplement, Social Security Bulletin," 1975); and on incidence rates by age and sex as shown in "Actuarial Study No. 74" and "Actuarial Study No. 75," Social Security Administration.

Social Security Administration actuaries attempted to assess the reasons for the increase in incidence rates in a report published in January 1977, "Experience of Disabled-Worker Benefits under OASDI, 1965–74." Their analysis points to a variety of factors, including increases in benefit levels, high unemployment rates, changes in attitude of the population, and administrative factors. These factors, as analyzed by the actuaries, are worth considering in some detail.

Starting off their discussion, the actuaries observe:

> We believe that part of the recent increase in incidence rates is due to the rapid rise in benefit levels since 1970, particularly when measured in terms of pre-disability earnings. From December 1969 to December 1975 there were general benefit increases amounting to 82 percent. Also, effective in 1973, medicare benefits became available to disabled worker

> beneficiaries who have been entitled for at least 2 years. We also believe the short computation period for the young workers, the weighting of the benefit formula for the low income workers, and the additional benefits payable when the worker has dependents can provide especially attractive benefits to beneficiaries in these categories. It is possible under the present formula for these beneficiaries to receive more in disability benefits than was included in their take-home pay while they were working. Benefits this high become an incentive to file a claim for disability benefits, and to pursue the claim through the appellate procedures. (p. 5)

In transmitting the Administration's proposed changes in the DI program in March of this year, former Secretary of HEW Joseph Califano pointed out that, in fact, 6 percent of DI beneficiaries receive more through their DI benefits alone than they made while working, and that 16 percent have benefits which exceed 80 percent of their prior net earnings.

The actuaries believe that another factor in the increase in incidence rates is the high unemployment rate that the country experienced after 1970. They argue that physically impaired individuals are more likely to apply for benefits if they lose their jobs in a recession than during an economic expansion when they can retain their jobs.

According to the actuaries, another factor influencing increases in incidence rates is changes in attitude. Elaborating on this theme, they state that "It is possible that the impaired lives of today do not feel the same social pressure to remain productive as did their counterparts as recently as the late 1960's." The actuaries quote John Miller, a consulting actuary and expert in the field of disability insurance, who commented in a report to the House Social Security Subcommittee on the subjective nature of the state of disability:

> The underlying problem in providing and administering any plan of disability insurance is the extreme subjectivity of the state of disability. This characteristic could be discussed at length and illustrated with an almost endless array of statistics but it can best be visualized by comparing a Helen Keller or a Robert Louis Stevenson with any typical example of the multitude of ambulatory persons now drawing disability benefits who could be gainfully employed if (a) the necessary motivation existed, and (b) an employment opportunity within their present or potential capability were present or made available. Thus the problem is not simply one of medical diagnosis. The will to work, the economic climate and the "rehabilitation environment" outweigh the medical condition or problem in many, if not in most, cases.
>
> (Reports of Consultants on Actuarial and Definitional Aspects of Social Security Disability Insurance, to the Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, p. 24.)

The authors were unwilling to attribute the increase in disability incidence rates to these factors to any specific degree, and observed only that they were responsible for "a large part" of the increases. Beyond that they state: "We feel that some administrative factors

must have also played an important part in the recent increases, but we cannot offer a definite proof to that effect."

One administrative factor mentioned is the multi-step appeals process, which enables the claimant to pursue his case to what the actuaries term as the "weak link" in the hierarchy of disability determination. Under the multi-step appeals process, a claimant who has been denied benefits may request first a reconsideration, then a hearing before an Administrative Law Judge, appeal his hearing denial to the Appeals Council, and, if his case is still denied, take his claim to the U.S. district court. The actuaries claim that by the very nature of the claims process, the cases which progress through the appeals process are likely to be borderline cases where vocational factors play an important role in the determination of disability. The definition of disability—"inability to engage in any substantial gainful activity by reason of a medically determinable impairment"—involves two variables: (1) impairment and (2) vocational factors. An emphasis on vocational factors, they say, citing William Roemmich, former Chief Medical Director of the Bureau of Disability Insurance, can change the definition to "inability to engage in usual work by reason of age, education, and work experience providing any impairment is present." To the extent that vocational factors are given higher weight as a claim progresses through the appeals process, the chances of reversal of a former denial is increased.

The actuaries also cite the "massive nature" of the disability determination process as one of the administrative factors which may be responsible for the growth in the rolls. There has been an enormous increase in the number of claims required to be processed by the system. In fiscal year 1969, the Social Security Administration took in over 700,000 claims for disability insurance benefits. By 1974 the number of DI claims per year had grown to 1.2 million. In addition, over 500,000 disability claims under the black lung program, which started during 1970, had been taken in. And the number of SSI disability claims being taken in approached another million. As the actuaries point out, all this was happening at a time when the administration was making a determined effort to hold down administrative costs.

During this period it would appear that there was an inevitable conflict within the administrative process between quality and quantity. The winner, it would appear, was quantity. The actuaries state:

> All of this put tremendous pressure on the disability adjudicators to move claims quickly. As a result the administration reduced their review procedures to a small sample, limited the continuing disability investigations on cases which were judged less likely to be terminated, and adopted certain expedients in the development and documentation in the claims process. Although all of these moves may have been necessary in order to avoid an unduly large backlog of disability claims, it is our opinion that they had an unfortunate effect on the cost of the program (p. 8).

A final factor given for the increase in the incidence rates is "the difficulty of maintaining a proper balance between sympathy for the claimant and respect for the trust funds in a large public system." The actuaries maintain that they do not mean that disability adjudicators consciously circumvent the law in order to benefit an

unfortunate claimant. They mean rather that in a program designed specifically to help people, whose operations are an open concern to millions of individuals, and where any one decision has an insignificant effect on the overall cost of the program, there is a natural tendency to find in favor of the claimant in close decisions. "This tendency is likely to result in a small amount of growth in disability incidence rates each year, such as that experienced under the DI program prior to 1970, but it can become highly significant during long periods of difficult national economic conditions." (p. 8.)

Although the above discussion of the factors in increased incidence rates was aimed specifically at the disability insurance program, it would seem to be applicable also to the SSI program. The same definition and the same administrative procedures are used in both programs. And it is logical to assume that the economic, human, and administrative factors which affect growth would be present in both programs.

2. DECREASE IN TERMINATIONS

At the same time that there have been increases in disability incidence rates, there have also been decreases in disability termination rates. As the table below shows, death termination rates have decreased gradually over the years from about 80 per thousand in 1968 to about 50 per thousand in 1977.

TABLE 43.—DISABILITY TERMINATION RATES UNDER DI, 1968–77

(Reprinted from "Actuarial Analysis of Operation of Disability Insurance System Under Social Security Program," by Robert J. Myers, cited earlier, (p. 7)).

	Number of terminations (thousands)		Termination rates [1]	
	Death	Recovery	Death	Recovery
Year:				
1968.....	99.9	37.7	79	30
1969.....	108.8	38.1	80	28
1970.....	105.8	40.8	72	28
1971.....	109.9	43.0	69	27
1972.....	108.7	39.4	62	22
1973.....	125.6	36.7	65	19
1974.....	135.1	[2] 38.0	63	18
1975.....	139.8	[2] 39.0	59	16
1976.....	137.1	[2] 40.0	53	15
1977.....	139.4	[2] 60.0	50	22

[1] Rate per 1,000 average beneficiaries on the roll.
[2] Estimated.

The actuarial study referred to earlier cites several reasons for the decline in the death termination rate: legislative changes which brought in younger workers, maturation of the program, the liberalized definition of disability in the 1965 amendments from permanent disability to one that is expected to last at least 12 months, and

improved medical procedures that have also contributed to the decline in death rates in the general population.

However, the actuaries state that although all of these reasons contributed to the decline, "it is doubtful that they can fully account for the rather rapid decrease that has been observed." Rather, they say, they believe that healthier applicants are being awarded disability benefits and consequently there is a tendency for the overall mortality rates to decline:

> The magnitude of the increase in the incidence rates is so substantial, that it is likely to have had a significant effect on the characteristics of applicants that are being awarded disability benefits. It is our belief that progressively healthier individuals have been granted benefits, and that progressively healthier individuals have been allowed to stay on the rolls (p. 12).

Examining the other significant factor in termination rates, recovery rates, the actuaries come to essentially the same conclusion:

> The rapid decrease in the gross recovery rate since 1967 cannot be explained in terms of legislated changes since there have not been any major changes in the law since then. As with the decline in the gross death rate, and probably even more so, it is believed that progressively healthier beneficiaries are being allowed to continue receiving benefits without being terminated (p. 12).

The actuaries also cite administrative changes as a possible reason for a decline in recoveries due to a determination of improvements in the beneficiary's physical condition. Pinpointing "administrative expediency," they note that the high workload pressures of past years forced SSA to curtail some of its policing activities. The Social Security Administration made continuing disability investigations of about 10 percent of the DI beneficiaries on the rolls in years prior to 1970. During fiscal years 1971 to 1974, when the administrative crunch of the black lung and SSI programs were at their peak, there was an investigation of just over 4 percent of the DI beneficiaries in a year.

A final factor which is mentioned in the actuaries analysis is high benefit levels, or high replacement ratios. Defining the replacement ratio as the annual amount of benefits received by the disabled worker and his dependents divided by his after tax earnings in the year before onset of disability, the actuaries claim that the average replacement ratio of disabled workers with median earnings has increased from about 60 percent in 1967 to over 90 percent in 1976. During this period the gross recovery rate decreased to only one-half of what it was in 1967.

More recently, the Social Security Administration actuaries commented on how replacement ratios affect the recovery rate by noting:

> High benefits are a formidable incentive to maintain beneficiary status especially when the value of medicare and other benefits are considered. We believe that the incentive to return to permanent self-supporting work provided by the trial work period provision has been largely negated by the prospect of losing the high benefits. ("Experience of Disabled-

Workers Benefits Under OASDI, 1972-76," actuarial study No. 75, June 1978.)

A study of disabled workers who were awarded benefits in 1972 which appeared in the April 1979 issue of the Social Security Bulletin found that, among certain workers with conditions most subject to medical improvements, those with high replacement rates were less likely to leave the rolls. More specifically, the study found that among younger workers, a relationship of benefits to recovery according to earnings-replacement level was apparent. Twenty percent of those under age 40 with higher replacement rates recovered from their disabilities. This percentage increased to 32 when the replacement rate was less than 75 percent. A similar effect was found for those with dependent children and for those with injuries such as fractures and disc displacements.

The authors conclude:

> Thus, although the overall recovery proportions seem alike for those with high and low earnings-replacement rates, receipt of benefits does appear to have an effect on some of the subgroups.

C. Current Status of the Program

1. WHAT RECENT STATISTICS SHOW

Recent statistics seem to indicate that the social security disability programs are leveling off. Title II disabled worker applications have been decreasing on an annual basis since 1974. SSI disability applications have been increasing, but at a rate significantly lower than in earlier years. As mentioned earlier, for the first 5 months of 1979 the number of title II disabled worker applications was virtually the same as for the same period in the previous year. SSI disability applications were up by 7.5 percent in that same period of time.

Application statistics, however, are perhaps not as significant as other program statistics—those telling how many are coming on the rolls and those telling how many are going off. Between 1975 and 1978 the number of benefits awarded to disabled workers dropped from 592,049 in 1975 to 457,451 in 1978, a 23 percent decrease. In the first 5 months of 1979 this trend continued, with awards in that period about 13 percent lower than for the same 5-month period in 1978. SSI awards to the disabled have also been declining, from a high of 436,490 in 1975, to 348,848 in 1978, a decline of about 20 percent. Statistics show that this trend is continuing into 1979. SSI awards on the basis of disability for the first 5 months of 1979 were about 7 percent below those of the previous year.

Program statistics also show a considerable increase in State agency denial rates. In fiscal year 1973, 47 percent of all State agency initial decisions relating to title II disabled workers were denials. The denial rate in 1978 was 60 percent. State agency initial decisions on SSI applications resulted in a denial rate of about 58 percent in 1977, increasing to 64 percent in 1978. For the last quarter in 1978 the denial rate reached nearly 67 percent.

In addition, available statistics show that the number of cessations as opposed to continuances in determinations of continuing disability for disabled workers have greatly increased as follows:

TABLE 44.—TITLE II DISABLED WORKERS, CESSATIONS AND CONTINUATIONS, 1975–78

Calendar year	Cessations		Continuations		Total cases (continuations and cessations)
	Number	Percent	Number	Percent	
1975.....	37,200	31.2	82,000	68.8	119,200
1976.....	37,600	33.5	74,700	66.5	112,300
1977.....	58,200	46.0	68,400	54.0	126,600
1978.....	61,400	50.8	59,400	49.2	120,800

Experts in the field of disability are reluctant to draw many conclusions from these statistics. There is a feeling of unease about their significance, particularly over the long term. The 1979 trustees' report shows an improved forecast for the DI trust fund over the one made last year. This is caused by projections of lower rates of enrollment than were made previously and were based on the actual slowdown in new awards since the last quarter of 1977 (although enrollment is still projected to rise in the future under all three sets of economic assumptions in the report—optimistic, intermediate, and pessimistic). The trustees add their own note of caution, however, observing that "this reduction in the incidence of disability was not anticipated and its causes are not very clear, so it is uncertain whether the trend will continue in the future."

2. EXPLANATIONS GIVEN FOR CHANGES IN THE GROWTH PATTERN

As the preceding quotation from the trustees' report indicates, there is a feeling of uncertainty among disability experts as to exactly why the growth in the programs appears to be leveling off. If one reads back through the analysis of the causes of growth prepared by the social security actuaries, one expects to find some basis for understanding why the growth may have slowed. The actuaries' analysis cites administrative factors as having an impact on the growing disability incidence rates in earlier years, as well as having an effect on the decline in terminations. Although other factors seem relatively unchanged, there has, in fact, been considerable change in the administration of the disability programs in the last 2–3 years.

The Ways and Means Committee Report on H.R. 3236, in referring to the new assumptions of reduced disability incidence rates, states that the reasons for these are not wholly known. However, the report refers to the fact that the Subcommittee on Social Security "has received considerable testimony that this may be the result of tighter administration and a growing reliance on the medical factors in the determination of disability." (p. 15)

The House Social Security Subcommittee staff issued a committee print on February 1, 1979, which includes statistics similar to those

above. Citing these statistics, the Subcommittee requested administrators of the State agencies to give "your opinion as to the reasons for these recent trends. . . . and deal with any other aspect of the 'climate of adjudication' which seems relevant to our inquiry." Some 30 administrators responded, and their observations were discussed in some depth in the committee print.

A number of States wrote that criticism of the disability program has had the effect of changing the "adjudicative climate." The Subcommittee print quotes one administrator as saying:

> I believe the primary reason for the recent conservative approach to disability evaluation is a direct result of the activities of the Subcommittee on Social Security, the General Accounting Office, and others involved in evaluating the effectiveness of the program. The Administration has apparently carefully considered all of the comments, inquiries, opinions, etc., and concluded that a "tightening up" is desired. This view may be somewhat of an over simplification; but in the real world it is quite likely the root cause of the recent trends.
>
> In summary, I believe the "adjudicative climate" has changed primarily as a result of the activities of your committee. I believe the change to be reasonable and desirable. Benefits are being awarded to those individuals who are not working and unable to work primarily as a result of their medically determinable physical and mental impairments, and benefits are being withheld from those individuals who are not working primarily as a result of other factors. (p. 12)

According to the staff analysis, however, more administrators pointed to the promulgation of more specific Federal guidelines and better documentation of cases (as the result of quality assurance requirements and procedures) as being mainly responsible for increased denials. Quotations from the letters of three administrators taking this view are as follows:

> I believe it is fair to state that most cases are more completely documented now than they were two years ago and that this more complete documentation has resulted in improved decisions. Of course, the increased documentation has increased administrative costs; however, it seems that the increase in administrative costs may have resulted in lower program cost; thus a net reduction in cost to the trust fund. The important point is that the better documentation has led to more "right" decisions.
>
> * * * * * * *
>
> Why the increase in denial and cessation rates? Is it due to some form of subtle persuasion from [the Central or Regional offices] to deny or cease benefits because of certain Trust Fund considerations? Perhaps the cost-effectiveness aspect is one cause and one result of the "tightening up," but we do not view it as the only or even major goal. Our reasoning is simply this: we have not been given a new set of rules under which to operate but, rather, needed definition and structure to concepts and criteria which have always existed as part of the

disability program since its inception. Are the increased denial and cessation rates, then, a result of a more appropriate application of program concepts and criteria to the disability determination process? Our feeling is yes. Demands for additional and more solid documentation cannot disfavor the allowable claimant but can disfavor the deniable claimant. What, if any, are the differences in demographic characteristics of and illness/disease incidence and treatment effectiveness in the population of today as compared to that of four years ago, and what role do they play in the increased denial-cessation rate? Are the criteria to allow or continue too rigid? The answer to the latter is, it is not for us to say. (p.13)

* * * * * * *

We feel that a combination of better quality assurance, better leadership from the Regional Offices as well as the Central Office, more definitive procedure and policy instructions, a closer adherence to the actual medical listings on which disabilities must be based, all of these have come together to create a more realistic approach to the aspect of disability decisions. Therefore, with these guidelines being followed closely, a good adherence to quality assurance recommendations, the denial rate has increased, the allowances that are allowed are becoming more realistic, and this trend will continue because there is a way yet to go in terms of accuracy relative to the continuation and the allowances processes. (p. 13)

* * * * * * *

The House subcommittee letter specifically asked the State administrators to evaluate the increase in denials on the basis of "slight impairment" which has taken place in recent years. Under the sequential determination procedure used in deciding whether an individual is disabled, the disability adjudicator must determine whether the individual has a severe impairment, even before he explores whether the individual meets or equals the medical listings, or, in the next step, is entitled to consideration of vocational factors. If the adjudicator decides that the condition is not "severe," but is, rather, a "slight impairment," then the individual is determined not to be disabled. The percentage of disabled worker cases denied on the basis of "slight impairment" increased from about 8 percent in 1975 to about 32 percent in 1977, increasing to 36 percent in the last 6 months of calendar year 1978.

According to the subcommittee staff, the States cited a number of elements which could account for the rise in percentage of denials based on slight impairment. These include increased Federal guidance on what constitutes slight impairment communicated by written and oral policy instructions, training sessions, and through cases returned to the States as the result of quality assurance review by the central office in Baltimore and the regional offices. All of these have emphasized increased physician involvement in adjudication and also increased documentation of cases.

Following are two analyses of the development by State administrators:

* * * * * * *

The slight impairment basis code has an interesting story. When I began adjudicating cases, the closest thing we had to a definition of "slight impairment" was that it meant "no impairment *at all.*" Thus, if we found any deviation from normal we would proceed to other considerations. In recent years, more and more effort has gone into trying to define what was meant by "slight" and into trying to give examples of such impairments. Now, there are available lists of impairments which, when occurring alone, or in combination with other (similar) impairments, are automatically considered slight. These are impairments that would not have been routinely considered slight in past years, but the consensus of medical opinion is that they actually are (colostomy, loss of one eye, etc.). Quite often one may find disagreements among medical practitioners about the impact of some of these impairments, but overall this approach (specified examples) is probably one of the best ways to promote uniformity in the use of this basis code. (p. 15)

* * * * * * *

Initially, there was concern that examiners, with an additional documentation "burden," might opt for the "slight impairment" denial to avoid the detailed vocational documentation now required when adjudicating on a "more-than-slight" impairment basis. While this may have begun to occur, it did not continue on a sustained basis, primarily because of the advent of the SPAR program in 1/77. Second tier feedback in the form of 2052's ("returns" outlining the deficiency but without the accompanying case) included basis code errors and increased emphasis on/and delineation of sequential analysis, the first step of which is to determine severity level.

It is not without reason, then, that the big jump in "slight impairment" denials occurred between 1976 and 1977 and continued to rise in 1978. Examiners began to look more carefully at severity level for it meant more or less work for them depending on whether the impairment was "slight" or "more than slight." Also, the 2052 basis code "returns" continued to come in and Q/A, taking its cue from this feedback, began to carefully monitor the application of sequential analysis. With the new DISM VII (Quality Assurance Instructions) (7/78), the State agency chief medical consultant now reviews many more claims than before and, for each, he notes his severity rating. We are now being trained and are learning to differentiate, not between an allowance and a denial, but among six levels of severity as the first step in sequential analysis, leading to sounder and more uniform decisions. (p. 16)

* * * * * * *

A number of States see problems with the growth in "slight impairment" denials. One administrator wrote:

We must also admit that use of this basis code has been inflated by both conscious and habitual examiner actions to

avoid vocational development. There has been an increased emphasis on vocational factors over the past several years. Documentation requirements are perceived as excessive. In fulfilling the criteria, the time demand and complexity of documenting vocational issues is burdensome. Then, despite valid efforts, the chances of a deficiency citation are great since the expectations are so detailed. Also, assessments of residual functional capacity are extremely judgmental and represent another area of high-error probability, The obvious solution for the examiner is to use the "slight impairment" basis and thereby avoid the questions of residual capacity and vocational factors altogether.

Certainly this practice is discouraged administratively and has been reduced; however, the method is still there and does influence borderline cases. The ramifications are severe. It reflects an absence of sequential analysis since the claim is prejudged to be a denial and then the absence of functional loss is ascribed. It has not been our experience that decisional errors frequently occur as a result of this practice, yet we cannot deny that potential. (p. 15)

* * * * * * *

As shown above, the statistics relating to cessations show an impressive increase. In 1975 only 31.2 percent of continuing disability investigations (CDIs) were resulting in cessations of disability. By 1978 this had grown to 50.8 percent. The State administrators generally shared the same explanations for this development. They referred to increased documentation of cases and the return of cases to the State agencies as the result of Federal quality assurance review. In addition the 100 percent review of continuances which was in effect at times during the period is said to have had a major effect. One State agency administrator summarized the factors as follows:

The increase in the number of cessations seems to be an interplay of three factors: (a) The approach to CDI cases is now much different than in earlier years. [State agencies] are now developing CDI cases much the same way that initial claims are handled. This results in a great decrease in the number of "no CDI issue" continuances. (b) Many cases that were allowed during the trauma period following implementation of the SSI program are now being reviewed under a more careful approach. (c) The increased documentation requirements previously mentioned also apply in CDI cases. Incidentally, a greater overall percentage of these cases are being reviewed by all three tiers of the review system.

I would be reluctant to place a great deal of weight on one other factor as far as the national picture is concerned—but it needs to be mentioned. Many cases being ceased by the [State agencies] are cases which were allowed at the hearing level with less objectivity than the [State agencies] uses. I do not wish to belabor the issue of ALJ adjudication, but I would like to again make the plea that all components—BHA included—be required to follow the same guidelines if we are handling claims under the same regulations. We are seeing an

> increasing ground swell of attorneys who seem to specialize in disability cases, and who do everything possible to impede handling of claims by the [State agencies] so that they can get the claim denied and escalated to the hearing level. They are aware that having a claim reviewed from a subjective rather than objective standpoint enhances the chances for a favorable decision. (p. 17)

Nearly all the administrators also pointed to the elimination in July 1976 of the requirement that "medical improvement" had to be shown before the State agency could terminate a case. The need to show medical improvement had long been cited as a problem because some administrators felt that they were being forced by that requirement to continue people on the rolls who should not have been awarded benefits in the first place.

Most of the above comments echo those heard by the staff of the Finance Committee in its discussions in the last two years with Federal and State disability administrators. They tend to confirm the crucial importance of administrative factors in the disability programs, and the sensitivity of the disability rolls to what might appear to be technical changes in requirements.

VIII. Pending Legislation

A. General Description

There are a number of bills amending the disability insurance and supplemental security income programs which will be of interest to the committee in any consideration of disability legislation.

The House of Representatives has passed H.R. 3236, the Disability Insurance Amendments of 1979, providing changes in the DI program which are designed to remove disincentives to employment. The House-passed bill is similar in a number of respects to the disability insurance amendments proposed in the 96th Congress by the Administration. Both include provisions for a "cap" on family benefits, as well as other provisions aimed at encouraging the disabled to return to work. These additional provisions would (1) permit a deduction of extraordinary impairment-related work expenses in determining whether an individual is performing substantial gainful activity, (2) extend the trial work period from 9 to 24 months and make the same trial work period applicable to disabled widow(er)s, (3) extend medicare coverage for an additional 36 months after cash benefits cease for individuals who have not medically recovered but have returned to substantial gainful work, (4) eliminate the second 24-month waiting period for medicare which a beneficiary presently must undergo if he returns to work but subsequently must return to the disability rolls, and (5) authorize demonstration projects to test ways to stimulate a return to work by disability beneficiaries. (These latter provisions to encourage a return to work are also included in S. 1643, introduced by Senator Durenberger. S. 1643 does not, however, include the provision for a "cap" on benefits.)

Both the House-passed bill and the Administration's bill include proposals affecting the administration of the disability programs, although these differ in a number of respects.

In addition the Senate has before it bills which amend the SSI disability program and which also are aimed at removing disincentives for disabled persons to seek employment. S. 591, introduced by Senator Dole, with Senator Moynihan, Bentsen, Ribicoff, Cranston, Danforth, Schweiker, and Javits as cosponsors, provides for special benefit status for persons who are determined to have a severe medical disability but lose eligibility for regular SSI benefits because they begin performing substantial gainful activity (earning more than $280 a month). Eligibility for this special status would be limited to those who meet or equal the Social Security Administration's medical listings for disability, and would not include individuals who meet the definition of disability on the basis of vocational factors. Cash benefits would be the same as provided for regular SSI recipients, and would phase out at $481 a month (at current benefit levels). Persons would be eligible for medicaid and social services up to this phaseout point, and could, depending on their particular circumstances, retain eligiblity for medicaid and social services beyond this level if they met certain criteria provided in the bill.

The provisions for special benefit status for persons who meet or equal the medical listings are somewhat similar to temporary provisions approved by the Finance Committee in the 95th Congress (H.R. 12972). However, the 95th Congress legislation was aimed primarily at protecting medicaid and social services eligibility for the severely disabled, and provided a special monthly payment of $10 a month rather than extending cash benefits on the same basis as for regular SSI recipients.

H.R. 3464, the Supplemental Security Income Amendments of 1979, as passed by the House is similarly aimed at assisting disabled individuals to undertake and continue employment. One of the major provisions of H.R. 3464 would expand current eligibility criteria for SSI recipients by changing the definition of what constitutes substantial gainful activity. The substantial gainful activity test for SSI eligibility would, in effect, be increased from its present level of $280 a month to a minimum of $481 for individuals ($689 in the case of a couple). Thus, an individual could be determined "not disabled" on the basis of his earnings only if they exceeded this amount. The SGA limit would be further increased by the cost of any impairment-related work expenses. The bill includes a number of other provisions affecting disabled SSI recipients, aimed both at encouraging a return to work and improved administration. The House-passed provisions are included in S. 1657, introduced by Senator Levin, with Senators Lugar, Durkin, Baucus, Hatch, Simpson, Sarbanes, Riegle, and Leahy as cosponsors. Identical provisions are included in a broader SSI bill, S. 1402, introduced by Senator Riegle.

(The Administration's draft disability bill referred to above also has provisions amending the SSI and medicaid programs. These provisions generally are written so as to coordinate the DI and SSI programs with respect to the trial work period, eligibility for medical benefits, and preservation of beneficiary status.)

S. 1203, introduced by Senator Bayh, would amend title II to eliminate the waiting period for benefits in the case of individuals who are terminally ill.

A more detailed description of these bills is provided below:

B. H.R. 3236, THE DISABILITY INSURANCE AMENDMENTS OF 1979

The stated major purpose of the bill is "to provide better work incentives and improved accountability in the disability insurance program." The House Committee on Ways and Means observes in its report on H.R. 3236 that "Recent actuarial studies in both the public and private sector have indicated that high replacement ratios (the ratio of benefits to previous earnings) have constituted a major disincentive to disabled people in attempting rehabilitation or generally returning to the work force."

Limit on family benefit.—In order to provide greater incentives to work, the House bill provides for a so-called "cap" on family benefits. The bill would limit total DI family benefits to an amount equal to the smaller of 80 percent of a worker's average indexed monthly earnings (AIME) or 150 percent of the worker's primary insurance amount (PIA). The 80 percent of AIME limitation has its major effect on wage earners at lower earnings levels; the 150 percent of PIA limitation would affect average and higher wage earners. Under the bill no family benefit would be reduced below 100 percent of the worker's primary benefit. The limitation would be effective only with respect to individuals becoming entitled to benefits on or after January 1, 1980, based on disabilities that began after calendar year 1978.

The 80 percent cap was adopted in response to the criticism that under present law family benefits often exceed 100 percent of a worker's average indexed monthly earnings. As the committee report points out, social security benefits are based on gross earnings, not earnings net of Federal and State taxes and work-related expenses. Thus, the 80 percent cap actually represents a higher percentage of "take-home" pay than would first appear.

The committee report argues that for workers at higher wage levels social security benefits should replace less than 80 percent of AIME. The reasons given are: at higher wage levels, concern for benefit adequacy is less, the likelihood of private supplementation is greater, and the discrepancy between gross earnings (upon which social security benefits are based) and predisability disposable earnings is greater than in the case of the lower paid worker. The 150 percent of PIA limitation is designed to produce family benefits for these higher paid workers that are less than 80 percent of AIME, with the percentage declining to about 50 percent of AIME at the highest earnings levels.

It is estimated that the limit on benefits would apply to 30 percent of newly entitled disabled workers. Seventy percent of those coming on the rolls do not have eligible dependents and thus would not be affected by the cap on family benefits. According to estimates, 123,000 disabled-worker families would be affected by the cap in the first year.

Reduction in dropout years.—Under current law, workers of all ages are allowed to exclude 5 years of low earnings in averaging their earnings for benefit purposes. In response to the argument that this gives an undue advantage to younger workers, the House bill provides for varying the number of dropout years according to the age of the worker. Under H.R. 3236, there would be no dropout years allowed for workers under age 27. The number of dropped years would gradually

increase to 5, as under present law, for workers age 27 and over, as follows:

Worker's age:	Number of dropout years
Under 27	0
27 through 31	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

In addition, the bill provides that if a worker provided principal care for a child under age 6 for more than 6 months in a calendar year that was a year of low earnings, that year could also be dropped (up to a total of 5 dropout years). This provision would become effective in January 1981. The Social Security Administration is directed to submit a report on how the provision would be implemented, with recommendations for any changes, by January 1, 1980.

Other provisions designed to encourage a return to work.—H.R. 3236 includes a number of provisions described in the report as being designed to "stimulate more disabled beneficaries to return to work despite their impairments." These are:

1. Permit a deduction of extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices, equipment, and drugs and services (necessary to control an impairment) from earnings for purposes of determining whether an individual is engaging in substantial gainful activity, regardless of whether these items are also needed to enable him to carry out his normal daily functions.

2. Extend the present 9-month trial work period to 24 months. In the last 12 months of the 24-month period the individual would not receive cash benefits, but could automatically be reinstated to active benefit status if a work attempt fails. The bill also provides that the same trial work period would be applicable to disabled widow(er)s. (Under present law, when the nine-month trial work period is completed, three additional months of benefits are provided. The bill does not alter this aspect of present law.)

3. Extend medicare coverage for an additional 36 months after cash benefits cease for a worker who is engaging in substantial gainful activity but has not medically recovered. (The first 12 months of the 36-month period would be part of the new 24-month trial work period.) Under present law medicare coverage ends when cash benefits cease.

4. Eliminate the requirement that a person who becomes disabled a second time must undergo another 24-month waiting period before medicare coverage is available to him. This amendment would apply to workers becoming disabled again within 60 months, and to disabled widow(er)s and adults disabled since childhood becoming disabled again within 84 months. In addition, where a disabled individual was initially on the cash benefit rolls but for a period of less than 24 months, the months during which he received cash benefits would count for purposes of qualifying for medicare coverage if a subsequent disability occurred within the aforementioned time periods.

5. Authorize waiver of certain benefit requirements of titles II and XVIII (medicare) to allow demonstration projects by the Social Security Administration to test ways in which to stimulate a return to work by disability beneficiaries.

Administration by State agencies.—The House bill would eliminate the provision in present law which provides for disability determinations to be performed by State agencies under an agreement negotiated by the State and the Secretary of HEW. Instead, the bill would provide for disability determinations to be made by State agencies in accordance with standards and criteria contained in regulations or other written guidelines of the Secretary. It would require the Secretary to issue regulations specifying performance standards and administrative requirements and procedures to be followed in performing the disability function "in order to assure effective and uniform administration of the disability insurance program throughout the United States."

The bill also provides that if the Secretary finds that a State agency is substantially failing to make disability determinations consistent with his regulations, the Secretary shall, not earlier than 180 days following his finding, terminate State administration and make the determinations himself. In addition to providing for termination by the Secretary, the bill provides for termination by the State. The State is required to continue to make disability determinations for 180 days after notifying the Secretary of its intent to terminate. Thereafter, the Secretary would be required to make the determinations.

Federal review of State agency determinations.—The bill would have the effect, over time, of reinstituting a review procedure used by SSA until 1972 under which most State disability allowances were reviewed prior to the payment of benefits. The bill provides for preadjudicative Federal review of at least 15 percent of allowances in fiscal year 1980, 35 percent in 1981, and 65 percent in years thereafter.

Periodic review of disability determinations.—Unless there has been a finding that an individual's disability is permanent, there would have to be a review of the case at least once every 3 years to determine continuing eligibility.

Claims and appeals procedures.—The bill includes a number of provisions relating to the adjudication and appeals process. These are:

1. Require that notices to claimants include a statement of the pertinent law and regulations, a list of the evidence of record, and the reasons upon which the disability determination is based.
2. Authorize the Secretary to pay all non-Federal providers for costs of supplying medical evidence of record in title II claims as is done in title XVI (SSI) claims.
3. Provide permanent authority for payment of the travel expenses of claimants (and their representatives in the case of reconsiderations and ALJ hearings) resulting from participation in various phases of the adjudication process.
4. Eliminate the provision in present law which requires that cases which have been appealed to the district court be remanded by the court to the Secretary upon motion by the Secretary. In-

stead, remand would be discretionary with the court, and only on motions of the Secretary where "good cause" was shown.

5. Continue the provision of present law which gives the court discretionary authority to remand cases to the Secretary, but add the requirement that remand for the purpose of taking new evidence be limited to cases in which there is a showing that there is new evidence which is material and that there was good cause for failure to incorporate it into the record in a prior proceeding.

6. Foreclose the introduction of new evidence with respect to an application after the decision is made at the administrative law judge hearing level. At the present time new evidence may be introduced until all levels of administrative review have been exhausted (through the Appeals Council).

7. Require the Secretary to submit a report to Congress by January 1, 1980, recommending appropriate case processing time limits for the various levels of adjudication.

Trust fund expenditures for rehabilitation.—Additional amendments are included which are intended to improve the effectiveness of rehabilitation services provided to DI beneficiaries by State vocational rehabilitation agencies. Present law authorizes an amount of up to 1.5 percent of disability insurance expenditures to be made available to rehabilitate title II beneficiaries under the beneficiary rehabilitation program. The House bill eliminates this special funding. The committee report justifies this change on the basis that the cost effectiveness of the provision has been questioned. The report cites a GAO study which estimated that for every $1 of rehabilitation expenditure, only $1.15 in savings is realized by the trust fund. The bill assumes that rehabilitation services for DI beneficiaries would be financed out of general revenues under the basic rehabilitation State grants program. However, it authorizes payment from the trust fund of a bonus to the States of an amount equal to twice the State share of the cost of services to DI beneficiaries which result in their performance of substantial gainful activity which lasts for a continuous period of 12 months, or which result in their employment for an equal period of time in a sheltered workshop. (The State share of the cost of rehabilitating individuals under the basic rehabilitation program is 20 percent.) This provision is intended to emphasize that the main purpose of trust fund expenditures for rehabilitation is to bring about benefit terminations.

Termination of benefits for persons in VR programs.—The House bill also provides that no DI beneficiary be terminated due to medical recovery if the beneficiary is participating in an approved VR program which the Social Security Administration determines will increase the likelihood that the beneficiary may be permanently removed from the disability rolls.

Cost estimates.—The following estimates of the effects of the bill have been provided by SSA actuaries. The estimates used are based on the so-called intermediate assumptions. The use of either the pessimistic or optimistic assumptions would produce different results.

TABLE 45.—ESTIMATED EFFECT ON OASDI EXPENDITURES, BY PROVISIONS OF H.R. 3236

[Pluses indicate cost, minuses indicate savings]

Provision [1]	Estimated effect on OASDI expenditures in fiscal years 1980–84 [2] (in millions)					Estimated effect on long range OASDI expenditures as percent of taxable payroll [2,3]
	1980	1981	1982	1983	1984	
Limitation on total family benefits for disabled-worker families (sec. 2)—						
Benefit payments	−$38	−$146	−$263	−$392	−$525	.....
Administrative costs	[4]	[4]	[4]	[4]	[4]	.....
Total	−38	−146	−263	−392	−525	−0.09
Reduction in number of dropout years for younger disabled workers (sec. 3)—						
Benefit payments	−12	−46	−89	−139	−194	.....
Administrative costs	[4]	+1	+1	+1	+1	.....
Total	−12	−45	−88	−138	−193	−.04
Deduction of impairment-related work expenses from earnings in determining substantial gainful activity (sec. 5)—						
Benefit payments	+1	+2	+5	+9	+13	.....
Administrative costs	[4]	[4]	[4]	[4]	[4]	.....
Total	+1	+2	+5	+9	+13	+.01
Federal review of State agency, allowances (sec. 8)—						
Benefit payments	−3	−20	−73	−133	−198	.....
Administrative costs	+7	+13	+16	+17	+17	.....
Total	+4	−7	−57	−116	−181	−.06
More detailed notices specifying reasons for denial of disability claims (sec. 9)—						
Benefit payments	[6]	[6]	[6]	[6]	[6]	.....
Administrative costs [7]	+13	+20	+21	+22	+23	.....
Total	+13	+20	+21	+22	+23	[8]

See footnotes at end of table.

TABLE 45.—ESTIMATED EFFECT ON OASDI EXPENDITURES, BY PROVISIONS OF H.R. 3236—Continued

[Pluses indicate cost, minuses indicate savings]

Provision [1]	Estimated effect on OASDI expenditures in fiscal years 1980–84 [2] (in millions)					Estimated effect on long range OASDI expenditures as percent of taxable payroll [2] [3]
	1980	1981	1982	1983	1984	
Limit trust fund payments for costs of vocational rehabilitation services to only such services that result in a cessation of disability, as demonstrated by a return to work (sec. 13)—						
Trust fund payments			−$42	−$83	−$86	.....
Administrative costs		([4])	([4])	([4])	([4])	.....
Total			−42	−83	−86	−.01
Payment for existing medical evidence and certain travel expenses (sec. 15 and 16)—						
Benefit payments	([6])	([6])	([6])	([6])	([6])	.....
Administrative costs [9]	+$17	+$21	+22	+23	+24	.....
Total	+17	+21	+22	+23	+24	([8])
Periodic review of disability determinations (sec. 17)—						
Benefit payments	−2	−25	−60	−100	−160	.....
Administrative costs [4]	+34	+40	+42	+43	+45	.....
Total	+32	+15	−18	−57	−115	−.03
Benefit payments	−54	−235	−480	−755	−1,064	.....
Payments for costs of vocational rehabilitation services			−42	−83	−86	.....
Administrative costs	+71	+95	+102	+106	+110	.....
Total net effect on OASDI trust fund expenditures	+17	−140	−420	−732	−1,040	−.21

[1] The benefit estimates shown for each provision take account of the provisions that precede it in the table.
[2] Estimates are based on the intermediate assumptions in the 1979 trustees report.
[3] The estimated change in long-range average expenditures represents the total net change in both benefits and administrative expenses over the next 75 yr.
[4] Additional administrative expenses are less than $1,000,000.
[6] None.
[7] Assumes short concise statement and applies only to DI claims.
[8] Less than 0.005 percent.
[9] Additional expenditures for the payment of certain travel expenses amount to less than $1,000,000 in each year.

Note: The above estimates are based on assumed enactment of H.R. 3236 in December 1979.

Source: Social Security Administration, Oct. 8, 1979.

TABLE 46.—LONG-RANGE COST ESTIMATES FOR THE PROVISIONS OF H.R. 3236 ASSUMING EFFECTIVE DATE OF JAN. 1, 1980: ESTIMATES SHOWN FOR EACH PROVISION TAKE INTO ACCOUNT INTERACTION WITH PROVISIONS THAT PRECEDE IN THE TABLE

	Estimated long-range cost as percent of taxable payroll based on 1979 trustees report's intermediate assumptions		
	OASI	DI	HI [1]
1. Limit total DI family benefits to the smaller of 80 percent of AIME or 150 percent of PIA. No family benefits would be reduced below 100 percent of worker's PIA	(2)	−0.09	(2)
2. Compute DI benefits using one dropout year for each 5 full elapsed years. However, if the worker provided principal care of a child (own child or spouse's) under age 6 for more than 6 mo in any calendar year which is included in the worker's elapsed years, the number of dropout years is increased by 1 for each such calendar year. The maximum number of dropout years allowed is 5. Continued application of this provision for retirement benefits when disabled worker attains age 65 but not for survivor benefits when he dies. (Child care dropout provision effective Jan. 1, 1981)	(2)	−.04	(2)
3. Exclude from earnings used in determining ability to engage in SGA the cost to the worker of any extraordinary work related expenses due to severe impairment including routine drugs and routine medical services	(2)	.01	(2)
4. Provide trial work period for disabled widows/widowers	(2)	.....	(2)
5. For any disabled worker, widow(er), or child who engages in substantial gainful activity within 13 mo after the completion of the trial period (TWP) DI benefits are terminated after the 15th mo following completion of the TWP. Suspend DI benefits for any month during the 15 mo following completion of the TWP in which the beneficiary engages in substantial gainful activity, excluding the 1st 3 such months	(2)	(2)	(2)
6. Extend medicare coverage for 24 mo after SGA termination following the completion of a trial work period	(2)	(2)	(2)
7. Eliminate the requirement that months in the medicare waiting period be consecutive for persons returning to beneficiary status within 60 mo of termination. (84 mo for disabled children or disabled widows/widowers)	(2)	(2)	.....
Proposals 6 and 7 combined	(2)	(2)	+0.01
8. Provide that determinations of disability be made by secretary or by State agency pursuant to an agreement with the secretary. The Federal-State agreement is optional and could be terminated by either State or secretary. Provide that secretary alone determine reimbursement to State for actual costs of making disability determinations	(2)	(2)	(2)

See footnotes at end of table.

TABLE 46.—LONG-RANGE COST ESTIMATES FOR THE PROVISIONS OF H.R. 3236 ASSUMING EFFECTIVE DATE OF JAN. 1, 1980: ESTIMATES SHOWN FOR EACH PROVISION TAKE INTO ACCOUNT INTERACTION WITH PROVISIONS THAT PRECEDE IN THE TABLE—Continued

	Estimated long-range cost as percent of taxable payroll based on 1979 trustees report's intermediate assumptions		
	OASI	DI	HI[1]
9. SSA preadjudicative review of at least 65 percent of State agency initial determinations (allowances only), fully effective in fiscal year 1982	(2)	−0.06	−0.01
10. Provide claimant with written summary of evidence used in making disability determination	(2)	(2)	(2)
11. Provide that the Secretary's authority to remand a court case to the ALJ be discretionary with the court upon a showing of good cause by the secretary. Require that the court may remand only on a showing that there is new evidence which is material, and that there was good cause for failure to incorporate it into the record in a prior proceeding.	(2)	(2)	(2)
12. For any person whose disability ceases as a result of rehabilitation (as demonstrated by 12 continuous months of employment either at the level of SGA or in a sheltered workshop), the DI trust fund will reimburse the U.S. Treasury the Federal share of the VR cost for that person. No DI trust fund reimbursement will be made otherwise	(2)	−.01	(2)
13. Provide that no beneficiary be terminated due to medical recovery if the beneficiary is participating in an approved VR program which SSA determines will increase the likelihood that the beneficiary may be permanently removed from the disability benefit rolls	(2)	(2)	(2)
14. Require secretary to pay all non-Federal providers for costs of supplying medical evidence of record in title II disability claims	(2)	(2)	(2)
15. Authorize payments from DI trust fund for claimant's travel expenses resulting from undergoing a medical exam required by Secretary. Pay for travel expenses of claimants, representatives, and witnesses in attending reconsideration interviews and hearings			
16. Require State agency or secretary to review the cases of disability beneficiaries at least once every 3 yr for purposes of determining continuing eligibility. If the beneficiary's disability is determined to be permanent, the periodic review is not required	(2)	−.03	(2)
Total for H.R. 3236[3]	(2)	−.21	−.01

[1] 25-yr average cost.
[2] Less than 0.005 percent.
[3] Due to rounding separate estimates for the provisions may not add to the total.

Source: Social Security Administration.

C. Disability Insurance Reform Act of 1979, as Proposed by the Administration

The Administration's disability amendments are expressly aimed at targeting expenditures for disability insurance benefits "in a manner more specifically directed to achieve the purposes of the program," to remove disincentives for the disabled to engage in gainful activity, and to make administrative improvements. The draft bill would amend both title II (disability insurance) and title XVI (supplemental security income program) of the Social Security Act.

In the March 12, 1979, letter to the Congress which accompanied the Administration's draft disability bill, the Secretary of HEW stated that "The cost of the disability insurance program has grown in the last decade and serious and legitimate questions about the wage replacement rate feature of the benefit structure continue to be voiced. Since the inception of the disability insurance program in 1956, disability insurance (DI) and old-age and survivors insurance (OASI) benefits have been calculated using the same formula. One result has been that, for a significant minority of the caseload, that rate at which benefits replace wages is extremely high; approximately 16 percent of the disability caseload has wage replacement rates in excess of 80 percent of disposable earnings, and for 6 percent that rate exceeds 100 percent."

Limit on family benefit.—In response to this criticism, the Administration bill provides for a "cap" on family benefits. There would be a limit of 80 percent of the individual's average indexed monthly earnings (AIME) as the maximum amount of total benefits that could be paid to the family (the individual and his dependents) on the basis of the worker's earnings record. (The House bill provides for the smaller of 80 percent of AIME or 150 percent of the primary insurance amount (PIA)). Current law, which would remain unchanged for those entitled to old-age and survivors insurance benefits, has higher limits. The provision would be effective only with respect to individuals becoming entitled to benefits after August 1979, based on disabilities that began after calendar year 1978.

Reduction in dropout years.—Under current law, workers of all ages are allowed to exclude 5 years of low earnings in averaging their earnings for benefit purposes. The Administration's bill, like the House bill, provides for varying the number of dropout years according to the age of the worker. Under both proposals, there would be no dropout years allowed for workers under age 27. The number of dropped years would gradually increase to 5, as under present law, for workers age 27 and over. In presenting this proposal, the Administration observed that "The proposal would bring the benefits of young disabled workers more into line with those provided to older workers." It would apply to workers becoming disabled after 1978, and entitled for months after August 1978.

Other provisions designed to encourage a return to work.—The Administration's proposal includes a number of provisions designed to eliminate disincentives to engage in substantial gainful activity and encourage a return to work. A number of these are similar or identical to provisions in H.R. 3236, as reported by the Ways and Means Committee (although H.R. 3236 omits any provisions affecting the SSI and medicaid programs):

1. Eliminate the requirement that a person who becomes disabled a second time must undergo another 24-month waiting period before medicare coverage is available to him. This amendment would apply to workers becoming disabled again within 60 months, and to disabled widow(er)s and adults disabled since childhood becoming disabled again within 84 months. In addition, where a disabled individual was initially on the cash benefit rolls but for a period of less than 24 months, the months during which he received cash benefits would count for purposes of qualifying for medicare coverage if a subsequent disability occurred within the aforementioned time period.

2. Extend the present 9-month trial work period to 24 months. In the last 12 months of the 24-month period the individual would not receive cash benefits, but could automatically be reinstated to active benefit status if a work attempt fails. The bill also provides that the same trial work period would be applicable to disabled widow(er)s. (See description of this provision in H.R. 3236.)

3. Extend medicare coverage for an additional 36 months after cash benefits cease for a worker who is engaging in substantial gainful activity but has not medically recovered. Under present law medicare coverage ends when cash benefits cease.

4. Provide that the extension of the trial work period, described in (2) above, would also apply to persons receiving benefits under the SSI program.

5. Provide for an extension of medicaid coverage for SSI recipients for an additional 36 months, under the same circumstances as are applicable to DI beneficiaries in (3) above.

6. Require that in determining whether an individual's earnings constitute substantial gainful activity, there must be excluded amounts spent by the individual for attendant care, or other items or services that he needs, because of his impairment, to engage in gainful activity. If care or services necessary to enable him to work are furnished without cost to him the Secretary will specify the amount of the deduction with respect to that care or service that is to be made for purposes of determining ability to engage in SGA. The same amounts are to be excluded for DI and SSI in the case of a person receiving benefits under both programs. These amounts are to be excluded even though the care or service may also be necessary to enable the individual to carry out his normal daily functions. The bill also provides the same exclusion for applicants and recipients under title XVI for purposes of determining SGA. In addition, if the blind or disabled individual pays the costs of these services or items himself, these amounts will be deducted in determining the amount of the SSI benefit. The Secretary is directed to prescribe the types of work-related expenses that may be deducted, and to set limits on the amounts of the deductions.

7. Require the Secretary to review the above amendments and report to the Congress, after 5 years, concerning their effectiveness in encouraging disabled individuals to return to substantial gainful activity.

Administration by State agencies.—The Administration bill, like the House bill, would eliminate the provision in present law which pro-

vides for disability determinations to be performed by State agencies under an agreement negotiated by the State and the Secretary of HEW. Instead, the provisions of the Administration's bill, which were adopted by the House, would provide for disability determinations to be made by State agencies in accordance with standards and criteria contained in regulations or other written guidelines of the Secretary. It would require the Secretary to issue regulations specifying performance standards and administrative requirements and procedures to be followed in performing the disability function "in order to assure effective and uniform administration of the disability insurance program throughout the United States."

The bill also provides that if the Secretary finds that a State agency is substantially failing to make disability determinations consistent with his regulations, the Secretary shall, not earlier than 180 days following his finding, terminate State administration and make the determinations himself. In addition to providing for termination by the Secretary, the bill provides for termination by the State. The State is required to continue to make disability determinations for 180 days after notifying the Secretary of its intent to terminate. Thereafter, the Secretary would be required to make the determinations.

Federal review of State agency decisions.—The Administration's bill would allow the Secretary to review and revise State agency disability determinations to make the findings either more or less favorable to the claimant. Under present law, the Secretary may review only allowances, and not denials.

Limit on introduction of new evidence.—The Administration's bill (like H.R. 3236) would amend present law to foreclose the introduction of new evidence with respect to an application after the decision is made at the administrative law judge hearing level. At the present time new evidence may be introduced until all levels of administrative review have been exhausted (through the Appeals Council).

Research and Demonstration projects.—The Administration's bill contains provisions similar to those in the SSI and DI bills approved by the House which would authorize the Secretary to waive certain requirements under titles II, XVI, and XVIII in order to carry out experimental or demonstration projects.

Judicial review.—Under the Administration's bill the Secretary's determinations with respect to facts would be final; court review would be limited to questions of statutory and constitutional interpretation. Present law provides that the findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive. The Administration's bill would delete the substantial evidence requirement. This would apply to decisions under both the DI and SSI programs.

Deeming of parents' income to disabled or blind children.—For purposes of SSI eligibility determination, the "deeming" of parents' income would be limited to disabled or blind children under age 18 regardless of student status. This provision is similar to one adopted by the Finance Committee in H.R. 7200, 95th Congress, and to a provision in H.R. 3464, as passed by the House in the 96th Congress. However, the House bill also provides that those individuals through 21 who are receiving benefits at the time of enactment would be protected against loss of benefits due to this change.

D. S. 591, Introduced by Senators Dole, Moynihan, Bentsen, Ribicoff, Cranston, Danforth, Schweiker, and Javits

S. 591 amends title XVI (the supplemental security income program) with respect to benefits for disabled recipients who have earnings from gainful employment. The purpose of the bill is to assist severely handicapped individuals to undertake and continue employment.

Benefits for individuals who perform substantial gainful activity despite severe medical impairment.—Under present law an individual qualifies for SSI disability payments only if he is "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The Secretary of HEW is required to prescribe the criteria for determining when services performed or earnings derived from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA). For 1979, the level of earnings established by the Secretary for determining whether an individual is engaging in substantial gainful activity is $280 a month. Thus, when an individual has earnings (following a 9-month trial work period) which exceed this amount, he loses eligibility for cash benefits, and may also lose eligibility for medicaid and social services.

S. 591 provides that for persons who are determined to have a severe medical disability, but cease to be eligible for regular SSI benefits because they are performing substantial gainful activity, special benefits could be paid until earnings reach the SSI breakeven point, $481 a month. These special benefits would be paid only to those who are determined to meet or equal the social security disability medical listings, without regard to consideration of vocational factors (such as age, education, or work experience). The amount of the special cash benefits would be reduced as earnings increase. Persons who received these special benefits would be eligible for medicaid and social services on the same basis as regular SSI beneficiaries. States would have the option of supplementing the special Federal benefits.

The bill also would allow continuation of medicaid and social services beyond the breakeven point ($481) if the Secretary of HEW determined that the termination of eligibility for these benefits would seriously inhibit the individual's ability to continue his employment, and if his earnings were not sufficient to allow him to provide for himself a reasonable equivalent of the cash and other benefits that would be available to him in the absence of earnings.

This provision is similar to a temporary provision approved by the committee in 1978 in H.R. 12972. However, H.R. 12972 limited the cash benefit to $10 a month and was aimed primarily at preserving eligibility for medicaid and social services.

Exclusion of certain work expenses in determining SGA.—S. 591 includes a provision, similar to provisions in the House-passed bills, H.R. 3236 and H.R. 3464, which require that in determining whether an individual is performing substantial gainful activity, there shall be excluded the cost of attendant care services, medical devices, equipment, or prostheses, and similar items and services (not including routine drugs or other routine medical care and services) which are necessary in order for the individual to work, whether or not these items are also needed to enable him to carry out his normal daily

functions. S. 591 specifies, in addition, that the Secretary of HEW shall determine those items and services which may be excluded under this provision.

Presumptive disability.—The bill allows a person who was once disabled for purposes of either title II or title XVI to be considered presumptively disabled if he leaves the rolls as a result of performing substantial gainful activity, but reapplies for benefits within a 5-year period. Benefits paid to a person who was subsequently determined not to be disabled would be subject to recovery.

Earned income in sheltered workshops.—Under the bill, earnings received in sheltered workshops and work activities centers would be considered as earned income, rather than unearned income for purposes of determining SSI benefits. This would assure that individuals with earnings from these kinds of activities would have the advantage of the earned income disregards provided in law for earnings from regular employment. The committee approved an identical provision in H.R. 7200, 95th Congress.

Cost estimates.—CBO has estimated the cost of the bill to be $5 million in fiscal year 1980, increasing to $11 million the following year as the provisions are fully implemented.

E. H.R. 12972, 95TH CONGRESS, AS REPORTED BY THE COMMITTEE ON FINANCE

Benefits for individuals who perform substantial gainful activity despite severe medical impairment.—As described under S. 591, present law provides that an individual who has earnings of $280 a month or more loses eligibility for SSI benefits, regardless of his impairment. This is the dollar amount of earnings considered under present regulations to constitute "substantial gainful activity," which is the basic test for whether an individual is disabled. Under the bill reported by the committee last year, a severely medically disabled individual (who meets or equals the Social Security Administration's medical listings) who loses his eligibility for regular SSI benefits because of performance of substantial gainful activity would become eligible for a special $10 monthly benefit. Eligibility for the benefit would be considered to be the same as eligibility for SSI for purposes of maintaining the individual's medicaid and social services coverage.

The special SSI benefit and the concomitant eligibility for other programs would continue until the individual's earnings reached the point at which his benefit amount would have been reduced to zero under the regular benefit computation formula ($481 at the present time). When the severely disabled individual's income exceeded the amount which would cause a regular benefit to be reduced to zero, the special benefit would be terminated unless the Secretary found (1) that the termination of the cash benefits and the loss of medicaid and social services eligibility would make it impossible for the individual to retain his employment; and (2) that the individual's earnings did not provide at least an equivalent of the combined benefits he would otherwise receive from the SSI, medicaid, and social services programs.

Disregard of attendant care costs in determining SGA.—The bill provides that if an individual has a functional limitation which requires that he have personal assistance in order to work, the amount which he must pay for attendant care will be disregarded in determin-

ing whether his earnings constitute substantial gainful activity. This disregard will apply even if the attendant care is necessary to enable him to carry out his normal daily functions.

The above provisions were to be implemented on a trial basis, expiring at the end of three years.

Cost estimate.—CBO estimated outlays of $1 million in the first year of the bill (fiscal year 1979), $2 million in the second year, and $3 million in the third year.

F. H.R. 3464, Supplemental Security Income Amendments of 1979, as Passed by the House

H.R. 3464 amends title XVI (the supplemental security income program) with respect to disabled recipients who have earnings from gainful employment. The stated major purpose of the bill is to assist disabled individuals to undertake and continue employment.

The determination of substantial gainful activity.—As described under S. 591, present law provides that an individual who has earnings of $280 a month or more loses eligibility for SSI benefits, regardless of his impairment. This is the dollar amount of earnings considered under present regulations to constitute "substantial gainful activity," which is the basic test for whether an individual is disabled.

Under H.R. 3464 an individual could be found "not disabled" on the basis of his earnings capacity only if he were unable to earn as much as $481 for a single individual, and $690 for an eligible couple. (Any future automatic cost-of-living increases in the Federal SSI benefit would automatically increase the current basic SGA amounts.) These amounts would be further increased by the amount of any impairment-related work expenses. Thus the SGA level would vary from individual to individual depending on his impairment-related work expenses and on his marital status. A single individual with monthly expenses of $150 would have an SGA level of $631 a month or $7,572 a year. If this same individual had an eligible spouse his SGA level would be $840 a month or $10,080 a year.

The effect of H.R. 3464 is to modify the SSI definition of disability by changing the definition of what constitutes substantial gainful activity. For individuals with severe disabilities which meet or equal SSA's medical listings, or who qualify on the basis of vocational factors, the increase in the SGA level would permit them to obtain employment at a higher level of earnings than is now possible without losing their entitlement to SSI benefits. It would also permit initial eligibility for any such severely disabled individuals who are not now eligible because they are, in fact, performing work at levels above the level of substantial gainful activity.

The determination of the benefit amount.—Present law provides that in determining eligibility for and the amount of SSI benefits, there shall be excluded the first $65 of monthly earnings, plus 50 percent of earnings above this amount. The $65 a month exclusion was established as a standard amount to take account of work expenses of all aged, blind and disabled recipients with earnings. These disregard provisions have the effect of establishing a Federal SSI breakeven point of $481 for an individual and $690 for an eligible couple. If an aged or disabled individual (or couple) has earnings above the breakeven point, he is not eligible for any Federal benefit. However, blind recip-

ients are, in addition, entitled to a disregard of individual itemized amounts spent as work expenses. This provision has the effect of raising the breakeven point for blind persons who have work expenses, thus increasing the amount of earnings that a blind individual may have and still retain SSI eligibility.

H.R. 3464 provides that, for the disabled, a standard work-related expense disregard equal to 20 percent of gross earnings would be allowed in determining the monthly SSI payment. In addition, impairment-related work expenses which are paid for by the individual would be disregarded. For purposes of determining the benefit amount, amounts of earnings would be disregarded as follows: (1) the first $65 of monthly earnings, (2) 20 percent of gross earnings, (3) impairment-related work expenses paid for by the individual, and (4) 50 percent of any remaining monthly earnings.

Disability status without SSI payments and presumptive disability determination.—Under H.R. 3464, a disabled SSI recipient would be allowed to retain disability status, without receiving SSI payments, for 12 months following termination of SSI benefits due to earnings in excess of the SGA limit. During this 12 month period, a person could immediately requalify for SSI payments if necessary because of a loss of or reduction in earnings. This 12 month period during which the individual would maintain disability status without SSI payments would follow the 9 month "trial work period," plus the 3 months allowed before actual termination of payments, provided under present law.

In addition, a person who loses title II (disability insurance) or SSI disability status due to earnings in excess of the SGA limit would be considered presumptively disabled if he reapplies for SSI benefits within four years following the loss of disability status. Such an individual would begin receiving SSI payments immediately upon a determination that he meets the income and assets tests and would continue to receive benefits unless and until it was determined that the disability requirements were not met.

In addition to the changes in the SSI disability program, the bill contains the following provisions:

SSI Demonstration Projects.—The Secretary of HEW would be authorized to conduct experimental, pilot or demonstration projects which, in his judgment, are likely to promote the objectives or improve the administration of the SSI program. The Secretary, however, would not be authorized to carry out any project that would result in a substantial reduction in any individual's total income and resources as a result of his participation in the project. The Secretary could not require any individual to participate in a project and would have to assure that the voluntary participation of individuals in any project is obtained through an informed written consent agreement which satisfies requirements established by the Secretary. The Secretary would also have to assure that any individual could revoke at any time his voluntary agreement to participate.

Deeming of Parents' Income to Disabled or Blind Children.—For purposes of SSI eligibility determination, the "deeming" of parents' income would be limited to disabled or blind children under 18 regardless of student status. Those individuals through 21 who are receiving benefits at the time of enactment would be protected against loss of benefits due to this change.

Decision Notices for SSI Applicants.—The Secretary of HEW would be required to provide SSI applicants with a decision notice containing a citation of the pertinent law and regulations, a summary of the evidence, and the reasons for the decision on their application.

SSI Payments During Participation in Rekabilitation Program.—An SSI beneficiary could not be terminated due to medical recovery while he is participating in an approved vocational rehabilitation program which the Social Security Administration determines will increase the likelihood that the person may be permanently removed from the disability benefit rolls.

Cost estimates.—According to the Congressional Budget Office, outlays for SSI and medicaid benefits under the House bill would be increased by $7 million in fiscal year 1980 (the bill becomes effective only in the last quarter of the year), increasing to $63 million in 1981, $118 million in 1982, $149 million in 1983, and $158 million in 1985. Most of these costs are attributable to the increase in the SGA level. In submitting its estimate for H.R. 3464, the Congressional Budget Office cited the problems it had in developing the estimate, noting "paucity of information" and difficulty in predicting behavioral response of either recipients or administrators. It cautioned that under certain circumstances "the cost estimates here could be significantly understated." The CBO statement which is included in the Ways and Means Committee Report on H.R. 3464 is quoted here in full:

> Cost estimates involving disability determinations are difficult and seldom precise. There is a paucity of information available on current disabled recipients and even less information is available on the potentially eligible recipients. In addition, it is difficult to predict the behavioral response of either recipients or administrators. This cost estimate has made no adjustment for three potentially important factors because of a lack of detailed information on which to base an adjustment. First, no adjustment has been made to reduce costs because of increased work response of current recipients to the increased work incentives provided in this bill. Second, no decreased work response has been calculated for those who might work less in an attempt to become eligible for either SSI or disability insurance. Finally, the estimate implicitly assumes no change in the medical or vocational factors currently used to determine disability. If the medical listings or vocational factors are liberalized as a result of the increase in the SGA limit, the costs estimated here could be significantly understated. (p. 38)

In addition to the difficulty of estimating the direct costs of the provision for the SSI program, there is also a question of its impact on the title II disability insurance program. While H.R. 3464 changes the meaning of "substantial gainful activity" only with respect to the SSI program, the same term is used—without legislative definition—in the title II program. Apart from the costs which would be involved if the Department found it necessary or desirable to modify the title II meaning of that term to conform to that in H.R. 3464, the actuarial office of the Social Security Administration estimates some spill-

over impact on the costs of that program, as is indicated in the memorandum below.

SEPT. 26, 1979.

MEMORANDUM FROM FRANCISCO R. BAYO, DEPUTY CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION, ON EFFECT OF H.R. 3464 ON DI COSTS

H.R. 3464 (Corman bill), which modifies the substantial gainful activity (SGA) amount for title XVI (SSI), will have a significant effect on DI costs. There are two reasons for this. The first is that some workers who are impaired enough to qualify under the definition of disability in present law but who nevertheless have not applied for benefits can more easily become entitled to DI benefits under the bill. The second reason is that the proposed change in the SGA concept for the SSI program implies a liberalization of the definition of disability for that program, which will ultimately also affect the definition of disability for the DI program.

With respect to the first reason, we think that under present law there is a significant number of workers who have not applied for disability benefits even though they are impaired enough to be found disabled. Their current earnings are substantially above the present law SGA levels, and they are not sure that their impairment is severe enough for them to qualify for benefits if their earnings were lower. Under present law, in order to become entitled to disability benefits, these individuals would have to leave their jobs (which they might be unable to get back) and file an application for benefits (which as far as they know could be denied). It is our opinion that many of them perceive the financial risks of trying to become entitled to benefits as being too high and prefer to continue working even though they are highly impaired.

The bill, with its proposed changes in SGA, would allow a large portion of these workers to apply and become eligible to SSI disability benefits with little or no change in their work or earnings patterns. Once these workers are eligible to receive SSI disability benefits their perception about their own situation could change significantly. They will recognize that there is little financial risk in allowing their earnings to drop since they are assured that a large portion of the drop in their earnings will be replaced by the SSI program. For some, their earnings will eventually drop enough for them to qualify under the DI program. Of those, there are some who will become entitled earlier than under present law, and there are others who under present law would not have become entitled to DI benefits at any time. Therefore, some DI costs will be generated by the bill that would not be incurred under present law.

With respect to the second reason we think that there are two important ideas that need to be understood. One is that the SGA concept is an integral part of the definition of disability. There are many who erroneously translate the SGA concept into the idea of "allowable earnings". However,

the SGA dollar level was developed and is primarily applied under present law as an administrative tool that assists in the determination of whether a person is or is not disabled. In addition, many people erroneously equate disability with an impairment. However, the definition of disability requires first an inability to engage in substantial gainful activity (SGA) and second that such inability be due to an impairment. Therefore, a change in what constitutes SGA is clearly a fundamental change in the definition of disability. Consequently, since the bill proposes a change in the SGA concept for SSI, it is also proposing a change in the definition of disability for SSI.

The second idea which needs to be understood is that the SGA concepts and the definitions of disability under the SSI and DI programs are highly interrelated. To date, the same adjudicators have administered both programs in the same way and have applied the same definition of disability. Under the bill, the situation will still be the same, except that the SGA concepts and hence the definitions of disability under the two programs will be different. We see this as posing a practical problem in the administration of the programs. Although we are not sure how this will be resolved, our best judgment is that the liberalizations in the SSI program under the bill will lead to a more liberal DI program, which will result in additional DI costs.

Although no one can exactly predict how many individuals will be affected or what their additional DI benefits will be, on the basis of our judgment we estimate that the average long-range cost of the DI program will increase by 0.05 percent of taxable payroll (based on 1979 trustees reports intermediate assumptions). This would be equivalent to about $500 million in calendar year 1979. Most of this increase in costs is estimated to be due to the first reason stated above We are assuming that only small additional costs will arise due to the practical side effect of the liberalization of the definition of disability in the DI program. These small additional costs that are estimated are based on the assumption that the application of the definition of disability in the DI program will be carefully monitored. If not carefully monitored, there would be very large cost impact on the DI program. For example, if the modifications proposed in the bill were to be made applicable to DI the long-range program cost would increase by at least 0.70 percent of taxable payroll. This would be equivalent to at least $7 billion in calendar year 1979.

G. S. 603, Introduced by Senators Javits, Stafford, Chafee, Schweiker, and Hayakawa

S. 603 is aimed at preserving medicaid eligibility for persons who are severely disabled but do not meet the requirements for disability benefits under the SSI program because they are performing substantial gainful activity.

Specifically, the bill would amend title XIX to allow States to provide coverage under medicaid for "severely disabled individuals

who meet such criteria of medical severity of disability as the Secretary shall prescribe in regulations, notwithstanding such individuals' performance of 'substantial gainful activity' within the meaning of title XVI. . . ." No cost estimate is available.

H. S. 1203, Introduced by Senator Bayh

S. 1203 would amend the title II disability insurance program to provide that the waiting period for disability benefits shall not be applicable in the case of an individual suffering from a terminal illness. Present law requires a 5-month waiting period before benefits may be payable.

Under the bill, terminal illness would be defined as "a medically determinable physical impairment which is expected to result in the death of such individual within the next 12 months." The amendment would be effective with regard to applications made after the enactment of the bill, or before the month of enactment (1) if notice of the final decision of eligibility for disability has not yet been given to the applicant, or (2) if the case has been appealed to a U.S. district court.

The cost of this bill is discussed in the following memorandum of the Social Security actuary's office:

Memorandum From Steve Goss, Office of the Actuary, Social Security Administration on Effect of Eliminating the DI Waiting Period for the Terminally Ill

Senator Birch Bayh has drafted a bill that will eliminate the 5 month waiting period for disabled workers who are "terminally ill." Terminal illness is defined as "a medically determinable physical impairment which is expected to result in death . . . within the next 12 months."

The bill does not specify whether death must be expected to occur within 12 months of onset of disability or within 12 months of the disability determination. For the purpose of the cost estimates that follow in this note, it is assumed that death must be expected to occur within 12 months of onset of disability.

Due to the difficulty involved in predicting whether an illness will result in premature death, especially within a limited time of 12 months or less, the level of accuracy of determinations of terminal illness cannot be expected to be very good. It is expected that many persons will be found reasonably likely to die within 12 months of onset who will in fact survive the year. Similarly many persons will die within 12 months of onset who will not have been expected to do so. For persons who die unexpectedly, retroactive payments will be made for the up to 5 waiting period months during which they will actually have been entitled under this provision. However, it is assumed that for persons who survive unexpectedly, no return of benefits for the five months during which they were not entitled will be required.

The long-range DI program cost for this bill as drafted is estimated at .03 percent of taxable payroll. However, if bene-

fits for the waiting period months are only paid restrospectively following the death of the disabled worker when death occurs within 12 months of his onset date, the long-range DI cost is estimated at .01 percent of taxable payroll. These estimates are based on the intermediate assumptions of the 1979 trustees reports.

I. S. 1643, Introduced by Senator Durenberger

S. 1643 includes the following provisions designed to encourage disabled title II beneficiaries to return to work despite their impairments. These provisions would:

1. Permit a deduction of extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices, equipment, and drugs and services (necessary to control an impairment) from earnings for purposes of determining whether an individual is engaging in substantial gainful activity, regardless of whether these items are also needed to enable him to carry out his normal daily functions.

2. Extend the present 9-month trial work period to 24 months. In the last 12 months of the 24-month period the individual would not receive cash benefits, but could automatically be reinstated to active benefit status if a work attempt fails. The bill also provides that the same trial work period would be applicable to disabled widow(er)s. (Under present law, when the nine-month trial work period is completed, three additional months of benefits are provided. The bill does not alter this aspect of present law.)

3. Extend medicare coverage for an additional 36 months after cash benefits cease for a worker who is engaging in substantial gainful activity but has not medically recovered. (The first 12 months of the 36-month period would be part of the new 24-month trial work period.) Under present law medicare coverage ends when cash benefits cease.

4. Eliminate the requirement that a person who becomes disabled a second time must undergo another 24-month waiting period before medicare coverage is available to him. This amendment would apply to workers becoming disabled again within 60 months, and to disabled widow(er)s and adults disabled since childhood becoming disabled again within 84 months. In addition, where a disabled individual was initially on the cash benefit rolls but for a period of less than 24 months, the months during which he received cash benefits would count for purposes of qualifying for medicare coverage if a subsequent disability occurred within the aforementioned time periods.

5. Authorize waiver of certain benefit requirements of titles II and XVIII (medicare) to allow demonstration projects by the Social Security Administration to test ways in which to stimulate a return to work by disability beneficiaries.

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