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Effects of Budget Constraints on SSA Disability Program

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

SUMMARY

-- Budget constraints SSA placed on the state disability determination services (DDSs) for fiscal year 1987 resulted in reducing their planned staff by 499 work-years, or 3.7 percent, under fiscal year 1986 levels.

-- Of the 54 DDSs, 40 had their staff levels reduced, and 41 experienced reductions in funds for purchasing medical evidence to adjudicate disability cases.

-- Because of the reductions in DDS staff, SSA limited the number of continuing disability reviews (CDRs) it expected DDSs to process. CDRs, which are needed to assess whether individuals on the disability rolls have medically improved enough to work, are required by the Social Security Disability Amendments of 1980. Based on SSA data, we estimated that CDR cases that were not processed in fiscal year 1987 because of the staffing reductions will cost the Disability Insurance Trust Fund over $200 million in unnecessary benefit payments a year.

-- We could not determine whether the amount of work SSA expects the DDSs to accomplish with reduced staffing is realistic because SSA's current productivity measurement standard does not allow for accurate or uniform comparisons. However, SSA is developing a more accurate measurement system which will take into account the many variances in DDS staffing and operating practices.

-- DDS personnel expressed concern that the increasing pressures to process more disability cases with fewer examiners and physician staff could cause quality to deteriorate.

-- SSA is planning to hold the fiscal year 1988 CDR workload to about 3 percent more than the reduced 1987 level and to further reduce DDS staff to about 3.5 percent below the 1987 budget.

-- In view of the cost effectiveness of processing CDR cases, SSA should process more CDRs and seek the resources the DDSs need to do so.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here to discuss the effects of recent budgetary constraints imposed on the state disability agencies by the Social Security Administration (SSA), a subject discussed in a report soon to be issued to your Committee[1]. During fiscal year 1987, and continuing at least into fiscal year 1988, most of the state disability determination services (DDSs) have been required to reduce staff levels, generally through attrition. SSA officials imposed these reductions after the Congress reduced SSA's fiscal year 1987 administrative budget request of about $4 billion by $171 million.

In January 1987, noting that state agencies were asserting that they were not receiving enough resources to perform effectively, you asked us to review and analyze several issues surrounding DDS funding and staffing. Specifically, you asked that we (1) address the effects of the budget constraints on the DDSs and (2) assess whether SSA's productivity standards are realistic, accurate, and nationally uniform.

We met with SSA staff involved in the budget process and reviewed data on DDS claims workload, staffing, operating costs, and other operational characteristics. We also visited five

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[1]Social Security Disability: Effects of Budget Constraints on Disability Program (GAO/HRD-88-2, Oct. 1987).

state agencies (Texas, Pennsylvania, Massachusetts, Louisiana, and Georgia) in February and March 1987 and analyzed data from questionnaires we mailed to 53 DDSs.

Our observations follow:

-- SSA chose to hold the fiscal year 1987 budget for the DDSs to the same level as initially budgeted for 1986, resulting in 3.7 percent fewer work-years for 1987 than used in fiscal year 1986. Forty DDSs had reductions in their staffing levels. In fiscal year 1988 SSA plans to make an additional 3.5-percent reduction in DDS staff resources.

-- Because of the reductions to DDS staff, SSA limited the number of continuing disability reviews (CDRs) it required the states to do in fiscal year 1987 to 216,000. SSA plans about the same workload level for fiscal year 1988. These reviews, legally required every 3 years, assess whether individuals on the disability rolls, whose conditions have not been considered to be permanent, have medically improved enough to work. This was a reduction in CDR workload of 262,000 from what was in the initially proposed budget for FY 1987. Not processing these CDRs may cost the trust fund over $200 million in annual benefit payments, or about three times the administrative costs saved by not doing the reviews. The same situation will probably exist in fiscal year 1988 unless SSA gives DDSs more

resources. Given the large potential saving to the trust fund, SSA should provide the resources to process the CDRs. If sufficient funds are not available in SSA's budget, legislative authority should be sought to expend additional trust funds to process the cases where medical improvements are expected.

-- SSA's current measure of DDS productivity, which was used to allocate staff to DDSs, does not allow for accurate or uniform comparisons of DDSs' productivity. SSA is developing a more accurate productivity measurement system, which will take into account the many variances in DDS staffing and operating practices.

-- Many of the DDS administrators and examiners we spoke to expressed concern that increasing pressures to process more cases with fewer staff could lead to shortcuts in the decision-making process at the DDSs and deterioration in the quality of case reviews.

The remainder of my testimony details these points.

REDUCING CDR WORKLOADS WILL COST MORE IN UNWARRANTED PAYMENTS THAN SAVED IN ADMINISTRATIVE EXPENSES

Generally, there are three types of disability workloads processed by DDSs--initial applications for benefits, requests for reconsideration reviews, and CDRs. Initial applications and reconsiderations are considered priority and "nondiscretionary." CDRs, on the other hand, are considered "discretionary," despite a provision in the Social Security Disability Amendments of 1980, requiring SSA to review beneficiaries whose conditions are not considered permanent at least every 3 years.

SSA's fiscal year 1987 budget submission to the Congress in March 1986 requested $760 million (including 13,750 work-years) for the DDSs to administer an estimated disability workload of 2.8 million cases, including about 478,000 CDRs.

When the Congress reduced SSA's total requested administrative budget for fiscal year 1987 by $171 million, SSA reduced the overall DDS budget by about 2.5 percent, or about $19 million. DDS work-years were also reduced to 329 less than the work-years expended in fiscal year 1986, and SSA reduced its planned CDR workload by 255,000 cases.

In December 1986, SSA made further reductions to the DDS budgets. Total state work-years were reduced to 12,880 (or 499 less than the work-years expended in fiscal year 1986), and the

estimated workload was reduced by about 81,000 cases (this included a reduction of 7,000 CDRs). Funds for purchasing medical evidence were also adjusted downward.

Although the overall fiscal year 1987 budget for the DDSs remained the same as the initial budget for fiscal year 1986, 40 DDSs had reductions in their staffing levels, and 41 had reductions in the funds they could use for procuring medical evidence. In effect, the DDSs experienced a budget cut of $14 million from 1986 levels because, during 1986, they were allocated $14 million more than the initial budget.

Because of the moratorium on CDRs from April 1984 to the end of December 1985 and the slow start-up of the CDR process in 1986, there are over 300,000 medical improvement expected cases for which scheduled review dates are past due. In addition, new medical improvement expected cases are having their scheduled review dates come "due" at the rate of about 12,500 a month. As of July 31, 1987, the DDSs had averaged adjudication of these cases at the rate of about 6,100 a month.

SSA's Office of the Actuary projects that, for every 10,000 medical improvement expected cases that are not reviewed, the Disability Insurance Trust Fund experiences unnecessary benefit payments of $8 to $9 million per year. SSA's projection is based on a cessation rate for medical improvement expected cases of about

20 percent, and allows for reversals of some cessation decisions following appeals. These annual payments will continue until such reviews are performed, or the individuals otherwise leave the benefit rolls.

With this amount of savings to be achieved by doing CDRs, the 262,000-CDR-case reduction in the 1987 budget represents an annual cost to the trust fund of more than $200 million in benefits. Estimated annual savings from processing these CDRs are about three times the administrative expenses saved by not doing CDRs. In addition, eventually these cases should be reviewed and the administrative costs to do them would be incurred at that time. In the meantime, each year's delay costs the trust fund the benefits that should not have been paid.

PRODUCTIVITY MEASUREMENTS AND EXPECTATIONS

To allocate resources among the DDSs, SSA used a productivity measurement system referred to as production per work-year. This means the amount of work produced (measured in cases completed), divided by the number of work-years used to complete that work. Once a national production goal was established for fiscal year 1987, staffing levels and production goals were set by SSA for each DDS, considering a number of factors, including expected workload, existing staffing, and planned attrition. Using these data, SSA

headquarters staff made the final judgments on each DDS's staff level.

Some DDS officials raised concerns, during our DDS visits and in response to our questionnaire, over the use of this measure as a means of comparing DDS productivity and as a means to address DDS staffing levels. When asked whether a different productivity measure would give a better comparison among DDSs, 33 (62 percent of those responding) said yes. Most identified the Cost Effectiveness Measurement System, a new system being developed by SSA, as a better system for measuring and comparing DDS productivity. Others suggested limiting the current measurement system to productivity of examiners and medical staff rather than including all DDS staff.

SSA's current measurement system considers all disability workloads the same, and counts only in-house DDS staff. It does not account for the many variances in DDS operations, particularly such differences as use of contracted labor, type of cases, and level or magnitude of assistance provided by other state agencies. For example, 43 of the 53 DDSs responding to our questionnaire were contracting for various services in 1987, including medical services, transcribing services, clerical personnel, computer services, mail services, security, and legal services. The 43 DDSs estimated that the contracted services cost more than $16

million for the year and would be equivalent to over 450 work-years if done in house.

The relative proportion of certain types of impairments in a DDS's workload can affect productivity. For example, some DDSs estimate that mental impairment cases take at least twice as many examiner and medical staff hours as other cases. In 1986, about 35 percent of the DDSs' initial disability decisions involved mental impairment cases. The proportion of mental cases adjudicated ranged from 22 percent in Nevada to 46 percent in Ohio.

SSA has recognized most of the weaknesses of its current measurement system. Because operating conditions vary greatly from state to state, SSA's new system will automatically adjust each DDS's reported cost and productivity data to reflect certain factors beyond the DDS control, such as case mix by program and adjudication level, and costs of outside services.

One factor the new system does not consider, which we believe is important, is the case mix by type of impairment. For example, some DDSs have significantly higher proportions of mental impairment cases, which take longer to do, and this should be accounted for in productivity comparisons.

AT WHAT PRODUCTION LEVEL DOES QUALITY DETERIORATE?

In addition to the impact on doing CDRs, the budget limitations could also affect the quality of disability determinations. While the 1984 disability amendments called for more extensive case development, the increasing pressures of doing more cases with fewer examiner and physician staff could lead examiners to take shortcuts. This could have an adverse effect on the quality of decisions, although we found no empirical evidence that was occurring.

As can be seen in the following table, the overall production per DDS work-year has declined since fiscal years 1980 and 1981. Some of this decline can be attributed to reduced workloads caused by the CDR moratorium. However, DDS administrators and examiners we spoke with said that the primary cause was the increased demand for more complete case development and more complex decision issues (e.g., mental impairments, multiple impairments, pain).

National Production

Fiscal year	Workloads	Work-years	Production per work-year
1980	2,326,600	9,701	240
1981	2,376,700	10,747	221
1982	2,480,068	12,399	200
1983	2,615,973	12,775	205
1984	2,264,723	12,776	177
1985	2,001,062	12,807	156
1986	2,229,718	13,379	167
1987*	2,463,727	12,880	191

*Budgeted as of December 1986 and not adjusted for a uniform workweek among all DDSs. During 1987, SSA adjusted work-years for the DDSs based on a standard workweek. We are showing unadjusted work-years here to keep 1987 on the same scale as the prior years.

SSA's production goal of 191 cases per work-year is similar to overall DDS production in the 2 years before the 1984 disability amendments. During 1982 and 1983 the DDSs' workloads were very high, and the adjudication system was under constant criticism for inadequate case development practices and resultant poor quality decisions, particularly in mental impairment cases. The 1984 Amendments prescribed standards of case review to improve the quality of decisions. The standards included more comprehensive development of evidence and more careful consideration of individual cases. We are concerned that actions taken to meet high production levels may result in declining service to beneficiaries and poor quality decisions.

From our visits to five DDSs and responses to our questionnaire, we learned of various concerns regarding possible negative impacts in states' disability operations because of the resource cuts in 1987, some of which could affect the quality of the disability determinations. The DDSs said that CDR hearings had been postponed, there were delays in assigning cases to examiners, examiner caseloads had been increased, physician reviews had been delayed, and other staff, such as quality assurance staff, were used to process cases. To update this informaton we contacted 25 states by telephone in September 1987 and found that the earlier comments and observations had not changed.

We examined data on the last 6 years of DDSs' performance. In many elements of performance, there are wide variances among the DDSs, including variances in production, timeliness, staffing, and claim allowance rates. How these differences affect quality, and at what point quality may deteriorate, are major questions for which we do not have answers at this time.

We intend further study of productivity issues and their effect on case development and quality.

CURRENT STATUS

Data for the first 11 months of fiscal year 1987 showed that the national production per work-year was 187. Adjusted for a standard workweek, it was 192.3. Thirty-four of the DDSs were below their productivity goal. During the first 10 months the DDSs have completed about 128,500 CDRs.

For fiscal year 1988, SSA is planning an increase in the overall DDS operating budget of 1.7 percent, or about $13 million over the fiscal year 1987 level. Associated with this is a small (10,741-case) increase in the national workload. SSA is planning to hold the CDR workload to about 3 percent more than the 1987 level of 216,000. Also, SSA plans to reduce the DDSs' staffs by about 3.5 percent below the 1987 level. The budgeted fiscal year 1988 work-years will be at one of the lowest levels during the decade, while the expected workload will be at one of the highest levels.

In view of a legal mandate to process most of these cases every 3 years, and the large potential savings to the trust fund, we believe SSA should seek sufficient resources, given productivity improvements in the DDSs, to process the CDR cases where medical improvement is expected.

This concludes my statement. We will be pleased to answer questions.