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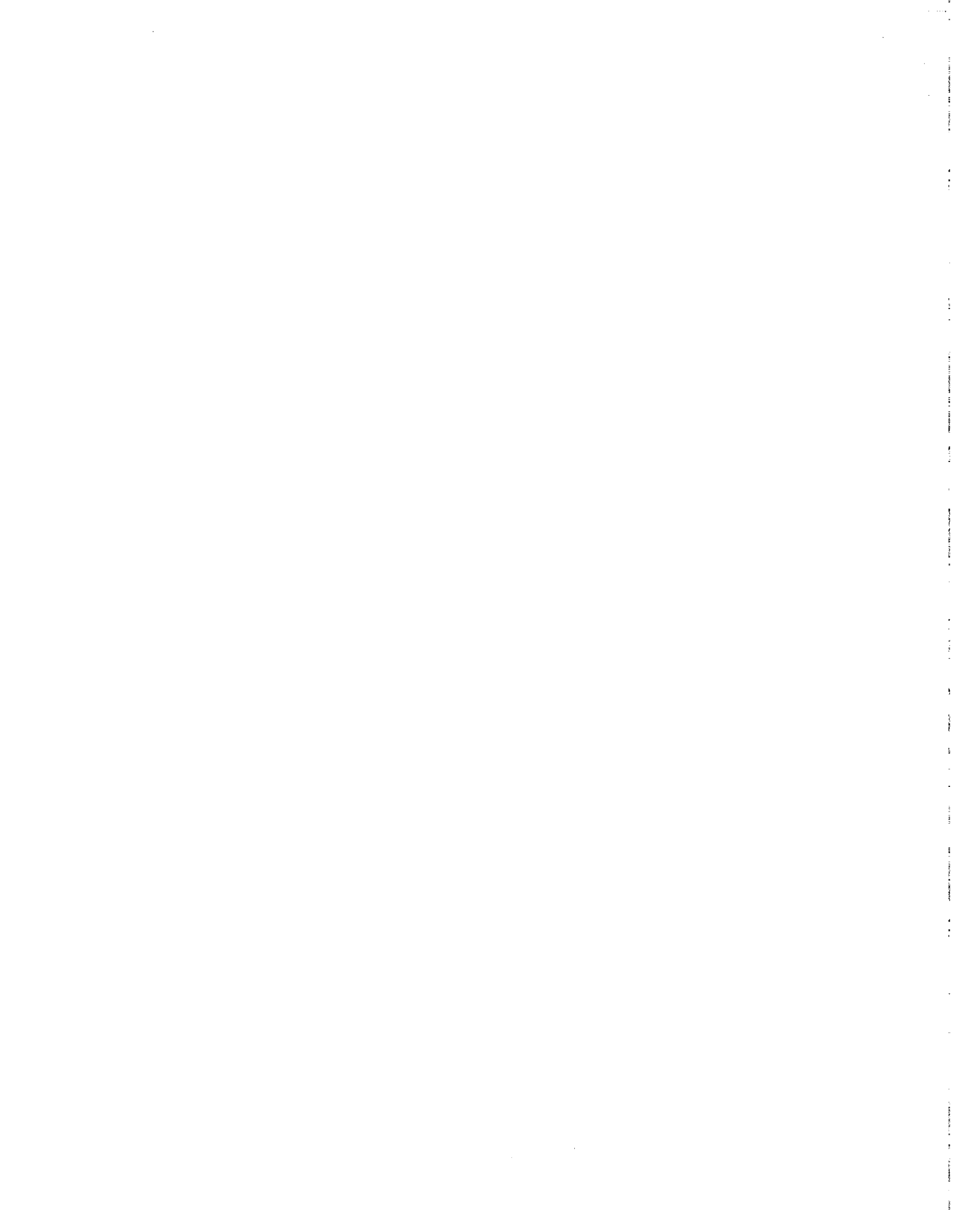
SOCIAL SECURITY

Federal Disability Programs
Face Major Issues

Statement of Jane L. Ross, Director,
Income Security Issues
Health, Education, and Human Services Division



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Mr. Chairman and Members of the Committee:

I am pleased to be here today to share with you findings from our ongoing work on Disability Insurance (DI) and Supplemental Security Income (SSI), the two major federal disability programs. DI and SSI, both administered by the Social Security Administration (SSA), have received much attention in recent years as program participation has grown dramatically. Accompanying this growth have been media reports that highlighted fraud and abuse in the SSI program, signaling to the public that the program has gone awry. Finally, critics contend that DI and SSI have trapped a generation of persons with disabilities in positions of dependency on these programs. Our reports and ongoing studies address these issues by reexamining the basic function and purpose of federal disability programs (see attached list of related GAO products).

DI and SSI programs present an all-or-nothing decision to those who apply. Applicants who meet the disability criteria receive cash benefits, and applicants found able-bodied receive no benefits. But this conflicts with prevailing views that disabled persons are an extraordinarily heterogeneous group. In addition, technological and medical advances have created more opportunities than ever for persons with disabilities to engage in meaningful and productive work. These new views coupled with advances suggest that the premise for DI and SSI may need to be modified. As a result, we may be underutilizing the productive capacity of many persons with disability.

In our testimony today, we show the tremendous growth in federal disability programs over the past 10 years and discuss reasons for that growth, including program factors and changes in society. We also comment on what is known about the impact of fraud and abuse on this growth and its effect on program integrity. In addition, we note legislative reforms included in the Social Security Independence Act last year that attempt to improve program integrity. Finally, we discuss the weaknesses in SSA's efforts to return DI and SSI beneficiaries to work. To develop this information, we analyzed administrative data for changes in the growth and composition of program caseloads; assessed program vulnerabilities to fraud and abuse; interviewed SSA and state officials, experts, and advocates; and conducted focus groups around the country with persons receiving federal disability benefits.

BACKGROUND

Before presenting our findings, let me provide some background on federal disability programs. The DI program was enacted in 1956 and provides monthly cash benefits and Medicare eligibility after a 24-month waiting period to severely disabled workers and their families. The program defines disability as an inability to engage in substantial gainful activity by reason of a physical or mental impairment. The impairment must be

medically determinable and expected to last not less than 12 months or result in death.

DI is administered by SSA and state disability determination services. The program is funded through Federal Insurance Contributions Act (FICA) taxes paid into a trust fund by employers and workers who must have worked long enough and recently enough to be entitled to benefits.¹ Cash benefits received by disabled workers average about \$660 a month and continue until a beneficiary returns to work, reaches retirement age (when disability benefits convert to retirement benefits), dies, or is found to have medically improved and regained the ability to work.

DI was originally established to extend Social Security old-age and survivors assistance to workers who became too disabled to work any longer. Although, in effect, the program served as an early retirement plan, original legislation also promoted the rehabilitation of disabled beneficiaries. At the time DI legislation was being considered, the House Committee on Ways and Means reported that it

"...recognizes the great advances in rehabilitation techniques made in recent years and appreciates the importance of rehabilitation efforts on behalf of disabled persons. It is a well-recognized truth that prompt referral of disabled persons for appropriate vocational rehabilitation services increases the effectiveness of such services and enhances the probability of success."

DI legislation required that persons applying for disability benefits be promptly referred to vocational rehabilitation agencies for services to maximize the number of such individuals who could return to productive activity.

SSI was enacted in 1972 as a means-tested income assistance program for persons who are aged, blind, or disabled. Unlike DI, benefits for SSI recipients are not based on work history. However, the two programs share the same procedure for deciding who is disabled and both programs terminate beneficiaries from the rolls in the event of medical improvement coupled with an ability to return to work. Moreover, the SSI law also required that applicants be referred for vocational rehabilitation.

SSI is funded through general revenues and like DI is administered by SSA and state disability determination services.

¹FICA payroll taxes are divided into the Disability Insurance Trust Fund, Old Age and Survivors Trust Fund, and the Medicare Trust Fund.

SSI disabled beneficiaries receive an average monthly cash benefit of about \$380 (beneficiaries in the 43 states that provide a monthly supplement received, on average, an additional \$110 in 1993) and immediate Medicaid eligibility.

Let me now turn to our findings.

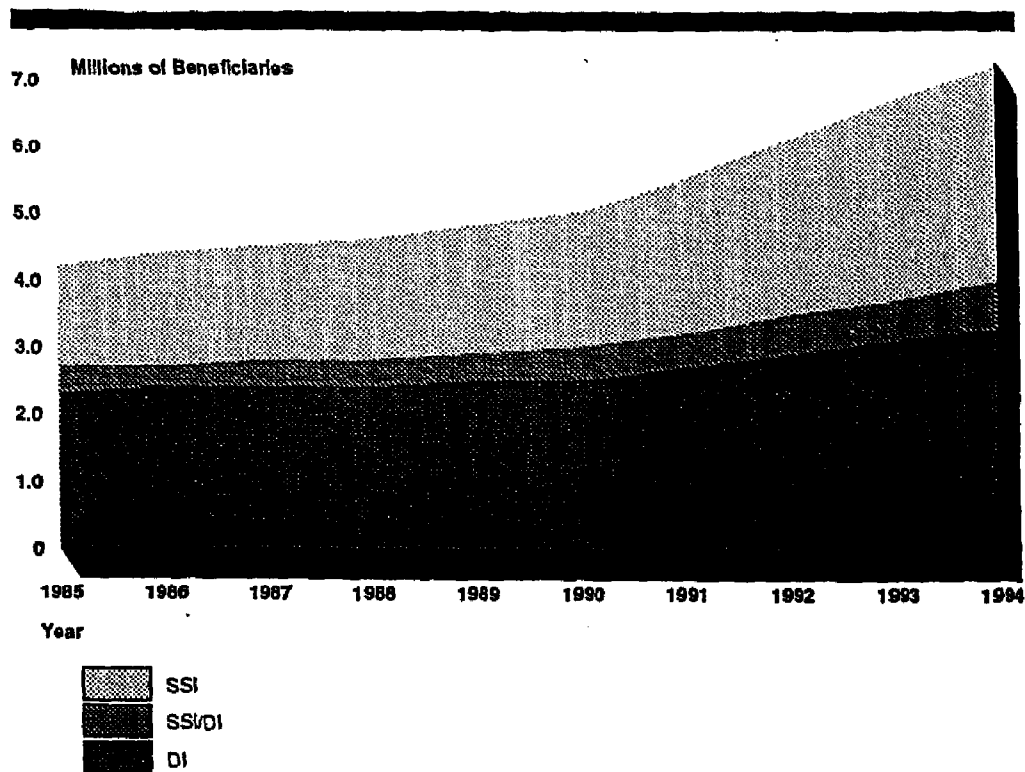
CASELOADS AND EXPENDITURES HAVE RISEN DRAMATICALLY

Participation in the disability programs has been increasing, and the pace of this growth has quickened recently (see table 1 and fig. 1). In 1985, 4.2 million blind and disabled persons under age 65 received DI or SSI benefits: 2.3 million received DI benefits, 1.6 million blind and disabled adults and children received SSI, and about 324,000 persons received both DI and SSI benefits; that is, their work history qualified them for Social Security coverage and their low income and assets qualified them for SSI. By 1994, the number of blind and disabled persons under age 65 receiving DI or SSI benefits reached 7.2 million--an increase of 70 percent from 1985. Specifically, DI increased 41 percent, SSI increased 105 percent, and the population receiving both DI and SSI increased 107 percent. Moreover, about 50 to 60 percent of the growth in size of these three subpopulations occurred over the last 3 years.

Table 1: Increases in Number of Beneficiaries and Cash Benefits (1985-94)

	1985	1994	10-year increase 1985-94 (percent)
Number of beneficiaries (in thousands)			
SSI children	265	893	236
SSI adults	1,295	2,311	78
SSI/DI	324	671	107
DI	2,332	3,292	41
Total	4,216	7,167	70
Cash benefits (in billions, adjusted for inflation)			
SSI	\$7	\$19	97
DI	\$19	\$38	45
Total	\$26	\$57	59

Figure 1: Growth in Federal Disability Programs (1985-94)



As the number of DI and SSI beneficiaries has grown, so has the amount paid in cash benefits.² In 1985, SSA paid \$19 billion in DI cash benefits and \$7 billion in SSI cash benefits. By 1994, cash benefits reached \$38 billion for DI and \$19 billion for SSI. Thus, the combined cash benefits in DI and SSI increased from \$26 to \$57 billion in 10 years (adjusted for inflation, the increase in the value of cash benefits was 59 percent). Moreover, the cost of DI and SSI benefits nearly doubles when factoring in the cost of health care coverage. For instance, in 1993, the cost of providing Medicare and Medicaid to beneficiaries was about \$55 billion, bringing the federal cost of cash benefits and health care coverage for the disabled to \$107 billion.

Impelled by estimates that the DI trust fund would be depleted in 1995, the Congress reallocated payroll tax receipts last year from the Social Security Old Age and Survivors Trust Fund into the DI Trust Fund. By the end of 2003, this measure will transfer about \$240 billion from the Old Age and Survivors Trust Fund into the DI Trust Fund.

PROGRAM FACTORS CONTRIBUTING TO GROWTH

What has caused the rapid growth in the number of DI and SSI beneficiaries in recent years? While the reasons for growth and their relative impact are not fully understood, evidence suggests that program factors have brought more persons into the programs and at the same time fewer persons have left. Allegations of fraud and abuse also raise concerns that some of the growth may include ineligible beneficiaries. We summarize these factors in table 2 and discuss them below.

²DI cash benefits include payments made to disabled workers and their dependents.

TABLE 2: Factors Contributing to Growth in SSI and DI

Program factors	
More persons brought into the program	<p><u>Eligibility expansion:</u> Legislative and regulatory changes have increased access to disability benefits.</p> <p><u>Program outreach:</u> SSA sought eligible persons to apply for disability benefits through outreach campaigns.</p>
Fewer persons leaving the program	<p><u>Continuing disability reviews (CDRs):</u> SSA has been performing fewer CDRs than required by law.</p>
Fraud and abuse	<p>Allegations have been made that SSI recipients in certain subgroups, including children, immigrants, and drug addicts and alcoholics, have received benefits for which they were ineligible.</p>
Additional factors	
Economic factors	<p>Corporate restructuring and recession may increase program application.</p>
Medical breakthroughs	<p>Individuals who would not have survived certain medical conditions in the past now have better chances to live longer through advanced medical technology.</p>
Immigration	<p>Growing numbers of immigrants admitted for legal U.S. residence may have contributed to the rising portion of this group on SSI.</p>
Shifting from state programs	<p>Some states help public assistance recipients move to SSI.</p>
Health insurance	<p>Individuals may have applied for DI or SSI or stayed on the rolls to obtain affordable health insurance.</p>

More Persons Brought Into the Programs

Several program changes introduced between the mid-1980s and the early 1990s have contributed to the increased number of persons receiving benefits. Among these changes are expanded eligibility standards and agency outreach efforts.

Eligibility Expansion. A major factor contributing to the increase in program growth over the past decade has been changes in eligibility standards, especially for mental impairments (which include mental retardation and mental illness). Standards

expanded largely due to the effects of legislative, regulatory, and judicial action.

In overseeing the program, the House Committee on Ways and Means reported that serious questions had been raised by federal courts, professionals in the fields of psychiatry and vocational counseling, and our agency about the adequacy of SSA's standards to assess mental impairment in both DI and SSI. Among other matters, the Committee expressed concern about the need to establish clear guidelines with respect to the disability determination process.

The Committee's concerns were addressed in the Social Security Disability Benefits Reform Act of 1984, which changed the manner in which SSA evaluated mental impairments. For example, new mental impairment standards were required to focus on evaluating the applicant's ability to function in a competitive work environment. Also, the act increased attention to the role of pain in restricting a person's ability to work and required SSA to consider the combined effects of multiple impairments when no one impairment is considered severe. Finally, the act placed a greater emphasis on medical evidence for disability claims from the applicant's treating physician and allowed SSA to consider nonmedical evidence offered, for example, by an applicant's family and friends.

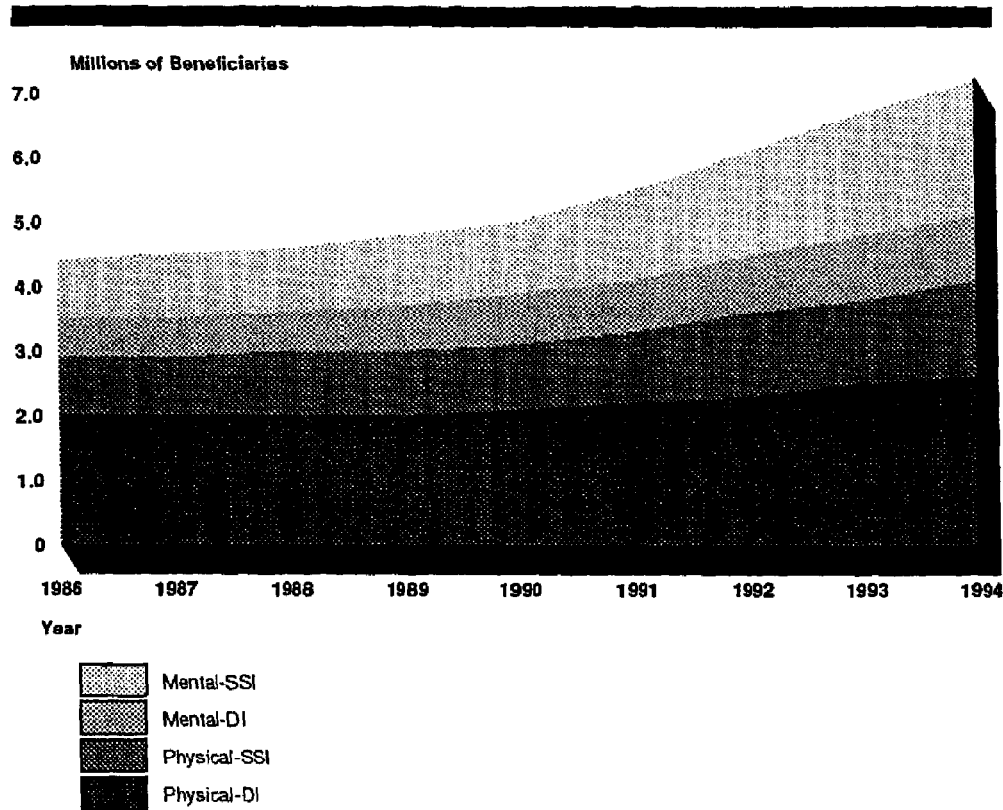
In 1985, SSA issued new regulations that revised the criteria for mental impairments. Among other changes, SSA issued distinct criteria for many qualifying mental impairments, developed a procedure to evaluate mental impairments that were not as severe as mental impairments listed in regulations, and established procedures to ensure that the medical portion of an applicant's case review be completed for cases initially denied if the evidence indicated the presence of a mental impairment.

In addition to the Social Security Disability Benefits Reform Act, SSI eligibility for children was also expanded by the 1990 Sullivan v. Zebley Supreme Court decision. Zebley held that SSA's interpretation of the law was too restrictive for children with less severe impairments than those who met SSA's strict medical listings of impairments. In 1990, SSA also expanded the number of childhood mental impairments in the listings from 4 to 11--adding such impairments as attention deficit hyperactivity disorder--and increased the weight of nonmedical evidence provided by parents, teachers, social workers, and others in determining childhood disability.

Together, these regulatory actions have changed federal disability programs--especially SSI--into increasingly including persons with mental impairments. The data show increases in the magnitude of mental impairment cases among all beneficiaries and newly awarded beneficiaries.

As seen in figure 2, the number of beneficiaries with mental impairments increased from 586,000 in 1986 to 1 million in 1994 (changing from 22 to 29 percent of the DI rolls). During this same period, the number of SSI beneficiaries with mental impairments increased from 940,000 to 2.1 million (changing from 50 to 59 percent of the SSI disability rolls).³

Figure 2: Number of DI and SSI Beneficiaries by Type of Impairments (1986-94)



Also, the percentage of newly awarded beneficiaries with mental impairments has increased. For instance, the percentage of all persons accepted into DI with mental impairments increased from 18 percent in 1985 to 26 percent in 1993. Data on comparable time periods in SSI are limited, but recent figures show that the percentage of all persons with disability accepted into SSI with mental impairments increased from 49 percent in 1991 to 55 percent in 1993.

³These figures include beneficiaries receiving both DI and SSI prorated by disability type and program.

Program Outreach. In addition to expanding eligibility standards, another contributing factor to increased program size has been SSA outreach efforts, especially for SSI. The purpose of outreach efforts has been to reduce the barriers that prevent or discourage potentially eligible individuals from applying for SSI benefits. Barriers identified in the past include lack of information about the program, perceived stigma from program participation, and the complexity of the application process.

SSA has conducted several outreach efforts since program inception. Recently, congressional and agency actions have been taken to ensure that all segments of the potential SSI population are made aware of their eligibility. For instance, a permanent outreach program for disabled and blind children was established by the Omnibus Budget Reconciliation Act of 1989; SSA made SSI outreach an ongoing agency priority in 1989; and in 1990, the Congress mandated that SSA expand the scope of its outreach efforts and provided \$21 million for SSA to complete a series of outreach demonstration projects.

As of 1994, SSA funded about 80 cooperative agreements targeting diverse populations such as African-Americans, Native Americans, the homeless, the mentally ill, and persons who tested positive for the human immunodeficiency virus (HIV). As part of this effort, the Congress required that SSA spend at least 5 percent of these funds to evaluate its outreach efforts. In response, SSA awarded a contract for a cross-project comparison to develop and promote models for effective outreach. Moreover, as part of the Zebley settlement, SSA was required to initiate a publicity and outreach program to schools and welfare offices to sign up more children.

Fewer Persons Leaving the Programs

At the same time that eligibility was expanded and outreach efforts brought more persons into the programs, fewer persons were leaving.⁴ Two statistics highlight this growing tendency to stay on the rolls. In 1985, 13 percent of DI beneficiaries left the rolls; by 1993, this number had dropped to 10 percent. Beneficiaries are also leaving the rolls at a slower pace. In 1985, 8 percent of DI beneficiaries had been receiving benefits for 15 years or more; by the end of 1993, the ratio had increased to 12 percent.

⁴In 1992, the basis for DI terminations was as follows: conversion to retirement status (52 percent), death (45 percent), and failure to meet medical criteria or because of return to work (2 percent). The basis for SSI disability terminations among adults was as follows: excess income (55 percent), death (19 percent), no longer disabled (0.5 percent), and other reasons (25 percent).

What are the causes of persons staying on the rolls longer? Part of the reason reflects the greater prevalence of children entering SSI--especially children with mental impairments--who may be expected to stay on the rolls longer, and the trend toward younger adults entering the programs. However, another factor may be a reduction in the number of continuing disability reviews performed by SSA.

Continuing Disability Reviews. The purpose of a continuing disability review (CDR) is to verify that an individual on the rolls still has a disability that prevents that person from working. The law requires SSA to conduct a CDR at least once every 3 years on DI beneficiaries where medical improvement is possible or expected. For a case where medical improvement is not expected, SSA is required to schedule a CDR at least once every 7 years. Also, 7 months ago, the Congress directed SSA, in the Social Security Independence Act, to perform a minimum number of CDRs for SSI beneficiaries. While SSA had authority to perform SSI CDRs, as with the DI program, relatively few were done. Accordingly, as now required, SSA plans to conduct 100,000 CDRs on SSI adults and on one-third of SSI children turning age 18 for each of the 3 fiscal years beginning in 1996.

In the early 1990s--because of SSA resource constraints and increasing initial claims workloads--the number of DI CDRs declined dramatically. Currently, the backlog of DI CDRs is about 1.8 million cases with about 500,000 additional cases coming due each year. The number of DI CDRs planned for fiscal year 1996 is 234,000, which is less than one-half the number of CDRs coming due annually. To help reduce the backlog of DI CDRs, SSA now uses computer profiling and beneficiary questionnaires to more efficiently target limited CDR resources. While this new process will help, much more needs to be done.

Combined with the surge in applications and the growing tendency to remain on the programs longer, the decrease in CDRs performed has profound implications for expenditures. For example, the average DI beneficiary will receive about \$13,200 in cash and medical benefits this year. Extrapolating this figure, the average disabled beneficiary entering DI today will receive about \$225,000 in cash and medical benefits if he or she retains disability benefits until conversion to retirement benefits at age 65. CDRs not performed on schedule means that significant expenditures may be spent on individuals not eligible for benefits.

Fraud and Abuse

Some ask how much of the growth over the past decade may be attributable to fraud and abuse. Although limited empirical data make it difficult to estimate the extent of the problem, widespread media reports have weakened public confidence in the

integrity of the SSI program. Anecdotal evidence regarding children, immigrants, and substance abusers has generated much of the concern. Last year, the Congress and SSA undertook various actions to address fraud and abuse for these populations. Especially troublesome have been allegations that parents coach their children to fake mental impairments by misbehaving or doing poorly in school so that they can qualify for cash benefits. Teachers and other education professionals in particular have raised concerns about rewarding behavioral problems and poor academic performance with cash payments, which can amount to more than \$5,000 per child per year. Critics believe that these cash payments and Medicaid act as incentives for parents to coach their children. In addition, concerns have been raised that the program could foster lifelong dependence on government assistance if children come to view the label "disabled" as a lifetime entitlement to income and medical benefits.

Suspected fraud and abuse in the immigrant population is tied to claims for disability benefits that have been filed with the assistance of translators. Fraudulent acts by translators have included coaching SSI applicants on how to appear mentally impaired, using dishonest health care providers to examine applicants and submit false medical evidence to support alleged mental impairments, and providing false information on the medical and family histories of applicants. The Social Security Independence Act takes steps to prevent fraud by third-party translators by, among other things, increasing penalties for fraudulent acts by translators and health care providers. It also requires SSA to redetermine eligibility if fraud is involved.

Allegations of abuse among substance abusers have resulted in close scrutiny of the drug addicts and alcoholics program, which grew nearly 700 percent from 13,000 cases in 1988 to over 100,000 last year. Another 150,000 beneficiaries had other impairments that qualified them for benefits in addition to their addictions. The vast majority of addicts received benefits without any requirement that they be in treatment. In addition, there was little assurance that cash benefits were not being used to support their addictions. As a result, the Social Security Independence Act required individuals whose alcohol or drug addiction was a contributing factor to their disability to receive treatment and payment through qualified representative payees in order to continue to receive benefits. This should enhance program accountability, while better meeting the needs of addicted beneficiaries.

ADDITIONAL FACTORS CONTRIBUTING TO GROWTH

A number of additional factors outside the programs have potentially affected the size of DI and SSI over the past decade. For example, economic factors--such as corporate restructuring

and the 1990-91 recession--may account for some of the increase. In times of high unemployment, impaired persons may be at greatest risk of losing their jobs and turn to DI for support.

Another factor may be an increased prevalence of some disabilities among the nonelderly population. For example, persons who would not have been expected to survive certain health conditions 10 years ago, such as kidney disease, are now being kept alive by medical and therapeutic advances. Further, young adults who would not have been expected to survive spinal cord injuries now have a much better chance of survival and more opportunities to regain many functions. Finally, infants born with congenital defects or low birthweight have a better chance of survival today than in the past, although they may sustain disabilities.

Also, the growing number of immigrants admitted annually for legal residence in the United States may have contributed to SSI growth. For example, 880,000 immigrants were admitted to the United States in 1993, compared with 570,000 in 1985. In addition, nearly 3 million former illegal immigrants attained legal residence status under the Immigration Reform and Control Act of 1986. Together, this increased population has likely contributed to the rising portion of disabled immigrants on SSI, which increased from less than 2 percent in 1982 to about 6 percent in 1993.

Another factor has been state efforts to enroll qualifying individuals receiving state welfare benefits in SSI. States may be motivated to do this to save state funds as well as to increase benefit levels available to their citizens. Based on discussions with 10 state welfare administrators, we estimate that at least one-half of all states fund programs that proactively assist disabled public welfare recipients through the SSI application process. For example, 5 states reported using such programs to generate gross savings of about \$90 million in a given year, by helping enroll in SSI nearly 26,000 individuals receiving state benefits. Most of these gains came from one state, which reportedly saved over \$60 million by helping nearly 15,400 public assistance recipients enroll in SSI instead of state general assistance in fiscal year 1994.

Finally, the recent increase in the number of persons without affordable health insurance may have affected the size of DI and SSI. The uninsured population under age 65 in the United States grew by 5 million persons between 1988 and 1992. Coupled with this growth, limitations in employer-based health care coverage for chronic conditions may have prompted some individuals to apply for DI or SSI for health care protection.

WEAK RETURN-TO-WORK EFFORTS

Our work to date--based in part on the results of our focus group discussions with beneficiaries--suggests that the structure and administration of DI and SSI do not facilitate the movement of persons from disability rolls to payrolls and, indeed, act to inhibit many who want to return to work from doing so. Disability advocates have expressed concern about the high percent of disabled adults who are not employed--as high as 66 percent by some estimates. And the results of a recent national survey indicate that four of every five persons with disabilities who are not working want to work.

The limited resources spent by the programs in returning beneficiaries to work and our discussions with them indicate that SSA has a poor record in returning beneficiaries to work. In fact, not more than 1 of every 1,000 DI and SSI beneficiaries leave the rolls as a result of SSA's return-to-work assistance.

Why do so few beneficiaries return to work? Perhaps the major reason is the perceived high risk in doing so. Program provisions--called work incentives--are intended to allow beneficiaries to try to return to work without jeopardizing their benefits should their work attempt fail, as well as ease their transition to work. However, successful attempts at returning DI beneficiaries to work are generally defined as earnings of \$500 per month or more. This amount, when annualized, is below the federal poverty threshold. Even with earnings this low, DI beneficiaries would lose their cash benefits and eventually their medical coverage. Under these conditions, some beneficiaries may be making a rational financial choice in not attempting to go back to work.

Another part of the problem may be that helping people with disabilities to work is not a priority of DI or SSI. This is especially evident when we look at vocational rehabilitation (VR), which appears to be a low priority and to have limited effectiveness. For example, for every \$100 SSA spends on cash benefits, it spends a little more than a dime on VR. Moreover, about 1 of every 200 DI and SSI beneficiaries are referred for VR services.

While we do not know what the appropriate level should be or what other employment assistance might be required, we believe that we need to determine how much this underrepresents the potential for returning beneficiaries to work. As we reported recently, VR beneficiaries receive, on average, only modest services and show limited long-term improvement.⁵ Another reason

⁵Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

for VR's limited effectiveness is the fact that it is offered to beneficiaries at the end of a complex 6 to 18 month application process, during which time applicants are focusing on proving their inability to work. However, experts generally agree that rehabilitation offered closer to the time of the onset of a disability has the most chance of success.

CONCLUSIONS

Each week, SSA sends out about \$1 billion in cash payments to persons on DI and SSI. These expenditures are particularly sobering in the context of our findings that

- program growth over the past decade has been tremendous;
- including medical benefits, expenditures now exceed \$100 billion annually;
- program integrity has been undermined by allegations of fraud and abuse; and
- the programs virtually return no one to work.

Our work shows that federal disability programs need improvement. We are working on identifying alternative ways in which federal disability programs can enhance the productive capacity of beneficiaries who want to work. To this end, we are ready to help the Congress in its deliberations on program improvement.

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

For more information on this testimony, please call Cynthia Bascetta, Assistant Director, at (202) 512-7207. Other major contributors include Brett Fallavollita, Senior Evaluator; David Fiske, Senior Evaluator; Susan Higgins, Senior Evaluator; Barbara Bordelon, Senior Evaluator; Ellen Habenicht, Evaluator; and Tom Smith, Senior Evaluator.

RELATED GAO PRODUCTS

Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations (GAO/HEHS-94-225, Sept. 9, 1994).

Disability Benefits for Addicts (GAO/HEHS-94-178R, June 8, 1994).

Social Security: Most of Gender Difference Explained (GAO/HEHS-94-94, May 27, 1994).

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).

Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993).

Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992).

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (GAO/HRD-92-56, Apr. 21, 1992).

Vocational Rehabilitation Program: Client Characteristics, Services Received, and Employment Outcomes (GAO/T-PEMD-92-3, Nov. 12, 1991).

Social Security Disability: Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991).

Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

Impact of Vocational Rehabilitation Services on the Social Security Disability Insurance Program (GAO/T-HRD-88-16, May 26, 1988).

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