Disability Decision Making:

Data And Materials

Social Security Advisory Board

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Social Security Advisory Board
An independent, bipartisan Board created by Congress and appointed by the
President and the Congress to advise the President, the Congress, and the Commissioner
of Social Security on matters related to the Social Security and Supplemental Security Income programs

TABLE OF CONTENTS

CHARTS

INTRODUCTION

The Social Security Advisory Board has been working for more than three years on the question of how SSA can improve its service to the public and for an even longer period of time on the changes that need to be made in the agency's disability programs. In the course of our work, it has become apparent that administration of the disability programs is at the heart of SSA's service delivery problems. By comparison, the payment of retirement and survivors benefits, the issuance of Social Security numbers, and other basic functions of the agency run more smoothly. These other responsibilities of the agency, while presenting significant challenges, do not present the enormous management challenges that are presented by the Disability Insurance (DI) and Supplemental Security Income (SSI) disability programs.

Administration of the disability programs will take about two-thirds of the agency's projected $7.1 billion budget for fiscal year 2001, or nearly $5 billion. In terms of executive management time and concerns, the programs appear to consume even more of the resources of the agency than this number suggests. Yet despite this large expenditure of money and effort, the disability programs continue to manifest serious administrative problems. In August 1998, the Board issued a report on the disability programs indicating how within the terms of the present programs their administration might be improved.[1] SSA itself undertook a number of initiatives beginning in the fall of 1999 and the Board has attempted to monitor the implementation of these initiatives to see whether there are improvements.[2]

As a result of our continuing work on the disability programs, the Board is issuing a new report in January 2001 titled *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change*. The purpose of the report is to provide the new Administration and the new Congress with a framework for considering the fundamental changes that need to be made if the disability programs are to meet the serious challenges they are facing.

This document, *Disability Decision Making: Data and Materials*, is intended to provide background information to help readers of the report gain a fuller understanding of how the disability programs are being administered and of the major problems that are inherent in the current administrative process. It includes data that raise significant questions, including questions about consistency and equity in decision making. Although as set forth below, this has been a long-standing concern, the fact that some 45 years after the initiation of the program these questions are not only still outstanding – but even more pronounced – is particularly troublesome. The Board recognizes that these questions are exceedingly complex and difficult to answer, but would expect that over time demonstrable progress could be made if they were addressed with a sufficiently high level of concern and effort.

The Long-Standing Concern About Consistency and Equity in Decision Making

Concern about consistency and equity in decision making goes back to the early days of the Disability Insurance program. In the fall of 1959, three years after the program was enacted, the Ways and Means Subcommittee on the Administration of the Social Security Program (the

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[1] *How SSA's Disability Programs Can Be Improved*, Social Security Advisory Board, August 1998.

[2] For a description of the agency's initiatives, see SSA's Disability Initiatives, p. 105.

Harrison Subcommittee) held a series of hearings that focussed in part on variations in decision making among the States. Speaking on behalf of the Social Security Administration, Deputy Commissioner George Wyman told the Subcommittee that the objective of achieving reasonable consistency presented "a real challenge." Former Commissioner of Social Security Robert Ball, who at that time was Deputy Director of SSA's Bureau of Old-Age and Survivors Insurance, explained to the Subcommittee that the agency had developed medical guides for use in adjudication with the objective of achieving "as high degree of equity in the application of this law across the country as possible."

Over the last four decades, as program rules have become more complex and the number of decisions being made at the appeals levels has increased, the challenge to the agency of producing disability decisions that are consistent and equitable has grown. Both the Congress and the agency have periodically taken steps to address the issue of consistency and equity.

In the latter part of the 1970s the House Ways and Means and Senate Finance Committees conducted an in-depth examination of the administration of the DI and SSI disability programs. The concern of the Committees was heightened by the issuance of a General Accounting Office (GAO) report in 1976 that raised serious questions about consistency in disability decision making by the State agencies.[3]

In their reports on proposed legislation (which ultimately was enacted as the Social Security Disability Amendments of 1980) both Committees expressed concern about inconsistencies in decision making. The Ways and Means Committee stated that "significant improvements in Federal management and control over State performance are necessary to ensure uniform treatment of all claimants and to improve the quality of decision making under the Nation's largest Federal disability program." The Finance Committee report expressed concern about "State-to-State, ALJ-to-ALJ variations and about the high rate of reversal of denials which occurs at various stages of adjudication, for it indicates that possibly different standards and rules for disability determinations are being used at the different locations and stages of adjudication."

The 1980 legislation incorporated several amendments aimed at addressing these concerns, including (1) giving SSA authority to set standards for the performance of State Disability Determination Services (DDSs), with the option of taking over the work of a DDS if the Commissioner finds that the State is substantially failing to make determinations in a manner consistent with regulations and other written guidelines; (2) requiring the agency to review a percentage of DDS decisions before payment begins; and (3) requiring the Commissioner to implement a program of own motion review of disability decisions made by administrative law judges (ALJs).[4]

In the Social Security Disability Benefits Reform Act of 1984 the Congress again sought to improve consistency between the DDSs and ALJs by enacting a provision requiring the

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[3] In 1981, SSA's Office of Policy issued a report critiquing the 1976 GAO study and presenting its own study of consistency of State agency decisions. The SSA study found less inconsistency than reported by GAO. Commenting on the results, the study stated that "Given the complexity of disability adjudication, a certain amount of disagreement in decisions is expected." In addition, it noted that "the results…in part could be interpreted as indicating that SSA should continue to focus its efforts to improve mainly the structure of the disability decision process, i.e., the guidelines and instructions used by the individual disability examiners."

[4] In her book, *Agency Under Stress* (The Brookings Institution, 1990), Martha Derthick discusses the turmoil in the disability programs in the early 1980s following enactment of the Social Security Disability Amendments of 1980. She comments on the differences in decision making by DDSs and ALJs, and the impact that these differences had on the continuing disability reviews that the agency conducted pursuant to the 1980 legislation.

Commissioner to establish, by regulation, uniform standards to be applied at all levels of determination, review, and adjudication.

Legislation enacted in 1986 required the appointment of a special Disability Advisory Council to study and make recommendations with respect to the DI and SSI disability programs. One of the primary concerns expressed by the Advisory Council in its 1988 report was the lack of uniformity in the determination of disability. The Advisory Council recommended a number of measures to address this concern, including:

- more effective use by the agency of its authority, through pre-effectuation review of decisions, to ensure the accuracy and uniformity of DDS decisions;
- establishment by the agency of more precise standards and criteria for determining eligibility;
- exercise of the agency's full authority and obligation under the law to ensure that the States faithfully perform their administrative role on behalf of the Federal government;
- alteration of SSA's quality assurance system to ensure that reviews are not conducted by the same region in which the cases originate;
- efforts by the agency to determine why State agency decisions differ if for reasons that cannot be explained by differences in applicant pools or court orders;
- expedited promulgation of regulations so as to promote the use of a standard set of criteria by the DDS and ALJ;
- action by the Congress to require the Department of Justice to prepare a study of possible alternatives to the current method of court review of disability cases, including an evaluation of alternative types of courts, and alternative placement of court review in the Social Security appeals process on the timeliness, accuracy and nationwide uniformity of decisions; and
- study by SSA of the Medical Improvement Review Standard.

In response to the Advisory Council's report, staff in SSA's Office of Program and Integrity Reviews undertook a statistical analysis of State agency data. The major finding of this internal study, which was never published, was that "in general, more than half the differences in filing and allowance rates among States are associated with different characteristics of State populations." The study observed that differing filing and allowance rates were therefore appropriate and reflected expected variation among the States. It was also noted, however, that there were several States where the actual allowance rate varied significantly from the "expected" rate and, with respect to those States, more intensive analysis was warranted.

Although they did not address the issue of consistency among States or between levels of decision making, other studies undertaken by SSA in the 1990s analyzed the reasons for fluctuations in the growth of the Disability Insurance program. These studies were prompted by the forecasts of the impending exhaustion of the DI Trust Fund following the sharp increase in awards in the late 1980s and early 1990s. These included the so-called "709 Report" issued by the Department of Health and Human Services in December 1992 and the "Report on Rising Cost of Social Security Disability Insurance Benefits" issued by SSA in February 1996. The latter was based in part on a study of the causes of the increases in DI and SSI disability applications and awards that was conducted by Lewin-VHI, Inc., under contract with the Department of HHS.[5] SSA's Office of the Chief Actuary also issued an actuarial study, S*ocial Security Disability Insurance Program Worker Experience,* in June 1999.

[5] The results of this study are discussed in *Growth in Disability Benefits, Explanations and Policy Implications*, edited by Kalman Rupp and David C. Stapleton (W.E. Upjohn Institute for Employment Research, 1998).

In addition to these studies, during the 1990s both the Congressional Research Service and the General Accounting Office issued reports that examined inconsistencies in decision making in Social Security's disability programs. In 1995 and 1997, the Social Security Subcommittee of the House Committee on Ways and Means also conducted hearings that addressed this subject.

The Social Security Administration's effort to redesign the disability determination process, which began in 1994 and is still evolving, included making the right decision the first time as one of its major objectives. The redesign plan also established "process unification" as one of the key "enablers" for improving the decision making process. SSA proposed to develop a single presentation of all substantive policies used in the determination process that would be binding on all decision makers. The primary instrument that the agency has used to do this is the issuance of Social Security rulings in the areas that the agency had identified as being responsible for major differences in decision making between State agencies and ALJs. In 1996, the agency issued a series of nine rulings and conducted nationwide training on these rulings for both DDS employees and ALJs and other SSA employees. Administrators in the State agencies have told the Board that implementation of these rulings by the State agencies has been uneven. It is unclear what, if any, impact the rulings have had on ALJ decision making.

The Definition of Disability and the Administrative Structure Make Consistency and Equity Difficult to Achieve

It is important to point out that both the definition of disability and the administrative structure of SSA's disability programs make consistent and fair decisions difficult to achieve. The definition of disability in the statute requires a determination of whether an individual's impairment is so severe that it precludes engaging in any substantial gainful activity. Although the agency has issued extensive regulations to guide decision makers, the determinations require the exercise of judgment, both as to the type and amount of evidence that is needed to document the case and whether the evidence supports a determination of eligibility. Most adjudicators appear to agree that there are a significant although undetermined number of difficult cases in which the evidence may lead different decision makers to different conclusions.

The administrative arrangements for determining disability involve different levels of government and different processes, depending upon the stage of an individual's claim. Although SSA is responsible for the program, the law requires that initial determinations of disability be made by agencies administered by the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. This State-based administrative mechanism was established by the Congress in 1954 on the theory that this arrangement would provide coordination with existing State vocational rehabilitation agencies, and was necessary in order to secure the cooperation of the medical profession, which already had working relationships with the rehabilitation agencies. In fact, although today most State disability agencies are still part of their State departments of rehabilitation, the close coordination of the disability determination process and the delivery of vocational rehabilitation services that was originally envisaged has generally not been achieved. In addition, the relationship of the State agencies with the medical profession has changed over the years and is becoming increasingly problematic as the result of rapid changes in the health care delivery system that involve more care through group providers and less through personal physicians.

Although the State agencies are required to follow the policy guidance of the Social Security Administration and are fully funded by the Federal government, there are few Federal requirements relating to their administrative practices. The agencies follow State established personnel policies with respect to such matters as salaries, benefits, and educational requirements; do their own hiring;

provide most of the training for adjudicators; follow their own quality assurance procedures; and pay State-established reimbursement rates for purchase of medical evidence.

By regulation, an individual whose claim is denied by the State agency may ask the agency to reconsider the decision and may present new evidence. The statute provides that individuals whose claims are denied at the reconsideration step may appeal that decision at a hearing conducted by an ALJ.[6] New evidence is frequently introduced at this stage of the appeal and in most hearings the claimant is represented by an attorney or by a non-attorney representative. The ALJ hearing is a *de novo* proceeding, involving a complete readjudication of the case. Currently, about one-quarter of all allowances are made at this level. Although ALJs must follow the agency's regulations and rulings, they have decisional independence to ensure a fair hearing.

Individuals whose claims are denied at the ALJ level may appeal their cases to the Appeals Council, which is the final step in the administrative appeals process. Claimants may continue to introduce new evidence and raise new issues. As noted above, since 1980 the Appeals Council has also been required to have a program of own motion review of ALJ cases. In fiscal year 2000, about 4,000 ALJ allowances were selected for pre-effectuation review, based on a profile of error-prone cases. Cases are first reviewed by SSA's Office of Quality Assurance (OQA), which forwards to the Appeals Council those cases in which it disagrees with the ALJ decision. If, after review, the Appeals Council agrees with OQA's assessment, it can reverse the decision or remand the case to the ALJ.

Many Factors Have Been Identified As Affecting the Dynamics and the Consistency of Decision Making

Over the years policy makers and administrators have identified many factors in addition to the inherent subjectivity of the statutory definition of disability that may affect the consistency of disability decision making.

These include:

- Economic differences (differences in State economic conditions, changes over time)
- Demographic differences (differences among States, changes over time)
- Differences in health status
- State actions (elimination of State general assistance programs, requiring individuals to file for SSA's disability programs as a condition of eligibility for State benefits)
- Differences in quality assurance (differences in how SSA's regional Offices of Quality Assurance determine the accuracy of State decision making, differences in quality assurance procedures applied to ALJs and State agencies, changes in quality assurance procedures over time)
- State differences in administrative practices (use of consultative examinations, the degree of involvement of doctors in making disability decisions, the amount allowed to be paid for the purchase of medical evidence of record, salaries and qualifications of disability decision makers)
- Hearing office differences in administrative practices (variation in use of vocational and medical experts at the ALJ hearing)

[6] The reconsideration step has been eliminated in the 10 so-called prototype States. The prototype States are implementing a set of changes introduced by SSA in October 1999 that are aimed at improving the disability determination process. The agency plans to implement the changes in the remaining States over the next few years.

- Differences in the training given to ALJs and State examiners; differences in State agency training practices
- The fact that most claimants are never seen by an adjudicator until they have an ALJ hearing
- Involvement of attorneys and other claimant representatives at the ALJ hearing
- Changes in the adjudicative climate (the "message" sent by SSA, the Congress, or others to those who adjudicate claims)
- Rules that allow claimants to introduce new evidence and allegations at each stage of the appeals process
- Lack of clear and unified policy guidance from SSA
- Erratic and inadequate funding for State agencies and for hearing offices
- SSA pressures on State agencies and on ALJs to meet productivity goals

There have also been many court decisions that have affected the way decisions are made, leading to changes in decision making over time, differences in decision making among different regions of the country, and differences in decision making between ALJs and DDSs.

For example, in the mid-1980s the 2nd Circuit in *Stieberger v. Heckler* (615 F. Supp. 1315) declared illegal SSA's former policy of not following circuit case law within the circuit that issued the decision. After the decision, SSA adopted its current policy: when there is a circuit court decision that the agency is unwilling to implement nationwide, the agency issues an acquiescence ruling stating that the agency will comply with the decision within the issuing circuit. Initially acquiescence rulings applied only to the ALJ level, but a regulation in 1990 extended them to State agencies.

In response to various court decisions and changing perceptions of how disability should be determined, SSA has implemented a number of policies that have introduced increased levels of judgment into the disability determination process. For example, the agency's regulations and rulings now require all adjudicators to assess such subjective factors as the weight that should be given to the opinion of a treating source and credibility with respect to allegations of pain and other symptoms.[7] At this time it appears that these more recent policies emphasizing subjective factors are not being uniformly implemented throughout the disability determination system.

The Urgent Need for Ongoing In-depth Assessment of the Disability Determination Process

Although, as discussed above, there have been periodic attempts in the past to shed light on various aspects of the disability programs, there has never been ongoing and in-depth analysis of a subject that has been of persistent concern to policy makers: are claimants receiving consistent and equitable decisions?

In fact, there are very few data available to help those outside of the agency to understand in even a rudimentary way how the disability programs are operating. It was in response to this lack of information that in the fall of 1999 the Social Security Advisory Board undertook to assemble and update some basic historical data. The Board considered these data to be essential to its continuing efforts to help the Congress, the President, and the agency to understand and address important issues of policy and service to the public.

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[7] Court cases include *Schisler v. Bowen*, 787 F. Supp. 76 (2nd Cir.1986), which dealt with treating source opinion, and *Hyatt v. Heckler*, 579 F. Supp. 985 (4th Cir. 1986), which dealt with assessment of pain.

The charts that are included in this document reflect the information that we have been able to assemble at this time. All of the charts are the work of the Board's staff. The data that were used in preparing them were provided by the Social Security Administration at the request of the Board or have appeared in SSA publications. Presentation of the charts generally follows the sequence of the disability determination process, from initial applications through the administrative and judicial appeals processes. In summary, the charts show:

- Variations in applications over time
- Variations in awards and allowance rates
- Variations in benefit termination rates over time
- Growth in number and variations in prevalence of beneficiaries
- Trends in continuing disability reviews
- Changes in the characteristics of beneficiaries
- Variations in DDS decision making
- Variations in State administrative arrangements
- Changes in the hearing process
- Changes in Appeals Council actions
- Changes in Federal court actions

Although the data used in the charts were originally collected for the use of the Board itself, we believe it is important to share them widely with individuals who are engaged in the administration of the disability programs, policy makers, and the public. We recognize that far more data than are presented here are required to present a full picture of how the disability programs are operating. However, we believe the charts that are included in this document raise fundamental questions for which there are currently no clear answers. These questions are important not only for understanding the past, but for thinking about whether there is a need for policy or administrative changes in order to improve disability decision making for claimants in the future. The questions include:

1. *What have been the reasons for the wide variations in the number of applications for DI and SSI disability over the years?*

2. *What explains the variations in State agency and ALJ allowance rates?*

3. *Why is the allowance rate among States as variable as it is?*

4. *Why is there so much variance among the States in reasons reported for both allowing and denying claims?*

5. *What accounts for the significant decline over the years in the percentage of DDS awards that are based on medical listings and the significant increase in awards on the basis of vocational factors? What are the implications of this change?*

6. *With so much variance in decision making, how do you explain the consistently high level of State agency decisional accuracy found by SSA's Office of Quality Assurance?*

7. *Do differences in State administrative arrangements and practices affect the quality of decision making?*

8. *What are the implications for claimants and for the process of the increased numbers of claimants who are represented by attorneys?*

9. *How does the growing use of outside vocational experts at the ALJ level affect decision making? Does their use at the ALJ stage of the process represent a substantial difference from the process in the State agencies, where such experts are not used?*

10. *What are the reasons for the large number of State agency decisions that are reversed at the ALJ hearing level?*

11. *What has been the impact of various Federal court decisions?*

12. *Based on historical and international experience, is it reasonable to expect greater consistency in decision making than the statistics in these charts seem to show currently exists?*

These questions are particularly critical now that the DDSs, led by the prototype States, are beginning to move toward full implementation of the agency's 1996 process unification rulings. There is broad agreement that these rulings are leading to a much higher degree of subjectivity in decision making by DDS examiners than was the practice in the past. As yet it is unclear whether the rulings will reduce significantly the amount of disparity in decision making between the DDSs and ALJs that has existed for most of the life of the disability programs.

The high degree of variability in outcomes that has persisted for many years seems, on its face, to be inconsistent with a program that is intended to operate uniformly throughout the United States and is based on a Federal statutory definition of disability that has not changed for 30 years. As noted above, there are many factors (such as economic and demographic changes, court decisions, regional differences in income and health status, and actions by State governments) that are commonly put forward as explanations for differences among State agencies. Similarly, differences between the DDS and ALJ levels can be at least partially explained by the fact that at the ALJ level the claimant has an opportunity to meet with the adjudicator face-to-face, there is often additional evidence, and, with the lapse of time, the claimant's condition may have worsened. Also, ALJs decide cases on the basis of an on-the-record hearing that is conducted in accordance with the same procedures as are required by the Administrative Procedure Act, while DDSs process claims on a less formal basis.

The fact remains, however, that the agency currently has no effective mechanism in place to provide consistent and reliable information on the extent to which the variations may also represent a failure to apply program policies and procedures on a uniform basis throughout the country and throughout the disability system. Clarifying the issue of horizontal equity, i.e., whether similarly situated individuals are receiving similar treatment, is essential to evaluating the fairness and effectiveness of the administrative structure of the disability programs. It is also essential to evaluating the program from the standpoint of the contributors and taxpayers who pay the costs of the program. It is not justifiable for programs that are expected to cost nearly $90 billion in fiscal year 2001 to lack such basic information. These concerns were reflected in the Board's 1998 report, *How SSA's Disability Program Can Be Improved*, which included as one of its recommendations that SSA contract for outside assistance in designing a new quality assurance system that would provide information to address the equity issue. SSA contracted for such assistance and we hope that the report of the contractor, which was recently completed, will assist the agency in making changes.[8]

[8] More recently the Board also recommended that SSA engage an outside contractor to evaluate disability prototype. The agency decided to conduct its own evaluation, but engaged an outside contractor, in essence, to evaluate the agency's evaluation. See *Assessment of the Evaluation Plan for the Disability Process Redesign Prototype*, The Lewin Group, Inc., September 18, 2000.

We believe that SSA urgently needs a new quality management system that will routinely produce the information the agency needs to properly guide disability policy and procedures and to ensure accuracy and consistency in decision making. Such a system is essential to provide ongoing evaluation of agency initiatives such as process unification and prototype. The system should incorporate all stages of decision making and it should be capable of producing special studies that will identify specific problems and help the agency to devise appropriate solutions. The information provided should be made available to persons who are concerned with the disability programs both within and outside of the agency.

The disability rolls are projected to grow over the coming decades as baby boomers reach an age of increased likelihood of becoming disabled. These growing workloads will make it increasingly important for the agency to have clear and workable policy and administrative rules and guidelines. This will require a better understanding than now exists of the factors that influence the dynamics of the disability rolls.

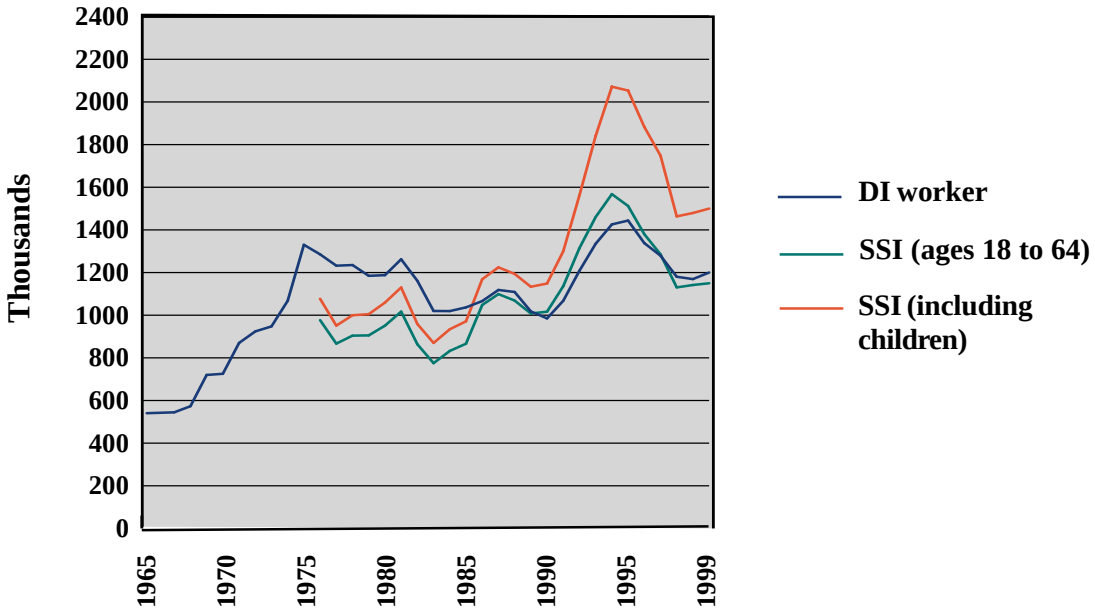
PART ONE

Data Relating to Disability Program Operations

I. Applications

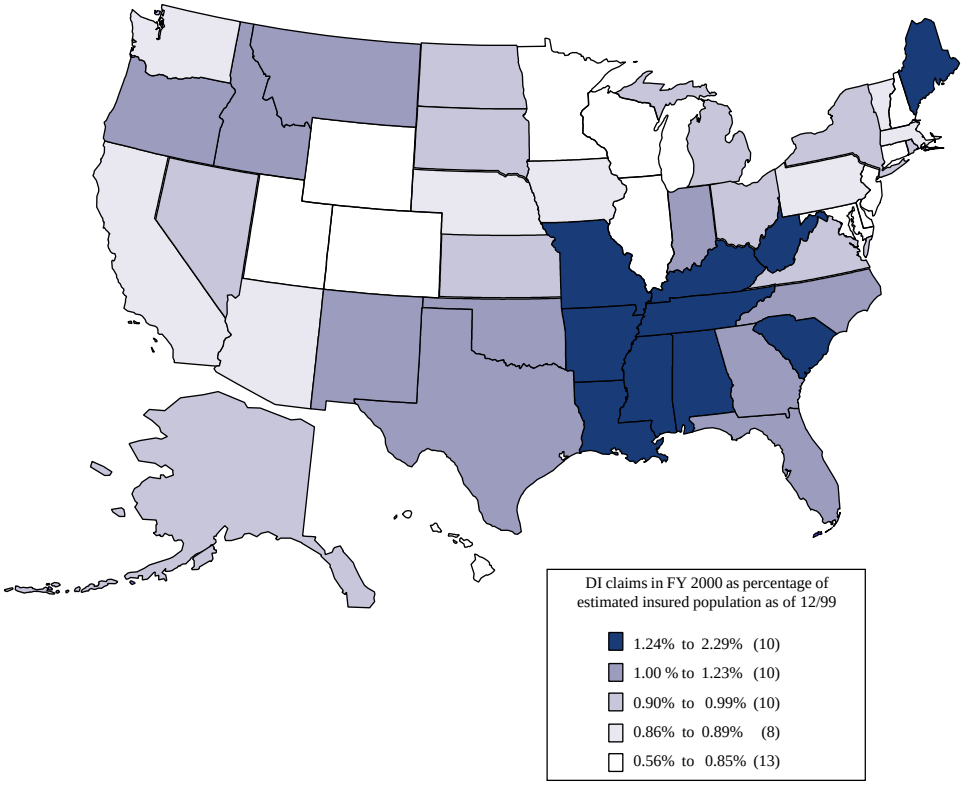
Chart 1. - DI and SSI Disability Applications

Calendar Years 1965 - 1999



The number of applications for DI and SSI disability has varied greatly over the years, although the overall trend has been upward. After declining from a high in the early 1990s, applications have recently shown an increase. SSI applications increased in 1998 and 1999 and DI applications increased in 1999. This trend continued in the first part of 2000. Past studies have shown some relationship between applications and unemployment, particularly for DI. Observers of the program also cite other factors affecting applications, including, for example, increases in numbers of workers insured for Disability Insurance, efforts by State and local governments to shift welfare caseloads and spending to the Federal government, court decisions, changes in regulations, and adjudicative climate. Numbers for DI and SSI are not additive because some applicants apply for benefits under both programs.

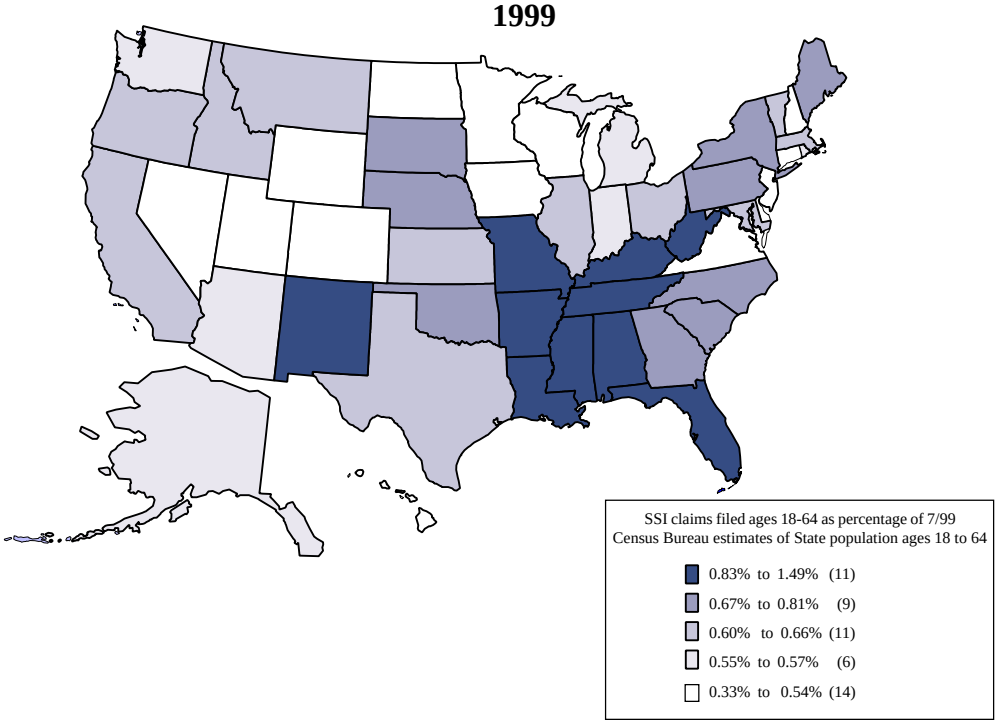
Chart 2. - DI Application Rates, By State
2000



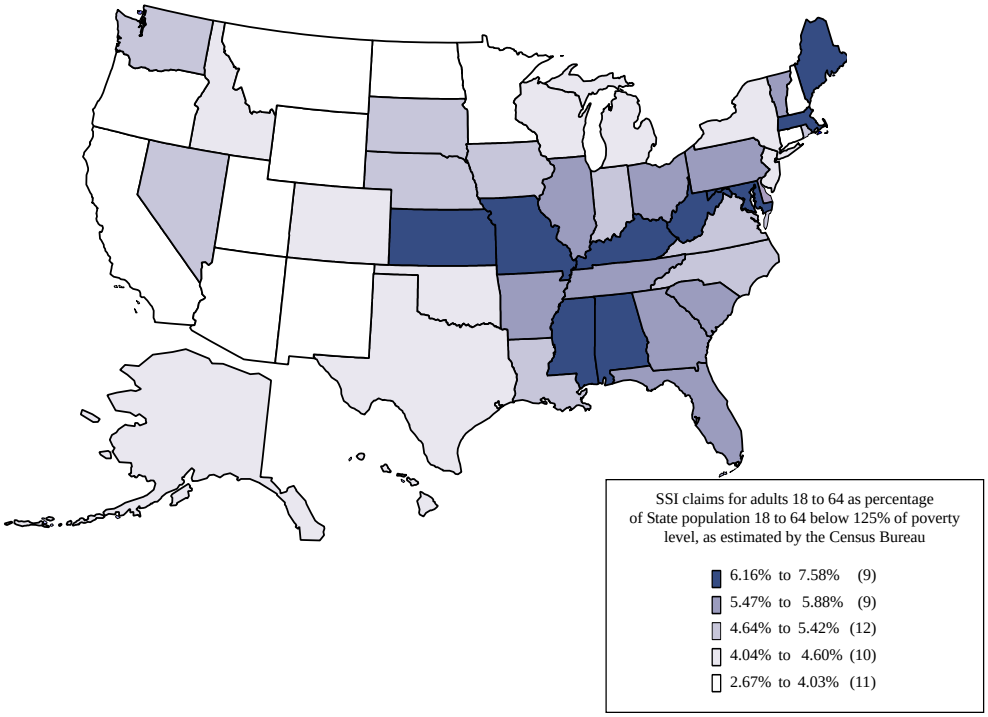
The highest DI application rates are generally in the Southeast.

Chart 3. - SSI Adult Disability Application Rates, By State

1999



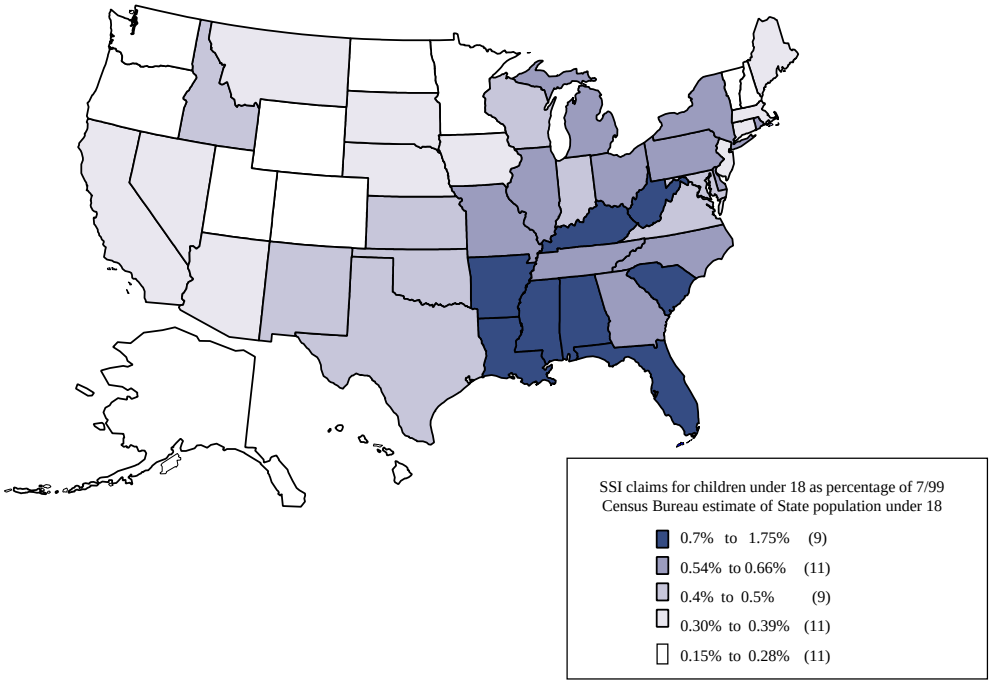
SSI adult application rates as percentage of the population show a similar pattern to DI application rates, but there are also differences such as higher rates in New York and California.



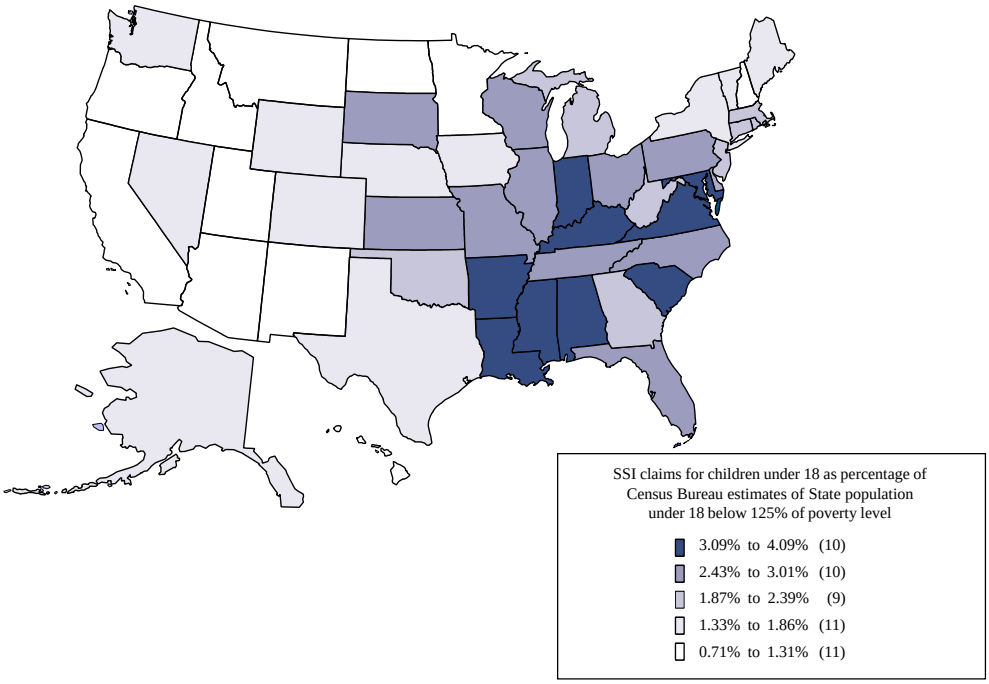
Viewed as a percentage of the population living in households with income below 125 percent of the poverty level in 1998, SSI adult application rates still cover a wide range, from 2.67 percent in North Dakota to 7.58 percent in Kentucky.

Chart 4. - SSI Child Disability Application Rates, By State

1999



Disability application rates for SSI children as a percentage of the population are highest in the Southeast but are also high in States such as New York, Pennsylvania, Ohio, Michigan, and Illinois.

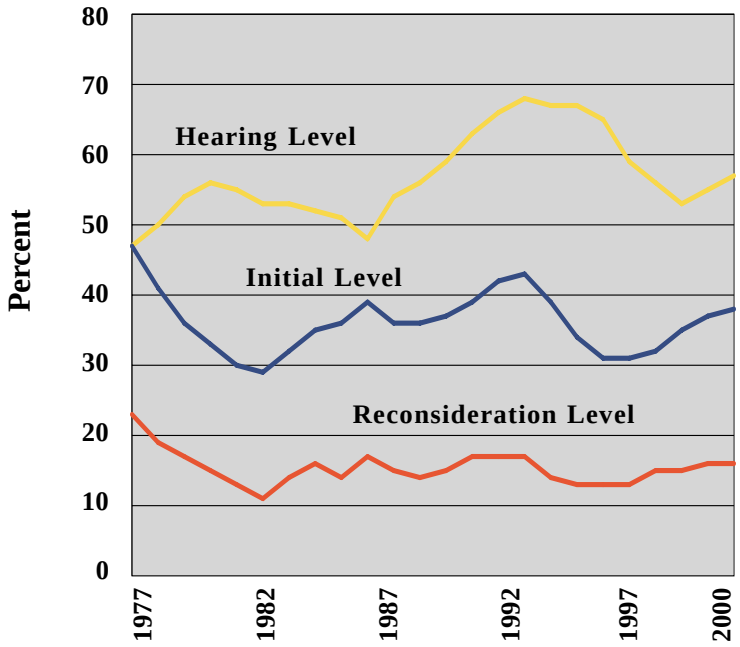


Expressed as a percentage of the population under 18 living in households with income below 125 percent of the poverty level in 1998, there is a wide range in SSI child disability application rates, from 0.71 percent in Hawaii to 4.09 percent in Maryland.

II. Allowance Rates/Awards

Chart 5. - Allowance Rates at Each Level of Decision Making, DI and SSI Combined

Fiscal Years 1977 - 2000



Note: The hearings level allowance rate shown here is the percentage of dispositions, which includes dismissals.

In the last two decades, the percentage of claims adjudicated at the ALJ level that are allowed has been considerably higher than the percentage allowed by the DDSs at the initial level. The allowance rates for both levels have shown large variations, sometimes moving in tandem, sometimes not.

Chart 6. - State Agency Allowance Rates for Initial Claims

Fiscal Years 1990 - 2000

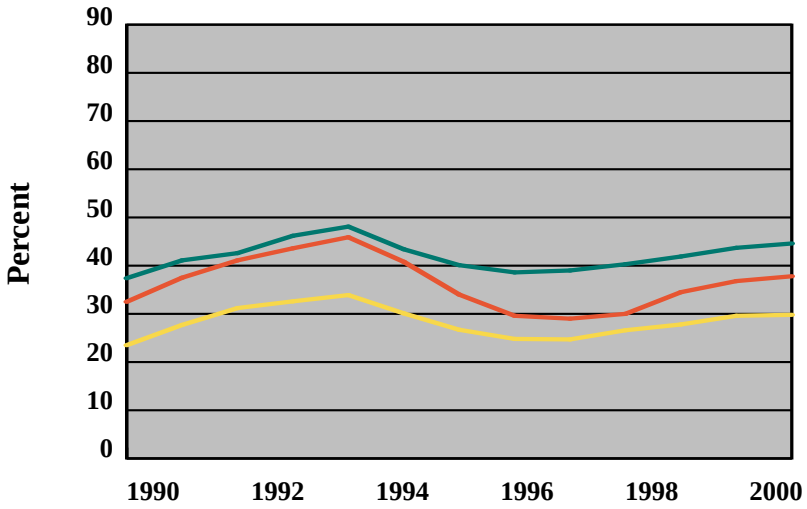
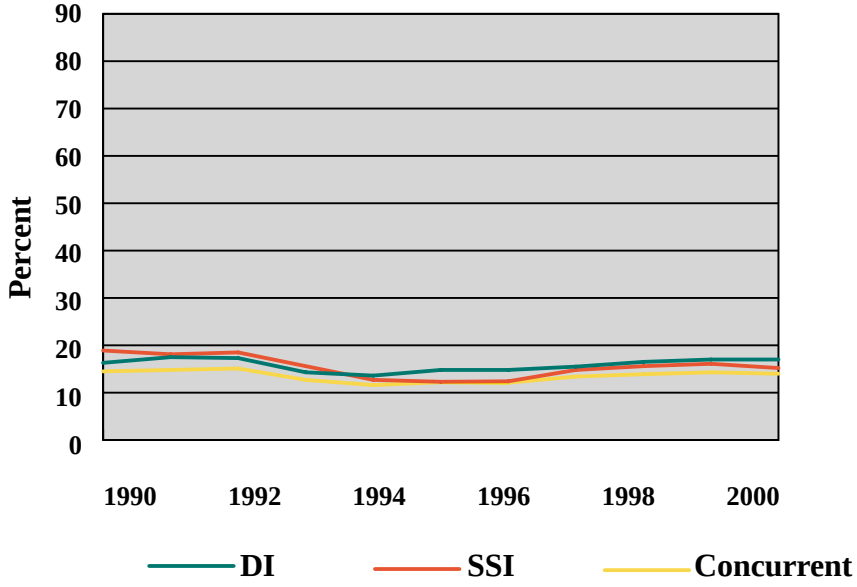


Chart 7. - State Agency Allowance Rates for Reconsiderations

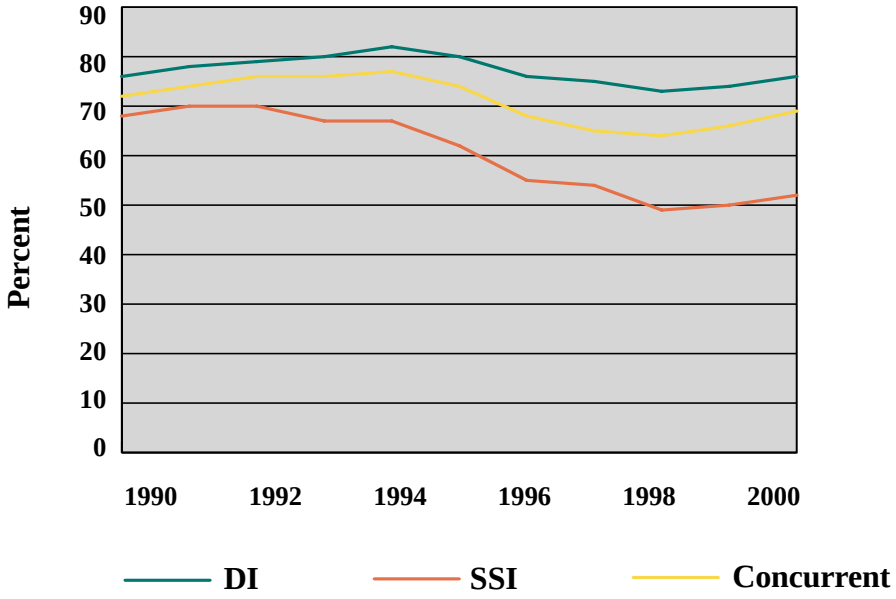
Fiscal Years 1990 - 2000



Since 1996, the percentage of applications allowed by State agencies at the initial level has grown for DI, SSI, and concurrent applications. Some in SSA and the State agencies attribute the growth in State agency allowance rates at least in part to the process unification rulings that SSA issued in the summer of 1996. Others attribute it to adjudicative climate.

Chart 8. - ALJ Hearing Decision Allowance Rates*

Fiscal Years 1990 - 2000

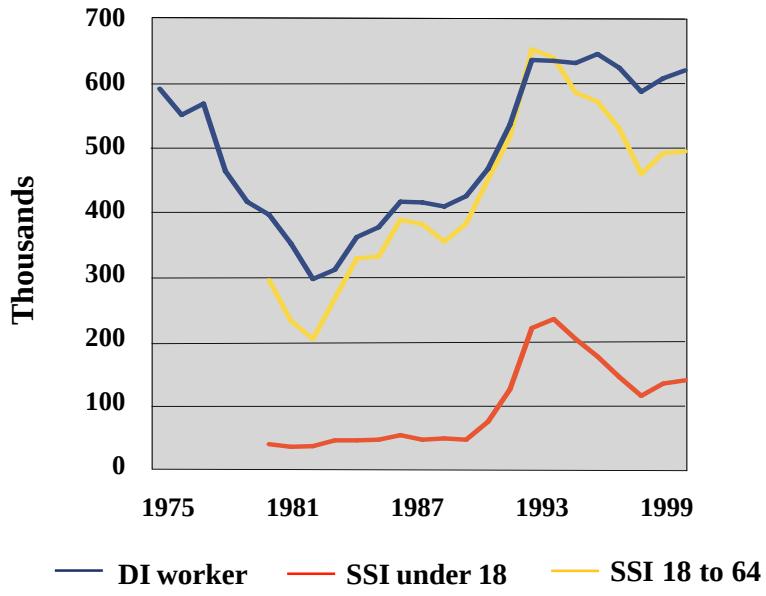


**Excludes dismissals.*

ALJ hearing decision allowance rates fell in the period 1995 to 1998, but began to climb again in 1999 and 2000. Note that allowance rates for SSI claimants are considerably lower than for DI.

Chart 9. - Disability Awards

Calendar Years 1975 - 1999

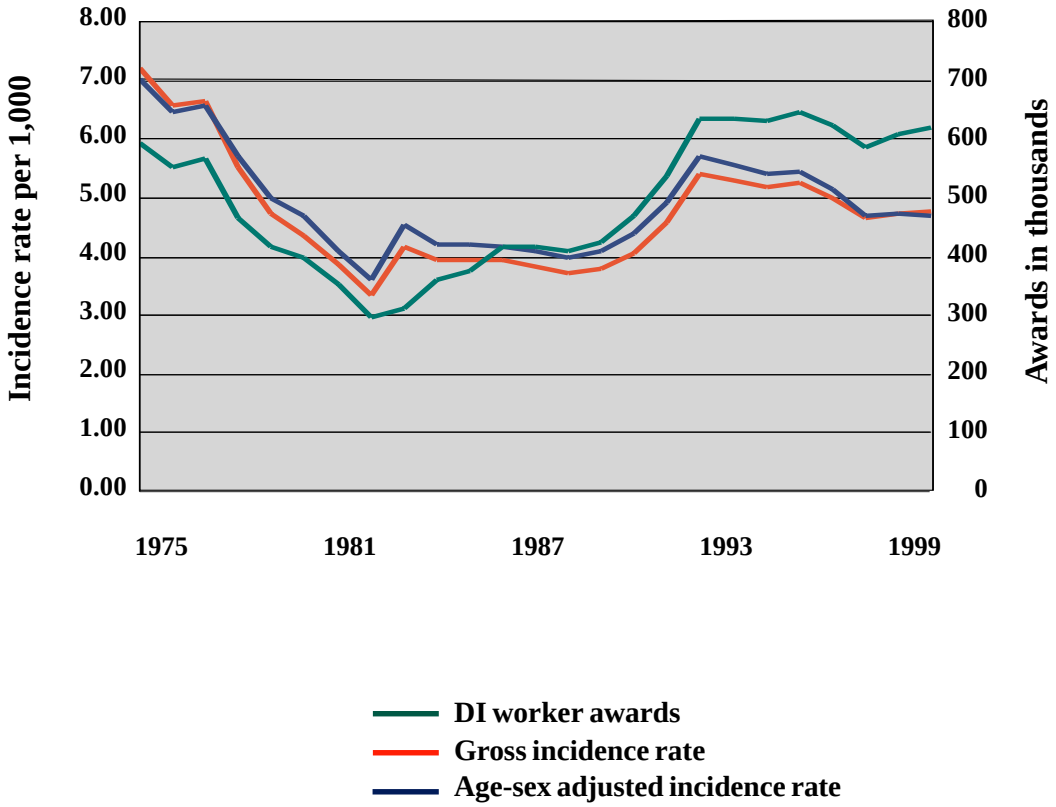


Note: Age breakouts for SSI not available before 1980.

The number of DI worker and SSI disability awards has increased greatly since 1982. DI worker awards declined slightly in 1996 and 1997, but resumed their climb in 1998. SSI awards for both adults and children also resumed their climb in 1998, after falling off sharply from highs in 1992 and 1993. Much of the rapid growth in SSI awards for children in the early 1990s was due to the Supreme Court's *Zebley* decision, which liberalized the criteria for determining disability for children.

Chart 10. - DI Worker Awards and Incidence Rates

Calendar Years 1975 - 1999



The DI gross incidence rate (the ratio of annual awards to the disability insured population) has varied in somewhat of a roller coaster fashion. It stood at 7.2 per thousand in 1975 and fell to a low of 3.3 per thousand in 1982. It rose again to 5.4 per thousand in 1992, fell to 4.6 in 1997, and began to rise again in 1998. The incidence rate has grown more slowly than the number of awards, reflecting the growth of the insured population.

The incidence rate is a common indicator of the status of the disability system. This chart shows both the gross incidence rate and the age-sex adjusted rate for DI benefits. The adjusted rate factors out the effects of the changes in the population in terms of both age and sex. It shows what the incidence rate would have been given the age and sex distribution of the insured population as of 1998.

Chart 11. - State Agency Initial Allowance Rates for DI and SSI, By State

Fiscal Year 2000

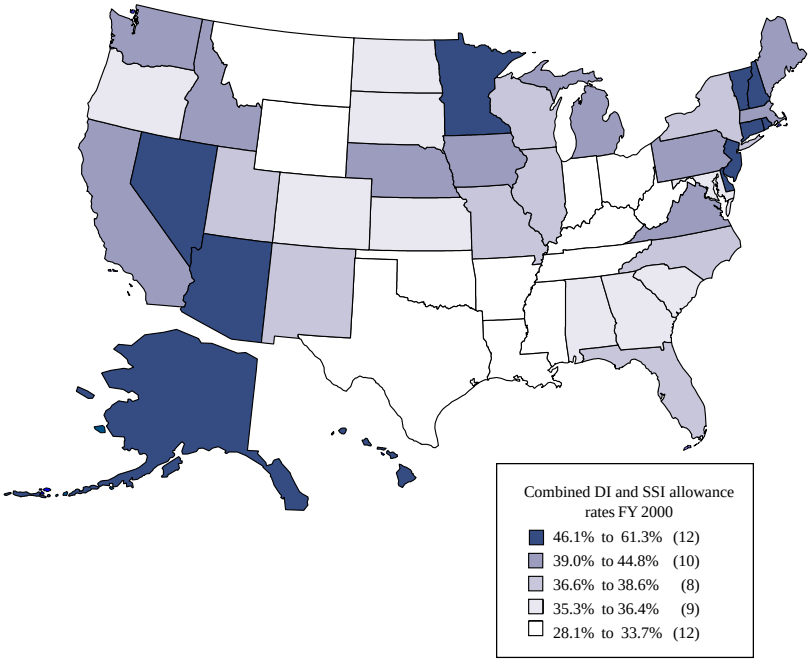
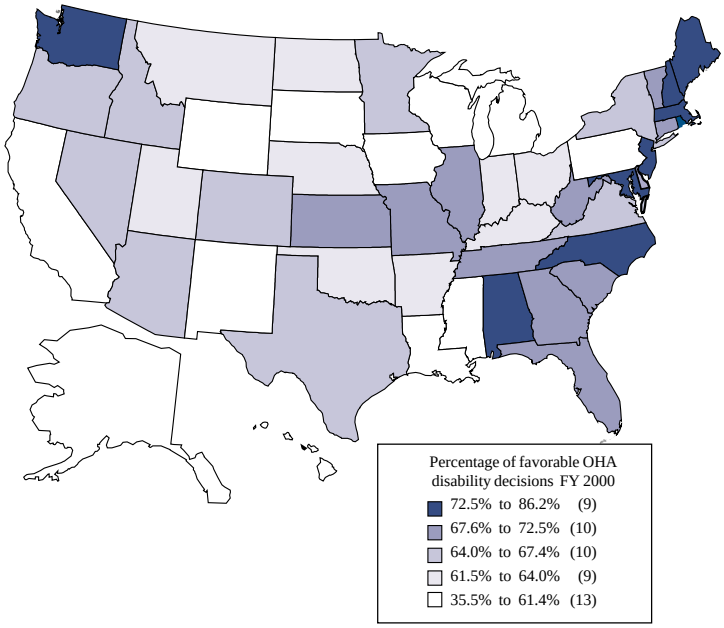


Chart 12. - Percentage of ALJ Disability Decisions Favorable to Claimants, By State

Fiscal Year 2000

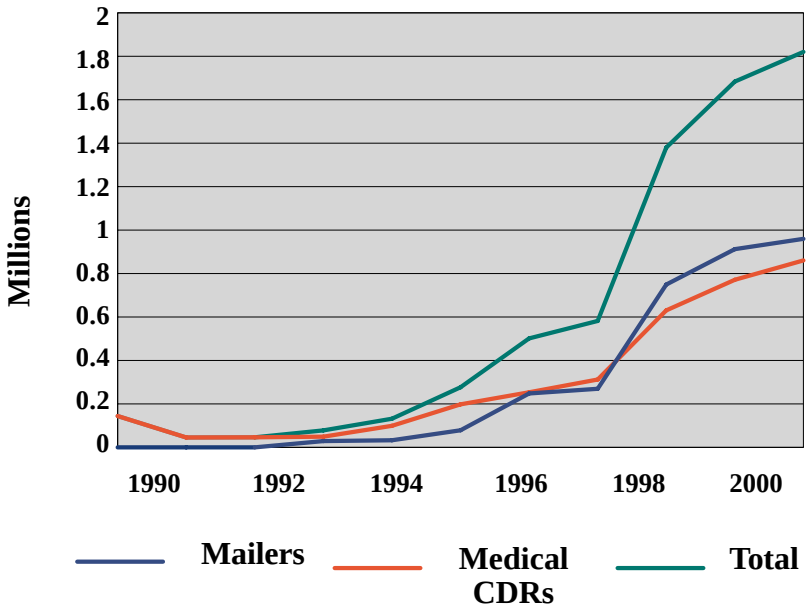


Compared to the distribution by State of initial allowances, the distribution of hearing decisions favorable to claimants is more scattered. There is no apparent correlation between low State agency initial allowance rates and high hearing allowance rates.

III. Continuing Disability Reviews

Chart 13. - Number of Continuing Disability Reviews (CDRs) Processed

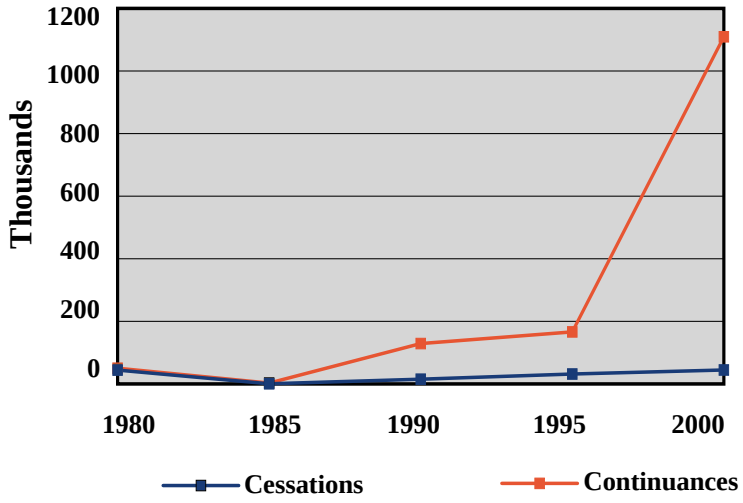
Fiscal Years 1990-2000



In 1996, Congress authorized $4.3 billion in funding for continuing disability reviews (CDRs) for fiscal years 1996 through 2002. CDRs are conducted for beneficiaries of both DI and SSI. SSA uses statistical profiling to identify beneficiaries' probability of medical improvement. Those with higher probability are scheduled for medical CDRs. Field offices contact these beneficiaries and ask them to provide updated information on their condition and their treatment sources. The field offices then send the cases to a State agency for decision. Beneficiaries with a lower probability of medical improvement are sent mailers with questions designed to raise issues of medical improvement. Beneficiaries send their responses to the mailer to a data operations center where they are recorded. If the answers to a mailer indicate that medical improvement may have occurred, the beneficiary is scheduled for a full medical CDR.

Chart 14. - CDR Decisions for DI Beneficiaries*

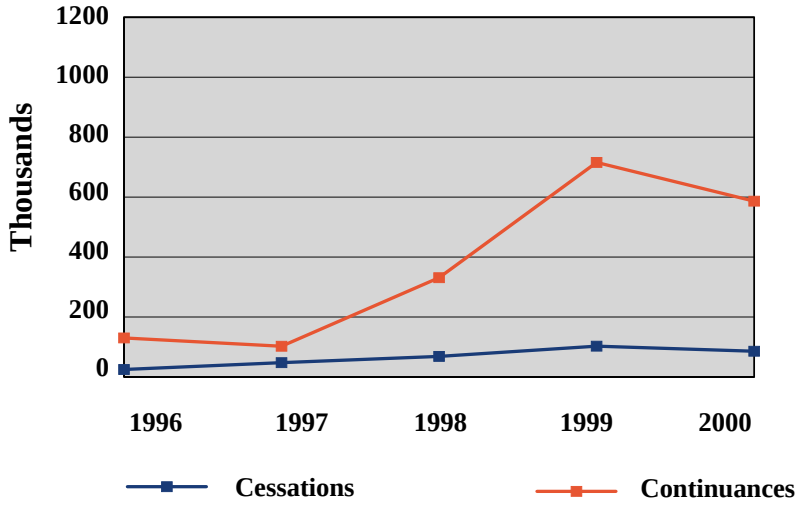
Fiscal Years 1980-2000



* *Includes disabled workers, disabled widows and widowers, and disabled children.*

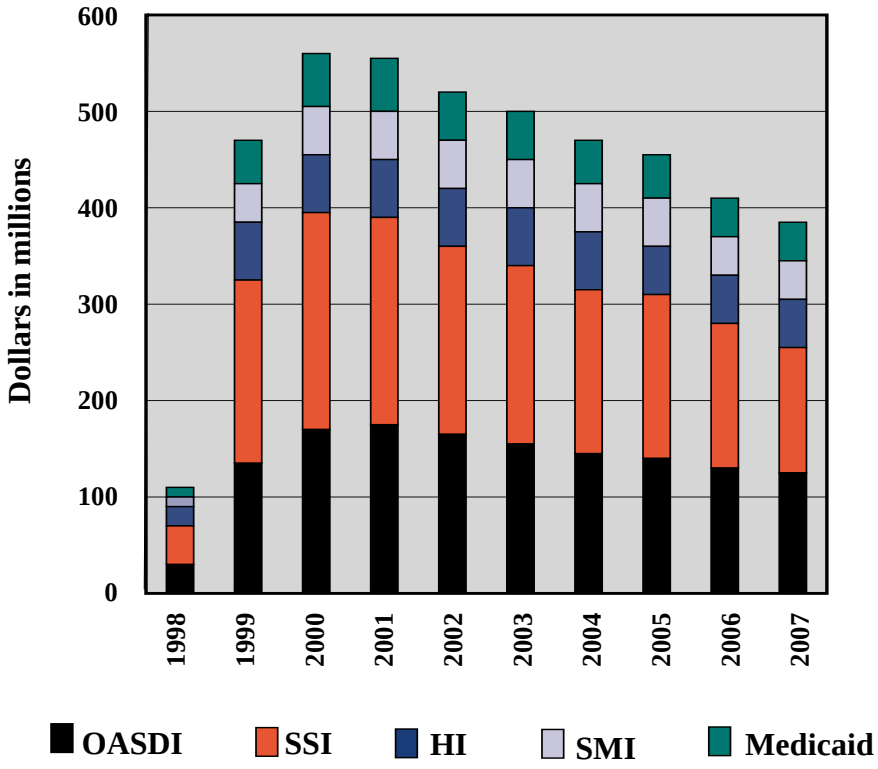
Chart 15. - CDR Decisions for SSI Beneficiaries*

Fiscal Years 1996-2000



* *Numbers of CDRs do not include redeterminations of SSI children required by the change in the definition of disability for children enacted in 1996. SSA conducted CDRs for SSI beneficiaries only in limited circumstances prior to 1996.*

Chart 16. - Estimated Federal Savings From CDR Cessations in Fiscal Year 1998, By Program



This chart shows the estimated reduction in benefit payments over a ten-year period resulting from initial CDR cessations in fiscal year 1998. The estimated reduction is based on a projected total of 70,300 ultimate cessations after all appeals. Although most CDRs do not result in cessation, SSA's CDR process has been yielding a favorable ratio of savings to costs. For fiscal year 1998, SSA's actuaries estimate the ratio of savings to administrative costs at $12 to $1. The actuaries expect the high savings-to-cost ratio to decline substantially in the future as the CDR backlog is depleted.

IV. Terminations

Chart 17. - Number of DI Terminations

Calendar Years 1975-1999

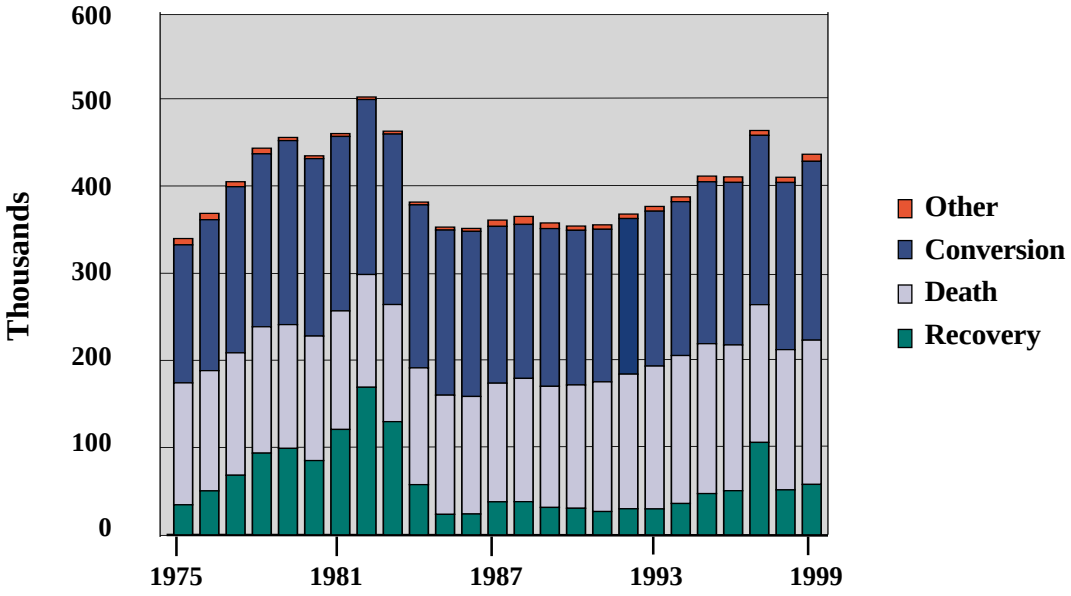
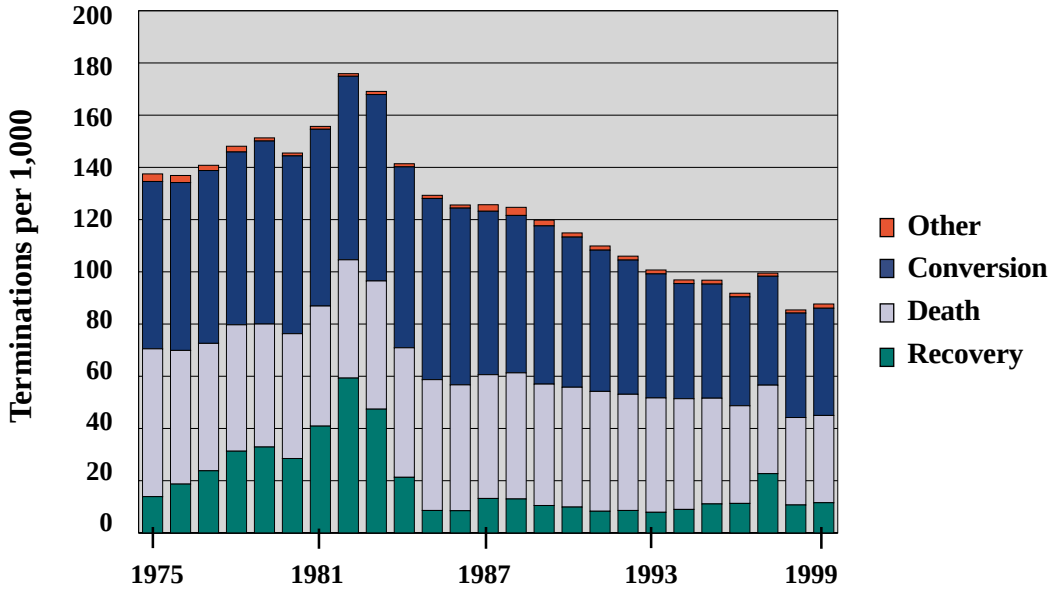


Chart 18. - DI Termination Rate

Calendar Years 1975-1999

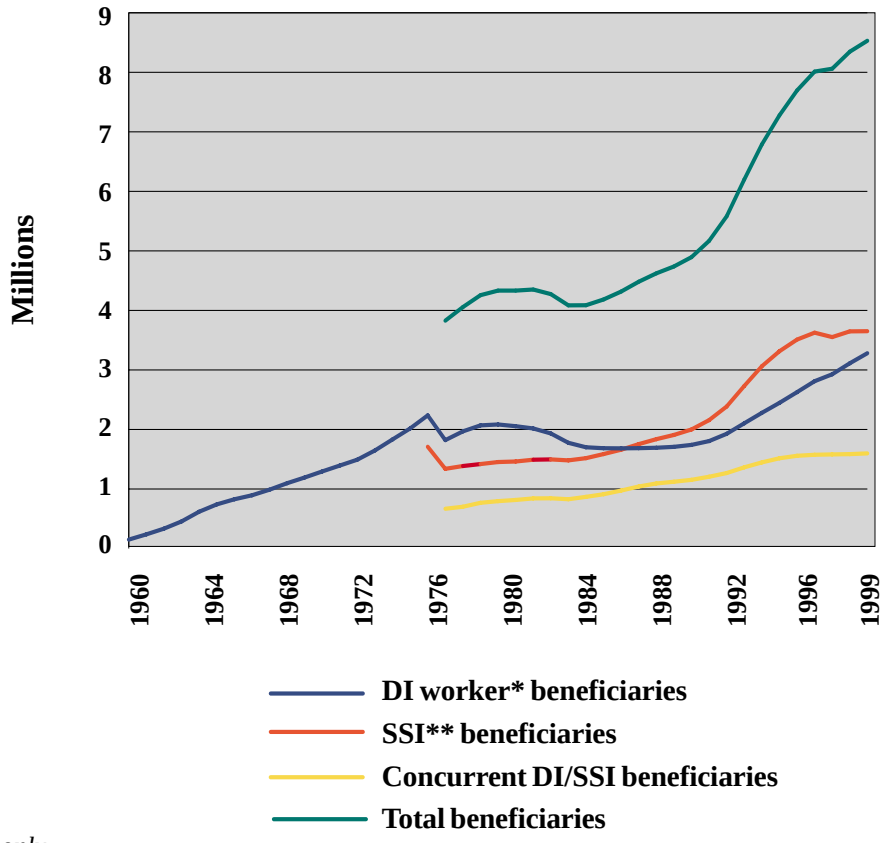


While the number of terminations of disabled worker benefits has generally increased since 1990, the termination rate (the number of terminations per 1,000 beneficiaries) has generally declined. Terminations due to death or conversion exceed those due to recovery from a disability except in 1982, when terminations for recovery exceeded those for death. (Conversion refers to transferring from a DI benefit to another type of benefit, generally to a retirement benefit at age 65.) These trends in terminations and termination rates reflect the overall growth in the number of DI beneficiaries as well as the increasing proportion of younger beneficiaries.

V. Beneficiaries

Chart 19. - DI, SSI and Concurrent Disability Beneficiaries

Calendar Years 1960 - 1999



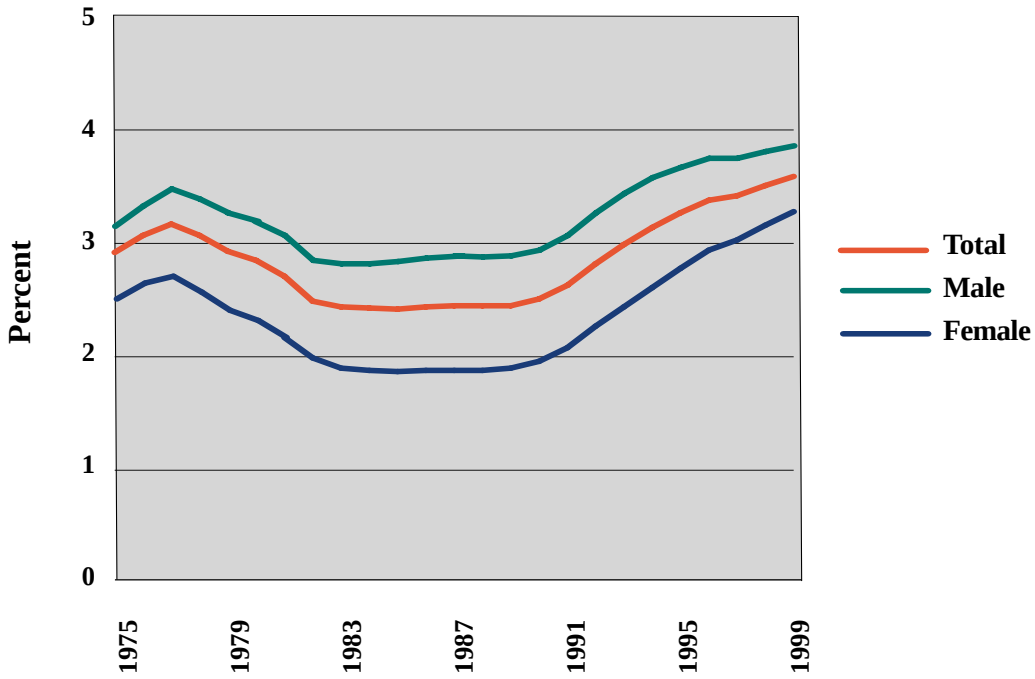
* *DI only*

** *SSI only*

The number of disability beneficiaries has continued to climb, and SSA's actuaries project future increases as the average age of the population increases and the baby boomers reach an age of increased likelihood of applying for disability. The number of SSI disability beneficiaries has exceeded the number of DI worker beneficiaries since 1986. In December 1999, 1.6 million wives, husbands, and children of disabled workers received DI benefits in addition to the number of DI worker beneficiaries shown above.

Chart 20. - Disabled Worker Beneficiaries as Percent of Population Insured for Disability

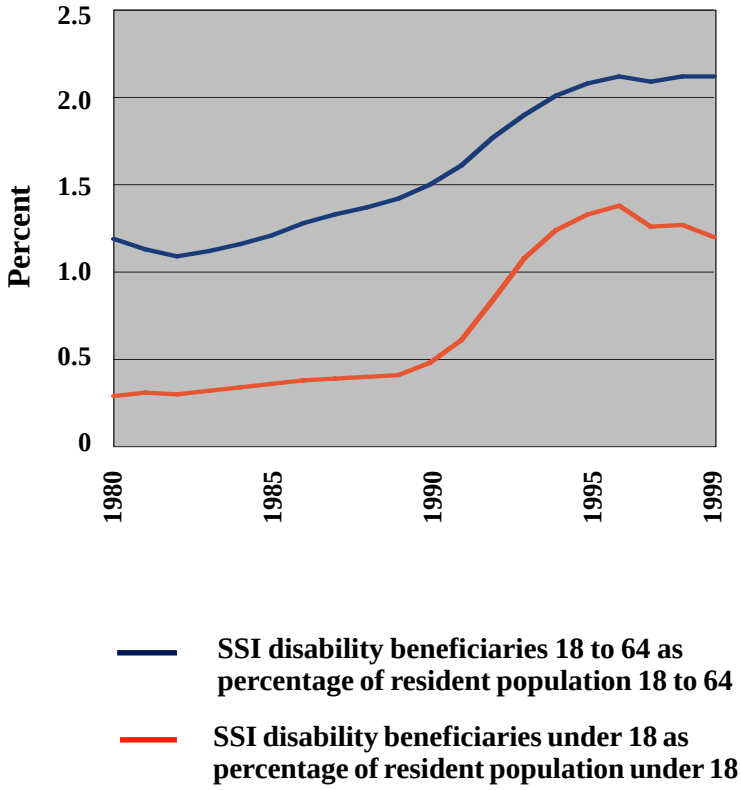
Calendar Years 1975-1999



This chart shows the DI prevalence rate. Since 1988 there has been a steady increase in the percentage of the population insured for disability that is receiving disability benefits.

Chart 21. - SSI Disability Beneficiaries as Percent of Population, By Age Group

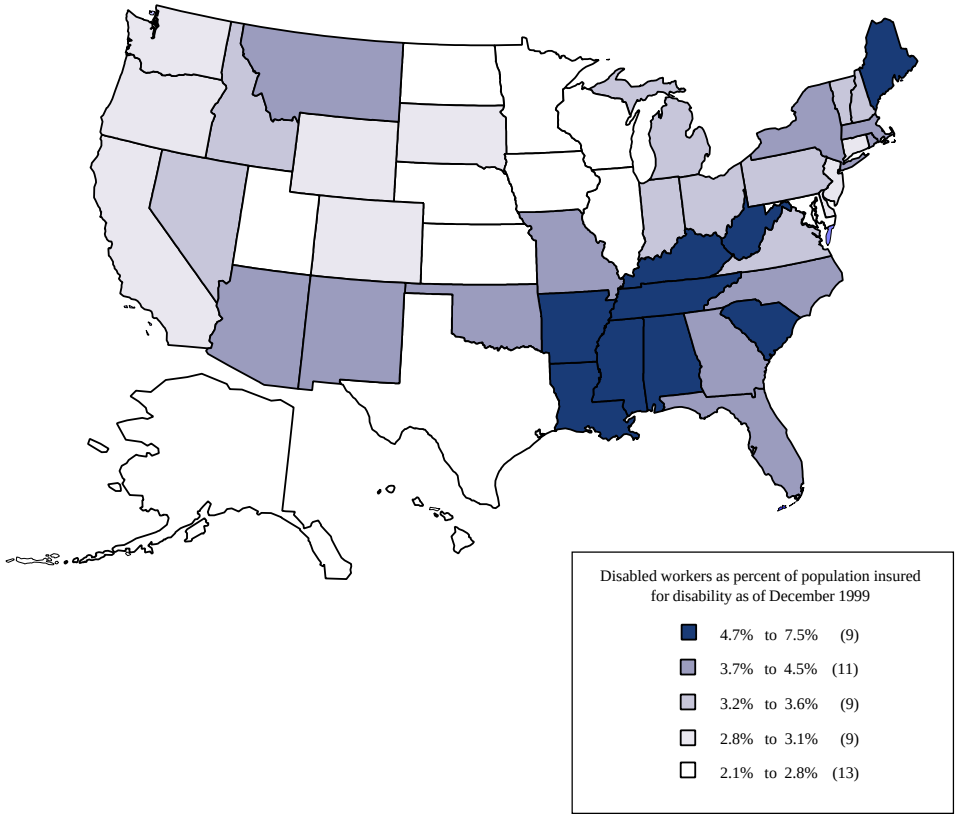
Calendar Years 1980-1999



Since 1980, the percentage of the adult population receiving SSI disability benefits has nearly doubled, and the percentage of children receiving benefits has increased fourfold. For both groups, growth was most rapid in the early 1990s. For adults, the figure has changed little since 1995. The percentage of children receiving benefits has declined slightly since that time.

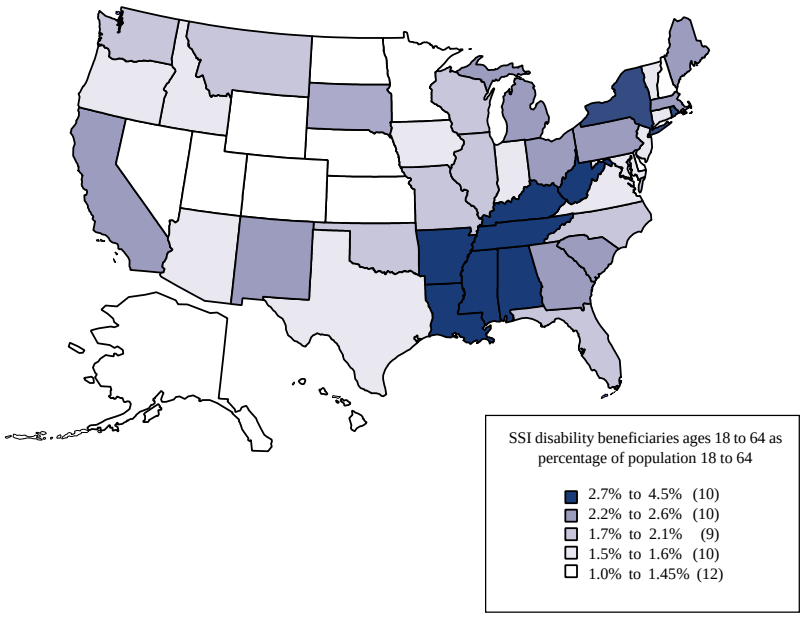
Chart 22. - Disabled Workers as Percent of Population Insured for Disability, By State

December 1999

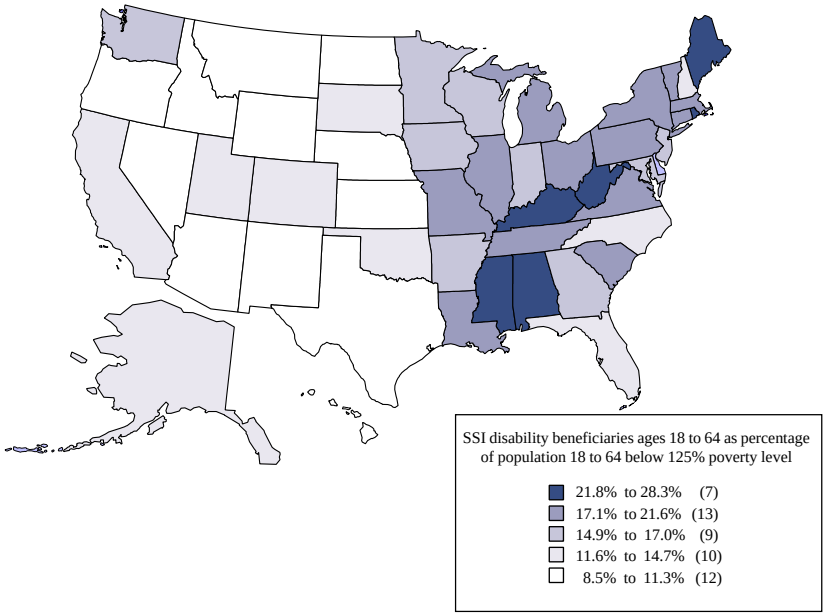


States with the darker colors have the higher percentage of population insured for disability who are receiving DI worker benefits. As can be seen, prevalence rates generally are highest in the Southeastern part of the U.S.

Chart 23. - SSI Disabled Adults as Percent of Population 18 to 64, By State

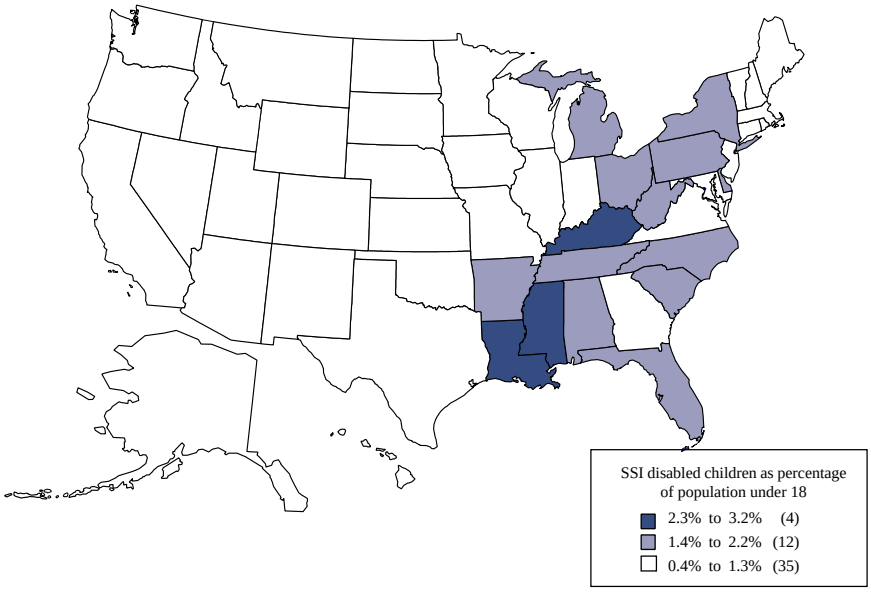


This chart shows SSI disabled adults ages 18 to 64 as of December 31, 1999, as a percentage of State population ages 18 to 64 as of July 1, 1999. As with DI, the SSI prevalence rate generally tends to be highest in the Southeastern part of the U.S.

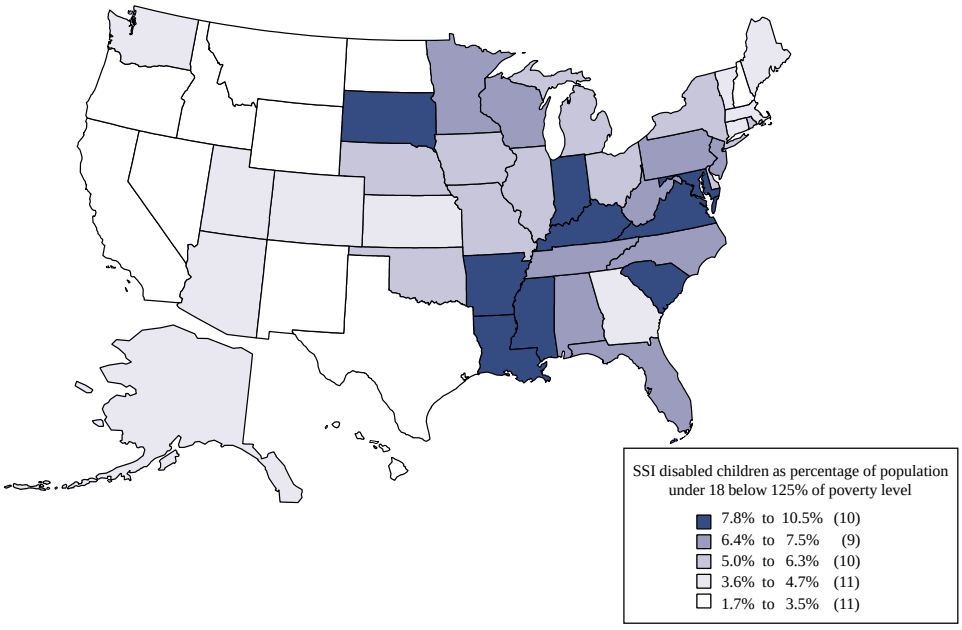


This chart shows SSI disabled adults ages 18 to 64 in December 1999 as a percentage of the State population in 1999 below 125 percent of the poverty level. Prevalence rates range from 8.5 percent in Montana to 28.3 percent in Kentucky. Rates are generally higher in the Eastern than in the Western part of the U.S.

Chart 24. - SSI Disabled Children as Percent of Population Under 18, By State



There is a wide variance among States in the percentage of the population under 18 receiving SSI disability benefits. In 35 States, 1.3 percent or less of the population under 18 receives SSI. In 4 States (Kentucky, Mississippi, Louisiana, and the District of Columbia), between 2.3 percent and 3.2 percent receive SSI. The map shows data for disabled children as of December 31, 1999 as a percentage of child population as of July 1, 1999.

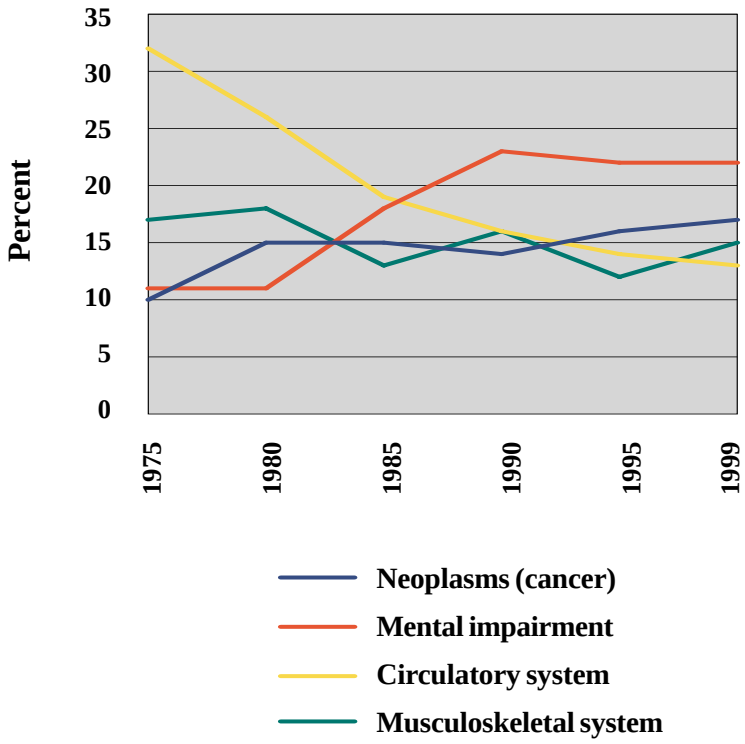


The variance among States is wide also when the prevalence of SSI children's benefits is expressed as a percentage of the population under 18 living in households with incomes below 125 percent of the poverty level. In 22 States, the number of SSI beneficiaries is 4.7 percent or less of that population, while in 10 States, the number of beneficiaries is 7.8 percent or more of that population.

VI. Beneficiary Characteristics

Chart 25. - Trend in State Agency Awards for DI By Major Cause of Disability

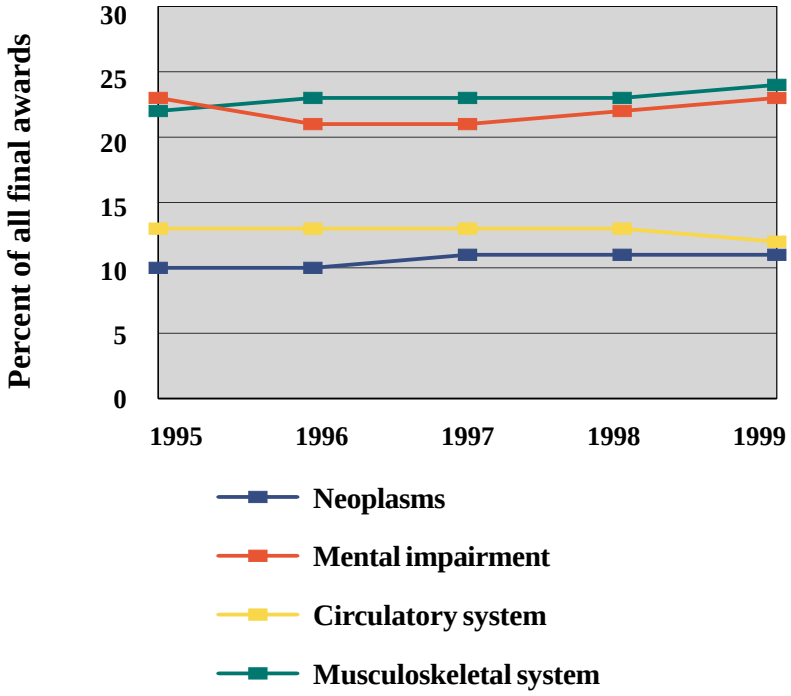
Calendar Years 1975-1999



Mental impairment has become the largest single reason for State agency disability awards. Other major causes are neoplasms, impairments of the musculoskeletal system, and impairments of the circulatory system. The percent of cases awarded on the basis of impairments of the circulatory system, however, has declined substantially over the years.

Chart 26. - DI Worker Awards After All Appeals By Cause of Disability

Calendar Years 1995-1999

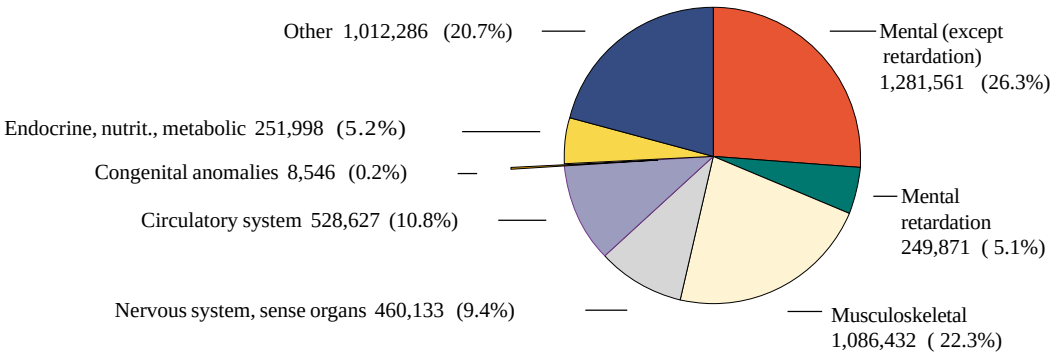


Unlike at the State agency level, the largest single reason for DI worker awards after all appeals is impairment of the musculoskeletal system. Beginning in 1996, this category overtook mental impairments as the largest category of final awards.

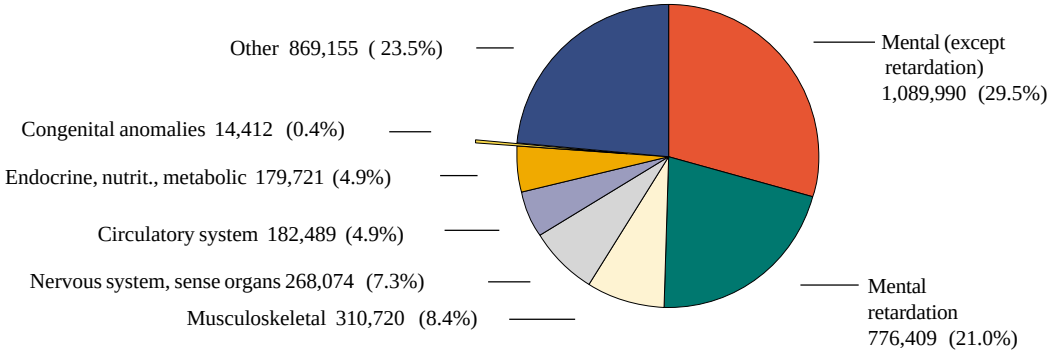
Chart 27. - Beneficiaries By Type of Impairment

December 1999

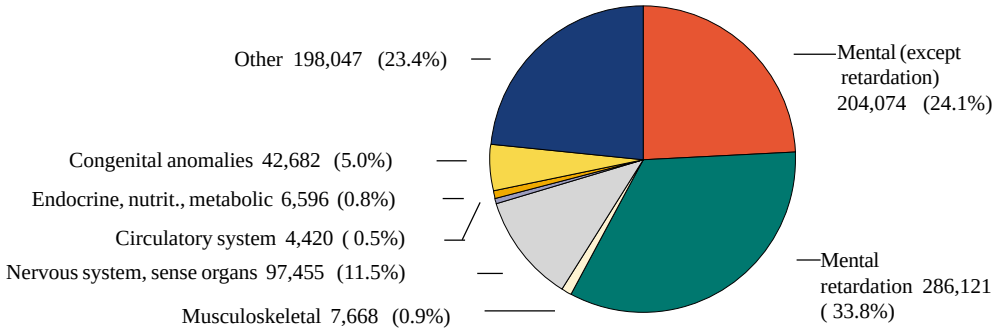
DI Beneficiaries



SSI Beneficiaries 18 to 64



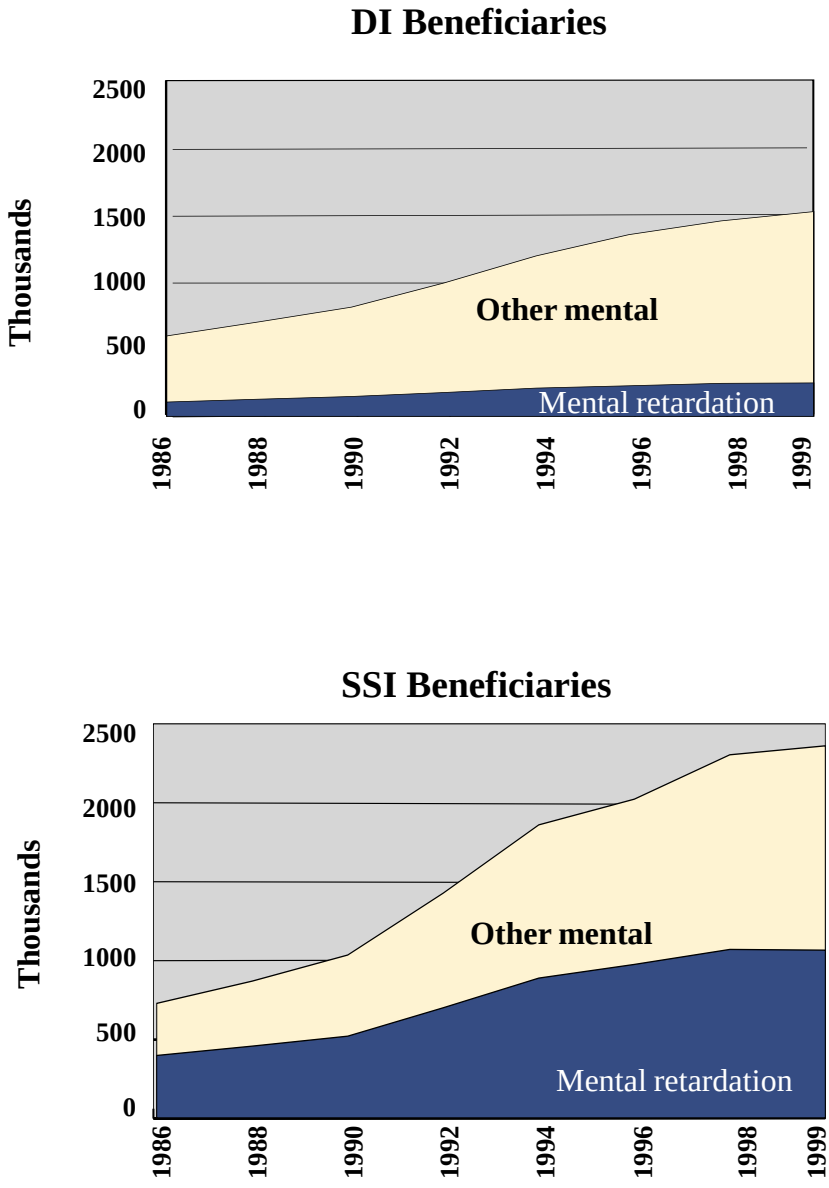
SSI Beneficiaries Under 18



Note: For purposes of comparison among groups of beneficiaries, the charts show causes of disability that account for at least 5 percent of one or more of the three groups of beneficiaries on the chart. The "other" category includes all other causes, which individually account for less than 5 percent of each of the three beneficiary groups, such as infectious and parasitic diseases, neoplasms, and several others. Although neoplasms represent a high percentage of the DI awards, the high mortality rate of individuals with neoplasms may explain why the percentage of beneficiaries with neoplasms is below 5 percent.

Chart 28. - Beneficiaries With Diagnosis of Mental Impairment

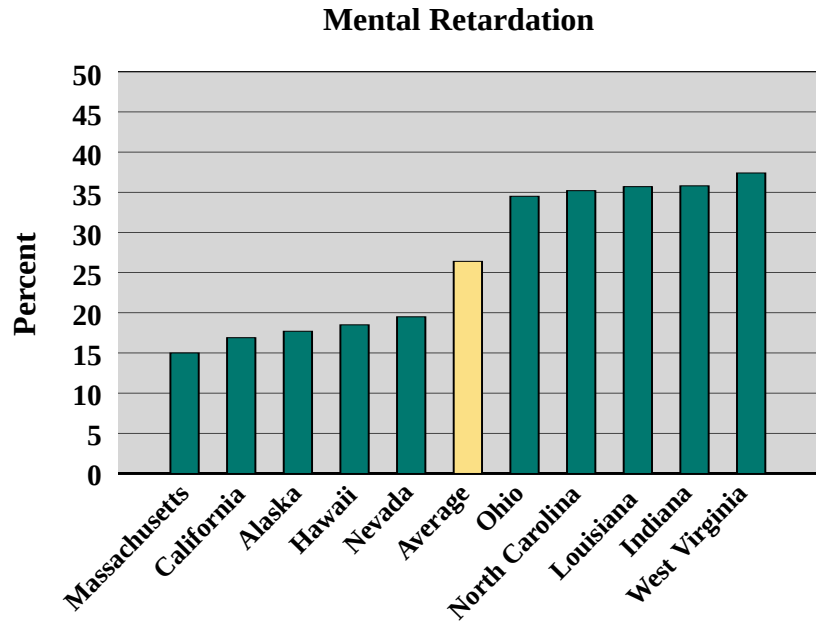
Calendar Years 1986-1999

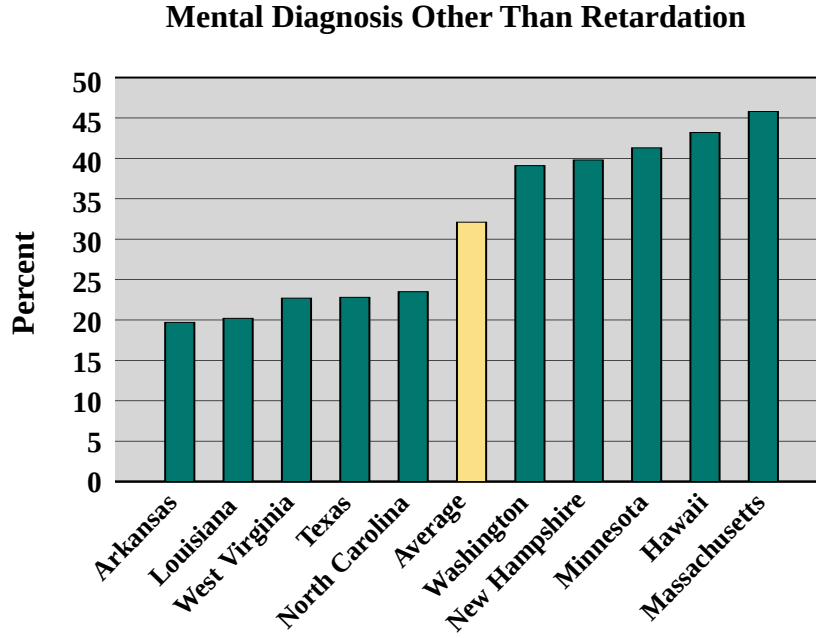


Since the mid-1980s, the number of beneficiaries with a diagnosis of mental impairment (either retardation or other) has grown significantly in both the DI and SSI programs. The growth in the SSI program has been particularly pronounced.

Chart 29. - SSI Beneficiaries Under Age 65 With Diagnosis of Mental Impairment: Low Five States, High Five States, and National Average

December 1999

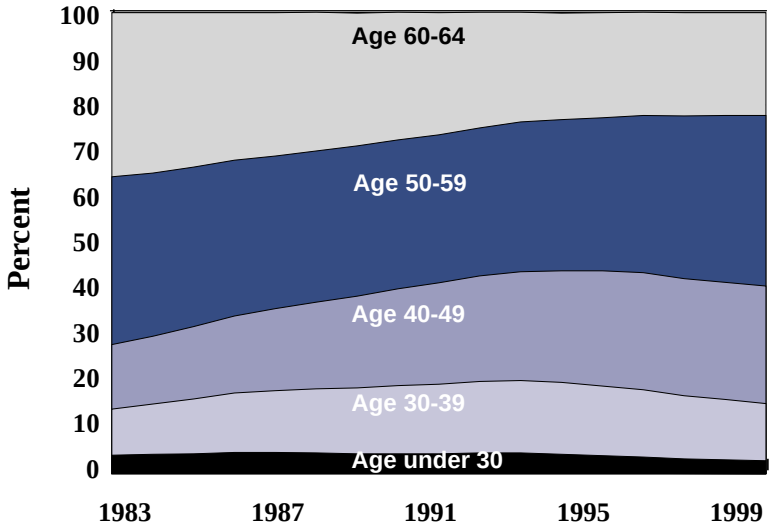




There are significant State-to-State differences in the diagnoses of SSI disabled beneficiaries. For example, the percentage of beneficiaries as of December 1999 with a diagnosis of mental retardation ranged from 15 percent in Massachusetts to 37 percent in West Virginia. The percentage of beneficiaries with a mental diagnosis other than retardation ranged from 20 percent in Arkansas to 46 percent in Massachusetts.

Chart 30. - DI Age Groups as Percent of Total DI Beneficiaries

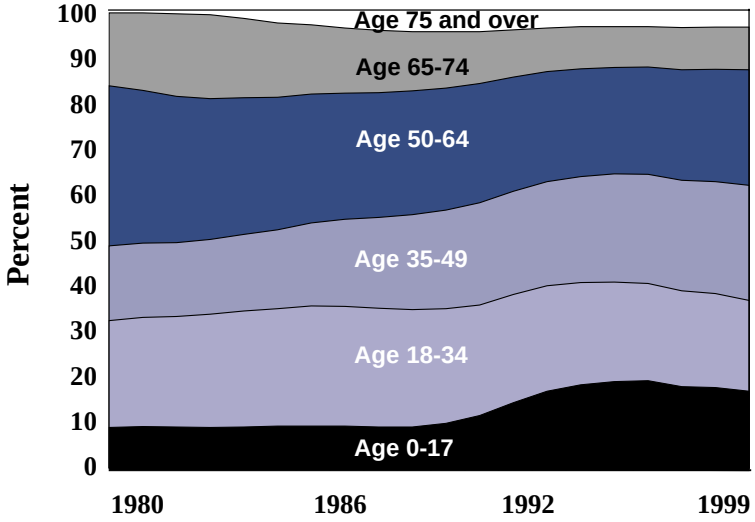
Calendar Years 1983-1999



Between 1983 and 1999, the 40 to 49 age group of DI beneficiaries grew to 26 percent from 14 percent of the total, while the 60 to 64 age group fell to 22 percent from 36 percent of the total. At age 65, DI beneficiaries are converted to retirement benefits.

Chart 31. - SSI Age Groups as Percent of Total SSI Disabled Beneficiaries

Calendar Years 1980-1999



While the number of beneficiaries in every age group of SSI disability beneficiaries has grown, some age groups have grown more rapidly than others. Beneficiaries under age 18 were 9 percent of the total beneficiary population in 1980 and had grown to 17 percent of the population by 1999. Beneficiaries in the 35-to-49 age group were 16 percent of the beneficiary population in 1980 and had grown to 25 percent in 1999.

Chart 32. - Average Age of Newly Awarded DI Beneficiaries

Calendar Years 1960-1999

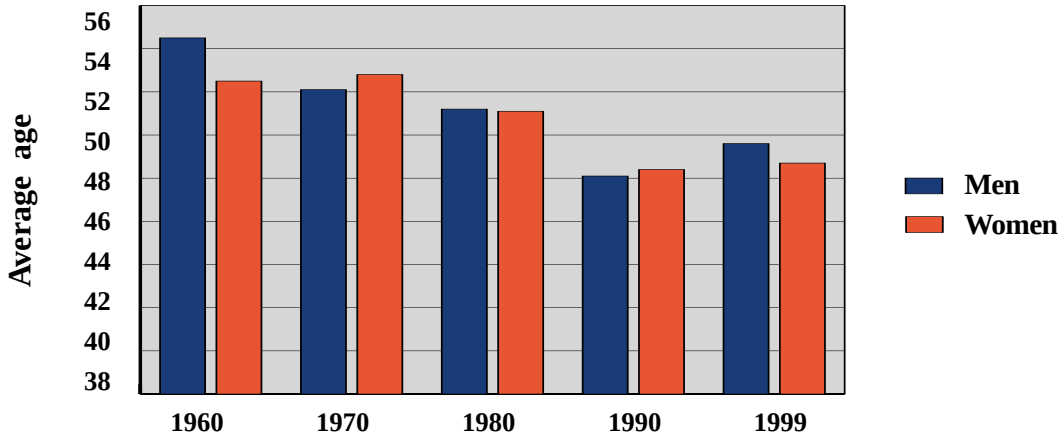
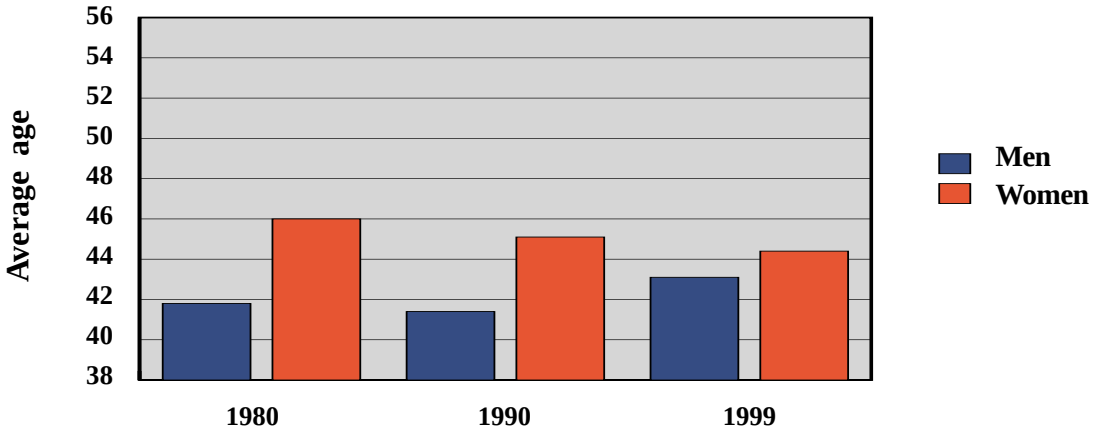


Chart 33. - Average Age of Newly Awarded SSI Disabled Adult Beneficiaries

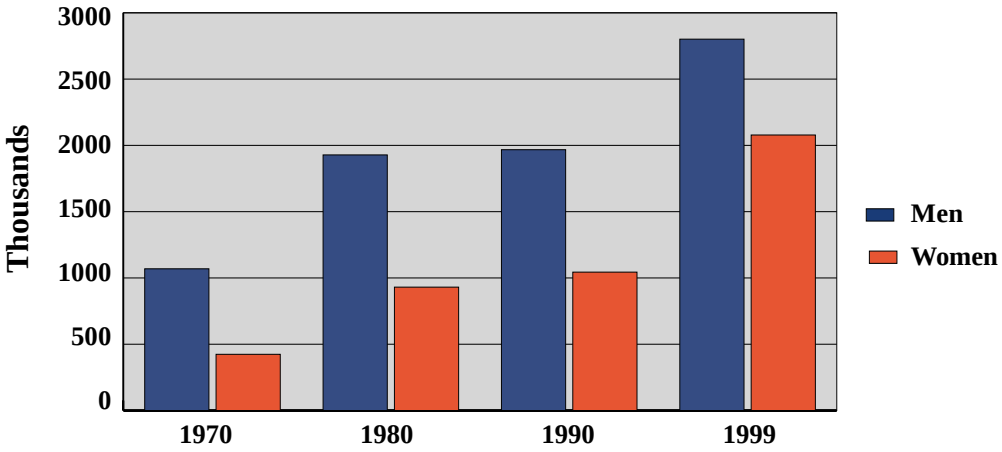
Calendar Years 1980-1999



Until recently, there was a marked downward trend in the age of newly awarded DI beneficiaries. The average age of newly awarded SSI adult beneficiaries (under age 18 not included) has been consistently lower than that of new DI beneficiaries.

Chart 34. - Number of DI Beneficiaries, By Sex

Calendar Years 1970-1999



Women comprise an increasingly large proportion of DI beneficiaries. In 1970, they were 28 percent of the total beneficiaries (and 33 percent of the insured population). In 1999, they were 43 percent of the total beneficiaries (and 47 percent of the insured population).

Chart 35. - SSI Disabled Beneficiaries Age 18 to 64, By Sex

Calendar Years 1993-1999

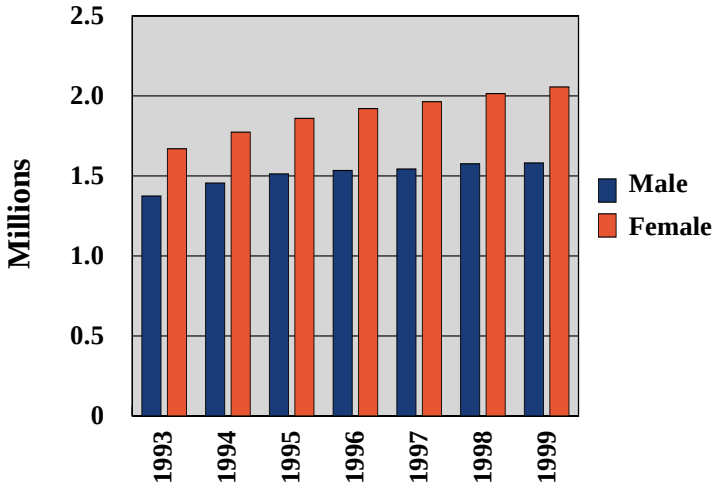
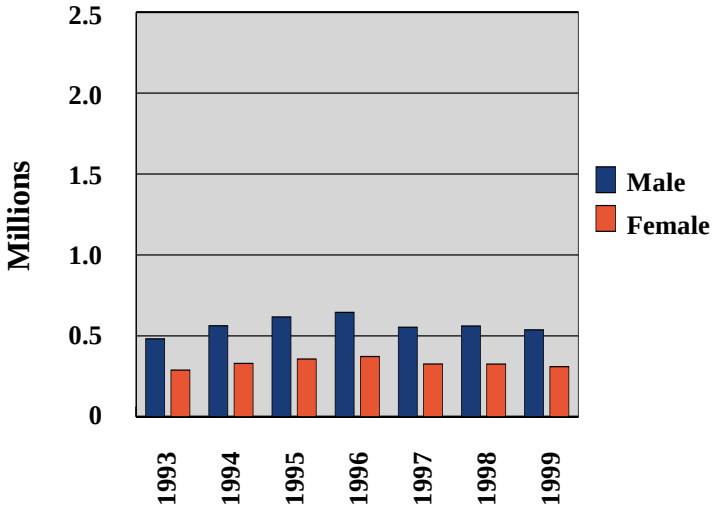


Chart 36. - SSI Disabled Child Beneficiaries, By Sex

Calendar Years 1993-1999



Females are a majority of SSI disabled adult beneficiaries. In the years shown, they have increased from 55 percent to 57 percent of the total. For child beneficiaries, on the other hand, males are in the majority, with 63 percent of the total in each of the years shown.