

Section 2. Disability Insurance Program

The disability insurance (DI) program provides monthly cash benefits for disabled workers under age 65 and their dependents. Benefits were provided to disabled workers age 50 or older by the 1956 Social Security Amendments; benefits for their dependents were provided by the 1958 Social Security Amendments; and benefits to disabled workers under age 50 were provided by the 1960 amendments.

GENERAL

Many provisions of the DI program are identical to those of the OASI program. For example, all workers who are covered by OASI are also covered by DI. Contributions are made under the same provision of the Internal Revenue Code and are made on the same wage base.

The DI portion of the OASDI tax is allocated to the Disability Insurance Trust Fund, which is the source of payment for monthly benefits to disabled workers and their dependents and for administrative expenses of the program. In addition, the revenue derived from the taxation of disability benefits is credited to the trust fund.

The purpose of both OASI and DI benefits is to replace income lost when the wage-earner is no longer able to work. However, significant differences exist between the two programs, primarily because of the different nature of the event insured. The OASI program insures a worker, his dependents and survivors against loss of income due to the

worker's retirement or death. The DI program insures against the loss of income due to the worker's physical or mental disability. In addition, the OASI program is administered solely by Federal employees in Federal installations, whereas the DI program is administered both through Federal Social Security offices and State disability determination services staffed by State employees.

BENEFITS

Summary

In general, DI monthly cash benefits are paid and computed on the same basis as in the OASI program. Benefit amounts are related to the past earnings of the insured worker. Medicare is provided to disabled workers, widow(er)s, or adult children after they have been entitled to disability benefits for 24 months.

In December 1993 there were 5.2 million DI beneficiaries in current-payment status. The total monthly benefits paid out were \$2.6 billion. Table 2-1 summarizes various types of beneficiaries of the DI program currently receiving benefits, average benefit amounts, and the number of new awards during 1993.

TABLE 2-1.--DISABILITY CASH BENEFITS: NUMBER IN CURRENT PAYMENT STATUS AND AVERAGE BENEFIT AMOUNT (DECEMBER 1992) AND NUMBER OF BENEFITS AWARDED DURING THE YEAR AND AVERAGE BENEFIT AMOUNT, 1993

		Current payment	
New awards			
(in thousands)	Average payment	Number (in thousands)	Average payment
Disabled workers.....	635	3,726	\$642
Wives and husbands of workers.....	75	273	156
Children of disabled workers.....	399	1,255	173

Source: Office of Research and Statistics, Social Security Administration.

Description of major benefit types

Disabled-worker benefit.--A monthly benefit payable to a disabled worker under age 65 insured for disability.

Spouses' benefit.--Monthly benefit payable to a spouse or divorced spouse of a disabled worker under one of the following conditions: (1) wife or husband (a) is aged 62 or older, or (b) has 1 or more entitled children of the worker who are disabled or under age 16 in his or her care; or (2) divorced wife (husband) is aged 62 or older and her (his) marriage to worker lasted 10 years before the divorce became final.

Child's benefit.--A monthly benefit payable to an unmarried child or eligible grandchild of a disabled worker who is under age 18 or a full-time elementary or secondary student under age 19.

Disabled adult child's benefit.--A monthly benefit payable to a disabled person aged 18 or over--a son or daughter or eligible grandson or granddaughter of a retired, deceased, or disabled worker--whose disability began before age 22.

Disabled widow (or widower).--A widow or widower may qualify for benefits on the deceased spouse's work record at age 50 through age 59. Effective January 1991, the definition of disability a widow or widower must meet to qualify for disability benefits is the same as that for a worker.

Definition of disability

Generally, disability is defined 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 for not less than 12 months or to result in death. Claimants may be determined to be disabled only if, due to such an impairment, they are unable to engage in any kind of substantial gainful work, considering their age, education, and work experience, which exists in the national economy. The work need not exist in the immediate area in which the claimant lives, nor must a specific job vacancy exist for the individual. Moreover, no showing is required that

the worker would be hired for the job if he or she applied.

There is a special definition and eligibility requirements for persons who are blind.

Waiting period

An initial 5-month waiting period is required before DI benefits are paid. Benefits are payable for the 6th month. However, benefits may be paid for the 1st full month of disability to a worker who becomes disabled within 60 months (for a disabled widow or widower the period is 84 months) after termination of DI benefits from an earlier period of disability.

Insured status

Workers are insured for disability if they are fully insured and, except for persons who are blind or disabled before age 31, have a total of at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which the worker became disabled. Workers who are disabled before age 31 must have total quarters of coverage equal to half the calendar quarters which have elapsed since the worker reached age 21, ending in the quarter in which the worker became disabled. However, a minimum of 6 quarters is required.

BENEFIT COMPUTATION

DI benefits are computed in the same manner as old age and survivors benefits except that the number of years of earnings which is excluded when determining the benefit amount is less

than 5 for workers under age 47. (The number of drop-out years allowed increases with the age of the insured worker at disablement.) The amount of the monthly benefit is based on the insured worker's primary insurance amount (PIA).

The following table lists major disability benefits with the percentage of the insured worker's PIA.

TABLE 2-2.--TYPE OF MONTHLY BENEFIT

Percent of PIA	
100	Disabled worker (any age).....
50	Dependents of disabled worker:\1\ Wife or husband (age 62), mother, father, children and grandchildren.....
71.5	Survivors:\1\ Disabled (age 50-59), widows or widowers.....

\1\Subject to maximum family benefit limitation.

Substantial gainful activity

The Secretary of HHS\1\ has specific regulatory authority to prescribe the criteria for determining when earnings derived from employment demonstrate an individual's ability to engage in substantial gainful activity (SGA).

\1\Throughout the remainder of this section when Secretary is used, it is the Secretary of Health and Human Services.

The Secretary has published regulations specifying the monetary amounts which indicate substantial gainful activity. Effective January 1, 1990, the SGA earnings level was raised to \$500 a month (net of impairment-related work expenses). Table 2-3 shows SGA amounts since 1968.

TABLE 2-3.--MONTHLY SGA AMOUNTS

	Year
SGA	
July	
1968-73.....	\$140
1974-75.....	200
.....	230
1976.....	240
.....	260
1977.....	280
.....	300
1978.....	500
.....	
1979.....	
.....	
1980-89.....	
.....	
1990-94.....	
.....	

Work incentives

The law provides a 45-month period for disabled beneficiaries to test their ability to work without losing their entitlement for benefits. The period consists of (1) a ``trial work period'' (TWP) which allows disabled beneficiaries to work for up to 9 months (within a 5-year period)\2\ with no effect on their disability or (if eligible) Medicare benefits, and (2) a 36-month ``extended period of eligibility,'' during the last 33 of which disability benefits are suspended for any month in which the individual is engaged in SGA. Medicare coverage continues so long as the individual remains entitled to disability benefits and, depending on when the last month of SGA occurs, may continue for 3 to 24 months after entitlement to disability benefits ends. When Medicare entitlement ends because of the individual's work activity, but he or she is still medically disabled, he or she may purchase Medicare protection.

\2\Only one TWP is allowed in any one period of disability. The TWP is completed only if the 9 months are within a 60-month period. By regulation, earnings of more than \$200 a month constitute ``trial work.''

If beneficiaries medically recover to the extent they

no longer meet the definition of disability, disability and Medicare benefits are terminated regardless of the trial work period or extended period of disability provisions. However, persons who contest this determination may choose to continue to receive disability benefits (subject to recovery) and Medicare benefits while their appeal is being reviewed, until a decision is rendered by an administrative law judge.

DI maximum family benefit

The maximum monthly amount of DI family benefits which is payable on a disabled worker's earnings record for workers who first become entitled after June 1980, is the smaller of 85 percent of the worker's average indexed monthly earnings or 150 percent of the worker's primary insurance amount. However, in no case can the benefit be reduced below 100 percent of the worker's primary insurance amount.

Offset for other public disability benefits

When a disabled worker under age 65 qualifies on the basis of total or partial disability (whether or not permanent) for benefits that are provided by Federal, State and local governments and worker's compensation, the Social Security benefits payable to him and his family are reduced by the amount, if any, that the total monthly benefits payable under the two or more programs exceed 80 percent of his average current earnings before he became disabled. Needs-tested benefits, Veterans' Administration disability benefits, and

benefits based on public employment covered by Social Security are not subject to the provision. A worker's average current earnings for this purpose are the larger of (a) the average monthly earnings used for computing his Social Security benefits, or (b) his average monthly earnings in employment or self-employment covered by Social Security during the 5 consecutive years of highest covered earnings after 1950, or (c) the average monthly earnings during the calendar year of highest covered earnings during a period consisting of the year in which disability began and the preceding 5 years without regard to the limitations which specify a maximum amount of earnings creditable for Social Security benefits. The combined payments after the reduction are never less than the total amount of the DI benefits payable before the reduction. In addition, the Social Security benefit after the reduction is increased by the full amount of the cost-of-living increase as applied to the unreduced benefit. Every 3 years the original amount of benefits subject to reduction is redetermined to reflect changes in average wage levels. If increases in the average national wages would result in a higher benefit than that payable based on the original computation, the benefit is increased effective January of the redetermination year.

The offset begins in the month during which concurrent entitlement begins under a Federal or State law.

The offset of the Social Security disability benefit will not be made if the State worker's compensation law provides for an offset against Social Security disability benefits.

However,
this waiver of the offset only applies where the State
program
began offsetting on or before February 18, 1981.

DETERMINATION OF DISABILITY

State agency determinations of disability

Disability determinations are made by State agencies
that
agree to make such determinations and substantially comply
with
the regulations of the Secretary. The Secretary is required
to
issue regulations specifying, in such detail as he or she
deems
appropriate, performance standards and administrative
requirements and procedures to be followed in performing
the
disability determination function ``in order to assure
effective and uniform administration of the disability
insurance program throughout the United States.'' Certain
operational areas are cited as ``examples'' of what the
regulations may specify. These include such items as the
nature
of the administrative structure, the physical location of
and
relationship among agency staff units, performance criteria
and
fiscal control procedures.

The law also provides that if the Secretary finds that
a
State agency is substantially failing to make disability
determinations consistent with his regulations, the
Secretary
shall, not earlier than 180 days following his findings,
terminate State administration and make the determinations
himself. The law also allows for termination by the State.
The
State would be required to continue to make disability

determinations for not less than 180 days after notifying the Secretary of its intent to terminate. Thereafter, the Secretary would be required to make the determinations.

Determining disability: Application of law and regulations

The adjudication of claims is accomplished on a sequential basis. The first step is to determine whether the individual is engaging in substantial gainful activity (SGA). Under current administrative practice, if a person is actually earning more than \$500 a month (net of impairment-related work expenses) he or she ordinarily will be considered to be engaging in SGA. By law, this limit is \$930 a month for disabled blind individuals in 1994. If it is determined that the individual is engaging in SGA, a finding is made that he or she is not disabled without consideration of medical factors. If an individual is found not to be engaging in SGA, the severity and duration of the impairment are explored. If the impairment is determined to be ``not severe'' (i.e., it does not significantly limit the individual's capacity to perform work), the individual is denied.\3\ If the impairment is ``severe,'' a determination is made as to whether the impairment ``meets'' or ``equals'' the medical listings published in regulations by SSA\4\ and whether it will last for 12 months. If it neither ``meets'' nor ``equals'' the listing (which will result in an allowance)

but
meets the 12-month duration rule, a determination is then
made
of whether the claimant is able to carry out his former
occupation. If he can, he is denied benefits; if he cannot,
the
nonmedical factors come into play.

\3\It is important to note that the ``severity'' step
became very
controversial in the 1980s, with several Federal circuit
courts ruling
that SSA's procedures violate the intent of the law that
every claimant
receive an individual determination based on medical and
vocational
factors. However, in a 1987 decision, the Supreme Court,
while raising
a number of concerns about SSA's procedures, upheld the
Agency's
application of the ``severity'' test at this stage of the
sequential
process. Bowen v. Yuckert, No. 85-1409, June 8, 1987.

\4\The Listing of Impairments contains over 100
examples of medical
conditions that would ordinarily prevent an individual from
engaging in
any gainful activity. Each listing describes a degree of
severity such
that an individual who is not working and has such an
impairment is
considered unable to work by reason of the medical
impairment. The
listing describes specific medically acceptable clinical
and laboratory
findings and signs which establish the severity of the
impairments. An
impairment or combination of impairments is said to ``equal
the
listings'' if the medical findings for the impairment are

at least
equivalent in severity and duration to the listed findings
of a listed
impairment.

At this stage, because of a judicial opinion and
subsequent
administrative and legislative ratification, the burden of
proof switches to the Government to show that the
individual
can, considering his impairment, age, education, and work
experience, engage in some other kind of substantial
gainful
activity which exists in the national economy. Such work,
however, does not have to exist in the immediate area in
which
he lives and a specific job vacancy does not have to be
available to him. Work in the national economy is defined
in
the law as work which exists in significant numbers either
in
the region where such individual lives or in several
regions of
the country.

SSA has developed a vocational ``grid'' designed to
reduce
the subjectivity and lack of uniformity in applying the
vocational factor. The grid regulations embody in a formula
certain worker characteristics such as age, education, and
past
work experience, in relation to the individual's residual
functional capacity (RFC) to perform work-related physical
and
mental activities. If the claimant has a particular level
of
residual work capability--characterized by the terms
Sedentary,
Light, Medium, Heavy and Very Heavy--an automatic finding
of

`disabled' or `not disabled' is required when applied to various combinations of age, education, and work experience.

Federal review of State determination

The Secretary may, on his own motion, review any determination by a State agency.

The law requires that the Secretary review 50 percent of the disability allowances and a sufficient number of other determinations to ensure a high degree of accuracy.

Periodic review of individuals receiving disability benefits

The 1980 Disability Amendments required that the Social Security Administration reexamine every individual on the rolls who is determined to be nonpermanently disabled for benefit eligibility at least once every 3 years. Where there is a finding of permanency, the Secretary may reexamine at such times as is determined to be appropriate. These reviews are in addition to the administrative eligibility review procedures existing prior to the 1980 amendments. Legislation enacted in late 1982 provided authority for the Secretary to slow down the rate of continuing eligibility reviews mandated by the 1980 amendments.

Medical improvement standard

The 1984 Disability Benefits Reform Act amended the law to require that in continuing eligibility review cases, benefits may be terminated only if the Secretary finds that there

has
been medical improvement in the person's condition and that
the
individual is now able to engage in substantial gainful
activity. There are several statutory exceptions to this
standard, which are described in greater detail in the
``Recent
Legislation'' section of this chapter.

Medical evidence

An individual is not considered under a disability
unless
he furnishes such medical and other evidence as the
Secretary
may require.

Under the law, the Secretary will generally reimburse
physicians or hospitals for supplying medical evidence in
support of claims for DI benefits. The Secretary also pays
for
medical examinations that are needed to adjudicate the
claim.

Attorneys' fees and representation

Attorneys and other individuals who represent
disability
claimants on appeal and who wish to charge a fee for their
services must have the fee approved by the Social Security
Administration (SSA). Under the law in effect through June
30,
1991, representatives must submit a fee petition detailing
the
number of hours spent on the claim and requesting a
specific
fee.

The Omnibus Budget Reconciliation Act of 1990 (Public
Law
101-508) generally replaced the fee petition process
(effective
July 1, 1991) with a streamlined process in which SSA will

approve any fee agreement jointly submitted by the claimant and the representative if the claimant is successful in his or her appeal for benefits and if the agreed-upon fee does not exceed 25 percent of past-due benefits, but not to exceed \$4,000.

As under previous law, the Secretary withholds 25 percent of the past-due benefits of a claimant represented by an attorney and pay the attorney the approved fee directly.

A court which renders a decision favorable to a claimant for social security benefits is permitted to set a reasonable fee for the attorney who represented the claimant before the court. The fee cannot exceed 25 percent of the past-due benefits that result from the court's decision. The Secretary may certify for payment to the attorney, out of the total of the past-due benefits, the amount of the fee set by the court.

VOCATIONAL REHABILITATION

The Social Security Act requires that persons applying for a determination of disability be promptly referred to State vocational rehabilitation agencies for necessary rehabilitation services. The act provides for withholding of benefits for refusal, without good cause, to accept rehabilitation services available under a State plan approved under the Vocational Rehabilitation Act in such amounts as the Secretary shall determine.

Public Law 97-35 eliminated reimbursement from the trust funds to the State vocational rehabilitation agencies for

rehabilitation services except in cases where the services have resulted in the beneficiary's performance of substantial gainful activity (SGA) for a continuous period of at least 9 months. Such a 9-month period could begin while the individual is under a vocational rehabilitation program and may also coincide with the trial work period or the individual's waiting period for benefits. The services must be performed under a State plan for vocational rehabilitation services under title I of the Rehabilitation Act. In the case of any State that is unwilling to participate or does not have a plan that meets the requirements of the Vocational Rehabilitation Act, the Commissioner of Social Security may provide such services by agreement or contract with other public or private agencies, organizations, institutions or individuals. The determination that the vocational rehabilitation services contributed to the successful return of the individual to SGA, and the determination of the amount of costs to be reimbursed, are made by the Commissioner of Social Security in accordance with criteria formulated by him. Payments under this provision can be made in advance or by way of reimbursement, with necessary adjustments for overpayments or underpayments.

DISABILITY CLAIMS AND APPEALS STRUCTURE

The Social Security appeals and case review process is a complex multilayered structure that is inextricably linked with

the disability determination process. Since about 94 percent of the hearing requests in fiscal year 1993 involve disability claims (both Social Security and supplemental security income), the process described will be for that type of claim. The application for disability benefits is made at the Federal Social Security district office where the claimant is interviewed and the sources of medical evidence are recorded.

After determining whether the applicant meets the insured status requirements, the case is then sent to the State agency

which, operating as an agent of the Social Security Administration, makes the initial determination of disability.

If a claimant or terminated beneficiary is dissatisfied with an initial denial or termination of disability benefits by the State agency, he can request a reconsideration within 60 days

of receipt of the notice of denial. The reconsideration is also

carried out by the State agency, but by personnel other than

those who made the initial determination. If upon reconsideration the claimant is again denied benefits, he will

be given a hearing before an administrative law judge (ALJ),

providing he files a request within 60 days of receipt of the

notice of denial. If the claim is denied by the ALJ, the claimant has 60 days to request review by the Appeals Council.

The Appeals Council may also, on its own motion, review a decision within 60 days of the ALJ's decision. The 1980 Disability Amendments required the Secretary to review a percentage of ALJ hearing decisions, and this review is being

conducted by the Appeals Council.

The Appeals Council may review, affirm, modify or reverse the decision of the ALJ, or it may remand it to the ALJ for further development. The claimant is notified in writing of the final action of the Appeals Council, and is informed of his right to obtain further review by commencing a civil action within 60 days in a United States district court.

Under current law, as amended by the 1984 Disability Benefits Reform Act, DI beneficiaries whose benefits have been terminated for medical reasons, e.g., recovery or improvement in the medical condition that was the basis for the disability, can elect to continue to receive disability and Medicare benefits through the hearing stage of the appeals process. The disability benefits are subject to recovery, however, if the initial termination decision is upheld as the final decision of the Secretary.

Table 2-4 shows the number of cases allowed and appealed at various levels of appeal for application decisions and Continuing Disability Reviews (CDRs) processed by State agencies. Table 2-5 presents information for fiscal years 1979 through 1993 of the number of cases which are reviewed and reversed at the ALJ level. Table 2-6 presents information on the number of continuing disability reviews--title II cases--that were conducted in fiscal years 1977-93. Note that due to a sharp increase in initial claims, the number of CDRs processed has declined in recent years from a high of 291,000 in 1988 to 49,000 in 1993.

TABLE 2-4. DISABILITY DETERMINATIONS AND APPEALS, FISCAL YEAR 1993

<TABLE 2-4>

TABLE 2-5.--ADMINISTRATIVE LAW JUDGE FAVORABLE RATES--DISABILITY INSURANCE\1\ INITIAL DENIALS AND TERMINATIONS,\2\ FISCAL YEARS 1979-93

Percent				
	Fiscal year			
Dismissed	Unfavorable	Favorable	Total	favorable

Initial denials:				
1979.....				
6,332	31,485	48,934	86,751	56.4
1980.....				
7,093	31,703	56,733	95,529	59.4
1981.....				
15,141	59,930	98,129	173,200	56.7
1982.....				
15,403	67,481	91,865	174,749	52.6
1983.....				
14,334	65,626	79,427	159,387	49.8
1984.....				
15,075	63,381	88,301	166,757	53.0
1985.....				
14,806	61,161	92,118	168,085	54.8
1986.....				
28,792	44,223	78,737	151,752	51.9
1987.....				
15,271	58,412	98,180	171,863	57.1
1988.....				
18,213	58,788	111,748	188,749	59.2
1989.....				

19,695	54,284	122,070	196,049	62.3
1990.....				
19,297	45,264	127,707	192,268	66.4
1991\3\.....				
19,880	44,594	144,945	209,419	69.2
1992\3\.....				
19,665	48,407	166,661	234,733	71.0
1993\3\.....				
20,190	47,579	171,508	239,277	71.7
Terminations:				
1979.....				
1,401	4,078	8,052	13,531	59.5
1980.....				
1,431	4,197	9,909	15,537	63.8
1981.....				
2,623	6,945	16,685	26,253	63.6
1982.....				
4,670	17,502	37,306	59,478	62.7
1983.....				
9,247	37,284	73,821	120,352	61.3
1984.....				
25,681	22,590	56,327	104,598	53.9
1985.....				
4,176	2,415	3,126	9,717	32.2
1986.....				
1,095	2,129	2,014	5,238	38.4
1987.....				
812	1,954	2,014	4,780	42.1
1988.....				
1,031	2,807	3,426	7,264	47.2
1989.....				
1,220	3,482	4,882	9,584	50.9
1990.....				
1,166	2,940	4,695	8,801	53.3
1991\3\.....				
1,007	2,140	3,935	7,082	55.6
1992\3\.....				
812	1,642	2,812	5,266	53.4
1993\3\.....				
720	1,281	2,079	4,080	51.0

 \1\Includes title II and concurrent title II/title XVI
 disability cases and concurrent title II/title XVI aged
 cases.

\2\Includes all termination cases regardless of the basis
 for termination.

\3\Final data.

Source: Office of Hearings and Appeals, Social Security
 Administration.

TABLE 2-6.--CONTINUING DISABILITY REVIEWS (CDR) INITIAL
 DECISIONS: TITLE II DISABLED WORKERS, DISABLED
 WIDOWS AND WIDOWERS, AND DISABLED CHILDREN
 CESSATIONS AND CONTINUATIONS, FISCAL YEARS 1977-93

Continuations		Cessations		
		Total cases		
Cessations		Total		
Number	Percent	and	Number	Percent
continuations		persons	disabled	Percent
		reviewed		
1977.....			41,475	38.7
65,745	61.3	107,220	\1\3,322,230	3.2
1978.....			38,847	46.4
44,804	53.6	83,651	3,447,767	2.4
1979.....			45,216	48.1
48,868	51.9	94,084	3,457,837	2.7
1980.....			44,273	46.8
50,227	53.2	94,550	3,454,010	2.7
1981.....			80,956	47.9
87,966	52.1	168,922	3,413,602	4.9

1982.....			179,857	44.8
221,325	55.2	401,182	3,263,354	12.3
1983.....			182,074	41.7
254,424	58.3	436,498	3,226,888	13.5
1984\2\.....			31,927	24.6
97,752	75.4	129,679	3,249,367	4.0
1985\2\.....			475	14.6
2,785	85.4	3,260	3,332,870	.1
1986.....			2,554	5.6
42,805	94.4	45,359	3,261,768	1.4
1987.....			20,343	12.4
143,712	87.6	164,055	3,433,524	4.8
1988.....			33,565	11.5
257,377	88.5	290,942	3,492,762	8.3
1989.....			24,102	9.2
237,722	90.8	261,824	3,559,840	7.4
1990\3\.....			15,154	10.5
129,026	89.5	144,180	3,678,509	3.9
1991\4\.....			5,697	12.5
39,749	87.5	45,446	3,866,645	1.2
1992.....			6,923	15.0
39,291	85.0	46,214	4,165,133	1.1
1993\5\.....			4,886	9.9
44,316	90.1	49,202	4,457,500	1.1

 \1\In current pay at end of fiscal year.

\2\The decline in the number of reviews in 1984 and 1985 was due to the national moratorium on reviews pending enactment and implementation of the new legislation with revised criteria for CDR's (enacted in fiscal year 1984, regulations promulgated late fiscal year 1985).

\3\The decline in CDR processing in 1990 was due to the unanticipated processing of approximately 40,000 class action court cases.

\4\The continued decline in CDR processing is due to the increase in the initial claims workloads.

\5\Includes non-State CDR mailer continuations.

Source: Office of Disability, Social Security Administration.

RECENT EXPERIENCE IN THE DISABILITY PROGRAM

DI awards and beneficiaries

Over the past 15 years, the DI program has experienced a period of sharp cost curtailment followed by a rebound in growth. The number of DI beneficiaries (disabled workers and their dependents) on the rolls peaked at 4.9 million in May 1978. The beneficiary population then declined sharply to 3.8 million in July 1984. Thereafter, the number of beneficiaries rose steadily, again reaching 5.3 million in January 1994.

Similarly, the number of new DI benefit awards declined from 592,000 in 1975 to approximately 299,000 in 1982. As shown in table 2-7, with the exception of a dip in 1987 and 1988, awards then rose steadily, reaching a high of 637,000 in 1992 before falling slightly to about 635,000 in 1993. (The large 1992 increase is partially attributable to SSA's short-term measures for dealing with increased DI applications. By increasing the volume of applications processed, these measures resulted in both increased awards and increased denials.)

The incidence of disability (number of awards per 1,000 insured workers) fell from an all-time high of 7.1 in 1975 to an all-time low of 2.9 in 1982. In 1993, this rate stood at 5.1 percent.

Tables 2-7 and 2-8 show the number of DI awards and applications, award rates, and the number of beneficiaries for selected fiscal years.

Backlogs and applicant waiting times

In recent years, the combination of increasing workloads and reduced staff has left the State Disability Determination Services unable to keep pace with their workloads. As shown in table 2-9, backlogs of pending claims have risen sharply, subjecting qualified applicants to long waits for benefits. Between 1988 and 1992, applications pending at the DDSs rose from 323,000 to 725,000, causing claimants to wait 50 percent longer, or three months instead of two, for an eligibility decision.

Between 1984 and 1990, DDS staff was cut by 19 percent--from 14,500 to 11,800.

TABLE 2-7.--DISABLED WORKERS' APPLICATIONS, AWARDS AND RATIO OF AWARDS TO APPLICATIONS AND AWARDS PER 1,000 INSURED WORKERS FOR SELECTED YEARS, 1960-93

Number of applications (in thousands)	Awards per 1,000 insured workers		
	Total awards	Awards as a percent of applications	
1960.....			

418.6	207,805	50	4.5
1965.....			
532.9	253,499	48	4.7
1970.....			
868.2	350,384	40	4.8
1971.....			
924.4	415,897	45	5.6
1972.....			
947.8	455,438	48	6.0
1973.....			
1,066.9	491,616	46	6.3
1974.....			
1,330.2	535,977	40	6.7
1975.....			
1,285.3	592,049	46	7.1
1976.....			
1,232.2	551,460	45	6.5
1977.....			
1,235.2	568,874	46	6.5
1978.....			
1,184.7	464,415	39	5.2
1979.....			
1,187.8	416,713	35	4.4
1980.....			
1,262.3	396,559	31	4.0
1981.....			
1,161.3	345,254	30	3.4
1982.....			
1,020.0	298,531	29	2.9
1983.....			
1,017.7	311,491	31	3.0
1984.....			
1,035.7	357,141	34	3.4
1985.....			
1,066.2	377,371	35	3.5
1986.....			
1,118.4	416,865	37	3.8
1987.....			
1,108.9	415,848	37	3.7
1988.....			
1,017.9	409,490	40	3.6

1989.....			
984.9	425,582	43	3.7
1990.....			
1,067.7	467,977	44	3.9
1991.....			
1,208.7	536,434	44	4.4
1992.....			
1,335.1	636,637	48	5.2
1993.....			
1,425.8	635,238	45	5.1

Source: Office of the Actuary, Social Security Administration.

In its budget proposal for fiscal year 1995, SSA projected that its backlog of initial disability claims would continue to rise sharply, increasing from 720,000 to 1,102,000 during 1995. Table 2-9 shows disability backlogs and applicant waiting times since 1988.

TABLE 2-8.--NUMBER OF DISABILITY INSURANCE BENEFICIARIES FOR
SELECTED YEARS: 1960-93
[Current payment status, December]

	Disabled workers	Spouses	Children
Total			
Year:			
1960.....	455,371	76,599	
155,481	687,451		
1965.....	988,074	193,362	
557,615	1,739,051		

1970.....	1,492,948	283,447
888,600 2,664,995		
1975.....	2,488,774	452,922
1,410,504 4,352,200		
1980.....	2,861,253	462,204
1,358,715 4,682,172		
1981.....	2,776,519	428,212
1,251,543 4,456,274		
1982.....	2,603,713	365,883
1,003,869 3,973,465		
1983.....	2,568,966	308,060
935,904 3,812,930		
1984.....	2,596,535	303,984
921,285 3,821,804		
1985.....	2,656,500	305,528
945,141 3,907,169		
1986.....	2,727,386	300,592
965,301 3,993,279		
1987.....	2,785,885	290,895
967,944 4,044,724		
1988.....	2,830,284	280,821
963,195 4,074,300		
1989.....	2,895,364	271,488
961,975 4,128,827		
1990.....	3,011,294	265,890
988,797 4,265,981		
1991.....	3,194,938	266,219
1,051,883 4,513,040		
1992.....	3,467,783	270,674
1,151,239 4,889,696		
1993.....	3,725,966	272,759
1,254,841 5,253,566		

 Source: Office of Research and Statistics, Social Security Administration.

TABLE 2-9.--DISABILITY BACKLOGS AND APPLICANT WAITING TIMES

[Claims pending and weeks of work on hand at the State

Disability

Determination Services (DDSs)]

Year	Total claims pending at end of year
1988.....	323,000
8.4	
1989.....	479,000
10.0	
1990.....	538,000
11.3	
1991.....	693,000
14.3	
1992.....	725,000
12.1	
1993.....	717,398
10.7	

\1\The number of weeks of work pending in the DDSs provides the best approximation of the amount of time an applicant must wait for an eligibility decision.

Source: National Council of Disability Determination Directors.

CHARACTERISTICS OF DI BENEFICIARIES

Tables 2-10 and 2-11 present data on the demographic, social, and medical characteristics of the disabled population over time. For instance, table 2-10 shows the increase in the

receipt of benefits by women, which reflects larger societal trends in female workforce participation. Table 2-10 also indicates the higher levels of educational attainment that characterize the present disabled population in comparison to that of 1970.

GAO STUDY OF TERMINATED BENEFICIARIES: 1981-84

In response to a request from the House Ways and Means Subcommittee on Social Security, the General Accounting Office (GAO) issued a report in November 1989, which compared the health, employment, and financial status of Disability Insurance (DI) beneficiaries with that of denied applicants and beneficiaries removed from the rolls during 1981-84. Based on written and oral interviews with a random sample of these individuals, the GAO found that:

1. Most DI beneficiaries removed from the rolls between 1981 and 1984 have been reinstated.

However, of those who were not, nearly half are not working.--

As of 1987, 63 percent of the beneficiaries who were determined ineligible for benefits during SSA's 1981-84

review had been reinstated to the disability benefit rolls. Another 4 percent had begun to receive Social Security retirement benefits, and 7 percent had died.

Altogether, only about 26 percent of those found ineligible remained terminated; 58 percent of these terminated individuals (or 15 percent of those earlier found ineligible) had returned to work.

2. Denied applicants continue to have employment

problems.--About 58 percent of the applicants who were denied benefits in 1984 and were not receiving benefits as of 1987 reported they were not working. Over two-thirds of these nonworking denied applicants had been out of work for at least 3 years, and 54 percent said they did not expect to ever work again. Of the denied applicants who were working at the time of GAO's health, survey, 71 percent said that because of their that they were limited in the kind or amount of work they could do. Over 40 percent were earning less in 1986 than they were before applying for disability.

3. Both DI beneficiaries and denied applicants who are not working report poor health.--GAO assessed the survey respondents' health status on the basis of their self-perceptions and reported abilities to perform the activities of daily living and personal care. Although the health status reported by denied applicants was slightly better than that of the allowed population, both generally reported poor health. In addition, self-reported health status differed significantly between the denied who worked and those who did not. After separating the denied into working and nonworking groups, the self-reported health status of the nonworking denied group closely resembled that reported

53.4	53.1	51.7	53.0	53.3	52.1	51.9	
51.4	50.5	50.3	32.9				
Sex:							
Male.....						74	68
69	70	67	66	66	64	64	64
63	62	49					
Female.....						26	32
31	30	33	34	34	36	36	36
37	38	51					
Education (years of school completed):							
No schooling\2\.....						2	1
1	1	2	1	1	1	1	1
1	1	1					
Elementary school (1 to 8).....						44	37
29	26	23	18	18	17	16	16
12	11	9					
High school.....						46	52
55	56	59	57	59	60	62	62
50	45	45					
9 to 11.....						23	24
23	22	22	19	20	19	19	19
15	14	11					
12.....						23	28
32	34	37	38	39	41	43	43
35	31	34					
Some college.....						9	10
12	14	14	16	15	17	17	17
14	12	45					
Unknown.....						0	0
3	3	2	8	7	5	5	5
23	31	0					

\1\Derived from 1990 census. Figures for age based on population aged 18 to 64. Figures for education based on persons aged 25 and over.

\2\Also includes special schools for handicapped.

Source: Office of Disability, Social Security Administration.

TABLE 2-11.--PERCENT DISTRIBUTION BY DISABLING CONDITION
 OF TITLE II DISABLED WORKER BENEFICIARIES ALLOWED
 BENEFITS IN SELECTED
 CALENDAR YEARS 1970-93

Year allowed benefits		Disabling condition and									
		mobility		1970		1975		1979		1982	
1985	1987	1988	1989	1990	1991	1992	1993				
Total percent\1\.....		100	100	100	100	100	100	100	100	100	100
100	100	100	100	100	100	100	100	100	100	100	100
Disabling condition:											
Infective and parasitic											
diseases\2\.....		3	1	1	1	1	1				
1	1	0	1	6	6	7	7				
Neoplasms.....		10	10	14	17						
15	12	16	18	17	16	13	15				
Allergic, endocrine											
system, metabolic and		nutritional diseases.....		4	3	3	4				
5	5	3	3	3	4	5	5				
Mental, psychoneurotic and											
personality disorders....		11	11	11	11						
18	23	22	22	23	24	25	26				
Diseases of the nervous											
system and sense organs..		6	7	8	9						
8	8	8	9	9	8	8	7				
Circulatory system.....		31	32	28	25						
19	17	18	17	16	15	14	15				
Respiratory system.....		7	7	6	7						

5	5	5	5	5	5	4	5	
	Digestive system.....				3	3	2	2
2	1	2	2	2	2	2	2	
	Skeletal musculo.....				15	17	17	16
13	14	14	11	12	13	13	12	
	Accidents, poisonings and violence.....				8	6	6	6
4	5	5	4	4	4	4	3	
	Other/unknown.....				2	3	3	2
11	9	7	9	5	5	5	5	

\1\Due to rounding, may not add to 100 percent.

\2\Beginning in 1990, AIDS/HIV cases are included in this category.

Source: Office of Disability, Social Security Administration.

were significantly worse than that of the working denied.

For

example:

--80 percent of the nonworking denied group and 78 percent

of the allowed population perceived their health as

fair to poor, with about 44 percent of both stating

they were in poor health; in contrast, only 13 percent of the working denied said they were in poor health;

--40 percent of the nonworking denied group and 51 percent

of the allowed population said they had to depend

on others for at least one personal care activity,

such as dressing, eating, or getting in and out of

bed; only 12 percent of the working denied needed

any help; and
--71 percent of the nonworking denied group and 76 percent of the allowed population could be classified as having severe functional limitations; in comparison, only 41 percent of the working denied could be so classified.

4. DI beneficiaries' impairments differed from those of denied applicants.--The denied applicants (both working and nonworking) reported back problems as the impairment that limited them the most; the allowed population most often reported mental and heart problems.

5. Both the allowed and denied populations reported serious financial problems.--The median family income reported by the nonworking denied was about \$6,500 in 1986. Total family income was below Census's poverty level for 61 percent of this group, and 35 percent depended on government programs other than Social Security (mainly public assistance) for half or more of their total family income.

Despite receiving DI benefits, 33 percent of the allowed population said they lacked enough income to get along; 43 percent reported income that is below the poverty level. At the time of GAO's survey in 1987, a significant proportion of the denied groups were without medical insurance coverage. Twenty-nine percent of the working denied and 25 percent of the

nonworking

denied reported no medical insurance coverage. Most of those without insurance said they had been without it since 1984 or earlier.

LEGISLATIVE CHANGES, 1984-93

98TH CONGRESS: THE DISABILITY BENEFITS REFORM ACT OF 1984

Public Law 98-460, the Disability Benefits Reform Act of 1984, made several substantial changes in the standards for review of disability beneficiaries, and in other provisions of the program as well. The following is a summary of the law.

1. Medical improvement standard

Public Law 98-460 established a medical improvement standard under which the Secretary may terminate disability benefits on the basis that the person is no longer disabled only if:

(1) There is substantial evidence demonstrating that

(a) there has been any medical improvement in the individual's impairment or combination of impairments

(other than medical improvement which is not related to

the person's ability to work), (b) the individual is

now able to engage in substantial gainful activity (SGA); or

(2) There is substantial evidence consisting of new

medical evidence and a new assessment of RFC which demonstrates that although there is no medical improvement, (a) the person has benefited from

advances

in medical or vocational therapy or technology

related

to ability to work, and (b) that he or she is now

able

to perform SGA; or

(3) There is substantial evidence that although there

is no medical improvement (a) the person has

benefited

from vocational therapy and (b) the beneficiary can

now

perform SGA; or

(4) There is substantial evidence that, based on new

or improved diagnostic techniques or evaluations,

the

person's impairment or combination of impairments

is

not as disabling as it was considered to be at the

time

of the prior determination, and that therefore the individual is able to perform SGA; or

(5) There is substantial evidence either in the file

at the original determination or newly obtained

showing

that the prior determination was in error; or

(6) There is substantial evidence that the original

decision was fraudulently obtained; or

(7) If the individual is engaging in SGA (except where he or she is eligible under section 1619),

fails

without good cause to cooperate in the review or

follow

prescribed treatment or cannot be located.

In making the determination, the Secretary was required to

consider the evidence in the file as well as any additional information concerning the claimant's current or prior

condition secured by the Secretary or provided by the claimant.

Determinations under this provision had to be made on the basis of the weight of the evidence, and on a neutral basis with regard to the individual's condition, without any inference as to the presence or absence of disability based on the previous finding of disability.

Effective date: Applied only with respect to the following categories:

- (1) Determinations by the Secretary made after the date of enactment;
- (2) Cases pending at any level of the administrative process on the date of enactment;
- (3) Cases of individual litigants pending in Federal court on the date the conference report was filed;
- (4) Cases of named plaintiffs in class action suits pending on that date;
- (5) Cases of unnamed plaintiffs in class action suits certified prior to that date; and
- (6) Cases where a request for judicial review was made on a decision of the Secretary made during the 60 days preceding enactment.

Cases in categories (3), (4), (5), and (6) had to be remanded to the Secretary for review under this standard. Individuals in (5) were to be sent a notice via certified mail informing them that they had 120 days after the date of receipt of the notice to request a review under the medical improvement standard.

No class action could be certified after the date the

conference report was filed which raised the issue of medical improvement with respect to an individual whose benefits were terminated prior to that date.

Persons whose cases were remanded to the Secretary were to receive benefits pending the Secretary's decision and appeal of that decision if they so elected. If found eligible, any person whose case was remanded under this provision was to receive benefits retroactive to the date they were last found ineligible.

2. Evaluation of pain

The Secretary of HHS was required, in conjunction with the National Academy of Sciences, to conduct a study concerning the questions of using subjective evidence of pain in determining whether a person is under a disability, and the state of the art of preventing, reducing or coping with pain. This study was completed and a report was submitted to the House Committee on Ways and Means and the Senate Committee on Finance in 1986. While making many recommendations, it basically supported the existing treatment of allegations of pain in disability determinations.

The provision also established a statutory standard for considering pain which was in effect until December 31, 1986.

3. Multiple impairments

In determining whether a person's impairment or

impairments

are of a sufficient medical severity to be the basis of a finding of eligibility for benefits, the Secretary was required to consider the combined effect of all of the person's impairments, whether or not any one impairment would alone be severe enough to qualify the person for benefits. The provision became effective for all determinations made on or after 30 days after enactment.

4. Moratorium on mental impairment reviews

A moratorium was imposed on reviews of all cases of mental impairment disability until the mental impairment criteria in the Listing of Impairments were revised to realistically evaluate the person's ability to engage in SGA in a competitive workplace environment. The moratorium applied to all cases on which an administrative or judicial appeal was pending on or after June 7, 1983. All persons claiming benefits based on mental impairment disability who received an unfavorable initial or continuing disability decision after March 1, 1981 were permitted to reapply for benefits within 12 months of enactment. The revised criteria were published in 1985.

5. Pretermination notice

The Secretary was required to initiate demonstration projects on providing face-to-face interviews for (1) pretermination continuing disability cases and (2) for all initial denial cases, in lieu of face-to-face evidentiary hearings at reconsideration, to be done in at least five States with a report due to the House Committee on Ways and Means

and
the Senate Committee on Finance on April 1, 1986. The
Secretary
was also required to notify individuals, upon initiating a
periodic eligibility review, that termination of benefits
could
be the result of the review, and that medical evidence may
be
provided. Although these studies have been completed, the
report has not yet been submitted to Congress.

6. Continuation of benefits during appeal

This provision provided for continuation of disability
and
Medicare benefits during appeal for all continuing
disability
review cases through the decision of the ALJ, at the
election
of the individual. Where the ALJ's decision is adverse to
the
individual, the disability benefits were to be repaid. The
provision was made permanent for SSI disability recipients,
and
applied to DI beneficiaries through December 1987. The
Omnibus
Budget Reconciliation Act of 1987 extended the provision
for DI
beneficiaries through December 1988; the 1988 tax technical
corrections bill extended the provisions through December
1989;
and the Omnibus Budget Reconciliation Act of 1989 extended
them
through December 1990.

7. Qualifications of medical professionals

This provision required the Secretary to make every
reasonable effort, in cases based on mental impairments, to
insure that a qualified psychiatrist or psychologist
completes

the medical portion of the case review and of the residual functional capacity assessment before any determination is made that an individual is not disabled. The Secretary was given the authority to contract directly for such services if the State agency is unable to do so.

8. Standards for consultative examinations/medical evidence

The Secretary was required to promulgate regulations regarding consultative examinations, including when they should be obtained, the type of referral to be made, and the procedures for monitoring the referral process. Further, the Secretary was required to make every effort to obtain necessary medical evidence from the treating physician before evaluating medical evidence from any other source, and to consider all evidence in the case record and development of complete medical history over at least the preceding 12-month period.

9. Administrative procedure and uniform standards

As required, regulations were published setting forth uniform standards for DI and SSI disability determinations under section 553 of the Administrative Procedure Act, to be binding at all levels of adjudication.

10. Nonacquiescence

While the conference agreement dropped both the House and Senate provisions relating to the Secretary's acquiescence with Court rulings, the intent was not to endorse the practice

of

``nonacquiescence.'' The conferees noted that questions had been raised about the constitutional basis of the practice, that many of the conferees had strong concerns about the practice, and that a policy of nonacquiescence should be followed only where steps have been taken or are intended to be

taken to receive a review of the disputed issue in the Supreme Court. The conferees also urged the Secretary to seek a resolution of the nonacquiescence issue in the Supreme Court.

In January 1990, SSA issued regulations relating to its adherence with circuit court decisions which are in conflict

with SSA's policies. Their key provisions are that: (a) SSA will apply a circuit court decision that conflicts with SSA policy, within the circuit and at all levels of administrative

adjudication, unless the Government decided to appeal the decision; and (b) SSA will publish in the Federal Register an

Acquiescence Ruling explaining how adjudicators should apply

the circuit court decision. SSA will also publish all other Social Security Rulings in the Federal Register.

11. Payment of costs of rehabilitation services

The provision permitted reimbursement to State agencies for

costs of VR services provided to individuals receiving DI benefits under section 225(b) of the Social Security Act who

medically recover while in VR, whether or not the person worked

at SGA for 9 months, and whether or not the person failed to

cooperate in the program.

12. Direction for Quadrennial Social Security Advisory

Council

The provision required the next quadrennial advisory council (as required in the Social Security Act) to study the medical and vocational aspects of disability using ad hoc panels of experts where appropriate. The study was to include alternative approaches to work evaluation for SSI recipients, effectiveness of VR programs, and other disability program policies, standards, and procedures. The Council issued its report in March of 1988.

13. Staff attorneys

The Secretary was to report, within 120 days of enactment, to the House Committee on Ways and Means and the Senate Committee on Finance, on the actions taken by the Secretary to establish positions which enable staff attorneys to gain the qualifying experience and quality of experience necessary to compete for ALJ positions. Statement of managers stated that it was assumed, given U.S. Office of Personnel Management (OPM) actions at the time, that statutory requirements for establishing specific positions were not required, and the Secretary was urged to take all reasonable steps to see that the OPM actions resulted in SSA staff attorneys becoming qualified for GS-15 ALJ positions.

14. SSI benefits for persons working despite impairment

This provision extended sections 1619 (a) and (b) through June 30, 1987, and required the Secretaries of HHS and

Education to establish training programs for staff personnel in SSA district offices and State VR agencies, and disseminate information to SSI applicants, recipients, and potentially interested public and private organizations. Sections 1619 (a) and (b) were made permanent in 1986.

15. Frequency of continuing eligibility reviews

The Secretary was required to promulgate regulations establishing standards for determining the frequency of continuing eligibility reviews. Final regulations were to be issued within 6 months and during that period no individual could be subjected to more than one periodic review.

16. Representative payees for Social Security and SSI beneficiaries

The Secretary was required to (1) evaluate qualifications of prospective payees prior to or within 45 days following certification, (2) establish a system of annual accountability monitoring where payments are made to someone other than a parent or spouse living in the same household with the beneficiary, and (3) report to Congress on implementation, and annually on the number of cases of misused funds and disposition of such cases.

LEGISLATIVE CHANGES IN THE 100TH CONGRESS

Public Law 100-203, the Budget Reconciliation Act of 1987

1. Continuation of benefits during appeal.--The existing provision for continued payment of disability benefits during the administrative appeal process was extended through

1988.

2. Lengthening of the extended period of eligibility for disability benefits.--The extended period of eligibility during which a disability beneficiary who returns to work may become automatically reentitled to benefits, was lengthened from the current 15 months to 36 months. Medicare eligibility is not continued beyond the period provided under current law.

3. Payment of attorneys' fees.--The administrative policy which permits ALJs to authorize attorneys' fees of up to \$3,000 without approval by an SSA regional office was reinstated.

Public Law 100-647, the Technical and Miscellaneous Revenue Act of 1988

1. Continuation of benefits during appeal.--The existing provision for continued payment of benefits was again extended, through 1989.

2. Interim benefits in cases of delayed final decisions.-- Interim benefits will be paid to individuals who have received a favorable decision from an administrative law judge but whose cases are under review by the Appeals Council and the Council has not rendered a decision within 110 days. These interim payments are not subject to recovery as overpayments if the final determination is unfavorable.

LEGISLATIVE CHANGES IN THE 101ST CONGRESS

Public Law 101-239, the Omnibus Budget Reconciliation Act of 1989

1. Continuation of benefits during appeal.--The existing provision for continued payment of benefits was again extended, through 1990.

2. Extension of disability insurance program demonstration authority.--The authority of the Secretary to waive compliance with the benefit requirements of titles II and XVIII for the purpose of conducting work incentive demonstration projects was extended for 3 years, through June 9, 1993.

3. Representation of claimants.--Effective June 1, 1991, the Secretary would be required to maintain an electronically retrievable list of claimants' legal representatives.

Public Law 101-508, the Omnibus Budget Reconciliation Act of 1990

1. Continuation of benefits during appeal.--The existing provision for continued payment of benefits during appeal was made permanent.

2. Improvement of the definition of disability applied to disabled widow(er)s.--The stricter definition of disability that was previously applied only to widow(er)s was repealed. Instead, a disabled widow(er) is subject to the same definition of disability as is already applied to disabled workers.

3. Creation of a rolling five-year trial work period for all disabled beneficiaries.--Effective January 1, 1992, the current trial work period will be liberalized so that a

disabled beneficiary will exhaust this period only after completing 9 trial work months in any 60-month period. In addition, the provision prohibiting a TWP for beneficiaries, who qualified for disability benefits without serving a waiting period, was repealed.

4. Continuation of benefits on account of participation in a non-State vocational rehabilitation program.-- Beneficiaries who medically recover while participating in an approved non-State vocational rehabilitation program are granted the same benefit continuation rights as those who medically recover while participating in a State-sponsored program.

5. Pre-effectuation review of favorable decisions by the Social Security Administration.--The percentage of favorable decisions made by State disability determination services that must be reviewed by SSA was reduced from 65 percent of all such decisions to 50 percent of allowances and a sufficient number of other determinations to maintain a high level of accuracy in such decisions. The reviews are to be targeted on those cases most likely to contain errors.

6. Vocational rehabilitation (VR) demonstration projects.-- The Secretary is required to conduct demonstration projects permitting disabled beneficiaries to select a public or private rehabilitation provider which would furnish rehabilitation services aimed at enabling them to engage in substantial gainful activity and to leave the disability rolls.
Legislative

changes in the 103d Congress no legislative changes to the disability insurance program were made in the first session of the 103d Congress.

LEGISLATIVE CHANGES IN THE 102D CONGRESS

No legislative changes to the disability insurance program were made in the 102d Congress.

LEGISLATIVE CHANGES IN THE 103D CONGRESS

No legislative changes to the disability insurance program were made in the first session of the 103d Congress.