

GAO

Report to the Committee on Finance,
U.S. Senate, and the Committee on Ways
and Means, House of Representatives

June 1999

SUPPLEMENTAL SECURITY INCOME

Progress Made in Implementing Welfare Reform Changes; More Action Needed



G A O

Accountability * Integrity * Reliability

**Health, Education, and
Human Services Division**

B-278984

June 28, 1999

The Honorable William V. Roth, Jr.
Chairman
The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Bill Archer
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The early and mid-1990s was a period of unprecedented growth in the Supplemental Security Income (SSI) disability program for children. The program provides monthly cash payments for blind or disabled children who meet the program's income and resource requirements. These payments may be used for any purpose that benefits the child, including provision of food, clothing, and shelter, as well as disability-related services.¹ From the end of 1989 through 1996, the number of children receiving SSI benefits more than tripled, from 265,000 to 955,000.² Concerned about this rapid growth and allegations of program abuse, the Congress made changes to tighten children's eligibility for the SSI program through the Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193), commonly referred to as welfare reform, enacted in August 1996. The Congress made these changes to the SSI program to ensure that only needy children with severe disabilities receive benefits.³

Specifically, the welfare reform act made the eligibility criteria for disabled children more restrictive and added provisions to ensure that

¹In most cases, a disabled child's SSI benefit is paid on behalf of the child to a representative payee, such as a parent or relative. The representative payee is responsible for determining the child's needs—defined as the immediate and reasonably foreseeable essentials for living—and using the payments only for the child's use and benefit. Representative payees must submit written reports accounting for the use of the benefit when requested by SSA to do so.

²The SSI program also provides monthly benefits to low-income adults who are aged, blind, or disabled. From the end of 1989 through 1996, the number of blind or disabled adults aged 18 to 64 receiving SSI increased 55 percent, from 2.3 to 3.6 million.

³The Congress, in its conference report on the welfare reform legislation, did not precisely define the term "severe disabilities." The conference report noted that the conferees use the term "severe" in its "common sense meaning."

only children who meet the more restrictive criteria continue to receive benefits. It also required the Social Security Administration (SSA) to issue regulations to implement these changes.⁴ The new law defined disability in children as a medically determinable physical or mental impairment that “results in marked and severe functional limitations.” Under this definition, SSA’s listing of impairments, which describe medical criteria for common physical and mental impairments that are considered so severe as to be disabling, are now the only basis on which children qualify for benefits.⁵ The law required SSA to make a one-time redetermination of the eligibility of children already on the rolls who may not meet the new eligibility criteria. Further, the law required SSA, on an ongoing basis, to conduct continuing disability reviews (CDR) of (1) low-birth-weight babies, (2) all other children under age 18 whose impairments are likely to improve, and (3) 18-year-olds.⁶ The law also required the child’s representative payee, at the time of each CDR, to document that the child is and has been receiving medically necessary and available treatment for his or her impairment.⁷ SSA administers the SSI program with assistance from state agencies known as disability determination services (DDS), which make initial and continuing eligibility determinations on behalf of SSA.

This report continues our effort to monitor SSA’s progress in implementing these key provisions, in response to the law’s mandate that GAO report to

⁴In light of the congressional mandate to issue regulations needed to carry out the new statutory provisions as expeditiously as possible, SSA, in accordance with the Administrative Procedure Act, issued interim final regulations in February 1997 with a request for public comments. These regulations went into effect on April 14, 1997.

⁵Prior to welfare reform, a child whose impairment was not severe enough to qualify under SSA’s medical listings could still be found eligible for benefits if his or her impairment substantially limited his or her ability to function in an age-appropriate manner.

⁶The law distinguishes between CDRs, required for low-birth-weight babies and other children whose impairments are likely to improve, and redeterminations required for 18-year-olds. Benefits generally cannot be terminated as a result of a CDR unless the recipient’s impairment has improved. However, benefits to 18-year-olds can be terminated if they do not meet the disability criteria for adults, regardless of whether their medical condition has improved. Because SSA considers the redeterminations of 18-year-olds as part of its CDR workload, this report refers to the reviews of 18-year-olds as CDRs.

⁷The treatment requirement does not apply to 18-year-olds. Although not addressed in this report, the law also included provisions that (1) restricted the purposes for which large retroactive SSI benefit payments to children can be used and (2) reduced the monthly SSI benefit to children in institutions whose care is paid for by private health insurance.

the Congress on the impact of these changes on the SSI program.⁸ Specifically, this report describes SSA's progress in (1) redetermining the eligibility of children already receiving benefits against the law's new eligibility criteria, (2) implementing the law's requirements for ongoing CDRs and the related treatment provision, and (3) revising the interim final regulations to implement the law's eligibility criteria and the medical listings for childhood impairments, which are used to determine whether a child is disabled.

To address these questions, we interviewed SSA headquarters' officials responsible for implementing the law's key provisions; reviewed childhood disability program policies, procedures, and records; and submitted written questions to SSA officials concerning the new treatment provisions and the status of revisions to the final implementing regulations and the medical listings for childhood impairments. We also discussed with SSA and Congressional Budget Office officials the estimated number of children affected by changes in the program's eligibility criteria. We performed this assignment between August 1998 and April 1999 in accordance with generally accepted government auditing standards.

Results in Brief

SSA has completed 98 percent of the one-time eligibility redeterminations required for 288,000 children already receiving benefits when welfare reform was enacted. By November 1998, these redeterminations had found about 115,300 children (or about 42 percent of the 273,600 children whose medical status was reexamined) to be ineligible for SSI.⁹ However, the actual number of children who ultimately will lose benefits is not yet known, because about half of the 115,300 children found ineligible have appealed the results of their redeterminations. SSA currently estimates that about 100,000 children (about 10 percent of children receiving SSI benefits at the end of 1996) will be found ineligible for SSI after all required redeterminations and appeals are completed.

In fiscal year 1997, SSA conducted CDRs, when required, on two of the three groups of children targeted by the new law: low-birth-weight babies (7,100) and 18-year-olds (48,800). However, SSA did not conduct CDRs in 1997 for the largest of the three groups—all other children under 18 whose

⁸Supplemental Security Income: SSA Needs a Uniform Standard for Assessing Childhood Disability (GAO/HEHS-98-123, May 6, 1998, and GAO/T-HEHS-98-206, July 7, 1998); and Supplemental Security Income: Review of SSA Regulations Governing Children's Eligibility for the Program (GAO/HEHS-97-220R, Sept. 16, 1997).

⁹This is the most recent period for which data are available. SSI benefits were terminated for an additional 9,900 children for nonmedical reasons, such as not meeting the program's financial eligibility requirements.

impairments are likely to improve. Existing backlogs and competing workloads have impeded SSA's ability to perform CDRs on this group. When fiscal year 1998 began, SSA had 371,000 CDRs to complete for these children. SSA plans to ensure that all required childhood CDRs will be completed or underway by 2000. The delay in conducting most CDRs also delayed application of the law's new requirement that the child's representative payee provide evidence, at the time of each CDR, that the child is and has been receiving medically necessary and available treatment for his or her impairment. SSA has just begun collecting information from DDSS documenting whether children have been receiving treatment.

SSA has not yet decided whether any revisions are necessary to the interim final regulations that were issued to implement the law's new definition of disability for children. SSA has taken initial steps to update its medical listing of impairments, which are used to determine whether a child qualifies for benefits. However, it has not revised its medical listings to ensure that all children are assessed against a uniform severity standard. While SSA says it has made updating the listings a priority and that it plans to eliminate inconsistencies among the listings as it proceeds, it has not set a timetable for achieving this. Until SSA completes this initiative, its medical listings for childhood impairments will continue to reflect multiple levels of severity and therefore will not ensure equity among children receiving SSI disability benefits.

Background

The welfare reform law made the eligibility criteria for children more restrictive and applied the new criteria to children already receiving benefits as well as to new applicants. The new law (1) redefined disability from an impairment comparable to one that would prevent an adult from working to one that results in "marked and severe functional limitations"; (2) eliminated the individualized functional assessment (IFA), which had been used to award benefits to children whose impairments were not severe enough to qualify under SSA's medical listings; and (3) removed maladaptive behavior as a discrete criterion for assessing a child's personal and behavioral functioning. The law required SSA to make a one-time redetermination of the eligibility of child recipients who had been found eligible on the basis of the IFA or maladaptive behavior.

To implement the new law, SSA issued interim final regulations in February 1997 that defined an impairment that results in "marked and severe functional limitations" as one that meets, medically equals, or functionally equals one of SSA's medical listings. The medical listings are

regulations describing medical signs, symptoms, and laboratory findings for a list of common physical and mental impairments that are so severe that disability can be presumed for anyone who is not working and who has an impairment that meets the criteria of the listing. Since the listings cannot include every possible impairment or combination of impairments a person can have, SSA's rules also provide that an impairment or combination of impairments can medically or functionally equal the severity of a listing.¹⁰ For a child to be determined eligible for benefits under this new and stricter standard of severity, his or her impairment must generally result in marked functional limitations in two areas of functioning, such as social and motor, or an extreme limitation in one area.¹¹ SSA has identified 28 listings, however, as ones most likely to allow children with less than two marked or one extreme functional limitation to be found eligible for benefits.

The law also added requirements for SSA to regularly review the continuing eligibility of children receiving SSI. It required SSA to perform CDRs (1) during the first year after birth for low-birth-weight babies and (2) at least once every 3 years for other children under 18 whose conditions are considered likely to improve.¹² At the time of these reviews, the child's representative payee must present evidence demonstrating that the child is and has been receiving medically necessary and available treatment for his or her impairment.¹³ If the representative payee cannot provide SSA with an acceptable reason for not complying with this provision, and SSA decides that it is in the child's best interest, SSA may pay the child's SSI benefits to another representative payee.¹⁴ The law also required SSA to

¹⁰There are separate listings for adults and children. The childhood listings are used first in evaluating childhood claims. If the child's impairment does not meet or equal the severity of a childhood listing, use of the adult listings may be considered.

¹¹Areas of functioning are assessed on the basis of children's ages. Social, cognition/communication, and motor areas are assessed for children of all ages; responsiveness to stimuli is assessed in children under age 1; and personal functioning and the ability to concentrate, persist at tasks at hand, or keep pace are assessed for children aged 3 and older.

¹²The law also specified that SSA could, at its option, review children who are unlikely to improve. In addition, the Balanced Budget Act of 1997 (P.L. 105-33) modified the welfare reform law, so that a CDR may be scheduled on a low-birth-weight baby after the baby's first birthday if the baby is not expected to improve within the first 12 months after birth.

¹³The payee need not show proof of treatment if SSA decides that the disabling impairment is not amenable to treatment.

¹⁴Acceptable reasons include that the treatment is (1) contrary to established teachings or tenets of the child's religion; (2) very risky, such as open-heart surgery or an organ transplant; or (3) involves amputation of an extremity or a major part of an extremity.

redetermine the eligibility of children, after they reach age 18, against the adult criteria for disability.¹⁵

SSA administers the SSI program with the help of state DDSS. DDSS make disability determinations and eligibility redeterminations, assess recipients' potential for medical improvement, and schedule and conduct CDRs. Adverse eligibility determinations are subject to appeal. Claimants initially determined by the DDS to be ineligible for benefits have 60 days to request the DDS to reconsider their cases. If they continue to receive an unfavorable result, they can appeal to an SSA administrative law judge, SSA's Appeals Council, and finally to federal court. It can take 2 years or more for cases to work their way through all levels of appeals.

Most One-Time Redeterminations Completed, But Final Outcomes Await Appeal

By November 1998, SSA had completed 98 percent of the 288,000 one-time redeterminations required for children who had been awarded benefits on the basis of the IFA or because of maladaptive behavior. Of the 273,600 children whose medical status was redetermined, about 115,300 (about 42 percent) were found no longer eligible for SSI benefits.¹⁶ However, the actual number of children who ultimately will lose benefits is unknown, because about 55,200 of the 115,300 children found ineligible have appealed the results of their redeterminations. SSA currently estimates that about 100,000 children will be found ineligible for SSI after all required redeterminations and appeals are complete.

This estimate is much lower than SSA's and the Congressional Budget Office's original estimates that 185,000 and 190,000 children, respectively, would be found ineligible for benefits as a result of these redeterminations. However, those estimates were made when the welfare reform legislation was enacted and reliable historical data were not available to project the number of children for whom redeterminations were required and the number of children who would still qualify for benefits under the new law.

SSA's new estimate considers the effect of the new regulations and the actions taken by SSA in response to its experience in implementing the regulations. When the interim regulations were issued in February 1997, SSA refined its initial estimate and projected that 135,000 children would

¹⁵The welfare reform law repealed the requirement that SSA conduct CDRs on one-third of SSI recipients attaining age 18 in each of fiscal years 1996, 1997, and 1998.

¹⁶SSI benefits were terminated for nonmedical reasons, such as not meeting the program's financial eligibility requirements, for an additional 9,900 children.

not qualify for benefits under the regulations. Subsequently, because of problems SSA identified during a “top-to-bottom” review of how the new interim regulations were being implemented, SSA decided to re-review the claims of about 36,000 children who had been found no longer eligible as a result of the redeterminations.¹⁷ By November 1998, SSA had re-reviewed about 21,800 of these children, reversing the decision to terminate benefits for about 5,000 of them. In addition, SSA granted about 63,300 children who had been found ineligible another opportunity to appeal, and about 26,900 children took advantage of this opportunity.

SSA Is Making Progress in Implementing Some CDR Requirements; Others Delayed

SSA has been able to conduct CDRs when required on two of the three groups of children targeted by the new law: low-birth-weight babies and 18-year-olds. However, SSA did not conduct CDRs on the largest of the three groups—all other children under 18 whose impairments are likely to improve. The delay in conducting these CDRs has delayed application of the new law’s requirement that a child’s representative payee document, at the time of each CDR, that the child is or has been receiving medically necessary and available treatment for his or her impairment.

Low-birth-weight babies and children turning age 18 constitute a rather small portion of all children receiving SSI benefits, and SSA has been able to stay current in processing the required CDRs for these two groups. In fiscal year 1997, DDSs completed CDRs on approximately 7,100 low-birth-weight babies and 48,800 18-year-olds for whom CDRs were required. Initial DDS determinations found over one-third of low-birth-weight babies and over one-half of 18-year-olds to be no longer eligible for benefits (see table 1).¹⁸

Table 1: CDRs Completed During Fiscal Year 1997

Recipient group	Total CDR determinations	Number determined ineligible	Percentage determined ineligible
Low-birth-weight babies	7,091	2,604	37
Children who attain age 18	48,834	26,399	54

Note: Data represent initial CDR determinations.

Source: SSA.

¹⁷SSA, Social Security: Review of SSA's Implementation of the New SSI Childhood Disability Legislation (Baltimore, MD: 1997).

¹⁸During fiscal year 1998, SSA scheduled CDRs for all of the approximately 12,400 low-birth-weight babies and 67,000 18-year-olds for whom CDRs were required. The outcomes of these CDRs were not available at the time we did our work.

According to SSA, CDRs conducted on low-birth-weight babies in prior fiscal years have also found many to be ineligible. SSA found that, as these babies grow older and gain weight, their impairments often improve to the extent that they are no longer disabled. In addition, the number and proportion of 18-year-olds determined ineligible could change in future years as SSA conducts more CDRs of children under age 18 and removes, at an earlier age, those no longer disabled.

Although SSA has not conducted all of the required CDRs for children under 18 whose conditions are likely to improve, it has developed a plan to become current in conducting all required childhood CDRs by 2000. When fiscal year 1998 began, SSA had a caseload of 371,000 CDRs to be completed for these children. This caseload developed because few CDRs had been done in the past and, in fiscal year 1997, SSA diverted DDS staff from conducting these CDRs in order to process the one-time redeterminations of child recipients.¹⁹ Having now completed most of these redeterminations, SSA expects to make progress in completing the required childhood CDRs and plans to ensure that all required childhood CDRs will be completed or underway by fiscal year 2000. It also plans to stay up-to-date thereafter with all childhood CDRs coming due.

The delay in conducting most of the required CDRs on children under age 18 has also delayed application of welfare reform's new treatment provision. Although SSA has issued implementing regulations and instructions and notified representative payees of the new treatment provision, the agency has just begun collecting management information needed to track implementation of this new requirement. In January 1999, SSA issued instructions to DDS adjudicators requiring them to document the results obtained from applying the treatment requirement. SSA stated that it does not expect to have meaningful management information in the immediate future to document the effect of the law's treatment requirement on children, because this provision is applied when CDRs are conducted, and SSA has only recently begun conducting CDRs in large numbers.

¹⁹The welfare reform law required SSA to complete the one-time redeterminations within 1 year of enactment. The Balanced Budget Act of 1997 extended the time frame for completing the redeterminations to 18 months or as soon as practicable thereafter.

Revisions to Regulations Still Pending; Multiple Eligibility Standards Remain

SSA requested and received public comments on its interim final regulations, issued in February 1997, to implement the law's new definition of disability for children. The agency has not issued revised final regulations in response to these public comments, and it does not expect to do so for some time. SSA states that it is still studying and analyzing the results of its experience in implementing the interim final regulations. SSA has initiated several research studies (and expects to conduct several more over the next few years) to determine how to refine its procedures and regulations for adjudicating children's disability claims. SSA stated that it would be premature to issue revised final regulations before its analysis and research are complete. In the meantime, SSA is still operating under the interim final regulations.

Under SSA's interim final regulations, meeting, medically equaling, or functionally equaling the medical listings is the only basis on which children can be found eligible for benefits. However, SSA has not updated most of its childhood medical listings for many years; therefore some listings do not reflect the latest advances in medicine and science, including advances in medical knowledge, methods of evaluating impairments, and treatment.²⁰

In addition, our May 1998 report on SSA's efforts to assess childhood disability pointed out that SSA's medical listings do not reflect a uniform level of severity—that is, not all listings require the same degree of functional limitation for the child to be found eligible for benefits. In defining an impairment that results in “marked and severe functional limitations” as one that meets, medically equals, or functionally equals one of SSA's medical listings, SSA's interim final regulations state that the child's impairment must generally result in marked functional limitations in two areas of functioning, such as social and motor development, or an extreme limitation in one area of functioning. SSA established the “two marked or one extreme” general rule from the severity criteria cited in the agency's mental disorders listings.

However, not all listings are set at a level of severity equivalent to two marked functional limitations or one extreme functional limitation.

²⁰Since 1990, SSA has updated its childhood medical listings for mental disorders, cardiovascular disorders, and respiratory disorders. Almost two-thirds of the children receiving benefits in December 1998 had mental, cardiovascular, or respiratory disorders. It also developed new listings for immune disorders and made several other revisions to its medical listings. However, the listings for neurological system, digestive system, endocrine system, and hemic and lymphatic system, special senses and speech, and growth impairment disorders have not been updated since 1977; and the listings for genito-urinary system and musculoskeletal system disorders have not been updated since 1985.

Although the welfare reform law defines disability in terms of functional limitations, many of the listings do not specify functional limitations at all; their severity criteria are expressed in terms of laboratory values, such as test results, or other signs and symptoms. Other listings include functional criteria as part of the criteria for assessing the impairment's severity, but do not clearly define the degree of functional limitation required for a child to be found eligible for benefits. For example, some listings describe functional limitations as "persistent" or "significant," which are not defined in relation to the terms "marked" or "extreme." Nonetheless, SSA has identified 28 listings as ones that are most likely to enable children whose impairments result in fewer than two marked functional limitations or one extreme functional limitation to be found eligible for benefits.²¹ Twenty-one of these listings have not been updated since 1977. According to SSA, many more listings may allow some children whose impairments are below the "two marked or one extreme" threshold to be found eligible for benefits.

Because the medical listings are now the only basis on which children can be found eligible for benefits, the lack of uniform severity criteria in the medical listings raises equity concerns. Consequently, our May 1998 report recommended that SSA act immediately to revise its medical listings to incorporate advances in medicine and science and to reflect a uniform standard of severity.

SSA has taken initial steps to update its medical listings for childhood impairments. SSA has stated that updating the medical listings for childhood impairments is a priority, and that it has begun to recruit additional staff and has increased its research budget specifically for this purpose.²² Although SSA has not set a completion date for revising the listings, in general, it plans to review the listings sequentially by body system, undertaking the "short-term fixes" first and eliminating inconsistencies among listings as it completes its review of each body system.²³ In addition to conducting research, SSA plans to consult with medical experts and seek public involvement as part of this effort.

²¹Children can meet or medically equal these listings if their impairments are more severe than these listings require. Therefore, some of the children who meet or medically equal these listings may have impairments that result in two marked functional limitations or one extreme functional limitation. However, SSA cannot identify the number of children who have been awarded benefits based on the 28 listings or how many of these children have impairments at the two marked or one extreme severity level.

²²SSA will also be updating the medical listings for adult impairments as part of this effort.

²³SSA's medical listing of impairments are grouped into categories known as body systems. The listings for childhood impairments are divided into 14 such body systems, including the musculoskeletal, respiratory, cardiovascular, and endocrine systems; special senses and speech; and mental disorders.

SSA told us that the current childhood listings are appropriate for identifying disabled children, and that it will ensure that the updated listings reflect impairments that result in marked and severe functional limitations, as required by the welfare reform law. Further, in observing that some listings contain only medical criteria and others include functional criteria, SSA questioned whether it is always possible to directly compare the severity of listings to each other. Moreover, SSA said that the “two marked or one extreme” rule is not appropriate in all cases. SSA explained that there are some listings for physical impairments, such as cancer, for which medical criteria alone are sufficient for determining that a child is disabled. As long as SSA ensures that all listings result in marked and severe functional limitations, it maintains that the listings will be uniform in severity to the extent feasible.

Conclusion

SSA has made significant progress in implementing welfare reform’s requirements for assessing children’s continuing eligibility for benefits. Specifically, it has completed almost all of the one-time redeterminations required for children who had been receiving benefits when welfare reform was enacted, and it has conducted CDRs when required on low-birth-weight babies and 18-year-olds. Further, it has a plan to ensure that all required CDRs for children under 18 whose conditions are likely to improve will be completed or underway by 2000. However, SSA has not yet decided whether any revisions are necessary to the interim final regulations that were issued to implement the law’s new definition of disability for children, and it has made little progress in updating its medical listings for childhood impairments. Although it has taken initial steps to accomplish the update, such as recruiting staff, it has not set a timetable for completing this task. Until SSA completes this initiative, its medical listings for childhood impairments will continue to reflect multiple levels of severity. Because the listings are the only basis on which children qualify for benefits, the lack of a uniform severity level in the listings raises equity concerns. Accordingly, the recommendation we made in our May 1998 report still has merit. Specifically, we believe that the SSA Commissioner should promptly set a timetable for updating the medical listings for childhood impairments and that the updated listings be set, to the extent possible, at a uniform level of severity in order to ensure equity among children receiving SSI disability benefits.

Agency Comments and Our Response

We provided a draft of this report to SSA for review and comment. SSA’s comments concerned our discussion of the need for SSA to revise its

medical listings for children. We revised our report to recognize that, since 1990, SSA has updated the childhood medical listings for mental, cardiovascular, and respiratory disorders and that most children receiving benefits have these disorders. We also revised our report to reflect SSA's comment that advances in treatment alone may not determine whether listings need to be updated. Nevertheless, because meeting or medically or functionally equaling the listings is the only basis on which children qualify for benefits, we believe SSA needs to continually review its listings to ensure that they reflect the latest advances in medical knowledge, methods of evaluating impairments, and treatment.

Finally, we revised our report to clarify that SSA identified 28 listings as the ones that are most likely to allow children with less than two marked functional limitations or one extreme functional limitation to qualify for benefits. SSA stated that relatively few children were awarded benefits based on the 28 listings, and it believes that most children who meet the requirements of these listings would have marked limitations in two areas of functioning or an extreme limitation in one area. We revised our report to recognize that some children who qualify for benefits under these listings may have functional limitations at the "two marked or one extreme" level. However, SSA cannot identify the number of children who have been awarded benefits based on the 28 listings, or the number of these children who function at the "two marked or one extreme" level.

SSA also provided technical comments, which we incorporated where appropriate. SSA's comment letter and page one of its comments are included in appendix I. (SSA's technical comments are not included.)

We are providing copies of this report to the Honorable Kenneth S. Apfel, Commissioner of Social Security, and other congressional committees with an interest in this matter. We will also make copies available to others upon request.

Please contact me or Carol Dawn Petersen on (202) 512-7215 if you have any questions about this report. Other major contributors were Ellen Habenicht, William Hutchinson, Daniel Schwimer, and Gretta L. Goodwin.

A handwritten signature in black ink that reads "Cynthia M. Fagnoni". The signature is written in a cursive style with a large initial 'C' and a distinct 'M'.

Cynthia M. Fagnoni
Director, Education, Workforce,
and Income Security Issues

Contents

Letter	1
Appendix I Comments From the Social Security Administration	16
Related GAO Products	20
Table	Table 1: CDRs Completed During Fiscal Year 1997 7

Abbreviations

CDR	continuing disability review
DDS	disability determination service
IFA	individualized functional assessment
SSA	Social Security Administration
SSI	Supplemental Security Income

Comments From the Social Security Administration



SOCIAL SECURITY

Office of the Commissioner

May 19, 1999

Ms. Cynthia M. Fagnoni
Director, Income Security
Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Fagnoni

Thank you for the opportunity to review the draft report, "Supplemental Security Income: Progress Made in Implementing Welfare Reform Changes; More Action Needed" (GAO/HEHS-99-103). Our comments on your report are enclosed. If you have any questions, please have your staff contact Barbara Doering at (410) 965-2290.

Sincerely,

A handwritten signature in black ink that reads "Kenneth S. Apfel".

Kenneth S. Apfel
Commissioner
of Social Security

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

Appendix I
Comments From the Social Security
Administration

GENERAL ACCOUNTING OFFICE DRAFT REPORT, "SUPPLEMENTAL SECURITY
INCOME: PROGRESS MADE IN IMPLEMENTING WELFARE REFORM CHANGES;
MORE ACTION NEEDED" (GAO/HEHS-99-103)

Thank you for giving us the opportunity to review this draft and provide comments. We offer the following comments about the sections in the draft that address the listings update issues. We are also appending a list of technical corrections.

The report indicates that we have not updated "most" of our childhood listings for "many years." We believe that this observation could be misleading without further explanation. In fact, we have updated many of our most important childhood listings in the years since 1990, and these listings account for most children who would qualify for benefits. For example, we have updated all of the mental, respiratory, and cardiovascular disorders listings.

The report also seems to draw a potentially misleading conclusion about newer treatments that may have lessened the effect that some impairments have on a child's ability to function. Children who benefit from new treatments generally will not have the signs, symptoms, laboratory findings or functional limitations required to meet or equal the requirements of most listings. Therefore, the fact that there may be new treatments now, or even in the future, may not be determinative as to the issue of whether the listings should be updated.

Finally, the report includes language that, perhaps unintentionally, mischaracterizes listings for 28 impairments and our position about these listings. The report indicates that these listings "are likely to allow children with less than two marked or one extreme functional limitation to be found eligible for benefits."

This is not an accurate characterization. In response to a question from the General Accounting Office (GAO) in connection with a prior report, we indicated that it is only possible that some children could be found disabled under certain listings yet not demonstrate the functional limitations we describe in our regulations. We indicated that these 28 listings are the ones that are most likely to include such children. This is not the same thing as the assertion in the draft report that these listings are likely to include such children. Moreover, the 28 listings include relatively few children, and we believe that most children who meet the requirements of these listings would demonstrate marked limitations in two areas of functioning or extreme in one.

Related GAO Products

Supplemental Security Income: SSA Needs a Uniform Standard for Assessing Childhood Disability ([GAO/HEHS-98-123](#), May 6, 1998, and [GAO/T-HEHS-98-206](#), July 7, 1998).

SSA's Management Challenges: Strong Leadership Needed to Turn Plans Into Timely, Meaningful Action ([GAO/T-HEHS-98-113](#), Mar. 12, 1998).

Supplemental Security Income: Review of SSA Regulations Governing Children's Eligibility for the Program ([GAO/HEHS-97-220R](#), Sept. 16, 1997).

Children Receiving ssi by State ([GAO/HEHS-96-144R](#), May 15, 1996).

SSA Initiatives to Identify Coaching ([GAO/HEHS-96-96R](#), Mar. 5, 1996).

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program ([GAO/HEHS-95-137](#), July 7, 1995).

Social Security: New Functional Assessments for Children Raise Eligibility Questions ([GAO/HEHS-95-66](#), Mar. 10, 1995).

Social Security: Federal Disability Programs Face Major Issues ([GAO/T-HEHS-95-97](#), Mar. 2, 1995).

Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns ([GAO/T-HEHS-95-67](#), Jan. 27, 1995).

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

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