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SENATE

REPORT
98-466

SOCIAL SECURITY DISABILITY AMENDMENTS OF 1984

MAY 18 (legislative day, MAY 14), 1984.—Ordered to be printed

Mr. DOLE, from the Committee on Finance, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 476]

The Committee on Finance, to which was referred the bill (S. 476) to amend title II of the Social Security Act to require a finding of medical improvement when disability benefits are terminated, to provide for a review and right to personal appearance prior to termination of disability benefits, to provide for uniform standards in determining disability, to provide continued payment of disability benefits during the appeals process, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY OF SOCIAL SECURITY DISABILITY PROVISIONS

The bill (S. 476), as amended by the Committee, modifies the standards and procedures to be used in determining disability and continuing eligibility for benefits under the Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) programs. In addition, the bill makes a number of changes to improve the accuracy of disability determinations, the uniformity of decisions between the different levels of adjudication, and the consistency of such decisions with Federal law and standards. Provisions are also included to ensure the adequacy of financing for the DI program.

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Medical Improvement

Modifies, for a period of 3½ years, the requirements and procedures used for determining continuing eligibility for social security disability benefits. If the Secretary finds that a beneficiary undergoing review has not medically improved, the Secretary must show that there has been one of the following improvements or changes in circumstances prior to determining whether such beneficiary is disabled under the meaning of the law: (a) the individual has benefited from medical or vocational therapy or technology; (b) new or improved diagnostic or evaluative techniques indicate the individual's impairment(s) is not as disabling as believed at the time of the last decision; (c) the prior determination was fraudulently obtained; or (d) there is demonstrated substantial reason to believe that the prior determination was erroneous. If any of these factors are met, the Secretary must then determine whether the individual can perform substantial gainful activity.

If the Secretary finds that the evidence does not show that the individual's condition is the same as or worse than at the time of the prior determination, the Secretary would determine whether the individual can perform substantial gainful activity.

(Benefits also would be terminated if the individual is currently engaging in substantial gainful activity or if the individual cannot be located or fails, without good cause, to cooperate in the review or to follow prescribed treatment that could be expected to restore his ability to work.)

This new standard, which expires December 31, 1987, would be applied to future determinations of continuing eligibility to individuals who currently have claims properly pending in the administrative appeals process, and to certain cases pending in court.

Continuation of Payments During Appeal

Reauthorizes, until June 1, 1986, the provision which permits individuals notified of a termination decision to elect to have disability insurance (DI) benefits and Medicare coverage continued during appeal until the administrative law judge hearing decision.

Uniform Standards

Makes the Social Security Administration (SSA) subject to the rulemaking requirements of the Administrative Procedure Act on matters relating to the determination of disability and the payment of disability insurance benefits.

Moratorium on Mental Impairment Reviews

Suspends eligibility reviews for individuals with disabilities based on mental impairments pending a revision of eligibility criteria. Also, require redetermination of eligibility under the new criteria (and reinstatement of benefits where appropriate) for individuals denied benefits after enactment and prior to the revision of the criteria, and to those terminated from the rolls since June 7, 1983.

Qualifications of Medical Professionals Evaluating Mental Impairments

Requires the Secretary to make every reasonable effort to ensure that a qualified psychiatrist or psychologist completes the medical portion of the evaluation or assessment of residual functional capacity in mental impairment cases in which a decision unfavorable to the claimant or beneficiary is made.

Nonacquiescence in Court Orders

Requires the Secretary to send to the Committees on Finance and Ways and Means, and publish in the Federal Register, a statement of the Secretary's decision, and the specific facts and reasons in support of such decision, to acquiesce or not acquiesce in U.S. Court of Appeals decisions affecting the Social Security Act or regulations issued thereunder. In cases where the Secretary is acquiescing, the reporting requirement would apply only to significant decisions.

Multiple Impairments

Requires the Secretary, in determining the medical severity of an individual's condition, to consider the combined effect of all of the individual's impairments without regard to whether any one impairment itself would be considered severe.

Evaluation of Pain

Directs the Secretary to appoint a Commission of experts (including significant representation from the field of medicine as well as other appropriate specialities such as law and administration) to conduct a study concerning the evaluation of pain in determining eligibility for disability benefits. This Commission would be directed to report by December 1986.

Pending the results of this study and any Congressional action which might be based on it, incorporates into the statute a requirement that disability determinations take into consideration subjective allegations of pain only to the extent they are consistent with medical signs and findings which show the existence of a medical condition which could reasonably be expected to produce the alleged pain, or other subjective symptoms (identical to the current rule applied by the Administration). The provision expires December 31, 1987.

Modification of Reconsideration Preview Notice

Requires the Secretary to conduct demonstration projects in five States in which the opportunity for personal appearance is provided prior to making a determination of ineligibility (in lieu of face-to-face hearings at reconsideration). This would apply only to periodic review cases. The Secretary would be required to report to Congress by April 1, 1986.

In addition, requires the Secretary to notify individuals upon initiating a periodic eligibility review that such review could result in

termination of benefits and that medical evidence may be submitted.

Consultative Examinations/Medical Evidence

Requires the Secretary to make every reasonable effort to obtain necessary medical evidence from an individual's treating physician prior to seeking a consultative examination. Additionally, the Secretary would be required to develop a complete medical history for individuals applying for benefits or undergoing review over at least the preceding 12-month period.

Vocational Rehabilitation

Authorizes reimbursement of vocational rehabilitation (VR) services provided to individuals who are receiving disability benefits under Section 225(b) of the Social Security Act and who medically recover while in VR. Reimbursable services would be those provided prior to his or her working at substantial gainful activity for 9 months, or prior to the month benefit entitlement ends, whichever is earlier.

Special Benefits for Individuals Who Perform Substantial Gainful Activity Despite Severe Medical Impairment

Reauthorizes, through June 30, 1987, Section 1619 of the Social Security Act, which permits severely impaired SSI recipients to receive a special payment and maintain medicaid eligibility despite earnings. In addition, the Secretaries of HHS and Education would be required to establish training programs on Section 1619 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.

Advisory Council

Directs the next quadrennial Social Security advisory council to study and make recommendations on various medical and vocational aspects of disability, including alternative approaches to work evaluation for SSI recipients, the effectiveness of vocational rehabilitation programs for SSI recipients, and the question of using medical specialists for completing medical and vocational forms used by State agencies. The council would be authorized to convene task forces of experts to deal with specialized areas. Members of the council must be appointed by June 1, 1985, and the report is scheduled to be issued by December 31, 1986.

Frequency of Periodic Reviews

Requires the Secretary, within 6 months of enactment, to issue regulations establishing the standards to be used in determining the frequency of periodic eligibility reviews. Pending issuance of such regulations, no individual could be reviewed more than once.

Monitoring of Representative Payees

Requires the Secretary to: (1) evaluate the qualifications of prospective payees either prior to or within 45 days following certification, (2) establish a system of annual accountability monitoring for cases in which payments are made to someone other than the entitled individual, or parent or spouse living in the same household, and (3) increase the penalties for misuse of benefits by representative payees. Also, requires the Secretary to report to Congress within 6 months of enactment on the implementation of this provision, and to report annually on the number of cases of misused funds and the disposition of such cases.

Fail-Safe

Requires the Secretary to notify the Congress by July 1, if the DI fund is projected to decline to less than 20 percent of a year's benefits. If Congress took no other action, the Secretary would scale back (in part or in full) the next cost-of-living increase for disability beneficiaries as necessary to keep the fund balance at 20 percent. If necessary, the Secretary would also scale back the increase in the benefit formula used for determining benefit levels for persons newly awarded disability benefits. Measurement of the fund assets would include any funds (now $5 billion) loaned by the DI trust fund under the interfund borrowing authority.

Measures To Improve Compliance With Federal Law

Requires the Secretary to federalize disability determinations in a State within 6 months of finding that the State is failing to follow Federal law and standards. (Such a finding must be made within 16 weeks of the time the State's failure to comply first comes to the attention of the Secretary.) This provision expires on December 31, 1987.

II. BACKGROUND

When the Senate originally agreed to adopt a disability insurance program as a part of the Social Security Act in the 1950's, opponents of the legislation argued that it would be impossible to administer such a program tightly so as to limit its benefits to those truly disabled, and to keep its costs within the bounds of what Congress might believe to be an appropriate payroll tax level. The Congress did not accept this argument, and the program was enacted into law.

The developments with respect to the cost of the program since that time do indicate that there was some basis for the fears then expressed. The costs of the program have grown substantially and have shown a far greater degree of volatility than is true of the old-age and survivors insurance program. Nevertheless, the Congress has continued to believe that the Social Security Act disability programs provide important protections to American workers and their families and that, with careful administration, the programs can be continued within the constraints of cost levels which taxpayers can reasonably expect to bear.

The Congress has found it necessary on occasion to reemphasize its concern that the costs of the program not be allowed to grow out of control as a result of overbroad construction of the statute or lack of careful administration. In the 1967 amendments, for example, the Congress found it necessary to address situations in which some courts were, by broadly construing the statute, providing benefits on a basis not intended by Congress. Specifically, in 1967 the Congress added explicit language to continue to make clear that eligibility under the program was to based on the inability to do any substantial work, without regard to the economy in the applicant's region or his inability to perform his prior occupation. In addition the Congress then added language requiring that benefits be based on objectively verifiable medical evidence.

In the 1980 disability amendments, Congress again found it necessary to deal with problems which had driven the cost of the program beyond the bounds that Congress had intended or found acceptable. Among the concerns addressed in the 1980 legislation were the problems of consistency of decision-making throughout the country and among different levels of the appeals process. Another major concern was the adequacy of administrative review both at the initial allowance level and in terms of continuing review of eligibility.

The concerns of the Congress that the Social Security Act disability programs be carefully administered, and that the definition of disability be applied in a way to assure that benefits are paid only to those who are unable to engage in substantial work, continue to be valid and are not in any sense repudiated by the pending legislation. The validity of the action taken in 1980 to provide for periodic review has been amply borne out by sample surveys showing substantial levels of ineligibility.

III. GENERAL STATEMENT OF PURPOSE

The Committee recognizes that the review process mandated under the 1980 amendments has resulted in some significant problems and dislocations which were not anticipated and which contributed to an unprecedented degree of confusion in the operation of the program. The transition from a too loosely administered program with few post-entitlement reviews to a more tightly administered program with regular, periodic reviews revealed weaknesses and ambiguities which need to be dealt with.

It is the purpose of the Committee bill to deal with these problems while continuing the Congressional insistence that this program be tightly and carefully administered. The present-law requirement of a periodic review of eligibility for all disability beneficiaries is unchanged by this bill. For those not classified as permanently disabled, these reviews are to be carried out at least once every 3 years to assess their continuing eligibility for benefits. This bill only affects the standards of review, not the requirement that reviews be undertaken, nor the size of the population that must be reviewed.

Under present law, the standard of eligibility is in ability to work, and that standard applies both in initial applications and in continuing eligibility cases. The Committee bill does not change

this basic standard of eligibility, but it does provide protection or reassurance for those who are correctly and properly allowed on the rolls that they will remain on the rolls if their condition fails to improve. It does not assure anyone that they will not be reviewed. And it continues to require that terminations continue for those who should not be getting benefits. Some people were improperly allowed in the first place and it is not until their eligibility is reviewed that the error is detected; other people recover their work ability, either due to medical or vocational improvement. In these cases termination of benefits should and will occur.

Where there was previously only one standard of review, then, the Committee amendment adds a new standard—not to protect ineligible persons, but to provide a reassurance to those properly allowed. This standard, along with other features of the bill, will eliminate the existing confusion on this matter by reemphasizing the Congressional intent that there be national uniformity under Federal standards established by Congress and authoritatively interpreted in the regulations of the Department. Many of the other provisions of the bill also are intended to resolve ambiguities and reestablish the important principle that this is a national program which must be administered as such in accordance with Congressional intent. For example, the provision subjecting the program to the Administrative Procedure Act is intended to improve national uniformity and to assure that the regulations of the Secretary are accorded proper deference. Similarly the bill deals with the issues of multiple impairments and pain because there are major concerns about the need for national policy guidance with respect to these issues.

The Committee expects that the enactment of this legislation will, in a major way, restore confidence and credibility to the disability insurance program. The Committee recognizes that concerns have been expressed that the legislation could be misinterpreted as a license for lesser review and easier administration. There is no such intent. Lest there be any doubt, the Committee has included in the bill a fail-safe provision so that taxpayers may know that the Committee does not intend an open-ended commitment of taxpayer funds should either those who administer the program at the State and Federal level or the courts disregard the intent of the Committee in such a way as to cause the costs of the program to grow out of control. The Committee does not anticipate that this will happen, and does not expect that the fail-safe mechanism will be needed.

IV. GENERAL DISCUSSION OF THE BILL

Medical Improvement

(Section 2 of the bill)

Present law

There is no distinction in the law between how eligibility for disability benefits is to be determined for people newly applying for benefits and those currently on the rolls being reviewed to assess their continuing eligibility. Eligibility or ineligibility is based on

the standards of disability (in the law, regulations, and Commissioner's rulings) in effect at the time of the most recent decision.

Under the law, disability means inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to end in death or has listed or can be expected to last for a continuous period of at least 12 months.

Prior to the Secretary's announcement, on April 13, 1984, of a temporary, nationwide moratorium on periodic reviews, 9 States were operating under a court-ordered medical improvement standard, and 9 States had suspended reviews pending implementation of a court-ordered medical improvement standard or pending action by circuit court.

Committee amendment

The Committee amendment modifies, through December 31, 1987, the requirements and procedures used for determining continuing eligibility for disability benefits. If the Secretary finds that there has been no medical improvement in the individual's impairment(s) (other than medical improvement which is not related to his work ability), the Secretary would have the burden to show that there has been one of the following improvements or changes in circumstances prior to determining whether such beneficiary is disabled under the meaning of the law: (a) the individual has benefited from medical or vocational therapy or technology; (b) new or improved diagnostic or evaluative techniques indicate the individual's impairment(s) is not as disabling as believed at the time of the last decision; (c) the prior determination was fraudulently obtained; or (d) there is demonstrated substantial reason to believe that the prior determination was erroneous.

If none of the above factors are met, benefits would be continued (whether or not the individual would have been found to be able to perform substantial gainful activity). If any of these factors are met, the Secretary would then determine whether the individual can perform substantial gainful activity. If he can, benefits would be terminated.

If the Secretary finds that the evidence does not show that the individual's condition is the same as or worse than at the time of the prior determination, the Secretary would determine whether the individual can perform substantial gainful activity, and, if he can, benefits would be terminated. (Benefits would also be terminated if the individual is currently engaging in substantial gainful activity or if the individual cannot be located or fails, without good cause, to cooperate in the review or to follow prescribed treatment that could be expected to restore his ability to work.)

In making a determination, the Secretary shall consider the evidence in the file as well as any additional information concerning the claimant's current or prior condition that is secured by the Secretary or provided by the claimant. (The Secretary is thus not limited to considering only the prior decision or the evidence developed at the time of the prior decision.)

In the case of a finding relating to medical improvement, the burden of proof is on the claimant. Burden cannot be met by allegations regarding the beneficiary's condition; objective evidence

containing clinical findings, laboratory findings and diagnoses, as outlined in regulations, must be provided. In other words, for benefits to be continued, the individual must state and the evidence in the file must show that the individual's medical condition is the same as or worse than at the time of the last decision (or, if there is medical improvement, it is not related to work ability).

In the case of a finding relating to factors a-d, the Secretary has the burden of proof. In other words, for benefits to be terminated on the basis of any of these reasons, the evidence in the file must show that one of these factors is met.

The Committee bill requires that regulations to implement the medical improvement standard shall be published within 6 months of enactment.

Reasons for change

The new standard of continuing eligibility is designed to respond to and address a number of serious problems in the disability review process. First and foremost, the Committee is reaffirming its commitment to and insistence upon a nationally uniform disability insurance program. In recent months, due both to independent actions by States that are in violation of Federal law and guidelines and to Court actions, the social security disability insurance program is no longer being administered in a nationally uniform manner, consistent with the goals of the Federal program. The issue of medical improvement and the standards to be applied in determining eligibility for people after they are on the benefit rolls has been one of the central issues of contention. This new standard is thus intended to make explicit to the States administering the disability insurance program and to the courts the standards to be applied in determining continuing eligibility for benefits—the standards as set forth in national policy by the Congress. As discussed below, the effective date of the medical improvement standard underscores the Committee's intention to ensure uniform application of the single standard of review.

Secondly, the Committee is reaffirming its commitment to and insistent upon a tightly administered disability insurance program. The standard included in the bill does not in any way relieve the Secretary of the obligation to carefully and regularly review the accuracy of the benefit rolls, as mandated by the 1980 disability amendments. Nor does it relieve the individual of the obligation to periodically reestablish his continuing eligibility. If the individual is found to have been allowed on the rolls erroneously, or on the basis of fraud, or if his condition has improved, either medically or vocationally, or is not as disabling as originally believed, benefits will be terminated if the individual can perform substandard gainful activity. Benefits will also be terminated if the individual is currently working, cannot be located, or fails, without good cause, to cooperate in the review or to follow prescribed treatment which could be expected to restore his ability to work. Clearly, it is not the Committee's intention to grandfather people onto the benefit rolls who can perform substantial gainful activity, as this would create a serious inequity—a double-standard—between current beneficiaries and new applications with identical impairments.

In this regard, the Committee considered carefully and rejected the proposal to shift the burden of proof in eligibility determinations from the claimant to the Government once the individual is on the benefit rolls. The weight of the evidence must demonstrate that the individual should remain on the rolls, not the reverse, where the weight of the evidence would have to warrant termination. In addition the Committee considered carefully and rejected the proposal to require that a quality or quantity of improvement (vocational or medical) be shown prior to determining whether the individual can work. The protections in the Committee amendment are for those whose conditions have remained the same or deteriorated since the time of their last disability decision. The amendment does not include protections for people who have improved, or who have failed to improve to some particular degree, so long as it is demonstrated that they can work. The Committee thus rejected putting up legal or procedural hurdles to removing from the rolls those people who can work and who have experienced some change in circumstances since the time of the last disability determination.

Third, the Committee is concerned that the confidence of the disabled population in the social security disability insurance program has been seriously eroded in recent years as a result of the periodic review process. This amendment is designed to provide reassurance to the severely impaired population who have every right to expect their benefits to be continued under this program. If an individual is correctly and properly allowed onto the benefit rolls, and if the evidence shows that his medical condition has not improved (other than in ways that are not related to work ability), the Secretary must demonstrate that there is some other stated change in circumstances prior to making a determination of work ability. Work ability, or the ability of the individual to be found eligible for benefits if newly applying, will no longer be the sole standard of continuing eligibility.

While the Committee is aware that there are many difficult details to be worked out by the Secretary pertaining to the administration of the new standard, the Committee expects the type of process described below to be followed as closely as possible.

Explanation of Continuing Eligibility Review Process With Medical Improvement Standard

Step 1: Beneficiary is notified of review and asked to come to local social security district office for interview:

Review process explained, including role of medical improvement in the process,

Beneficiary explains current condition and how condition compares to condition at time of last review,

District office assists beneficiary in listing medical treating sources and other information on current activities (including any work),

(If, at any point during the review, the beneficiary is found to be working at substantial gainful activity, the review is ceased and benefits terminated.) [1]

Interviewer observes condition of beneficiary to determine if review should be ceased at this point and benefits continued.

Step 2: State agency secures and reviews medical evidence, both that provided by the claimant and secured by the Secretary. (Review may be ceased at this point and benefits continued based on the evidence in the file.) [2]

Step 3: If a continuance decision is not made in Step 2, the record of evidence is reviewed to establish whether the individual has medically improved and to determine whether he is disabled under the meaning of the law (i.e., can he perform substantial gainful activity?)

NO MEDICAL IMPROVEMENT

If the Secretary finds that there has been no medical improvement in the individual's impairment(s) (other than medical improvement which is not related to his work ability), the Secretary must determine whether any one of the following factors is met:

(a) the individual has benefited from medical or vocational therapy or technology,

(b) new or improved diagnostic or evaluative techniques indicate the individual's impairment(s) is not as disabling as believed at the time of the last decision,

(c) the prior determination was fraudulently obtained, or

(d) there is demonstrated substantial reason to believe that the prior determination was erroneous (not considering the claimant's current medical condition).

If the answer to each of these factors is no, benefits are continued (whether or not the individual would have been found to be able to engage in substantial gainful activity).

If the answer to any of these factors is yes, the Sectetary then makes a determination of whether the individual can engage in substantial gainful activity.

If the Secretary determines that he can, benefits are terminated;

If the Secretary determines that he cannot, benefits are continued.

MEDICAL IMPROVEMENT

If the Secretary finds the evidence does not establish that the individual's impairment(s) is the same as or worse than at the time of the prior determination (disregarding medical improvement which is not related to his work ability), the Secretary determines whether the individual is able to perform substantial gainful activity.

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[1] Review shall also be ceased and benefits terminated if the individual cannot be located, or fails, without good cause, to cooperate in the review or to follow prescribed treatment that could be expected to restore his ability to work.

[2] Review may be ceased and benefits continued at any point in the process that is warranted by the evidence in the file.

If the Secretary determines that he can, benefits are terminated;

If the Sectetary determines that he cannot, benefits are continued.

The Committee is aware that certain beneficiaries may be unable to cooperate in a review as a result of the very nature of their impairment (mental impairment cases, for example). Current SSA operating guidelines provide that such persons be accorded special assistance and that, where appropriate, a third party—such as a family member or treating physician—become involved in the process. The Committee stresses the importance of these guidelines and urges the Secretary to exercize caution in applying the failure to cooperate exception to the medical improvement standard.

The Committee believes that the standard in this amendment is one that provides protections for beneficiaries who belong on the rolls, yet is understandable and workable—essential features for a standard that is to be uniformly applied.

Fourth, the Committee is aware that, notwithstanding the effort to create a clear standard that can be tightly administered, the complexity and the enormity of the disability determination process makes an assessment of the likely impact of the new standard most difficult. Over 1 million people with widely different disabilities apply for benefits each year and over 400,000 beneficiaries are reviewed each year to assess their continuing eligibility. These disability determinations are made by 12,000–13,000 State agency employees in some 54 States and jurisdictions under the direction and monitoring of the Secretary. Three levels of administrative appeals, then the opportunity for appeal to the Federal courts, add thousands more people to the decision-making process. How the new standard will actually be applied will be determined by the actions of all of these agents—the Secretary, the States, and the courts.

The acturial cost estimates received by the Committee underscore the inherent uncertainty. Whereas the Social Security Administration believes the new standard will involve a substantial cost and significantly impact the rate of present-law terminations, the Congressional Budget Office estimates a much lower cost and a lesser impact on terminations.

The Committee's uncertainty about how the new standard will actually impact beneficiaries, program administration, and the trust funds has led the Committee to include a sunset on the provision—it expires on December 31, 1987. By this time, the Committee expects that over 1 million people will have been reviewed under the new standard (including 200,000—300,000 who have not yet been reviewed for the first time under the periodic review requirement), in addition to the individuals who will be eligible for redetermination under this bill. The Committee should then be in a strong position to assess the merits and workability of the new standard.

To help ensure that the Committee carefully monitor developments over the next 3 years and make a timely decision on the reauthorization of the standard, Section 18 of the Committee amendment, which tightens Federal control over State disability determinations, also expires on December 31, 1987.

Effective date

The effective date in the Committee amendment clearly delineates which cases are to be determined or redetermined and under the new standard. The nw standard would (subject to the 3-year sunset) be applied to future determinations of continuing eligibility and to all individuals who currently have claims properly pending in the administrative appeals process. The amendment would further direct that continuing disability cases properly pending in the Courts (as of the date of Committee action) would be remanded to the Secretary for review by the Secretary under the new standard. (This amendment would also apply to new court cases which are timely filed by individuals who have completed the administrative appeals process during the period between March 15, 1984 and 60 days after enactment.) This remand procedure would apply only to individual litigants and to members of class actions identified by name.

In the case of other members of class actions, a different rule would be followed. The Secretary would be required to notify any member of a class who has, prior to the date of Committee action, been properly certified as a class member (even though not individually named) that these individuals would be allowed a period of 60 days from the date of notification to request a review of the determination that they are no longer disabled. If they make such a request within the 60 days, their case will be reviewed administratively under the new standards established by the bill. The result of that review could be further appealed under rules of appeal established by the Social Security Act and Secretary's regulations. If they fail to request such a review, however, they would lose the right of judicial review of their case—just as claimants under current law lose such rights if they fail to make timely appeals, and as unnamed members of class action litigation now lose thier rights of appeal if they fail to make a timely application for the relief which is ordered under the class action.

In the case of any individual with respect to whom a continuing disability determination has become administratively final prior to the date of Committee action and who has not initiated a court action either individually or as a member of a class properly certified prior to such date, the amendment would provide that the administrative determination of the Secretary is final and conclusive and not subject to appeal. In other words, the amendment would not allow for redeterminations in the case of individuals who have failed to exercise their appeal rights and therefore have no reason to consider themselves protected by the certification of a class action. This would avoid the possibility that a future certification of one or more class actions—or even a nationwide class action might give the Committee decision much broader retrospective effect (and for higher cost) than the Committee intends.

Individuals remanded to the Secretary for review or those who request review within the allowable time limit could elect to receive payments on an interim basis pending redetermination of their eligibility under the new standard. These payments would commence with the month in which the individual requests that such payments be made. Individuals who are found eligible for ben-

efits under the new standard would receive any additional benefits that may be due for the retroactive period since their benefits were ceased. Any interim payments made to individuals found ineligible under the new standard would be subject to recovery as overpayments under the same conditions that apply to payments made under the continuation of benefits during appeal provision in existing law.

Because of the apparent complexity of the effective date provision, a detailed rationale for the Committee's action is appropriate. The Committee has determined that the legislation should establish precisely the application of the new medical improvement provisions in order to eliminate the confusion and disruption resulting from the extensive litigation now pending in the courts on medical improvement.

The plaintiffs in many of these pending suits have sought to represent a class of all present or former recipients of disability benefits who reside in a particular state or judicial circuit. The Administration has informed the Committee that there are in excess of 30 such class actions or putative class actions pending, often purporting to be brought on behalf of thousands of individual claimants. The overwhelming majority of these individual claimants are not aware that they are members of a class or putative class in a suit brought by someone else and have essentially abandoned their claims by not personally seeking judicial review. The disruptive impact of these class actions is particularly severe in those cases in which the plaintiffs have sought to represent a class that is so broadly defined as to include hundreds or thousands of claimants who either (a) did not exhaust their administrative remedies (which is a prerequisite to obtaining judicial review of the denial of their claims) or (b) previously allowed an administrative denial of their claim at some level to become final and binding because they failed to seek further administrative review or to seek judicial review of a final decision by the Appeals Council within 60-days.

A major purpose of this legislation is to resolve the current controversy over the medical improvement issue, without unnecessarily increasing the cost of the disability program by broadly applying the new standard to thousands of individuals who had effectively accepted the finding of ineligibility and abandoned their claims by not following prescribed procedures for seeking review of the denial of benefits.

Insofar as the Committee has not provided for cases that are no longer live and properly pending on the date of enactment to be reopened and reconsidered, this provision merely restates existing law that precludes judicial review of administrative denials of claims that the claimants themselves allowed to become final. *Califano* v. *Sanders,* 430 U.S. 99 (1977). And because the new medical improvement standard will be applied to claims that are not stale; that is, claims that are live and properly pending in the administrative appeals process or in court on the date of enactment—there will be no further litigation on the medical improvement issue in connection with those claims either. The combined effect, then, will be to eliminate all of the current litigation on the medical improvement question under existing law and to start afresh under the new statutory standard.

Whether a claim raising the question of medical improvement is properly pending on the date of enactment and therefore is subject to the new medical improvement standard in this legislation will be determined by reference to the requirements of Section 205 of the Social Security Act and the implementing procedural regulations promulgated by the Secretary.

Under the amendment, if a claimant has a determination pending before the Secretary, his claim would automatically be considered under the new statutory medical improvement standard in the course of any further administrative review. If, however, a claimant's determination is not pending before the Secretary because the claimant has not sought further administrative review within the prescibed time limits, the administrative decision denying his claim for benefits becomes final and binding and is not subject to further administrative or judicial review. *Califano* v. *Sanders,* 430 U.S. 99 (1977). The administrative decision denying the claim therefore would not be reopened and reconsidered under the new statutory medical improvement standard.

The amendment also provides for application of the new statutory medical improvement standard to claims properly pending in court on the date of enactment. Under Section 205(g) of the Social Security Act, a claimant may obtain judicial review only of the Secretary's "final decision" on a claim made after a hearing, and only if he seeks judicial review within 60 days of that final decision. Governing regulations in turn provide that the Secretary's "final decision" subject to judicial review is rendered only after the individual has pressed his claim for benefits through all levels of the existing administrative appeals process, including seeking review by the Appeals Council. The Supreme Court held in *Weinberger* v. *Salfi,* 422 U.S. 749, 764, 766 (1975), that full exhaustion of the administrative appeals process established by the Secretary's regulations is a jurisdictional prerequisite to seeking judicial review pursuant to Section 205(g) of the Social Security Act, and the Supreme Court recently reaffirmed that holding in *Heckler* v. *Ringer,* No. 82-1772 (May 14, 1984), slip op. 2, 3, 16. Accordingly, the only claims raising the medical improvement issue that would be "properly pending" in court under existing law on the date of enactment would be the claims of individuals who exhausted their administrative remedies through the Appeals Council stage and then sought judicial review under Section 205(g) of the Social Security Act within 60 days.

There will, however, be many thousands of individuals who may have exhausted their administrative remedies without thereafter personally seeking judicial review pursuant to Section 205(g), but who are unnamed members of a class in a suit filed as a class action or putative class action raising the medical improvement issue on behalf of all claimants in a particular state or judicial circuit. Under the amendment, if a district court has actually certified a case as a class action, the claims of all class members in such a certified class action who fully exhausted their administrative remedies on or after a date 60 days prior to the filing of the class action will be regarded as "properly pending" in court. However, to protect against the substantial increase in the cost of this legislation that could result from a rash of class certifications in present-

ly uncertified class actions prior to the enactment of this legislation, this special protection for unnamed class members applies only to class actions certified on or before May 16, 1984, the date of the Finance Committee's action on the bill.

The claims of the members of certified classes who fully exhausted their administrative remedies will not automatically be remanded to the Secretary for reconsideration under the new standard. This is because these class members have not pressed their claims in court, possibly because they had accepted the correctness of the decision, and therefore effectively abandoned them. Instead of providing for an automatic reconsideration of such cases, the amendment provides for the Secretary to send a notice to each member of the certified class informing him that if he wants to pursue his claim for benefits notwithstanding his failure to seek judicial review under Section 205(g) following the Appeals Council's denial of his claim, he must notify the Secretary within 60 days. If the class member responds within 60 days, his claim will be reconsidered under the new medical improvement standard in this legislation. If the class member does not notify the Secretary within 60 days that he wants to have his claim reconsidered under the new standard, the amendment provides that the previous Appeals Council decision denying his claim will be final and binding and will not be subject to judicial review.

A claimant who has not individually sought review of his case in a timely manner is not, however, protected under the amendment by the pendency of a class action suit in which no class has been certified prior to the date of the Committee's action. His individual claim would be barred from judicial review, unless of course the Secretary, in a particular case extended the time for seeking judicial review under her discretionary authority in Section 205(g). This would avoid the possibility that a future certification of one or more class actions—or even nationwide class action—might give the Committee decision much broader retrospective effect (and much higher costs) than the Committee intends.

The Committee's decision to bar judicial review of claims of putative members of uncertified classes (who have not individually protected their appeal rights) was based on the following considerations:

(1) In the case of uncertified class actions, it is extremely speculative as to whether and to what extent a class would ever be certified. Thus, claimants cannot have reasonably relied on the mere pendency of a class action complaint to excuse them from pursuing their rights individually.

Putative members of uncertified classes have little if any likelihood of learning about the pendency of suits which include class allegations, let alone about the details of the proposed class and the relief being sought. There is therefore no reason to believe that this group of claimants refrained from perfecting their appeals in the hope of being included in class relief. They simply abandoned their claims. To the extent individual claimants may have been misled by the pendency of a class suit, the Committee notes that the Secretary retains the discretion to extend the time to appeal or to reopen the case administratively;

(2) Members of this group have no cases in court either individually or by means of a class action. Moreover, each of them received a notice from the Secretary advising them of the time limit for seeking judicial review and they let that time lapse. Since Section 205(g) of the Act is an authorization to sue the United States, its 60-day time limit for filing suit is jurisdictional and cannot be tolled by the pendency of a class suit. *Hunt* v. *Schweiker,* 685 F.2d 121 (4th Cir. 1982). Since this legislation in effect causes the denial of class certification for these persons, the putative members are in the same position they would have been had the various courts merely denied certification. In either event, their abandoned claims could not be reviewed in court.

(3) The number of claimants who might ultimately be certified in the pending suits is unknown and, in the nature of things, unknowable. There is, however, no escaping the fact that the number of class members is potentially staggering. If these claimants were permitted to revive their lapsed claims, thousands of claimants who had long since abandoned their claims might seek to reopen and relitigate them under the new statute. The burden these untold thousands of cases would pose to the orderly administration of the Social Security program is unacceptable—given the lack of interest shown by these claimants in keeping their own cases alive, and the crushing load of properly perfected cases the agency is struggling to process. In addition, the cost of including this vast class of unknown persons in the new statute could add over $1 billion to $2 billion to the cost of the bill. The Committee cannot justify this drain on the Trust Fund for the benefit of a group of individuals who had, but chose not to exercise, opportunities for appeal.

(4) Closing out these claims in consistent with the Social Security review system, which is generally designed to provide individualized review of final decisions of the Secretary. This approach also is consistent with the overall intent of the bill to avoid retroactive application to the maximum extent possible. At the same time, however, the Committee wants to ensure that neither the courts nor the Secretary will have to struggle in the pending cases to define what the prior law in termination cases meant. Thus, if the amendment were to permit these uncertified classes to proceed under the prior law, one of the principal purposes of this legislation—to bring a halt to the acrimonious and burgeoning "medical improvement" litigation—would be defeated.

CONTINUATION OF PAYMENTS DURING APPEAL

(Section 3 of the committee amendment)

Present law

DI benefits are automatically payable for the month the beneficiary is notified of ineligibility and for the 2 following months. Benefits do not generally continue during appeal. Based on a Supreme Court decision, supplemental security income (SSI) payments must continue through opportunity for an evidentiary hearing.

Under a temporary provision in P.L. 97-455 (as extended by P.L. 98-118), individuals notified of a termination decision could elect to

have DI benefits and Medicare coverage continued during appeal—through the month proceeding the month of the administrative law judge (ALJ) hearing decision. These additional DI benefits are subject to recovery as overpayments if the initial termination decision is upheld. This provision expired for terminations on or after December 7, 1983. Committee amendment: The Committee amendment reauthorize payments pending appeal through the ALJ hearing for terminations prior to June 1, 1986.

The original provision authorizing payments pending appeal resulted in large part because of the lack of uniformity of decisions between the State agencies and the administrative law judges (ALJs). In the early stages of the periodic review process, States agencies were finding about 50 percent of the people reviewed ineligibile for benefits, and among those who appealed to an ALJ, about 60 percent were having benefits reinstated. The provision making continued payments available to people found ineligible for DI was thus temporary in nature, based on the view that either significant administrative, or legislative reforms would be necessary to remedy this untenable situation. It is the Committee's belief that the reforms contained in this bill will reduce the need for these payments by: (1) improving the quality and accuracy of disability determinations at the first stage of decision-making, (2) enhancing the uniformity of decisions between different levels of appeal, and thereby (3) reducing the number of appeals and the rate of decisions which are being reversed by ALJ's.

UNIFORM STANDARDS

(Section 4 of the committee amendment)

Present law

The guidelines for making social security disability determinations are contained in regulations, social security rulings, and the Program Operating Manual System (POMS).

Regulations, or substantive rules, have the force and effect of law and are therefore binding on all levels of adjudication—state agencies, administrative law judges, the Social Security Administrations (SSA's), Appeals Council, and the Federal Courts. On a voluntary basis, SSA issues its regulations in accordance with the public notice and comment rulemaking requirements of the Administrative Procedure Act (APA). The APA requirements do not, however, apply to social security programs because of a general exception for benefit programs.

Rulings consist of interpretative policy statements issued by the Commissioner and other interpretations of law and regulations, selected decisions of the Federal courts and ALJs, and selected opinions of the General Counsel. Rulings often provide detailed elaboration of the regulations helpful for public understanding. By regulation, the rulings are binding on all levels of adjudication.

The POMS are a compilation of detailed policy instructions and step-by-step procedures for the use of State agency personnel in developing and adjudicating claims. The POMS are not binding on the Administrative Law Judges, the Appeals Council, or the Courts.

Committee amendment

The Committee amendment would require the Secretary to establish by regulation uniform standards, of eligibility to be binding on all levels of adjudication in determining whether individuals are disabled under the meaning of the Social Security Act. Such regulations must be published in accordance with the rulemaking requirements of the APA (thus removing SSA's exclusion from the provisions of the APA on matters relating to the determination of disability.)

It is the Committee's goal to ensure uniform decisionmaking at all levels of the disability adjudication process through the publication of regulations under the APA. It is the intent of the Committee, however, that the Secretary be required to publish in regulations only those changes in policies and procedures that could be reasonably expected to have an impact on findings of eligibility. The Committee is particularly concerned that SSA retain the flexibility to respond quickly to changes in conditions through the issuance of other less formal vehicles including Rulings and POMS.

Effective date

This provision is effective on enactment.

MORATORIUM ON MENTAL IMPAIRMENT REVIEWS

(Section 5 of the committee amendment)

Present law

Under the Disability Amendments of 1980, all DI beneficiaries with non-permanent impairments must be reviewed at least once every 3 years to assess their continuing eligibility for benefits. Individuals with permanent impairments may be reviewed less frequently. Presently, there is no distinction in the law between the rate of review for individuals with physical and mental impairments.

Under an Administration initiative (of June 7, 1983), periodic eligibility reviews have been suspended for those mental impairment cases involving functional psychotic disorders, pending a revision, arrived at in consultation with outside mental health experts, of the criteria used for determining disability.

Under a subsequent Administration action (announced April 13, 1984), all periodic eligibility reviews have been suspended temporarily.

Committee amendment

The Committee amendment suspends eligibility reviews for all individuals with disabilities based on mental impairments pending a revision of the eligibility criteria. Such revisions would be made in consultation with outside mental health and vocational rehabilitation experts. Also, a redetermination of eligibility under new criteria (and reinstatement of benefits where appropriate) would be required for individuals denied benefits after enactment and prior to revision of criteria, and to those terminated from the rolls since June 7, 1983.

Effective date

Such revised eligibility criteria must be published as regulations within 90 days after enactment.

QUALIFICATIONS OF MEDICAL PROFESSIONALS

(Section 6 of the committee amendment)

Present law

By regulation, the State review team making disability determinations must consist of a State agency medical consultant (physician) and a State agency disability examiner. Under SSA operating instructions, both must sign the disability determination.

Committee amendment

The Committee amendment would require that in the case of an individual seeking benefits on the basis of a mental impairment, in which a decision unfavorable to the claimant or beneficiary is being made, the Secretary must make every reasonable effort to ensure that a qualified psychiatrist or psychologist completes the medical portion of the evaluation and any assessment of residual functional capacity.

The Committee does not intend that the Secretary be considered to have made every reasonable effort to obtain the services of qualified personnel for purposes of this provision in cases where such services could clearly be obtained if compensation for those services were made available at levels which meet the pervailing norms for such services. If such a situation arises, the Committee expects the Secretary to exercise her authority to require proper administration by the States or to utilize appropriate Federal resources to assure that determinations continue to be fully carried out in mental impairment cases with qualified psychiatrists and psychologists.

The Committee is aware that this amendment—by placing emphasis on the use of mental health specialists for making disability determinations in mental impairment cases—may appear to be setting a precedent requiring specialization among the types of physicians and other qualified professionals who make determinations. Carried to the extreme, this could impede the making of timely decisions, thereby causing substantial backlogs, and significantly disrupt the effective administration of a process which requires millions of determinations each year. The merits and consequences of such specialization have not been evaluated, and warrant serious consideration. As a result, Section 14 of this bill directs the next social security advisory council to study and make recommendations on this issue.

Effective date

This provision is effective for determinations made on or after date of enactment.

NONACQUIESCENCE TO CIRCUIT COURT DECISIONS AFFECTING POLICY

(Section 7 of the committee amendment)

Present law

The Social Security Administration (SSA) abides by all final judgments of Federal courts with respect to the individuals in particular suits, but does not consider itself bound to implement the policy approach embodied in such decisions with respect to nonlitigants. In the infrequent case that a circuit court decision is contrary to the Secretary's interpretation of the Social Security Act and regulations, SSA may at times issue a ruling of nonacquiescence stating it will not adopt the court's decision as agency policy. There are now 8 rulings of nonacquiescence.

Committee amendment

In the case of U.S. Court of Appeals decisions affecting the Social Security Act or regulations, the Committee amendment would require the Secretary to send to the Committees on Finance and Ways and Means, and publish in the Federal Register, a statement of the Secretary's decision to acquiesce or not acquiesce in such court decision, and the specific facts and reasons in support of the Secretary's decision. In cases where the Secretary is acquiescing, the reporting requirement would apply only to significant decisions.

The Secretary would make these reports within 90 days after the issuance of the court decision or the last day available for filing an appeal, whichever is later.

The Committee is aware that a dispute exists as to the right of the Secretary to not acquiesce in circuit court decisions. While the Committee is concerned that a policy of mandatory acquiescence would be difficult to reconcile with the long standing Congressional importance attached to national uniformity, this legislation does not attempt to resolve that issue. Those who argue that the Secretary has no such right frequently cite the case of *Marbury* v. *Madison* in support of their contention that the Secretary's position violates the principle that the courts may interpret the laws. On the other hand, the Committee received testimony from the Department of Justice that the ability to not acquiesce is an important element of the Government's ability to pursue litigation in an orderly manner. Accordingly, the implications of changing this practice range widely beyond the Social Security Act. In its testimony, the Justice Department cited a recent case, *United States* v. *Mendoza* in which the Supreme Court upheld the Government position in an issue closely related to nonacquiescence. Clearly, if a constitutional issue is involved, it cannot be settled in this legislation and must be left for ultimate resolution by the Supreme Court. For this reason, the Committee bill provides that "nothing in this section shall be interpreted as sanctioning any decision of the Secretary not to acquiesce in the decision of a U.S. Court of Appeals."

Effective date

For U.S. Court of Appeals decisions rendered on or after date of enactment.

MULTIPLE IMPAIRMENTS

(Section 8 of the committee amendment)

Present law

In determining whether an individual is disabled, a sequential evaluation is followed: current work activity, duration and severity of impairment, residual funcational capacity, and vocational factors are considered in that order. Medical considerations alone can justify a finding of ineligibility where the impairment(s) is not severe. An impairment is nonsevere if it does not significantly limit the individual's physical or mental capacity to perform basic work-related functions.

By regulation, the combined effects of unrelated impairments are considered only if all are severe (and expected to last 12 months). As elaborated in rulings, "inasmuch as a nonsevere impairment is one which does not significantly limit basic work-related functions, neither will a combination of two or more such impairments significantly restrict the basic work-related functions needed to do most jobs."

Committee amendment

In determining the medical severity of an individual's impairment, the Secretary would be required under the Committee amendment to consider the combined effect of all of the individual's impairments without regard to whether any one impairment itself would be considered severe.

It is the expectation of the Committee that in most cases, multiple nonsevere impairments do not have a cumulative severe impact. The Committee is concerned, however, that the disability evaluation process accomodate those circumstances in which an individual has multiple impairments, the severely limiting effect of which is not reflected in any one of them.

In adopting this amendment, the Committee wishes to emphasize that the new rule is to be applied in accordance with the existing sequential evaluation process and is not to be interpreted as authorizing a departure from that process. As the Committee stated in its report on the 1967 amendments, an individual is to be considered eligible "only if it is shown that he has a severe medically determinable physical or mental impairment or impairments." The amendment requires the Secretary to determine first, on a strictly medical basis and without regard to vocational factors, whether the individual's impairments, considered in combination, are medically severe. If they are not, the claim must be disallowed. Of course, if the Secretary does find a medically severe combination of impairments, the combined impact of the impairments would also be considered during the remaining stages of the sequential evaluation process.

Effective date

For determinations made on or after January 1, 1985.

EVALUATION OF PAIN

(Section 9 of the committee amendment)

Present law

Under the law, an individual's disability (whether mental or physical) must be medically determinable, expected to end in death or last for 12 continuous months, and must prevent any substantial gainful activity. There is no specific statement in the law as to how pain is to be evaluated. The law does provide that eligibility must be based on "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."

SSA's policy on how pain is to be evaluated is contained in regulations which were issued in August 1980. By regulation, symptoms of impairments, such as pain, cannot alone be evidence of disability. There must be medical signs or other findings which show there is a medical condition that could "reasonably be expected" to produce those symptoms.

Committee amendment

The determination of whether an individual is eligible for social security disability benefits can often involve difficult evaluations of medical and vocational evidence. The Congress has provided general policy guidance to the administration indicating the clear intent that benefits be provided only to those who have severe medical conditions which preclude their engaging in substantial gainful activity. To assure the integrity of the program, Congress has also specifically indicated that eligibility must be based on verifiable and objective medical evidence. Further the Congress has indicated that it attaches high importance to the administration of the disability program with a high degree of national uniformity. To carry out these general policies in the day to day administration of the program, the Congress necessarily relies upon the Administration to undertake on a continuing basis a careful evaluation of the state of medical art and, through regulations and other quidelines, to apply criteria and evidentiary rules which are consistent with them.

It has come to the attention of the Committee, that there are a number of outstanding court cases which are challenging the current policies of the Administration concerning the weight to be attached to claimant's subjective allegations concerning pain and other symptoms. The Committee questioned representatives of the Administration of this matter during its consideration of the legislation and understands that the Administration has been, on a continuing basis, consulting some of the best available medical experts on the extent to which subjective allegations of this type can be verified. At this time, the Administration has found that the weight of opinion does not justify a departure from present practice as being consistent with the program principles enunciated by the Congress.

The Committee is always reluctant to statutorily codify detailed eligibility criteria which are more properly promulgated by regulations. Such regulations should receive appropriate deferrence from

the courts. However, if courts ignore the Secretary's regulatory authority and the expressed Congressional concerns for careful administration, national uniformity, and verifiable evidence, the Committee has little choice but to draw the statute as narrowly as possible. For this reason, the Committee has included in the statutory rules for determining disability a specific rule for evaluating subjective allegations of pain. It is the clear intention of the Committee that this rule should be seen as a codification of the regulations and policies currently followed by the Administration. This rule prohibits basing eligibility for benefits solely on subjective allegations of pain (or other symptoms). There must be evidence of an underlying medical condition and (1) there must be objective medical evidence to confirm the severity of the alleged pain arising from that condition or (2) the objectively determined medical condition must be of a severity which can reasonably be expected to give rise to the alleged pain.

The Committee recognizes that this is an area involving difficult medical questions to which complete answers may not be available. For this reason, the Committee is recommending a high-level study to be conducted over the next two years by a panel of at least 12 experts to be appointed by the Secretary of Health and Human Services. This body is to include in its membership significant representation from the field of medicine who are involved in the study of pain along with representation from other appropriate fields including law and administration. This panel is to be appointed within 60 days of enactment and is to report to the Committee on Finance and the Committee on Ways and Means no later than December 31, 1986.

The Committee anticipates that the results of this study will help clarify this issue. If necessary, the Committee will be ready to consider further legislation which may be appropriate in the light of the study. In any event, the Committee amendment would cease to be a part of the statute after December 31, 1987. Since the provision simply codifies existing practice, the termination of the provision would not modify the rules governing the program, but it would fully restore the Administration's current degree of flexibility to implement regulatory changes which might then appear appropriate. Any such changes would, of course, have to be consistent with the policy guidance contained in the law and its legislative history.

MODIFICATION OF RECONSIDERATION AND PREREVIEW NOTICE

(Section 10 of the committee amendment)

Present law

A person whose initial claim for disability benefits is denied or who is determined after review to be no longer disabled, may request a reconsideration of that decision within 60 days. In the past, reconsideration has been a paper review of the evidentiary record, including any new evidence submitted by the claimant, conducted by the State agency.

Under a provision of P.L. 97-455, enacted January 12, 1983, disability beneficiaries found ineligible for benefits must be given op-

portunity for a face-to-face evidentiary hearing at reconsideration. Such hearings may be provided by the State agency or by the Secretary.

Committee amendment

The committee amendment would require the Secretary to notify individuals upon initiating a periodic eligibility review that such review could result in termination of benefits and that medical evidence may be submitted.

In addition, the Secretary would be required to conduct demonstration projects in at least 5 States in which the opportunity for personal appearance is provided prior to determination of ineligibility (in lieu of face-to-face hearing at reconsideration). This would apply to periodic review cases only. A report would be due to Congress by April 1, 1986.

The Committee is aware that one of the reasons for the difference in decisions made by State agencies and administrative law judges (and the high rate at which administrative law judges reverse termination decisions) is the fact that the hearing decision involves face-to-face contract between the claimant or beneficiary and the decision-maker. Whether or not those decisions made with personal appearance contact are more accurate, given the inherent subjectivity that may be introduced, has not been established.

This provision would, on a demonstration basis, permit the opportunity for face-to-face appearance prior to the State agency making a decision to terminate benefits. The Committee has made a decision not to mandate this change for all denial decisions or all termination decisions in recognition of the need for caution in this area. Procedural changes such as these, particularly when coupled with the many reforms in this bill, can have significant and unforseen consequences on the administration of the program and the rate of allowances.

This provision will complement the legislation enacted in 1983 (P.L. 97-455) which requires that face-to-face evidentiary hearings be provided at the reconsideration hearing level for all terminated beneficiaries.

Effective date

As soon as practicable after date of enactment.

CONSULTATIVE EXAMS/MEDICAL EVIDENCE

(Section 11 of the committee amendment)

Present law:

Consultative exams are medical exams purchased by the State agency from physicians outside the agency. By regulation, consultative examinations may be sought to secure additional information necessary to make a disability determination or to check conflicting information. Evidence so obtained is to be considered in conjunction with all other medical and nonmedical evidence submitted in connection with a disability claim.

Committee amendment:

The Committee amendment requires the Secretary to make every reasonable effort to obtain necessary medical evidence from the individual's treating physician prior to seeking a consultation examination. In proposing this amendment, it is the Committee's purpose to underscore the importance of obtaining evidence from the claimant's or beneficiary's physician who is likely to be the medical professional most able to provide a detailed, longitudinal picture of the individual's medical condition.

The Committee does not intend to alter in any way the relative weight which the Secretary places on reports received from treating physicians and from consultative examinations. Nor is it intended that the Secretary shall be precluded from obtaining consultative examinations when the Secretary finds it necessary to secure additional information or to resolve conflicting evidence.

The Committee amendment would also require the Secretary to develop a complete medical history for individuals applying for benefits or undergoing review over at least the preceding 12 month period. However, in cases involving applications for disability benefits where the claimant alleges that the disability began less than 12 months prior to his application, obtaining a medical history of at least 12 months may be unnecessary.

Effective date

These provisions are effective for determinations made on or after the date of enactment.

VOCATIONAL REHABILITATION

(Section 12 of the committee amendment)

Present law

Presently, States are reimbursed for VR services provided to DI beneficiaries which result in their performance of substantial gainful activity (SGA) for at least 9 months. For such individuals, services are reimbursable for as long as they are in VR and receiving cash benefits. If the individual is reviewed and found to have medically recovered while in VR, cash benefits may continue (under Section 225(b) of the Social Security Act, a work incentive provision enacted in 1980) but VR services may not be reimbursable since the individual's ability to engage in SGA is attributable to medical improvement rather than rehabilitation.

Committee amendment

The committee amendment authorizes reimbursement for VR services provided to individuals who have medically recovered but are receiving disability benefits under Section 225(b). Reimbursable services would be those provided prior to his or her working at SGA for 9 months, or prior to the month benefit entitlement ends, whichever is earlier.

Effective date

On enactment.

SPECIAL BENEFITS FOR INDIVIDUALS WHO PERFORM SUBSTANTIAL GAINFUL ACTIVITY DESPITE SEVERE MEDICAL IMPAIRMENTS

(Section 13 of the committee amendment)

Present law

Under the SSI program, an individual who is able to engage in substantial gainful activity (SGA) cannot become eligible for SSI disability payments. Prior to the enactment of a provision in 1980, a disabled SSI recipient generally ceased to be eligible for SSI when his or her earnings exceeded the level which demonstrates SGA—$300 monthly.

Under Section 1619 of the Social Security Act, enacted in the Disability Amendments of 1980, SSI recipients who have seven medical impairment and who work and earn more than SGA ($300 monthly) cease to be eligible for SSI as such, but may receive a special payment and maintain medicaid coverage and social services. The amount of the special payment is equal to the SSI benefit they would have been entitled to receive under the regular SSI program were it not for the SGA eligibility cut-off. Special benefit status is thus terminated when the individual's earnings exceed the amount which would cause the Federal SSI payment to be reduced to zero (i.e., when countable monthly earnings exceed $713). Medicaid and social services may continue, however.

Section 1619 expired on December 31, 1983. It is being continued administratively, however, during 1984 under general demonstration project authority.

Committee amendment

The Committee amendment reauthorizes Section 1619 through June 30, 1987. In addition, the Secretaries of HHS and Education are required to establish training programs on Section 1619 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.

This provision will supersede the Secretary's one-year extension of Section 1619.

ADVISORY COUNCIL

(Section 14 of the committee amendment

Present law

Section 706 of the Social Security Act provides for the appointment of a 13-member quadrennial advisory council on social security. It is responsible for studying all aspects of the social security and medicare programs. Each council is to be comprised of representatives of employee and employer organizations, the self-employed, and the general public.

The next advisory council is scheduled to be appointed in 1985 and to make its final report by December 31, 1986.

Committee amendment

The Committee amendment directs the next quadrennial advisory council to study and make recommendations on various medical and vocational aspects of disability, including the alternative approaches to work evaluation for SSI recipients, the effectiveness of vocational rehabilitation programs for DI and SSI recipients, and the question of using medical specialists for completing medical and vocational forms used by State agencies. The council would be authorized to convene task forces of experts to deal with specialized areas.

Members of the Council must be appointed by June 1, 1985.

FREQUENCY OF PERIODIC REVIEWS

(Section 15 of the committee amendment)

Present law

Under a provision enacted in 1980, all DI beneficiaries, except those with permanent impairments, must generally be reviewed to assess their continuing eligibility at least once every 3 years.

Under a provision enacted in 1983 (P.L. 97-455), the Secretary is provided the authority to waive this 3-year review requirement on a state-by-state basis. The appropriate number of cases for review is to be based on the backlog of pending cases, the number of applications for benefits, and staffing levels.

On April 13, 1984, Secretary Heckler announced a termporary, nationwide moratorium on periodic eligibility reviews.

Committee amendment

The Committee amendment requires the Secretary to issue final regulations, within 6 months of enactment, establishing the standards to be used in determining the frequency of periodic eligibility reviews. Pending issuance of such regulations, no individual can be reviewed more than once.

In proposing this amendment, the Committee does not in any way intend to suggest that the Secretary is being granted authority to waive or modify the present-law requirements pertaining to the periodic review of all DI beneficiaries. Regular eligibility reviews are mandated by law.

Situations have arisen, however, which are of concern to the Committee and which could be clarified through the issuance of such a regulation. For example, it is not the intention of the Committee that individuals who are found eligible for benefits after a lengthy administrative appeal find themselves subjected to a second eligibility review after only a relatively brief period. Conversely, with the number of people now classified administratively as being permanently impaired approaching 40 percent of the disabled-worker benefit rolls, the Committee is concerned that the responsibility to assess the continuing eligibility of such beneficiaries not be neglected. A failure to periodically review eligibility in these cases could seriously undermine the intent of the 1980 legislation. Finally, there are individuals who are medically diaried and expected to recover in less than 3 years. For these individuals, reviews should be scheduled accordingly.

MONITORING OF REPRESENTATIVE PAYEES

(Section 16 of the Committee Amendment)

Present law

The Social Security Act permits the Secretary of Health and Human Services to appoint a representative payee for an individual entitled to social security or supplemental security income (SSI) benefits when it appears to be in the individual's best interest. Payees must be appointed for individuals receiving SSI based on drug or alcohol addictions.

The Social Security Act defines penalties for misuse by payees of social security and SSI payments, but places no requirements or restrictions on the selection and monitoring of payees.

A payee convicted of misusing a social security beneficiary's funds is guilty of a felony, punishable by imprisonment for not more than 5 years and/or a fine of not more than $5,000. A payee convicted of misusing an SSI recipient's funds is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year and/or a fine of not more than $1,000.

Prior to 1978, all payees except parents or spouses with custody, legal guardians and State and Federal institutions were required to account annually. Systematic accounting procedures for these payees were suspended as a work-saving measure between 1978 and March 1984. (However, State institutions are subject to an on-site accounting process at least every 3 years and this process has not been suspended.) In March 1983, a Federal district court ordered the Social Security Administration (SSA) to institute a system of periodic mandatory payee accounting within 1 year *Jordan* v. *Heckler*. In March 1984, SSA implemented an accounting system under which a random sample of 10 percent of all payees are required to account annually. At the request of the plaintiff, the court subsequently revised its order in *Jordan* so as to require an annual accounting from all payees.

Committee amendment

The entitlement of retirees, survivors, and the disabled to social security benefits is an important element in the economic security of often vulnerable individuals. When the Social Security Administration finds that such individuals cannot manage their own funds, it has a serious obligation to exercise caution is selecting an alternate payee and to undertake reasonable efforts to assure proper use of and accountability for the benefits disbursed to that payee. The Committee amendment would establish a statutory base for that obligation of the agency. At the same time, the Committee amendment recognizes that it is neither necessary nor appropriate to require governmental supervision or detailed accounting in the case of close familial relationships (parent and child or spouses living together) absent some allegation or overt reason to suspect the possibility of misuse of funds.

More specifically, the amendment would require the Secretary to: (1) evaluate the qualifications of prospective payees either prior to or within 45 days following certification, (2) establish a system of annual accountability monitoring for cases in which payments are

made to someone other than the entitled individual, or parent or spouse living in the same household, (3) establish a system whereby parent and spouse payees who live in the same household as the entitled beneficary would peridocially verify that they continue to live with the beneficiary, and (4) increase the penalties for misuse of benefits by representative payees. (The amendment also permits the Secretary to establish an accounting system for State institutions which serve as payees.)

The fine for a first offense by a payee convicted of misusing SSI benefits would be increased to not more than $5,000 and, for both programs, a second offense by a payee would be made a felony punishable by imprisonment for not more than 5 years and/or a fine of not more than $25,000. Individuals convicted of a felony under either program may not be selected as a representative payee.

Finally the Secretary would be required to report to Congress within 6 months of enactment on the implementation of the new system, and also to report to Congress annually on the number of cases of misused funds, and the disposition of such cases.

Effective date

On enactment.

FAIL-SAFE FINANCING

(Section 17 of the Committee amendment)

Present law

Under permanent law, each social security trust fund is intended to have sufficient resources to meet its full benefit obligations. The main source of funding for the Disability Insurance Trust Fund is that portion of the social security tax allocated for disability. At present, the disability part of the tax is 1 percent of taxable payroll (employee and employer combined). It is scheduled to rise to 1.2 percent in 1990 and to 1.42 percent in 2000 and thereafter. Temporary legislation enacted in 1983 also allows for borrowing among the trust funds in view of the relatively low balances in the cash benefits funds at the present time. This authority expires, however, in 1988. Present law does not contain any authority for making benefit payments in the event the social security trust funds should prove to have inadequate resources.

Committee amendment

The Committee believes that the social security disability insurance program provides important protections to American workers and their families against the threat of income loss should they suffer disabling medical conditions which prevent them from engaging in substantial gainful employment. The cost of this program is significant, and it is considerably higher than originally estimated. Nevertheless, the Committee believes that those who support this program through social security payroll taxes are willing to bear those costs provided that they can have confidence that the program will be carefully administered that that its benefits will be limited to the intended, eligible population.

The Committee views the present bill as an important measure to restore order and confidence to the disability program. It does have significant short-term costs, but if current estimates are correct it should not seriously affect the long-range stability of the disability program or of the social security funds generally. The Committee is, however, aware that the disability program has shown considerable volatility, and there is the unfortunate possibility that the pending legislation could be misinterpreted as a signal of Congressional intent for looser program administration. Should that happen, the costs of the program might escalate rapidly. Such a development is neither anticipated nor desired by the Committee.

To assure that taxpayers and beneficiaries may have confidence in the continuing fiscal integrity of the program, the Committee amendment includes a fail-safe provision. This provision will put those who administer the program at the Federal and State level, and the courts, on notice that there is not an open-ended commitment of taxpayer funds to underwrite rapidly expanding costs which might follow from lax administration or overbroad construction of the law. At the same time, the provision will serve to prevent a situation in which the fund might be rapidly depleted to the extent of placing the continuing regular payment of basic benefits in doubt.

Specifically, the fail-safe provision in the Committee amendment would operate as follows. If the disability fund is projected to decline to less than 20 percent of a year's benefits as of the start of any year, the Secretary would be required to notify the Congress by the preceding July 1. If Congress took no other action, the Secretary would scale back (in part or in full) the next cost-of-living increase for disability beneficiaries as necessary to keep the fund balance at 20 percent. If necessary, the Secretary also would scale back the increase in the benefit formula used for determining benefit levels for persons newly awarded disability benefits. In making the determination under this provision, the Secretary would be required to consider actual assets properly owned by the DI trust fund. Thus, the fund would get full credit for the approximately $5 billion which it has temporarily loaned to the OASI fund under the interim interfund borrowing arrangements. With these assets, it is now projected that the DI fund would not dip below the 20 percent level until well into the next century.

The fail-safe provision in the Committee amendment is generally similar to a fail-safe provision for the OASI and DI programs combined which the Committee recommended and the Senate approved as part of the 1983 amendments. That provision, however, was not included in the conference agreement on that legislation.

Effective date

On enactment.

MEASURES TO IMPROVE COMPLIANCE WITH FEDERAL LAW

(Section 18 of the Committee Amendment)

Present law

Since 1956, when the Disability Insurance program was enacted, the States have been responsible, on a voluntary and reimbursable basis, for determining whether individuals are disabled under the meaning of the law. Under the law, States administering the program are required to make disability determinations in accord with Federal law and the standards and guidelines established by the Federal Department of Health and Human Services. The program is 100 percent Federally financed, with all benefit costs as well as all of the administrative costs incurred by the States either directly financed or reimbursed by the Federal government.

The law provides for the Secretary to commence actions to take over the disability determination process of a State fails to follow Federal rules. However, the law includes a large number of procedural steps which must be complied with before such a Federal assumption can be accomplished. The Secretary may not commence making disability determinations earlier than 6 months after: (1) finding, after notice and opportunity for hearing, that a State agency is substantially out of compliance with Federal law; (2) developing all procedures to implement a plan for partial or complete assumption of the disability determinations which grant hiring preference to the State employees; and (3) the Secretary of Labor determines that the State has made fair and equitable arrangements to protect the interests of displaced employees.

Committee amendment

Since States bear no part of either administrative or benefit costs of the program, there has always been an inherent risk that determinations might not be made with the best interests of the program in mind. States could take the view that they are acting against their own interest to the extent that they deny wholly Federal benefits to their citizens, especially since this may in some instances result in added State costs under general assistance or other programs. Until recently there was no indication that State governments were attempting to influence the disability determination process in a manner which departed from Federal law and regulations concerning standards of eligibility. As a practical matter, however, a 1976 review by the General Accounting Office found that the State agency system resulted in too little national uniformity of decisionmaking and recommended increased efforts by the Social Security Administration to control the process. A follow-up GAO study in 1978 found the situation not improved and recommended the development of a plan to bring the system under complete Federal management.

Recently States have begun to directly challenge the authority of the Federal government to prescribe the standards to be applied in determining eligibility. Numerous States have either refused to conduct reviews under the standards prescribed by the Secretary or have conducted the reviews under a medical improvement standard contrary to the Secretary's authoritative interpretation of the law.

In some cases, such actions were based on court orders but in several instances (10 States, as of March 1984), the action was taken solely on the authority of the Governor. In hearings before other committees Governors have given some indication that they may be prepared to challenge Federal authority in areas other than medical improvement. Thus far, the Department has taken no action to require States to resume following Federal standards.

The Committee recognizes that the traditional cooperative arrangments between the States and the Federal government have been beneficial to the program and hopes that those arrangements can continue. On the other hand, the sole Federal responsibility for the funding of the program, the necessity of having a uniform national program, and the national importance of maintaining the integrity of the Social Security Trust Funds necessitate that the Congress and the Administration remain fully in control of and accountable for the policies applicable to the Social Security Act disability programs. A situation in which individual States begin tailoring those policies or selectively applying them cannot be tolerated.

The 1980 amendments properly sought to assure that any transition from State to Federal administration is done on an orderly basis and with due concern for the legitimate interests of affected employees. However, such procedural concerns cannot take precedence over the need to assure the continuing application of uniform Federal rules and standards to the disability determination process. For this reason, the Committee amendment would modify the provisions of law dealing with State determination of disability to assure better Federal monitoring of the situation and to require the Secretary to take prompt and effective action to deal with any future situations in which States refuse to follow Federal rules or to apply Federal standards of eligibility. The Secretary would be required to federalize disability determinations in a State within 6 months of finding that such State is failing to follow Federal law and standards.

Specifically, when the Secretary has reason to believe that a State is not following Federal law and standards, the matter must be promptly investigated and a preliminary finding must be made within 3 weeks. If the preliminary finding indicates that the State is out of compliance, the Secretary must immediately notify the State and request a response agreeing to follow Federal standards. If a satisfactory response is received within 21 days of the preminary finding, the Secretary would simply monitor the situation over the next 30 days to determine that the State is, in fact, in compliance. If a satifactory response has not been received by that deadline or if the State does not perform in accordance with such a response, the Secretary would be required to make a final finding. this finding would be made no later than 60 days after the preliminary finding, except that an additional 30 days would be allowed if the state requests and the Secretary, in her discretion grants, a hearing before the Secretary on the issue. The Secretary's decision on the matter would not be subject to appeal.

If the Secretary finds that the State is unwilling or unable to follow Federal guidelines in determining disability, the Secretary would be required to federalize the disability determination process

in that State as quickly as possible using SSA personnel or other means of administration available to the Federal government. To the extent feasible, the Secretary would attempt to meet the requirements of existing law which are designed to provide for an orderly transfer of functions, but in no event could the full Federalization take place more than 6 months after the final finding. Moreover, even during that 6 months the Secretary would be required to take such steps as may be necessary to assure that the final decision on all claims processed by that State was made in accordance with Federal standards of eligibility. This might require a Federal re-review of all claims or of those claims involving particular issues with respect to which the State was out of compliance.

This provision expires on December 31, 1987.

V. BUDGETARY IMPACT OF THE BILL

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, sections 308 and 403 of the Congressional Budget Act of 1974, and paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the committee states that the estimates of the Administration and the CBO are as follows:

[Memorandum, May 18, 1984]

From: Eli N. Donkar, Office of the Actuary
Subject: Estimated Additional OASDI Benefit Payments Under S. 476 as Reported by the Senate Committee on Finance

The attached table presents the estimated additional OASDI benefit payments that would result from the proposed disability amendments contained in S. 476 as reported by the Senate Committee on Finance on May 16, 1984. The estimates are based on the alternative II-B assumptions of the 1984 Trustees Report. In this respect, the basic program assumptions underlying these estimates are the same as those used for my memorandum dated May 4, 1984, showing similar estimates for earlier versions of these proposals. In particular, these estimates do not reflect the effects of the national moratorium on periodic reviews announced April 13, 1984 by Secretary Heckler.

The final Committee bill represents a combination of provisions contained in the two packages of proposals described in my earlier memorandum. In addition, S. 476 contains three new sections that provide for (1) closer monitoring of cases where benefits are sent to representative payees, (2) improved State compliance with Federal law and standards established for the disability determination process, and (3) a mechanism to automatically restrict the level of annual cost-of-living benefit increases to DI beneficiaries if DI Trust Fund assets fall below 20 percent of annual DI outlays.

The attached table indicates that there are two key provisions with respect to costs attributable to the bill under this set of assumptions. The first of these, contained in section 2, would temporarily institute a revised procedure for the determination of continuing disability eligibility. The revised procedure would include a modified "medical improvement" standard, whereby an individual's disability benefits could generally not be terminated if the individual could demonstrate that his condition had not medically

improved since a previous determination of disability had been made.

The bill provides for the expiration of this new procedure at the end of calendar year 1987. The committee has indicated its intention to review the experience under the revised procedure, with the possibility that the medical improvement standard could be extended beyond its legislated expiration date. The current estimates, however, only reflect the costs resulting from the effect of the medical improvement standard during the period ending in 1987.

Previous estimates have included a range of examples with respect to the possible retrospective application of a medical improvement standard. However, the current bill includes specific language with respect to the application of this provision; it would apply to new decisions after enactment and to certain cases in the appeals "pipeline" as of the date of committee action on the bill.

The "pipeline" is defined in the bill to include those cases that (1) have not yet had a final decision of the Secretary, (2) cases covered under individual Federal court appeals, and (3) other cases covered under class action suits where the class was certified by the date of committee action. Therefore, the attached estimates for the current bill include only one set of costs for the medical improvement standard.

The second provision with a significant cost is section 3 which would provide for the continuation of benefits during the appeal of a medical cessation. Benefits could continue on appeal through the Administrative Law Judge decision in cases where the initial cessation was issued before June 1986. Furthermore, no payments would be made under this provision for months after January 1987.

It should be noted that a third section of the bill has the potential for a significant impact on DI Trust Fund outlays, although under the alternative II-B assumptions it would have no effect. Section 17 provides for the automatic adjustment of benefit increases otherwise applied to benefits paid from the DI Trust Fund. Under that provision, DI benefit increases would be reduced if a specified DI "trust fund ratio" is estimated to decline below a 20-percent "trigger level." Benefits payable to new beneficiaries joining the rolls might also be affected, if required to maintain a 20-percent level of trust fund assets. Under the alternative II-B assumptions, this trust fund ratio is estimated to stay above 30 percent during the projection period 1984-89. Therefore, the cited provision would not result in benefit reductions.

Under more adverse conditions, however, such as those contained in the 1984 Trustees Report alternative III assumptions, the corresponding ratios are estimated to fall below the "trigger level" beginning in 1988. Consequently, under that set of assumptions, this provision would result in reduced benefit increases for DI beneficiaries beginning in December 1986.

The average OASDI cost over the long range (1984-2058) is estimated to be less than 0.005 percent of taxable payroll, for each section of the bill separately and for the total cost of all sections combined.

Attachment.

ESTIMATED ADDITIONAL OASDI BENEFIT PAYMENTS UNDER S. 476 AS REPORTED BY THE SENATE COMMITTEE ON FINANCE

[In millions]

Section	Proposal	Fiscal year—						Total 1984–87
		1984	1985	1986	1987	1988	1989	
2	Revised CDR procedure, including medical improvement standard [1]	$150	$440	$400	$410	$400	$250	$2,050
3	Continuation of benefits during appeal (through ALJ for initial cessations before June 1986)	60	130	110	60	50	40	450
4	Uniform standards for disability determinations	(2)	(2)	(2)	(2)	(2)	(2)	(2)
5	Moratorium and revised criteria for mental impairment cases	(3)	(3)	(3)	(3)	(3)	(3)	(3)
6	Qualifications of certain medical professionals	(2)	(2)	(2)	10	10	20	40
7	Compliance with certain court orders							
8	Multiple impairments		(2)	(3)	10	10	20	40
9	Study on evaluation of pain	(2)	(2)	(2)	(2)	(2)	(2)	(2)
10	Modification of reconsideration prereview notice	(2)	(2)	(2)	(2)	(2)	(2)	(2)
11	Case development and medical evidence							
12	Payment of costs of rehabilitation services	(2)	(2)	(2)	(2)	(2)	(2)	(2)
14	Advisory council							
15	Regulations on fequency of reviews	(2)	(2)	(2)	(2)	(2)	(2)	(2)
16	Monitoring of representative payees	(2)	(2)	(2)	(2)	(2)	(2)	(2)
17	"Fail-safe" reduction of automatic benefit increases for DI beneficiaries	(4)	(4)	(4)	(4)	(4)	(4)	(4)
18	Measures to improve State compliance with Federal law and standards for the disability determination process	(5)	(5)	(5)	(5)	(5)	(5)	(5)
	Total for bill [6]	260	460	480	480	460	320	2,460

[1] See covering memorandum concerning which groups would be subject to the new procedure.
[2] Cost or savings less than $5 million.
[3] No cost is shown for this provision since existing Administration initiatives are expected to accomplish the same results under present law.
[4] No cost is shown for this provision since, under this set of assumptions, the approriate DI trust fund ratio does not fall below the 20-percent "trigger level" in this period.
[5] No cost is shown for this provision since estimates assume that any noncompliance of States would end upon enactment of a medical improvement standard for continuing disability reviews.
[6] Include $90 million due to continuation of benefits during appeal for past CDR terminations which would be reopened and evaluated under the new medical improvement standard but which would not be reinstated.

Notes:
(1) The above estimates do not reflect the affects of the national moratorium on periodic review cases announced on Apr. 13, 1984, by Secretary Heckler. See memorandum dated Apr. 24, 1984, by Eli N. Donker for a discussion of this issue.
(2) Estimates shown for each section alone exclude the effects of interaction with other proposals. Total costs for bill reflect such interactions.
(3) Due to the uncertainly concerning the effects of many of these proposals, actual experience could vary substantially from these estimates.
(4) Estimates are based on the 1984 trustees report alternative II–8 assumptions.

Source: Social Security Administration, Office of the Actuary, May 18, 1984.

U.S. CONGRESS,
CONGRESSIONAL, BUDGET OFFICE,
Washington, D.C., May 18, 1984.

Hon. ROBERT DOLE,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the provisions of S. 476, the Social Security Disability Amendments of 1984, as ordered reported by the Senate Committee on Finance on May 18, 1984. We have not received a copy of this bill. The attached cost estimate is based on committee documents, and on conversations with committee staff.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

RUDOLPH G. PENNER.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 476.
2. Bill title: Social Security Disability Amendments of 1984.
3. Bill status: As ordered reported by the Senate Committee on Finance, May 18, 1984.
4. Bill purpose: To amend Title II of the Social Security Act to provide for reform of the disability determination process.
5. Estimated cost to the Federal Government: The following table shows the estimated costs of this bill to the federal government. These estimates assume an effective date retroactive to May 1, 1984, unless otherwise noted. The estimate was prepared without a draft of the bill. Estimates were prepared based on committee documents and on conversations with committee staff.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF S. 476

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989
Budget function:						
Function 550: [1]						
Budget authority	3	10	12	11	5	6
Estimated outlays	3	10	12	11	5	6
Function 570:						
Budget authority	1	28	19	8	13	6
Estimated outlays	7	73	55	42	43	30
Function 650:						
Budget authority	−1	−14	−31	−45	−55	−67
Estimated outlays	46	220	225	127	136	121
Function 600: [1]						
Budget authority	1	5	8	10	8	11
Estimated outlays	1	5	8	10	8	11
Total costs or savings:						
Budget authority	4	29	8	−16	−29	−44
Estimated outlays	57	308	300	190	192	168

[1] Funding for entitlements that requires further appropriations action.

BASIS FOR ESTIMATE

This bill would change the disability process for those individuals who undergo continuing disability reviews (CDR's) and for those who apply for Disability Insurance (DI) and Supplemental Security Income (SSI) benefits. Historically, continuing disability reviews have been performed on medical diaried cases—these cases which the Social Security administration (SSA) evaluates as having some chance of medical improvement within a specific length of time. In 1981, SSA began an intensified process of periodically reviewing all cases on the rolls not considered permanently disabled.

It is difficult to project the costs of the provisions in this bill for several reasons. First, there are little data available on the characteristics of the people who have been terminated from the DI rolls as a result of the continuing disability investigations. Second, the Administration has changed some of its policies regarding the review process a number of times, and it is unknown how these changes will affect the number of terminations from the program. In addition, there are many class action cases pending in the court

system. The impact of this bill on the outcome of these cases is unclear. Finally, the language of the provisions allows for various interpretations which would affect costs.

This cost estimate assumes that 110,000 medical diary reviews would be performed annually. The number of periodic reviews is assumed to decline from less than 300,000 in 1984 to 120,000 in 1989, as the percentage of beneficiaries already reviewed increases. Approximately 45 percent of the medical diary reviews are estimated to result in initial terminations of benefit payments, but CBO estimates about 57 percent of these beneficiaries would have their benefits restored after appeals are reviewed. For periodic reviews, the percentage of initial terminations is projected to decline from 40 percent in 1984 to 20 percent in 1989. About 55 percent of those initially terminated from the rolls after a periodic review are estimated to have their benefits restored in the appeal process.

There are also costs to the Medicare program which would result from a larger number of recipients continuing to receive DI benefits, because most DI beneficiaries also receive assistance from the Hospital Insurance (HI) of Supplemental Medical Insurance (SMI) components of the Medicare program. Estimates of these costs are based on the average number of disabled beneficiaries receiving HI and SMI and on the average benefit payments for these programs. There are also costs to the Medicaid program because SSI beneficiaries generally receive Medicaid.

Table 2 displays CBO's outlay estimates for the major sections of the bill. Following the table is a description of the methodology used for the estimates of the outlays for each section listed in Table 2.

TABLE 2.—ESTIMATED OUTLAYS RESULTING FROM THE MAJOR PROVISIONS IN S. 476

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989
Termination of benefits based on medical improvement:						
DI	22	86	123	130	113	90
HI and SMI	4	25	35	40	35	25
Medical	(1)	3	4	4	3	3
SSI	1	3	4	4	3	3
Multiple impairments:						
DI	(1)	4	7	11	13	15
HI and SMI	(1)	(1)	(1)	1	2	2
Medical	(1)	(1)	1	1	1	1
SSI	(1)	1	2	2	3	3
Continued payment during appeal:						
DI	25	149	112	−20	0	0
HI and SMI	3	48	20	0	0	0
Medical personnel qualifications:						
DI	(1)	(1)	(1)	10	10	20
HI and SMI	(1)	(1)	(1)	1	1	3
Medical	(1)	(1)	(1)	1	1	2
SSI	(1)	(1)	(1)	2	2	5
Compliance with court orders	(2)	(2)	(2)	(2)	(2)	(2)
Vocational rehabilitation:						
DI	(1)	2	4	7	8	8
HI and SMI	(1)	(1)	(1)	(1)	(1)	(1)
SSI	(1)	(1)	(1)	(1)	(1)	(1)
Extension of sections 1619a and 1619b:						
Medical	3	7	7	6	0	0

TABLE 2.—ESTIMATED OUTLAYS RESULTING FROM THE MAJOR PROVISIONS IN S. 476—Continued

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989
SSI	(1)	1	2	2	0	0
Total outlays [3]	57	308	300	190	192	168

[1] Less than $500,000.
[2] The costs of this provision cannot be estimated because they depend on future court decisions.
[3] The details do not add to the totals due to interaction between provisions.

Note.—This estimate was prepared based on conversations with committee staff. A draft of the bill as ordered reported has not been received.

TERMINATION OF BENEFITS BASED ON MEDICAL IMPROVEMENT

The medical improvement provision in S. 476 would require SSA to show that a current recipient's disabling condition has medically improved before the benefit could be terminated. Under current law, the condition of a beneficiary is compared to the medical listings and other guidelines to determine if the recipient is still disabled. SSA does not have to establish medical improvement, but only that the recipient is not disabled under current standards.

In 1979, the medical standards were made more precise; some beneficiaries who previously qualified under the old standards are now being terminated as not disabled under the new. These new standards toughened and codified stricter evaluation guidelines in determining disability. Prior to the new standards, 33.9 percent of reviews resulted in cessations; after 1979, these cessations before appeal were 40.9 percent of those reviewed. It is assumed that the resulting 20 percent increase in cessations were for those not meeting the new procedures but previously found disabled under the old. CBO assumes that 20 percent of those currently terminated are the result of this change, and are the group that would be affected by this medical improvement standard.

Of the 20 percent initially denied benefits under current law for medical improvement, we project that 85 percent would appeal and 75 percent of those who appeal would be continued on the rolls. Therefore, under current law, about 64 percent of the people losing benefits initially and whose disabilities have not improved would ultimately be continued on the DI rolls. Costs for the medical improvement provision would result from the continuation of benefits for the remaining 36 percent, who under current law, would not appeal or who would lose an appeal and would consequently be dropped from the rolls. In 1985, the first full year this provision would be in effect, it is estimated that approximately 6,500 people would be retained on the rolls as a result of this provision. The additional number of beneficiaries receiving DI as a result of this provision would fall over time as CBO's estimate of the number of CDRs performed declines. The costs to DI, including administrative expenses, are estimated to rise from $22 million in 1984 to $130 million in 1987, declining to $90 million by 1989. This estimate is assumed to be applied only to prospective cases and to certain cases currently in the court system. In SSI, only concurrent cases—those receiving both DI and SSI—would be affected because no CDRs have been planned for SSI only cases.

This medical improvement provision will expire on December 31, 1987. It is possible that a larger number of terminations than currently estimated will occur after that date, since those not terminated from the rolls in the intervening period may be reevaluated after 1987. This could negate some of the costs shown in 1988 and 1989. This estimate does not include any effect of such potential savings in 1988 and 1989.

The standards set by this provision will also apply to individual litigants in pending court cases and to certain members of certified class action suits. The impact that this part of the provision will have on the ultimate decision in the court cases is difficult to estimate. Specifying standards could facilitate judgments in favor of the claimant and result in increased program costs. However, judgments could still go against the claimant, or the law could be interpreted less favorably toward the claimant, lowering costs attributable to the bill. No impact on costs or savings is included in this estimate from the provision's impact on pending court cases.

MULTIPLE IMPAIRMENTS

This provision would require SSA to consider whether the combination of the applicant's disabilities is severe enough to keep the individual from working at the "significant gainful activity" level in the case where no one impairment is considered severe enough to warrant benefit payments. The SSA estimates that about 500 additional cases per year would be added to the rolls as a result of this provision. This would increase DI costs by a range of less than $500,000 in 1984 to $15 million in 1989. In SSI, about 150 cases would be added initially, increasing SSI costs by a negligible amount in 1984 and by $3 million in 1989.

CONTINUED PAYMENT DURING APPEAL

This provision would provide for continued payment of disability benefits through the Adminstrative Law Judge (ALJ) level of appeal for those individuals who appeal SSA's decisions to end their benefits as a result of CDRs. This provision would affect terminations through June 1986 and continue benefit payments until January 1, 1987. The estimated costs, including administrative costs, are $25 million in 1984 and $149 million in 1985. The costs arise as a result of extra benefits paid to those who ultimately lose their appeal but do not repay the interim benefits as required under this provision. The estimate assumes that seven months of additional benefits are paid to each individual and that 15 percent of those who are finally terminated repay the extra beneifts. This repayment is expected to occur in the year after the benefits are paid.

MEDICAL PERSONNEL QUALIFICATIONS

This provision would require that the Secretary of HHS make every reasonable effort to ensure that a psychologist or a psychiatrist complete a medical evaluation in mental impairment cases before the individual can be denied benefits. The SSA expects fewer than 500 individuals will be added to the rolls annually as a

result of this change in procedure. DI costs would be less than $500,000 in 1985, rising to $20 million by 1989, while SSI costs would total $5 million by 1989.

VOCATIONAL REHABILITATION

This provision changes the regulations concerning benefit payments for individuals participating in vocational rehabilitation programs. The SSA estimates that about 300 individuals per year would be affected by this change. DI costs would range from negligible in 1984 to $8 million in 1989. SSI costs would be insignificant.

COMPLIANCE WITH COURT ORDERS

This provision requires SSA to apply the decisions of the circuit courts of appeal to all beneficiaries residing within states within the circuit, until or unless the decision is overruled by the Supreme Court. This provision could substantially increase costs but these effects cannot be estimated since they would depend on the outcome of future court decisions.

FAIL SAFE FINANCING PROPOSAL

This provision would require the Secretary of HHS to reduce or eliminate the cost-of-living adjustments and to reduce benefits for current and future disabled workers if the Disability Insurance trust fund's reserve is projected to decline to less than 20 percent of a year's outlays. This mechanism would trigger only if the Congress takes no other action. The trust fund balance used for this calculation would include the funds owed to it by the OASI trust fund—currently $5 billion. CBO does not project the DI fund to fall below this level. The estimated DI costs in this bill do not trigger the benefit reduction mechanism.

EXTENSION OF SECTIONS 1619a AND 1619b

Sections 1619a and 1619b provide SSI and Medicaid benefits to disabled individuals who work and who would not otherwise be eligible for benefits because their earnings exceed the "substantial gainful activity" level. These sections, which expired on December 31, 1983, are extended by these amendments through June 30, 1987. Section 1619a is estimated to add 575 persons to the SSI rolls in 1984 and 950 by 1986. Section 1619b is estimated to add 8,300 persons to the Medicaid rolls in 1984 and 10,500 by 1986.

6. Estimated cost to State and local governments: A number of the provisions of this bill would increase expenditures of state and local governments. The estimated net impact of the bill on state and local expenditures is less than $5 million a year.

The changes in SSI would increase state and local government costs because virtually all states supplement federal SSI benefits. By making more persons eligible for SSI benefits, state costs would increase. States are also affected by the added outlays in Medicaid because states finance a portion of the program. The current state financing share is 46 percent.

There could be some offsets to these added SSI and Medicaid costs to the extent that persons made eligible for DI and SSI by the

bill might otherwise be eligible for general assistance or health care financed fully by states and localities. These potential offsets are not included in the cost estimate.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by Stephen Chaikind and Janice Peskin.

10. Estimate approved by C. G. Nuckols for James L. Blum, Assistant Director for Budget Analysis.

VI. REGULATORY IMPACT OF THE BILL

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate.

VII. VOTE OF THE COMMITTEE

In compliance with paragraph 7(c) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote of the committee on the motion to report the bill. S. 476 as amended, was ordered favorably reported by a rollcall vote of 20 yeas and 0 nays.

VIII. ADDITIONAL VIEWS OF HON. RUSSELL B. LONG

Although I continue to have reservations about S. 476, the Finance Committee has made important modifications in the bill:

The medical improvement standard in the Committee bill is a less complete presumption of continuing eligibility for persons who were not disabled when they began receiving disability benefits;

A measure of protection of the disability insurance trust fund, if the cost of the bill far exceeds the estimates, is incorporated in a fail-safe provison which will scale back cost-of-living increases if the fund begins to deteriorate;

By incorporating a statutory definition of pain the Committee bill re-emphasizes that legislative policy is set by the Congress and that the Congress expects the Administration and the courts to interpret and apply that policy in the light of the Congressional intent that the disability insurance program be carefully administered and nationally uniform; and

By providing a mandatory expedited timetable for dealing with State failure to follow Federal rules in determining eligibility, the Committee bill would prevent another protracted deterioration in State administration of this Federal program such as in now occurring.

The Medical Improvement Standard

Under legislation enacted in 1980, the Administration has conducted a large number of continuing disability reviews to see if persons on the disability insurance rolls are still disabled. A significant number of persons were removed from the rolls.

Under present law, when a recipient of disability insurance benefits is reviewed to determine whether he is still disabled, the same definition of disability applies to him as is used for a new applicant, namely: Is he able to engage in "substantial gainful employment"?

S. 476 as introduced would for the first time have set a different standard of continuing eligibility for a person already on the rolls. Finding him capable of engaging in substantial gainful activity would not have sufficed to end his benefits; the Secretary would also have had to show that he had undergone medical improvement since he was first determined to be disabled.

The Committee bill amends and improves this provision. The original bill would have almost totally foreclosed the Secretary from removing from the rolls a person who was not disabled when he bagan receiving benefits. The Committee bill instead lets the Secretary challenge the original disability determination, develop additional evidence and require the complainant to prove that his condition has not medically improved.

Even with this modification, the Social Security Act for the first time will have permitted persons who are able to engage in substantial gainful employment to continue receiving disability insurance benefits.

The Committee bill is estimated to cost $2.5 billion over a five-year period. Virtually this entire amount will be paid to persons who are able to work.

These very significant costs of this legislation are justified by the proponents of the bill on the basis of the need to deal with the current chaotic situation which prevails in the administration of the social security disability program. Even if this argument were to be accepted, it remains deeply troubling for us to expend $2.5 billion, at a time when we are struggling to cope with alarming Federal deficits, to provide benefit payments to individuals who would be unable, despite several levels of appeals, to establish their eligibility.

The situation will be much worse if the legislation, instead of resolving the current chaotic situation, simply serves as a signal for further efforts to broaden eligibility. The bill as reported by the Committee on Finance clearly does not intend such a result. However, the costs and caseloads of this program have over the years proven highly volatile and difficult to control. The adoption by the Congress of a dual standard of eligibility creates a tension which could be laying the groundwork for further expansion of the program. It may prove difficult to maintain a situation in which individuals are denied admission to the benefit rolls—even though equally or less disabled persons who managed to get on the rolls are allowed to keep receiving benefits.

Disability Program Needs Further Review and Revision

S. 476, as reported by the Committee on Finance, attempts to deal with major problems which now exist in the way the program is administered. I believe a number of the provisions of the bill will help in this regard. For example, the specific provision reaffirming the existing regulation on the evaluation of pain will resolve whatever confusion there may be on this issue. It emphasizes again the Congressional view of the need to limit eligibility to cases where disability can be established by objective medical evidence. The timetable for dealing with State defiance of Federal rules should help the Secretary deal with such problems more forcefully. Even the medical improvement provision, though it is troublesome from a policy perspective, at least will resolve a large body of litigatioin according to a policy standard which is set, as it should be, by the Congress and not the courts.

While these features of the Finance Committee bill are desirable improvements in the program, I am concerned that there remain major problems in the structure of the disability program which are not adequately addressed by the pending legislation. If Congress is to bring this program back under control and restore the confidence of both taxpayers and beneficiaries in its evenhandedness, we will need to undertake stronger measures than those contained in this bill.

Consistency of decisionmaking.—One of the arguments most frequently advanced in support of the medical improvement standard is that many, or even most, of the benefit terminations as a result of the recent eligibility reviews were erroneous. The evidence offered in support of this argument is that more than half of the terminations appealed to an administrative law judge (ALJ) were overturned at that level.

While the statistic is correct, the conclusion drawn from it is not. The phenomenon of a reversal rate by ALJs exceeding 50 percent is not peculiar to the recent review process. Both for continuing reviews and initial awards, the ALJs have consistently over the past ten years reversed more than half of the cases appealed to them.

This prolonged pattern of high reversal rates indicates only that different standards are being applied at different levels of the administrative structure. This problem has been recognized for some time. The 1980 amendments attempted to address the problem by mandating a study of its causes and by requiring the Secretary to undertake to review a significant portion of cases which are reversed by ALJs. In addition to these actions, the agency has undertaken to publish rulings aimed at providing a uniform set of basic eligibility guidelines for all levels of the administrative process.

Thus far, at least, there is no evidence that any of these measures are having a significant impact. It may be too early for any results to show up, particularly in the present confused administrative atmosphere. But if the present approach does not succeed in achieving consistent decisionmaking within the present program structure, the Congress may need to consider modifications in that structure.

The role of the courts.—In the 1956 hearings on the question of establishing a disability program, witnesses from the insurance industry predicted that the courts would be only too eager to broaden the scope of the program beyond what Congress intended. That prediction has proven to be quite accurate. In the 1967 amendments the Committee report cited several examples of ways in which the courts had broadened the original intent of the statute. The Committee then directed the Administration to report to the Congress on "future trends of judicial interpretation of this nature," and added to the statute provisions designed to counteract those court cases.

The situation has not noticeably improved. In a recent case *Polaski* v. *Heckler,* a U.S. District Court judge excoriated the Secretary for following her own regulation in violation of what he deemed to be the "fundamental policies at the heart of the disability program." He found these fundamental policies embodied in a law review article by another judge to the effect that the disability statute "should be broadly construed and liberally applied." On the basis of his findings that the Secretary was not obeying what he calls "Eighth Circuit Law," this judge ordered the Secretary to substitute his policy judgment for hers (and that of the Congress) in carrying out the Social Security Act in an area covering seven States.

This case would not be so troubling if it were atypical. But apparently it is almost the judicial norm. Courts do, of course, have the responsibility to carry out the law and to resolve questions of

interpretation. In so doing, however, they should be guided by the statute and its legislative history, not by abstract theories found in law review articles. If the judge in this case had bothered to examine the statute and legislative history, he would have ample evidence of Congress's concern not that the law be more broadly construed, but that it be more narrowly construed. He would also have found great concern on the part of Congress that this law be administered more uniformly. This might have led him to give more weight to national law than to "Eighth Circuit Law." In the United States, the law is the law of the land and it is made by Congress. The courts, including the district and circuit courts, have an important role in carrying out and enforcing the law. But Circuit courts are not regional legislatures.

In its provision on the evaluation of pain, the Committee deals with one of the areas in which the Courts have been broadening the program. However, it is clear from the law review article quoted in the *Polaski* case that there are many other aspects of the program on the judicial agenda. If the regional courts are going to persist in ignoring the policy objectives expressed by Congress and persist in refusing to grant appropriate deference to the duly promulgated regulations of the Secretary, the Congress may be forced to find ways of dealing with this situation.

There have, of course, been some changes in the eligibility requirements for disability benefits since 1956. These changes, however, explain only about one-third of the growth of the program (on the basis of the cost estimates made when they were added to the law). The bulk of the growth in the costs of the disability program cannot be adequately explained except on the basis that the program has been administered in such a manner as to pay benefits to a broader population than Congress intended the program to serve.

Even more troubling than the mere fact that program costs are greater than originally estimated is the evidence that it remains a highly volatile program. Its costs could easily expand well beyond present levels. At the time the program was first enacted, the experts estimated that by 1990 there would be a little more than a million disabled workers drawing benefits. Today there are 2.6 million workers drawing benefits. This is a large increase. But just a few years ago—in 1977—the benefit rolls were growing so rapidly that the actuaries projected they would exceed 5 million disabled worker beneficiaries by 1990. That is roughly 5 times the original estimate.

In dollar terms (using a constant dollar concept based on 1984 payroll levels), the projected long-range average costs of the program have increased from $5 billion in 1956 to $23 billion today—a fourfold increase. But today's projected costs are far from the historic high. That occurred in 1977, when instead of the original 0.33 percent of payroll or the present 1.45 percent of payroll, the long-range program costs were projected to require a tax (on a comparable basis) of about 3.4 percent of payroll—some 10 times as high as the original estimate. This extreme point in the cost of the program was partially caused by a problem in the benefit formula. But even after that problem was corrected by the 1977 amendments, the long-range average cost of the program was estimated to be 2.49 percent of payroll—over 7 times the original cost. In compara-

ble constant dollar terms, this translates into a long-range annual average cost of $40 billion per year.

Viewed in this perspective, it is clear that this is a program with a serioius potential for getting further out of control. It could easily add billions of dollars per year to the deficit and could endanger the stability of the social security system generally. It is particularly important to note that the program is now again showing a trend towards increased costs. As a result of the actions by the States and the courts and the various moratoria imposed by the Administration, the rates of termination are on a downward trend. This is not surprising. But the program has also recently shown an upswing in the allowance rates and in application rates.

Federal-State relationship.—A troubling recent development in the disability program is the tendency of some States to defy Federal rules in carrying out this program which is wholly Federally funded. Even more troubling is the fact that the Secretary took no action to being the errant States back into line. The Committee bill does attempt to deal with this for the future by establishing firm and mandatory time frames for proceeding to Federalized operations in States which refuse to comply. This situation must be monitored, however, if it is not to recur.

The handicapped population.—One reason for the volatility of the disability program is that it is intentionally limited to only the most severely disabled—those who because of their impairment cannot engage in any substantial gainful work activity. This limitation is based not solely on cost but on grounds of policy. The law should not encourage those who retain the capacity for self-support to become dependent.

Unfortunately, if society cannot provide employment opportunities for handicapped individuals who are not totally disabled, they will understandably seek to be found eligible for benefits under the disability programs. And it will be difficult for the administrators of those programs to deny them eligibility.

If we are to succeed in controlling the cost of the disability insurance program, we must find more effective ways of opening up jobs to those handicapped people who have the capability to become productive members of society. While this problem is beyond the scope of the pending bill, our failure to solve this problem has a great deal to do with why this bill is needed. There would be no requirement for a medical improvement standard if we could offer a job to any handicapped person who could work.

I hope the Congress will turn its attention to this issue and that the administration will consider whether it cannot recommend to Congress some significant measures to increase the availability of job openings for the handicapped.

THE GROWTH OF THE DISABILITY PROGRAM

When the disability program was enacted in 1956, it was projected that the program could be permanently financed by a combined employer-employee tax of 0.42 percent of payroll. After adjusting for the proportion of covered wages which are subject to tax, that is closer to a rate of 0.33 percent in today's terms. Since that time, the cost of the program has grown significantly. In the 1984 report

of the Social Security trustees, the long-range costs of the program are estimated at 1.45 percent of payroll, some 4 times what was originally estimated. Expressed on a consntant-dollar basis in relation to 1984 payroll levels, the long-range average cost of the program has increased from $5 billion per year to $23 billion per year.

Just in the past year, the social security actuaries have been required to significantly increase their estimates of what this program will cost even if there is no additional legislation. For the 10-year period ending 1992, the 1984 trustees report indicates that without any legislative change the projected disability program costs have increased by $5.5 billion. The estimates of the long-range average annual costs have similarly increased by over $1 billion per year.

For this reason, there are grounds for serious concern over the possibility that the enactment of disability legislation could be taken as a signal which would unleash another explosion of program costs. If that were to take place, the currently estimated costs of the bill, although they are substantial, would pale in comparison with the true costs of the bill. There is good reason to expect that the enactment of this legislation in the form it passed the House or in the form in which it was referred to the Finance Committee would produce just such results. The Finance Committee has modified this legislation and, in particular, has attempted to clarify it in several ways to limit the possibility that it could mistakenly be seen as the starting signal for another round of program growth. Even so, careful moitoring will be required, given the historic difficulty of controlling the program. In particular, it would be very difficult to responsibly support this legislation if the safeguards included by the Finance Committee were weakened in any significant degree.

RUSSELL B. LONG.

IX. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of Rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill, S. 476, as reported by the committee).

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Calendar No. 899

NOTICE: In lieu of a star print, errata are printed to indicate corrections to the original report.

98TH CONGRESS 2d Session | SENATE | REPORT 98–466

ERRATA

MAY 18 (legislative day, MAY 14), 1984.—Ordered to be printed

Mr. DOLE, from the Committee on Finance, submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany S. 476]

CORRECTIONS

Page 2, line 1: delete "for a period of 3½ years" and insert "through December 31, 1987"; paragraph 4, line 2: insert comma after "eligibility"; last paragraph, line 3, add "s" to "require".

Page 7, next to last line: delete the word "currently".

Page 8, line 6: the word "lasted" is misspelled; paragraph 6, line 6, new paragraph before "(Benefits"; last paragraph, second line, insert "This" before "Burden".

Page 10, strike second sentence and insert: Only if the individual satisfies the burden of showing that his medical condition has not improved would the burden be upon the Secretary to show some other change in circumstances that would warrant terminating benefits. If the claimant cannot meet the burden of showing no medical improvement or the Secretary can show a change in circumstances, eligibility would be determined under the present law test of ability to engage in substantial gainful activity.

Page 13, line 2: delete "and"; line 3: the word "new" is misspelled; line 13: insert "a"; paragraph 2, line 15, the word "their" is misspelled; last line of paragraph 3: the word "for" should be "far".

31–010 O

Page 18, line 6, indent Committee amendment; line 10 of second paragraph: delete comma after "administrative"; line 3 of fourth paragraph, insert apostrophe in Administration's; line 4 of fourth paragraph, delete comma after "(SSA's)".

Page 19, line 2: delete comma after "standards".

Page 21, paragraph 4, line 16: insert comma after "Mendosa,".

Page 22, line 3 of paragraph 1: the word "functional" is misspelled; line 2 paragraph 4: the word "cumulatively" is misspelled.

Page 23, paragraph 3, line 15: the word "guidelines" is misspelled.

Page 25, line 5 of paragraph 4: the word "contract" should be "contact".

Page 27, paragraph 2, line 2: the word "seven" should be "severe."; line 3: add "s" to impairment; line 9: delete the word "thus".

Page 28, paragraph 5: the word "temporary" is misspelled.

Page 30, line 4: the word "beneficiary" is misspelled; the word "periodically" is misspelled; next to last line delete the first "that" and insert "and".

Page 32, paragraph 2: insert the word "which" after "State".

Page 33, paragraph 4, line 7: the partial word "preli-" is misspelled.

Page 34, after the author's name and affiliation (on memo) add "Social Security Administration".

Page 43:

In the original printing of Senate Report 98–466, several paragraphs of the additional views of the Honorable Russell B. Long were misplaced. The additional views are correctly reprinted below.

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employer-employee tax of 0.42 percent of payroll. After adjusting for the proportion of covered wages which are subject to tax, that is closer to a rate of 0.33 percent in today's terms. Since that time, the cost of the program has grown significantly. In the 1984 report of the Social Security trustees, the long-range costs of the program are estimated at 1.45 percent of payroll, some 4 times what was originally estimated. Expressed on a constant-dollar basis in relation to 1984 payroll levels, the long-range average cost of the program has increased from $5 billion per year to $23 billion per year.

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even if there is no additional legislation. For the 10-year period ending 1992, the 1984 trustees report indicates that without any legislative change the projected disability program costs have increased by $5.5 billion. The estimates of the long-range average annual costs have similarly increased by over $1 billion per year.

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