

August 2002

SSA AND VA
DISABILITY
PROGRAMS

Re-Examination of
Disability Criteria
Needed to Help
Ensure Program
Integrity



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Abbreviations

DI	Disability Insurance
DOT	Dictionary of Occupational Titles
O*NET	Occupational Information Network
SGA	substantial gainful activity
SSA	Social Security Administration
SSI	Supplemental Security Income
VA	Department of Veterans Affairs



United States General Accounting Office
Washington, DC 20548

August 9, 2002

The Honorable Jo Anne B. Barnhart
Commissioner of Social Security Administration

The Honorable Anthony J. Principi
Secretary of Veterans Affairs

The three largest federal disability programs providing cash assistance, which are administered by the Social Security Administration (SSA) and the Department of Veterans Affairs (VA), in 2001 collectively provided \$89.7 billion in cash benefits to approximately 10.2 million adults with a physical or mental condition that reduced their earning capacity. With such an extensive cash outlay and such a large beneficiary population, it is important to use updated scientific, workforce, and economic information to evaluate claims for disability benefits. Over time, progress in the fields of medicine and technology has provided a better understanding of how disease and injury affect the ability to work. Likewise, changes in the labor market have affected the skills needed to perform work and the settings in which work occurs. Together, scientific advances and labor market changes redefine the extent that physical or mental conditions affect the ability of people with disabilities to work. If federal disability programs do not update scientific and labor market information used in assessing program eligibility, they risk overestimating the limiting nature of some disabilities while underestimating others. Moreover, not keeping abreast of this information puts federal programs at risk of undermining their efforts to help some persons with disabilities achieve economic independence or work to their full potential.

Although the three largest federal disability programs differ in their underlying purpose, they face a similar underlying challenge. SSA administers both the Disability Insurance (DI) program and the Supplemental Security Income (SSI) program. DI provides benefits to workers with severe long-term disabilities who have enough work history to be insured for coverage under the program. SSI provides benefits to disabled, blind, or aged individuals with low income and limited resources,

regardless of their work histories.¹ VA, meanwhile, compensates veterans for their physical or mental conditions that are service connected.² Despite these differences in the populations they serve and basic rules of eligibility, these programs share the similar task of making complex and difficult decisions about individuals with impairments and their ability to work in today's environment. Beneficiaries served by these programs also have links to rehabilitation services to help them prepare for, find, and maintain employment.

In the past, we and others have reported the DI, SSI, and VA programs as being out-of-step with medical and technological advances and changes in the workforce and the economy. In this report, we review the extent to which DI, SSI, and VA's disability criteria have been updated based on (1) scientific advances, including medical and technological innovations; and (2) labor market changes, including the growth in service- and knowledge-based industries over manufacturing-based industries. We also discuss implications of incorporating these advances and changes into the programs. To address these issues and to consider their implications on the design of these federal disability programs, we reviewed agency documents, SSA's advisory board reports, our prior reports, and other literature. In addition, we interviewed agency officials and several experts in the field. We conducted our work between June 2001 and July 2002 in accordance with generally accepted government auditing standards.

Results in Brief

The DI, SSI, and VA disability criteria have not been fully updated to reflect medical and technological advances. About 12 years ago, both SSA and VA began reviewing relevant medical advances and updating the criteria they use to evaluate claims. However, both agencies are taking years to revise the medical criteria and, consequently, the lengthy time frames could undermine the very purpose of an update. Moreover,

¹ References to the SSI program throughout this report refer to disabled or blind, not aged, recipients who are of working age. SSI benefits are also available to children with disabilities, although SSA uses a different definition of disability for children than for adults.

² In addition, VA provides a disability pension to certain veterans who are permanently and totally disabled by non-service-connected impairments and served during a wartime period. Under the Veterans Education and Benefits Expansion Act of 2001, enacted on December 27, 2001, veterans who are 65 years of age or older do not have to be permanently and totally disabled to become eligible for pension benefits, as long as they meet the other requirements for income and military service.

because of the limited role of treatment in the statutory and regulatory design of these programs, the updates have not fully captured the benefits afforded by advances in treatment. That is, agencies generally factor in the effects of treatment only when an applicant has received or, for SSA, has also been prescribed treatment. For example, the effects that medication to control severe mental illness may have on an applicant's ability to work are not automatically factored into agencies' disability decision making. As a result, people applying for benefits are not necessarily evaluated at their fullest potential for work in their corrected condition. Likewise, efforts to update programs' criteria have not incorporated innovations in assistive technologies—such as advanced prosthetics and wheelchairs—because of similar program design issues.

Also, the disability criteria used by DI, SSI, and VA programs to determine who has a disability have not incorporated labor market changes. Programs continue to use outdated information about the types and demands of jobs in the economy in determining the impact that impairments have on individuals' earning capacity. SSA uses an outdated database—last updated in 1991—for information on the types and demands of occupations in the national economy. The agency is working on identifying a replacement database but this undertaking could take years to complete. VA, meanwhile, has not updated its estimates of the effect that impairments have on earning capacity to reflect today's labor market. Its last update was made in 1945. Moreover, without a current understanding of the impact of physical and mental conditions on earnings given labor market changes, VA and SSA may be overcompensating some individuals while denying or undercompensating other individuals because of outdated information on earning capacity.

In order to incorporate scientific advances and labor market changes into the DI, SSI, and VA programs, some steps can be taken within the existing program design and some would require more fundamental change. Within the context of the programs' current statutory and regulatory framework, agencies will need to continue their medical updates and vigorously expand their efforts to more closely examine labor market changes. At a more fundamental level, SSA and VA could consider changes to the disability criteria that would revisit the programs' basic orientation. As part of this effort, agencies would consider the implications of assessing individuals under corrected conditions for maximizing their employment in a knowledge- and service-based economy. Moreover, under this scenario, agencies could place a greater emphasis on assisting individuals find the appropriate employment assistance and obtain employment. Reorienting programs in this direction would align them with

broader social changes that focus on building and supporting the work capacities of people with disabilities. To this end, approaches taken from private disability insurers and other countries offer useful insights. This shift, however, would raise a number of significant policy issues that have not yet been fully explored. For example, are there certain circumstances when programs would require a beneficiary to accept interventions to enhance work capacities as a precondition for benefits? Likewise, would the cost of providing treatment and assistive technologies in the disability programs be higher than cash expenditures paid over the long-term?

In light of the outmoded criteria, this report contains recommendations that agencies use their annual performance plans to help ensure they place greater priority on updating their disability criteria within the context of the programs' current design. This report also recommends that SSA and VA study the broader implications of how scientific advances and labor market changes could affect the programs' eligibility criteria and benefits package. Appendix I contains SSA's comments on the draft of our report while VA's comments on the draft are shown in appendix II.

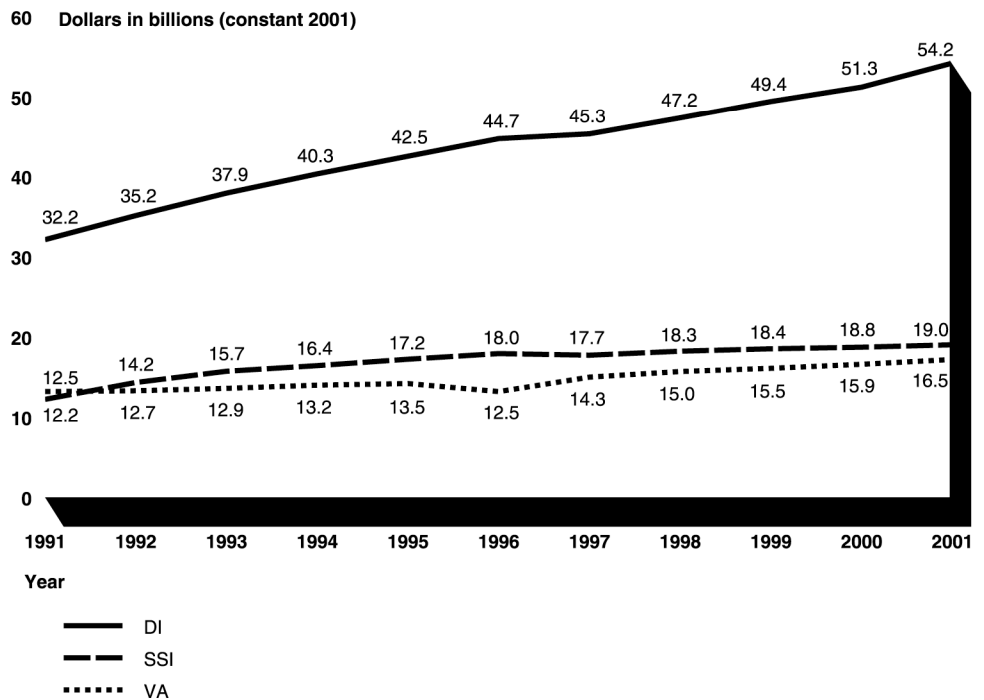
Background

The DI, SSI, and VA programs are three separate federal disability programs that differ in their underlying intent, populations they serve, and the specific approach used by SSA and VA to assess disability. Yet, each program provides financial assistance to individuals with a reduced capacity to work due to a physical or mental impairment. Program beneficiaries also have a connection to vocational assistance that can help program beneficiaries minimize the economic loss resulting from their disabilities.

Programs Have Grown in Recent Years

All three programs have experienced growth in recent years. The amount of cash benefits paid to program beneficiaries has increased over the past 10 years (see fig. 1). In 2001, DI provided \$54.2 billion in cash benefits to 5.3 million disabled workers, SSI provided \$19.0 billion in federal cash benefits to 3.7 million disabled and blind individuals age 18-64, and VA provided \$16.5 billion in disability compensation benefits to about 2.3 million veterans.³ Since 1991, the cash benefits for these programs increased by 69 percent, 55 percent, and 32 percent, respectively (adjusted for inflation). In addition, since 1991 the number of DI, SSI, and VA beneficiaries grew by 65 percent, 53 percent, and 6 percent, respectively.

Figure 1: DI, SSI, and VA Cash Payments to Adults with Disabilities, 1991-2001



Source: GAO analysis of SSA and VA data.

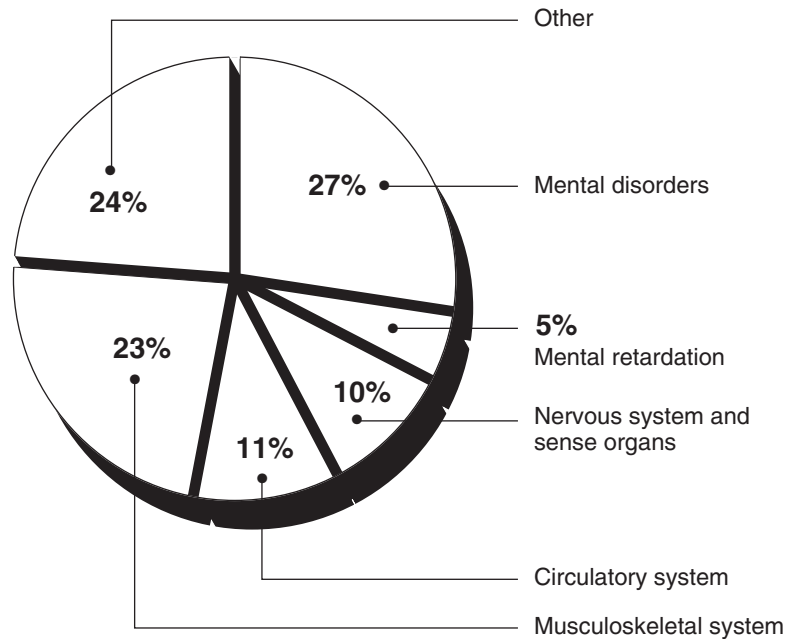
³ These figures do not include cash benefits awarded to other eligible groups, such as disabled widow(er)s and disabled adult children of disabled workers (DI) and children with disabilities (SSI). Included among the 5.3 million DI beneficiaries are about 1.1 million beneficiaries who were dually eligible for SSI disability benefits because of the low level of their income and resources. DI and SSI data are based on 2001 calendar year while VA data are based on 2001 fiscal year.

The size of the programs could grow in the years ahead. In fact, DI and SSI are expected to grow significantly over the next decade. By 2010, SSA expects worker applications for DI to increase by as much as 32 percent over 2000 levels. In 2000, VA predicted that while the number of veterans receiving disability benefits will decrease approximately 18 percent over the next 10 years, the caseload will decline annually by less than 1 percent during this time period. VA explained that veterans will likely incur more disabilities than the past because, for example, veterans of the all-volunteer force are older at time of discharge with longer periods of service, and also because better outreach and access makes veterans more aware of benefits to which they are entitled. Moreover, VA's estimate of the number of veterans assumed the United States would not be engaged in any major global or regional conflict. The recent war on terrorism, however, could affect VA's future projections on the size of the disabled veterans population.

SSA Provides Benefits to People Found to Be Work Disabled

SSA provides disability benefits to people found to be work disabled under the DI or SSI program. Established in 1956, DI is an insurance program that provides benefits to workers who are unable to work because of severe long-term disability. In 2000, the most common impairments among DI's disabled workers were mental disorders and musculoskeletal conditions (see fig. 2). These two conditions also were the fastest growing conditions since 1986, increasing by 7 and 5 percentage points, respectively.

Figure 2: Percentage Distribution of DI Disabled Workers by Impairment Categories, 2000

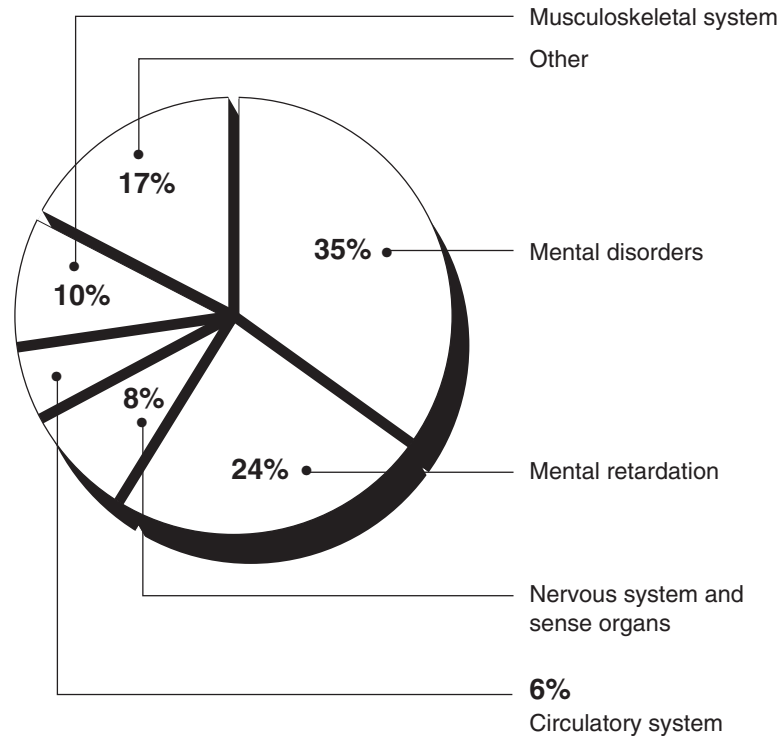


Source: *Annual Statistical Supplement to the Social Security Bulletin, 2001.*

Workers who have worked long enough and recently enough are insured for coverage under the DI program. DI beneficiaries receive cash assistance and, after a 24-month waiting period, Medicare coverage. Once found eligible for benefits, disabled workers continue to receive benefits until they die, return to work and earn more than allowed by program rules, are found to have medically improved to the point of having the ability to work, or reach full retirement age (when disability benefits convert to retirement benefits). To help ensure that only eligible beneficiaries remain on the rolls, SSA is required by law to conduct continuing disability reviews for all DI beneficiaries to determine whether they continue to meet the disability requirements of the law.

SSI, created in 1972, is an income assistance program that provides cash benefits for disabled, blind, or aged individuals who have low income and limited resources. In 2000, the most common impairments among the group of SSI blind and disabled adults age 18-64 were mental disorders and mental retardation (see fig. 3). Mental disorders was the fastest growing condition among this population since 1986, increasing by 9 percentage points.

Figure 3: Percentage Distribution of SSI Adult Disabled Recipients by Impairment Categories, 2000



Source: *Annual Statistical Supplement to the Social Security Bulletin, 2001.*

Unlike the DI program, SSI has no prior work requirement. In most cases, SSI eligibility makes recipients eligible for Medicaid benefits. SSI benefits terminate for the same reasons as DI benefits, although SSI benefits also terminate when a recipient no longer meets SSI income and resource requirements (SSI benefits do not convert to retirement benefits when the individual reaches full retirement age). The law requires that continuing disability reviews be conducted for some SSI recipients for continuing eligibility.

The Social Security Act's definition of disability under DI and SSI is the same: an individual must have a medically determinable physical or mental impairment that (1) has lasted or is expected to last at least 1 year or to result in death and (2) prevents the individual from engaging in substantial

gainful activity (SGA).⁴ Moreover, the definition specifies that for a person to be determined to be disabled, the impairment must be of such severity that the person not only is unable to do his or her previous work but, considering his or her age, education, and work experience, is unable to do any other kind of substantial work that exists in the national economy. (See app. III for a more complete description of SSA's five-step process to determine DI and SSI eligibility.)

While not expressly required by law to update the criteria used in the disability determination process, SSA has stated that it would update them to reflect current medical criteria and terminology. Over the years, SSA has periodically ensured that the medical information and the structure of its *Listing of Impairments*—which describe impairments that are presumed by the agency to be severe enough to prevent a person from doing substantial gainful activity—were both acceptable for program purposes and consistent with current medical thinking. The last general update to the *Listing of Impairments* (also known as the *Medical Listings*) occurred in 1985, at which time expiration dates ranging from 3 to 8 years were inserted for individual body systems to ensure the agency periodically reviews and if necessary, updates the *Medical Listings*.

The statutes establishing the DI and SSI programs presume that disability, for program eligibility, is long-term and based on an either-or decision. That is, a person is either capable or incapable of engaging in substantial gainful work. However, the Social Security Act allows beneficiaries to use a “ticket” issued by the Commissioner of SSA to obtain free employment services, vocational rehabilitation services, or other services to find employment.⁵ Also, Congress has established various work incentives intended to safeguard cash and health benefits while a beneficiary tries to

⁴ Regulations currently define SGA for both the DI and SSI programs as employment that produces countable earnings of more than \$780 a month for nonblind disabled individuals. The SGA level is indexed to the annual wage index. The SGA level for DI blind individuals, set by statute and also indexed to the annual wage index, is currently defined as monthly countable earnings that average more than \$1,300.

⁵ The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) was signed into law in December 1999. In February 2002, SSA began sending tickets to beneficiaries living in the 13 states chosen for the first round of implementation. SSA regulations require that to be eligible to receive a ticket, a beneficiary must, among other factors, have a permanent medical condition or a condition for which medical improvement is possible but cannot be predicted (a beneficiary whose impairment is expected to improve is not eligible to receive a ticket unless the individual has undergone at least one continuing disability review). Participation in the ticket program is voluntary.

return to work.⁶ Despite these provisions, few DI and SSI beneficiaries have left the rolls to return to work,⁷ although the ticket program may have an impact on future rates. The either-or process produces a strong incentive for applicants to establish their inability to work to qualify for benefits, and work-related supports and services (including health coverage) are offered only after individuals have completed the eligibility process. Yet our past work found that DI beneficiaries believe that health interventions—such as medical procedures, medications, physical therapy, and psychotherapy—are primary factors in assisting them to work.⁸

VA Provides Benefits to Veterans Found to Have Reduced Earning Capacity

VA's disability program compensates veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during military service.⁹ In 2000, the most common impairment category among all disabled veterans was illness and injury to bones and joints (see fig. 4). This impairment category also experienced the fastest growth among the disabled veteran population since 1986, increasing by 6 percentage points.

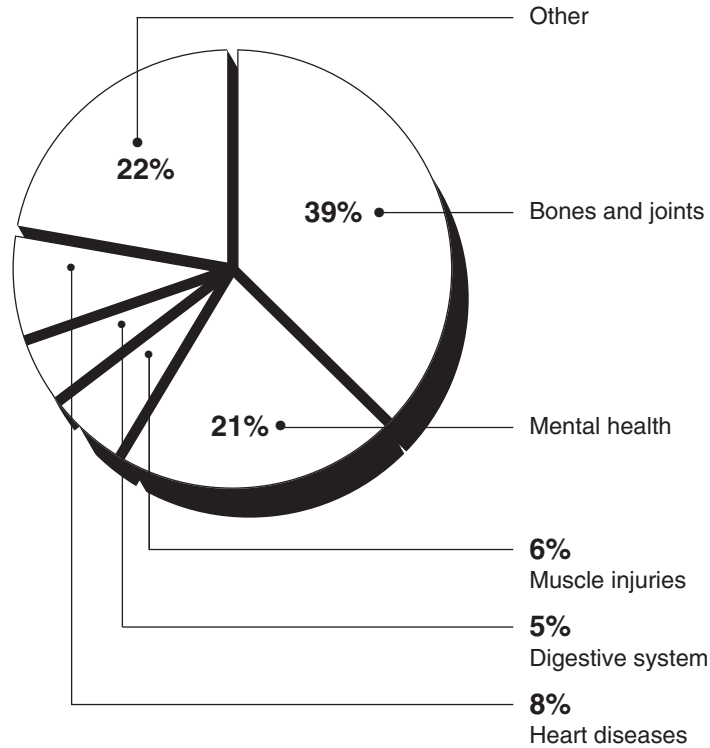
⁶ For example, the DI work incentives provide for a trial work period in which a beneficiary may earn any amount for 9 months within a 60-month period and still receive full cash benefits. The SSI work incentives, among other features, allow beneficiaries to earn more than the SGA level and retain part of a cash benefit.

⁷ U.S. General Accounting Office, *Social Security: Disability Programs Lag in Promoting Return to Work*, [GAO/HEHS-97-46](#) (Washington, D.C.: Mar. 17, 1997).

⁸ U.S. General Accounting Office, *Social Security Disability Insurance: Multiple Factors Affect Beneficiaries' Ability to Return to Work*, [GAO/HEHS-98-39](#) (Washington, D.C.: Jan. 12, 1998).

⁹ Veterans' Benefits, 38 U.S.C. §§ 1110 and 1155.

Figure 4: Percentage Distribution of Veterans Receiving Disability Compensation by Impairment Categories, 2000



Note: Percentages do not add to 100 percent due to rounding.

Source: VA's Compensation and Pension Master File.

VA's program is similar to the DI and SSI programs in that all three programs provide cash benefits to persons whose physical or mental impairments have been deemed to reduce their ability to earn a living.¹⁰ However, VA relies upon an average reduction in earning capacity across a group of individuals with a similar condition rather than the actual reduction for an individual veteran applying for benefits. As a result, a veteran with a disability is entitled to disability cash benefits whether or not employed and regardless of the amount earned. The cash benefit level

¹⁰ We met with several veterans service organizations to discuss the issues in this report. These organizations stated that they believe disability compensation benefits, in addition to representing payment for economic loss, also represent compensation for noneconomic loss due to an injury or illness as well as service to the country.

is based on the “percentage evaluation,” commonly called the disability rating, that represents the average loss in earning capacity associated with the severity of physical and mental conditions. VA uses its *Schedule for Rating Disabilities* to determine which disability rating to assign to a veteran’s particular condition. Ratings for individual diagnoses in the schedule range from 0¹¹ percent to 100 percent.¹² For example, VA presumes that the loss of a foot as a result of military service results in a 40 percent impairment in earning capacity, on average, among veterans with this injury. All veterans who lose a foot as a result of military service, therefore, are entitled to a 40 percent disability rating. Unlike the DI and SSI programs, the law does not specifically require VA to conduct continuing disability reviews to determine whether veterans continue to meet the disability requirements of the law.

The Schedule for Rating Disabilities was first developed in 1919 and had its last major revision in 1945. Two major studies have been conducted since the implementation of the 1945 version of the schedule to determine whether the schedule constitutes an adequate basis for compensating veterans with service-connected conditions. One was conducted by a presidential commission in the mid-1950s and a second by VA in the late 1960s. Both concluded, for various reasons, that at least some disability ratings in the schedule did not accurately reflect the average impairment in earning capacity among disabled veterans and needed to be adjusted.

The law states that VA shall, from time to time, readjust the schedule based upon experience. Keeping the schedule current is important because cash benefits are based on the schedule. We previously reported, however, that VA’s rating schedule that was being used in the late 1980s had not been adjusted to incorporate the results of many recent medical advances, and as a result, some veterans may be undercompensated and others may be overcompensated for their service-connected disability.¹³

¹¹ A veteran can receive a 0 percent noncompensable rating that may be increased to a compensable rating of 10 percent or more if the veteran’s condition worsens. A 0 percent rating generally means that VA has determined that a veteran has a condition that can be classified as service-connected; however, it is not severe enough to qualify for monetary compensation on the basis of the medical criteria specified in the schedule.

¹² Congress sets the specific benefit amount for each of the disability ratings. Congress typically adjusts the benefit amount each year. In 2002, the basic monthly amount for veterans without dependents ranged from \$103 for conditions assigned a rating of 10 percent to \$2,163 for conditions assigned a rating of 100 percent.

¹³ U.S. General Accounting Office, *Need to Update Medical Criteria Used in VA’s Disability Rating Schedule*, [GAO/HRD-89-28](#) (Washington, D.C.: Dec. 29, 1988).

Further, we recommended that VA (1) prepare a plan for a comprehensive review of the rating schedule and, based on the results, revise medical criteria accordingly and (2) implement a procedure for systematically reviewing the rating schedule to keep it updated.

Veterans with a service-connected disability rated at 20 percent or higher who are found by VA to have an employment handicap can receive rehabilitation services. Eligible veterans can receive vocational counseling, training, job search assistance, and supportive rehabilitation services. In addition, VA offers veterans a medical benefits package that provides a full range of outpatient and inpatient services, including primary and specialty care as well as drugs.

Advances in Medicine and Technology, Labor Market Changes, and Social Changes Have Affected Work-Related Capabilities of People with Disabilities

Recent scientific advances in medicine and assistive technology and changes in the nature of work and the types of jobs in our national economy have generally enhanced the potential for people with disabilities to perform work-related activities. Advances in medicine have afforded the scientific community a deeper understanding of and ability to treat disease and injury. Medical advancements in treatment (such as organ transplantations), therapy, and rehabilitation have reduced the severity of some medical conditions and have allowed individuals to live with greater independence and function in settings such as the workplace. Also, assistive technologies—such as advanced wheelchair design, a new generation of prosthetic devices, and voice recognition systems—afford greater capabilities for some people with disabilities than were available in the past.

At the same time, the nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment. In the 1960s, earning capacity became more related to a worker's skills and training than to his or her ability to perform physical labor. Following World War II and the Korean Conflict, advancements in technology, including computers and automated equipment, reduced the need for physical labor. The goods-producing sector's share of the economy—mining, construction, and manufacturing—declined from about 44 percent in 1945 to about 18 percent in 2000. The service-producing industry's share, on the other hand—such areas as wholesale and retail trade; transportation and public utilities; federal, state and local government; and finance, insurance, and real estate—increased from about 57 percent in 1945 to about 72 percent in 2000.

Although certain jobs in the service economy continue to be physically demanding—a cashier in a fast food restaurant might be expected to stand for most of his or her shift—other service- and knowledge-based jobs can allow greater participation for persons with physical limitations. In addition, telecommuting and part-time work provide other options for persons with disabilities. However, some labor market trends—such as an increasing pace of change in office environments and the need for adaptability—can pose particular challenges for some persons, such as those with severe mental illness and learning disabilities. Moreover, other trends—such as downsizing and the growth in contingent workers—can limit job security and benefits, like health insurance, that most persons with disabilities require for participation in the labor force. Whether these changes make it easier or more difficult for a person with a disability to work appears to depend very much on the individual’s impairment and other characteristics, according to experts.

Social change has promoted the goals of greater inclusion of and participation by people with disabilities in the mainstream of society, including adults at work. For instance, over the past 2 decades, people with disabilities have sought to remove environmental barriers that impede them from fully participating in their communities. Moreover, the Americans with Disabilities Act supports the full participation of people with disabilities in society and fosters the expectation that people with disabilities can work and have the right to work. The Americans with Disabilities Act prohibits employers from discriminating against qualified individuals with disabilities and requires employers to make reasonable workplace accommodations unless it would impose an undue hardship on the business.

Disability Criteria Not Fully Updated to Reflect Scientific Advances

The disability criteria used by the DI, SSI, and VA disability programs to help determine who is qualified to receive benefits have not been fully updated to reflect scientific advances. Both SSA and VA are currently in the midst of a process that began around the early 1990s to update the medical criteria they use to make eligibility decisions, but the progress is slow. The updates include dropping or adding conditions that qualify one for benefits, modifying criteria needed to establish the presence and severity of certain medical conditions, and wording changes for clarification and guidance in making decisions. Agencies report that they made some of these changes due to medical advances in treatment that have reduced the severity and occurrence of some medical conditions. Nevertheless, the statutory and regulatory design of these programs limits the role of treatment in determining who is disabled. Therefore, treatment advances, by definition, have not been folded into the updates. Moreover,

because of the statutory design of these programs, the role of assistive technologies is not recognized in making disability decisions. Consequently, the updates have not fully incorporated innovations in this field, such as advanced prosthetics and wheelchair designs.

Slow Process to Update Medical Criteria Jeopardizes Progress Already Made

SSA's current effort to update the disability criteria began in the early 1990s. To conduct the current update, SSA gathers feedback on relevant medical issues from state officials who help the agency make disability decisions. In addition, SSA has in-house expertise to help the agency keep abreast of the medical field and identify aspects of the medical criteria that need to be changed. SSA staff develop the proposed changes and forward them for internal, including legal and financial, review. Next, SSA publishes the proposed changes in the *Federal Register* and solicits comments from the public for 60 days. SSA considers the public comments, makes necessary adjustments, and publishes the final changes in the *Federal Register*.

Between 1991 and 1993, SSA published for public comment the changes it was proposing to make to 7 of the 14 body systems in its *Medical Listings*.¹⁴ By 1994, the proposed changes to 5 of these 7 body systems were finalized, although SSA told us that changes to 2 systems were relatively minor. SSA's efforts to update the *Medical Listings* were curtailed in the mid-1990s due to staff shortages, competing priorities, and lack of adequate research on disability issues. Since the mid-1990s, we, SSA's Office of the Inspector General, and the Social Security Advisory Board have expressed concern that SSA was not updating the *Medical Listings* regularly but simply extending the expiration dates that were originally developed by SSA so as to ensure that it would conduct the updates. In fact, the Office of the Inspector General¹⁵ recommended that SSA develop a performance measure of its update activities for inclusion in SSA's annual performance plan.¹⁶ SSA did not agree with the recommendation, responding that revisions to the *Medical Listings* are

¹⁴ Our analysis excludes SSA's changes to the childhood-related *Medical Listings*.

¹⁵ Office of the Inspector General, Social Security Administration, *Status of the Social Security Administration's Updates to the Medical Listing*, A-01-99-21009 (Washington, D.C., 2000).

¹⁶ The Government Performance and Results Act of 1993, Public Law 103-62, requires SSA to develop performance indicators that assess the relevant service levels and outcomes of each program activity.

subject to some factors not fully in their control (e.g., progression of scientific advances, input from experts and the public, and shifting congressional priorities), which can affect timing and prioritization of effort. In our view, these uncertainties—in addition to the size and costs of the programs—in fact elevate the need for establishing a time frame to ground SSA in its efforts and help keep the agency on track. Moreover, SSA is allowed to revise performance measures in its annual plans.¹⁷

SSA resumed updating the *Medical Listings* in 1998. Since then, SSA has taken some positive steps in updating portions of the medical criteria it uses to make eligibility decisions, although progress is slow. As of early 2002, SSA has published the final updated criteria for 1 of the 9 remaining body systems not updated in the early 1990s (musculoskeletal) and a portion of a second body system (mental disorders). SSA also plans to update again the 5 body systems that were updated in the early 1990s. In addition, SSA has asked the public to comment on proposed changes for several other body systems. During the course of our work, SSA initially indicated to us that the agency planned to publish proposed changes for all body systems by 2002 and submit changes to the Office of Management and Budget for final clearance by 2003. Recently, the new administration at SSA (a new commissioner was confirmed in November 2001) reviewed the schedule and timing for the revisions. The results of this review pushed back the completion date for publishing proposed changes for all remaining body systems to the end of 2003.¹⁸ The revised schedule, as of May 2002, is shown in table 1.

¹⁷ Agencies are permitted to revise the performance targets in their performance plans—based upon congressional action, the occurrence of unanticipated exigencies, consideration of actual performance data from the prior year, and other reasons—under the Government Performance and Results Act of 1993 as implemented by OMB Circular No. A-11, Part 2: *Preparation and Submission of Strategic Plans, Annual Performance Plans, and Annual Program Performance Reports* (Washington, D.C., 2000).

¹⁸ Social Security Administration, “Semiannual Unified Regulatory Agenda,” *Federal Register* 67, no. 92 (13 May 2002): 34016 – 34038.

Table 1: Progress of SSA’s Current Efforts to Update *Medical Listings*

Action	Body system	Date of current update	Date of previous update
Updates finalized			
	Mental disorders (partial system update)	2000	1985
	Musculoskeletal	2002	1985
Updates in process			
		Proposed changes published for comment in the <i>Federal Register</i>	
	Hemic and lymphatic	Nov. 2001	1985
	Malignant neoplastic diseases	Nov. 2001	1985
	Digestive	Nov. 2001	1985
	Skin	Dec. 2001	1979
		Plan to submit proposed changes to OMB	
	Multiple body systems	Oct. 2002	1993
	Genitourinary	Nov. 2002	1985
	Cardiovascular	Dec. 2002	1994
	Endocrine	Jan. 2003	1993
	Respiratory	Jan. 2003	1993
	Special senses and speech	Mar. 2003	1985
	Neurological	Aug. 2003	1985
	Immune	Sept. 2003	1993
	Mental disorders (remaining portion)	Nov. 2003	1985

Source: GAO Analysis of SSA documents.

SSA’s slow progress in completing the updates could undermine the purpose of incorporating medical advances into its medical criteria. For example, the criteria for musculoskeletal conditions—a common impairment among persons entering DI—were updated in 1985. Then, in 1991, SSA began developing new criteria and published its proposed changes in 1993 but did not finalize the changes until 2002; therefore, changes made to the musculoskeletal criteria in 2002 were essentially based on SSA’s review of the field in the early 1990s. SSA officials told us that in finalizing the criteria, they reviewed the changes identified in the early 1990s and found that little had taken place since then to warrant changes to the proposed criteria. However, given the advancements in medical science since 1991, it may be difficult for SSA to be certain that all applicable medical advancements are in fact included in the most recent update. Similarly, we are concerned about the time frames for completing the full update on the criteria for another major impairment category—mental disorders. While SSA finalized in 2000 a portion of the changes for mental disorders first proposed in 1991, the agency deferred action on the

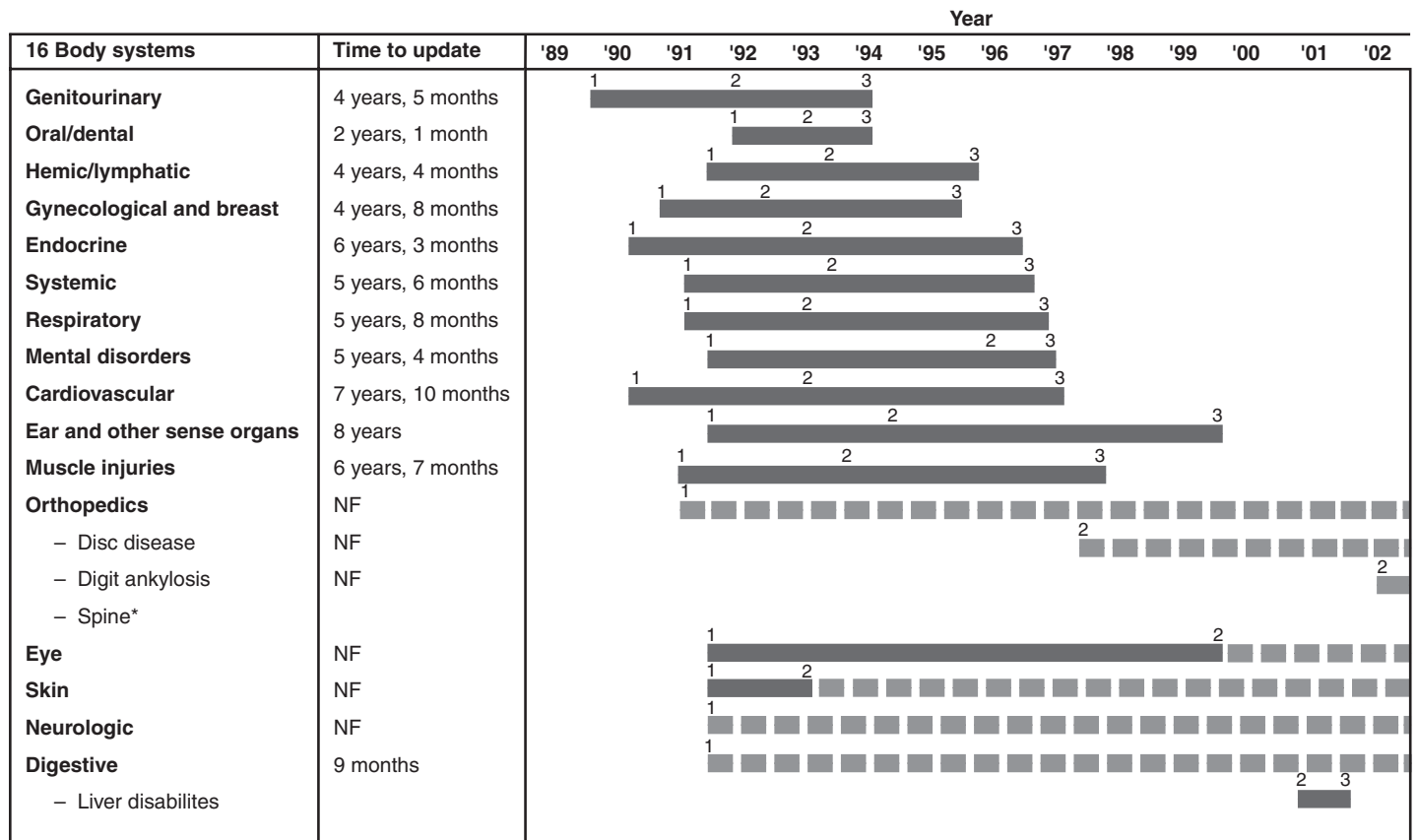
remaining portion pending further review. SSA recently announced plans to publish these proposed changes by November 2003.

Keeping to a set schedule and making necessary updates could help SSA minimize the use of outmoded criteria in a large number of disability decisions. For example, SSA used the criteria for musculoskeletal conditions that were developed in 1985 until 2001. This means that in the year prior to the update—2000—SSA allowed 222,750 adults to enter the DI or SSI program on the basis of medical criteria that were 15 years old.

VA has made more progress than SSA in updating the medical criteria used to evaluate its disability claims, but overall the process is slow. In 1989, VA hired a contractor to bring together practicing physicians to review and develop updated criteria for several of the body systems contained in the *Schedule for Rating Disabilities*. The practicing physicians, who were organized by teams according to specific body systems, were tasked with proposing changes that were consistent with modern medical practice and stated in a manner that could be easily interpreted by rating personnel. The results of the teams' efforts were reviewed by VA in-house staff. After making necessary adjustments, the proposed changes were forwarded to various VA offices for review. Proposed changes were published in the *Federal Register* and opened for a 60-day comment period. As of March 2002, VA had finalized the criteria for 11 of 16 body systems. VA is currently reviewing the remaining body systems.

VA has generally taken more than 5 years to complete the update for each body system (see fig. 5). VA has not yet completed updating the medical criteria for several important body systems. For example, criteria used for evaluating orthopedic impairments were last updated in 1986. Yet the number of veterans with a disabling orthopedic condition has risen significantly in the past decade, outpacing the number of veterans receiving benefits under any other single disability group. Therefore, veterans with an orthopedic impairment who applied for VA disability benefits since 1996 were evaluated with medical criteria that were at least 10 years old.

Figure 5: Time Frame of VA's Efforts to Update the *Schedule for Rating Disabilities*



Legend

- 1 Advance notice of proposed rule making published in Federal Register
- 2 Proposed criteria published in Federal Register
- 3 Final criteria published in Federal Register
- NF Not finished
- ■ ■ In process

*VA has not published an advance notice or proposed criteria. Further action is pending following the completion of updates for disc disease.

Source: GAO analysis of VA data.

We found two factors contributing to the amount of time to update VA's medical criteria. First, the review given to the proposed changes is lengthy. VA's legal counsel as well as other entities within VA, such as the Veterans Health Administration, Office of Congressional and Legislative Affairs, and Office of Inspector General, review all proposed changes to the *Schedule*

for Rating Disabilities. The Office of Management and Budget also reviews the changes. This entire review process can take up to 3 years. Second, the number of staff assigned to coordinate the updates at VA also contributes to the lengthy time to complete the updates. For example, one staff person is assigned less than half time to coordinate the update efforts.

VA does not have a well-defined plan to conduct the next round of medical updates. Although VA provided us with a statement acknowledging the need to re-review the medical criteria in the future, it had neither a strategy nor time frame for completing the task.

Agencies Have Changed Several Aspects of Disability Criteria

SSA has made various types of changes to the *Medical Listings* thus far. As shown in table 2, these changes, including the proposed changes released to the public for comment, add or delete qualifying conditions; modify the criteria for certain physical or mental conditions; and clarify and provide additional guidance in making disability decisions. In addition, SSA has made a number of editorial changes.

Table 2: Types of Changes Made (or Proposed) to SSA’s *Medical Listings* during Current Update

Type of change	Examples	Rationales
Revise qualifying conditions	Remove peptic ulcer. ^a	Advances in medical and surgical management have reduced severity.
	Add inflammatory bowel disease by combining two existing conditions already listed: chronic ulcerative and regional enteritis.	Reflect advances in medical terminology.
Revise evaluation and diagnostic criteria	Expand the types of allowable imaging techniques.	The <i>Medical Listings</i> previously referred to x-ray evidence. With advancements in imaging techniques, SSA will also accept evidence from, for example, computerized axial tomography (CAT) scan and magnetic resonance imaging (MRI) techniques.
	Reduce from three to two in the number of difficulties that must be demonstrated to meet the listings for a personality disorder. ^b	Specific rationale not mentioned.
Clarify and provide additional guidance	Remove discussion on distinction between primary and secondary digestive disorders resulting in weight loss and malnutrition.	Distinction not necessary to adjudicate disability claim.
	Expand guidance about musculoskeletal “deformity.”	Clarify that the term refers to joint deformity due to any cause.

^aA condition removed from the *Medical Listings* means that SSA no longer presumes the condition to be severe enough to ordinarily prevent an individual from engaging in substantial gainful activities. However, an individual with a condition removed from the *Medical Listing* could still be found eligible under other considerations in the evaluation process as described in appendix III.

^bThe criteria for a personality disorder are met when (a) the individual has certain behaviors defined in the *Medical Listings* and (b) those behaviors result in at least two of the following: (1) marked restriction of activities in daily living; (2) marked difficulties in maintaining social functioning; (3) marked difficulties in maintaining concentration, persistence, or pace; or (4) repeated episodes of decompensation (as specified in the *Medical Listings*).

Source: GAO analysis of SSA publications appearing in *Federal Register*.

In recognition of medical advances, VA has also made several types of changes to its *Schedule for Rating Disabilities* during the current update. As shown in table 3, the types of changes have been quite similar to changes made by SSA. Revisions generally consist of (1) adding, deleting, and reorganizing medical conditions in the *Schedule for Rating Disabilities*; (2) revising the criteria for certain qualifying conditions; and (3) wording changes for clarification or reflection of current medical terminology. VA also has made a number of editorial changes.

Table 3: Types of Changes Made (or Proposed) to VA’s *Schedule for Rating Disabilities* during Current Update

Type of change	Examples	Rationales
Revise schedule	Add pneumoconiosis as a qualifying disease under interstitial lung diseases.	Allows for a more complete representation of this disease category.
	Create new category for “schizophrenia and other psychotic disorders.”	New category is in accordance with terminology used in the standard medical texts.
Revise criteria	Evaluation of anemia should include clinical findings and not be based solely on hemoglobin levels.	Provides a more accurate measure.
	Under certain conditions, varicose veins developed after leaving the service can be considered as service-connected.	Specific rationale not mentioned.
Wording change for clarification or reflection of current medical terminology	Replace “frequent” with “twice per year” when assessing frequency of surgical therapies for recurring stone formation in the ureter.	Standardizes the term for more precise evaluations.
	Change “new growth” to “neoplasm.”	Improve technical accuracy.

Source: GAO analysis of VA publications appearing in the *Federal Register*.

Design Issues Have Limited the Incorporation of Treatment, Corrective Medical Devices, and Assistive Technologies into Criteria

Program design issues have limited the extent that advances in medicine and technology have been incorporated into the DI, SSI, and VA's disability decision making. SSA has indicated that the updates are being made in recognition of medical advances in treatment and technology, and we found examples in SSA's publications in the *Federal Register* of this occurring. Our methodology for this study, however, does not allow us to determine the extent of SSA's efforts to incorporate medical advances into the *Medical Listings*. Nevertheless, the design of these programs limits the role of treatment in deciding who is disabled. SSA's regulations require that in order to receive benefits, claimants must follow treatment prescribed by the individual's physician if the treatment can restore his or her ability to work.¹⁹ The implication of this regulation is that if an individual is not prescribed treatment, SSA does not consider the possible effects of treatment in the disability decision, even if the treatment could make the difference between being able and not being able to work. Moreover, the programs do not require individuals to receive nonprescribed treatment before or during the time they are assessed for eligibility. Thus, treatments that can help restore functioning to persons with certain impairments may not be factored into the disability decision for some applicants. This limited role of treatment means, by definition, the updates have not fully captured the benefits that treatments can provide to persons with certain impairments. For example, medications to control severe mental illness, arthritis treatments to slow or stop joint damage, total hip replacements for severely injured hips, and drugs and physical therapies to possibly improve the symptoms associated with multiple sclerosis are not automatically factored into SSA's decision making for determining the extent that impairments affect people's ability to work. Additionally, this limited approach to treatment raises an equity issue: Applicants whose treatment allows them to work could be denied benefits while applicants with the same condition who have not been prescribed treatment could be allowed benefits.

While some of VA's changes to the *Schedule for Rating Disabilities* reflect advances in medicine, the changes have generally not incorporated the potential benefits of treatment. While treatment can improve an individual's ability to function in the workplace, the program is not designed to factor in the potential benefits of treatment when evaluating a

¹⁹ SSA does not consider the effects of treatment that has been prescribed but not received under certain circumstances, such as when the treatment is contrary to the established teaching and tenets of the individual's religion.

veteran's service-connected disability. That is, veterans applying for disability benefits—much like, for example, workers applying for DI benefits—are not required to undergo treatment before or after they are given a disability rating. Moreover, the VA program does not, unlike DI and SSI, factor in the potential effect of prescribed treatment on an applicants' abilities.

As with treatment, the benefits of innovations in assistive technologies—such as advanced prosthetics and wheelchair designs—have not been fully incorporated into DI, SSI, and VA disability criteria because the statutory design of these programs does not recognize these advances in disability decision making. That is, programs are not designed to assess an applicant's ability to work under corrected conditions. Conceivably, using innovations such as a prosthetic device could reduce the limiting nature of an applicant's impairment and could also reduce, if programs were designed differently, eligibility for or the amount of cash benefits. And some technologies may not involve sophisticated electronics. For example, a factory worker with a back impairment who works on an assembly line could benefit from an ergonomic stool or chair and matting that would cushion the floor and reduce fatigue. According to VA, technological advances, such as voice recognition devices—which can help people who do not have the use of their hands to interact with a computer—are not considered during the rating process to determine the extent to which technology could improve a veteran's earning capacity.

Disability Criteria Not Updated to Reflect Labor Market Changes

The disability criteria used by DI, SSI, and VA programs for determining who is disabled have not incorporated labor market changes. In determining the effect that impairments have on individuals' earning capacity, programs continue to use outdated information about the types and demands of jobs in the economy. Given the nature of today's economy, which offers varied opportunities for work, agencies' use of outdated information raises questions about the validity of disability decisions.

SSA Relies upon Outdated Labor Market Information to Assess Impact of Impairments on Capacity to Perform Work

For an applicant who does not have an impairment that SSA presumes is severe enough ordinarily to prevent an individual from engaging in substantial gainful activity, SSA evaluates whether the individual is able to work despite his or her limitations.²⁰ Individuals who are unable to perform their previous work and other work in the national economy are awarded benefits. SSA relies upon the Department of Labor's Dictionary of Occupational Titles (DOT) as its primary database to make this determination; however, Labor has not updated DOT since 1991 and does not plan to do so. Since 1993, Labor has been working on a replacement for the DOT called the Occupational Information Network (O*NET). It contains information on about 970 occupational categories, while DOT had 13,000 occupational titles.

Labor and SSA officials recognize that O*NET cannot be used in its current form in the DI and SSI disability determination process. The O*NET, for example, does not contain SSA-needed information on the amount of lifting or mental demands associated with particular jobs. The agencies have discussed ways that O*NET might be modified or supplemental information collected to meet SSA's needs, but no definitive solution has been identified. SSA officials have indicated that an entirely new occupational database could be needed to meet SSA's needs, but such an effort could take many years to develop, validate, and implement. Meanwhile, as new jobs and job requirements evolve in the national economy, SSA's reliance upon an outdated database further distances the agency from the current market place.

VA Relies upon Outdated Information in Estimating Economic Loss Resulting from Physical and Mental Impairments

The percentage ratings used in VA's *Schedule for Rating Disabilities* are still primarily based on physicians' and lawyers' estimates made in 1945 about the effects that service-connected impairments have on the average individual's ability to perform jobs requiring manual or physical labor. Although VA is revising the *Schedule for Rating Disabilities*' medical criteria, the estimates of how impairments affect veterans' earnings have generally not been reexamined. As a result, changes in the nature of work that have occurred in the past 57 years—which potentially affect the extent to which disabilities limit one's earning capacity—are overlooked

²⁰ SSA refers to this level of ability to work despite physical and mental limitations as a residual functional capacity. Specifically, SSA evaluates whether the applicant has an impairment that prevents him or her from performing previous work or considering his or her age, education, and work experience, performing any other kind of substantial work that exists in the national economy.

by the program's criteria. For example, in an increasingly knowledge-based economy, one could consider whether earning capacity is still reduced, on average, by 40 percent for loss of a foot.

VA recognizes that there have been significant changes in the nature of work, but does not believe that these changes need to be reflected in the disability ratings. One official noted that a disability rating is essentially an indication of medical severity: the more severe the medical condition, then the higher the rating. Moreover, it was stated, changes in the nature of work are captured in the types of vocational rehabilitation services offered to veterans (e.g., veterans could receive computer skills training). Finally, the official noted that disability compensation should not be adjusted if an individual veteran is able to work despite a disabling condition.

In the past, we suggested to Congress that it may wish to consider directing VA to determine whether VA ratings correspond to veterans' average loss in earning capacity and adjust disability ratings accordingly.²¹ VA responded to us that the schedule, as constructed, represents a consensus among Congress, VA, and the veteran community, and that the ratings generally represent an equitable method to determine disability compensation. In conducting the work for our present assignment, VA told us that they believe the consensus remains and the ratings continue to generally represent an equitable approach. We continue to believe, however, that changes in the nature of work afford some veterans with a disability the opportunity to become more fully employed and that the current estimates of the average reduction in earning capacity should be reviewed. Further, we believe that updating disability criteria is consistent with the law.

²¹ U.S. General Accounting Office, *VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses*, [GAO/HEHS-97-9](#) (Washington, D.C.: Jan. 7, 1997).

Incorporating Scientific Advances and Labor Market Changes into Disability Criteria Has Several Implications

Incorporating scientific advances and labor market changes into DI, SSI, and VA programs can occur within the existing program design and at a more fundamental level. Within the context of the programs' existing statutory and regulatory design, agencies will need to continue updating the criteria they use to determine which applicants have physical and mental conditions that limit their ability to work. As we noted above, agencies began this type of update in the early 1990s, although their efforts have focused much more on the medical portion than labor market issues. In addition to continuing their medical updates, SSA and VA need to vigorously expand their efforts to more closely examine labor market changes. SSA's results could yield updated information they use to make decisions about whether or not applicants have the ability to perform their past work or any work that exists in the national economy. VA's results could yield updates to the average loss in earning capacity resulting from service-connected injuries and conditions.

More fundamentally, SSA and VA could consider the impact that scientific advances and labor market changes have on the programs' basic orientation. Whereas programs currently are grounded in assessing and providing benefits based on incapacities, fully incorporating the scientific and labor market issues we highlight in this report implies that agencies would assess individuals with physical and mental conditions under corrected conditions for employment in an economy increasingly different from that which existed when these programs were first designed. Factoring medical and technological advances more fully into the DI, SSI, and VA programs implies that some if not many applicants would receive up-front assistance—including help in finding and maintaining employment—to help agencies evaluate individuals under their fullest potential to work. In fact, the types of beneficiaries who currently might have benefited from such assistance but have not received either timely medical or vocational assistance (for example, DI beneficiaries during the 24-month wait period for Medicare benefits) could get a package of up-front service under a new approach. Moreover, reorienting programs in this direction is consistent with increased expectations of people with disabilities and the integration of people with disabilities into the workplace, as reflected in the Americans with Disabilities Act. However, for people with disabilities who do not have a realistic or practical work option, long-term cash support is likely the best option.

In reexamining the fundamental concepts underlying the design of the DI, SSI, and VA programs, approaches used by other disability programs may offer some valuable insights. For example, our prior review of three private disability insurers shows that they have fundamentally reoriented

their disability systems toward building the productive capacities of people with disabilities, while not jeopardizing the availability of cash benefits for people who are not able to return to the labor force.²² These systems have accomplished this reorientation while using a definition of disability that is similar to that used by SSA's disability programs.²³ However, it is too early to fully measure the effect of these changes. In these private disability systems, the disability eligibility assessment process evaluates a person's potential to work and assists those with work potential to return to the labor force. This process of identifying and providing services intended to enhance a person's productive capacity occurs early after disability onset and continues periodically throughout the duration of the claim. In contrast, SSA's eligibility assessment process encourages applicants to concentrate on their incapacities, and return-to-work assistance occurs, if at all, only after an often lengthy process of determining eligibility for benefits. SSA's process focuses on deciding who is impaired sufficiently to be eligible for cash payments, rather than on identifying and providing the services and supports necessary for making a transition to work for those who can. While cash payments are important to individuals, the advances and changes discussed in this report suggest the option to shift the disability programs' priorities to focus more on work.

We recognize that re-examining the programs at the broader level raises a number of significant policy issues, including the following:

- **Program design and benefits offered.** Agencies would need to consider the impact on program design, including fundamental issues of basic eligibility structure and benefits and services provided. Would the definition of disability change? To what extent would programs

²² U.S. General Accounting Office, *SSA Disability: Other Programs May Provide Lessons for Improving Return-to-Work Efforts*, GAO-01-153 (Washington, D.C.: Jan. 12, 2001). This report also addresses the reorientation of the social insurance systems of Sweden and The Netherlands toward a return-to-work focus. In addition, this report addresses the German social insurance system, which has had a long-standing focus on the goal of rehabilitation before pension.

²³ In general, for the three private insurers that we studied, claimants are initially considered eligible for disability benefits when, because of injury or sickness, they are limited in performing the essential duties of their own occupation and they earn less than 60 to 80 percent of their predisability earnings, depending upon the particular insurer. After 2 years, this definition generally shifts from an inability to perform one's own occupation to an inability to perform any occupation for which the claimant is qualified by education, training, or experience. It is this latter definition that is most comparable to the definition used by SSA.

require some beneficiaries to accept assistance to enhance work capacities as a precondition for benefits versus relying upon work incentives, time-limited benefits, or other means to encourage individuals to maximize their capacity to work? Would persons whose work potential is significantly increased due to medical and technological assistance receive the same cash benefits that are currently provided? Would criteria need to be established to identify persons whose severity presumes a basis for permanent cash benefits? Would program recipients with earned income above a certain level still be eligible for no-cost assistance or do they begin to help pay for the support? To change program design, what can be done through the regulatory process and what requires legislative action?

- **Accessibility.** Agencies would need to address the accessibility of medical and technological advances for program beneficiaries. Are new mechanisms needed to provide sufficient access to needed services? In the case of DI and SSI, what is the impact on the ties with the Medicare and Medicaid programs? For VA, accessibility issues may not be as critical because of existing links to health and vocational rehabilitation benefits provided by VA.
- **Cost.** Agencies would need to address cost implications, including the issue of who will pay for the medical and assistive technologies (will beneficiaries be required to defray costs?). For example, would the cost of providing treatment and assistive technologies in the disability programs be higher than cash expenditures paid over the long-term? The cost to provide medical and technological treatment could be quite high for some program recipients, although much less for others. Moreover, net costs would need to be considered, as some expenditures could be offset with cost savings by paying reduced benefits.
- **Integration with other program components.** Agencies would need to address how to integrate a new emphasis on medical and technological assistance when making disability determinations with the health care and vocational assistance already currently available to program beneficiaries. Notably, VA's program components of cash assistance, vocational rehabilitation, and medical care may uniquely position the agency to develop an integrated model and evaluate the results. During our work, VA officials pointed out that vocational rehabilitation services are already available to veterans to help them return to work and that such services include incorporating the advances and changes addressed in this report. Yet, the restorative benefits of medical, technological, or vocational interventions are not

considered when VA makes an initial assessment of the economic losses that result from a condition or injury. With a limited amount of program funding, integrating these program components may help VA to equitably distribute program funds among veterans with disabilities.

Agencies' research efforts could help address these broader policy issues. In fact, SSA is beginning to conduct a number of studies that recognize that medical advances and social changes require the disability programs to evolve. SSA's 2002 annual performance plan contains a strategic objective to promote policy change based on research, evaluation, and analysis. SSA has funded a project to design a study that would assess the extent to which the *Medical Listings* are a valid measure of disability, and began work to design a study for SSA to identify the most salient job demands in comparison to applicants' residual functional capacity. Additionally, SSA is sponsoring the National Study of Health and Activity, a project intended to enable SSA to estimate how many adults live in the United States who meet the definition of disability used by SSA and to better understand the relationship between disability, work, health care, and community. Also, SSA has funded a study to examine the impact and cost of assistive technology on employment of persons with spinal cord injuries and the associated costs. Finally, SSA had planned to conduct a demonstration project to determine the impact of medicine and therapy on beneficiaries with mood disorders such as major depressive disorder and bipolar disorder in returning them to work. The project was partly in response to evidence found by SSA that some beneficiaries with mood disorders had not received promising treatment. SSA has placed the project on hold while it reconsiders the purpose of the project.

Such research projects could provide important insight into ways that medical and technological advances can help persons with disabilities work and live independently. The research could also begin to provide important information about the cost and outcomes of program changes that bring up-front help to individuals receiving or applying for disability benefits. Nevertheless, individually, these studies do not directly or systematically address many of the implications of factoring in medical advances and assistive technologies more fully into the DI and SSI programs.

Conclusions

Given the large size of the DI, SSI, and VA programs, it is incumbent that they remain current with medical advances and the changes in the demands and opportunities in the world of work. Updating disability criteria within existing program structures is prudent, not only as a means

to best ensure program integrity, but also for agencies to meet their fiduciary responsibilities for public funds. We recognize the challenge to updating disability criteria. Yet we have concerns that while agencies are making some progress, their commitment to this effort appears to be inconsistent with the stakes involved: medical updates have been slow and there are few written strategies for performing timely updates in the years ahead. Moreover, these agencies have done little to better take into consideration the implications of labor force changes on the ability of persons with disabilities to earn a living. To the extent that SSA and VA do not update criteria used to reach disability decisions, they cannot ensure their disability decisions are valid.

Updating the disability criteria within the context of current program design will not fully capture the work-enhancing opportunities afforded by recent scientific advances and labor market changes. That is, current program design does not assess individuals under corrected conditions. To fully capture these advances and changes, policymakers would need to comprehensively re-examine some fundamental aspects of the DI, SSI, and VA programs, including the type, timing, and conditions of providing assistance to persons with physical and mental conditions. Such an examination is a complex but increasingly important undertaking. Indeed, Congress' approach to these issues could be quite different given the unique characteristics of each program. But nevertheless, without a comprehensive analysis about alternatives and their impacts, it is likely that little progress will be made.

Recommendations for Executive Action

To further advance the discussion of issues raised in this report, we recommend that the Commissioner of Social Security take the following actions:

- Use SSA's annual performance plan to delineate strategies for and progress in periodically updating the *Medical Listings* and labor market data used in its disability determination process.
- Study and report to Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on the DI and SSI programs' eligibility criteria and benefit package. The analysis should estimate the effects on the size, cost, and management of these and other relevant programs and identify the legislative action, if any, necessary to initiate and fund such change.

To further advance the discussion of issues raised in this report, we recommend that the Secretary of Veterans Affairs take the following actions:

- Use VA's annual performance plan to delineate strategies for and progress in periodically updating the *Schedule for Rating Disabilities* and labor market data used in its disability determination process.
- Study and report to Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on the VA disability programs' eligibility criteria and benefit package. The analysis should estimate the effects on the size, cost, and management of the program and other relevant VA programs and identify the legislative action, if any, necessary to initiate and fund such change.

Agency Comments and Our Response

We sent a draft of this report to SSA, VA, and the Department of Labor for comments. SSA and VA submitted comments to us, which are reproduced, respectively, in appendixes I and II. Our responses to their comments appear below. In addition, technical comments and clarifications from these two agencies were incorporated as appropriate.

SSA's Comments and Our Response

SSA concurred with our recommendation to use its annual performance plan to delineate strategies for, and progress in, periodically updating the *Medical Listings* and labor market data used in its disability determination process, and it cited the strategic objective in its 2003 performance plan to promote policy changes that take account of changing needs based on medical, technological, demographic, job market, and societal trends. However, the performance goals associated with this objective do not refer specifically to updating either the *Listings* or labor market data. We believe such specific measurable goals are needed in light of the many years that have passed since DI and SSI disability criteria have been fully updated.

In addition, SSA provided several other comments on our findings concerning the agency's efforts to update the disability criteria. First, SSA mentioned it is unable to determine why our report concludes that the DI and SSI updates do not reflect medical advances, citing their published commitment to do so and our recognition in the report of the agency's efforts to incorporate some medical updates into the *Listings*. We do not dispute SSA's contention, which is similar to a point also made by VA, that the agency considers the effects of treatment, medication, and assistive technologies in some if not many updates to the *Listings*. However, the issues we raise are at a more fundamental level. Our report specifically

states that, under the statutory and regulatory design of these programs, SSA does not automatically evaluate individuals applying for benefits under corrected conditions. Thus, it is our belief that the programs themselves have not been fully updated to reflect scientific advances, because interventions that could enhance individuals' productive capacities are not, by design, factored into the disability decision-making process. Second, SSA commented that the DOT, even though it has not been revised since 1991, remains the most complete and up-to-date source of comprehensive occupational information. While characterizing the database in this manner may be technically accurate, the database was generally recognized as outdated by SSA and Labor officials we interviewed, and we note that Labor does not plan to update the database. Similarly, SSA commented that creating a new database on jobs in today's economy for DI and SSI decision making is only one alternative (and, as SSA notes, an unlikely and undesirable one). In our view, absent a significant change in the decision-making process, SSA has only a few options: it will need to either modify the database that Labor developed to replace the DOT, modify the DOT, or develop a new database. Each option could require substantial effort, and regardless of which approach the agency selects, it will need to update the job-related information it uses.

Regarding our recommendation that SSA study and report to Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on DI and SSI's eligibility criteria and benefit package, SSA again states that it already considers in its *Listings* the effect that new medical treatment and assistive technologies would have on these two disability programs. Moreover, it states, the agency is not reluctant to promulgate regulatory changes or to suggest any legislative changes it considers appropriate as the need for change arises. We do not agree that SSA currently meets our recommendation. Our recommendation underscores the need to move beyond updating the disability decision-making process within the existing program design. Instead, SSA needs to make a more systematic study of options that would maximize an individual's work potential by focusing on early and appropriate supports and interventions that take advantage of the advances and changes we identify in this report. As we note in the report, SSA has several research studies that could provide useful information in consideration of the larger design issues. Yet these studies do not directly or systematically address many of the implications of factoring in medical advances and assistive technologies more fully into the DI and SSI programs. The agency needs to lay out a master plan to systematically explore these larger policy and design issues.

VA's Comments and Our Response

VA did not concur with our recommendation to use its annual performance plan to delineate strategies for and progress of periodically updating the *Schedule for Rating Disabilities* and labor market data used in its disability determination process. VA stated that developing timetables for future updates to the *Schedule for Rating Disabilities* is inappropriate while its initial review is ongoing. We continue to believe that VA needs to include measurable goals about how and when it will complete the current round of medically-focused updates as well as future updates. VA should incorporate this information into its plan because portions of the *Schedule for Rating Disabilities* still remain to be updated and the agency has taken years to update individual body systems. In addition, VA should now begin to develop strategies for the next round of updates because portions of the *Schedule for Rating Disabilities* updated during the current round were completed about 8 years ago and were based on expert input collected about 12 years ago. As such, it is important to begin planning for the next cycle of review. VA's annual performance plan can help the agency hold itself accountable for ensuring that disability ratings are based on current information.

VA also did not concur with our recommendation to use its annual performance plan to discuss strategies and progress on updating the *Schedule for Rating Disabilities* because the agency does not plan to initiate an economic validation study or a revision of the *Schedule for Rating Disabilities* based on economic factors. The agency stated that prior attempts to change the *Schedule for Rating Disabilities* by conducting an economic validation were met with dissatisfaction among Congress, the veteran community, and VA. Moreover, VA noted that it believes the *Schedule for Rating Disabilities* is medically based; represents a consensus among Congress, VA and the veteran community; and has been a valid basis for equitably compensating America's veterans for many years. We do not disagree that validating the *Schedule for Rating Disabilities* could lead to significant if not controversial changes, and the *Schedule for Rating Disabilities* does have a medical component and has been used as a basis for disability compensation for years. However, our analysis of the extent to which the VA—as well as DI and SSI—disability criteria were updated was grounded in the current law that authorizes this program. The law states that veterans are entitled to compensation for the average reduction in earning capacity for injuries incurred or aggravated while in service. Because earning capacity is clearly linked to the types and demands of jobs in the economy, and given that the economy has changed over time, updating the *Schedule for Rating Disabilities* based on labor market changes is sound administrative policy. Moreover, the concept of disability has changed significantly since the economic data assumptions in the *Schedule for Rating Disabilities* were

last updated in 1945, further supporting the need to keep current with workforce requirements and opportunities.

In addition, VA did not agree with our finding that VA disability criteria have not been fully updated based on medical advances, noting that disabilities are commonly evaluated based on disabling effects while on treatment. We do not dispute VA's contention that it recognizes the effects of treatment, medication, and assistive technologies that have been received by veterans in some, if not many, of its disability ratings. Much like our response to a similar comment made by SSA, our conclusion is based on the overall design of the program rather than on whether specific ratings have been updated to reflect treatment options. VA does not automatically evaluate a veteran's average reduction in earning capacity under corrected conditions when making a decision about benefit eligibility and as such, a veteran not receiving a medical intervention or assistive technology that could increase work capacity is not evaluated according to his or her potential or actual capacity to work. Again, although VA's current approach is consistent with program design, it also downplays the role that medical and technological advances can play in helping enhance work capacity. Consequently, we conclude that the program is not fully aligned with medical and technological advances.

Finally, VA did not concur with our recommendation that it study and report to Congress the effect that such a comprehensive consideration of medical treatment and assistive technologies would have on the program. VA believes moving in this direction would present a radical change from the current program, and the agency raised questions about whether Congress and the veteran community would support the idea. We believe that our society is very different from the times when VA and SSA disability programs were first designed. In addition to scientific advances and economic changes, expectations for people with disabilities are different. We believe more information is needed about the effects of a fuller consideration of these advances and changes on the program. VA should systematically study the implications of such changes and provide the results to Congress to facilitate future decision making.

Copies of this report are being sent to appropriate congressional committees and other interested parties. The report is also available at no charge on the GAO Web site at <http://www.gao.gov>. If you have any

questions about this report, please contact me at (202) 512-9889. Other contacts and staff acknowledgments are listed in appendix IV.

A handwritten signature in black ink that reads "Robert Robertson". The signature is written in a cursive style with a large, prominent initial "R".

Robert E. Robertson, Director
Education, Workforce, and
Income Security Issues

Appendix I: Comments from the Social Security Administration

Note: GAO incorporated technical comments, as appropriate.



SOCIAL SECURITY

Office of the Commissioner

June 26, 2002

Mr. Robert E. Robertson
Director, Education, Workforce and
Income Security Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Robertson:

Thank you for the opportunity to review and comment on the draft report, "Social Security Administration and Veteran's Administration Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity" (GAO-02-597). Our comments on the report are enclosed. If you have any questions, please have your staff contact Trudy Williams at (410) 965-0380.

Sincerely,


Anne B. Barnhart
Commissioner

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE MD 21235-0001

COMMENTS OF THE SOCIAL SECURITY ADMINISTRATION (SSA) ON THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT, "SOCIAL SECURITY ADMINISTRATION AND VETERAN'S ADMINISTRATION PROGRAMS: RE-EXAMINATION OF DISABILITY CRITERIA NEEDED TO HELP ENSURE PROGRAM INTEGRITY" (GAO-02-597)

Recommendation 1

SSA should use its annual performance plan to delineate strategies for and progress in periodically updating the Medical Listings and labor market data used in its disability determination process.

Comment

We concur. One of the 23 Supporting Strategic Objectives in SSA's FY 2003 Annual Performance Plan is to "Promote policy changes, based on research, evaluation and analysis, that shape the disability program in a manner that increases self-sufficiency and takes account of changing needs, based on medical, technological, demographic, job market, and societal trends."

Recommendation 2

SSA should study and report to Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on the disability (DI) and supplemental security income (SSI) programs' eligibility criteria and benefit package. The analysis should estimate the effects on the size, cost, and management of these and other relevant programs and identify the legislative action, if any, necessary to initiate and fund such change.

Comment

We believe that SSA already considers the effect that new medical treatment and assistive technologies would have on the disability programs we administer. As the need for change arises, we are not reluctant to promulgate regulatory changes or to suggest any legislative changes we think appropriate. This can continue to be accomplished without the requirement of a formal study and report to Congress.

Other Comments

In several places, the draft report discusses how SSA's disability program rules consider or fail to consider medical advances, assistive technology and medical treatment. The report, on page 14, paragraph 1, sentences 5-7, states, "Nevertheless, the statutory design of these programs limits the role of treatment in deciding who is disabled. Therefore, treatment advances by definition, have not been folded into the updates. Moreover, because of the statutory design of these programs, the role of assistive technologies is not recognized in making disability decisions. Consequently, the updates have not fully incorporated innovations in this field, such as advanced

Now on pp. 14 and 15.

prosthetics and wheelchair designs.” The revisions to the listings do reflect advancements in medical knowledge and treatment, including engineering advances and prosthetics. In a recent update to the listings SSA stated, “...we are committed to ensuring that the listings for the musculoskeletal body system continue to reflect appropriate advances in medical knowledge, treatment and methods of evaluating musculoskeletal impairments.” (See 66 Fed.Reg. 58010 (2001).) SSA also stated in the update that, “Engineering advances have produced prosthetic devices which minimize ...so that some individuals wearing artificial limbs ...are able to work.” (See 66 Fed.Reg. 58018.)

As noted elsewhere in the draft, the disability program design limits the extent to which SSA might assess an applicant on the basis of anticipated benefits from medical treatment that has not been prescribed by the individual's treatment source(s), and that the individual has not undergone. However, program updates (i.e., revisions to the *Listing of Impairments*) do reflect advances in medical treatment. That is one of the most important reasons we periodically update these criteria. Further, program rules require that we consider any benefits that individuals have received from medical treatment when making our disability determinations.

SSA has not been able to update all sections of the *Listing of Impairments* as quickly as we would like. Consequently, some sections of the *Listings* do not fully reflect more recent medical advances. However, treatment advances have been folded into these updates. We note that, on page 20, the draft report acknowledges that SSA has informed GAO that its program updates reflect medical advances in treatment and that GAO has found examples in SSA's publications in the *Federal Register* of this occurring. In addition, the report states that GAO's study did not allow it to determine the extent of our efforts to incorporate medical advances. Consequently, we are unable to determine why the report concludes that our program updates do not reflect medical advances.

While the report does mention some of the research that is designed to address the policy issues raised by the report, some equally important research efforts, in particular the Disability Research Institute's (DRI) work on job demands, are not addressed. The ongoing DRI project is designed to develop a way for SSA to study the most salient job demands in comparison to applicants' residual functional capacity. Additionally, the planned demonstration project on early intervention is directly relevant to the policy implication mentioned on page 25, sentence 2, which reads, “Factoring medical and technological advances more fully into the DI, SSI, and VA programs implies that some if not many applicants would receive up-front assistance—including help in finding and maintaining employment—to help agencies evaluate individuals under their fullest potential to work.”

Technical Comments

On page 1, the letter to the Commissioner states that 11.3 million are served by DI, SSI and VA. However, this figure includes substantial overlap in these programs and thus overstates the number served.

Now on p. 22.

Now on p. 26.

On page 4, the first sentence in the “Background” section says “The DI, SSI, and VA programs...that differ in their underlying intent, populations they serve, and the specific approach they use to assess disability.” This statement is not accurate since DI and SSI do not differ in their approach to assessing disability.

On pages 4 and 5, payment levels cited are referred to as calendar year when they are actually fiscal year values.

On page 9, in the first sentence, the word "substantial" should be inserted before "gainful work."

Page 9, sentence 2 of the report states, “However, the statutes also allow beneficiaries to use a payment voucher—referred to as a ticket—to obtain free employment services, vocational rehabilitation services, or other services to find employment.” We believe that the use of the term “voucher” is inappropriate. We recommend that this sentence be revised to read, “However, the statute also provides that the Commissioner may provide a “ticket” to beneficiaries that they may use to obtain vocational rehabilitation, employment or other support services from an approved Employment Network (EN) or State Vocational Rehabilitation agency (VR agency) of their choice.”

On page 22, regarding SSA’s use of the Department of Labor’s (DOL) Dictionary of Occupational Titles (DOT): although it has not been revised since 1991, the DOT remains the most complete and up-to-date source of comprehensive occupational information. As the report goes on to say, the O*NET cannot be used in its current form in the DI and SSI disability determination process. Even when fully populated with updated data, O*NET will not meet SSA’s occupational data needs.

On page 23, in the first paragraph, sentence four states, “SSA officials have indicated that an entirely new occupational database could be needed to meet SSA’s needs, but such an effort could take many years to develop, validate, and implement.” Although this statement is technically correct, that is only one possible scenario—and an unlikely and undesirable one. Neither SSA nor DOL expect that to be necessary, and we are working together to meet SSA’s occupational data needs within the context of DOL’s occupational data systems.

Now on p. 8.

Now on p. 24.

Now on p. 24.

Appendix II: Comments from the Department of Veterans Affairs

Note: GAO comments supplementing those in the report text appear at the end of this appendix.



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 24, 2002

Mr. Robert E. Robertson
Director, Education, Workforce,
and Income Security Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Robertson:

The Department of Veterans Affairs (VA) has reviewed your draft report, **SSA AND VA DISABILITY PROGRAMS: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity** (GAO-02-597). VA does not agree with GAO's recommended approach to revising the method for disability determinations. The medically based Schedule for Rating Disabilities represents an equitable method for determining compensation and pension ratings. Indeed, VA is systematically updating the body systems contained in the Schedule to reflect advances in medicine.

The enclosure discusses in detail VA's nonconcurrency with GAO's recommendations.

Sincerely yours,

A handwritten signature in cursive script that reads "Anthony J. Principi".

Anthony J. Principi

Enclosure

Enclosure

THE DEPARTMENT OF VETERANS AFFAIRS
COMMENTS TO GAO DRAFT REPORT
SSA AND VA DISABILITY PROGRAMS:
***Re-Examination of Disability Criteria Needed to Help
Ensure Program Integrity***
(GAO-02-597)

GAO recommends that to further advance the discussion of issues raised in this report, the Secretary of Veterans Affairs take the following actions:

- **Use VA's annual performance plan to delineate strategies for and progress in periodically updating the *Schedule for Rating Disabilities* and labor market data used in its disability determination process.**

Do not concur - VA does not plan to initiate an economic validation study or a revision of the rating schedule based on economic factors. In 1973, VA conducted an Economic Validation of the Rating Schedule (ECVARS), but no changes were adopted because of widespread dissatisfaction in Congress, the veteran community, and VA.

This recommendation is very similar to the major point in a former GAO report titled ***VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses*** (GAO/HEHS-97-9, dated January 7, 1997). VA reiterates its position on that report by stating (a) the Schedule for Rating Disabilities from its beginnings in the early 20th Century has been medically based, as are all other major disability compensation systems; (b) the Schedule represents a consensus among Congress, VA, and the veteran community; and (c) the current medically-based schedule has been a valid basis for equitably compensating America's disabled veterans for so long, and VA sees no reason to validate the ratings solely from an economic perspective.

The study of the President's Commission on Veterans' Pensions (the Bradley Commission), referenced by GAO in its 1997 report, concluded that the basic purpose of disability compensation for VA was not to strictly adhere to the basic standard of assigning percentages based on average impairment of earning capacity. Furthermore, VA's standard has been primarily a physical disability standard that also takes into consideration pain, suffering, shortening of life, disfigurement, and social inconvenience. The report also states that on the whole, veterans' compensation tends to result in average wage losses of those who are disabled being made up through compensation.

See comment 1.

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(Continued)

At meetings during the course of this audit, VA reported that the Department intends to update each portion of the Schedule for Rating Disabilities as soon as a comprehensive review is completed. VA does not believe it is appropriate to develop a firm timetable for future changes while the initial review is ongoing.

- **Study and report to Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on the VA disability programs' eligibility criteria and benefit package. The analysis should estimate the effects on the size, cost, and management of the program and other relevant VA programs and identify the legislative action, if any, necessary to initiate and fund such change.**

Do not concur - The proposed concept would present a radical change from VA's current program. This recommendation presumes that VA, Congress, and the veteran community would all be supportive of the idea that in order to receive full benefits, veterans should be required to take full advantage of the range of modern medical treatment and assistive devices available through the Veterans Health Administration.

The recommendation erroneously takes for granted that disabled veterans do not currently receive such treatment and assistance. Many of VA's treatment and rehabilitation programs (for example, post-traumatic stress disorder treatment programs and spinal injury treatment and rehabilitation programs) are among the highest rated in the world.

See comment 2.

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THE DEPARTMENT OF VETERANS AFFAIRS
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(GAO-02-597)
(Continued)

General Comments

Now on p. 25.

GAO's report states that a valid study of labor market data should be done as a basis for updating the Schedule for Rating Disabilities. (page 24)

See comment 3.

- VA is not at all confident that such a study is feasible or would be useful. For example, the National Research Council completed a study for the Social Security Administration earlier this year titled, "Visual Impairments: Determining Eligibility for Social Security Benefits." One conclusion of the study was that it is not possible to establish a relationship between visual function and employment. While visual function is clearly measurable, the inability to establish a relationship between it and employment only underscores the difficulty in establishing a relationship for more complex conditions based on subjective and objective findings.
- Clearly, it is not an easy task to determine how disease and injury affect the ability to work. Therefore, the major disability compensation systems in the world have settled on medical impairments as the basis of their determinations.
- Finally, it is not clear from the report that GAO understands that the great majority of disabled veterans are working, including a number who are evaluated at 100 percent. The term "disability" for VA purposes encompasses all gradations of impairment from slight to total. Many who are fully employed suffer the effects of their disability in various ways, some subtle and some obvious. There may, for example, be pain, anxiety, fatigue, weakness, or nausea that does not prevent employment but that would certainly make it more difficult to work. Therefore, fully employed veterans may deserve compensation based on a medical impairment even if the effects on employment are not obvious and are hard to measure.

See comment 4.

The GAO report generalizes that the updated criteria have not fully captured the benefits afforded by advances in treatment and that the current program design does not assess individuals under corrected conditions. It specifically states that

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THE DEPARTMENT OF VETERANS AFFAIRS
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(GAO-02-597)
(Continued)

the effects that medication to control severe mental illness may have on an applicant's ability to work are not automatically factored into decision making. The report asks to what extent would programs require some beneficiaries to accept assistance as a precondition for benefits.

See comment 5.

- GAO's statement is not borne out by the facts. A thorough study of the Schedule for Rating Disabilities and its application would reveal that disabilities are commonly evaluated based on disabling effects while on treatment. For example, there is an extensive section on evaluating joints after replacements (although this section has not yet been updated), and VA evaluates heart disease after coronary artery bypass; peripheral vascular disease after arterial bypass or grafting; renal, liver, and heart disease after transplant; Hodgkin's disease following treatment; and diabetes mellitus and hypertension while on treatment. Of the approximately 147,000 veterans service-connected for hypertension, for example, over 90 percent are evaluated at zero or 10 percent indicating that they are being treated effectively, are taking their medication, and have been evaluated taking into account the benefits of treatment. Without treatment, their disability ratings would be much higher.
- In reference to mental disorders, if GAO means that VA does not speculate in its ratings on what the possible effectiveness of full treatment might be, that is certainly correct. No one can be sure whether a particular mental disorder (or other types of disorders) will respond even to optimal treatment. However, the evaluation criteria take into account all beneficial effects of medications that a veteran may take. A rating is assigned based not on a diagnosis but on the actual effects of a mental disorder on social and occupational impairment. Ratings reflect that better functioning veterans receive less compensation.

See comment 6.

The report states that VA may be providing benefits to some who have little, if any, reduced earning capacity and may be denying or undercompensating other individuals whose condition severely reduces earning capacity.

- This sweeping statement is without a specific example of either situation. Furthermore, this assessment reverts to the concept of individual assessment based on an individual's particular disability and job. In 1933, VA abandoned the occupational variant concept and returned to the original so-called

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(Continued)

"average man" concept of evaluation that is still in use, and which is a reflection of 38 U.S.C. 1155.

Further, the report states that the law does not specifically require VA to conduct reviews of disability determinations, as SSA does. This is correct. Review examinations are ordinarily scheduled only when a condition has been shown to be unstable or is expected to improve or is only minimally disabling. Conducting additional examinations in cases that do not meet these criteria would be a waste of resources and would be unlikely to result in substantial savings.

The report implies that veterans are not receiving nor taking advantage of optimal modern treatment but offers no supporting evidence. It also suggests that benefits should be linked to the acceptance of treatment.

- Service-connected veterans are offered free treatment at VA medical facilities if they receive greater than a zero-percent evaluation. The more than four million veterans, both service-connected and nonservice-connected, seen annually in VA's medical system indicates large numbers already take advantage of this treatment.
- Many people with mental disorders, for example, both veterans and non-veterans, do not take their medications regularly. To some extent, this may occur because of the effects of the mental disorder itself. Withholding or decreasing compensation in the case of veterans who are already mentally disabled but fail to take their medication is a punitive concept not in keeping with VA's mission.

See comment 2.

GAO Comments

1. VA cites the 1955 President's Commission on Veterans' Pensions (commonly called the Bradley Commission) as support that VA's disability ratings represent noneconomic factors, such as pain and suffering, in addition to average loss of earnings. However, as we reported in 1997,¹ "the Commission's overall recommendation with regard to the *Schedule* was that it should be revised thoroughly on the basis of factual data to ensure that it reflects veterans' average reduction in earning capacity, as required by law. The Commission stated that the basic purpose of the program is economic maintenance and, therefore, it is appropriate to compare periodically the average earnings of the working population and the earnings of disabled veterans..." Even if the ratings are intended to reflect noneconomic factors, this does not negate the need for updating the schedule due to changes in the labor market. The extent to which, if at all, disability compensation reflects noneconomic factors is a policy issue which lies beyond the scope of this report.
2. We recognize that veterans who are paid disability benefits can also be receiving various types of treatment and assistance. Our recommendation reflects the need for more information on the implications of integrating the effects of treatment and assistance into the disability determination process, including the process to determine (1) the impact of physical and mental conditions on earnings and (2) the appropriate type and timing of benefits—such as cash, medical, and vocational assistance—to minimize the reduction of earnings associated with the disabilities.
3. We recognize that the link between medical impairments and the ability to work is complex and difficult to measure and can be affected by other factors like social support and individual motivation. Yet the VA program, by legislative design, compensates for loss in earning capacity that results from injuries or medical conditions. Thus, we believe, it is important to maintain good data on the skills and demands in the labor market to provide the best estimate of loss in earning capacity that is reasonably associated with particular injuries and conditions. In our 1997 report, we lay out options for the design and methodology for estimating loss in earnings among veterans with disabilities.² But VA's comment underscores the larger point we are making: Past assumptions that underlie these programs are

¹ See [GAO/HEHS-97-9](#), p.15.

² See [GAO/HEHS-97-9](#).

increasingly outmoded as the confluence of scientific, economic, and social forces are redefining the relationship between impairments and abilities. Additional information on how programs can take advantage of this change will help Congress make better-informed decisions on disability policy.

4. We recognize that veterans can work and still receive disability compensation benefits. In fact, at the beginning of fiscal year 2002, two-thirds of veterans had a rating at 30 percent or less, implying that many veterans receiving disability compensation are working. Moreover, we recognize that VA's use of an "average" reduction in earnings capacity implies that some veterans rated at 100 percent are employed, including those without an actual reduction in earnings. See comment 1 for our response to VA's point that benefits may be partially compensated on noneconomic factors.
5. See the third paragraph of our response to VA comments in the body of the letter (p. 33).
6. As we report in 1997, VA conducted the Economic Validation of the Rating Schedule (ECVARS) in the 1960s in response to the Bradley Commission recommendations and recurring criticisms that ratings in the schedule were not accurate. This study was designed to estimate the average loss in earning capacity among disabled veterans by calculating the difference between the earnings of disabled veterans, by condition, and the earnings of nondisabled veterans, controlling for age, education, and region of residence. On the basis of the results, VA concluded that of the approximately 700 diagnostic codes reviewed, the ratings for 330 overestimated veterans' average loss in earnings due to their conditions, and about 75 underestimated the average loss among veterans.

Appendix III: Five-Step Sequential Evaluation Process for Determining DI and SSI Eligibility

To determine whether an applicant qualifies for DI or SSI disability benefits, SSA uses a five-step sequential evaluation process. In the first step, an SSA field office determines if an applicant is working at the level of substantial gainful activity and whether he or she meets the applicable nonmedical eligibility requirements (for example, residency, citizenship, Social Security insured status for DI, and income and resources for SSI). An applicant who is found to be not working or working but earning less than the substantial gainful activity level (minus allowable exclusions), and who meets the nonmedical eligibility requirements, has his or her case forwarded to a state Disability Determination Service (DDS) office. Applicants who do not meet these requirements, regardless of medical condition, are denied benefits. DDS offices gather medical, vocational, and other necessary evidence to determine if applicants are disabled under the Social Security law.

In step two, the DDS office determines if the applicant has an impairment or combination of impairments that is severe and could be expected to last at least 12 months. According to SSA standards, a severe impairment is one that significantly limits an applicant's ability to do "basic work activities," such as standing, walking, speaking, understanding, and carrying out simple instructions; using judgment; responding appropriately to supervision; and dealing with change. The DDS office collects all necessary medical evidence, either from those who have treated the applicant or, if that information is insufficient, from an examination conducted by an independent source. Applicants with severe impairments that are expected to last at least 12 months proceed to the third step in the disability determination process; applicants without such impairments are denied benefits.

At step three, the DDS office compares the applicant's condition with the Listing of Impairments (the *Medical Listings*) developed by SSA. The *Medical Listings* describe medical conditions that, according to SSA, are severe enough ordinarily to prevent an individual from engaging in substantial gainful activity. An applicant whose impairment is cited in the *Medical Listings* or whose impairment is equally as severe or more severe than those impairments in the *Medical Listings* and who is not engaging in substantial gainful activity is found to be disabled and awarded benefits. An applicant whose impairment is not cited in the *Medical Listings* or whose impairment is less severe than those cited in the *Medical Listings* is evaluated further to determine whether he or she has vocational limitations that, when combined with the medical impairment(s), prevent work.

In step four, the DDS office uses its physician's assessment of the applicant's residual functional capacity to determine whether the applicant can still perform work he or she has done in the past. For physical impairments, residual functional capacity is expressed in certain demands of work activity (for example, ability to walk, lift, carry, push, pull, and so forth); for mental impairments, residual functional capacity is expressed in psychological terms (for example, whether a person can follow instructions and handle stress). If the DDS office finds that a claimant can perform work done in the past, benefits are denied.

In the fifth and last step, the DDS office determines if an applicant who cannot perform work done in the past can do other work that exists in the national economy.¹ Using SSA guidelines, the DDS considers the applicant's age, education, vocational skills, and residual functional capacity to determine what other work, if any, the applicant can perform. Unless the DDS office concludes that the applicant can perform work that exists in the national economy, benefits are allowed. At any point in the sequential evaluation process, an examiner can deny benefits for reasons relating to insufficient documentation or lack of cooperation by the applicant. Such reasons can include an applicant's failure to (1) provide medical or vocational evidence deemed necessary for a determination by the examiner, (2) submit to a consultative examination that the examiner believes is necessary to provide evidence, or (3) follow a prescribed treatment for an impairment. Benefits are also denied if the applicant asks the DDS to discontinue processing the case.

¹ By definition, work in the national economy must be available in a significant amount in the region where the applicant lives or in several regions of the country. It is inconsequential whether (1) such work exists in the applicant's immediate area, (2) job vacancies exist, or (3) the applicant would actually be hired.

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contacts

Kay E. Brown, Assistant Director (202) 512-3674
Brett S. Fallavollita, Analyst-in-Charge (202) 512-8507

Staff Acknowledgments

The following people also made important contributions to this report:
William A. McKelligott, Barbara W. Alsip, and Daniel A. Schwimer.

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