

Opening Statement of Senator Tom A. Coburn, M.D.

Oversight of Rising Social Security Disability Claims and the Role of Administrative Law Judges

**Subcommittee on Energy Policy, Health Care and Entitlements
Committee on Oversight and Government Reform
United States House of Representatives**

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Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

As a doctor, the issue of providing medical care to the disabled is personal. I have cared for thousands of disabled patients, many of which have received support at one time or another through the Social Security Disability Insurance program. That is why for the past two-and-a-half years my office has undertaken a massive investigation of the program to find its problems and, hopefully, to fix them.

Last September we released a report, which I will detail below, that gave a look into the program few have seen before. In fact, throughout our investigation we were told repeatedly by top SSA officials that our inquiry was “unprecedented” in its scope. They intended this as a criticism, though we accepted it as a compliment. Even still, we were only able to look at part of the program and I applaud this Committee for its work in this area. As the need for reform grows in the coming years, we will all benefit by a thorough understanding of the facts.

When Congress enacted the Social Security Disability Insurance (“SSDI”) program in 1956, the goal was to create a safety net for individuals who, after working for a time, became disabled and could no longer provide for themselves. Today, it has become something much different. Applications are on the rise and the Trust Fund that pays benefits is scheduled for exhausted in just a few years. All the while, Congress has ignored evidence the program is in dire need of modernization and reform.

As a result of Congress failing to act, the program rolls are growing at an unsustainable rate. At the end of 2012, 11 million people were receiving SSDI with beneficiaries receiving a total of \$136.9 billion (up 6.2 percent from 2011) according to the most recent Social Security Trustees Report.¹ In 2012, the need-based disability program Supplement Security Income (“SSI”) paid out over \$44 billion in benefits.² In April 2013, 6.24 million people were receiving SSI disability benefits.³

Not surprisingly, as more people are accepted to the program, more people apply. Just last year alone, the Social Security Administration (“SSA”) received almost three million applications for

¹ The 2013 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.

² Information provided by the Congressional Research Service.

³ Social Security Administration, Supplemental Security Income Recipients, April 2013.

disability benefits.⁴ The agency has to carefully consider each of these claims given each decision to award disability benefits is estimated to cost the taxpayer \$300,000 in federal lifetime benefits.

Given the state and the cost of these programs, it is clear that something has to change.

The Agency Pressures ALJs to Decide a High Number of Cases. The need for reform is most evident at the Administrative Law Judge level (“ALJ”) of appeal. Here, ALJs are under pressure from several forces. First, in 2007, the agency imposed its “Plan to Eliminate the Hearing Backlog,” which asked each ALJ to decide 500 to 700 cases each year. In practice, that means each ALJ is expected to decide two cases a day.

However, a single case file can easily reach 500 pages – with many topping 1,500 pages, which is more than many people can read in a week. The majority of these files are detailed medical records that take time to understand. The notion that every ALJ is expected not only to read two of these each day, but also write detailed, multi-page decisions about them is unrealistic.

While we all want to see disabled applicants dealt with quickly, blindly imposing a quota creates huge problems. Most of all, it removes the ability of ALJs to give claimants the personal attention each deserves, and instead reduces people to statistics.

Agency Rules Give ALJs Incentives to Approve Cases. With the pressure to decide such a high number of cases, SSA makes it easier to approve a case than deny it. While this generates the fewest complaints from Congress and from claimants, it does not always mean the cases are decided *accurately*. An example of how this works is seen in the time SSA gives an ALJ to write a favorable case versus what is required for a denial. The agency has estimated it should only take an ALJ four hours to prepare a decision approving benefits. On the other hand, the agency believes writing a denial should take eight hours. With a 500 case minimum goal, ALJs have incentives to approve a lot of those cases just to keep up with the workload and avoid trouble.

This pressure needs to be counterbalanced at the appeals level by allowing an agency representative into the hearing process. By the time most claimants appeal to an ALJ, they are represented by an attorney or representative. This creates an unbalanced hearing where the claimant is represented, but no one is representing the Government, and in turn, the American taxpayer.

Some attorneys take advantage of the situation and attempt to manipulate ALJs into approving a high number of cases. Many claimant attorneys submit medical evidence created by doctors who they know will find claimants disabled and, at times, withhold medical evidence counter to a finding of disability, such as evidence the claimant’s health is improving. At the same time, attorneys have incentives to keep appealing cases, because the older a case gets, the larger the possible payout for attorneys. Under program rules, attorneys can receive up to \$6,000 out of a claimant’s back-pay, which is larger for older cases.

⁴ Social Security Administration, Selected Data from Social Security’s Disability Program, <http://www.ssa.gov/OACT/STATS/dibStat.html>.

The result is 60 percent of claims, on average, are approved at the ALJ level of appeal. This number is shocking given these claimants have already been denied benefits twice at lower levels in the appellate process. This creates a culture where claimants are encouraged to appeal, since your chances to be approved increase the more your appeal.

Senate Investigation Finds A Quarter of ALJ Decisions Reviewed Were Problematic.

Beginning in 2011, our office undertook a review of 300 case files for claimants approved to receive disability benefits. One hundred each came from separate regions of the country, including 100 from my own state of Oklahoma. We hoped to see if there were things we could learn about how the agency was deciding its cases. In our September 2012 report, we came to a startling conclusion: a quarter of the cases reviewed relied on questionable evidence and practices.

While we did not attempt to determine whether or not those approved for benefits were disabled or not, we felt certain that the agency's decision-making process was deeply flawed. And this was true in all three regions we reviewed. The problems we uncovered included:

- *Attorney Procured Medical Opinions.* Some ALJs awarded benefits based solely on a doctor's opinion the claimant's attorney purchased. Many attorneys send their claimants to be reviewed by a doctor the attorney knows will provide a disabling medical opinion. A trend we found was for attorneys to send their clients to doctors who would examine them for some form of physical pain, but then add a mental disability as well, such as developmental disorders, depression, bi-polar disorder, etc. Many times the claimant never mentioned a mental problem, but suddenly, they had one.
- *Insufficient and Contradictory Medical Evidence.* In many cases, the ALJ issued a decision approving benefits without citing adequate, objective medical evidence to support the finding or addressing contradictory evidence.
- *Poor Hearing Practices.* Some ALJs held perfunctory hearings lasting less than five minutes where they failed to ask the claimant any questions.
- *Improper Reliance on Medical-Vocational Guidelines.* The majority of claims approved by ALJs utilized the medical-vocational grid rules – a process they refer to as “gridding” – which the agency has determined ALJs use at a rate of 4 to 1 compared to awards made due to medical listings. Often, claimant representatives and ALJs would negotiate an award of benefits by changing the disability onset date to the claimants' 50th or 55th birthday.
- *Late-Breaking Evidence.* Some case files showed disability applicants, usually through their representatives, submitted medical evidence immediately before or on the day of an ALJ hearing or after the hearing's conclusion, a practice leading to confusion about the supporting evidence and inefficiencies in case analysis. In one case a single page of evidence was both created and submitted just hours before an 8:00 a.m hearing, but it became the sole basis for an ALJ awarding benefits.

- *Ignoring Evidence the Claimant is Working.* Some ALJs failed to review the medical file for evidence the claimant is working and should be denied benefits. In a number of cases, the claimant told their physician (who wrote it in their file) they were working, which would make them ineligible for benefits. The ALJ never asked the claimant if they were working at the hearing, or addressed the work in awarding the claimant benefits.

When we presented these findings to the Social Security Administration, they not only agreed with them, but informed us that they had found similar problems. During the course of our investigation SSA conducted its own internal review and found 22 percent of ALJ awards across the country merited further scrutiny. This was nearly identical with our findings that a quarter of ALJ decisions were problematic.

The Disability Programs Are in Dire Need of Reform. It is clear that something has to change to protect this program for disabled Americans who find themselves with no other option. At the ALJ level, the most obvious answer is including a representative for the Government at the ALJ hearing level to explain why the government denied the claimant twice before and create a balanced hearing. Further, including a government representative would make both the claimant and their attorney think twice about pursuing an appeal. Such as reform is supported by both the Social Security Advisory Board and the Association of Administrative Law Judges.

In the past, I have outlined a number of other commonsense reforms to update and modernize the disability programs. I urge Congress to take a hard look at this program. Otherwise, in just a few short years, it will not be available for those Americans who have no other choice but to rely on it.