HEARING ON THE CHALLENGES OF ACHIEVING FAIR AND CONSISTENT DISABILITY DECISIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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WITNESSES

(TRUTH IN TESTIMONY) HEARING ON THE CHALLENGES OF ACHIEVING FAIR AND CONSISTENT DISABILITY DECISIONS

WEDNESDAY, MARCH 20, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:07 a.m., in Room B–318, Rayburn House Office Building, the Honorable Sam Johnson [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

Chairman Johnson Announces Hearing on the Challenges of Achieving Fair and Consistent Disability Decisions

Washington, Mar 13, 2013

U.S. Congressman Sam Johnson (R–TX), Chairman of the House Committee on Ways and Means Subcommittee on Social Security, today announced a hearing on achieving fair and consistent disability decisions. **The hearing will take place on Wednesday, March 20, 2013, in B–318 Rayburn House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Under the Social Security Act, disability is defined as "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." The disability must be so severe that the person is unable to do any "substantial gainful work which exists in the national economy," whether or not a specific job exists or the person would actually be hired. The disability must result from a physical or psychological condition that is "demonstrable by medically acceptable clinical and laboratory diagnostic techniques."

The responsibility for making initial disability decisions is shared by the States and the Social Security Administration (SSA). All 50 States, plus the District of Columbia and Puerto Rico, maintain fully federally-funded agencies, known as Disability Determination Services (DDS), which decide initial and continuing eligibility for benefits. In making the initial determination, DDS examiners review the available medical evidence under a five-step sequential evaluation process.

The independent, bipartisan Social Security Advisory Board has raised concerns as early as its 1998 report, *How SSA's Disability Programs Can Be Improved,* about the complex administrative structure under which the Disability Insurance (DI) program operates, as well as the fact that eligibility is "fundamentally a judgmental process in which different decision makers will frequently have different views." In 2001, the Board issued two reports: *Disability Decision Making: Data and Materials,* and a companion report *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change.* In these reports, the Board raised questions about the fairness and the consistency of the process, noting wide and unexplained variations in outcomes between different regions of the country and different levels of adjudication, as well as major changes in how disability is determined based on court decisions that have not been overturned by Congress.

In February 2012, the Board updated its *Aspects of Disability Decision-Making: Data and Materials,* noting the "longstanding lack of consistency in the disability determination process that may award benefits to individuals who do not meet the SSA disability criteria and deny benefits to individuals who do meet the criteria." The Board stated that the "updated data continue to highlight significant questions about [the] SSA's disability decision-making process and about the disability programs . . . ."

In announcing the hearing, Social Security Subcommittee Chairman Sam Johnson (R–TX) said, **"As we work to secure the future of this vital program, hardworking taxpayers deserve to know that disability decisions are fair, consistent and protected from con artists trying to cheat the program. In the past, Congress expanded the ways people can qualify for benefits. Instead of relying on objective standards to reach decisions, examiners and judges on the front lines have increasingly had to make more judgment calls. Given the advances in medical treatment and rehabilitation, we need to**

fundamentally understand how agency policies may be influencing decisions and determine whether these policies still make sense for the times we live in."

FOCUS OF THE HEARING:

The hearing will examine policies that have expanded the role of subjective evaluations in determining whether applicants qualify for benefits and how these policies may result in unexplained variations in decision-making, weakening public confidence in the consistency and fairness of this national program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, April 3, 2013**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

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Chairman JOHNSON. We are waiting on my compatriot from the other side of the aisle, but I am going to go ahead and get us started, because we are past time. I will call the meeting to order.

And I want to say good morning, and happy first day of spring. We can all smile, can't we, because it has quit snowing, right? Wrong.

[Laughter.]

Chairman JOHNSON. Fairness and consistency are essential to ensuring America's confidence in Social Security's disability insurance program. Their importance has been consistently recognized since the disability program was created in 1956.

As we know, Social Security's definition of who is disabled is a strict one. Whether someone is disabled depends on medical evidence, and whether a severe physical or mental condition, referred to in the program as "impairment," prevents someone from working. But for some conditions, there are also subjective criteria based in statute that affect the way the definition is applied. In these cases, making the final decision on whether an individual is disabled is as much an art as a science.

In the early 1980s, there was a growing public concern about the increasing number of statutorily-required continuing disability reviews that removed thousands of people from the rolls. In response, federal courts all over the country began to step in to stem the tide of benefit terminations by requiring the use of a medical improvement standard in making the decision to terminate benefits. The courts also issued orders requiring the Secretary to apply a particular standard for evaluating disability on a statewide or a circuit-wide basis.

Soon after, Congress passed the Disability Benefit Reform Act of 1984, which added several new criteria that increased the importance of subjective evaluations in deciding whether someone was disabled, and codified the medical improvement standard against which medical reviews would be conducted. According to the Congressional Budget Office, the '84 Act shifted the criteria for disability insurance eligibility from a list of specific impairments to a more general consideration of a person's medical condition and ability to work.

The amendments allowed applicants to qualify for benefits on the basis of the combined effect of the medical condition, each of which alone might not have resulted in a decision that the individual was disabled. The amendments also allowed symptoms of mental illness and pain to be considered, even in the absence of a clear-cut medical diagnosis, and revise mental impairment criteria in the listing of impairments.

It is very clear that our colleagues in the 98th Congress were anxious about Social Security's actions, and the increasing inconsistencies caused by so many different circuit court decisions. Their concern, clearly stated in conference, was to preserve the consistency and uniformity of this national program in the way it served those who were truly disabled. What our colleagues did not foresee was that easing the criteria would contribute to growing the disability insurance rolls, including increasing the number of younger workers on the rolls.

Today, those with mental and musculoskeletal disorders have grown to 60 percent of the rolls, and those assessments are usually based on the more subjective steps of the evaluation process.

The other result of the '84 Act, and one our colleagues clearly did not intend, is the substantial variation among decision-makers in the same offices, the same regions, and at different decision levels. That means two decision-makers can review the case and make a different decision, and yet still be right.

So, I might look at a claimant's file and decide that the person is entitled to benefits. My colleague, Mr. Becerra, could look at the same file and decide the person is not entitled to benefits. And as you will hear today, we could both be right under the Agency's complex policies. If that sounds as though an award of benefits may come down to who is making the decision, you are right. Got to remember, this is the United States Government.

It shouldn't surprise anyone that claimant representatives, those who represent individuals applying for disability have figured this out. The Supreme Court said this system for deciding disability was meant to be simple enough for the average person to understand. Yet, over the last 20 years, individuals applying for disability have gone from being represented 10 percent of the time to over 80 percent of the time.

Most claimant representatives are well-intentioned, and want to do their best. But they are quick to take advantage of confusing and complex policies to try to ensure an award. Their behavior underscores how far this process has moved away from a national program with uniform rules to one that is about who makes the decision. And they have been very successful at it. Last year the representative industry pulled in over $1 billion from back payments of those who need these funds the most.

Another indicator that the rules aren't as hard and fast and consistent as a national program should be is the fact that we have folks who are trying to cheat the system. Close to half the state disability determination services have access to cooperative disability investigating units, who investigate suspicious applications and, as a result of their efforts, stop crooks from getting on the rolls. That leaves examiners in half the country with no way of proving whether their suspicions are right or not. Our Inspector General has been doing a good job with that, by the way.

Social Security can't know the number of people who are receiving benefits who don't deserve them. Yet increasingly, our constituents tell us they know someone who is receiving benefits but shouldn't. That undermines the public's confidence in the program, the Agency, and this body. Further, the bipartisan, independent Social Security Advisory Board has been shining a bright light on these issues since 1998. Since then, they have issued seven reports and several data updates, repeatedly raising concerns about how the program operates and the fairness and consistency of the process.

In a February 2012 report update to aspects of the disability decision-making data and materials, the board states that updated data continue to highlight significant questions about Social Security's disability decision-making process, and about the disability program, listing ongoing inconsistencies in decision-making. The large gap between policy and administrative feasibility, continued use of the outdated dictionary of occupational titles, the definition of disability, and the need for an in-depth assessment of the disability decision-making process among its concerns.

My number one priority in holding these hearings is to make sure we keep this program strong for those who really need it. And that means taking a good and hard look at what may not be working, assessing the options for changes, and taking action.

I want to thank our witnesses for being here today, and I look forward to hearing your testimony later.

Mr. Becerra, you are recognized for five minutes.

Mr. BECERRA. Thank you, Mr. Chairman. The Social Security disability trust fund belongs to the workers who paid into it. So decisions about whether applicants meet the strict criteria for benefits need to be made very carefully and as consistently as possible. This is not always easy. Work-ending disability or illness comes in many different forms, from terminal illness to an accumulation of many physical and mental limitations that worsen with age.

That said, some applicants will always involve close calls: people who are just barely able or just barely unable to work. The challenge is to decide cases as fairly and consistently as possible, but not at the cost of denying earned benefits, simply because certain disabilities, by their nature, are more difficult to assess.

Because of the diversity of applicants, and the challenge of drawing a line between can't work and can work, SSA needs to have the tools and resources necessary to make decisions that are as fair and accurate as possible. This means SSA needs to have clear, specific, and updated policies for disability examiners and ALJs that they can follow in evaluating those who apply for benefits. They need effective training for adjudicators at all levels, so that they can correctly and consistently perform the complex analysis required to make the right decision. Quality control to correct and prevent errors, identify training needs, and useful policy clarifications are also important.

SSA needs the resources necessary to keep its policies up to date, to train its staff, and to ensure quality control. At the same time, because of the inherent challenges of determining whether a worker's impairments are severe enough to render him or her unable to work, we must ensure due process protections for those who are navigating the DI program while sick and unable to work.

As we examine the challenges SSA faces in determining who is eligible, especially in those close-call situations, we should keep in mind that most people who apply to Social Security for these disability benefits are turned down. The eligibility standard is very strict. It doesn't allow for benefits for partial disability or any disability that isn't expected to last for at least a year, or lead to death.

Medical evidence must show that the condition prevents the individual from working at any job in the national economy, not just their previous type of work. As a result, the majority of people who apply for benefits do not qualify. Even after appeals, only about 4 in 10 applicants ever qualify for benefits. It is worth noting that even rejected applicants who don't get disability benefits are very limited in their ability to work.

We take our responsibility to safeguard the Social Security Trust Fund for workers very seriously. We are very concerned about the decision by the House Republican Majority to block the investment in the program integrity system. This is the initiative within SSA that helps weed out the fraud and make sure unnecessary payments are not made to people who really should be working.

By failing to fully fund these Social Security case reviews at the level agreed to in the Budget Control Act of 2011, this House is being penny wise and pound foolish. If the agreed-upon number of reviews had been funded for 2013, it would have saved the taxpayers and the trust fund between $1.6 to $2.4 billion over the next decade.

Mr. Chairman, I want to thank you for calling this hearing. It is a complicated, but important question. In the end, our most important goal must be to ensure Americans receive the Social Security benefits they have earned, and that they need to make ends meet. I look forward to learning more about today's issue from today's witnesses, and I look forward to hearing the best way that we can move forward.

So, I thank our witnesses in advance for having come, and we look forward to hearing from you.

Mr. Chairman, with that——

Chairman JOHNSON. Thank you.

Mr. BECERRA [continuing]. I yield back the balance of my time.

Chairman JOHNSON. We do need to get rid of fraud in the system.

Thank you all for being here. As is customary, any Member is welcome to submit a statement for the hearing record.

Before we move on to our testimony, I want to remind our witnesses to please limit your oral remarks to five minutes. However, without objection, all of the written testimony will be made part of the written record.

We have one witness panel today. And seated at the table are Patrick O'Carroll, Jr., Inspector General, Social Security Administration, accompanied by Heather Hermann, National Coordinator, Cooperative Disability Investigations Program, Office of the Inspector General, Social Security Administration. Glad you all made it down here before the snow.

[Laughter.]

Chairman JOHNSON. Arthur Spencer, Associate Commissioner, Office of Disability Programs, Social Security Administration. Kathy Ruffing, Senior Fellow, Center on Budget and Policy Priorities. Trudy Lyon-Hart, Director, Office of Disability Determination Services, Vermont Agency of Human Services, on behalf of the National Council of Disability Determination Directors. David Hatfield, Administrative Law Judge—it says retired, but I had a conversation with him, he is still a judge——

[Laughter.]

Chairman JOHNSON. [continuing]. Wexford, Pennsylvania. Welcome. Thanks for being here——

Mr. BECERRA. And Judge, when the Chairman says you are still a judge, you are still a judge, so——

[Laughter.]

Chairman JOHNSON. Welcome and thanks for being here. Mr. O'Carroll, good to see you again. Please go ahead.

STATEMENT OF PATRICK P. O'CARROLL, JR., INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY HEATHER HERMANN, NATIONAL COORDINATOR, COOPERATIVE DISABILITY INVESTIGATIONS PROGRAM, OFFICE OF THE INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION

Mr. O'CARROLL. Good morning, Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee. I am joined by Heather Hermann, national coordinator for our CDI program.

In fiscal year 2012, SSA received about 3.2 million disability insurance claims, and paid more than $135 billion in disability benefits. This is a critical time to focus on the future of the disability program and avoiding improper payments.

In my written statement I discuss a number of systemic and policy issues that could save millions in dollars, including revising the Agency's policy on administrative finality, terminating payments timely once beneficiaries are deemed ineligible, and addressing the concept of medical improvement. However, I would like to take a few minutes to discuss two of the greatest integrity tools we have available, the CDI program and continuing disability reviews, or CDRs.

Medical CDRs determine whether a beneficiary remains disabled and eligible, and are critical in reducing overpayments in the disability program. SSA has a goal of conducting 435,000 medical CDRs this year. However, the current backlog is about 1.2 million. Our audit work has found that the Agency would have avoided paying hundreds of millions of dollars to ineligible beneficiaries if CDRs were conducted when they were due.

Sometimes DDS has even asked CDI units to investigate a beneficiary during a CDR. That combines the value of our two most effective integrity tools, which is one of the many reasons we believe DDSs in all 50 states should have access to a CDI unit.

In one recent example, a CDI unit investigated a man who had received disability for almost 18 years, and was undergoing a CDR. He alleged severe back problems and other ailments. When investigators interviewed the man, he showed no signs of the back pain or discomfort he alleged. And when the investigators looked into the man's social media presence, they found he was something of a YouTube star, which we would like to show you.

[Video shown.]

Mr. O'CARROLL. As you can see, his video suggests that his back problems might have been exaggerated. With this information, the DDS terminated the man's benefits.

Special Agent Hermann will now tell you a little bit more about CDI.

Heather?

STATEMENT OF HEATHER HERMANN, NATIONAL COORDINATOR, COOPERATIVE DISABILITY INVESTIGATIONS PROGRAM, OFFICE OF THE INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION

Ms. HERMANN. Thank you, and good morning. Since 1998, CDI has been successful in detecting abuse in SSA's disability programs and preventing payment on disability cases involving potential fraud.

Since the program was established, CDI work nationwide has resulted in projected SSA savings of $2.2 billion. The process typically begins with a referral from a state DDS or SSA, or from administrative law judges during the appeals process. They refer benefit claims or reviews that have been identified as suspicious. When the CDI investigation is complete, they send a report detailing their findings to the DDS, which determines whether the person is eligible for benefits.

In this case, the man with the cane was on disability, alleging brain and pelvis injuries. But he bought the cane on his way to a consultative exam. Here we see him using the new cane for support. But after the exam, we see him walking freely and carrying the cane in his left hand. And later that same day, we see him back at the pharmacy, returning the cane for a refund. With this information, the Missouri DDS terminated the man's benefits, and found he was overpaid $11,000. This is typical of the work that our 24 CDI units—soon to be 25, as we open a unit in Puerto Rico—do every day.

The National Association of Disability Examiners and the Government Accountability Office support CDI expansion. And the program has received great support from your subcommittee, as well. We look forward to continuing to assist SSA in this vitally important and growing initiative.

Mr. O'CARROLL. In conclusion, to improve the DI program we support CDI program expansion, investing in integrity reviews like CDRs, establishing a self-supporting program for stewardship activities, and policy or legislative changes that could reduce the program complexity.

Thank you again for the invitation to testify today, and we will be more than happy to answer questions.

[The prepared statement of Mr. O'Carroll follows:]

U.S. House of Representatives

Committee on Ways and Means
Subcommittee on Social Security

SOCIAL SECURITY
ADMINISTRATION
OIG

Statement for the Record

Challenges of Achieving Fair and Consistent Disability Decision

The Honorable Patrick P. O'Carroll, Jr.
Inspector General, Social Security Administration

Heather Hermann, Assistant Special Agent-in-Charge
and Cooperative Disability Investigations National Coordinator

March 20, 2013

Good morning, Chairman Johnson, Ranking Member Becerra, and members of the Subcommittee. It is a pleasure to appear before you, and we thank you for the invitation to testify today. I am joined by Heather Hermann, the National Coordinator of the Office of the Inspector General's (OIG) Cooperative Disability Investigations (CDI) program. Today, we are discussing the Social Security Administration's (SSA) Disability Insurance (DI) program and the policies and initiatives the Agency relies on to ensure program integrity and payment accuracy.

SSA's Disability Insurance

SSA DI is the nation's primary Federal disability program. According to the most recent data from SSA, the Agency provided about $10.7 billion in DI payments in January 2013, to about 10.9 million citizens across the country. That total represents more than 8.8 million disabled workers, and about 2.1 million spouses and children. In all, SSA paid more than $135 billion in DI benefits in Fiscal Year (FY) 2012, a record amount. Also in FY2012, SSA received about 3.2 million initial disability claims, and at the end of December 2012, the Agency's level of pending initial claims stood at more than 700,000. Thus, it is a critical time for the Agency to focus on the future of the DI program.

Disability overpayments, which we are focused on today, cover a number of scenarios, but they are largely benefit payments made to ineligible program participants. They can be the result of program complexities, administrative errors or fraudulent activity. The OIG's efforts to reduce DI overpayments focus on investigating suspected Social Security fraud; and reviewing SSA's programs and operations to make recommendations to improve program integrity and efficiency.

Disability Reviews and Recommendations

We know some individuals will purposely withhold, exaggerate, or fabricate work or medical information to collect benefits that they are not eligible to receive. For many years, we have identified our Cooperative Disability Investigations program (CDI) and SSA's continuing disability reviews (CDRs) as two highly effective guards against disability overpayments. CDI has been extremely successful in detecting fraud in SSA's disability programs and preventing improper payments, specifically on the front end of the claims process. The work of CDI Units across the country is critical to the OIG and SSA's cooperative efforts to limit improper payments in SSA's disability programs. Special Agent Hermann and I will discuss CDI in more detail shortly.

Increasing levels of disability claims and beneficiaries also challenge SSA's ability to deliver world-class service, creating workloads that strain resources, causing delays and backlogs, and leaving the Agency vulnerable to fraud and abuse. SSA must balance service initiatives, such as processing new claims, with stewardship responsibilities, such as conducting timely work and medical CDRs, to determine if a beneficiary remains disabled and eligible. In a March 2010 report, we determined SSA's number of completed medical CDRs declined by 65 percent from FY2004 to FY2008, resulting in a significant backlog. We estimated SSA would have avoided paying at least $556 million during Calendar Year (CY) 2011 if SSA had conducted the medical CDRs in the backlog when they were due.

Medical CDRs are effective in reducing overpayments in the DI program. SSA estimates that every $1 spent on medical CDRs yields about $9 in SSA program savings and Medicare and Medicaid over 10 years. According to SSA, the Agency conducted 443,233 medical CDRs in FY2012, up from 345,000 in

FY2011, though the Agency still has a backlog of 1.2 million CDRs. SSA's FY2013 goal for medical CDRs is 435,000 based on the level of funding under the current Continuing Resolution.

SSA employs a CDR profiling system that determines which CDRs are due annually and uses data from SSA's records to determine the likelihood of medical improvement for disabled beneficiaries. Those with a predicted high likelihood of medical improvement, undergo a full medical review at the State Disability Determination Services (DDS). Beneficiaries with a predicted medium or low likelihood of medical improvement are sent a mailer questionnaire. If the completed questionnaire indicates medical improvement, SSA will send the case to the DDS for a full medical review. The profiling system prioritizes cases for CDRs, but the Agency then decides how many to conduct each year, based on a variety of factors.

I should note here that SSA and OMB do not consider *unavoidable* overpayments to be improper payments. Thus, payments that would not have been made if a medical CDR was conducted when due are *not counted* as improper payments by SSA. We, however, believe these payments do constitute improper payments and should be part of the discussion about SSA's payment accuracy, as funds could have been preserved by performing all identified medical CDRs.

Even when a CDR *is* conducted and the DDS determines medical improvement, it does not always mean that SSA terminates benefits timely, or at all. In a November 2012 report, we identified DI beneficiaries and their auxiliaries who improperly received payments after their medical cessation determinations, for a projected total of about $48.9 million. Also, some beneficiaries cannot be terminated because of the medical improvement review standard (MIRS), which we will review later this year. During a CDR, SSA follows MIRS to determine if a beneficiary's impairment has *improved* since his/her most recent favorable determination and can perform work activities. However, if SSA mistakenly placed the individual on disability in the first place—if they were not disabled when the favorable determination was made—MIRS makes it difficult for SSA to take the person *off* disability, because under current legislation, there is *no medical improvement*. Our auditors will attempt to estimate the amount of benefit payments SSA could save if MIRS were not in place in its current form.

Also problematic is SSA's policy on administrative finality, which we have long urged SSA to consider revising so that more improper payments can be stopped and recovered. Administrative finality dictates that determinations for payments and payment amounts become binding and final, unless they are timely appealed or later reopened and revised within certain periods. Consequently, if conditions to reopen a determination do not exist, or time limits expire, SSA generally will *not* revise the determination, and will continue to pay the erroneous benefits throughout a beneficiary's lifetime. SSA does not assess an overpayment or pursue recovery.

For example, during prior reviews, we identified a beneficiary receiving a full retirement benefit under her own Social Security number (SSN) and another full benefit under her deceased spouse's SSN, which resulted in an $870 monthly overpayment, beginning in July 1982. Because administrative finality applied, the second monthly benefit continued to be paid; when we completed a July 2012 report on this issue, the overpayment totaled $215,000 and would continue to increase throughout the beneficiary's lifetime without any sanctions. SSA has agreed to review and evaluate administrative finality policies.

Notwithstanding the issue of medical improvement, SSA must also determine which beneficiaries are no longer eligible due to work and earnings. SSA conducts work CDRs to determine whether beneficiaries have returned to work; however, reviewing work activity and earnings is a complex and time-consuming process that requires staff to consider all of the return-to-work provisions of the *Social Security Act*. In a September 2010 Congressional Response Report, we said the Agency should devote additional resources to making improvements to identify and prevent DI overpayments to those beneficiaries who return to work.

Because SSA has to evaluate earnings and work incentives before stopping benefits—it cannot simply terminate benefits when wages are reported—simplifying these provisions could have a positive effect. We believe reducing the complexity of SSA's disability programs and work provisions would reduce millions of dollars in overpayments each year. A proposal also exists to change the Federal wage-reporting process from annual to quarterly reporting. A change of this nature would increase the frequency that employers report wages to SSA, improving the timeliness of the work CDR process. In addition, SSA has developed a legislative proposal—the Work Incentive Simplification Pilot—to simplify DI work provisions, which would reduce administrative complexity, enhance correlation of program rules among SSA's disability programs, and encourage DI beneficiaries to return to work because they would not face a permanent loss of benefits and Medicare. Our auditors are planning to evaluate the pilot in FY2014.

Cooperative Disability Investigations

One of the most effective ways that SSA can prevent overpayments in the DI program is dedicating resources to and expanding CDI. To improve program integrity, SSA should continue to make available the investigative efforts of CDI Units to DDSs across the country. For many years, we have highlighted for this Subcommittee how CDI Units assist DDS employees who suspect fraud in an initial disability claim.

DDSs that have local CDI Units have the advantage of referring any suspected fraud to the CDI Unit for investigation. CDI investigation reports include information the DDS cannot normally obtain during the application or CDR process to make a disability determination, including independent observations and surveillance video of the claimant/beneficiary, interviews with the claimant/beneficiary or third parties, and corroborated results of social media, Internet and government database searches.

In FY2012:

- CDI opened 4,707 cases; about 81 percent of the cases were on initial claims, and about 19 percent were related to beneficiaries already receiving benefits.
- DDSs denied or ceased benefits on 4,099 cases after CDI investigations. Thirteen individuals were criminally prosecuted and Civil Monetary Penalties were imposed on 19 individuals, because of CDI investigations.

CDI Units generally focus on preventing improper disability payments from ever occurring, but DDS employees can also enlist CDI Units to investigate in-pay beneficiaries who might not be eligible to continue receiving payments. For example, the Missouri DDS received an anonymous complaint alleging that a man who was receiving disability benefits due to brain and pelvis injuries was not disabled, because he played basketball and football, ran, lifted boxes, and repaired and drove automobiles without difficulty. The man had begun receiving benefits because he claimed he was unable to write, drive, or stand without a supportive device.

The DDS referred the case to the Kansas City CDI unit, which conducted surveillance revealing the man could walk without using a supportive device. Video surveillance then recorded the man purchasing a walking cane at a pharmacy *on the way to his consultative exam* (CE). He used the cane to attend the CE, but after he left the exam, he *returned the cane to the pharmacy for a cash refund.* During the transaction, the man signed the receipts for his refund; CDI investigators later obtained a copy of the signed receipts. The CDI Unit forwarded this and other information to the Missouri disability examiners, who then terminated the man's disability benefits. SSA also assessed an overpayment of nearly $11,000.

SSA and OIG jointly established CDI in FY1998, in conjunction with State DDS and State or local law enforcement agencies. In 1998, CDI launched with Units in five states. The program currently consists of 24 Units covering 21 states, and is in the process of establishing a Unit in the Commonwealth of Puerto Rico. In FY2012 alone, CDI efforts resulted in almost $340 million in projected savings to SSA's disability programs—the program's greatest single-year savings total—for a return on investment of $17 to $1. Since the program was established, through FY2012, CDI efforts have resulted in $2.2 billion in projected savings to SSA's disability programs.

Each CDI Unit comprises an OIG Special Agent who serves as the Team Leader; employees from that State's DDS and SSA, who act as programmatic experts; and State or local law enforcement officers. The process typically begins with a fraud referral from the DDS or SSA to the CDI Unit. The Team Leader screens the referral, and the SSA and DDS employees provide programmatic insight. When the Unit accepts a referral for investigation, CDI investigators use traditional law enforcement techniques to gather evidence. For example, they may conduct interviews, or conduct surveillance of the applicant or beneficiary. The completed CDI Report of Investigation is sent to the DDS, which considers that information in determining whether a person is eligible to receive (or continue receiving) benefits. There are also, in some cases, opportunities for criminal prosecution or the imposition of civil monetary penalties or administrative sanctions.

While CDI's primary mission is to obtain evidence that can resolve questions of fraud before benefits are ever paid, the previous case example showed the Units also investigate in-pay beneficiaries; for example, DDS examiners may refer beneficiaries to CDI during CDRs, combining these two important integrity tools. In one recent example, the Salt Lake City CDI Unit investigated a 40-year-old beneficiary who had received DI benefits for almost 18 years. He alleged impairments including depression, anxiety, asthma, obesity and sore muscles. He also indicated that his depression prevented him from leaving his house or visiting public places.

However, when CDI investigators interviewed the man outside of his residence, he showed no signs of discomfort or signs that he had a bad back, which was his primary diagnosis in his benefit claim. He stood and talked with the investigators for more than 25 minutes. When he left and entered his residence, he walked upright and with fluid motions.

The CDI Unit then discovered evidence on various social media sites, including Facebook, MySpace and YouTube. In videos the subject posted to YouTube, he is seen dancing to heavy metal music, swinging on a swing set, and riding a scooter around his property. The videos showed him dancing to the music, with rhythmic gestures, playing an air guitar, thrashing around his living room, jumping out of a swing, and writhing on the ground. He can be seen kicking and pushing himself around on a scooter, with little effort.

Additional surveillance showed the subject get into his car and drive for several miles. He was a cautious driver, obeying local traffic laws and managing current traffic conditions. The CDI Unit submitted its findings to the Utah DDS, which ceased his benefits.

Though they can refer cases of potential fraud to OIG field offices, DDS in states without CDI do not have this additional avenue to investigate suspicious initial claims and have to make the best decision with the information available. Several years ago, the National Association of Disability Examiners recommended expansion of the CDI program to all 50 states. The Government Accountability Office has commended CDI's efforts to reduce fraud and waste in SSA's disability programs, and the initiative has received tremendous support from this Subcommittee. The OIG and SSA share that enthusiasm and are committed to expanding the CDI program and ensuring disability program savings for the Agency.

Conclusion

The OIG has conducted, and continues to conduct, significant audit and investigative work to identify areas where SSA's DI program is vulnerable to improper payments, and we continue to recommend actions to reduce and eliminate those vulnerabilities. SSA can limit improper disability payments at the front end of the application process with anti-fraud initiatives like the CDI program, and it can ensure program integrity going forward with regular stewardship reviews, such as CDRs, and reviews and evaluations of existing policies and procedures. As several examples have shown, CDI helps maintain the level of accuracy and integrity in SSA's disability programs that the American public deserves, reducing improper payments, deterring fraud, and saving taxpayer dollars.

We will continue to provide information to SSA's decision-makers and to this Subcommittee, and we look forward to assisting in these and future efforts to improve these critical programs. We thank you again for the invitation to be here today. We would be happy to answer any questions.

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Chairman JOHNSON. Thank you, sir. You know, those are just a few of the incidents that occur. We were in Dallas, listening to some of this, and watched a guy take a wheelchair out of the hearing, fold it up, put it in the truck, walk around the car, and get in and drive away. People are making a mess of our disability program. And thanks to our IG, we are getting some good information on it, and hopefully stopping some of it. By far, not all of it, though.

Mr. Spencer, welcome. Please proceed, sir.

STATEMENT OF ARTHUR R. SPENCER, ASSOCIATE COMMISSIONER, OFFICE OF DISABILITY PROGRAMS, SOCIAL SECURITY ADMINISTRATION

Mr. SPENCER. Chairman Johnson, Ranking Member Becerra, Members of the Subcommittee, thank you for inviting me to discuss the Social Security Disability Insurance program. I am Art Spencer, Social Security's Associate Commissioner for Disability Programs, and responsible for disability policy.

A lot has been said and written about the DI program in recent years, some true. Much, though, that is half true or even incorrect. I hope that I can help you today with the right information you need to make the best decisions about the program's future.

The DI program provides benefits to disabled workers and their dependents. Workers become insured under the program based on their contributions to the Social Security Trust Fund. For this reason, the DI benefit is rightfully described as an earned benefit.

When we decide whether a person qualifies for DI benefits, we are required to follow the definition of "disability" that Congress included in the Social Security Act. The Act generally defines "disability" as the inability to engage in any work, substantial gainful activity, due to a medically-determinable physical or mental impairment that has lasted or will last for at least 12 months, or result in death. This is a very strict standard, and most people don't meet it.

While some have attributed DI program growth to loosening of the rules, that is simply not the case. As our Chief Actuary explained to the subcommittee last week, the aging of the population and expansion of the workforce are the main drivers of program growth.

To apply the statutory definition of "disability," we do a rigorous and structured analysis of each case, using five steps called the sequential analysis process, or sequential evaluation process.

At step one, we determine whether a person is working and engaging in SGA, substantial gainful activity. If so, we deny the claim.

At step two, we assess the existence and severity of a person's impairment using objective medical evidence. If we do not find a severe impairment, we deny the claim.

At step three, we determine whether the severe impairment meets or equals the criteria of one of our medical listing of impairments found in our regs. The listings describe for each major body system the impairments that can be considered so debilitating that they could reasonably prevent someone from working. We use a process to regularly update the listings following advances in medical science. We have updated 10 of the 14 systems, and are working hard on the final 4.

If a person has a listings-level impairment, we allow the claim. If not, we proceed to step four. At step four, we consider whether a person's residual functional capacity allows him or her to do any work that they have successfully done. If they can do any work that they have done, we deny the claim.

At step five, we determine whether the claimant, given his or her residual functional capacity, age, education, and past work experience can do other work that exists in the national economy. If they cannot do any work that exists in significant numbers in the national economy, we do allow the claim. But if they can do any work that exists in the economy, we deny the claim.

Our partners at state agencies call disability determination services, make initial disability decisions. They also reconsider the decisions of denied claimants who appeal. For those claims that the DDSs allow, we perform an independent and comprehensive review of at least 50 percent of the cases before any payment is made. These pre-effectuation reviews allow us to correct errors before we issue a final decision.

People denied benefits by the DDSs can request a hearing before an administrative law judge. And thereafter they can appeal to our appeals council or to federal district court.

Throughout all levels of our administrative process, program experts review the quality of the decisions, re-target our feedback and our training to those areas where our experts find the most frequent errors.

We have also developed technology to help adjudicators make accurate decisions. For example, our electronic claims analysis tool is a web-based application that guides DDS adjudicators through the sequential evaluation process. We are piloting a similar tool in our hearings offices called the Electronic Bench Book. Our hearings offices also use How MI Doing to improve their quality. It explains the reasons for appeals council remands, and allows adjudicators to view their performance in relationship to other offices, regions, and the nation's.

As we continue to improve the DI program, we need congressional support. Thank you for the opportunity to appear before you today, and I am happy to answer any questions that you might have.

[The prepared statement of Mr. Spencer follows:]

HEARING BEFORE

THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 20, 2013

STATEMENT
FOR THE RECORD
ARTHUR R. SPENCER
ASSOCIATE COMMISSIONER FOR DISABILITY PROGRAMS
OFFICE OF RETIREMENT AND DISABILITY POLICY
SOCIAL SECURITY ADMINISTRATION

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee:

Thank you for this opportunity to discuss the Social Security Disability Insurance (DI) program. It is a crucial part of America's safety net. Through this program, we provide vital support to some of the most vulnerable members of our society. Today, I will discuss how we evaluate disability claims, the disability claims process, and some steps we are taking to improve the DI program.

Introduction

At the Social Security Administration (SSA), we do everything within our power to meet the public's expectation of exceptional stewardship of program dollars and administrative resources. Doing so preserves the public's trust in our program and ensures that benefits go toward assisting only the right people in the right amount and at the right time. Too many people depend on us for us not to strive to do the job right the first time.

The DI program provides benefits to disabled workers and to their dependents and survivors. Workers become insured under the DI program based on their contributions to the Social Security trust funds through taxes on their wages (at a rate of 6.2 percent on the first $113,700 earned with an equal amount from their employer) and self-employment income (at a rate of 12.4 percent on the first $113,700 earned). In 2011, we paid nearly $129 billion in DI benefits to 10.6 million people. Under the Social Security Act (Act), most DI beneficiaries receive Medicare after being entitled to monthly cash benefits for 24 months.

The Act generally defines disability as the inability to engage in any substantial gainful activity (SGA) due to a physical or mental impairment that has lasted or is expected to last at least one year or to result in death. Under this very strict standard, a person is disabled only if he or she cannot work due to a medically determinable impairment. As the Committee on Ways and Means noted in its report that accompanied the Social Security Amendments of 1956, even a person with a severe impairment cannot receive disability benefits if he or she can engage in any SGA. Moreover, the Act does not provide short-term or partial disability benefits.

Before continuing with my testimony, I would like to remind the Subcommittee of a salient feature of the DI program. An applicant (claimant) cannot receive disability benefits simply by alleging pain or other non-exertional impairments or limitations. We require objective medical evidence and laboratory findings that show the claimant has a medical impairment that: 1) could reasonably be expected to produce the pain or other symptoms alleged, and 2) when considered with all other evidence, meets our disability requirements.

I will now discuss the way we evaluate disability claims.

Evaluating Disability Claims – The Sequential Evaluation Process

Under the DI program, we evaluate adult claimants under a standardized five-step evaluation process (sequential evaluation), which we formally incorporated into our regulations in 1978. At step one, we determine whether the claimant is engaging in SGA. SGA is significant work normally done for pay or profit. The Act establishes the SGA earnings level for blind persons and requires us to establish the SGA level for other persons. If the claimant is engaging in SGA, we deny the claim without considering medical factors.

If a claimant is not engaging in SGA, at step two we assess the existence, severity, and duration of the claimant's medically-determinable impairment (or combination of impairments). The Act requires us to consider the combined effect of all of a person's impairments, regardless of whether any one impairment is severe. Throughout the sequential evaluation, we consider all of the claimant's physical and mental impairments singly and in combination.

If we determine that the claimant does not have a medically determinable impairment, or the impairment or combined impairments are "not severe" (i.e., they do not significantly limit the claimant's ability to perform basic work activities), we deny the claim at the second step. If the impairment is "severe," we proceed to the third step.

Listing of Impairments

At the third step, we determine whether the impairment "meets" or "equals" the criteria of one of the medical Listing of Impairments (Listings) in our regulations.

The Listings describe for each major body system the impairments considered so debilitating that they would reasonably prevent an adult from working at the level of SGA. The Act does not require the Listings, but we have been using them in one form or another since 1955. The listed impairments are permanent, expected to result in death, or last for a specific period greater than 12 months.

Using the rulemaking process, we revise the Listings' criteria on an ongoing basis. When updating a listing, we consider current medical literature, information from medical experts, disability adjudicator feedback, and research by organizations such as the Institute of Medicine. As we update the Listings for entire body systems, we also make targeted changes to specific rules as necessary.

If the claimant has an impairment that meets or equals the criteria in the Listings, we allow the disability claim.

As part of our process at step three, we have developed an important initiative – our Compassionate Allowance (CAL) initiative – that allows us to identify claimants who are highly likely to be disabled because the nature of their disease or condition clearly meets the statutory standard for disability. With the help of sophisticated new information technology that flags these cases, we can quickly identify potential CALs and then swiftly make decisions. We currently recognize 200 CAL conditions and continue to review our CAL policy to ensure it is based on the most up-to-date medical science.

Residual Functional Capacity

A claimant who does not meet or equal a listing may still be disabled. The Act requires us to consider how a claimant's condition affects his or her ability to perform previous work or, considering his or her age, education, and work experience, other work that exists in the national economy. Consequently, we assess what the claimant can still do despite physical and mental impairments – i.e., we assess his or her residual functional capacity (RFC). We use that RFC assessment in the last two steps of the sequential evaluation.

We have developed a regulatory framework to assess RFC. An RFC assessment must reflect a claimant's ability to perform work activity on a regular and continuing basis (i.e., eight hours a day for five days a week or an equivalent work schedule). We assess the claimant's RFC based on all of the evidence in the record, such as treatment history, objective medical evidence, and activities of daily living.

We must also consider the credibility of a claimant's subjective complaints, such as pain. Such decisions are inherently extremely difficult. Under our regulations, disability adjudicators use a two-step process to evaluate credibility. First, the adjudicator must determine whether medical signs and laboratory findings show that the claimant has a medically determinable impairment that could reasonably be expected to produce the pain or other symptoms alleged. If the claimant has such an impairment, the adjudicator must then consider all of the medical and non-medical evidence to determine the credibility of the claimant's statements about the intensity, persistence, and limiting effects of symptoms. The adjudicator cannot disregard the claimant's statements about his or her symptoms simply because the objective medical evidence alone does not fully support them.

We do consider limitations or restrictions resulting from age, gender, body habitus (e.g., body type and stature), conditioning, or inherent strengths or predispositions attributable to the claimant's medically determinable impairments. However, while the RFC assessment is "subjective" in the sense that we base it on the individual facts of each claimant's case, we minimize this inherent subjectivity by applying consistent policy standards. For example, our electronic case analysis tool, which I describe later, helps ensure policy consistency.

Once we assess the claimant's RFC, we move to the next steps of the sequential evaluation.

Medical-Vocational Decisions

At step four, we consider whether the claimant's RFC prevents the claimant from performing any past relevant work. If the claimant can perform his or her past relevant work, we deny the disability claim.

If the claimant cannot perform past relevant work (or if the claimant did not have any past relevant work), we move to the fifth step of the sequential evaluation. At step five, we determine whether the claimant, given his or her RFC, age, education, and work experience, can do other work that exists in the national economy. If a claimant cannot perform other work, we will find that the claimant is disabled.

We use detailed vocational rules to minimize subjectivity and promote national consistency in determining whether a claimant can perform other work that exists in the national economy. The medical-vocational rules, set out in a series of "grids," relate age, education, and past work experience to the claimant's RFC to perform work-related physical and mental activities. Depending on those factors, the grid may direct us to allow or deny a disability claim. For cases that do not fall squarely within a vocational rule, we use the rules as a framework for decision-making. In addition, an adjudicator may rely on a vocational expert to identify other work that a claimant could perform.

DI Program Growth

I would like to take a moment to address the recent growth in the DI program. Some observers have attributed this growth to loosened eligibility criteria. However, as you heard from our Chief Actuary last week, the increased size and changed age distribution of the population under 65 is the main driver of long-term DI program growth. For example, the aging of the baby boom generation accounts for a large portion of the growth in DI awards, and that growth has been predicted for many years. Increased labor force participation among women over the past decades, which has led to an increase in the proportion of the population who meet the DI program's coverage requirements, is another important factor in the growth of the DI program.

I will now discuss the disability claims process.

Disability Claims Process

Our disability process consists of several levels of review. Our partners in the State agencies play a crucial role in our disability claims process. When we receive a disability claim, we generally send the claim to a State disability determination services (DDS). We rely upon the 54 State and territorial DDSs to develop medical evidence and determine whether claimants are disabled or whether beneficiaries continue to be disabled.

If the claimant is dissatisfied with the initial disability determination, our regulations provide for three levels of administrative review. The first allows for a reconsideration by the DDS. If denied at the reconsideration then appeal is available for a hearing before an administrative law judge (ALJ). If denied again at the ALJ, then a claimant may request a review by our Appeals Council. If the Appeals Council denies the request for review (or if the Appeals Council grants the request and issues a decision), the claimant may appeal to Federal district court.

Let me emphasize there is only a single national definition of disability. When evaluating disability claims, every decision-maker must use the criteria set forth in the Act and our regulations. We communicate these criteria in several ways. The Program Operations Manual System is a primary source of information used by our employees to handle disability claims. It contains instructions that explain how to apply disability criteria to a particular case. We also publish rulings and make available to the public a series of precedential decisions relating to our disability programs.

Furthermore, we have developed tools at the DDS and hearing levels to ensure that adjudicators follow our policies consistently. At the DDS level, we have the Electronic Claims Analysis Tool (eCAT), which we require our decision makers to use. eCAT is a policy compliant web-based application designed to assist the user throughout the sequential evaluation process. The tool aids in documenting, analyzing, and adjudicating the disability claim according to our regulations. We are piloting a similar tool at the hearing level, the Electronic Bench Book. Additionally, a hearing-level tool called "How MI Doing?" gives adjudicators extensive information about the reasons their cases were subsequently remanded and allows them to view their performance in relation to the average of other ALJs in the office, region, and Nation.

Moreover, as required by the Act, we perform a pre-effectuation review of at least 50 percent of all DDS initial and reconsideration allowances for DI claimants. These pre-effectuation reviews allow us to correct errors we find before we issue a final decision, and to provide instructional feedback to our DDS adjudicators. In addition, our Office of Quality Performance (OQP) reviews samples of initial, reconsideration, and hearing level decisions. These reviews help ensure consistency at all levels of the process.

Increasing Efficiency, Consistency, and Accuracy

As an ongoing effort to improve our service to public, we have taken steps to improve the efficiency, consistency, and accuracy of our disability claims process. I will highlight a few of them.

Efficiency

We are continually identifying ways to streamline the disability claims process. Over the next several years, we will be making significant improvements. For example, we are modernizing our Internet disability appeals by streamlining data collection and improving functionality.

As we expand and improve our online services, we must provide the DDSs with the tools they need to quickly and accurately decide disability cases. In addition to the CAL initiative I discussed earlier, our Quick Disability Determination process uses a computer-based predictive model in the earliest stages of the disability process to identify and fast-track claims where a favorable disability determination is highly likely and medical evidence is readily available, such as low birth-weight babies, certain cancers, and end-stage renal disease. Claimants who are so severely disabled and clearly meet our disability definition benefit from obtaining a quick decision and receiving their payments.

We believe Health Information Technology (IT) has the potential to revolutionize our disability determination process. We rely upon doctors, hospitals, and others in the healthcare field to timely provide the medical records that we need; we send more than 15 million requests for medical records annually. This largely paperbound workload is a very time-consuming part of the disability decision process. As the medical community moves toward electronic health records, we are moving toward an electronic system of requesting and receiving medical records. We now can quickly obtain electronic medical records from 14 health care organizations. With the consent of our claimants, we will have near instantaneous access to their medical records.

Health IT will dramatically improve the speed, accuracy, and efficiency of this process, thus reducing the cost of making a disability decision for both the medical community and the taxpayer. Currently, the average time for initial disability decisions is 21 percent lower in cases with electronic medical evidence obtained through Health IT, and we decided 3 percent of those cases within 48 hours. Once Health IT becomes standard, our accuracy should improve significantly.

Consistency and Accuracy

We are also taking steps to improve our decision-making. To ensure the consistency and quality of DDS decisions, we established the Request for Program Consultation (RPC) process. The RPC process allows DDSs and our quality reviewers to resolve differences of opinion they have on cases that OQP has cited as deficient. In general, DDSs use the process to resolve the most complex cases. Our policy experts at our headquarters thoroughly review these cases. We post all RPC resolutions and related data on our Intranet so that all of our staff can review them and perform trend analysis. The process serves several key functions. It provides real life examples of proper policy application, identifies issues and areas for improved disability policy, and provides our regional offices and DDSs information to assess local quality issues. Since 2007, we have reviewed over 6,000 cases and posted their resolutions online. Further, the RPC team has worked directly with policy components to develop policy clarifications, training, and other resources that can further improve the consistency and quality of disability determinations at all adjudicative levels.

We also developed a Policy Feedback System (PFS)--a web application that gathers empirical data from individual disability claims so that we can identify policy issues, develop training, and prioritize workloads. PFS is a strategic tool, which allows users to customize reports and drill down to specific data, enabling them to analyze data and ensure consistency of adjudication. While the RPC process focuses only on those cases that involve a dispute between DDSs and our quality reviewers, the PFS includes all electronic cases.

To make consistent, better-informed decisions on whether disability claimants meet our disability criteria, we are working with the Bureau of Labor Statistics (BLS) to determine if they can meet our data needs. Specifically, we signed an interagency agreement with BLS to test the collection of data on strength, specific vocational preparation, and non-exertional requirements using the specific definitions and measurements required by our regulations for a broad set of occupations.

We are also working to develop additional aids for our decision-makers. For example, we are working to develop Computer Adaptive Testing (CAT) instruments. CAT is a form of computer-based testing that tailors question selection based upon the claimant's ability level. Unlike a fixed-form test that asks the same questions of everyone, CAT instruments ask claimants and their providers only the most informative questions based on a person's response to previous questions. Using this approach allows the instrument to ask fewer questions (in total) because the selected questions are based on the individual's level of function. Using research and technology that is methodologically rigorous, we are developing the CAT instrument to obtain information on claimants' functional abilities in a manner that is systematic, comprehensive, and efficient.

Finally, the World Health Organization developed the International Classification of Functioning, Disability and Health (ICF), which is a universal classification of disability and health for use in health and health-related sectors. The ICF establishes a common framework or language for describing functional status information. There are four basic domains, with associated codes, in ICF classification: body functions, body structures, activities and participation, and environmental factors. We are part of a broad-based effort to study possible uses for ICF coding. We could use it, for example, to describe function in activities of daily living, to describe RFC (to satisfy a specific set of disability criteria), or to develop a compendium of job descriptions that includes mental and physical functional requirements.

Conclusion

Since 1957, Social Security disability benefits have provided a vital safety net for those Americans who make up the most vulnerable segment of society. The programs we administer demand stewardship that is worthy of their promise of economic security from generation to generation. We are firmly committed to sound management practices and know the continued success of our programs is inextricably linked to the public's trust in them. Properly managing our resources and program dollars is critical to that success. Equally important to our success is Congress providing us with adequate, sustained, and predictable funding to carry out our work.

We look forward to continuing to work with you as you consider ways to improve the disability programs.

Chairman JOHNSON. Thank you, sir. I appreciate your testimony.

Ms. Ruffing, welcome. Please go ahead.

STATEMENT OF KATHY RUFFING, SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

Ms. RUFFING. Mr. Chairman, Ranking Minority Member Becerra, and Members of the Committee, I appreciate the invitation to testify today about this program that is so very important to over 8 million people who, because of a severe medical impairment, can no longer work substantially; to members of their families; and to 150 million workers who have earned protection from the program, if such a misfortune should happen to them.

The DI program has grown rapidly over the last several decades, and that has led some critics to charge that the program is somehow out of control or in crisis. That is not correct. We have shown, like the Social Security actuaries, that the overwhelming bulk of the growth in the program can be traced to three very straightforward demographic factors: the aging of the baby boomers into the fifties and sixties, the years of greatest risk for disability; the growing labor force participation of women who can now qualify for benefits on their own work; and the rise in the full retirement age in the Social Security program. Over five percent of people who are now on DI would have been called retired workers a decade ago, not disabled workers.

It turns out that when you properly age and sex-adjust the rates of disability, the rate has, in fact, grown only very modestly. It has not doubled or tripled, as some critics claim. Yet program participation has grown. We can't always quantify the reasons, but we can name some of them. And, of course, one of them is legislation, the Disability Benefits Reform Act of 1984, which Chairman Johnson, I think, very accurately summed up.

I would like to add an historical note here, which is that DBRA of 1984 came as a reaction to the overzealous actions of the Reagan Administration, and that is passed both Houses of Congress unanimously. People who criticize it as somehow subjective or liberal are sometimes forgetting that history.

Another factor that was, in fact, recognized in DBRA of 1984 is the competitive nature of today's workplace. It is true that work is generally less physical than in the past. But that is a two-edged sword. For older workers with limited education, and for workers of any age with cognitive impairments, a technologically advanced and a fast-paced workplace is a very harsh environment.

Other factors that have probably buoyed participation in the program include the rise in cost and declining availability of private health insurance, the indirect effect of the rise in the retirement age, and the economic downturn which, at minimum, has boosted applications and, to a lesser extend, awards.

I would like to note briefly that these pressures have not affected the SSI program equally. That program has been quite stable since the mid-1990s.

As we know, it is difficult to qualify for disability benefits. The substantial gainful activity criterion is only a little over $1,000 a month. That is less than 40 percent of the median wage of a high-school graduate with no college. The program does permit and even encourage work. And yet statistics show that most DI beneficiaries never work again after the onset of disability, although they are permitted to do so.

Studies of rejected applicants, studies of so-called parking behavior, and studies of beneficiaries who are converted to retirement benefits all point to the same conclusion: DI beneficiaries are unable to perform substantial work.

We at the Center on Budget strongly advise that disability be addressed in the context of overall solvency for the Social Security program, which is a formidable but achievable goal. I would like briefly, though, to focus on something Congress can do right now, which is focus on—which is fund continuing disability reviews. Congress left money on the table in both 2012 and 2013. We believe that Congress can still act in time to fund those reviews properly.

We look forward to working with you to safeguard and strengthen this vital program.

[The prepared statement of Ms. Ruffing follows:]

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March 20, 2013

Testimony of Kathy A. Ruffing

Senior Fellow, Center on Budget and Policy Priorities

Before the
Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives

Mr. Chairman, Ranking Member Becerra, and members of the subcommittee, I appreciate the invitation to appear before you today.[1]

The Social Security Disability Insurance (DI) program provides modest but vital benefits to workers who become unable to perform substantial work on account of a serious medical impairment. Although some critics charge that spending for the program is "out of control," the bulk of the rise in federal disability rolls stems from demographic factors: the aging of the U.S. population, the growth in women's employment, and Social Security's rising retirement age. Other factors — including the economic downturn — also have contributed to the program's growth, but its costs and caseloads are generally in step with past projections. There is little evidence that DI benefits are going to people who could support themselves by working.

The Social Security trustees project that the DI trust fund — which is legally separate from the Old-Age and Survivors Insurance (OASI) trust fund for the retirement and survivors' programs — will become insolvent in 2016; the Congressional Budget Office concurs. If policymakers take no action to bolster the fund, beneficiaries' checks will have to be cut by about one-fifth after that. But the fund's anticipated insolvency should come as no surprise; when policymakers last changed the allocation of taxes between DI and OASI in 1994, they expected the DI fund to run dry in 2016.

Ideally, policymakers should address DI's pending depletion in the context of overall Social Security solvency. Both DI and OASI face fairly similar long-run shortfalls; DI simply requires action sooner. Key features of Social Security — including the tax base, the benefit formula and cost-of-living adjustments, and insured-status requirements — are similar or identical for the two programs, and most DI recipients are near or even over OASI's early-retirement age. Tackling DI in

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[1] Most of the material in this testimony appears in Kathy A. Ruffing, *Social Security Disability Insurance is Vital to Workers with Severe Impairments*, Center on Budget and Policy Priorities, August 9, 2012, http://www.cbpp.org/cms/?fa=view&id=3818.

isolation would leave policymakers with few — and unduly harsh — options, and lead them to ignore the strong interactions between the disability and retirement programs. A balanced solvency package would also be an opportunity to make needed improvements in the Supplemental Security Income (SSI) program, which is distinct from Social Security but has important intersections.

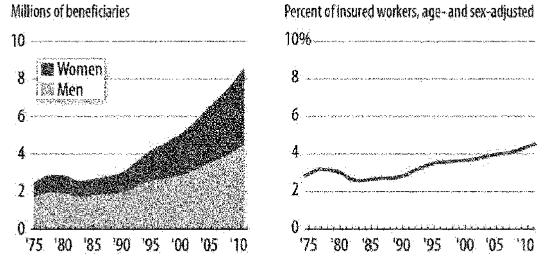
There is no reason to restructure DI fundamentally, and many reasons not to do so. If policymakers are unable to agree in time on a sensible solvency package, they should reallocate taxes between the retirement and disability funds — a traditional and noncontroversial action that has occurred often in the past.

Demographics Explain Most of Growth in Disability Insurance Beneficiaries

Contrary to the impression conveyed by many recent critics, changes in the workforce explain most of the growth in the disability rolls.

In December 2012, 8.8 million people received disabled-worker benefits from Social Security. Payments also went to some of their family members: 160,000 spouses and 1.9 million children. The number of disabled workers has tripled since 1980, and doubled since 1995 (see the left panel of Figure 1).

Figure 1
Demographics Explain Most of Growth in Social Security Disability Insurance Rolls



Source: Social Security Administration, Office of the Chief Actuary. Data are age- and sex-adjusted using 2000 weights.

Meanwhile, the "working-age population" — conventionally described as people age 20 through 64 — has grown much less rapidly. It has increased by about 40 percent since 1980, and by less than one-fifth since 1995. However, the growth in the number of people receiving DI and the growth in the "working-age population" are not directly comparable. Several important factors have swelled the number of disabled workers substantially during the last few decades:

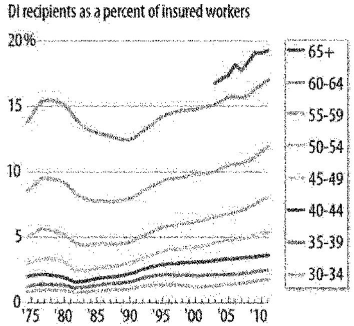
- **Baby boomers have aged into their high-disability years.** Aging takes a toll on many workers' bodies and minds long before retirement age. People are roughly twice as likely to be disabled at age 50 as at age 40, and twice as likely to be disabled at age 60 as at age 50. (See Figure 2.) As the baby boomers — the huge cohort of people born between 1946 and 1964 — have grown older, the number of disability cases has risen substantially.
- **More women have qualified for disability benefits.** In general, workers with severe impairments can get DI benefits only if they have worked for at least one-fourth of their adult

life and for five of the last ten years. Until women joined the workforce in huge numbers in the 1970s and 1980s, relatively few women met those tests; as recently as 1990, male disabled workers outnumbered women by nearly 2 to 1. Now that more women have worked long enough to qualify for DI, the ratio has fallen to 1.1 to 1.

- **Social Security's full retirement age rose from 65 to 66.** When disabled workers reach full retirement age, they begin receiving Social Security retirement benefits rather than DI. The increase in the retirement age has delayed that conversion. In December 2012, more than 450,000 people between 65 and 66 — *over 5 percent of all DI beneficiaries* — collected disabled-worker benefits; under the rules in place a decade ago, they would have been receiving retirement benefits instead.

The Social Security actuaries express the number of people receiving DI using an "age- and sex-adjusted disability prevalence rate" that controls for these factors. That rate rose from 3.1 percent of the working-age population in 1980 to 3.5 percent in 1995 and an estimated 4.6 percent in 2012. (See the right panel of Figure 1.) Expressed another way, age- and sex-adjusted rates of receipt are 48 percent higher than in 1980 and about 30 percent higher than in 1995. That is a significant increase. It is not nearly as dramatic, however, as some alarmists have painted.

Figure 2
Disability Rates Rise Steeply With Age



Source: CBPP based on data from the Social Security Administration, Office of the Chief Actuary.

Other Factors Have Also Boosted Rates of Receipt

Yet rates of receipt have indisputably risen, even when adjusted for age and sex and for the rising retirement age. Why? The reasons are not fully understood, but include:

- **Legislative changes.** In the early 1980s, the Reagan Administration used its influence over the process of determining eligibility, including new powers to conduct medical reviews granted in a 1980 law, to limit the number of people approved for DI and to terminate benefits for thousands of people already on the rolls. Disability caseloads fell even during a deep economic slump. A backlash ensued from governors, members of Congress, and the courts. Ultimately Congress *unanimously* enacted the Disability Benefits Reform Act of 1984 (DBRA) to clarify eligibility and to limit terminations to cases where the agency could show that the beneficiary's medical condition had improved. Notably, DBRA required the agency to consider the impact of multiple impairments and to issue new regulations for evaluating mental impairments that "realistically evaluate the ability of a mentally impaired person to engage in [substantial work] in a competitive workplace."[2] Although some scholars disparage the new rules as "liberal" or "subjective," they nevertheless reflected Congress's determination to give fair weight to the full range of medical evidence in complex cases.

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[2] Katharine P. Collins and Anne Erfle, "Social Security Disability Benefits Reform Act of 1984: Legislative History and Summary of Provisions," *Social Security Bulletin*, Vol. 48, No. 4, April 1985.

An unfortunate tactic of some program critics is to compare today's receipt rates with those of the early- and mid-1980s. That amounts, however, to cherry-picking the data. Rates of receipt fell to record lows in 1982 through 1984 in the heyday of the Reagan Administration crackdown, and those thus are atypical years for DI receipt. By enacting DBRA on a bipartisan basis, lawmakers convincingly repudiated the practices of that time.

- **Workplace factors**. Work is less physical than in the past, leading some analysts to expect a declining prevalence of disability. But a surprisingly large fraction of jobs — including those performed by older workers — still involves arduous physical demands or difficult working conditions. Even sedentary work carries its own set of health hazards, such as obesity.[3]

  The accelerating pace of globalization and technological change has been particularly unforgiving to older, less-educated workers and those with cognitive impairments. Whereas in the past such workers — even if they had serious health problems — might have been able to find jobs, the *combination* of poor health and poor labor market prospects has probably tipped many onto the disability rolls.[4] A trio of researchers who generally argue that the shift to jobs that emphasize "mind over muscle" bodes well for the future employment of older workers nevertheless caution that "[c]ognitively demanding work may be better suited for older people than physically demanding work, but probably not for those with limited education."[5]

- **Rising cost and declining availability of health insurance.** DI beneficiaries qualify for Medicare after a two-year waiting period. With employer-sponsored health insurance eroding and the individual-policy market becoming costlier or outright unavailable, Medicare eligibility may loom larger and larger in some workers' decisions to apply for DI. Researchers have found evidence that it is a significant factor for some applicants, and some suggest that implementation of the Affordable Care Act may diminish pressures on the DI program.[6]

- **Rising retirement age**. Social Security's rising retirement age has a very simple, *direct* effect on disability caseloads by delaying the conversion to retirement benefits. It also has an *indirect*

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[3] Hye Jin Rho, "Hard Work? Patterns in Physically Demanding Labor Among Older Workers," Center for Economic and Policy Research, August 2010; Darius Lakdawalla, Dana Goldman, and Baoping Shang, "The Health and Cost Consequences of Obesity Among The Future Elderly," *Health Affairs* 10 (2005); H. Stephen Kaye, "Improved Employment Opportunities for People with Disabilities," Disability Statistics Report (17), U.S. Department of Education, National Institute on Disability and Rehabilitation Research, 2003.

[4] See, for example, David H. Autor, David Dorn, and Gordon H. Harrison, "The China Syndrome: Local Labor Market Effects of Import Competition in the United States," National Bureau of Economic Research Working Paper 18054, May 2012.

[5] Richard W. Johnson, Gordon B.T. Mermin, and Matthew Resseger, "Employment at Older Ages and the Changing Nature of Work," AARP Public Policy Institute, November 2007. Reductions in funding for sheltered work, and the difficulty faced by the mentally ill in obtaining job accommodations notwithstanding the Americans with Disabilities Act, may also have pushed some people who are unable to cope with a competitive, more technological workplace onto the disability rolls; see Virginia P. Reno and Lisa D. Ekman, "Social Security Disability Insurance: Essential Protection When Work Incapacity Strikes," *Journal of Policy Analysis and Management*, Vol. 31, No. 2 (2012).

[6] Kajal Lahiri, Jae Song, and Bernard Wixon, "A Model of Social Security Disability Insurance Using Matched SIPP/Administrative Data," *Journal of Econometrics* 145 (2008); Norma B. Coe, Kelly Haverstick, Alicia H. Munnell, Anthony Webb, "What Explains State Variation in SSDI Application Rates?" Center for Retirement Research at Boston College, Working Paper 2011-23, December 2011.

effect by making disability benefits relatively more attractive. The basic benefit for a disabled worker is the same benefit paid to a worker who files at his or her full retirement age. Workers may file for reduced retirement benefits as early as age 62. As the full retirement age rises, that reduction becomes deeper. The full retirement age has already risen from 65 to 66 and will reach 67 in the next decade. Some researchers believe this growing wedge between reduced and full retirement benefits explains significant growth in the DI program, although others conclude it has boosted applications more than actual receipt.[7]

- **Economic downturn.** Many observers — buttressed by press stories and academic studies[8] — assume that the Great Recession and its aftermath account for rapid growth in the disability rolls. Yet economists generally find that while a sour economy significantly boosts *applications* to the program, it has a much smaller effect on *awards*. The implication is that economic downturns tend to attract more marginal, partially disabled applicants, but their applications are more likely to be denied.[9] Therefore, while the economic downturn has surely contributed to the program's growth, its influence should not be overstated.

One frequently overlooked facet of recent growth in the DI rolls is the fact that women have caught up with men. Until the mid-1990s, *insured* women of any age — that is, women who had worked enough to qualify for DI in the event of disability — were only about three-fourths as likely as insured men to receive DI benefits. Now they are equally likely to do so. (See Figure 3.) Because this comparison is limited to insured workers, this change is *not* simply explained by women's rising labor force participation. Researchers — who have overwhelmingly focused on how DI affects males' labor force participation — have rarely noted this trend and have studied it even less. Whatever the reasons for this trend, it does not seem valid to criticize as a deficiency, or a sign of recent laxness in the program, the growth in DI receipt that results from insured women reaching parity with insured men.

Trends in DI contrast with those in Supplemental Security Income (SSI), which is also run by the Social Security Administration but which — unlike DI (which receives a share of the Social Security payroll tax) — is means-tested and financed by general revenues. SSI pays subsistence benefits to people who are elderly or disabled and have little or no income and assets. People with severe disabilities who lack the work history for DI — as well as some who receive a very small DI benefit

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[7] Mark Duggan, Perry Singleton, and Jae Song, "Aching to Retire? The Rise in the Full Retirement Age and Its Impact on the Disability Rolls," National Bureau of Economic Research Working Paper 11811 (December 2005); Xiaoyan Li and Nicole Maestas, "Does the Rise in the Full Retirement Age Encourage Disability Benefits Applications? Evidence from the Health and Retirement Study," Michigan Retirement Research Center Working Paper 2008-198 (September 2008); Norma B. Coe and Kelly Haverstick, "Measuring the Spillover to Disability Insurance Due to the Rise in the Full Retirement Age," Center for Retirement Research at Boston College, Working Paper 2010-21, December 2010.

[8] Stephan Lindner and Austin Nichols, "The Impact of Temporary Assistance Programs on Disability Rolls and Re-Employment," Working Paper 2012-2, Center for Retirement Research at Boston College, January 2012; Matthew S. Rutledge, "The Impact of Unemployment-Insurance Extensions on Disability Insurance Application and Allowance Rates," Working Paper 2011-17, Center for Retirement Research at Boston College, October 2011; Alan Krueger and Andreas Mueller, in progress, "Applications for Disability Insurance and the Exhaustion of Unemployment Insurance Benefits: New Evidence from a Survey of Unemployed Workers."

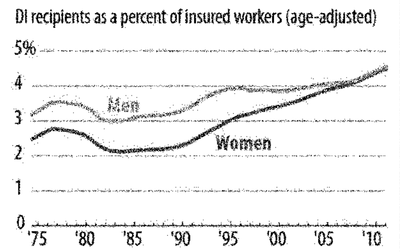
[9] Kalman Rupp and David C. Stapleton, "Determinants of the Growth in the Social Security Administration's Disability Programs—An Overview," *Social Security Bulletin*, Vol. 58, No. 4, October 1995;. Till von Wachter, Jae Song, and Joyce Manchester, "Trends in Employment and Earnings of Allowed and Rejected Applicants to the Social Security Disability Insurance Program," *American Economic Review*, December 2011.

— can turn to SSI for help to meet their basic needs. Until the recent economic downturn, the number of working-age SSI recipients between 18 and 64 had been stable or declining as a percentage of the U.S. population since the mid-1990s.[10] That trend is almost certainly related to the maturation of the DI program. As more people (especially women) qualify for DI on the basis of their prior work history and receive DI benefits that lift them over SSI's meager income limits, fewer qualify for SSI — a fact that is often overlooked.

Eligibility Criteria Are Stringent

The DI program aids people who, because of a severe medical impairment, can no longer support themselves by working. Its eligibility criteria are stringent:

Figure 3
Women's Receipt of Disability Insurance Has Caught Up With Men's



Source: CBPP based on data from Social Security Administration. Data are age-adjusted using 2000 weights.

- **Insured status.** Applicants for DI benefits must be both *fully insured* and *disability insured.* In general that means they must have worked for at least one-fourth of their adult lives and in at least five of the last ten years.[11] Applicants who cannot meet these requirements do not qualify for DI. (They may turn to SSI if their income and assets are very low.)

- **Severe impairment.** Applicants must show that they suffer from a "severe, medically determinable physical or mental impairment that is expected to last 12 months or result in death." Acceptable medical sources are licensed physicians or (for certain conditions) licensed psychologists, optometrists, speech/language pathologists, or podiatrists.[12] The agency generally gives greater weight to the applicant's treating physician, but treats that provider's opinion on the nature and severity of the applicant's impairment as controlling only when it is well supported by clinical and laboratory diagnostic techniques and is consistent with the other substantial evidence in the case record.[13] Other professionals — such as nurse practitioners or licensed clinical social workers — do not suffice, nor do statements from the applicant's family, friends, teachers, or co-workers. The Social Security Administration (SSA) will order and pay for a consultative examination where merited.

- **Inability to perform substantial work.** Applicants must be unable to perform substantial gainful activity, which is currently defined as an inability to earn $1,040 per month ($1,740 for

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[10] *Annual Report of the Supplemental Security Income Program*, May 2012, Table IV.B7.

[11] For applicants who become disabled very young — before age 31 — the recency requirement stipulates that they must have had earnings in half of the years since attaining age 21 (rather than in five of the last ten years).

[12] These acceptable medical sources are lists in the Code of Federal Regulations, §404.1513.

[13] See Code of Federal Regulations, §404.1527.

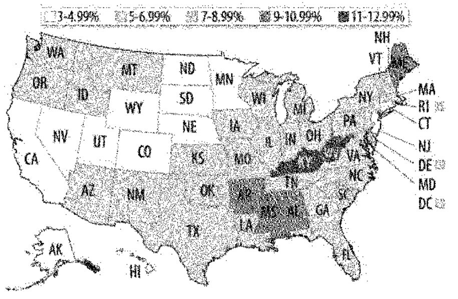
the blind).[14] That threshold amounts to working less than full-time (about 35 hours a week) at the minimum wage of $7.25, or less than 40 percent of the median earnings of full-time workers with a high school diploma but no college.[15] The law specifically requires that the applicant's impairment must render him not just unable to do his past work, but unable — considering his age, education, and work experience — to do *any other* kind of work that exists in the national economy, regardless of whether that work exists in his geographic area or whether he would be hired if he applied. So-called vocational factors — experience and education — are considered for older applicants with limited skills and education.

- **Waiting period**. The law requires that the impairment must already have lasted for at least five months before the applicant can qualify for DI. Together with the requirement that the impairment must be expected to last another 12 months or result in death, this emphasizes that DI is *not* a program for the temporarily disabled. SSI may be available during that period for very poor applicants; sick leave, private insurance, family resources, or savings might tide over others. The waiting period provides an intuitive reason why applications rise during recessions. In a robust economy, few workers will quit a job to subsist on little or nothing for five months with an uncertain prospect of a DI award; but in a recession, a spell of unemployment can last long enough for a disabled worker to satisfy the waiting period.

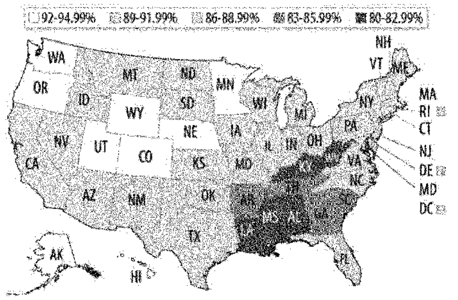
Claimants apply to the SSA, which rejects people who are technically disqualified (chiefly because they lack insured status) and submits the remaining applications to each state's disability determination service (DDS) for medical evaluation. If denied by the DDS, the applicant may appeal. Ultimately, of about 1,000 initial applications, about 410 are awarded benefits — more than one-third

Figure 4
Higher Rates of Disability Receipt Are Linked to Low Education, Other Factors

Percentage of Each State's Resident Population Age 18-64 That Receives Social Security Disability, SSI, or Both



Percent of Each State's Native-Born Population 25 and Over That Has Completed High School



Source: CBPP based on data from Social Security Administration and Bureau of the Census.

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[14] See http://www.ssa.gov/OACT/COLA/autoAdj.html. The SGA threshold rises in step with average wages.

[15] According to the Bureau of Labor Statistics, median weekly earnings for high school graduates 25 and older, employed full-time, were $652 in 2012.

of them on appeal.

Typical processing times at the DDS level are three to four months, and processing times at the hearing level average about a year.[16] The allowance rate at the Administrative Law Judge (ALJ) level (also known as the hearing level, generally the second level of appeal) is quite high, which has led to some valid concerns about inconsistency in decisions; yet it is important to remember that ALJs are often seeing claimants whose condition has deteriorated since their application was turned down and whose case file is better documented when it reaches the ALJ (often with the help of an attorney) than it was at the DDS stage.

Some critics imply that the geographic disparity in receipt of DI and SSI benefits is a sign of inconsistent standards. That is not correct. States that have a less-educated population (as evidenced by lower rates of high-school graduation), an older median age, fewer immigrants, and an industry-based economy (that is, with a greater-than-average concentration of mining, manufacturing, and forestry) also tend to have more disability recipients. (See Figure 4.) The program's eligibility rules explicitly take into account applicants' age, education, and ability to do past work or to transfer skills to another field of work. Geographic variation is a natural result.[17]

If accepted, claimants are subject to periodic review to verify that they are still disabled. These continuing disability reviews (CDRs) are, by law, supposed to be conducted at least once every three years unless the beneficiary's disability has been judged to be permanent. SSA estimates that CDRs result in eventual savings of nearly $10 in benefits (in Social Security, SSI, Medicare, and Medicaid) for each $1 they cost to conduct.[18] Nevertheless, as discussed below, Congressional cost-cutting efforts have hampered SSA's ability to conduct these reviews on schedule.

DI Provides Modest, but Critical, Benefits

DI recipients receive modest benefits, which are calculated by applying a progressive formula to their average earnings from early adulthood until the onset of disability (with up to five years of zero or low earnings dropped). Under the formula, higher earners receive larger *dollar* benefits but a lower *percentage* of their past earnings — a fraction known as the "replacement rate" — than do workers who received lower wages over their careers.

Most disabled workers collect benefits only for themselves. In a minority of cases, other family members may also be eligible to collect — most commonly, the minor children of the worker.[19]

The economic circumstances of most disabled workers are modest, and in some cases, even precarious. The average monthly DI benefit in December 2012 was just $1,130 (or $13,564 on an

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[16] Table 3.5, "Key Performance Targets," in Social Security Administration, *Full Justification of Estimates For Appropriations Committees,* February 2012, http://www.socialsecurity.gov/budget/2013FullJustification.pdf.

[17] Kathy A. Ruffing, "The Geography of Disability," Center on Budget and Policy Priorities Off the Charts blog, November 28, 2012, http://www.offthechartsblog.org/the-geography-of-disability/.

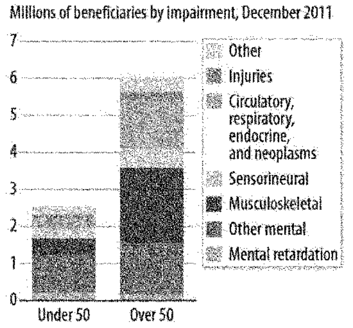
[18] Social Security Administration, *Annual Report of Continuing Disability Reviews*, May 1, 2012, http://www.socialsecurity.gov/legislation/FY%202010%20CDR%20Report.pdf.

[19] Spouses are eligible for benefits only if they are either age 62 or older, or are caring for the worker's eligible children.

annual basis). Only 7 percent of DI beneficiaries collected more than $2,000 a month.[20] A careful comparison of disabled workers' benefits to their past earnings found that their benefits replaced about 55 percent to 60 percent of average *lifelong* earnings for a median worker, and about 50 percent to 55 percent of *final* earnings prior to the disability.[21] People who receive disability insurance benefits undergo a sharp drop in their standards of living.[22]

Because it is a social-insurance program — not a means-tested program — DI pays benefits to eligible workers based on their medical condition and their past work, without regard to their assets or non-earnings income. Nevertheless, most beneficiaries depend on their DI benefits for their subsistence. Surveys show that DI benefits make up more than 90 percent of income for nearly half of non-institutionalized recipients, and more than 75 percent of income for the vast majority of recipients. Almost one-fourth of DI beneficiaries fall below the poverty line, and the majority live below 200 percent of the poverty line.[23] About 13 percent of disabled-worker beneficiaries also collect SSI, which indicates that they are very poor — SSI lifts them to just over three-fourths of the poverty line — and that they have few or no assets.[24]

Figure 5
Typical Disabled Worker is Over 50 and Has Severe Mental, Musculoskeletal, or Other Impairment



Source: Social Security Administration.

Few Beneficiaries Could Support Themselves by Working

Practically since the DI program's creation, economists and policymakers have debated whether it results in workers leaving the labor market. Evidence suggests, however, that few beneficiaries could earn more than very small amounts if they did not receive DI.

The typical DI beneficiary is in his or her late 50s — 70 percent are over age 50, and 30 percent are 60 or older — and suffers from a severe mental, musculoskeletal, circulatory, respiratory, or another debilitating impairment.[25] (See Figure 5.) Mortality rates among DI beneficiaries are three to five times as high as for the general population. Nearly one-quarter of beneficiaries lack a high

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[20] Computed from http://www.ssa.gov/OACT/ProgData/benefitlevel.html. Specifically, 11 percent of male beneficiaries and 3 percent of females received $2,000 per month or more.

[21] L. Scott Muller, "The Effects of Wage Indexing on Social Security Disability Benefits," *Social Security Bulletin*, Vol. 68, No. 3, 2008.

[22] Bruce D. Meyer and Wallace K.C. Mok, "Disability, Earnings, Income and Consumption," National Bureau of Economic Research Working Paper 18869, March 2013.

[23] Anne DeCesaro and Jeffrey Hemmeter, "Characteristics of Noninstitutionalized DI and SSI Program Participants," Social Security Administration, Office of Research, Evaluation, and Statistics, Research and Statistics Note No. 2008-02, January 2008.

[21] Table 3.C6, *Annual Statistical Supplement to the Social Security Bulletin*, 2011.

[25] Age data for December 2011, from the Social Security Administration, Office of the Chief Actuary, http://www.ssa.gov/OACT/ProgData/beniesQuery.html; diagnostic data from Social Security Administration, *Annual Statistical Report on the Social Security Disability Insurance Program*, 2011.

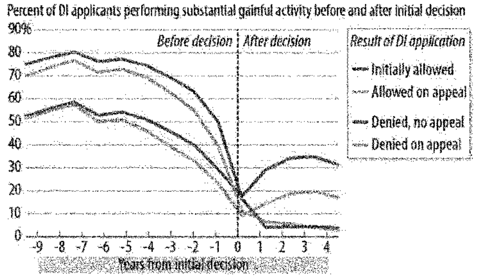
school diploma, and only 10 percent have a four-year college degree.[26] Labor-market prospects for such applicants are poor.

It is important to note that DI beneficiaries are permitted to work. After all, the criterion for eligibility is not complete inability to work, but rather the inability to perform substantial gainful activity (SGA). There is no bar on recipients earning up to the SGA threshold — currently $1,040 per month — while collecting benefits. Recipients may earn *unlimited* amounts for a short period without jeopardizing their benefits, while they test their ability to return to work. DI benefits are low, and one would expect beneficiaries to take advantage of these rules by trying to supplement their benefits with earnings if they are able to do so.

Most beneficiaries, however, do not have earnings. (See Figure 6.) Researchers report that only 12 percent of DI recipients were employed in 2007, when the labor market was still strong. A larger fraction (28 percent) of beneficiaries who were tracked for ten years worked at some point after their DI application was approved, but generally episodically and at low earnings. Only 7 percent had their benefits suspended for even a single month because their earnings exceeded the threshold. Just 4 percent had their benefits *terminated* because of earnings, and of those, more than one-quarter subsequently returned to the DI rolls. Not surprisingly, beneficiaries who were younger than 40 when they began to receive DI — a distinct minority of beneficiaries — resumed working at higher rates than did older disabled workers.[27]

Figure 6

DI Applicants Experience Sharp Drop in Earnings Before Application; Few Work Afterward



Source: Nicole Maestas, Kathleen Mullen and Alexander Strand, "Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt," Michigan Retirement Research Center Working Paper 2010-241. Additional plot points, through 4 years after decision, courtesy of the authors.

If beneficiaries could readily work, we might expect a substantial number to make use of the program's work incentive features to maximize their earnings *without* losing DI benefits. Yet there's scant evidence of such behavior. Studies of beneficiaries who hold their earnings just under the SGA (a behavior known as "parking"), presumably to avoid triggering benefit suspension, and of DI beneficiaries who are converted to retirement benefits (when their earnings are no longer subject to any restrictions) indicate some work capacity but not enough to be economically meaningful.[28]

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[26] De Cesaro and Hemmeter, *op. cit.*

[27] Arif Mamun, Paul O'Leary, David C. Wittenburg, and Jesse Gregory, "Employment Among Social Security Disability Program Beneficiaries, 1996-2007;" Su Liu and David C. Stapleton, "Longitudinal Statistics on Work Activity and Use of Employment Supports for New Social Security Disability Insurance Beneficiaries," *Social Security Bulletin*, Vol. 71, No. 3, 2011.

[28] Jody Schimmel, David C. Stapleton, and Jae Song, "How Common is 'Parking' Among Social Security Disability Insurance Beneficiaries? Evidence from the 1999 Change in the Earnings Level of Substantial Gainful Activity," *Social Security Bulletin*, Vol. 71, No. 4, 2011; Nicole Maestas and Na Yin, "The Labor Supply Effects of Disability Insurance

Researchers note that even *rejected* applicants — who are, presumably, less disabled than successful claimants — fare poorly in the labor market, thus illustrating that the program's eligibility criteria are indeed stringent. The latest and most exhaustive study finds that barely half of rejected applicants have *any* earnings; even fewer had *significant* earnings; and — for those with earnings — median amounts are very low. (See Table 1.)[29]

A widely cited recent study provocatively implies that in as many as one-quarter of cases, applicants' fates might hinge on whether they are assigned to a relatively lenient or extremely tough DDS examiner. It nevertheless concludes that the effects on work and earnings are relatively small — on average, only $1,600 to $2,600 a year.[30]

Table 1

Even Rejected Applicants Fare Poorly in Labor Market

	Accepted applicants	Rejected applicants	Non-applicants
With *any* earnings two years after application	20%	53%	82%
With *significant* earnings two years after application	13%	43%	79%
Median nonzero earnings	$3,500	$10,000	$35,000

Source: CBPP based on von Wachter, Song, and Manchester, 2011. Data are for men age 45 through 64. Nonapplicants were selected to mimic applicants in terms of age and previous earnings. For simplicity, figures for accepted applicants are a weighted average of those allowed at the DDS and ALJ levels. "Significant" earnings were defined as the equivalent of three months of full-time work at minimum wage, or about $2,700 in 2000. Median earnings are expressed in 2000 dollars.

In short, there is little reason to think that many DI beneficiaries could support themselves by working. The program's beneficiaries are people who worked in the past, lost their ability to work substantially, and only rarely recover. Its criteria are sufficiently stringent that it rejects many applicants who struggle mightily in the labor market thereafter.

Policymakers Should Address DI in Context of Overall Solvency

As Stephen Goss, the chief actuary of the Social Security Administration, testified last week, the DI program faces financial challenges.[31] It is currently experiencing its peak demographic stress, and pressures will lessen as the economy recovers and as the baby boomers "age out" of the disability

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Work Disincentives: Evidence from the Automatic Conversion to Retirement Benefits at Full Retirement Age," Michigan Retirement Research Center, Working Paper 2008-194, September 2008.

[29] The table focuses on applicants age 45-64, who dominate the DI rolls. The authors found somewhat higher rates of employment among younger applicants: 58 percent of rejected male applicants age 30 to 44 (versus about 19 percent of accepted applicants) had non-negligible earnings two years after application, compared with 85 percent of nonapplicants. Again, however, the amount of earnings for applicants was paltry. The median *rejected* applicant who worked made just $8,000; *accepted* applicants earned far less.

[30] Nicole Maestas, Kathleen Mullen, and Alexander Strand, "Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt," Michigan Retirement Research Center Working Paper 2010-241, 2010.

[31] Testimony by Stephen C. Goss, Chief Actuary, Social Security Administration, before the House Committee on Ways and Means, Subcommittee on Social Security, March 14, 2013.

program and onto the retirement rolls. Nevertheless, the DI program faces sustained deficits under current policies, and its trust fund is expected to be exhausted in 2016.

Over the long run, DI and the much larger OASI program face similar funding gaps. For both programs, the 75-year imbalance is about one-fifth of income or one-sixth of costs. DI's insolvency, however, looms much closer. The separate OASI trust fund would face depletion in 2035. Combined, the two trust funds would run out in 2033.[32]

DI's projected exhaustion should not come as a surprise. When lawmakers last redirected some payroll tax revenue from OASI to DI in 1994, the program's actuaries projected that step would keep DI solvent until 2016. Despite fluctuations in the meantime, the current projection anticipates depletion in 2016.

When the trust funds are depleted, if policymakers took no action, benefits would be cut to whatever level could be covered by incoming tax receipts. In the case of DI, that means benefits would be cut by about one-fifth in 2016, though by slightly smaller fractions in later years.

Such a sudden and sharp cut in benefits — benefits that recipients depend on for most or all of their income — is unacceptable. Because the DI and OASI programs face similar shortfalls, and because their eligibility criteria and benefit calculations are so closely intertwined, it makes sense to address them together. Lawmakers should take steps reasonably soon to put the *entire* Social Security program on a sound footing for the long run and divide payroll tax revenues between the two programs as necessary.

Addressing the programs in tandem makes compelling sense:

- **More options are available.** Many leading options to improve solvency — such as raising the taxable maximum (currently $113,700) or using the "chained CPI" to compute cost-of-living adjustments in Social Security and other programs (as well as to adjust features of the tax code that are indexed for inflation)[33] — would bolster both the OASI and DI programs. Limiting the menu to options that would affect only DI (other than a straightforward payroll-tax increase) would leave few options, most of which would be draconian.

- **Many features are common to both programs.** Key features of the OASI and DI programs are similar or identical. The insured-status tests, the method of computing Average Indexed Monthly Earnings (AIME), and the formula for calculating the Primary Insurance Amount (PIA, or basic benefit) from AIME are seamless in the two programs, and provisions for spouses' and children's benefits are similar. Some proposals to achieve solvency treat these similarities as an afterthought, concentrating on the retirement program and offhandedly stating

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[32] *The 2012 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, April 2012, http://www.ssa.gov/OACT/TR/2012/index.html; Kathy Ruffing, *What the 2012 Trustees' Report Shows About Social Security*, Center on Budget and Policy Priorities, May 10, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=3774.

[33] Kathy Ruffing, Paul N. Van de Water, and Robert Greenstein, "Chained CPI Can Be Part of a Balanced Deficit-Reduction Package, Under Certain Conditions," Center on Budget and Policy Priorities, February 22, 2012, http://www.cbpp.org/cms/?fa=view&id=3690.

that the options in question would not apply to DI recipients until they're converted to retirees. But that can lead to perverse and inequitable results.

Changes in the AIME and PIA calculations are powerful tools for affecting the future level of benefits and should be carefully coordinated across Social Security's retirement, disability, and survivors' programs.

- **Some Social Security retirement changes would have strong spillover effects onto disability benefits.** Another potent tool for achieving savings in Social Security is to increase the retirement age. This option appears in many deficit-reduction plans — for example, in the Bowles-Simpson plan, in proposals advanced in 2008 and 2010 by Congressman Paul Ryan, in illustrative options developed for the National Academy of Sciences, and many others.[34] While raising the retirement age would not directly affect disabled-worker beneficiaries, it would — in the absence of other changes — worsen pressures on the disability program, by widening the gap between disability and early-retirement benefits and by delaying the age at which DI beneficiaries are converted to Social Security retirement beneficiaries

  Table 2

  Rising Retirement Age Widens the Wedge Between Disability and Early-Retirement Benefits

Year attaining age 62	Full retirement age (FRA)	% of PIA paid to age-62 retiree	% of PIA paid to disabled worker
Before 2000	65	80%	100%
2000-2005	FRA increases by 2 months per year		100%
2005-2016	66	75%	100%
2017-2022	FRA increases by 2 months per year		100%
2022 and beyond	67	70%	100%

  PIA=Primary Insurance Amount, the basic amount on which all Social Security benefits are based. Source: Social Security Administration.

  The basic benefit for a disabled worker is 100 percent of PIA — the same benefit paid to a worker who files at his or her full retirement age. That equivalence dates back to the inception of the DI program, when the full retirement age was 65 and there was no early-retirement option for men.[35] The introduction of early retirement for men created a differential between disability and early-retirement benefits, and the increase in the retirement age to 66 — and eventually to 67 — widen that differential. (See Table 2.) Options to raise the retirement age further would exacerbate the gap.

  Policymakers should take a hard look at the wedge between early-retirement and disability benefits before the retirement age rises to 67 under current law, and they certainly must address the issue if they propose to raise the age further.

- **Changes in related programs should be considered**. Social Security retirement and disability insurance, Medicare, Medicaid, and SSI serve overlapping populations. A balanced

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[34] See, for example, options C1.1 through C2.8 on the actuaries' "menu" at http://www.ssa.gov/OACT/solvency/provisions/index.html.

[35] Early retirement for women was introduced in 1956, for men in 1961. Few women qualified for DI in those early years of the program — male beneficiaries outnumbered females by about 4 to 1.

solvency package would consider those interactions and make selected changes to non-Social Security programs, as appropriate.

Because Social Security benefits are so modest and make up the principal source of income for most recipients, legislators should use tax increases to generate at least half of the savings in a solvency package. Those could come from raising the maximum amount of wages subject to the payroll tax (which now encompasses only about 83 percent of covered earnings, well short of the 90 percent figure envisioned in the 1977 amendments); broadening the tax base by subjecting voluntary salary-reduction plans, such as cafeteria plans and health-care Flexible Spending Accounts, to the payroll tax (like 401(k) plans and similar retirement accounts); and raising the payroll tax rate. Future workers are expected to be more prosperous than today's. Under the trustees' assumptions, the average worker will be 50 percent better off — in real terms — in 2040 than in 2012, and twice as well off by 2070. It is appropriate to devote a small portion of those gains to the payroll tax, while still leaving future workers with much higher take-home pay. Social Security is a popular program, and poll respondents consistently express a willingness to support it through taxes.[36]

If policymakers cannot agree on a well-rounded solvency package before 2016, they should — as a stopgap — reallocate payroll taxes between the two programs. Congress has done that on at least six occasions in the past, and in both directions, demonstrating that this is a traditional and uncontroversial step.[37] The actuaries estimate that temporarily raising the DI share (currently 1.8 percentage points) of the 12.4 percent payroll tax by 0.8 percentage points through 2014, and then by amounts that gradually shrink to just 0.2 percentage points in 2021-2029, would enable both of the trust funds to pay scheduled benefits through 2033 — their combined exhaustion date.[38]

Policymakers Should Provide Sufficient Administrative Funds

Appropriations for SSA's operations (including the tasks performed for SSA by the state disability determination services) are part of discretionary spending, a category that faces a tight squeeze in the years ahead. SSA's administrative funding has been frozen since 2010, despite growing caseloads in all three of its programs (OASI, DI, and SSI).[39] Moreover, the Budget Control Act (BCA) of 2011 adopted aggregate caps on discretionary spending that will cut non-defense discretionary programs significantly, in real terms, by 2021; and that's before the automatic cuts imposed by sequestration.[40]

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[36] Jasmine V. Tucker, Virginia P. Reno, and Thomas N. Bethell, *Strengthening Social Security: What Do Americans Want?*, National Academy of Social Insurance, January 2013; Pew Research Center for the People and the Press, *Public Wants Changes in Entitlements, Not Changes in Benefits*, July 7, 2011; Colette Thayer, *Social Security 75th Anniversary Survey Report: Public Opinion Trends*, AARP, August 2010.

[37] Using a narrow definition of "reallocation" — one in which the total tax rate remained the same but the split between OASI and DI changed — there were six such instances (three from OASI to DI, three from DI to OASI). Using a broader definition — one in which the total tax rate changed and the OASI and DI rates changed in opposite directions — there were an additional five instances (three from OASI to DI, two from DI to OASI).

[38] Memorandum to Alice Wade, Deputy Chief Actuary, from Chris Chaplain and Jason Schultz (Supervisory Actuaries) and Daniel Nickerson (Actuary), April 23, 2012. Estimates are based on the assumptions of the 2012 trustees' report.

[39] SSA also handles many administrative functions related to Medicare enrollment, but those costs are reimbursed by the Medicare trust funds.

[40] Richard Kogan, "Congress Has Cut Discretionary Funding By $1.5 Trillion Over Ten Years," Center on Budget and Policy Priorities, November 8, 2012, http://www.cbpp.org/cms/index.cfm?fa=view&id=3840; Richard Kogan, "OMB

SSA needs adequate funding to perform its jobs. Those include not just processing applications and administering payments, but carrying out crucial program integrity activities. The BCA included a special "cap adjustment" for such activities — which in SSA's case include continuing disability reviews (CDRs) and SSI redeterminations of financial eligibility. These limited funding increases do not require offsetting reductions in other non-defense appropriations; in effect, such increases are outside the statutory caps on annual non-defense appropriations that the BCA established.

As noted previously, CDRs are estimated to reduce eventual benefit payments by nearly $10 for every $1 in increased administrative funding, by removing from the rolls people who are no longer eligible. Congress nevertheless *failed* to take full advantage of the allowable cap increases adjustment in the 2012 appropriation, and is on track to do so again in 2013.[41] While lawmakers debate how to restore long-run solvency to Social Security, funding disability reviews properly is a sensible, money-saving step that they should take right now.

Conclusion

DI's trust-fund exhaustion comes as no surprise — it was anticipated in 1995[42] — and should not be considered evidence that the program is out of control. While researchers cannot fully dissect *all* of the reasons for the program's growth, it's clear that the bulk of it comes from demographic factors, women's entry into the labor force in large numbers, and the increase in the Social Security retirement age, and that the DI program's growth will taper off in the next decade.

DI is an integral part of the Social Security program, and legislators should address it in the context of overall Social Security solvency. The common features and interactions of DI and OASI would make efforts to fix the two programs separately a mistake.

Because Social Security's finances are fairly predictable, it is not difficult to craft revenue and benefit proposals that would place the program on a sound long-term footing. The best proposals would protect vulnerable workers and beneficiaries and give all participants ample warning of future changes to this vital program. That will enable them to plan their work, savings, and retirement with confidence — while continuing to count on Social Security's protection in the event of early death or disability.

If policymakers are unable to agree on a well-rounded solvency package before DI faces depletion, they should reallocate taxes between the two programs as a stopgap, as they have done multiple times in the past, while intensifying efforts to develop a long-term solvency package that restores the program's financial health for decades to come.

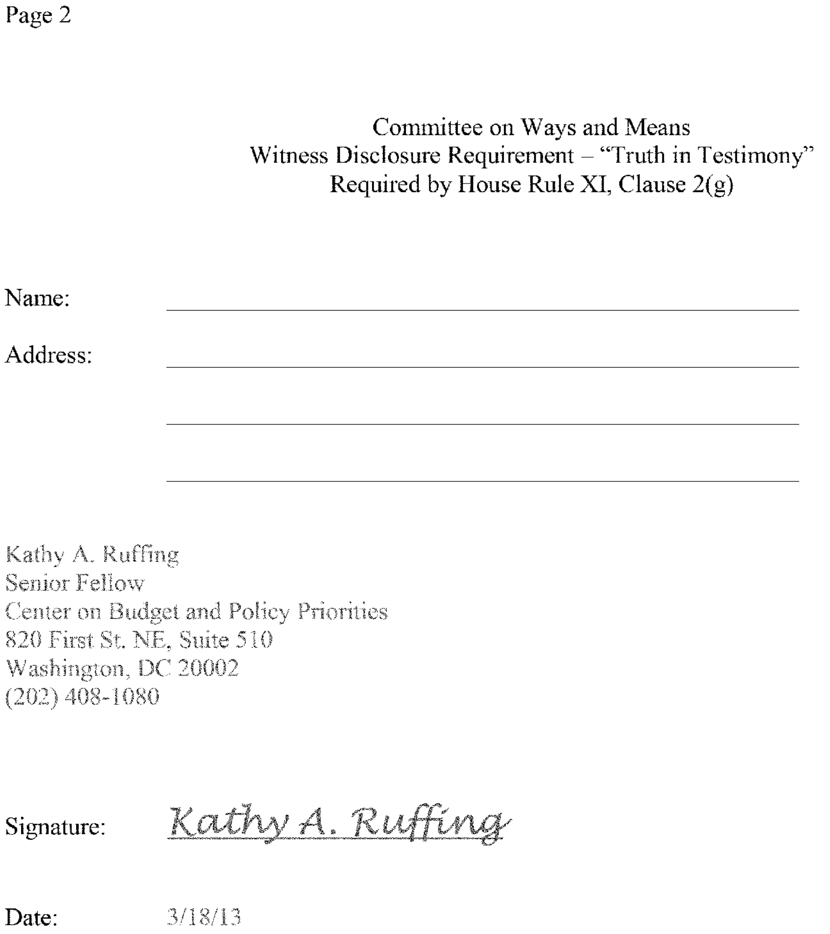
Announces Amounts of Budget Cuts Under Sequestration," Center on Budget and Policy Priorities Off the Charts blog, March 4, 2013, http://www.offthechartsblog.org/omb-announces-amounts-of-budget-cuts-under-sequestration/.

[41] Kathy A. Ruffing, "Failure to Fund Disability Reviews Is Penny Wise and Pound Foolish," Center on Budget and Policy Priorities Off the Charts blog, March 11, 2013, http://www.offthechartsblog.org/failure-to-fund-disability-reviews-properly-is-penny-wise-and-pound-foolish/.

[42] The 1994 Trustees Report anticipated that DI would be depleted in 1995. The 1995 report anticipated depletion in 2016. In the meantime, the Social Security Domestic Employment Reform Act of 1994 (Public Law 103-387, signed on October 22, 1994) made several changes to the OASDI program, including directing a modestly larger portion of the 6.2 percent payroll tax to DI.

Committee on Ways and Means
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Kathy A. Ruffing		
1. Are you testifying on behalf of a Federal, State, or Local Government entity? a. Name of entity(ies). b. Briefly describe the capacity in which you represent this entity.	Yes ☐	No ■
2. Are you testifying on behalf of any non-governmental entity(ies)? a. Name of entity(ies). Center on Budget and Policy Priorities b. Briefly describe the capacity in which you represent this entity. Senior Fellow	Yes ■	No ☐
3. Please list any Federal grants or contracts (including subgrants or subcontracts) which you have received during the current fiscal year or either of the two previous fiscal years: None		
4. Please list any offices or elected positions you hold. None		
5. Does the entity(ies) you represent, other than yourself, have parent organizations, subsidiaries, or partnerships you are not representing? International Budget Partnership; D.C. Fiscal Analysis Institute	Yes ■	No ☐
6. Please list any Federal grants or contracts (including subgrants or subcontracts) which were received by the entity(ies) you represent during the current fiscal year or either of the two previous fiscal years, which exceed 10 percent of entity(ies) revenues in the year received. Include the source and amount of each grant or contract. Attach a second page if necessary. None		



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Committee on Ways and Means
Witness Disclosure Requirement – “Truth in Testimony”
Required by House Rule XI, Clause 2(g)

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Chairman JOHNSON. Thank you, ma’am. I guess I got to push my button, too. Thank you, ma’am.

Ms. Lyon-Hart, welcome again. Please proceed.

STATEMENT OF TRUDY LYON-HART, DIRECTOR, OFFICE OF DISABILITY DETERMINATION SERVICES, VERMONT AGENCY OF HUMAN SERVICES, ON BEHALF OF THE NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

Ms. LYON-HART. Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, thank you for this opportunity to testify on the challenges of disability determination. I speak on behalf of the National Council of Disability Determination Directors, representing the management of the disability determination services. We process nearly 4.8 million cases a year, working with Social Security to provide consistent, fair, accurate, timely, and cost-efficient decisions to disability applicants, and to ensure program integrity.

The disability criteria are very strict by design. DDSs allow roughly a third of initial claims, about 70 percent of all favorable decisions, with better than 97 percent accuracy. DDSs also process medical continuing disability reviews, CDRs, resulting in $9 of program savings for each administrative dollar spent.

DDSs face serious challenges. Backlogs keep rising, now nearly 190,000 cases waiting many months to be assigned to an adjudicator while a hiring freeze continues for a third year. When we hire, it takes two years training to recover lost capacity.

Budgets are challenging all across government. With tight oversight, DDSs keep expenditures mission-critical and cost-effective. We ask Congress for the funding to serve disability applicants and bring CDRs up to date in a carefully planned, strategic way.

We also recommend considering policy changes to improve consistency and preserve integrity of this important program. My testimony today will speak to three highly complex policies that have the most potential for inconsistency in decision-making. I will also touch on the medical improvement standard for CDRs.

The first policy is evaluation of symptoms. A medical impairment that could cause the symptom is required. But objective findings are often not sufficient to determine resulting limitations. The same diagnosis affects different people differently. Policy requires assessing credibility, evaluating the consistency and degree of support for the statements throughout the record, not a gut feeling about the person's truthfulness.

Second is medical source opinion. Treating source opinions are controlling only if well-supported by objective medical evidence and consistent with other substantial evidence. If not controlling, opinions must still receive appropriate weight, considering all facts of the case.

Third is residual functional capacity, an administrative assessment of what the person can do on a sustained basis, requiring difficult judgements about function, given fluctuating symptoms and differing medical opinions.

Adjudicators may interpret these policies differently in individual cases. The information itself is subjective. Policy defines the factors we must consider, but does not direct any specific decision.

SSA and DDS work together to improve quality and consistency: intensive training, mentoring, performance management, technology to support case analysis, nationalized quality review, and centralized program consultation. All are helpful, but more work is needed.

We should think carefully about changing policy. It would not be right or fair to many truly disabled people not to consider their symptoms and the opinions of the doctors that know them best. However, we should look for ways to decide disability with fewer resources and more consistency.

A few words about CDRs and the medical improvement standard. This policy was developed in the mid-eighties in response to public outcry over the way people were being taken off the rolls. With few exceptions, the policy requires significant work-related medical improvement for benefit cessation, whether or not the prior allowance established a truly disabling impairment. Adjudicators may not substitute their judgement for that used in the prior allowance.

In practice, medical cessations are not common. We recommend a review of statute and policy to advance program integrity, while doing no harm to people who continue to qualify. Due process and the real effects of aging, chronic impairment, and time out of the workforce are important. Even under current policy, medical CDRs provide substantial savings. Unfortunately, funding has not been sufficient for timely processing of either CDRs or new applications. And both are critical.

In conclusion, DDSs have long provided high-quality service and program stewardship. Together with SSA, we have made strides in consistency, despite the challenge inherent in deciding who can and cannot work. Sufficient resources are critical for continuing this work. With our knowledge of front-line adjudication, we recommend careful policy revision to improve the program.

Thank you again for the opportunity to provide this testimony, and I would be glad to answer any further questions.

[The prepared statement of Ms. Lyon-Hart follows:]

TESTIMONY OF
TRUDY LYON-HART, PRESIDENT
NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS
to the
SUBCOMMITTEE ON SOCIAL SECURITY
OF THE
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
March 20, 2013

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee:
Thank you for the opportunity to testify on behalf of the National Council of Disability Determination Directors (NCDDD) to provide information on Social Security Disability Program policy and the challenges in its application in disability determination. NCDDD is a professional association composed of the Directors and managers of the Disability Determination Services (DDS) agencies located in each state and the District of Columbia. NCDDD's members direct the work of approximately 15,000 employees. Annually we process over 4.8 million cases, including initial claims, continuing disability reviews, and reconsideration-level appeals.

NCDDD's goals focus on providing consistent, fair, accurate, timely, and cost-efficient decisions. The DDS community works in partnership with the Social Security Administration (SSA) to provide high quality public service to individuals applying for disability benefits, and to help ensure the integrity of the disability program.

The Social Security disability criteria are very strict by design. In recent years, the DDSs have allowed 33-36% of initial claims, and 11-14% of the reconsideration-level appeals. However, the DDS allowances make up the vast majority of the allowances overall – last year, for example, the DDSs cleared 1,014,601 initial and 92,601 reconsideration allowances. In any given year, over 70% of applicants who receive a favorable disability determination receive it from the DDS, at the initial or reconsideration level, without a long wait for a decision by an Administrative Law Judge.

Both our allowance and denial determinations are very accurate. By statute, SSA reviews 50% of the allowances before the decisions are effectuated, and the DDS "PER" (pre-effectuation review) error rate has been under 3% for the past 5 years. SSA also performs a quality review sample of both allowances and denials, and the DDS net accuracy rate has been 97% or better over the last 3 years.

The DDSs also process medical Continuing Disability Reviews (CDRs) under the Medical Improvement Review Standard (MIRS). The MIRS policy protects people from being taken off the rolls without proof that their medical condition has significantly improved. Despite a very low cessation rate under this policy, processing medical CDRs results in $9-10 of program savings for every administrative dollar spent.

The DDSs face serious challenges in maintaining high quality service and program stewardship, as greater numbers apply for benefits while a hiring freeze continues for a third fiscal year. Occasionally SSA has been able to fund a small amount of DDS replacement hiring. However, the DDSs do not recover lost capacity for two more years – the time it takes to train a new adjudicator. Without sufficient funds for advance hiring and adjudicator training, the DDSs have great difficulty processing additional stewardship workloads such as CDRs.

Initial and reconsideration cases are already sitting without being worked for months in many DDSs. As of March 8, 2013, nearly 19% of the pending initial cases and 34% of the reconsiderations (totaling almost 190,000 cases) were backlogged awaiting assignment to an adjudicator. Balancing inadequate resources between the initial/reconsideration and the CDR workloads is increasingly detrimental to both customer service and program integrity. In some states, initial and reconsideration cases may have priority over CDR completion since initial applicants have not had the opportunity to receive critical benefits and associated health care.

Budget cuts and shortfalls present challenges across all of government. Under tight regulatory and budget oversight, the DDSs historically have kept expenditures mission-critical and cost-effective. We regularly give high quality service, productivity, and return on investment for the funding we receive. We request Congress provide the funding necessary for us to serve the vulnerable population of people with disabilities and to carry out the number of CDRs necessary to bring program stewardship up to date in a carefully planned, strategic way. Along with this administrative funding, we recommend certain policy challenges be examined and where appropriate changed to improve decision-making and preserve the integrity of this important program for the future.

The following testimony provides an overview of disability evaluation and discusses specific policy areas that are problematic in their complexity and potential for inconsistency in decision-making.

Overview of Disability Evaluation for Social Security

The DDSs make complex medical determinations for the Social Security disability program in accordance with Federal law, regulations, Social Security rulings and policy guidance. The statutory definition of disability for adults is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) that can be expected to result in death or to last for a continuous period of at least 12 months. A medically determinable impairment must be documented by medical evidence including relevant clinical signs, symptoms and laboratory findings. While individuals provide a list of their medical providers when they apply, the DDS does the work of obtaining the medical reports and records, ordering additional examinations or tests if needed, and obtaining sufficiently detailed reports to cover the individual's impairments according to Social Security's evidentiary requirements for disability evaluation.

In deciding claims, the DDS follows the sequential evaluation policy in the *Code of Federal Regulations*. For adult claims, this involves consecutively assessing current work activity, the severity of the impairment(s), whether the impairment meets or equals those described in the *Listing of Impairments*, the residual functional capacity for past work and finally the capacity for other work in the national economy, considering age, education and work experience. The first three steps help streamline the process and conserve administrative resources for the most difficult areas of evaluation. The first two rule out people who are currently performing substantial gainful activity or who have no medically determinable impairment imposing any significant work-related limitations. The third step – determining Listing-level severity – helps us award benefits quickly to those with exceptionally severe impairments.

The *Listing of Impairments* describes medical conditions that are considered severe enough to prevent any gainful activity. Most of the entries are not based solely on diagnosis but also require specific medical findings and associated functional limitations demonstrating great severity. These impairments are generally permanent, expected to be of lengthy duration, or cause death. Examples include terminal cancers, ALS, amputation of two hands, strokes resulting in permanent loss of use of two limbs, and chronic schizophrenia with repeated, extended episodes of decompensation.

The fourth and fifth steps of sequential evaluation require a full medical/functional/vocational assessment that is much more labor-intensive than the previous steps. The DDS must make findings of fact about the individual's remaining capacity to perform and sustain a detailed set of work-related functions, physical and mental, such as lifting, carrying, walking, standing, sitting, stooping, use of hands and arms, understanding, remembering, concentrating, persisting on task, interacting with people, and handling changes. This Residual Functional Capacity (RFC) assessment also includes the ability to work around various environmental challenges such as dust, fumes, hazards, and extreme temperatures. The RFC is derived from an in depth analysis of the medical and functional information the DDS has obtained from healthcare records, medical, psychological or other types of evaluations, and the statements of the applicant and other knowledgeable sources. RFC assessment must consider the impact of the individual's symptoms on function, the credibility of the individual's statements, and the amount of weight to give to medical source opinions.

Once RFC is established, the DDS must determine whether the individual has the capacity to perform any past relevant work performed within the prior 15-year period, either as the person performed it, or as usually performed in the national economy. If the individual cannot do any past work, then the DDS must determine whether there are other jobs existing in the national economy that the person can perform, considering age, education and past work experience.

Policy Areas of Particular Complexity

Determining whether someone can or cannot work by nature involves more than just objective medical findings. The same diagnosis and the same or similar clinical findings may affect one person quite differently than another in their functional capacity for work, for many reasons. Accurate disability determination is not an exact science. It involves adjudicative judgments, and in Social Security disability many of the policies to be applied are often very detailed and complex. Three policy areas are particularly challenging. They are the core of disability evaluation for those individuals whose impairments are not clearly disabling on a purely objective medical basis.

1. Symptoms and Credibility

   The evaluation of pain and other symptoms and their limiting effects starts with determining whether the person has a medically determinable impairment that could cause the symptoms. Once the related impairment is established, the DDS must evaluate the intensity, persistence and functional limitations affecting basic work activities, based on descriptions provided by the applicant, the medical reports, and any other reports or observations. The assessment includes considering the credibility of the person's statements and determining the appropriate weight to give them. The policy directs consideration of various factors: description of symptom location, duration, frequency, and intensity; precipitating or aggravating factors; impact on daily activities; medications, treatments, and other measures to relieve the symptoms, their effectiveness, and any side effects. Credibility assessment is not a "gut feeling" about the person's overall truthfulness, but rather an evaluation of the consistency of the statements throughout the record and the support for them in the medical findings and other information in the file. However, we cannot disregard an individual's statements solely because the objective medical evidence does not substantiate them. While the policy provides guidance and lists the factors to consider in symptom evaluation, in the end there is no way to measure conclusively symptom severity and credibility. The adjudicator is expected to draw reasonable conclusions based on the evidence in each individual case.

2. Medical Source Opinion

   The policy requires adjudicators consider all medical source opinions, (i.e. statements about the nature and severity of the impairment/s). Different medical sources may have different observations and opinions. Controlling weight must be given to treating source opinions that are well supported by objective medical evidence and not inconsistent with other substantial evidence in the file. Controlling weight should not be given to opinion without substantiation or supporting objective findings. When controlling weight is ruled out, the opinion must still be considered and weighed. Factors the policy directs us to consider include the relationship between the source and the claimant, the source's specialty, the value of the supporting evidence, and the consistency of the opinion with other evidence in the file. There is no exact formula for the relative weighing of all these factors. It can be very complicated to sort out all the opinions and facts that tend to support or contradict them, and then it can be very challenging to decide and explain the appropriate weight for each. Different adjudicators can legitimately weigh all these factors differently and come to different conclusions.

3. Residual Functional Capacity (RFC) and Sustainability

   The RFC is the administrative assessment of what work-related functions the individual can do (physically and mentally). It is based on all the evidence, including the objective medical findings, the individual's statements about limitations (to the degree the adjudicator has found them credible) and the opinion evidence (to the degree of weight the adjudicator has assigned each opinion based on how much it is supported by and consistent with the rest of the evidence). The RFC should reflect the most that a person can do on a sustained basis over time. It is particularly difficult to assess applicants who have fluctuating levels of pain or fatigue, or other symptoms that wax and wane in a variable way.

These are the most difficult judgment areas, where different adjudicators may interpret and apply the policies differently in individual cases. These are also the areas where the information being evaluated is subjective by nature, coming from applicant self-reports and opinions from different sources with different perspectives. The subjectivity of these decisions does not mean that adjudicators can decide cases based on their personal beliefs and assumptions about the claimant's impairment severity. The policies clearly direct the adjudicator to consider specific factors, and they provide some guidance about how to assign weight. What the policies do not – and cannot – do is provide a formula that directs a specific decision in an individual case. These case evaluations call for careful attention to detail and thoughtful analysis of all the information in the case file, as well as knowledge of the functional ramifications of medical findings.

SSA and the DDSs maintain programs to teach this type of decision-making, and the DDSs do an excellent job achieving sustained high accuracy of their decisions, despite the ambiguity of the policy, and the challenges of high workload, insufficient staffing, and continued loss of experienced staff. Although individual case decisions are generally found to be accurate, achieving consistency all across the country and at all appeal levels, especially in these areas of subjective decision-making, is a continuous improvement project.

The DDSs work collaboratively with SSA to improve consistency. All DDSs provide intensive training and mentoring to new adjudicators, as well as ongoing mentoring and refresher training. SSA and DDSs are working together to make the best training resources readily available to all DDSs across the nation, through organization and continual updating of online resources, video on demand training sessions, national policy dialogues and refreshers, online training case examples, and web-based state-to-state sharing of training materials. Information technology tools such as the electronic claims analysis tool (eCAT) also help to standardize the way DDS adjudicators think through the evaluation process and explain their decisions in writing. The predictive modeling software that identifies cases that are appropriate for the Quick Disability Decision (QDD) and the Compassionate Allowance (CAL) processes also help to bring consistency to the disability determination process.

Quality reviews and performance management are also important tools. SSA holds DDSs accountable for accuracy, productivity, processing time, and cost control. The DDSs translate these requirements into adjudicator performance requirements. DDSs do internal quality reviews, in addition to the quality reviews SSA performs. SSA's quality reviews are now done nationally, rather than regionally, and there is a centralized process for resolution of policy questions and disagreements. These two practices in combination have the potential over time to greatly improve consistency across all DDSs and SSA quality review offices. The database of cases with policy feedback is also valuable for identifying policy areas that generate the most questions and are particularly problematic, so that SSA can look at ways to improve the policy. The database is also helpful in assessing further training needs, both nationally and for an individual office.

Achieving national consistency is an ongoing process. Continued progress is needed and is dependent upon sufficient resources. High workloads, budgetary challenges and staff losses slow down the progress. Lack of resources to review cases for policy clarification, to analyze data and to develop training impedes progress. In the DDSs, high workloads and loss of experienced staff impedes our ability to carry out an optimal number of quality reviews or pursue quality improvement initiatives.

Although disability evaluation will always involve a certain amount of subjectivity, the policies in these most subjective areas should be reviewed and consideration given to ways they could be made less resource intensive and easier to apply consistently. This is not a simple task. It would not be right or fair to many truly disabled people to completely ignore the opinions of the doctors that know them best or discard consideration of their pain and other symptoms and the way these symptoms limit their personal capacity for work. However, we should explore ways to determine disability that could require fewer resources and yield outcomes with more consistency. This exploration should involve the collaboration of medical and policy experts and experts in the front line challenges of applying policy to individual cases.

Continuing Disability Reviews – the Medical Improvement Review Standard

The Medical Improvement Review Standard (MIRS) was developed in the mid-1980s in response to public outcry over the implementation of continuing disability reviews (CDRs) that led to many people being removed from the rolls in a problematic way. Many of these people had been on the rolls and out of the workforce for a great many years. They had been granted benefits before the establishment of the strict criteria (particularly for mental impairments) in place in the early 1980s. The CDR reviews of the early 1980s applied the strict current criteria and did not consider the impact of advancing age and many years in supportive living situations out of the workforce. Many of the people losing their benefits had no ability to cope or adapt. In 1983, a moratorium was placed on CDR processing, and in 1984, the medical improvement requirement became law.

The MIRS requires us to determine whether any of the beneficiary's impairments present at the last favorable determination have improved, and if so, whether the improvement is related to the ability to work and whether the person now has the capacity to work. Improvement must be based on changes in symptoms, signs, and/or laboratory findings, resulting in increased work-related functional capacity such that the person can now engage in substantial gainful work. In assessing current ability to work, we consider all current impairments, not just the ones present in the past. The policy requires that we also consider the effects of the aging process and the related decrease in organ function, exercise ability, and other deficits that become irreversible over time, especially with sustained periods of inactivity. In addition, we must consider the effect of time on the rolls away from the workplace. Age and time on the rolls become especially critical factors when the beneficiary has reached age 50 or older.

The policy includes some narrowly defined exceptions, which open the door to stopping benefits in a few situations even though the person's impairments have not improved, or we cannot make a determination about medical improvement. These exceptions apply when the person's ability to work has improved due to advances in medical or vocational therapy, or when new evaluative techniques show that the impairment is not as disabling as it was thought to be at the time of the previous decision. There are also exceptions for lack of cooperation with the CDR process and for proven fraud. There is an additional exception for situations when substantial evidence shows on its face that the prior allowance was in error. However, the latter can be applied only for obvious, concrete errors; current adjudicators cannot question or substitute their own judgment over the judgment of the adjudicator of the prior favorable decision.

In practice, DDS adjudicators cease benefits in only a small percentage of cases. Given that the criteria require permanent or long-term inability to do any substantial gainful work, it is not surprising that many beneficiaries continue to qualify. Even with cases where benefits were originally granted through adjudicative judgment, the stricture against substituting judgment at the CDR limits the use of the error exception to cease benefits. In practice, this exception can rarely be applied.

We recommend a review of the statutory and regulatory MIRS policy to consider improvements that would enhance program integrity and bring greater consistency, while doing no harm to beneficiaries who continue to quality. We do not recommend discarding the policy altogether. Some consideration of the real effects of aging and time on the rolls, the impact of chronic impairment on functioning and ability to return to the workforce is reasonable. Due process and careful consideration of all the factors in each beneficiary's case are very important. Decisions about how to redesign the policy to remove the right people who really can work, while doing no harm to those who cannot, must be made very thoughtfully and carefully.

Even within the narrow limits of MIRS, the cessations the DDS makes provide substantial program savings for the investment of administrative dollars. It is unfortunate that SSA and the DDSs have not had sufficient funding to maintain CDR processing so that all cases are reviewed promptly when their diary dates come due. Nor is it appropriate service to American people with disabilities to delay the processing of current claims in favor of processing more CDRs with the available funds. Full funding for both workloads is critical.

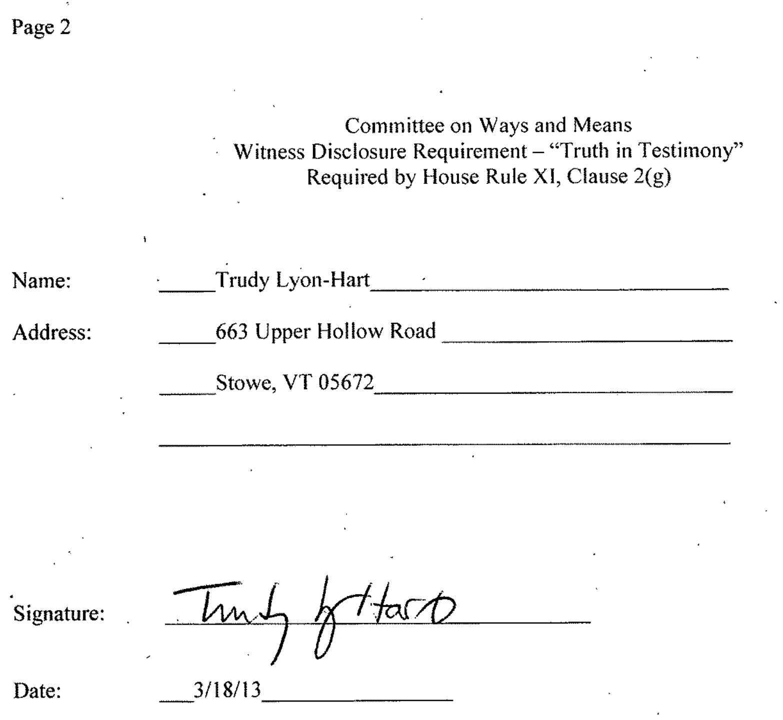
Conclusion

The DDSs have a long record of collaboration and accomplishment working with SSA to provide high quality service and careful program stewardship. Together we have made strides in advancing consistency in the application of policy, despite the challenge inherent in deciding who really can and cannot work. There is much more that can be done with sufficient resources for strategic hiring to build and maintain an experienced, highly trained staff. The most challenging policies should be evaluated with careful consideration. NCDDD would like to play a continuing role in such policy evaluation, sharing our ideas and experiences adjudicating cases on the front line and advising on issues of policy application and workability as new policies are considered.

Mr. Chairman, on behalf of NCDDD, I thank you again for the opportunity to provide this testimony. We will be happy to provide any additional information you need and answer any questions you have.

Committee on Ways and Means
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: **Trudy Lyon-Hart**		
1. Are you testifying on behalf of a Federal, State, or Local Government entity? a. Name of entity(ies). b. Briefly describe the capacity in which you represent this entity.	Yes ☐	No ☒
2. Are you testifying on behalf of any non-governmental entity(ies)? a. Name of entity(ies). **National Council of Disability Determination Directors (NCDDD)** b. Briefly describe the capacity in which you represent this entity. **I serve as NCDDD President**	Yes ☒	No ☐
3. Please list any Federal grants or contracts (including subgrants or subcontracts) which <u>you have received</u> during the current fiscal year or either of the two previous fiscal years: **None**		
4. Please list any offices or elected positions you hold. **President, NCDDD** **Director, Disability Determination Services, Agency of Human Services, State of Vermont**		
5. Does the entity(ies) you represent, other than yourself, have parent organizations, subsidiaries, or partnerships you are not representing?	Yes ☐	No ☒
6. Please list any Federal grants or contracts (including subgrants or subcontracts) which were received by the entity(ies) you represent during the current fiscal year or either of the two previous fiscal years, which exceed 10 percent of entity(ies) revenues in the year received. Include the source and amount of each grant or contract. Attach a second page if necessary. **None**		



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Committee on Ways and Means
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Name: Trudy Lyon-Hart

Address: 663 Upper Hollow Road
Stowe, VT 05672

Signature: Trudy LHart

Date: 3/18/13

Chairman JOHNSON. Thank you, ma'am.

Judge Hatfield, welcome. Please go ahead.

STATEMENT OF DAVID HATFIELD, ADMINISTRATIVE LAW JUDGE (RETIRED), WEXFORD, PENNSYLVANIA

Judge HATFIELD. Thank you, sir. Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, thank you for this tremendous opportunity to speak to you today. I am extremely pleased to see you are focusing on policy, and I encourage continuing congressional oversight of the disability program.

My name is David Hatfield, I am a retired administrative law judge. I worked for 36 years in the Social Security Administration, participating in the disability process at almost every level, both in policy and adjudication. I am not here today representing an organization or a constituency group. I am not here to say there should be fewer or more people on disability. I am here as an informed, concerned citizen to speak plainly about disability policy, which I believe is the primary cause of inconsistent adjudication.

The last large-scale reform of the program was in 1984. It shifted a program of reliance on objective medical evidence to an assessment of an individual's ability to function. SSA has since issued extensive regulations and numerous clarifying rulings on pain and opinion evidence, many of which are restatements of court interpretations of the 1984 changes.

The result is, frankly, a recipe for decision-making that no cook would dare touch. The policies have allowed too much subjectivity and have become overly complicated, confusing, and outdated. The policy has emphasized subjective factors to the point that, at the ALJ level, just about any case could be allowed or denied, and either decision can be written in a way that is consistent with existing Agency policy. Is that a fair process?

Policy has also become overly complicated. Evaluation of pain was a short paragraph before 1988. It is now several pages, with more pages of rulings mandating considerations of all kinds of factors. The handling of opinion evidence has also been expanded. And these are not merely guidelines for evaluating evidence, but are specific requirements that need to be addressed in every unfavorable decision. If I don't evaluate a neighbor's written statement saying the claimant is disabled, yet there are four medical opinions in file saying he isn't disabled, the case comes back.

Lost in all these gotcha requirements is the question of whether the claimant is truly disabled, and whether there is substantial evidence in the record. This high burden adversely affects timeliness and, in my opinion, alters decision-making.

We must stop the tail wagging the dog. The standard of review needs to be amended to include a harmless error component, or alternatively, change to a more deferential standard. We must put an end to redoing thousands of decisions that are already supported by substantial evidence.

Confusing policy should also be eliminated, including the often misused controlling weight standard for treating source opinions, another concoction of the courts. It trumps all other evidence, but only if it is "well supported and not inconsistent with the other substantial evidence." But what does "other substantial evidence" mean? The trump card is often misapplied.

Finally, many policies are simply outdated, such as the medical vocational guidelines. They were established in 1979. It is now 34 years later, and they remain untouched. They must be updated to reflect the current economy and workforce.

Second, regulations regarding representatives. There are none. More than 80 percent of the claimants at the hearing level are now represented, yet there are no rules and no burdens placed on representatives. Evidence can be submitted at any time; it is essentially a free-for-all. This hurts claimants, as they are being cheated out of their due process hearings.

Third, permanent disability. It is time to re-examine the permanence in disability. With the advances in medical science, we know there are many impairments that, with medical treatment, should not only improve but disappear. I had cases where the claimant met the duration requirement and was certainly disabled at the time of my hearing, but I knew he would be better in six months. I couldn't do anything about it, as my jurisdiction ended at my decision.

So let's consider specified term disabilities, and let those folks even return to work within their time-specified period of disability with no penalty. After all, helping people to get back to work should be our number one priority.

Ten years ago, the chair of the Social Security Advisory Board told this Committee that a full-scale review of disability policy had not been done in twenty years. Ladies and gentlemen, it has now been 30 years.

Thank you again for this opportunity to express my views and thoughts.

[The prepared statement of Judge Hatfield follows:]

Testimony of David G. Hatfield

Before the Social Security Subcommittee

House Ways and Means Committee

March 20, 2013

Chairman Johnson, Ranking member Becerra, and members of the Subcommittee:

Thank you for this tremendous opportunity to speak to you today on identifying Social Security policies that affect the consistency of decision making and fairness of the process. I am extremely happy to see you are focusing on policy, and I encourage continued Congressional oversight of the disability program.

My name is David Hatfield, a retired Administrative Law Judge. I worked for 36 years in the Social Security Administration in a variety of adjudicative and policy roles. I processed claims at the initial level when I was a Claims Representative, adjudicated cases at the Appeals Council level as an Administrative Appeals Judge, implemented class action orders, court remands and reversals as the Director of Civil Actions, and adjudicated cases at the hearings level as an Administrative Law Judge. In addition I served as Hearing Office Chief Judge, Assistant Regional Chief Judge, and as acting Chief Administrative Law Judge. On the policy side, I helped formulate the agency's acquiescence policy and drafted acquiescence rulings, was the policy director for Hearing level policy and procedures, developed a decision writing and policy checking tool (the Findings Integrated Templates, or FIT) that is used now in almost every ALJ disability decision, and chaired a Commissioner-level policy and procedure steering committee, among other projects through my career. In short, I have participated in the disability process at almost every level, both in policy and adjudication.

I am not here today representing an organization or a constituency group. I am not here on behalf of the agency. I am not here to say there should be fewer or more people on disability. I do not have a hidden or personal agenda. I am here as an informed, concerned citizen to speak plainly about Social Security policy, an area that, based on my experience and observations, is the primary cause of inconsistent adjudication. In the past focus has been on the process, including such attempts as Disability Process Reengineering, Hearings Process Improvement (HPI), and Disability Service Improvement (DSI), to name just a few. All had elements that were successful, but none of them addressed the underlying policy of the process.

The last large scale reform of the Disability Insurance program was the 1984 Disability Benefits Reform Act, a reaction to the tightening of medical eligibility criteria and to the number of terminations due to an increased number of continuing disability reviews. That reform shifted a program of reliance on objective medical evidence to an assessment of an individual's ability to function. Since 1984, SSA has issued extensive regulations explaining the assessment of function, and then has clarified or explained those regulations further through Social Security Rulings. Many of these regulations and rulings are capitulations in the Federal Courts' interpretations of the 1984 statutory changes. The result is a recipe for decision making that no cook would dare touch. The policies have allowed too much subjectivity and have become overly complicated, confusing, and outdated.

I. SUBJECTIVE

This subcommittee has explored disparities in pay and deny levels among the ALJs and the state DDSs. Oversight difficulties, regional differences, state funding, and other reasons have been noted. I believe that the policy emphasizing subjective factors, created over the past 30 years, is the major reason for the disparities. As a result, at the ALJ level, the same case can be allowed or denied, and either decision can be written in a way that is consistent with existing agency policy.

Here's why. Once a medically determinable impairment is established, everything, including the claimant's subjective allegations of pain and other symptoms, is considered. As stated earlier, some of the statutory changes made in 1984 were a reaction to the agency's over-reliance on strictly the objective medical evidence. Consideration of pain and other symptoms as well as a claimant's ability to function in a work-like setting were highlighted. However, with more regulations and continued clarifying rulings, many driven by court decisions, the agency has gone to the other extreme. By emphasizing subjective factors like pain and other symptoms (with evaluation and articulation requirements) too early in the decision making process, agency policy causes inconsistent adjudications.

The statute says a person must have a "medical impairment…which could reasonably be expected to produce the pain or other symptoms alleged".[1] This is the one and only area where only objective medical evidence is required from the claimant. Once this is established, however, an individual's symptoms may be used in determining each remaining step of the process. A claimant's allegations of pain and other symptoms can be found to be very persuasive by one adjudicator with very little underlying objective evidence, while another adjudicator may find that the symptoms are not persuasive given the lack of objective and other evidence.

Here is a fairly typical example. A claimant is 50 years old and complains of back pain. An MRI shows some degenerative disc changes. The claimant has now met his burden of establishing a medical determinable impairment. He says the pain requires him to sit most of the day, and walking or standing makes the pain worse. Now the adjudicator must proceed through the evaluation process and assess functioning, where all of his symptoms, including pain, are taken into account. The claim might be

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[1] 42 U.S.C. 423(d)(5)(a)

allowed by one adjudicator if he accepts the complaints of pain, given vocational factors. Another might deny, finding that the objective medical and other evidence do not support the allegations. Neither would be "incorrect" under current agency policy. The point here is that, over 30 years, the majority of adjudications (and practically all at the hearings level) have become very subjective with adjudicators either agreeing with the claimant's allegations or having to respond in great detail why those allegations are not supported.

Data suggests such cases are not "screened out" on medical considerations alone. The use of the medical screen out tool, severity, has decreased considerably since 1981. That year 43% of DDS denials were based on no severe impairment, compared to 13% in 2000, and rising to just 18% in 2010.[2]

Another example of subjective policy lies in the determination whether the claimant can do other work. As Jeffrey Lubbers pointed out in a hearing before this subcommittee last year, some factual issues can and should be resolved through rule making rather than case by case adjudication, particularly in such a massive adjudication program as the Social Security disability program.[3] In that vein, the agency did attempt such adjudication through rulemaking with the creation of the Medical Vocational Guidelines (informally known as the "Grids") in 1979.[4] The Grids were devised to allow the decision maker to use administrative notice to discharge the Commissioner's burden of showing whether a significant number of jobs exist in any given case. The problem is that the Grids only apply if the claimant has solely exertional limitations.[5] The majority of claimants today also have non-exertional limitations, such as mental, environmental, or postural limitations. The Grids, then, only apply to direct a conclusion of disabled in few cases, and rarely ever direct a conclusion of not disabled. The vast majority of cases require other vocational evidence to determine the ultimate question as to whether there is a significant number of jobs a claimant can do despite his limitations. ALJs use vocational experts (VEs) to discharge this burden. There are thousands of VEs used, all testifying daily on these matters, and giving their own professional opinion (and given no formal training by the agency). Inconsistent decisions result. Some ALJs don't regularly use vocational experts, resulting in even more disparity and inconsistency. The DDS level, where there is little or no vocational expert input, uses an erosion concept of the occupational base and no finding on significant numbers. The result is obvious – inconsistent adjudications throughout. This affects over 50% of all adjudications, since over 50% of cases are decided on vocational considerations.

It is time for the agency to convene a group of vocational experts and to revamp the Grids to encompass non-exertional limitations. It should not be hard: ALJs receive testimony everyday regarding the existence of jobs based on exertional and nonexertional llimitations. Expanding the Grids so that they can once again be used would bring less variation and discretion and more consistency, achieving fairness and uniformity to the process.

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[2] *Disability Decision Making: Data and Materials*, Chart 42 – Social Security Advisory Board (January 2001 and updated January 2012)

[3] Statement of Jeffrey Lubbers, before the House Committee on Ways and Means, Subcommittee on Social Security (June 27, 2012)

[4] 20 CFR 404, Subpart P, Appendix 2 – Medical-Vocational Guidelines

[5] 200.00(e) to Appendix 2

II. COMPLICATED

Disability adjudication should not be complicated. After all, we are dealing with one question: is the claimant disabled or not disabled? Yet, in the last 30 years, lots of ink has been spilled in the Regulations and Rulings trying to explain how to get to the answer to this question. Evaluation of symptoms, including pain, was a short paragraph before 1988. However, in response to court cases outlining specific criteria that need to be assessed, a full analysis of the issue including the need to consider many specific factors was mandated by expanding the Regulations and issuing detailed Rulings.[6] The handling of opinion evidence was similarly expanded.[7]

These Rulings have been viewed by the Appeals Council and the Courts as not merely guidelines for evaluating evidence but as specific requirements that need to be addressed in every unfavorable decision. These "articulation" requirements have created an almost impossible standard to meet in drafting a decision that would be considered "legally sufficient". Lost in all these articulation requirements is the question whether the claimant is truly disabled and whether there is substantial evidence in the record to support the ALJ's decision. This high burden of making a legally sufficient denial decision has, in my opinion, adversely affected timeliness and decision making. A bias has been set in the system at the hearing level in favor of allowance, given the stringent and overly complicated articulation requirements in a denial decision. If these requirements were imposed on favorable decisions productivity would be markedly impaired and the backlog would rise exponentially.

So what is the solution? I suggest that the "substantial evidence" standard at the Appeals Council and in the Federal Courts be amended to include a harmless error component, or alternatively the standard be changed to the more deferential "arbitrary and capricious" or "abuse of discretion" standard. The substantial evidence standard has been questionably employed by Courts when reviewing Social Security disability claims, and is at odds with an adjudication process that involves two levels of adjudication followed by a de novo hearing.[8] As noted above, this rigorous court oversight has unduly influenced policy and complicated decision making. We must put an end to remanding thousands of decisions that are supported by substantial evidence but have not, for example, "fully discussed all the factors involving a claimant's subjective complaints" or "not addressed all of the third party lay opinions". It is very important to note that missing one hurdle means a total disqualification: it is the Appeals Council's policy that when it or a court remands a decision, the entire decision is vacated and

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[6] *See* Social Security Ruling 88-13 (superseded by SSR 95-5p, which was superseded by SSR 96-7p), followed by 20 CFR 404.1529.

[7] *See* 20 CFR 404.1527; SSR 96-2p, SSR 96-5p, SSR 96-6p, SSR 06-03p

[8] Paul Verkuil, *An Outcome Analysis of Scope of Review Standards*, 44 WM. & MARY L. REV. 679 (2002). The author noted that the 50% affirmation rate of SSA cases at the District Court level was far outside the predictable outcome of review using the substantial evidence standard (75 – 85%).

the case must again be fully developed, another de novo hearing held, and a new decision written. This puts a tremendous strain on resources at the hearing level, delays other claimants' cases, and burdens an already taxed system.[9]

III. CONFUSING

Often, adjudicators are unclear as to exactly what the policy is. For example, in weighing medical opinions, adjudicators are genuinely confused about when to apply the controlling weight standard. The regulation essentially makes the treating source opinion a trump card if it is "well supported by medically acceptable clinical and laboratory techniques and is not inconsistent with the other substantial evidence."[10] But what does substantial evidence mean? Does it mean if there is any evidence that conflicts then that standard is not used? Does it mean some evidence? When I reviewed other ALJ decisions on peer review and on the Appeals Council, the use of controlling weight was almost always used incorrectly.

I agree with the Administrative Conference of the United States' (ACUS) draft recommendation that the concept of controlling weight was a creature of the courts and should be eliminated, as it blurs adjudication and leads to inconsistent decisions.[11] All medical opinions should be evaluated under the same factors currently in the regulations. There should be no trump cards.

IV. OUTDATED

While some policies noted have been clarified and expanded to the point of being overly complicated or confusing, many of the policies have been ignored and not updated to reflect the current work force and economy. For example:

The Medical Vocational Guidelines (the "Grids"). These were established in 1979 to bring more consistency and uniformity in decision making. As noted previously, the Grids were designed to allow the adjudicator to take administrative notice as to the existence of a significant number of jobs the claimant could or could not do. It is built on a matrix of factors, including age, education, work experience, and residual functional capacity. The Guidelines have essentially been untouched since

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[9] HALLEX II-5-1-2

[10] 20 CFR 404.1527(d)(2).

[11] *Assessing the Efficacy of the Treating Physician Rule – Draft Report,* Administrative Conference of the United States (February 2013)

1979. Certainly the work force and types of occupations available in 1979 are very different than today's. It is just common sense that factors such as age, education, and work experience would not remain static for over 30 years, and yet that is what today's policy reflects – a 1979 economy. There is a wealth of information available and many experts who could review the Grids and make them current. This modernization of an important adjudicatory tool (in 2010 over 50% of all allowances and over 35% of all denials at the DDS level were based on vocational considerations) would help tremendously with consistency and uniformity.[12]

Video hearing regulations. The regulations currently allow a claimant to decline a video hearing for any reason.[13] This opt-out provision was created to ensure claimants were comfortable with the new technology and address any due process concerns about that new technology. After thousands of video hearings and decisions rendered, many going through the entire appeals process, I believe it is time to acknowledge that it is the same due process hearing as an in-person hearing. Therefore, I would recommend that absent compelling reasons, there would be no right to refuse a video hearing. The video hearing shortens the time a claimant has to wait for hearing, saves administrative costs, and statistics show allow and deny rates are not significantly different than in-person hearings.[14] The regulations need to reflect that the video hearing is just like the in-person hearing in all aspects. The technology is so good that when I presided over dockets of both in-person and video hearings I could not recall which ones were video or in-person when I wrote my instructions.

Regulations regarding representatives. The hearing procedure regulations were written at a time when less than 10% of the claimants at the hearing level had representation. They appropriately reflected a paternalistic agency, ensuring that a claimant's due process was protected. Today, more than 80% of the claimants have a representative, drawn from a pool of very experienced and well paid people, yet the procedural regulations have not changed.[15] The representatives have very few requirements or responsibilities imposed on them. While the present rules need to remain for unrepresented claimants, I strongly recommend exceptions to those rules when a claimant is represented. They would not only reflect the current reality but would promote better due process hearings, leading to better and more consistent decision making. For example, I would require the representative to:

- obtain and submit all missing evidence, including any evidence the agency believes is relevant. Also the representative would be compelled to disclose all the evidence to the Agency that is known. Sanctions would be imposed when a representative is caught withholding evidence.
- submit all evidence before the hearing, so that the claimant receives a due process hearing on all the issues. The ALJ needs all the facts to provide a full, inquisitorial hearing and make a reasoned decision. Too often hearings become essentially discovery proceedings, where salient facts and evidence are being introduced for the first time, without the benefit of review or

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[12] *Disability Decision Making: Data and Materials, supra* note 6, Charts 40 and 42.
[13] 20 CFR 404.936(e)
[14] Krent and Morris, *Achieving Greater Consistency in Social Security Disability: An Empirical Study and Suggested Reforms, Draft Report* (March 3, 2012)
[15] *Disability Decision Making: Data and Materials, supra* note 6, chart 55

thought. This naturally protracts the process and some decisions are issued without consideration of all the facts.

- Provide a good cause statement to the Appeals Council whenever additional evidence is submitted as to why that evidence could not have been submitted earlier, the same standard employed at the District Court level.[16]

Residual Functional Capacity premised on Full Time Work. Social Security Ruling 96-8p, published in 1996, defines a regular and continuing basis as 8 hours a day, 5 days a week. In other words, when assessing what the claimant can do despite his impairment, an adjudicator has to consider the claimant's functioning only in a full time work setting. If the adjudicator determines that the claimant can only, for example, function six hours a day (lies down the other two), there would be no jobs the person could perform and would therefore be found disabled. This does not reflect the current work force, and I submit was never contemplated in the Act or regulations. The result has been many allowances based on a person being able to function less than full time, even though there are thousands and thousands of jobs at the substantial gainful activity level that can be performed on a part time basis. This policy needs to be reexamined.

Permanent disability. It is time to reexamine the "permanence" in disability. Should disability in all cases be an all or nothing proposition, permanently disabled or not disabled? Could the drafters in 1957 have foreseen the tremendous number of persons currently declared permanently disabled? With the advances of medical science, we know much more than we did in the 1950s. There are many impairments that, with medical treatment, should not only improve but disappear. I recommend that a commission be convened to study this issue, with the possibility of differentiating those cases where disability is indeed permanent and those which should improve. The latter would have a specified ending, or term, as a recent draft recommendation made to ACUS has described.[17] However, I disagree with the draft's suggestion that the adjudicator would make that determination. Adjudicators are not trained in this area and inconsistent application would result. Instead, I believe a matrix could be established through rule making that would consider the impairment, age of the claimant, and other factors. I would also allow these "specified term" disabled claimants to return to work within their period of disability with no penalty. These are the claimants that through early intervention should be able to return to work, and that should be the overriding goal.

These are just five examples of many areas in which disability policy has not kept up with the times. I believe Congress should require the Agency to do a complete review of its disability policy, modernizing it and ensuring that it reflects the realities of current adjudication.

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[16] 42 U.S.C 405(g)

[17] Krent and Morris, *supra* note 12, page 86

CONCLUSION

I have highlighted some areas of policy that need to be updated, clarified, changed, or even eliminated. These are just a few. A complete review needs to take place. In 2001, Stanford Ross, then Chairman of the Social Security Advisory Board, testified before this subcommittee and said:

"Today, there is a serious gap between disability policy and the administrative capacity required to carry out that policy. **There has not been a full-scale review of disability policy and process in over 20 years. The result is a great deal of incoherence and at times demonstrable unfairness."** (emphasis added).[18]

Since 30 years have now passed since the last full-scale review, Mr. Ross' words carry even more weight today. This review is needed now. This full scale review, however, must be performed by people who are intimately involved in adjudication. I would recommend a Disability Board that would report directly to the Commissioner and would be represented by policy experts inside and outside of SSA and from adjudicators at every level.

I care deeply about the disability program, as it is a critical part of the social insurance and welfare system. The American people expect decisions to be consistent and they deserve a fair system.

Thank you again for this opportunity to express my views and thoughts.

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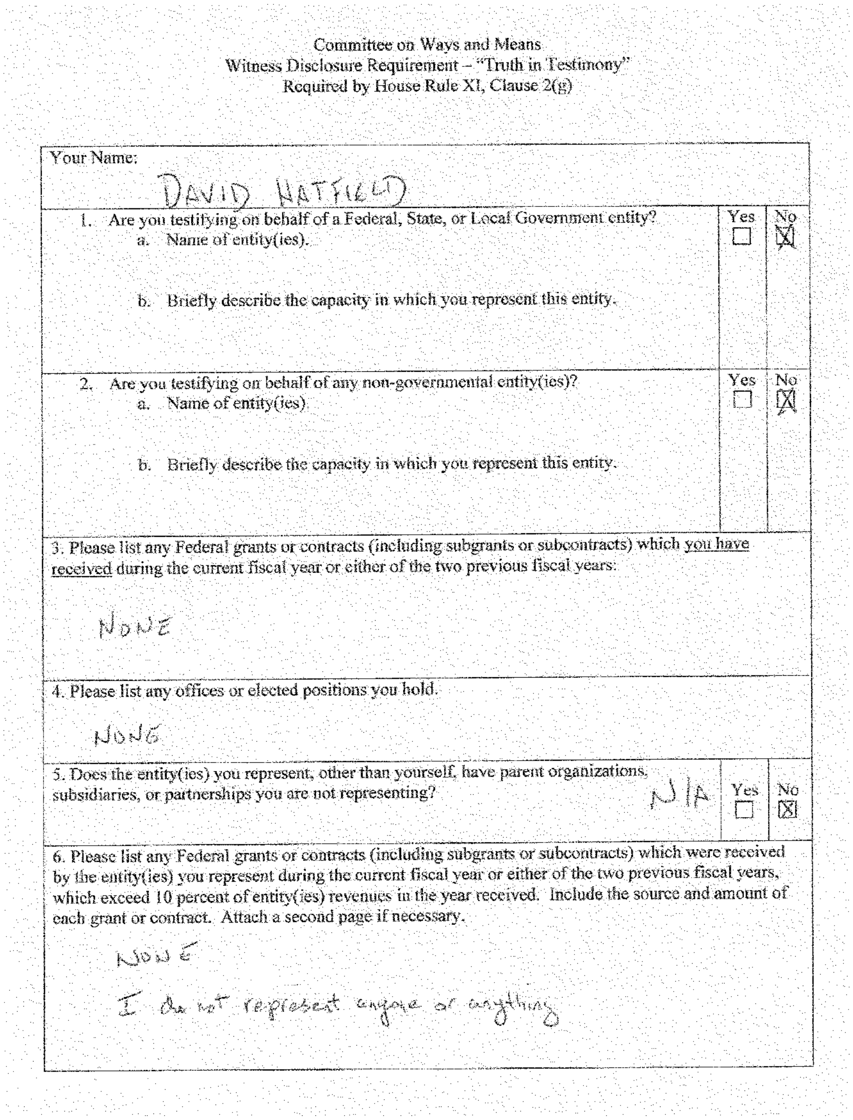
[18] Statement of Stanford G. Ross, Chairman, Social Security Advisory Board, before the House Committee of Ways and Means, Subcommittee on Social Security – June 28 2001



Committee on Ways and Means
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name:
DAVID HATFIELD

	Yes	No
1. Are you testifying on behalf of a Federal, State, or Local Government entity? a. Name of entity(ies). b. Briefly describe the capacity in which you represent this entity.	☐	☒
2. Are you testifying on behalf of any non-governmental entity(ies)? a. Name of entity(ies). b. Briefly describe the capacity in which you represent this entity.	☐	☒

3. Please list any Federal grants or contracts (including subgrants or subcontracts) which you have received during the current fiscal year or either of the two previous fiscal years:

NONE

4. Please list any offices or elected positions you hold.

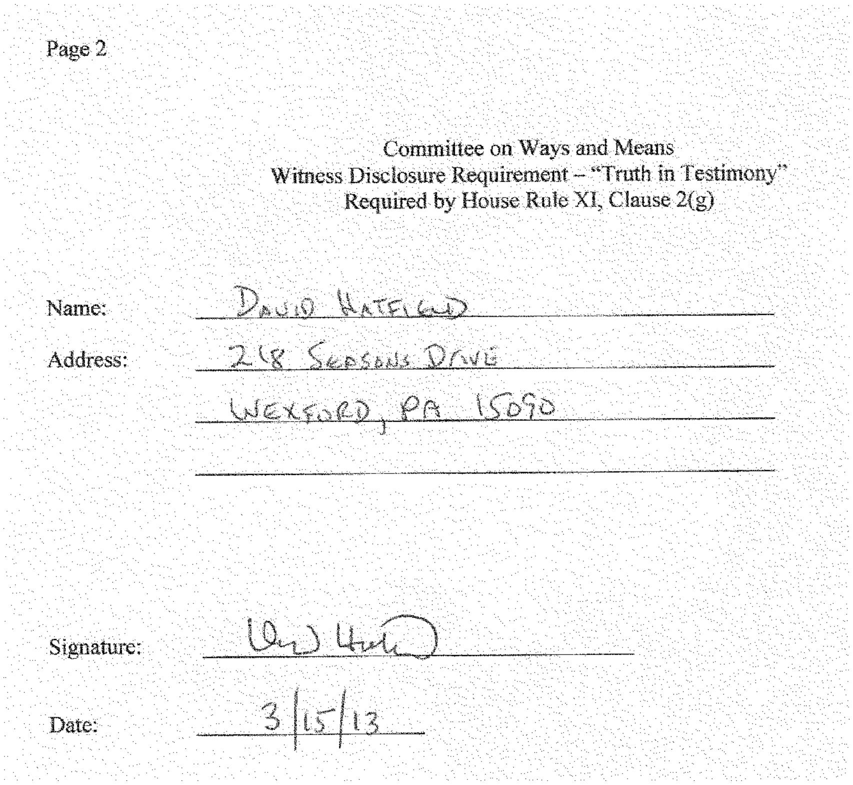
NONE

	Yes	No
5. Does the entity(ies) you represent, other than yourself, have parent organizations, subsidiaries, or partnerships you are not representing? N/A	☐	☒

6. Please list any Federal grants or contracts (including subgrants or subcontracts) which were received by the entity(ies) you represent during the current fiscal year or either of the two previous fiscal years, which exceed 10 percent of entity(ies) revenues in the year received. Include the source and amount of each grant or contract. Attach a second page if necessary.

NONE

I do not represent anyone or anything



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Committee on Ways and Means
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Name: DAVID HATFIELD

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WEXFORD, PA 15090

Signature:

Date: 3/15/13

◆

Chairman JOHNSON. Thank you, sir. Thirty years, huh? As is customary, for each round of questions I will limit my time to five minutes and ask my colleagues to also limit their questioning to five minutes, as well.

Members should always speak clearly into the microphone, but it is especially important to try to help Ms. Ruffing hear us today.

One half of the country is disadvantaged because they do not have access to a Cooperative Disability Investigative unit, a CDI. Ms. Hermann, those state disability determination services that have access to local Cooperative Disability Investigative units have the advantage of being able to refer any suspected fraud cases to that unit for surveillance or other government database or social media. These units operate in 21 states. What happens in the other states? Does fraud remain undetected? And what cost to the taxpayers?

Ms. HERMANN. In the other states who don't have access to a CDI unit, they can refer those allegations to their local Office of the Inspector General. The Office of the Inspector General will review them. However, you know, the decision to investigate or not is based on local priorities and their local caseload.

So, often times, the DDS must make whatever decision, based on the information they have available to them.

Chairman JOHNSON. Or they ignore them.

Ms. HERMANN. We hope they don't ignore them. We hope that they still refer them to the OIG.

Chairman JOHNSON. I hope you are right. Judge Hatfield, you know representing Social Security claimants is a thriving industry. In fact, persons representing claimants pulled in over $1 billion in fees last year, all of which was skimmed right off the top of back benefits that were awarded those who were found disabled. I know most of those representatives want to do their best for claimants, but it seems to me they are quick to take advantage of confusing and complex policies to try to ensure an award.

Is there any standard on what someone who is representing a claimant is required to submit to the ALJ before the hearing?

Judge HATFIELD. No, Mr. Chairman, there really isn't. It is really up to the ALJ to enforce that. Some reps are good at submitting evidence, others are not. But the—ultimately, it is the judge's responsibility to ultimately ensure the record is fully developed.

There are really essentially no rules of practice in the Social Security regulations. So what happens is that evidence trickles in, it can come in at the day of the hearing. I am here to ensure claimants get a good, due-process hearing. That is what the regulations require. And so I need to read that record. It is non-adversarial, by the way. So I need to read that record and be sure I can ask the kinds of questions to the claimant to make sure I make a proper decision. I can't do that if evidence comes in at the day of the hearing, for instance, talking about a new impairment, for instance.

So, what happens? I can delay the hearing, which is not fair to the claimant. I can let the representative sit, at the end of the day, and I have done that. Time is money. But ultimately, what I do is I have to read the evidence before the hearing, delaying all the other cases that I have for that day, so that I can ensure the claimant is having a due-process hearing.

So, my feeling is that the record should be closed before the hearing. And it is not for the judges, it is not for—you know, to be a judge. It is for the claimant. It is for a due-process hearing, so that I can ask the right questions at the hearing.

Chairman JOHNSON. Yes, that sounds like some of the people are cherry-picking the evidence and delaying giving it to you so they are going to get a favorable decision, probably. It might even slow down the decision. Is that true?

Judge HATFIELD. That is true. And in terms of that, we rely on the representatives to send in the evidence. If the evidence is adverse to the claimant, there is nothing in the regulations at this point that requires a representative to submit that evidence unless I—you know, I know about it and I ask for it. There is no sanctions against a representative if they don't submit that evidence. So——

Chairman JOHNSON. In your experience, did you find people hiding evidence from you?

Judge HATFIELD. A couple of times. Generally—and this is in Pittsburgh, where the representatives are, by and large, very good, and they are very honorable people. But when I was the acting chief judge, I knew of other instances across the country where this happened, yes.

Chairman JOHNSON. Thank you. Mr. Spencer, is it true that a person can receive both unemployment and disability at the same time?

Mr. SPENCER. Yes, sir, it is true. There is no prohibition that would restrict someone getting both unemployment and Social Security disability insurance.

Chairman JOHNSON. Okay. Do you believe that is a good idea or not?

Mr. SPENCER. It has never been put into our rules before. It has always been totally separate.

We are [continuing]. We have looked at this, and would certainly be willing to continue to work with your staff and your subcommittee——

Chairman JOHNSON. Thank you.

Mr. SPENCER [continuing]. If you would like to move in that direction.

Chairman JOHNSON. I appreciate that. Mr. Becerra, you are recognized.

Mr. BECERRA. Thank you all for your testimony and for helping us on this issue.

I think we should make one thing clear. None of us wants to see the bad apples. They ruin it for everyone else. As I think you have all indicated, these are earned benefits. And so, any American who has truly lost the ability to work should be able to turn to a program that was established as a result of his or her taxes that he or she paid into the system for this very reason.

But when you see a video of someone who is trying to take advantage of the system, it gets you very angry. And we have to kill that, because if we don't, then it not only makes it difficult for us to have confidence that we are giving out these taxpayer benefits that have been earned when they are rightfully earned, but it also, I think, undermines the confidence that the public has to have in the system.

And so, I want to make sure we make a point here. Mr. O'Carroll, you pointed out some cases—I have got some numbers here. Tell me if I am wrong. There were some—in 2012 some 13 people who were subject to criminal prosecution as a result of some of your work, the CDI work, right?

Mr. O'CARROLL. Yes, sir.

Mr. BECERRA. I have a number that 19 other cases were subject to civil monetary penalties. So 19 other people were subject to civil monetary penalty, as a result of all your CDI work.

Mr. O'CARROLL. That is correct.

Mr. BECERRA. That is 32 people. The number of people that you investigated is somewhere around 3,300.

Mr. O'CARROLL. Yes, sir.

Mr. BECERRA. So of the 3,300, about 32 you found cause to go after them civilly or criminally. That number is based on 3.2 million people who apply for disability insurance benefits. And so I want to make something very clear. We have to beef up your units so you all can find these folks. But there were 32 that you found out of 3.2 million who applied for disability insurance benefits. And so it is not rampant, but it sure makes you mad when you find it. And so we have to go after those bad apples.

I think the judge made it very clear, as well. If you can't have a system that is working well, if you start to go towards an adversarial system, which is not what we have right now, where people are going at it like attorneys will when you have got a case in court, most of these folks are going to get trampled, because most of these folks can't afford to get a high-priced attorney. They are out of work, they are disabled, or they are very modest-income, to begin with. And so, I hope we never lose the non-adversarial character of these hearings, where the ALJ is extremely important. The judge is essentially, as you said, the gatherer of all the information.

I do agree with you on one thing, Judge. We can't expect you to make the best decisions if you are getting information at the end of the hearing. You should be getting as much as you can before the hearing. And so, when you are at the hearing you can really probe that applicant or his or her representative and find out, "Is there anything else I am missing in this file so I can make a decision?" And so I hope you will continue to give us some guidance on how we can get there. And I think all of you can provide that, as well.

I want to finish by asking a little bit about these CDRs, the continuing disability reviews. And I just whispered to the chairman a little while ago that I think this is something we can handle bipartisanly. I am not here to try to go after my colleagues on the Republican side because they are trying to reduce the size of government and, as a result, one of the casualties is funding for these CDRs, which we agreed would be in the budget after the Budget Control Act passed in 2011. But when you save nine taxpayer dollars for every dollar invested in a CDR to make sure that someone who has got benefits really should continue to get it, and if we find through this review, the CDR review, that they no longer are disabled, and should be getting back to work, we should go after that with a vengeance. Because, once again, we provide integrity in the system.

So, Ms. Ruffing, quick question. Is it your sense that if we had the investment in CDRs, that we could truly make sure that those who have become disabled are the ones—only the ones who are receiving the disability insurance benefit?

Ms. RUFFING. I think that is a fair statement. Cumulatively, over 2012 and 2013, Congress is on track to under-fund CDRs by about 400 million below the Budget Control Act allowance. And a back-of-the-envelop estimate suggests to me that that, over the long run, will cost us between 2.5 and 3.5 billion. As you say, that is penny wise and pound foolish.

Mr. BECERRA. So, not only is it costing us, but we are going to have more videos of people who shouldn't have remained on disability insurance, which is going to make it a caustic program, because people are going to have real ambivalence about whether we should support it.

I hope, Mr. Chairman, this is something that we should do bipartisanly, to try to make sure that we go after the fraud, those who are receiving the benefit when they don't qualify. That way we can leave it for all those who really do deserve to have the benefit they paid for.

With that I will yield back the balance of my time, and I thank you all for your testimony.

Chairman JOHNSON. I think Mr. O'Carroll feels the same way, and he is working that program pretty hard.

Mr. Tiberi, you are recognized.

Mr. TIBERI. Thank you, Mr. Chairman. I am not sure anybody here would be in line to answer this question, but maybe Judge Hatfield can.

From my limited experience in dealing with folks I know who have had a disability, I want to just follow up on something Mr. Becerra said about claimants not being able to afford an attorney. My experience has been that most lawyers in this line of work actually get paid contingent on benefits being received from a claim. Is that your experience, Judge?

Judge HATFIELD. Yes, that is. Almost all of the attorneys work under that type of arrangement. And you can see them on nightly television every night.

Mr. TIBERI. I wasn't going to mention that. But the point being if my little sister, who makes $40,000 a year, gets injured, she can get an attorney, a very good attorney, based upon the contingency of her claim and winning her claim.

Judge HATFIELD. Yes, that is true.

Mr. TIBERI. I thought so.

Judge HATFIELD. That is true.

Mr. TIBERI. Just wanted to clear that up. In your testimony on page seven you say it is time to re-examine—your words, not mine—"the permanence of disability." Tell us more of what you mean in terms of time for a change in that.

Judge HATFIELD. It—as the chairman had described the statutory act, it is—a person has to be disabled at least one year, or it could result in death. It is—but in my experience, there have been many, many cases where the person is disabled, they meet that one-year requirement, they have been waiting, say a year, to get before me, but it has been a—say an accident, a trauma, something like that, where they are undergoing medical treatment, they are going to get better. It is clear they are going to get better. I can't do anything about that. I can only decide the case at the time of my decision and find them "permanently disabled."

And my thought is to be able to, with the advances of medical science—I mean 1957 is when the disability program started. Things have changed much in medicine since then. It seems to me we should be able to get together a group of people who could identify certain impairments that should improve with medical treatment, or perhaps even disappear within a certain period of time.

And as I suggested, those persons would get a term disability, based on their impairments and age, or maybe some factors involved, and then they could go to work during that time. Let them go to work. We expect those folks would go to work. Instead, we put them on permanent disability, and then do a CDR, say, 12 years later, or 10 years later. That person is out of the workforce. They are never, probably, going to go back.

So, you know, the whole point here is try to get folks back to work. It seems to me if we do that quickly at the front end, give them this sweetener of no penalty to work—and, of course, if they are still disabled and they didn't go back to work, they can always re-file after the expiration of their term.

Mr. TIBERI. Thank you. You have been a judge for a long time before you retired. We had CBO here last week. We had the Chief Actuary here last week. Mr. Spencer, in your testimony you mention the growth of the program being demographics as the main driver of the DI program. But both Mr. Goss and the CBO have been clear in their testimony, the written testimony, that the 1984 change in the law, which Ms. Ruffing mentioned again today, that was passed unanimously—but that that change in the federal policy is another contributing pattern to the growth of the program.

And in fact—again, CBO's words, not mine, that the change in federal policy has contributed—the '94 Act—the '84 Act, excuse me, contributed to the growth of the disability insurance program, since it led to a larger number of disability insurance beneficiaries with musculoskeletal or mental impairments, many entering the rolls at younger ages and staying in the program longer than the average beneficiary.

Anecdotally, from your seat on the bench that you served, did you see an increase over the years?

Judge HATFIELD. Well, actually, I wasn't an ALJ prior to 1984, so I probably——

Mr. TIBERI. Hard for you to compare.

Judge HATFIELD.—couldn't comment on that. But yes——

Mr. TIBERI. In terms of those number of cases?

Judge HATFIELD. I think there were quite a few of those cases that came before me, mental impairments, musculoskeletal, absolutely. And I think there was a rise in those, and I think that the statistics show that there was a rise in those over the years. The percentage of people being paid based on those two impairments rose significantly during that time.

Mr. TIBERI. Thank you. So you think that should warrant a look at the '84 law to see if we can tweak it?

Judge HATFIELD. That is—that would be my suggestion, yes. I think that what—what I am suggesting is after 1984 the reaction of the courts imposed certain requirements that the Agency decided to adopt through ruling and regulation. And so I think it is time to sort of reflect as to whether that really was the intent of Congress, or whether it was just court interpretation.

Mr. TIBERI. Thank you. I yield back.

Chairman JOHNSON. The gentleman's time has expired. Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman. I want to thank the witnesses today for testifying. You know, I have only been in Congress a couple years, but I always like to relate back to my history as a private citizen and a businessman. And I know that, over the years, I ran into three different individuals that were collecting disability.

And as you were talking, I was thinking of those three. One clearly deserved disability and was not able to work any more. The second definitely had some impairments, but probably could work at a desk, at a computer, and do some work. The third used to golf with me every week. And I always used to wonder how that third individual was collecting disability as he came to golf in a golf league every week. So, you know, it is kind of interesting when you look back over these situations, and then you hear the testimony.

But with those things, I guess I would like to know what is—Mr. Spencer, what is the definition of "severe" impairment?

Mr. SPENCER. In the first place, let me start by agreeing with Judge Hatfield, that we don't look at each individual impairment separately, we must combine the impairments to find that severe level. But severity, to have a severe impairment or impairments means it has significant impact on your ability to stand, walk, sit, lift, carry, get along with people, understand instructions cognitively, those type of basic functions that you need to work. Having a severe impairment does not mean that you are going to be granted disability benefits, it is just the first bar you must get over. If you don't have a severe impairment, we stop and you do not get awarded benefits.

Mr. RENACCI. And then what would be the definition of, "any work that exists in the economy?" And I use that as someone who might be severely impaired, but can maybe work at a computer and do work from that standpoint.

Mr. SPENCER. That is a great question. Any work in the national economy means that there are jobs in the region or contiguous regions in sufficient numbers that you can do, given what you have left. So I mentioned sitting, standing, lifting, carrying. If we determine, based on all your medical evidence, including the subjective medical evidence, that you can sit 6 to 8 hours a day, that you can lift 10 to 20 pounds frequently, that you don't need super-frequent breaks, that you have a regular job, we can look for sedentary work for you. And if that work exists in the economy, we will deny benefits.

It is not based on whether they are hiring, it is not—these jobs. It is not based on whether you want to apply. It is based on whether you have the mental or physical capacity to do work that exists. Does that help?

Mr. RENACCI. Yes. Mr. O'Carroll, I know my colleague brought up, and I thought it was a good point, the 3.2 million claims and 32 cases that you found. Do you believe there is an opportunity to find more? What would be the way to find more? I mean that is a small number, but clearly it appears there might be a bigger number.

Mr. O'CARROLL. Thanks, Mr. Renacci, for that question, because one of the things I had written with my notes here, when we are talking about the 32 prosecutions that we were doing of the millions that are—claims are out there, when—those are the ones that were in pay, and that is part of our CDI program that we identified. Obviously, with our other disability fraud investigations, we are prosecuting hundreds of other people.

However, the other part of the philosophy behind the CDI program was pre-effectuation, was to be able to identify people, provide the information to the decision-makers up front, before people get on to the benefits. And since we are preventing it in advance, there is—that—none of the government money is lost that way.

So, what we are finding with the success of the CDI program is that judges are asking us to do more inquiries with the CDI program, we are being asked by the disability examiners to do more.

And, as a result of it, we are looking at more people in pay. But at the moment, of people in pay compared to people on the pre-effectuation, it is about—I would say about 84 percent are pre-effectuation, so we are talking about 16 percent is where that number of 32 comes from.

And then, in completion of your question on it, what we have been saying from the beginning is that the purpose of the CDIs is to provide the decision-makers with information that can be used on this thing. And what we have been saying all along, and this Committee has been very supportive on, is expanding the CDI units so that when the DDSs or the judges or any of the decision-makers have questions on it, we can be providing the information and, again, showing the videos like we are doing here, when the public sees them, much like the person playing golf with you. Hopefully we have a camera following that person around on other times that they are doing what could be considered, you know, occupational-type things.

Mr. RENACCI. Thank you. I yield back, Mr. Chairman.

Chairman JOHNSON. Thank you. My friend from Texas, Mr. Doggett, you are recognized.

Mr. DOGGETT. Mr. Chairman. Judge Hatfield, you suggested a number of forms that I want to explore. But just at the outset, I believe you responded previously to Chairman Johnson that most of the representatives that came in front of you during your time serving as a judge were honorable people who were doing their job effectively.

Judge HATFIELD. Yes, that is correct.

Mr. DOGGETT. And I just have to say that I do find a little troubling the use of this term, "skimmed off the benefits," and the size for the whole country. It has been a long time since I practiced law, but I knew few lawyers then and know few now who would take a Social Security disability case. There is no recovery unless there are benefits, which means, often in complex cases, there is no recovery. And I believe that, from the people that I have seen in more recent years in my district office, over the last couple of decades people who had no representation, who had limited education, or, even if they had some education, had difficulty with the complexities of this system, that many folks would not be able to access the insurance benefits that they have paid over their working life to get, unless they had honorable representation to participate.

It is reasonable that across this country, with the number of people who make application for benefits, that there is some compensation. And absolutely, somebody who is out of work, who is disabled, unless they can find someone to take their case on a contingency, they won't have any representation at all.

When we describe—though the term may be applicable—when we describe corporations who have a legal department or other department to deal with the government, we don't refer to those individuals as having skimmed off the corporate earnings; we refer to it as part of the normal operating process. And I think that that is true here.

I think every Member, regardless of party, on this Committee is strongly against fraud. I am as outraged as anyone else to see the program jeopardized by somebody dancing on the Internet, just as we should be outraged when a pharmaceutical company steals millions of dollars from the Medicaid program, or a health care provider steals from Medicare. So, fraud, and how we ferret it out, is very important. But not denying benefits and not disparaging those who represent people who have paid into this system to get the benefits to which they are entitled, I think is equally important.

Now, Mr. Spencer, you mentioned that the standard is not a low one to get Social Security benefits. Don't most people who apply for Social Security disability benefits get denied?

Mr. SPENCER. Trudy is right. At the DDS level it is about 33 percent are allowed. But the important thing to really remember with that number is that, while the hearings allowance is higher—it is about 50 percent now, it has dropped—they have a much smaller set of cases. So, in fact, about 70 percent of all the allowances in the program are made by the DDSs, and 85 percent of DDS decisions end up being the final decision of the Social Security Administration. So, yes, only about 40 percent of folks who apply are awarded benefits.

Mr. DOGGETT. And you reiterated the testimony we heard not from a representative for the disabled or an advocate, but from the chief actuary here in this very committee room recently, that, despite all the alarmist articles that the sky is falling and the disability program is about to crash, that, in fact, we have a very sound disability program, there is not a crisis, there is not an excess of claims, though there certainly may be some fraudulent claims, and there may be some fraudulent representatives out there that need to be ferreted out. But, in fact, with the same kind of transfer among the funds as has occurred in previous decades, this fund will be on firm footing going for decades ahead, and that we can continue to provide benefits to an aging workforce, and to a workforce that involves more women in the workplace than occurred in prior generations.

Mr. SPENCER. Yes, you summarized Mr. Goss's testimony.

If I might, when we think about Judge Hatfield's approach to maybe temporary disability, while you are doing that let me remind you that there are three levels of CDR diaries: one year for people that we know should improve; three years for people that we are not sure if they will improve; and seven years for people with terminal illnesses, or with impairments that will not improve, like intellectual disability.

So, while you are planning, we could deal with a lot of these lengthy folks on the rolls that haven't been reviewed by funding the CDR program.

Mr. DOGGETT. My time is up. I would just like if any of the witnesses or if Judge Hatfield would like to expand on it, I wanted to go into the medical vocational standards and permanence of disability. You can forward further written comments if you have recommendations for how we can improve this system, make it work more effectively, and see that the disabled individual, as well as the taxpayer, is adequately protected here. Thank you very much. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, sir. Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Chairman. And thank you all for being here.

I think one of the concerns I have is the sustainability of these programs. And I don't think there is anybody here that would ever say that somebody who is deserving of these benefits doesn't get them. But, by the same token, it must be very difficult, Judge, sitting where you have sat all those years, to look at what is happening. I was reading in your testimony, and on page four you talk about some of the things. A bias has been set in the system at the hearing level in favor of allowance. And this is under the complicated section you had, section two.

But I worry about it, because I will tell you. I read also in the notes that deciding disability is also a complex and expensive process. Administering the DI and Supplemental Security Income programs consumes two-thirds of SSA's approximately $11.5 billion operating budget this fiscal year. So again, it is the sustainability of these programs. And that seems to me that the dollars just keep growing and growing.

But for you to come up with a decision based on somebody sitting in front of you is very difficult. Because I am trying to figure out these definitions of if you are fully disabled or your definition of pain. Pain is pretty much subjective. There are some people who have a very low threshold of pain, other people have a high threshold of pain. I am like Mr. Renacci. I have friends who are on disability, but are not incapacitated. And I understand that. I understand that.

But I read in your testimony, and I think it is incredibly important. We have seen a lot of technological advances in medicine. And I know in our job market, in the private sector, things that would have been hard to do several years ago are no longer hard to do. I have friends who have had to go from one form of employment to another because one went away. It had nothing to do with a disability, it had to do with a loss of a job. And they transform very quickly into another phase.

But when you are sitting there, and you are looking at all this information, it is difficult. And it looks to me like it is very subjective. How do you balance those programs out, or how do you work with that?

Judge HATFIELD. It is difficult. It is a difficult job. And I want to say that the administrative law judge court does a really terrific job of trying to sort that out. I mean that is what they are doing every day, and they are trying to achieve 500 to 700 of these decisions every year, which is the expectation, which is a lot of cases.

And so, we are moving cases along, and we have to consider everything. We have to consider sometimes 500, 1,000 pages of medical evidence, the claimant's testimony, of course, and all those sort of amorphous factors in the file, as well, what kinds of medications they take, what is their daily activities.

So—and this is where I go back to the due process hearing—that is really the centerpiece to try and get—ferret out, based on what the claimant is saying. Is it consistent or inconsistent with the record? And that is why it is so important to have a full record before me, because it is non-adversarial. I have to ask the questions, I have to know what to ask in advance. In short, it is a tough job.

Mr. KELLY. The whole process. In your closing, you said in your conclusion today there is a serious gap between disability policy and the administrative capacity required to carry out that policy.

Now, going back to what Stanford Ross said in 2001—and I think that this has been taking too long to get to where we need to be on this review. It just seems to me that you are kind of left hanging out there without having substantive information or an update in these policies to be able to make decisions that are in the best interest of those people who are coming before you.

And as you say in here, the case load is so big, that there is a lot of other people that need to get there and can't get there because it is so backed up.

So, what would it take to get this review? I mean is there something that I don't understand coming from the private sector? We would have to—we don't have years to wait on things. I mean here we kind of measure everything in 10-year periods, the way we spend money, the way we are going to cut spending, everything else. But I would say this is a program that needs to be looked at sooner rather than later.

Judge HATFIELD. I agree, and I—one of the suggestions I make is to have some sort of board or some body that would involve adjudicators, as well as policy experts inside and outside of SSA that would sit down and really work this out.

I think it is very important to get the adjudicators' perspective on this policy, as well, because we see how a policy where there may be some shalls and musts turns into these requirements that I have to put in every decision, when the bottom line is really is this claimant disabled or not disabled.

Mr. KELLY. Well, listen. Again, I appreciate you all being here. Because I think one of the things is, as we lose—or these programs lose credibility with the American public, that is where we start to have a real problem. And I have got a lot of friends that really are very deserving, and we need to get to them quicker. But there has to be a way to speed this process up. So, thank you for being here.

Mr. Chairman, I yield back.

Chairman JOHNSON. Thank you. Ms. Black, do you want to question?

Mrs. BLACK. I certainly do, Mr. Chairman, and thank you for allowing me to ask a question. Not being a member of the subcommittee, it is an honor to sit in on the subcommittee.

I want to go to the Social Security Advisory Board, and the fact that they have, on a number of occasions, done reports. And in those reports—and I want to turn here to my notes—the first one in 1998 that was done, entitled, "How Social Security Disability Programs Can Be Improved," that was done in 1998. And in that particular report it did say—it discusses the complexity of the administrative structure, and as well, the eligibility as fundamentally a judgement process is what they said in that report.

And then again in 2001, there was another report done by the board, and it was entitled, "Disability Decisions-Making Data and Materials," and there was a companion report: "Charting the Future of Social Security Disability Programs: the Need for Fundamental Change." And again, in this report, they noted that there was a question of fairness and consistency of the process, noting wide and unexplained variations in the outcomes between the different regions of the country and different levels of adjudication, and major changes on how disability is determined, based on court decisions that have never been reviewed by Congress. So Congress has some responsibility in this, as well.

And then, more recently, in March of 2011 there was another report, “A Vision for the Future: Social Security Administration.” And in here, once again, they talked about the complexity of the program. And this is a quote out of the report. “After 75 years, many of the policies governing the SSA’s programs have become overly complex and, in some cases, unintentionally conflicting, thereby impeding the Agency’s ability to administer its programs effectively.”

And once again—and this is the last one—in February of 2012 the board had another updated report entitled, “Aspects of Disability Decision-Making Data and the Materials,” and I quote here, “Long-standing”—noting the, “Long-standing lack of consistency in disability determination process that may award benefits to individuals who do not meet the SSA disability criteria, and deny benefit to individuals who do meet the criteria.”

One of the things that I continue to hear from my constituency is this complexity, is that it is such a weave of complexity that they have a hard time working through the process. And most of my constituents end up getting a lawyer. Very few of the cases that, at least I am aware of—and I am sure there are a lot of them I am not aware of, to be fair—do come to me, and even when I was at the state level, to say, “Look, this is so complex, can you help me?”

And what I would like to know from those who may know of this report, these reports, if you have—and I guess, Mr. Spencer, maybe that first one is for you—if you are aware of these reports, if you have taken any of the suggestions in trying to help with that complexity.

And, in addition to that, are there some recommendations out of these reports that you think that we could still apply at some point in time?

And third, is there anything that we in Congress can do to help you to make sure it is less complex, and to help those who are applying to get through the process?

Mr. SPENCER. I will certainly address the first. And if you could remind me of the second and third——

[Laughter.]

Mrs. BLACK. Okay, sure.

Mr. SPENCER. Absolutely I am familiar with the reports. We work very closely with the Social Security Board, both the board and the staff. They have got great ideas. They ask us for data, we share data. We meet with them very regularly.

I think that I want to emphasize that our first goal in disability policy is consistency, to make sure that this very complicated program—and it is—that there is a modicum of complexity. And yet, to find as much simplification as you can.

Let me just emphasize that, from my analysis over time—and I have been with the program a very long time—I think that it is very complicated primarily to serve as a protection for each individual, that it is very difficult to put an individual into certain impairment categories and have it always work. A good example of that right now is—is it Valerie Harper, the woman who played Rhoda on TV? She is dying. She has months to live. She looks pretty good. She looks fine, and she is on TV and talking about it. So it is really hard to see an individual and know that, well, this person meets the requirements of disability or not.

What we emphasize in the policy shop is getting guidance out, and case-by-case guidance. Yes, we write regulations and rulings and we write instructions. But at the same time, we also build electronic tools that walk a person through the complexity in the DDS side, at the eCAT, on the hearing side we are moving forward on Electronic Bench Book, so that if you have got a question as you are looking at this document, this tool, you can actually have the policy come down and guide you.

We build fake cases for adjudicators to show allowances and denials, and we gather data. We have something called the residual functional—I am sorry, the Request for Program Consultation Process, where people disagree on cases, and we have over 6,000 very difficult cases——

Mrs. BLACK. Mr. Spencer?

Mr. SPENCER. Yes, I am——

Mrs. BLACK. I don't mean to interrupt you.

Mr. SPENCER. Okay.

Mrs. BLACK. But I am reclaiming my time, which I actually don't have, because I see I have a red light.

Chairman JOHNSON. That is correct.

Mrs. BLACK. But, Mr. Chairman, if I may ask, I think this is a really important question, given that there are advisory board recommendations. And I would like each of the panelists if they do have an opinion on how those recommendations could be implemented, whether it is something that we can work with them, if they can give us, in written form back to this Committee, their recommendations on where they think that this could occur, and how we might be able to help, given we are Congress and looking at this thing.

Chairman JOHNSON. I know the IG can. So thank you, we appreciate it. Your time has expired. Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman. Mr. Spencer, I did have one follow-up, and I know my time had expired. And it gets back to your organization. And I know the American people were always concerned about fraud and abuse, and you were really the gatekeeper in your organization at the starting point. And I heard your five-step approach to evaluate claimants, and I think those are very good approaches.

I ask you about a sixth approach, and that is what happens—does your organization ever look to those that have gotten through, the golfer, the guy with the cane, and all these, and then bring those back and decide how they got through, what caused them to get passed? Even though you have this five-step approach, and it is a good approach, and you are really—looks like you are really attempting to do the best you can, what do you have in the process that says, "Let's pull these back in and see what happened"?

Mr. SPENCER. That is a super question. The DDSs and the decision-makers, especially at the CDR level, that is the first line of defense, to send referrals over to our OIG partners.

But whenever we find fraud cases, we absolutely like to see them and figure out what went wrong. We do that not only on OIG cases, but on pre-effectuation, before decisions are made, where someone might recommend an allowance. And part of our review, because before allowance is paid, we look at at least 50 percent of all those allowance proposed decisions. And if we find that something looks funny, the case is held up, the case is referred, we investigate it for either fraud or similar fault.

So, yes, the five-step process is a very broad process. But whenever we suspect fraud, the decision-makers and the policy folks go into that in some detail.

Mr. RENACCI. So do you—when you re-evaluate, do you put new processes in place to make sure that some of these items are caught?

Mr. SPENCER. Yes, we have given guidance on what to do when you suspect fraud, that is true. But we fully support the work of our OIG. I was a Disability Determination Services Director in New Jersey, when we started one of the very first CDI units in New Jersey, for example. But yes, we pay a great deal of attention, and learn as much as we can from every case.

Mr. RENACCI. All right. Thank you, Mr. Spencer. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. Mr. Kelly, do you have a follow-up?

Mr. KELLY. I do, Chairman. I wanted to go back to the administrative—and Ms. Black and I were just talking about this, and I am trying to understand. If two-thirds of an $11.5 billion budget is being funded into the administration of it, there has to be something basically or fundamentally wrong with the way it is set up. I mean does anybody—this doesn't pass a smell test if we are saying, oh, it is a little bit—yes, a little bit complicated? Two-thirds of 11.5 billion? A little over $7 billion is going to the administrative costs?

I mean to me there have to be bells going off somewhere, lights flashing somewhere. Who is looking at this? And how does that compare to other agencies and their breakdown? Because I am getting the feeling that—I know we got a big government, I know we got a lot to cover. But I am really concerned when administrative costs are eating up that amount. And anybody can tell me. Anybody have a feel for that?

[No response.]

Chairman JOHNSON. Don't everybody speak at once.

Ms. RUFFING. I will venture an opinion here, and it is the fact that disability determination and continuing program integrity activities are inherently complicated. There are approximately 45 million people on the old age and survivors program, and approximately 10 million on the disability insurance program. Please correct me, but those are in the ballpark. But the retirement program really only requires you to verify that somebody is 62 years old or over, or that they were married to a deceased worker. That is pretty simple to do. There is nothing——

Mr. KELLY. Well, excuse me. I mean—not to interrupt you, but I have to. I mean I understand the scope of it. But there is no way in the private sector you could look at a program where two-thirds of it is being eaten up by administrative costs and think that this is a program that is effective and efficient. It just doesn't make sense.

But, of course, I am coming from an area where you actually have to pay for it out of your own pocket, you don't have these deep wells that you can reach into to grab revenue all the time.

I am really concerned about this. I mean I understand the complexity of it, but there is something wrong. The administrative process takes up two-thirds of an $11.5 billion budget? That is almost 8 billion—Jim, you are a CPA. It comes out to, what, 7.5, 7.6? It is a lot of money.

Mr. SPENCER. Our administrative costs, as a factor of our program costs, is 1.5 percent. So——

Mr. KELLY. Wait a minute, wait. Your administrative cost is 1.5 percent?

Mr. SPENCER. Of the money we pay out, the program costs.

Mr. KELLY. The money you pay out.

Mr. SPENCER. So——

Mr. KELLY. What is your total budget, though? I mean it is not 1.5 percent of your total budget.

Mr. SPENCER. Oh, no.

Mr. KELLY. No.

Mr. SPENCER. I don't have that.

Mr. KELLY. Okay.

Mr. SPENCER. I can get that for you.

Transcript Insert

Mr. KELLY. Well, let's compare apples to apples and oranges to oranges.

Mr. SPENCER. Yes.

Mr. KELLY. I understand what you paid out——

Mr. SPENCER. I think a lot of private disability insurance will run between a four and a five percent cost. We have significantly less——

Mr. KELLY. Of what they pay out.

Mr. SPENCER. Of what they pay out.

Mr. KELLY. Okay. But that is not the entire budget.

Mr. SPENCER. No, no, no, sir.

Mr. KELLY. Okay. Because there is nothing—there is not a model out there that works on a 1.5 or 4 percent administrative cost. I mean I worked in a lot of charities back home. If you can keep it somewhere under 15 percent, you are walking in rarified air.

So this is alarming, though. This amount of money we are spending for administrative costs really is alarming, which goes back to Judge Hatfield. This has become so complicated and so complex and so willy-nilly, I mean what do you want the pain to be? Pain is what I may think what pain is, you may think what pain is. But permanent disability versus—maybe there is some other way to do it. I don't want to take anything away from anybody, but the sustainability of these programs is in great jeopardy because of the structure.

So, Mr. Chairman, thank you.

Chairman JOHNSON. The gentleman's time has expired. Thank you for your questions.

Ms. Hermann, what are the most common types of disability fraud that CDI units investigate?

Ms. HERMANN. We investigate all types of disability fraud. But the most common things we see are people—it really runs the spectrum—people outright faking their disabilities to people who are mildly exaggerating some of their—the things they are able to do. And it, again, runs the spectrum from pain, generalized back pain, migraines, all the way to, you know, mental disorders, personality disorders——

Chairman JOHNSON. When you find somebody that is fraudulently trying to take money from the system, how fast does the money stop? Or is it immediate?

Ms. HERMANN. That is actually a good question for some of the SSA counterparts here. Our investigations, we try to do as quickly as possible, but still as thoroughly as possible, so——

Chairman JOHNSON. Well, then you give them to him. And do you stop the payments?

Mr. SPENCER. We do. As soon as fraud is suspected, payments can be suspended. And we re-evaluate the case, ignoring all the suspect evidence.

Chairman JOHNSON. Mr. O'Carroll, what percentage of CDI investigations focus on initial claims?

Mr. O'CARROLL. Chairman, that is about, I would say, 84 percent is initial claims. So about 16 percent are in pay.

Chairman JOHNSON. And why is the program more focused on applicants, rather than those already receiving benefits? And you got any more videos that you want to show us?

[Laughter.]

Mr. O'CARROLL. I just happened to bring some extra videos with me.

But to tee it up again, just as you had said, Chairman, on it, what we wanted to do with the CDI program at the beginning of it, was stop the money from going out the door. And that is why our focus, from the beginning of it, was to get the information to the decision-makers before the benefits go out. Because it is so hard to recoup the money once it is lost. It is better to get it on the front end.

However, because of the success, and doing the videos that I will be showing you in a minute, it has become so good a tool for providing judges with the information, for finding the DDS people with the information, that we are getting more and more referrals, so we are doing more and more in pay. And those are the ones that—as came up earlier, those are the ones, when they are in pay, that are more likely to be prosecuted.

But with this, we did bring a couple of other examples, and I will show them to you now.

[Video shown.]

Mr. O'CARROLL. In this first video, we have—this first woman, she is the lead singer in a musical group, and she claims she was disabled and isolated herself from others. CDI investigators located this tube [sic] on YouTube and then shared it with the DDS.

The next woman we see is jogging at a softball game, and she claims she suffered from chronic back pain. And she talked about the softball game, as well as other workouts and activities, on her Facebook page.

And finally, this is the case of the drummer girl who was featured—she was featured on Fox News. The case became, as a result of a CDR on the woman, who was receiving benefits for back pain and other disorders. We discovered she was actually a very talented drummer in an all-female band. And the investigators located some videos on YouTube, and then they went to the concert and filmed the whole thing, which is what we used, and then we turned it over to the DDS and she didn't get her benefits.

Chairman JOHNSON. Thank you. I appreciate that.

I think that is all I want to do at this point. Mr. Becerra, you are recognized.

Mr. BECERRA. Thank you, Mr. Chairman. Thanks for letting us ask a second series of questions. And actually, to Mr. Kelly's point, that is why there is an expense to the Administration of the DI program, because we have to pay your salary, and Ms. Hermann's salary, and all the folks who are going to go out there to make sure we do this right. Then we have to make sure we pay Judge Hatfield to conduct the hearing, we have to pay Mr. Spencer and Ms. Lyon-Hart, to make sure that the process is done properly.

When you think about it, in terms of the actual amount spent administering the program, one or two percent, that is great, in terms of the benefits that are doled out. And I actually think, given that you have to deal with tens of millions of Americans who are either getting survivor's benefits, retirement benefits, or disability benefits, that, for the cost, I just want to say to each and every one of you who are working, because I don't know if we said this to you, but each and every one of you who work in this field, thank you.

Thank you for what you have done in helping make determinations, and helping process the folks, and helping make sure that Americans can have confidence in the system. I don't think, often times, we recognize how much work you do. And so, when you find that person who is trying to take advantage, it is important. Because there is going to be someone who does come through the door of the judge who really can't afford an attorney, who really has a case, but doesn't know how to prosecute it for himself or herself. And that is where the judge comes in and all the folks who make sure that those Americans who paid into the system for years and years and years have a chance to make it happen.

So, quite honestly, I think, Mr. Kelly, if we look into this, we will find that, for the money, you can't find a better-administered program than what you have with the Social Security——

Mr. KELLY. Would the gentleman yield?

Mr. BECERRA. Absolutely.

Mr. KELLY. There is a huge difference between the percentage of what is paid out and the total percentage of the budget that is allotted. Administrative costs that eat up two-thirds? I can tell you, Mr. Becerra, coming from the private sector, there is nobody operating any business today in the private sector that looks at two-thirds of the administrative—going to the administrative costs of what they are spending, and thinking they are running a successful business. It can only be done inside Washington, and that is because we got other people that fund it for us.

Mr. BECERRA. And, Mr. Kelly, name me another company that has to deal with millions of people who claim that they are disabled after paying benefits and have to go through the process.

Mr. KELLY. We are comparing apples and oranges.

Mr. BECERRA. Comcast doesn't have to do that. AT&T doesn't have to do that. Northrop Grumman doesn't have to do that. This is tough.

It ain't easy, nor should it be easy to get those benefits. But Americans are entitled to get those benefits, if they worked hard and they can prove that they are now qualified.

And so, I honestly think, if we look into this, no one does it better. And I guarantee you Northrop Grumman, AT&T, Comcast pay a lot more for attorneys than the Social Security Administration pays their ALJ judges and everybody else who tries to put these cases together. I guarantee you AT&T has a far bigger budget to do its investigations and so forth than does the SSA to have Mr. O'Carroll do that great work that he and Ms. Hermann are doing.

And so, I think that we could put all that out there transparently. And I guarantee you that many of us would be willing to dive on the sword to say that SSA is working very hard to make sure that the system is working for Americans who paid into it.

Let me ask a couple of quick questions. So—by the way, thank you. By the way, can I also, Mr. Chairman, say thank you to Kim and the staff on this Subcommittee? Because we have had a couple of great hearings, where I think we are digging deep into what we can do to make the program work better. And I want to thank the cooperation that we have seen from our staff, both Majority and Minority staff, in helping us really have what I think are solid hearings, where people want—Members of Congress want to stay and actually ask a second round of questions of the witnesses. So I want to say thank you to Kim and all the staff on our side, as well, Kathryn and staff.

Judge Hatfield mentioned something that caused me some cause for concern, until I thought about this a little bit. Mr. Spencer, isn't it the case that, with regard to those people who have a severe but not a permanent disability, that those are the types of cases that SSA most likely is going to send Mr. O'Carroll to go look at first?

Mr. SPENCER. Well, yes but. And the reason I say, "yes but," there are impairments that last a year, but we expect them to get better. So our first line of defense is, in fact, the CDR. At any time, if we suspect that something is not right in a claim, we refer that over to the OIG, because they are the experts in these type of——

Mr. BECERRA. And the CDRs, which we have been told save us nine bucks for every buck invested in that investigation, is what this congress chose to under-fund. And so, Mr. Chairman, there again, I hope we do something more about trying to make sure those reviews can be done.

And final question, Mr. Spencer, lots of variation in the rate at which people are awarded disability benefits, because there are a lot of differences among those folks who apply. What are the things that SSA does to make sure that a person with the same type of limitation in one part of the country gets the same answer, no matter where he or she files, compared to someone else in another part of the country?

Mr. SPENCER. We have a comprehensive quality assurance process. The states have an internal QA. As I said, 50 percent of all allowances are reviewed by a federal component before benefits are awarded. We take the information we gain from that, we feed it back as training. We gather data, we have something called a policy feedback system, where folks look for good case examples, and then we build training modules around those good cases, cases that should be allowed or denied.

As I mentioned, the RPC process takes complex cases and gives feedback to the decision-makers, so that they know what the policy guidance is. Those are just some examples, sir.

Mr. BECERRA. Thank you. Mr. Chairman, thank you very much.

Chairman JOHNSON. Thank you. Ms. Black, will you close us out? Do you have another question?

Mrs. BLACK. Thank you, Mr. Chairman. My last question was for the judge.

Judge Hatfield, so the ALJ's get specific training on hearing these cases?

Judge HATFIELD. Yes, they do. In fact, I was the lead instructor for many, many years in the Agency. They get initial training, which is about four weeks. And then, after a year, they come back and have supplemental training for a week, where, after they have heard some cases, they are able to discuss the issues in more depth.

Mrs. BLACK. And is there a review of their cases to just see how many cases are being approved, related to just looking at, geographically, the whole country? Because I know in some of the studies that I have done, it seems that certain areas of the country have judges that are approving more cases than others. And again, that is just looking at it cursorily, not looking deeply to find out why that is.

But is there any sort of review to make sure that what they are hearing and in the cases that they are reviewing, especially if they are unusually high numbers, that they are reviewed?

Judge HATFIELD. The Appeals Council, which is the administrative body above the judges, chiefly looks at cases based on denials of review, a claimant's initiated appeals. And that has been their largest workload for years and years. They have expanded lately—tremendously, actually—to look at allowances, as well. And I think they are looking at more allowances at this point.

But in terms of looking at a particular judge, there has been a history in the agency, sort of a bloody history, honestly, of looking at targeting particular judges and their allowance and denial rates. So it is a little tricky in that area. I will say, though, and I said this before in my testimony, is there is somewhat of a bias at the ALJ level to pay a case, because the allowances aren't looked at as deeply as the denials. Denials are on appeal. Whereas, in the DDS, as Art said, they look at about 50 percent of the allowances. But in terms of the denials—so there may be a bias in that particular part of the process to deny a case, as opposed to pay.

So, I believe there isn't quite the balance here between allowances and denials at each level that there should be.

Mrs. BLACK. I think that is another area, when you look at the disparity geographically, that we might want to look at a little deeper to find out what the justifications are there, and why it seems that some areas the judges find in favor much, much more than other areas.

So thank you for your testimony.

Chairman JOHNSON. That has been a problem. As a matter of fact, especially in Puerto Rico. I won't say any more than that. You know what I am talking about.

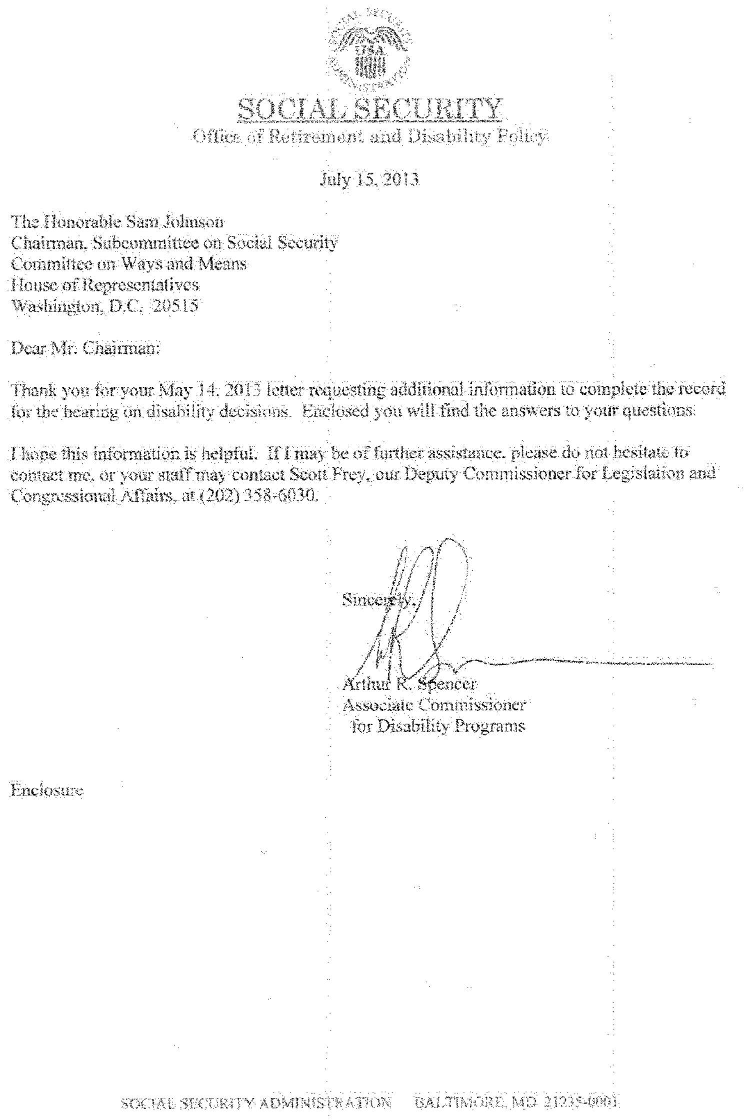
Thank you, witnesses, for your testimony. I thank you also to the Members that are here. Understanding the challenges of achieving fair and consistent disability decisions is critical to making sure that the Disability Insurance program can keep serving the people it needs to serve the most.

And, with that, this Committee is adjourned. Thank you.

[Whereupon, at 11:47 a.m., the subcommittee was adjourned.]

Questions For The Record

Arthur Spencer



SOCIAL SECURITY
Office of Retirement and Disability Policy

July 15, 2013

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your May 14, 2013 letter requesting additional information to complete the record for the hearing on disability decisions. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me, or your staff may contact Scott Frey, our Deputy Commissioner for Legislation and Congressional Affairs, at (202) 358-6030.

Sincerely,

Arthur R. Spencer
Associate Commissioner
for Disability Programs

Enclosure

SOCIAL SECURITY ADMINISTRATION BALTIMORE, MD 21235-0001

Questions for the Record
For the March 20, 2013 Hearing
On Disability Decisions
Questions from Chairman Johnson

1. **In your testimony, you indicated that the Social Security Administration (SSA) has an interagency agreement with the Bureau of Labor Statistics (BLS) to test occupational data collection methods that could lead to the development of a new Occupational Information System to replace the long outdated Dictionary of Occupational Titles (DOT).**

    a) **How much will SSA spend on the interagency agreement with BLS from start to finish? What is the timetable for testing and use of the new system if testing is successful? When will adjudicators have a tool in their hands they can use?**

    At this time, we cannot provide actual costs because those costs will depend on the results of ongoing feasibility testing. Last fiscal year (FY), we spent $392,000 on the interagency agreement. This fiscal year, we anticipate spending $10.8 million. We anticipate spending $14.8 million in FY 2014 and $16 million in FY 2015.

    Our timetable for the new system is as follows:

FY 2013	• At the beginning of this fiscal year, BLS began implementing its data collection test plan.
FY 2014	• BLS will continue testing any outstanding issues and will conduct a small-scale production test to prepare for the full-scale data collection. The small-scale production test will not include a full sample and will be based on the FY 2013 testing result.
FY 2015	• Depending on FY 2014 small-scale production test results, BLS may begin gathering full-scale production data, some of which may be available in FY 2016. • After full-scale production data is complete, we will test the effects of using the data in our adjudicatory process prior to full-scale implementation.

    Adjudicators may be able to use the new occupational information system (OIS) as early as FY 2016. This date depends on the results of the small-scale production test, the gathering of actual production data, and testing the production data in our adjudicatory process.

    To be clear, we are working with BLS to develop current occupational data for use in our disability programs. BLS is not updating or replacing the DOT.

b) When did efforts to update the DOT begin? How much funding has been spent to date?

The OIS project began in FY 2008 with initial research exploring whether the Department of Labor's Occupational Information Network (O*NET) or other occupational classification systems could meet our disability evaluation needs. We determined that neither O*NET nor any other then currently available system would be able to meet our requirements without modification. From FY 2009 to FY 2012, we convened the Occupational Information Development Advisory Panel (OIDAP). The OIDAP consisted of experts in industrial and organizational psychology, worker rehabilitation, and disability program law. The OIDAP made recommendations to us regarding OIS development and held regular public meetings that allowed stakeholders to share their advice and concern regarding the development of our OIS. In July 2012, the charter for the OIDAP expired and we entered into an interagency agreement with BLS to help support the development of new occupational data for us.

From FY 2008 through FY 2012, we spent roughly $3.8 million on the OIS project.

OIS Spending by Fiscal Year

Fiscal Year	Spending	
2008	$	665,000
2009	$	342,000
2010	$	815,000
2011	$	990,000
2012	$	984,000
Total	$	3,796,000

Please note that the FY 2012 figure includes the $392,000 that we spent on the interagency agreement with BLS.

2. What standard qualifications are in place for vocational experts used by the DDSs and/or used by the Administrative Law Judges (ALJs)? How are they trained?

At the State level, disability determination services (DDS) agencies do not use vocational experts (VEs). Instead, they use vocational specialists who know how to apply vocational factors to a specific medical-vocational determination. Using its own personnel standards, each State DDS determines which employees qualify as vocational specialists.

Regarding vocational specialist training, we have developed a wide variety of vocational training resources that any DDS adjudicator can access directly from his or her personal computer workstation. These training resources include PowerPoint slides, desk guides, online case studies, and numerous videos on demand (VOD). We have also converted a previous three-day headquarters "Vocational Specialist" training into a series of VODs that DDS employees can access at their workstations called "Vocational Specialist at the Desktop" training. This series provides DDS employees with training on complex vocational policy areas, such as residual functional capacity, remaining occupational base, and Steps 4 and 5 of the sequential evaluation process.

At the hearing level, we use VEs. VEs are independent contractors. To qualify as a VE, a contractor must be trained and skilled to render impartial opinions relevant to evidence at the hearing level of the disability claims process. A VE should have current knowledge of the following:

- working conditions and physical demands of various occupations;
- transferability of skills;
- the existence and number of jobs at all exertional levels in the national economy; and
- job placement for workers with disabilities.

The VE should also possess the following:

- up-to-date knowledge of, and experience with, industrial and occupational trends and labor market conditions;
- an understanding of how we determine whether a claimant is disabled;
- current and extensive experience in counseling and job placement of people with disabilities; and
- knowledge of, and experience using, vocational reference sources. These sources include the DOT, County Business Patterns by the Bureau of the Census, the Occupational Outlook Handbook published by BLS, and any occupational surveys of occupations prepared for us by various State employment agencies.

Because VEs are independent contractors, we do not provide their training. However, we have developed a VE orientation PowerPoint presentation that our regional offices share with their VEs.

3. **Is there a process in place for the SSA to respond to recommendations from the Administrative Conference? If yes, please describe.**

Once we receive a report and recommendations from the Administrative Conference of the United States (ACUS), our internal components with the related subject matter expertise perform detailed reviews of the report and conduct any necessary additional research. The components work together to evaluate which of ACUS' recommendations best address the issue or area of concern that we asked ACUS to study, while simultaneously weighing the challenges that we face in the current environment. The components will reach agreement on the best course of action, which may or may not include implementing the ACUS recommendations or versions of the recommendations.

4. **Since 2003, Social Security's disability programs have remained on the Government Accountability Office's high-risk list because they rely on out-of-date criteria in making disability benefit decisions. Social Security is in the process of performing comprehensive updates of each of the fourteen body systems in the Listing of Impairments used to determine if someone is disabled, but some of the reviews have been ongoing for the last 19 to 33 years. Two of the listings, mental and neurological disorders, have not been comprehensively revised for more than 27 years. Why the delay? In addition, please provide a table which provides detailed information regarding the status of each listing update. Please also include a summary of the process for how listings are updated.**

   We are currently revising our Listing of Impairments (Listings) governing the evaluation of mental and neurological disorders through the multi-step rulemaking process. These revisions will reflect current medical knowledge and practices, advances in medical technology, and our adjudicative experience.

   We have made a commitment to update all of our Listings, recognizing that some Listings have not been updated in many years. These Listings are complicated, and we want to make sure that we revise them correctly. To some extent, the complexities of certain body systems, such as mental and neurological, have caused the delays in updating the corresponding Listings.

   I have enclosed a chart that provides the status of each Listing update (Enclosure 1) and a summary of the process for how we update Listings (Enclosure 2). Please note that the chart reflects the anticipated dates of publication as published in the fall 2012 Unified Agenda. We will be making some changes to the anticipated dates of publication for some of the Listings, and these changes will be published in the spring 2013 Unified Agenda.

5. **Please explain why, in Fiscal Year 2012, the Puerto Rico Disability Determination Services (DDS) awarded benefits 59.1 percent of the time, when Mississippi DDS awarded benefits 25 percent of the time.**

   Our research indicates that factors outside of the DDS' or our control substantially affect State-to-State variation in allowance rates. These factors include the composition of initial determinations by age, gender, primary diagnosis, and the presence of a secondary diagnosis. Claim filing rates also vary from State-to-State, and this can significantly affect allowance rates. Historically, States with high filing rates tend to have low allowance rates and vice-versa. Other State characteristics, such as economic conditions, demographics, and health levels, correlate strongly with the filing rate. Consequently, these characteristics indirectly influence the allowance rate.

   In addition, there is no Supplemental Security Income (SSI) program in Puerto Rico, so its allowance rate is only for Social Security Disability Insurance (SSDI) claims. SSI determinations tend to have a much lower allowance rate and pull down a State's overall allowance rate. Other States with SSDI allowance rates that are comparable to Puerto Rico include Wyoming.

New Hampshire, New Jersey, South Dakota, Vermont, North Dakota, and Massachusetts; these States have allowance rates that range from roughly 62 to 50 percent. The national allowance rate for FY 2012 for SSDI claims is 42.5 percent.

6. **What responsibilities does a claimant have in the development of their claim and in the appeal of a previous decision? What responsibilities does the agency have? Are these responsibilities required by statute, regulation, or agency policy?**

   Regardless of the level of adjudication, the Social Security Act (Act) and our regulations make proving disability the claimant's responsibility. The Act requires a claimant to provide medical and other evidence showing that he or she is disabled. Section 223(d)(5)(A) of the Act, 42 U.S.C. 423(d)(5)(A). See also section 1614 of the Act, 42 U.S.C. 1382c(a)(3)(H)(i) (applying the provisions of section 223(d)(5) to disability determinations under title XVI). Our regulations specify that a claimant must provide evidence, without redaction, showing how his or her impairment(s) affects his or her functioning and any other information that we need to decide the claim. Our regulations further require a claimant to provide, if we request it, evidence regarding non-medical factors that demonstrate how a claimant's impairment(s) affects his or her ability to work (such as activities of daily living). 20 C.F.R 404.1512(c) and 416.912(c).

   The Act also requires us to develop a complete medical history of at least the preceding 12 months before we deny a disability claim. When deciding a disability claim, we must make every reasonable effort to obtain the medical evidence that we need from the claimant's medical sources. Section 223(d)(5)(B) of the Act, U.S.C. 423(d)(5)(B). See also section 1614 of the Act, 42 U.S.C. 1382c(a)(3)(H)(i). If the claimant's medical sources cannot or will not give us sufficient medical evidence to decide the claim, our regulations allow us to purchase a consultative examination or test. 20 C.F.R. 404.1517 and 416.917.

7. **What are the qualifications for a DDS examiner? How does Social Security ensure that training is provided consistently nationwide to DDS examiners? What professional development and continuing education opportunities are offered to ensure examiners have the skills needed to make decisions effectively?**

   Each State DDS determines which employees qualify as examiners pursuant to its own personnel standards, and the professional development and continuing educational opportunities offered to its examiners. We do not provide specific professional development and continuing educational opportunities, but we provide policy-compliant training materials on all aspects of the disability program. We also provide training materials to address new or updated policy, processes, initiatives, and quality trends. We design our training to meet the needs of all staff and address State-specific needs. All of our training materials are readily available to all DDSs via our Intranet, VODs, and video conferences. In addition, we provide training through other formats, such as on-site training.

8. **At this Subcommittee's March 13, 2013 hearing, we learned that some people are receiving benefits for as many as 12 years on average. If a person was determined to be disabled 12 years ago and their condition has not changed, but they would not qualify for disability under today's standards, what happens?**

   In your scenario, we would most likely continue benefits even if the beneficiary would not qualify under today's standards. When conducting a continuing disability review (CDR), the Act requires us to use the Medical Improvement Review Standard. When applying this standard, we begin by comparing the beneficiary's current condition to the findings related to that condition when we last found the beneficiary disabled. Thus, we would compare the beneficiary's current condition to findings from 12 years ago. Before we terminate eligibility, we would have to show:

   - medical improvement in the beneficiary's condition;
   - increase in their ability to perform basic work activity; and
   - ability to engage in substantial gainful activity.

   However, there are exceptions to this rule. For example, if the beneficiary became eligible through fraud, we would immediately re-determine that eligibility even if the condition were unchanged.

9. **Recently, Social Security changed the process for determining if a person can work by having examiners look at jobs in the national economy before looking at past work. Please explain the policy and why it was implemented.**

   In July 2012, we issued regulations that gave adjudicators the discretion to proceed to Step 5 of sequential evaluation when we have insufficient information about a claimant's past relevant work history to make a finding at Step 4. We implemented this policy to expedite cases in which the adjudicator currently does not have sufficient vocational evidence to evaluate work at Step 4 but is able to deny the claim at Step 5. Vocational development can be extremely time-consuming, and this expedited process can save valuable processing time by appropriately making a "not disabled" determination at Step 5. Of course, if we find that the claimant may be unable to adjust to other work at Step 5 or if one of our special medical-vocational profiles may apply, the adjudicator will return to Step 4 to develop the claimant's work history and make a finding about whether the claimant can perform his or her past relevant work.

   Our revised policy states:

   - If there is enough vocational evidence in the file to find that the claimant can perform at least one past relevant job (either as he or she performed it or as it is generally performed in the national economy), the adjudicator should deny the claim at Step 4 of sequential evaluation.

   - If there is not enough vocational evidence to determine whether the claimant is able to perform past relevant work, the adjudicator may either develop the vocational evidence to evaluate the claim at Step 4 or proceed to Step 5. Before using the expedited process, the adjudicator will first consider whether any of the special medical-vocational profiles might be applicable.

- If the adjudicator can determine that the claimant can adjust to other work in the national economy, he or she will deny the claim at Step 5.
- If the adjudicator cannot deny the claim at Step 5, he or she must return to Step 4 and develop the needed vocational evidence regarding past relevant work.

10. A paper recently released by Jeff Liebman and Jack Smalligan suggests temporarily switching Social Security's State DDS costs from discretionary to mandatory spending. They believe this change would provide the resources the agency needs to stay current with continuing disability reviews, better document claims at the initial application step, and reduce case backlogs. After 5 years, Social Security would have to demonstrate that the increased expenditures more than pay for themselves with reduced spending. What are the agency's views regarding this proposal?

Jeff Liebman and Jack Smalligan developed some interesting proposals related to the SSA disability program, which we are currently reviewing. Thus, we are not ready to offer views on the specific proposals relating to the future of DDS funding.

However, on a similar idea relating to mandatory funding, the President's Budget for FY 2014 includes a special legislative Administration proposal that would provide a reliable stream of mandatory funding to significantly ramp up our program integrity work. Program integrity work ensures that only those eligible for benefits receive them.

The annual appropriations process has not provided us with the resources necessary to conduct all of our scheduled CDRs and redeterminations, leading to a backlog of 1.3 million CDRs. We estimate that each additional dollar spent on CDRs would save the Federal Government $9 and each additional dollar spent on redeterminations would save the Federal Government $5.

The proposal would create a new Program Integrity Administrative Expenses account, which would be separate from our Limitation on Administrative Expenses account. The new account would cover a substantial amount of our costs for CDRs and redeterminations over the next 10 years. If approved, the funds would be available for two years and would provide us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work. The Budget proposal would lead to net savings of $38 billion over 10 years.

In FY 2014, the budget proposal would provide $1.227 billion, allowing us to handle significantly more CDRs. With this increased level of funding, the associated volume of medical CDRs is 1.047 million, although it may take time to ramp up to that level. For comparison, we conducted 443,000 CDRs in FY 2012.

11. The Inspector General's testimony highlighted findings from a July 2012 audit regarding administrative finality, indicating that the SSA agreed to review and evaluate administrative finality policies. What specific progress has been made?

We formulated several ideas for changing the rules of administrative finality. We intend to vet these ideas with external stakeholders, including the public.

Enclosures (2)

Enclosure 1 – The Honorable Sam Johnson

Status of the Medical Listings Revisions

Body System	Current Status
Growth Impairments NPRM*	NPRM published 5/22/13 at 78 FR 30249; public comment period closes 7/22/13.
Musculoskeletal System NPRM	NPRM drafted. Anticipated date of publication: 11/2014.
Special Senses - Vision final rule Special Senses - Hearing Loss and Disturbances of Labyrinthine-Vestibular Function ANPRM**	Final rule published 3/28/13 at 78 FR 18837. ANPRM drafted.
Respiratory System NPRM	NPRM published 2/4/13 at 78 FR 7968; reviewing public comments to begin drafting the proposed final rule.
Cardiovascular System NPRM	Drafting NPRM. Anticipated date of publication: 4/2014.
Digestive System NPRM	NPRM drafted. Anticipated date of publication: 6/2014.
Genitourinary Impairments NPRM	NPRM published 2/4/13 at 78 FR 7695; reviewing public comments to begin drafting the proposed final rule.
Hematological Disorders NPRM	NPRM drafted. Anticipated date of publication: 11/2013.
Skin Disorders NPRM	NPRM drafted. Anticipated date of publication: 12/2014.
Congenital Disorders that Affect Multiple Body Systems final rule	Final rule published 2/4/13 at 78 FR 7659.
Neurological NPRM	NPRM drafted. Anticipated date of publication: 12/2013.
Mental Disorders final rule	Drafting final rule.
Malignant Neoplastic Diseases NPRM	NPRM drafted. Anticipated date of publication: 3/2014.
Evaluating Human Immunodeficiency Virus Infection and Evaluating Functional Limitations in Immune System Disorders NPRM	NPRM drafted.
Language and Speech Disorders NPRM (proposed new Listing)	ANPRM published 2/6/12 at 77 FR 5734; Drafting NPRM. Anticipated date of publication: 11/2014.

*Notice of proposed rulemaking (NPRM)

**Advance notice of proposed rulemaking (ANPRM)

Business Process for Revising the Medical Listings

Background

The Listing of Impairments (Listings) revision process is an ongoing, multi-phase effort to update and revise the Listings, which describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity, regardless of the individual's age, education, or work experience. In the case of children under age 18 applying for Supplemental Security Income (SSI), the listed impairments are severe enough to cause marked limitations in two domains of functioning or an extreme limitation in one domain. Most of the listed impairments are permanent or expected to result in death. For some impairments, the Listing includes a specific statement of duration. For all other Listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months. The criteria in the Listings are applicable for evaluation of claims for disability benefits under the Social Security disability program or payments under the SSI program.

The Listings are organized by major body systems—14 for adults (Part A) and 15 for children (Part B), although adult criteria can be applied to children if the disease processes have a similar effect on adults and children. We have over 100 listed impairments.

We update and revise the Listings to reflect the universal standard of care, as well as to include the latest advances in medical treatment and technology that affect a person's ability to function. The Listings also reflect our adjudicative experience through our own case reviews, the quality review system adjudicator feedback, as well as research and advocate input.

Listings Revision Process

There are five high-level phases involved in the Listings revision process: information gathering, drafting the Notice of Proposed Rulemaking (NPRM), completing the internal agency review process, publishing the NPRM in the *Federal Register* for public comment, and publishing the final rule in the *Federal Register*.

Since 2004, we have comprehensively updated approximately 70 percent of the listings and are on track to propose revisions in the *Federal Register* for all listings by the end of 2014. We are committed to completing targeted revisions of the Listings on a 5-year basis; the 5-year period starts after we complete the comprehensive body system revision.

Step 1: Information Gathering

Internal

Internally and almost immediately after a Listing is updated, disability claims adjudicators ask, and we respond to, questions about how to apply the recently updated medical criteria. We also review Request for Program Consultation (RPC) and Policy Feedback System (PFS) data to look for trends in adjudicative practice that highlight the need for policy clarification. We developed the RPC process to resolve differences of opinions between adjudicators and quality reviewers concerning disability determinations. We post all RPC resolutions and related data on our Intranet to make them available to all agency staff. We use the information to identify issues and areas where we might improve disability policy. The PFS supports our initiative of improving disability policy by gathering data from the large amounts of programmatic information that we collect throughout the disability process and by using the data to identify areas for policy change and improvement.

We release a questionnaire to our internal users/adjudicators to solicit input about their experience using the revised medical criteria throughout a one-year period. In addition, our staff performs literature searches and research to learn about advancements and recent changes in medical treatment and technology.

External

One year after we implement revised medical criteria, we send a questionnaire to external advocacy and other interest groups to learn about their experience with the rules. The groups include patients, medical experts, technicians, clinicians, and the public. We maintain contact lists for each body system and a general contact list for our use to notify the public when our regulations are available in the *Federal Register* for public review and comment. Recently, we launched a test of an open government public engagement option to invite internal and external comments on an issue that will provide insight into our work to update and revise the Listings.

Formal Outreach

We conduct formal outreach by soliciting comments from the public and by meeting with advocacy and interest groups. We publish an Advance Notice of Proposed Rulemaking (ANPRM) in the *Federal Register* to provide information and pose specific questions that we believe will be helpful to solicit comments from the public that we can use to update and revise the Listings. In the past, we hosted public outreach conferences to give advocacy and other interest groups an opportunity to share their concerns and experience about certain impairments. Over the past four years, we have hosted these meetings internally or by teleconference due to budget constraints. We host these outreach meetings as needed and up to the point where we begin drafting the NPRM.

To keep the Listings medically up to date, it is critical that we get advice from independent medical experts in a variety of medical and clinical disciplines. We have partnered with the National Academy of Sciences (NAS), Institute of Medicine (IOM), to research the Listings and provide independent, unbiased, and authoritative medical and clinical advice. The IOM Committee of Medical Experts to Assist Social Security on Disability Issues is a standing multidisciplinary expert medical committee convened by the NAS. It provides us advice through meetings, workshops/symposiums, and Federal Advisory Committee Act (FACA)-compliant consensus study committees. By having independent medical experts provide us with necessary updates, we maintain our objectivity, and by using FACA-compliant consensus study committees that include members that have clinical expertise in a particular body system, we quickly obtain publically available reports that provide us with advice and recommendations on improving the effectiveness of the Listings.

Under our previous contract which expired in December 2012, the IOM convened two consensus study committees (cardiovascular and immune/human immunodeficiency virus (HIV)) and produced two reports with 36 recommendations for improvements to the Listings that we use to evaluate cardiovascular disorders (28 recommendations) and HIV infection (8 recommendations). We have used these recommendations to draft NPRMs.

The current contract proposal provides for the continuation of an expert medical committee to advise the Commissioner on when we should revise the Listings to keep them up to date. For example, the first task order provides for a consensus study committee to evaluate our use of symptom validity testing in our disability evaluation process (including Step 3, at which we use the Listings) for both physical and mental impairments.

At the end of the information gathering phase and from all of the efforts outlined above, we compile a list of the issues and topics that we use to draft the NPRM.

Step 2: Draft NPRM

In the draft NPRM step, small teams consisting of medical policy analysts, medical officers, and other agency medical consultants, with occasional input from outside experts, work together to do research, analyze issues, and write regulations to update and revise the Listings. The body system lead analyst develops a work plan to conduct regular meetings to draft the NPRM. The team uses these meetings to draft proposed changes to the Listings (proposed medical criteria) and the introductory text (information that adjudicators need to use the Listings) and the preamble (explanation of changes to the Listings).

Before the team begins drafting the NPRM, they create an issue paper that contains the list of issues and topics that were compiled throughout the information gathering phase. The issue paper is used as a guide for the team to complete this phase of the process.

At the point where the team completes drafting the NPRM, we send the proposed rules to another agency component to review a number of previously adjudicated cases to learn about the potential impact of the proposed Listings. We analyze and summarize the case review impact and submit it to our Office of the Chief Actuary for its use to conduct a cost-benefit analysis for the agency.

Step 3: Complete Review Process

This step marks the beginning of the agency internal review process. Any ANPRM, NPRM, or proposed final regulation first undergoes an internal agency review. Then, we send the documents to the Office of Management and Budget (OMB) to obtain its review and approval to publish in the *Federal Register*. After OMB completes its review and approves the regulation, OMB returns it to the agency to obtain the Commissioner's signature before it is published in the *Federal Register*.

Step 4: Publish ANPRM/NPRM in *Federal Register* for Public Comment
The ANPRM/NPRM is published in the *Federal Register* for review and comment for usually 60 days. The public submits comments to www.regulations.gov.

Step 5: Publish Final Rule

In the publish final rule step, at the end of the NPRM public comment period, we review the public comments and consider them when drafting the proposed final rule. The proposed final rule undergoes an internal agency review. Then, we send the documents to OMB to obtain its review and approval to publish in the *Federal Register*. After OMB completes its review and approves the proposed final rule, it is returned to the agency to obtain the Commissioner's signature before it is published in the *Federal Register*.

We publish the final rule in the *Federal Register*, along with a summary of the public comments and how we addressed them. Simultaneously, we develop adjudicator training on the final rules to coincide with the rules' effective date.

David Hatfield

These are my responses to the May 14, 2013 questions:

1. As noted in my written testimony, pain and other symptoms are required to be considered as early as the second step in the sequential evaluation process. Therefore, in almost every case before me, I was required to consider the claimant's allegations of pain. I considered everything in the record when evaluating pain, including the objective evidence, medical and lay opinions, and the other factors set forth in 20 CFR 404.1529 (medications, activities of daily living, etc). All of these factors needed to be considered, evaluated, and discussed in every hearing decision that was not fully favorable to the claimant. If this discussion omitted certain factors or evidence, the case could be remanded by the Appeals Council or the courts. These overly burdensome articulation requirements set forth in the Social Security Rulings stem in large part from court interpretations of the Disability Benefits Reform Act of 1984. Each Circuit Court's interpretation is slightly different, but some essentially require an ALJ to rebut subjective claims by the claimant. For example, the Ninth Circuit has an "excess pain" standard, indicating that "if the claimant submits objective medical findings that would normally produce a certain amount of pain, but testifies that she experiences pain at a higher level, the Secretary is free to decide to disbelieve that testimony…but must make specific findings justifying that decision." Cotton v. Bowen , 799 F.2d 1404, 1407 (9 Cir., 1986). In essence, these evidentiary requirements have placed a burden of disproving subjective disability on the Commissioner.

2. Once a medically determinable impairment is established, all evidence, objective and subjective, must be considered. This means that the subjective evidence (claimant's statements regarding pain, for example) must be evaluated in practically every disability case. Adjudicators do weigh the evidence regarding the claimant's allegations of pain differently, thus leading to many inconsistent decisions, in my opinion. Consistency and uniformity of decision making should be the Agency's goal in order to be fair to all claimants, yet the emphasis on subjective factors in the regulations and rulings creates the opposite effect.

3. At step 5 the burden shifts to the Commissioner to determine whether the claimant can do other work that exists in significant numbers in the national economy. This burden can be satisfied by the Medical-Vocational Guidelines, but only in very few cases as those Guidelines only apply to solely exertional limitations. ALJs usually discharge this burden by calling a vocational expert to the hearing to give impartial vocational testimony. DDSs do not have vocational experts, and instead train their adjudicators on the Dictionary of Occupational Titles. Because DDSs do not have vocational experts to help determine the issue of significant numbers, the DDS employs an "erosion of the occupational base" test, where they look to see if other nonexertional or exertional limitations erode the occupational base. The ALJs follow the statutory and regulatory language requiring the Commissioner to show that a significant number of jobs exist or do not exist. That requirement cannot be met by erosion but rather by

expert opinion. In my opinion, these two different tests employed by different adjudicative levels contribute greatly to inconsistent decision making. Regarding the training of vocational experts, as I noted in my testimony there is no formal training given to vocational experts by SSA. In addition, there is nothing in the regulations regarding the training, experience, or qualifications of vocational experts. In the Philadelphia region where I worked, I believe vocational experts needed to have a minimum of a Master's degree in rehabilitation, but I am not aware what the standards are in other areas of the country.

4. The concept of "controlling weight" is confusing to adjudicators and is thus not applied uniformly. The regulations place emphasis on the treating source's unique relationship with the patient, but they go further to state that if the treating source opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight." 20 CFR 404.1527(d)(2). What does "other substantial evidence" mean? It is not explained. Some adjudicators view this language as essentially meaning that if there is a treating source opinion in the record that says the claimant is disabled, then it trumps all other evidence and is given controlling weight. Others view the language to mean that if there is any other piece of evidence that would be contrary to the treating source opinion, then the controlling weight standard could not be applied. When I reviewed ALJ decisions in Peer Review and on the Appeals Council, I found that many ALJs interpreted this regulation differently, given the ambiguity and lack of clarity of the language. This has led to inconsistent decision making.

5. I believe I have answered this question in response to questions 1 and 2. Credibility in SSA parlance means the credibility of the claimant's statements regarding pain and other symptoms. I have already noted that there are many factors required to consider allegations, resulting in an overly onerous burden placed on the adjudicator.

6. This is an area where SSA must improve. It is often late in responding to statutory changes. For example, SSA responded to the 1996 Contract with America Advancement Act regarding cases involving drug addiction and alcoholism by issuing an "Emergency Teletype" in 1997. This "emergency" memo was not replaced by formal, binding policy until this year - 17 years after the law was enacted. During those 17 years adjudicators floundered and guessed as to how to adjudicate cases where drug addiction and alcohol were involved. Thousands of cases were adjudicated without any clear guidelines or legally binding policy, leading again to inconsistent decision making.

7 I have testified that the courts have had a significant impact on the program, particularly since the 1984 Amendments. SSA has capitulated to court interpretations of those Amendments, particularly in the area of treating source opinion and the consideration of the claimant allegations of pain and other symptoms. Regarding the Acquiescence policy, I do not believe the Acquiescence Rulings themselves have had a significant impact on consistency. The Rulings that have been published since the policy took effect in 1985 have not affected great numbers of cases. What has happened, however, is that in considering circuit court holdings that affect a significant amount of cases, such as in the area of treating source opinion and the standards on evaluating pain, the Agency has chosen to either adopt the circuit court holding nationally or has claimed that the holding does not vary with Agency policy and in fact reflects policy accurately (Polaski and Schisler are two examples).

8. I do not have concerns with video hearings, and in fact testified that claimants should not have a unilateral right to decline video hearings. Thousands of hearings have been conducted by video, with no challenges (that I am aware of) to the due process nature of such a proceeding. The technology allows the ALJ to see and her all parties clearly.

9. The CDR process is not working. I never assumed that when I set a diary date in a decision that it would be complied with by SSA in a timely manner. The language in ALJ decisions setting diary dates is merely precatory, and this is based on years of experience. CDRs are not conducted timely, usually because of outside influences, such as budget and workload. I believe a better approach is the one I recommended in my written testimony. There should be an expert panel convened to determine and establish guidelines for setting periods of disability, based on the impairments involved, the claimant's age, etc. Not all claimants are permanently and totally disabled, yet SSA treats them that way. Many conditions get better with time and/or treatment. Claimants found disabled but with treatment should improve would be given a specified term of benefits. After the expiration of that term, if they believe they are still totally disabled, they can reapply at that time. Because these would be the cases where persons should improve and return to the work force, I would eliminate all work tests during the disability term for these individuals and allow them to return to work without any penalty.

Thank you again for the opportunity to testify and present my views. I am pleased that the subcommittee is focusing on SSA's disability policies.

David G. Hatfield

Trudy Lyon Hart

ncddd

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

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President Elect	*Erik Williamson*
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May 23, 2013

Representative Sam Johnson, Chairman
Attn: Kim Hildred, Staff Director
Subcommittee on Social Security
Committee on Ways and Means
U. S. House of Representatives
B-317 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Johnson,

Thank you again for providing the opportunity for NCDDD to present testimony at the Committee on Ways and Means, Subcommittee on Social Security hearing on March 20, 2013 concerning to the challenges of achieving fair and consistent disability decisions.

The following are my responses to your questions for the record:

1. What training are DDS examiners given to prepare them to assess limitations regarding pain? How do examiners evaluate allegations of pain? Since everyone's threshold for pain is different, does that mean that different examiners could weigh information about pain differently?

Examiner training in assessing limitations regarding pain includes the relevant sections of SSA's standard Disability Examiner Basic Training Package and intensive mentoring and supervision over many months as examiners learn to apply the criteria case by case. Medical consultants are provided program education via SSA's Medical/Psychological Consultant Handbook.

Examiners apply the criteria in Social Security Rulings 96-3p, 4p and 7p, and follow related Social Security policy guidance to evaluate the severity and functional impact of symptoms and the credibility of the claimants' statements regarding these issues. They weigh the evidence, analyze and resolve any apparent contradictions in the all the information, and assess the medical and other evidence that helps to describe the impact on the individual claimant. They obtain input from DDS medical consultants as needed or required.

Whenever subjective information is weighed and analyzed, there is the possibility of different decision makers coming to different conclusions. The policy guidelines are designed to ensure that decision makers consider the same factors and go through the same decision process.

2. On page 7 of your testimony, you discuss the history of the medical improvement review standard, how it works and your recommendation for a review of this standard. During a

continuing disability review, a person's benefits can be stopped if an examiner determines that they have medically improved. At this Subcommittee's March 13, 2013 hearing, we learned that some people are receiving benefits for as many as 12 years on average. If a person was determined to be disabled 12 years ago and their condition has not changed, but they would not qualify for disability benefits under today's standards, what happens? What if the file doesn't have a lot of information in it or somehow gets lost? Can someone be deemed medically improved then?

Generally, if a person's condition has not changed since the last favorable determination, they will be found still disabled under the Medical Improvement Review Standard, even if they would not meet today's standard. There are a few narrowly defined exceptions (see page 7 of my testimony).

If material from the prior file is lost, and the person's current medical condition does not meet the current disability standard, SSA and DDS reconstruct the prior file to the extent possible. If the reconstruction results in adequate evidence to clearly document the basis for the comparison point decision (most recent favorable decision), the DDS applies the medical improvement standard. If a lost folder cannot be adequately reconstructed, SSA policy directs that a favorable current decision must be made [20 CFR §404.1594(c)(3)v].

Electronic disability folders are less apt to be lost. As more time elapses since the advent of SSA's electronic folder system, lost folder situations should become more rare and less problematic.

3. As part of the decision-making process, examiners may be required to determine if a person has the functional ability to do jobs that exist in the national economy. How do examiners determine whether these specific jobs exist in significant numbers in the national economy? Do you have access to experts or do you rely on the outdated Dictionary of Occupational Titles?

As directed by SSA, examiners use the Dictionary of Occupational Titles (DOT) and other guidance provided by SSA in regulations, rulings and the Program Operation Manual System (POMS). Some DDSs have specific employees trained as vocational specialists. These are experts in the Social Security Disability Program's vocational policy.

The DOT has not received a substantive update in many years, and the Department of Labor database that replaced it (O*NET) does not provide sufficient information for the requirements of disability determination. A new Occupational Information System is in planning and development stages with SSA and the Bureau of Labor Statistics. In the meantime, use of the DOT provides greater consistency in decision-making than would exist if each DDS based their vocational assessments on local expert opinions alone. The statutory requirement is the inability to perform occupations in the *national* economy, not whether jobs in these occupations exist in the *local* economy.

4. On page 4 of your testimony, you stated that examiners have to give controlling weight to treating source opinions in certain circumstances. What does "controlling weight" mean?

When a treating source medical opinion is well supported by objective medical evidence and not inconsistent with other substantial evidence, SSA policy directs adjudicators to give it controlling weight. This means that the opinion must be adopted in the disability determination (Social Security Ruling 96-2p). Controlling weight does not apply to legal conclusions such as whether a person's impairment meets or equals the Listings, or whether the person is "disabled" (Social Security Ruling 96-5p).

5. In your testimony you stated that a credibility assessment is not a "gut feeling" about the person's overall truthfulness, but rather an evaluation of whether the medical findings and other evidence support what the person says. Furthermore, you noted that examiners cannot disregard what the person says solely because the objective medical evidence does not substantiate them. What does the finding of credibility come down to?

The finding of credibility comes down to the degree to which a person's statements can be believed and accepted as true based on the degree to which the statements are consistent with the objective medical and other evidence in the record. Credibility is not an all-or-nothing finding: the person's statements may be found partially credible.

6. Can you discuss why, in Fiscal Year 2012, the Puerto Rico DDS awarded benefits 59.1 percent of the time, when the Mississippi DDS awarded benefits 25 percent of the time?

Allowance rates can be affected by many factors, including regional demographic and economic factors. NCDDD does not have knowledge of DDS-specific circumstances and cannot address this question. Please refer this question to SSA.

7. Does Social Security require a claimant to fully complete the application for benefits, or does DDS have to contact the claimant to fill in any gaps in the application? What percentage of applications is complete when they arrive at a DDS, with all information needed to make a decision? What type of information is most often missing?

SSA Field Offices have responsibility for overseeing the application process. NCDDD does not have data to show the percentage of application forms that are/are not completed by the claimant or what information is most often missing. In practice, the need for SSA or DDS to clarify or obtain further information depends on the specifics of the individual claim. For example, detailed vocational information is generally unnecessary if the claimant's condition meets or equals a medical listing.

8. Is the claimant required to bring in medical evidence? How much time does it take an examiner to get all the information needed to make a decision? What percentage of an examiner's time is spent tracking down information, as compared to making a decision about a case? If claimants were required to submit all information, would it speed up the decision making process?

If claimants have copies of their medical evidence, they are encouraged to submit it. Otherwise, DDSs generally obtain the medical evidence. The time it takes to do so varies considerably depending on individual case situations. The proportion of time spent "tracking down information" versus making a decision varies from case to case and from medical source to medical source.

Requiring claimants to obtain and include all their medical evidence with their application would likely extend rather than speed up the claim process. DDSs have business processes and electronic tools that make obtaining medical evidence a very efficient process. Our evidence requests are tailored to what is necessary and pertinent to the disability determination for the specific case, whereas the claimant does not know this and could spend considerable time getting copies of records that have no bearing on the case. Often a claim can be decided *favorably* on one or a few pieces of evidence without waiting for all the evidence to arrive.

Having the DDS obtain the evidence directly from the medical sources also is a good way to protect against potential fraud (filtering or tampering with the evidence).

9. What role does a DDS examiner have in making the initial decision? What role does the doctor have in making the initial decision? What are the qualifications for a disability examiner? Does the level of education required vary by State?

The examiner and the doctor are considered an adjudicative team. The examiner is responsible for the overall disability determination, which requires synthesis of many factors – programmatic, vocational and onset-related as well as medical/functional. The doctor provides input for the assessment of medical severity and/or residual functional capacity. Twenty DDSs operate under the "Single Decision Maker" test regulations; in these DDSs, specially trained "SDM" examiners have the authority to make determinations within certain parameters based on the SDM's programmatic medical expertise with or without consultation with a medical consultant.

Qualifications for DDS examiners are defined by the states that employ them. Different states may have different educational and experience requirements. Most require a Bachelor degree or equivalent. All provide a rigorous training program for new examiners, followed by intensive mentoring and supervision until the examiner has demonstrated the capacity to maintain performance standards for accuracy, timeliness, and productivity.

10. How does Social Security ensure that training for DDS examiners is provided consistently nationwide? What professional development and continuing education opportunities are offered to ensure are examiners have the skills needed to make decisions effectively?

SSA maintains the Disability Examiner Basic Training Package and the Medical/Psychological Consultant Handbook, as well as many other training resources, including video on demand and PowerPoint training presentations, online case studies, national "policy dialogue" conference calls, desk guides, and online indices of policy guidance.

The effectiveness of examiners' decision-making is ensured on the front line through DDS internal quality assurance and performance measurement. Social Security ensures it through federal quality reviews, analysis of the data from these reviews, and development of training and/or clarification of policy based on the results. The electronic case analysis tool (eCAT) also provides examiners and medical consultants a policy-compliant decision guide for each case with links to relevant online policy guidance.

Individual DDSs offer professional development and continuing education opportunities to their employees. For example, some have career ladders based on levels of expertise and performance.

11. How does Social Security limit your ability to pay for expert opinions? Would access to more experts help make better decisions?

Social Security works with the DDSs to determine our budgetary needs, which routinely include the cost of medical and psychological consultants for case assessment and consultative examinations by various specialties, and in some DDSs, vocational specialist positions (see #3 above). SSA provides funding authorization to the DDSs, as available within the overall SSA/DDS budget limitations.

SSA and DDS must prioritize their expenditures, especially in tight budget times. Fee schedules for specialist services are generally guided by Medicare rules and/or State policies. The focus is on policy compliance. If fully funded and if the experts were fully trained in Disability Program policy as well as their area of expertise, using them might help make better decisions.

Thank you for allowing me the opportunity to address these questions. As always, NCDDD remains available to provide input to the Subcommittee on the complexities of disability decision making and possible approaches to the critical situation facing the Social Security Disability Program. NCDDD members stand ready to participate in the solutions necessary to secure this vital program for present and future generations.

Sincerely,

Trudy Lyon-Hart
President, NCDDD

Public Submissions For The Record

Jim Grennan

I am Jim Grennan, an attorney. I have represented clients seeking Social Security disability benefits for more than 40 years. This letter is being submitted to The House Ways and Means Social Security Subcommittee that will hold a hearing on "The Challenges of Achieving Fair and Consistent Disability Decisions."

My experience leads me to believe that the answer to fair and consistent decisions on a claimant's claim for disability can best be achieved requiring that each physician provide an opinion of a patient's residual functional capacity if the physician saw the claimant within a year prior to the date that the claimant made a claim for disability benefits. Such could be provided through statute and regulation with a penalty of being refused any payment by Medicare.

I believe that such a law and regulation would greatly reduce the variety of decisions throughout Social Security by providing a solid basis for determining disability. A letter to the claimant stating why the claim was denied would likely reduce the number of appeals. Such an explanation is presently not given. It most likely would reduce the backlog of cases waiting to be head by an Administrative Law Judge. Such would make known whether or not the claimant has the residual functional capacity to perform gainful employment. In the absence of the above, the determination of disability is a guess based upon medical records that do not contain a statement of the claimant's residual functional capacity.

Sincerely,

Jim Grennan

Kathleen McGraw

HEARING ON THE CHALLENGES OF ACHIEVING FAIR AND CONSISTENT DISABILITY DECISIONS

Statement of Kathleen A. McGraw for the Record

There are few government programs more in need of a legislative overhaul and update than the Social Security Disability Program. Having watched the video of the March 20th hearing, I was disappointed by the failure of the witnesses with one or two exceptions—Judge Hatfield and Ms. Hart—to address the subject matter of the hearing. A problem has been identified with respect to the consistency of outcomes in disability decisions, and identifying the cause of the problem is critical to effecting change and improvement.

Why do I have something to contribute on this subject?

As a recently retired ALJ with the Social Security Administration (SSA), I have no organization affiliation; I am writing as a concerned citizen with considerable knowledge of the disability program. Before becoming the Deputy Regional Chief ALJ for the Atlanta Region of the Office of Disability Adjudication and Review (ODAR) in May 2006, I was an ALJ in the Atlanta North hearing office for 11 years. When the agency issued its 1996 rulings which have greatly impacted the disability program, I was a trainer for Process Unification training—SSA's first attempt to train its adjudicators both at the Disability Determination Services (DDS) and at the hearing level at the same time in the same room. I taught new ALJ's for 14 years, and I was also an instructor for writers and case technicians. For a number of years I was the Chair of the Social Security Section of the Federal Bar Association. In that capacity, on numerous occasions, I met with congressional staffers, GAO personnel, and the Social Security Advisory Board. I testified twice before the Ways and Means Subcommittee on Social Security. For the 3½ years before my retirement in March 2012, I was also the Chief Negotiator for SSA in the contract negotiations with the AALJ, the judges' union. Before joining SSA, I was an administrative judge with the Merit Systems Protection Board (MSPB) for 13 years.

Two areas for consideration of the Subcommittee on Social Security.

1) **The implementing rules and regulations promulgated by SSA for the evaluation of disability claims provide for too much subjectivity and require near impossible collection and weighing of subjective evidence by SSA adjudicators.**

The 1996 Process Unification rulings, along with subsequent rulings on obesity (SSR 02-1p) and opinion evidence (SSR 06-3p), are some of the best illustrations of the excessive burdens placed on adjudicators. Not only must the medical evidence be considered but also all other aspects of the claimant's life as they may relate to the credibility of his subjective complaints.

When SSA conducted Process Unification training on the 1996 rulings, the purpose was to make sure all adjudicators at all levels followed the same rules and regulations in evaluating disability claims. Talk to any DDS Administrator and she will tell you that doing so would bring the DDS's to their knees. There is simply no way given the number of claims they receive that they could apply all the provisions for evaluating a claimant's subjective complaints as dictated by SSA regulations and rulings. DDS adjudicators focus almost exclusively on the medical evidence. They pay lip service to subjective factors but for the most part nothing more than that. It is fairly safe to say that two claimants with the same set of objective medical findings for a back impairment will receive the same residual functional capacity (RFC) at the DDS level regardless of widely disparate assertions regarding their degree of pain and limitation of functioning.

At the hearing level, however, the ALJ is expected to apply all the regulations and rulings, and make an exhaustive inquiry into the claimant's subjective complaints—this allows for a wide variation in outcome from one ALJ to another. One ALJ may believe a claimant and another may not. On appeal, reviewing bodies hold the ALJ's feet to the fire when it comes to complying with the rulings and regulations; there is no concept of harmless error. Just take a look at a few federal court decisions and the demands on an ALJ become quickly apparent. Given the overwhelming disability work load that affords an ALJ about a total of 3 hours per case for review of the file, holding a hearing, and issuing a decision, it can come as no surprise that corners are cut.

At the hearing level, it is far easier to credit a claimant's subjective complaints and allow a case than it is to deny the case. The allowance requires a short sweet decision; the disallowance requires a decision that demonstrates compliance with all the requirements of Social Security's regulations and rulings. Given the complexity and demands of those rulings and regulations, any good representative can always find some error in a decision that will lead to reversal and remand of the case to the ALJ.

I have a vivid memory of a U.S. Magistrate's written recommendation to the U.S. District Court on an appeal of one of my cases. The Magistrate noted my failure to explicitly address some medical documentation and opinion evidence, and she then looked at that evidence and determined that it did not undermine my decision. While I had committed error by not explicitly addressing the evidence, it was clear from the record that my decision was supported by substantial evidence, and the Magistrate recommended affirming my decision. The District Court Judge, however, rejected the Magistrate's recommendation and remanded the case because I had failed to comply with the letter of SSA's regulations and rulings—never mind it was clear the claimant was not disabled. Since SSA has no harmless error doctrine, the court found the case had to be remanded.

The disability system cries out for a harmless error doctrine given the labyrinth of rulings and regulations adjudicators have to navigate to avoid remand of a case. In addition, there needs to be a reexamination of the rulings that pertain to evaluation of subjective complaints and opinion evidence.

2) **The representative community has inordinate influence over SSA policy and procedure.**

While appearing to champion the interests of the claimants they represent, representative organizations are at root interested in paving the way for the financial success of their members. This is not in any way to disparage the good work that many individual representatives perform; rather, it is to acknowledge the underlying purpose of representative organizations. Their members do indeed make money, and as noted by members of the subcommittee, lots of money--sometimes with very little effort--but they do so only when claimants are awarded disability. Thus, representative organizations have an overarching self-interest in preserving the claimant-friendly system that exists.

Just take a look at the aggressive opposition representative organizations mount whenever SSA even thinks about or pilots changes such as closing the record or setting deadlines for evidentiary submissions. Under the current regulatory scheme, representatives need only present the evidence the claimant wants SSA to consider. They have no obligation to assure the record is truly complete and comprehensive. That is the duty of the ALJ and representative organizations do not want that to change.

As Judge Hatfield testified, it is time to impose some affirmative obligations on representatives rather than the current exhortations to do the job for which they are well compensated.

Closing

Achieving consistent disability adjudications at a minimum requires a reexamination into the consideration afforded a claimant's subjective complaints. This could be done at the threshold step of defining a severe impairment, and it could be further addressed by limitation of the expansive rulings on subjective complaints. The program also needs to adopt a harmful error doctrine for review of ALJ decisions. Entitlement to disability should not be dependent on the luck of the draw as to which adjudicator a claimant's case is assigned. This is an important national program, and it demands consistency of outcome without regard to where a claimant resides.

Contact Information

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Kathryn Evans

March 18, 2013

The Ways and Means Committee

RE: Hearing on the Challenges of Achieving Fair and Consistent Disability Decisions

To whom it may concern;

I am writing with regards to my adult daughter, Patricia, who was injured at age 9 from a bicycle vs. pick-up truck accident in May, 1991. I am her mother, Kathryn and have cared for her since her accident. She sustained a traumatic brain injury which has left her with diminished mental capacity of about age 12, has uncontrolled complex partial seizures, and has severe cervical spinal stenosis and osteoarthritis all as a result of the accident. While her seizures were 150 per month, with the help of fantastic doctors in Chicago, they are now down to about 25 per month. She needs 24/7 constant care to prevent serious injury or death and is unable to live on her own.

She is currently receiving SSI of $710.00, foods stamps for herself and her daughter, and receives skilled nursing while I am working. She does not cook, clean, or contribute to any part of her daughter's rearing. She needs stand-by assistance while in the shower, total assistance of washing her hair, and shaving her under arms. She uses a rolling walker whenever her legs are too weak or unsteady to ambulate on her own. She is in some kind of pain on a daily basis and must be medicated.

To put it bluntly, my reason for writing you is **IF** reductions and cuts are made to SSI and Home & Community Based Waivers, I would not be able to work, pay taxes, and provide for my family any longer. It would send all three of us into financial ruin and homeless. I am a very hard worker, have always worked 60 hours a week until very recently, and I consider myself an upstanding citizen who always tries to find the good in every person.

What I don't seem to understand is why our government has gotten way too big for their britches, spends like there is no tomorrow, and continually shoves new laws and legislature down the throats of its citizens while exempting themselves. How can anyone in America get paid their regular annual salary and insurance after only serving 1 term in Congress?

I think that before the government decides to cut benefits from all senior citizens, all disabled individuals, and from all children in the US who cannot fight back, we need to **cut ALL of the government's wasteful spending first and foremost**, then start eliminating all of the extra dead weight from Congress, next should be deep and severe cuts for the President and all of his pork belly spending, including all of the Mrs. vacations and recreational spending while the working poor cannot even think of taking a vacation. Talk about entitlements, it begins at the White House and Congress. Reduce, reduce, reduce!!! Then maybe you can find a few other things to cut while you are focusing on the debt reduction before coming after those who are unable to stand up for themselves. Shame on you and shame on us (We, the people) for letting you get away with it for such a long time.

While I do not like the government helping my daughter and grand-daughter, I have no choice. She cannot live on $710 a month....can you? I didn't think so. I can't either. Stop cutting from the bottom and start at the top and then work your way down.

Take a cue from the American citizens that are out there working themselves to the bone to give their family food, shelter, and clothing. **YOU TOO**, can learn to live on a modest budget just like we do. That is the way it is supposed to be. Get with the program before it is too late.

MAY GOD BLESS AMERICA in spite of herself because nobody else will!!

Respectfully,

Kathryn AC Evans
444 E 300 N
Valparaiso, IN 46383
(219) 916-1847
kcenco3@aol.com

This letter pertains to my daughter, Patricia R. Casey at the above address who receives SSI and community & home based waivers.

NOSSCR

**NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
(NOSSCR)**

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Executive Director
Nancy G. Shor

**Written Statement for the Record
on behalf of the
National Organization of Social Security Claimants' Representatives**

Hearing on the Challenges of Achieving Fair and Consistent Disability Decisions

**Subcommittee on Social Security
House Committee on Ways and Means**

Hearing date: March 20, 2013

Submitted by:

Nancy G. Shor, Executive Director
Ethel Zelenske, Director of Government Affairs

* * *

Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability and Supplemental Security Income (SSI) disability benefits. NOSSCR members represent these individuals with disabilities in proceedings at all SSA administrative levels, but primarily at the hearing level, and also in federal court. NOSSCR is a national organization with a current membership of more than 4,000 members from the private and public sectors and is committed to the highest quality legal representation for claimants.

At the March 20, 2013, hearing and at previous hearings held by the Subcommittee, much has been said about the Social Security Disability Benefits Reform Act of 1984 ("DBRA"), Pub. L. No. 98-460. The Act has been frequently mischaracterized and inaccurately describes what it did – and did not – legislate. We are submitting this Statement for the Record to provide information regarding key provisions of DBRA and to provide background regarding the policies that were in effect at SSA prior to DBRA's passage.

BACKGROUND

The Social Security Disability Benefits Reform Act of 1984 was passed by a unanimous, bipartisan vote in both the House of Representatives (402-0) and the Senate (99-0) in September 1984. President Reagan signed the law on October 9, 1984, when it became Pub. L. No. 98-460.

The bill was described by Members of Congress from both parties as a necessity to end the chao then swirling around the Social Security disability determination process. On the day the bill was passed, then Rep. J. J. Pickle (D-TX), a previous Chairman of this Subcommittee, stated on the floor of the House: "... [T]oday the program is in a state of chaos and if we do not act immediately to restore order, it will utterly collapse. Perhaps my cry of alarm sounds exaggerated. It is not."

In the early 1980s, the process was in crisis. Hundreds of thousands of disabled individuals, including tens of thousands with mental impairments, had their benefits improperly terminated; thousands of claimants with mental impairments were improperly denied benefits; 29 States refused to follow the Social Security Administration's (SSA) instructions for termination of benefits; federal courts were clogged with appeals; 200 federal courts across the country threatened the government with contempt of court citations for refusing to pay benefits when ordered.

Representatives and Senators, on a bipartisan basis, noted the need for the legislation. A key Republican Conference Committee member, Rep. Willis Gradison (R-IA), stated that the bill "makes necessary reforms in the administration of the social security disability program ... I am hopeful that these initiatives will make significant strides toward reestablishing the integrity of the disability program and ending beneficiary trauma."

Floor statements in the Senate upon passage of the conference report were no less fervent. Sen. Robert Dole (R-KA), the Chairman of the Senate Finance Committee at the time, stated: "In my view, the conference report is a major accomplishment, representing the culmination of more than 2 years of congressional deliberation on the very difficult and emotional issue of disability insurance reform. It ... is intended to clear up the chaotic situation in the State disability agencies and the Federal courts.

In this Statement, we will discuss the major provisions of DBRA, addressing what the Act provided and the background necessitating the change.

MENTAL IMPAIRMENTS

Section 5 of DBRA had two main provisions regarding mental impairments: (1) SSA was required to revise the listings of impairments for mental disorders; and (2) "The revised criteria and listings, "alone and in combination with assessments of the residual functional capacity of the individuals involved, shall be designed to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment."

Explanation. After years of litigation, GAO investigations, and Congressional hearings, Congress passed Section 5 of DBRA, requiring SSA to overhaul its procedures for adjudicating Title II and SSI disability claims based on mental impairments. The legislation did not change the basic statutory definition of disability, namely, that "disability" is the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423(d)(1)(A).

DBRA did require SSA to issue new listings of impairments for mental disorders and develop new procedures for evaluating residual functional capacity for individuals with mental disorders whose impairments did not meet a listing.

Before DBRA, SSA relied upon outdated concepts of mental impairment and terminology that did not reflect current medical practice. SSA policy focused on current signs and symptoms and relied only on activities of daily living, which are not good measures of the ability to function in a work-setting for an individual with a mental impairment. This prejudiced (1) individuals whose signs and symptoms were in remission or were controlled by treatment, but who still were unable to work and (2) individuals who had the requisite current signs and symptoms but could engage in simple activities of daily living.

SSA's policies and procedures in the early 1980s were exemplified by its psychiatric review form used to decide disability claims based on mental impairments. The form used a numerical severity rating of 17 signs and symptoms, supplemented only by reports of activities of daily living. It had no space for consideration of evidence relevant to the ability to work. A separate assessment of residual functional capacity, as required by the regulations, was not performed because it was considered "redundant." As a result, there was no individualized, realistic evaluation of the ability to work. The courts found SSA's procedures unlawful.[1]

SSA's procedures for assessing mental impairments had an extremely harmful impact on claimants. In two years (1981 and 1982), more than 80,000 beneficiaries with mental illness had their benefits terminated, for many, their only source of income. Tens of thousands new claimants had their applications denied. The 1984 legislation was a response to correct this terrible situation.

Even before enactment of Pub. L. No. 98-460, SSA convened a work group of representatives from national professional organizations focused on mental disabilities. Most of the group's recommendations were adopted by SSA to implement the provisions of section 5(a). For example, the new listings were more closely tailored to follow the edition of the American Psychiatric Association's Diagnostic and Statistical Manual current at that time. The changes reflected current thinking about mental impairments and included: (1) expanding the diagnostic categories (the "A Criteria") from just four to eight; (2) revising the functional criteria (the "B

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[1] *City of New York v. Heckler*, 578 F. Supp.1109 (E.D.N.Y. 1984); *Mental Health Ass'n of Minn. V. Schweiker*, 554 F. Supp. 157 (D.Minn. 1982). Both decisions were affirmed on appeal. *City of New York* was appealed to the U. S. Supreme Court by SSA and was affirmed on other grounds (related to the class action).

Criteria") to include criteria related to the requirements of work; and (3) giving greater importance to the overall degree of limitation, rather than the number of individual activities.

For those individuals who did not have a listing-level impairment, SSA revised its procedures for assessing residual functional capacity, i.e., what the individual could do in light of his/her limitations. The statute requires an individualized assessment of ability to work. As noted above, in the early 1980s, a separate assessment of residual functional capacity (RFC), as required by the regulations, was not performed because it was considered "redundant." SSA policies had a presumption that a claimant with a mental impairment under the age of 50 who did not have a listing-level impairment would likely retain the RFC for unskilled work.

The policy guidance issued in response to litigation and Pub. L. No. 98-460,[2] which is still in effect, emphasizes the importance of the RFC assessment and that the failure to meet a listing does not equal the ability to perform at least unskilled work. Significant changes related to the RFC assessment include:

- The loss of key work-related capacities can be disabling, which are the ability to: (1) understand, carry out, and remember instructions; (2) respond appropriately to supervisors and co-workers; and (3) respond appropriately to pressures in a work setting.
- The role of stress. The guidance rejects the notion that individuals with mental impairments are able to engage in low stress, unskilled work. Since the response to work pressures is highly individualized, no assumptions can be made. Some individuals may have difficulty adjusting to even low stress work.
- New forms, drafted by the same group that worked on the listings, which require the reviewing psychiatrist or psychologist to evaluate 20 separate components of work functioning, including specific aspects of work, e.g., ability to perform within a schedule, to maintain regular attendance and to be punctual, and to accept instructions and respond appropriately to supervisors.

MULTIPLE IMPAIRMENTS

Section 4 of DBRA provided that SSA shall consider combined effect of all impairments to determine severity, "without regard to whether any such impairment, if considered separately, would be of such severity." This provision has been codified at 42 U.S.C. § 423(d)(2)(B).

Explanation. Prior to passage of DBRA, SSA did not consider the combined effects of multiple impairments in evaluating disability. SSA went so far as to state, in a 1982 policy statement,[3] that it would not consider the combined effects of "non-severe" impairments. This policy resulted in serious inequities for individuals suffering from a variety of serious problems, where a single one did not meet the test as a "severe" impairment under the regulatory sequential evaluation of disability. The federal courts rejected this approach in a number of individual and class actions.

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[2] Social Security Rulings (SSR) 85-15 and 85-16.

[3] SSR 82-55.

Upon passage of the law, floor statements further clarified the need for this provision. Rep. Pickle stated: "Under the conference agreement, the effect of a combination of impairments, not one of which alone may be disabling, may now be considered when determining whether the person's impairment is medically severe enough to qualify him for benefits."

Rep. Silvio Conte (R-MA) stated: "There are many individuals, particularly the elderly, who suffer from a variety of medical conditions. Though each separate impairment might not be severe enough to prohibit someone from working, the combination of conditions can be totally disabling."

EVALUATION OF PAIN

Section 3(a)(1) of DBRA amended 42 U.S.C. § 423(d)(5) by adding the following:

> An individual's statement as to pain or other symptoms shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability.

Explanation. Under the policy in effect at the time, pain and other subjective symptoms, such as dizziness or numbness, were taken into account ***only*** if fully explained by laboratory or other diagnostic procedures. If not fully explained, debilitating pain, even where corroborated and credible, was discounted. Pain and other symptoms cannot always be fully explained by conventional diagnostic techniques. Rep. Conte, on the floor of the House the day the Conference Report was voted out, stated: "Another problem with present law is the fact that many disability recipients allege pain that cannot be found using regular medical techniques. That does not mean, however, that these people are not suffering pain …."

Section 3(a)(1) technically expired on December 31, 1986. The conferees in 1984 stated that the standard in DBRA was only intended to codify SSA's policy on pain at the time. During the same period, there were multiple court cases challenging the standard that SSA used in evaluating pain, which was not well-articulated and did not, in practice, follow the standard in DBRA. As a result, the courts stepped in to fill the void caused by SSA's failure to promulgate comprehensive rules for evaluating subjective symptoms like pain. Case law precedent in different federal circuits shared a basic view: (1) If there is an underlying medical condition and the person's pain is "reasonably related" to that condition, then it must be considered; and (2) If the person's statements are found not credible, then the adjudicator must state the reasons.

The extensive circuit case law played an important role in development of SSA's comprehensive regulations, issued in November 1991.[4] These regulations drew from the body of case law in providing a detailed framework for evaluating subjective symptoms, including pain. In the summary to the final rule, SSA states:

> These expanded regulations incorporate the terms of the statutory standard for evaluating pain and other symptoms contained in section 3 of the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98-460).

The preface to the final rule further explains:

> The policy for the evaluation of pain and other symptoms, as expressed in the statutory standard and clearly set forth in these final rules, requires that: (1) For pain or other symptoms to contribute to a finding of disability, an individual must first establish, by medical signs and laboratory findings, the presence of a medically determinable physical or mental impairment which could reasonably be expected to produce the pain or other symptoms alleged; and (2) once such an impairment is established, allegations about the intensity and persistence of pain or other symptoms must be considered in addition to the medical signs and laboratory findings in evaluating the impairment and the extent to which it may affect the individual's capacity for work.

Under this standard currently used by SSA, allegations of pain alone are not sufficient to establish disability. As noted by Arthur Spencer, SSA Associate Commissioner for Disability Programs, in his written statement for the March 20, 2013 hearing:

> … I would like to remind the Subcommittee of a salient feature of the DI program. An applicant (claimant) cannot receive disability benefits simply by alleging pain or other non-exertional impairments or limitations. We require objective medical evidence and laboratory findings that show the claimant has a medical impairment that: 1) could reasonably be expected to produce the pain or other symptoms alleged, and 2) when considered with all other evidence, meets our disability requirements.

CONCLUSION

During the early 1980s, the Social Security and SSI disability determination process was in chaos. Congress held numerous hearings and considered a number of bills to address the situation, deliberating over the course of several years. It finally passed – unanimously in both Houses of Congress – the Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460. As this Congress considers the challenges facing the process today, it is important to keep in mind the circumstances that led to the passage of the 1984 legislation.

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[4] 56 Fed. Reg. 57928 (Nov. 14, 1991). The notice of proposed rulemaking was published in September 1988. 53 Fed. Reg. 35516 (Sept. 14, 1988).

Scott Morris

April 30, 2013

Representative Samuel Johnson
Chair, Subcommittee on Social Security
House Ways and Means Committee
Ways and Means Committee Office
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Johnson:

I thought long and hard about writing this letter to you. However, I thought that you might appreciate input from someone with my background. I am writing in my personal capacity as a concerned citizen who is a federal employee exercising his rights under 5 U.S.C. §7211, and I am not representing any organization or constituency.

I am a new Social Security Administrative Law Judge, having been appointed in August 2011, with almost 27 years in continuous federal service. I write this letter from a completely different perspective than those who have spent the vast majority of their careers within this organization. For starters, I am not currently, nor have I ever been, a member of the union. I served about 14 ½ years on active duty as an Army Judge Advocate, 28-years of total service, including being recalled to active duty on two occasions Post 9-11. While in the military, I served as a prosecutor, defense counsel, appellate counsel, taught at the Army's law school at the University of Virginia, and was recalled to active duty to serve as a Deputy Legal Advisor to the Chairman, Joint Chiefs of Staff. Prior to joining the Social Security Agency, I had spent the previous 12 years as an enforcement attorney for the Federal Aviation Administration representing it before NTSB and DOT Administrative Law Judges. In short, I have a significant amount of trial and administrative hearing experience with other Agencies in the federal government.

Your Committee has routinely heard from members of the social security hierarchy about the virtues of the system and their on-going efforts. You have heard from the National Organization for Social Security Claimant's Representatives (NOSSCR) about its views on how to further promote the system, frankly in a manner that would be even more limiting on those that have to implement it. You have heard from members of the ALJ union about its perception about the issues it confronts for its members. You have heard from the social security leadership about their views and how they are marching towards reducing the backlog. You have heard from social security judges that have spent most of their careers within the social security system. You have heard from law professors that pontificate about the system with really little insight into how the disability system is actually run at the ground level. But the people that you have not heard from are the field judges (non-management) that are in the trenches day in and day out trying to implement a system that is long due for overhaul.

When the average person hears about reforming Social Security, they frequently focus on the benefits to those who have worked their entire lives and have reached those Golden Years hoping to have funds to sustain them for the relatively few years they have left on this Earth. But there is a troubling phenomenon festering within this benefit system and that is the current construct for disability benefits. As Judge Hatfield pointed out to the Committee in his March 20, 2013, testimony, the concept of providing safety nets for those who become disabled earlier in life is a noble and honorable one, one that reflects our society's values. However, the system that I am working within is not such a system. The system is not designed to be an adversarial one. However, in the cases that come before me, I would estimate that 85-90% of the claimant's have a representative. So on one side of the table I have an advocate. As you know, the current system does not provide an advocate to represent the Agency. This in itself presents a challenge.

However, not only must a Social Security ALJ deal with a counsel on one side, but the current Agency rules and procedures put tremendous pressure on Social Security Judges in a variety of ways affecting the quality of decisions. I think that it is important that you understand these pressures and the Agency's actions, whether by choice or tacit ignorance, and the impact this has on Social Security ALJs and their adjudication process. In this light I want to point out two areas of concern and propose a way ahead:

- Quotas, called goals and the practical consequences are costing the American taxpayer tens of billions of dollars in erroneous payments.
- Judges are denied the authority to control their proceedings and to gather necessary evidence to make informed decisions.

In the military tradition of the bottom line up front, I make the following recommendations:

- I join Judge Hatfield, who testified before you in March 2013, in advocating that the Agency have a representative at these hearings. It makes no sense that one of the highest paid employees in the Agency is required to sift thru a mountain of paper or electronic documentation to find the salient facts to make a decision. I am paid to make decisions and have no difficulty doing this. An Agency representative would return balance to these proceedings. If this is not possible, then implement a regulation that states with clarity that the claimant's representatives are required to provide all evidence, not just favorable evidence, for review.

- Empower ALJs with more formal procedural rules, such as: requiring all documents to be considered in a claim must be provided at least 5 days prior to the hearing; authorizing use of pre-hearing orders; if appropriate, requiring claimants to complete questionnaires prior to the hearing; authorize judges when they deem appropriate, to require briefs; authorize the use of other evaluative tools such as the MMPI, access to social media and access to the claimant's criminal conviction history. However, also provide and require latitude in these rules when claimants are pro se

- Require validation of this 500-700 annual decision quota by requiring the Agency to track not just the number of cases, but the quantity of documents within the case files themselves.

Underlying rationale for these recommendations.

1. Problems with the Agency's quota euphemistically called goals for its ALJs.

   A. The math does not add up.

The Agency posits that each ALJ is expected to issue between 500-700 legally sufficient decisions annually.[1] There is constant pressure by Agency management to obtain this quota to the point that the Agency has promulgated a database available to the ALJs entitled "Am I on Pace?"[2] This diagram tracks how the judge is progressing. If the ALJ is on track to achieve 500-700 decision in the fiscal year, then they are in the "Green" zone. If the ALJ is in the 700-900 range, they are in the "Gold" zone. What is interesting about these quotas are how the Agency pursues those that either issue more decisions than 900 or less than 500. Are you aware of the Agency taking disciplinary action against any ALJ that has issued more than 900 decisions, unless that judge's proclivity becomes a newsworthy event? Contrary, there are lots of adverse actions against ALJs whose productivity is less than 500 cases. I ask that the Committee simply look at the numbers.

The problem is the Agency keeps an incredible array of data, except that which can justify this arbitrary and capricious 500-700 quota. Chief Judge Bice has previously indicated that they have "limited" an ALJ to no more than 1,200 hearings annually. I ask the Committee to consider applying basic math as well as common sense as to whether these numbers make any sense. I submit that the fact that the Agency has "limited" an ALJ to just 1,200 cases per year is powerful evidence of its mindset about quantity over quality once one does the math.[3]

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[1] *See generally*, Testimony of Chief Judge Bice, HEARING BEFORE THE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS PERMANENT SUBCOMM. ON INVESTIGATIONS, UNITED STATES SENATE, SEPTEMBER 13, 2012.

[2] This is in the program "How am I doing?"

[3] *See generally* footnote 9, *infra,* and accompanying text.

The critical piece of data missing from this quota is how large are these files that the judges are required to read, not skim, but read? Frankly, I do not know. Sadly, neither does the Agency. Recently the Regional Chief Judge for Region X testified that, in this region, the average size of the files range from around 1,000 to 1,500 pages.[4] Senator Coburn indicated during the hearings in September 2012 that their review indicated that the average size of the evidence was 500 pages.[5] This is a critical piece of evidence to determine whether it is reasonable for an ALJ to conduct 500 hearings or 200 hearings. I have seen files with as few as 100 pages and I have cases where the medical evidence exceeds 3,000 pages. Two weeks ago I had fifteen hearings in one week where I had approximately 8,000 pages of evidence. One cannot expect an ALJ to read this amount of evidence under the productivity quota established by the Agency. Senator Coburn rightly questioned the feasibility of doing this given this volume.

I cannot say with certainty what the average size is for other ALJs, but I became interested in how large the cases are that I have been reviewing so I started keeping records since March of this year. My figures are only based on 2 of 5 of the sections contained within CPMS, called the E and F sections. During the period March 6, 2013 through April 22, 2013, I prepared 77 cases for hearing. I discovered that my average number of pages in the E and F sections of the file alone was 638.13. The smallest file had only 113 pages in the E&F sections, but the largest file (at this stage of the proceedings) was 3,244 pages. Twelve of these files were over 1,000 pages and another 10 were over 800 pages. I still have 10 cases in post-hearing development where additional documents will be generated. My hearing with the largest file (consisting of 3,244

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[4] Testimony of Regional Chief Judge DeLaittre on October 11, 2012.

[5] *See* videocast of the hearing at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/social-security-administrations-disability-programs. He makes this statement at time tac 43:16-43:40 (last visited on April 12, 2013). I note that this number comes from a state with far less robust indigent health care access than my own.

pages) had to be postponed because I received over 1,800 pages the weekend prior to the hearing. However, even if one were to entirely delete this file from the calculation (and ignore that I had read about 900 pages of that case thus far), my average case size would still be 603.84 pages for these portions of the case file! This is an important point because I ask how does one read this volume of evidence day in and day out in the time the Agency allows? The dirty little truth is, in order to avoid the scrutiny of Agency management, many ALJs are donating many hours without compensation[6] or more troubling they may not be reading all of the evidence, and the Agency promotes this approach, although not in writing.[7] So how much time does the Agency allot to read the average file, in my case, of approximately 600 pages (E and F sections only) per case, to make the quota of 500 cases per year?

An ALJ is paid for a 40-hour work week. There are 52-weeks in a year so that's 2080 hrs. For those of us who have served a substantial period in federal service, we are entitled to 208 hrs of annual leave. That leaves 1,872 hrs. In addition, there are 10 federal holidays thus reducing the total number of hours available to 1,792 hrs. Judge Bice has previously testified that it is reasonable that each hearing should take about 1 hour.[8] That leaves 1,292 hours left to review the record to see if additional records or evidence is needed, read the record before the hearing, conduct any supplemental hearings or gather and read any post-hearing documents, prepare instructions for the writers to draft the decision, and then read and edit the decision once prepared. 1,292 hours divided by 500 cases, means that to accomplish this quota in a perfect work environment, the ALJ is allotted 2.58 hours per case. Now this does not include time taken away for mandatory training, sick leave, administrative errors (read computer problems), or any

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[6] As an aside, the volunteering of services arguably creates an Anti-deficient Act issue.
[7] During a meeting with the local ALJs, the RCALJ told judges that they were not required to read the entire file.
[8] Minority Report, *infra*, at 36. The report states Judge Bice indicated that "[w]ith few exceptions, a good hearing takes 45 to 60 minutes to conduct, sometimes longer."

other of a dozen other possible additional duties. Nor does it include either of the two-15 minute breaks that any federal employee is entitled to during an 8-hr work day. Now assume the most conservative figure that each case averages just 500 pages. *If reading the file was the only task an ALJ was to perform, other than conducting a hearing itself, that requires relentlessly reading over 193 pages per hour.*[9]

Do you really believe that these judges that are deciding over 700 cases are actually reading all of the evidence or providing the individual claimant (or the public) a fair evaluation of their claim? Of course, some will say that they have more time because they use less time in their hearings. How much time do they allow this claimant to be heard after they have waited two years or more to have their case heard? My point is the Agency quota is unrealistic. Each decision we make has a profound impact on the claimant and can have a significant impact to the public fisc. Isn't it better that we give the claimant and the public an evaluation of the evidence that they both deserve? We have an obligation not only to the claimant but to the public.

The Agency covers itself in its incessant requests for faster case processing by providing videos telling the judges to read the evidence, but this is done with a clear undertow that you do so as long as you meet the quota. The administrative staff is reminded almost daily to about where the office is in meeting the arbitrary goal given to the office for any given month. To

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[9] Now, let's look at the math if an ALJ falls at the high end of the "Green" zone and issues 700 decisions. Assuming the same seasoned federal employee, one starts with 2080 available hours, minus 208 hours for annual leave, minus 80 hours for federal holidays, minus 700 hours for hearing time. That leaves this judge just 1,092 hours to perform all the remaining tasks for these 700 cases. In other words, this judge supposedly can do all this using just over 1.5 hours per case. Again, if the judge is only reading the file, and we assume the more conservative number provided by Senator Coburn's research, this judge would have to read on average 320 pages per hour Again, this ignores all of the other requirements other than holding hearings and just reading the case file. Finally, let's assume the number that the Agency has "limited" an ALJ to: 1,200 cases. Given this number, this judge is supposedly able to read the evidence, conduct substantive hearings, issue instructions, edit and sign their decisions, and do the other administrative actions averaging 1.08 hours per claimant. Even if one assumes this super judge only uses 30 minutes for their hearings, this leaves this judge just over 30 minutes to read 500 pages, and do all the other tasks required of them. *Finally, even if this judge conducted no hearings, but merely issued on-the-record decisions which are only authorized in fully favorable decisions, this super judge would still have to read on average 463 pages per hour.* I find this incredible and hopefully you will as well.

accomplish this quota, I have heard on numerous occasions both at training (informally of course) and from fellow judges that you don't need to read all the evidence. One can merely skim it, picking out certain exhibits, and then let the writers weed through the details. But that is not what the oath of office that I took told me to do. And it is not what the Agency's own regulations or policy tells me to do. 20 C.F.R. §404.1529 as well as SSR 96-7p time and again point out the ALJs obligation to read all of the evidence.[10] If the Agency leadership wants the

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[10] 20 C.F.R. §404.1529. How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. By objective medical evidence, we mean medical signs and laboratory findings as defined in § 404.1528 (b) and (c). By other evidence, we mean the kinds of evidence described in §§ 404.1512(b)(2) through (8) and 404.1513(b)(1), (4), and (5), and (d). These include statements or reports from you, your treating or nontreating source, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work. We will consider all of your statements about your symptoms, such as pain, and any description you, your treating source or nontreating source, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. (Section 404.1527 explains how we consider opinions of your treating source and other medical opinions on the existence and severity of your symptoms, such as pain.) We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

And (c)

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work*—(1) *General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work. In evaluating the intensity and persistence of your symptoms, ***we consider all of the available evidence***, including your history, the signs and laboratory findings, and statements from you, your treating or nontreating source, or other persons about how your symptoms affect you. We also consider the medical opinions of your treating source and other medical opinions as explained in § 404.1527. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work, when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities.* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities, ***we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section***. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and *we will evaluate your statements in relation to the objective medical evidence and other evidence*, in reaching a

ALJs to just skim the evidence, it has the power to change the rules. As the Agency is so willing to point out, ALJs are required to follow Agency policy. But our own rules require us to consider all of the evidence and to not just skim the file or to make a gut decision.

B. The review process itself favors ALJs issuing favorable decisions.

The second part of this burden comes after a decision is made. If an ALJ issues a favorable decision, that decision is normally 5-7 pages long, the vast majority of it being boilerplate. Until the Huntington, West Virginia scandal, the Agency essentially did no quality review about the accuracy of favorable decisions. Further, favorable decisions are never appealed. On the other hand, an unfavorable decision normally ranges from 11 to more than 30 pages, and must be defended vigorously by the ALJ. These decisions are subject to appeal and are remanded for a variety of reasons, many being meritorious. However, many decisions are remanded for minor omissions that have no bearing on the ultimate outcome of the decision. Unfortunately, there is no deference given to the trier of fact in these proceedings nor is there an evaluation for harmless error.[11] Merely failing to mention a tangential lay witness statement that would have no impact on the outcome of the decision can be grounds remanding a case.[12]

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conclusion as to whether you are disabled. We will consider whether ***there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your history***, the signs and laboratory findings, and statements by your treating or nontreating source or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.
SSR 96-7p
"Assessment of the credibility of an individual's statements about pain or other symptoms and about the effect the symptoms have on his or her ability to function must be based on a consideration of all of the evidence in the case record."

[11] On this point see the testimony of retired Judge David Hatfield, before the Social Security Subcom., House Ways and Means Committee on March 20, 2013, available at http://waysandmeans.house.gove/uploadedfiled/hatfield-testimony32013.pdf (last visited April 12, 2013)

[12] In the Ninth Circuit, the ALJ's failure to address lay witness testimony generally is not harmless. Curry v. Sullivan, 925 F.2d 1127, 1131 (9th Cir. 1991). In failing to address a lay witness statement, the error is harmless only if "a reviewing court . . . can confidently conclude that no reasonable ALJ, when fully crediting the testimony, could have reached a different disability determination." Stout v. Comm'r, Soc. Sec. Admin., 454 F.3d 1050, 1056

Therefore, the writing and editing necessary to defend unfavorable decisions is far more labor intensive. When one adds the not so subtle pressure to make quota, from simply a human factors perspective, there is a bias to issue a favorable decision: they are less work, no one really looks at the quality of the judge's analysis in light of the evidence,[13] and it is far easier to make this arbitrarily imposed quota. The effect of this constant pressure to produce with little oversight of favorable decisions was recently discovered by Congress,[14] and results in essentially paying down the backlog.[15]

My point about this pressure for quantity over quality is that taxpayers that are paying for this mindset. The recent report sponsored by Senator Coburn indicated that 22% of the favorable decisions in its random survey of 300 cases were erroneous awards. Each favorable decision on average costs the taxpayer $300,000[16] because once on the social security rolls, very few are ever removed. Twenty-two percent of 300 is 66 claimants that could have been receiving benefits erroneously. I say "could have been" because these are cases were caught by the Agency's

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(9th Cir. 2006); *see also* Robbins v. Soc. Sec. Admin., 466 F.3d 880, 885 (9th Cir. 2006). This standard is markedly different than the harmless standard applied to other administrative proceedings.

[13] During the September 2012 Senate Committee hearings, one of the HOCALJs looked at the reversal rate of his judge's unfavorable decisions and took the position that if one of his judge's has a low reversal rate for unfavorable decisions, he believed that it was just as likely that his favorable decisions were equally valid. This is flawed logic because it ignores the fact that a person with a high pay rate is only going to deny the most egregious cases where it is clearly an unfavorable decision. If a Judge just pays any close case, and favorable decisions are not subject to any real scrutiny, there is little risk of criticism. As has been evidenced by the Agency's actions, high volume judges are really not subject to scrutiny until something occurs that is newsworthy. Finally, I point out that the Agency says that it now "limits" judges to 1200 cases per year, but they have yet to explain how it is possible to do that many cases given the data that currently exists as to the size of these files.

[14] *See,* U.S. Senate, Committee on Homeland Security and Governmental Affairs, Permanent Subcommittee on Investigations, *Social Security Disability Programs: Improving the Quality of Benefit Award Decisions, Minority Staff Report* (2012), released in conjunction with the Permanent Subcommittee Investigations September 13, 2012 hearings (hereafter Minority Report).

[15] Recall that a claim has already been denied twice previously by medical professionals versed in Social Security regulations and policies. When individual judges have high pay rates one really has to ask themselves who is not applying the correct standard. It is true that frequently additional evidence comes to light after these two prior denials. However, it seems improbable that that would occur 80 or 90 percent of the time, consistent with some ALJs fully favorable pay rates.

[16] This figure comes from Senator Coburn's webpage, http://www.coburn.senate.gov/public/index.cfm/pressreleases?ContentRecord_id=e95d5151-e697-4eb8-9bad-2121eebe4690 (last visited April 12, 2013).

quality control system during its random sampling of cases. Sixty-six times $300,000 equals $19.8 million dollars. However, the Agency only reviews about 1% of the fully favorable decisions for quality control purposes.[17] Even if one was to cut that figure by fifty percent, we are talking about significant funds. If we were to extrapolate that error rate to all fully favorable decisions issued by the Agency annually we are talking immense sums of public funds, literally tens if not hundreds of billions of dollars over the life of these claimants.[18]

2. Agency rules and policies obstruct the judge's ability to assess credibility and to control their proceedings.

When I was going thru the ALJ application process I read about the theory of the roll of the social security judge and the three-hat rule.[19] I found the theory of an inquisitorial system admirable. What I was not prepared for was the reality of being a judge confronted by an advocate on one side and apathy, or at least passivity, on the other. As I mentioned, probably 85-90% of the cases that come before me have a representative. As a general rule, the bar has been professional and forthright. However, the tension arises where the ALJ inquires about evidence that may not be favorable to the claimant's application. These proceedings are not supposed to be adversarial.[20] However, many attorneys do not treat this as a non-adversarial process. This is not to be unexpected as our entire judicial system is designed around an adversarial process.

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[17] In FY 2011, the Agency's quality control division reviewed 3,962 cases. *See*, Minority Report, *supra*, at 14, n. 31. However, Social Security Judges issued over 400,000 favorable decisions.

[18] According to the Minority Report, Social Security ALJs issue 700,000 decisions per year. *See* Minority Report, *supra*, at 20. In FY 2010 the average allowance rate for Social Security ALJs was 67%. *See* U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Social Security, Statement for the Record Challenges Facing the Next Commissioner of Social Security by The Honorable Patrick P. O'Carroll, Jr., Inspector General, Social Security Administration, April 26, 2013, at 4. Sixty-seven percent of 700,000 cases equates to issuing 469,000 favorable decisions (paying a claim). The Agency reported an error rate of 22% in the favorable decisions during its random review for quality control purposes. Minority Report, *supra,* at 22. If the error rate is just 10%, for fully favorable decisions that the Agency did not discover, that equates to about 46,900 erroneous decisions times $300,000 in benefits over the life of the claimant, or $14.07 billion dollars annually in potential future exposure to erroneously granted benefits over the life of those claimants. If one used the 22% error rate, this number climbs to approximately $35 billion.

[19] *See generally, Richardson v. Perales*, 404 U.S. 389, 410 (1971).

[20] *See* 20 C.F.R. §§404.900(b) and 404.1740.

What is exceedingly frustrating is what few rules or policies the Agency has promulgated concerning the hearing process and procedures; they essentially strip the ALJ of any real authority to regulate these proceedings.[21] Further, the Agency impedes the judge from finding potentially salient facts. For example, I remain astonished that the Agency will not provide an ALJ with a claimant's criminal conviction history.[22] I have asked why and been given two different reasons: privacy rights of the claimant and that it's not relevant to our decisionmaking process. Both reasons are patently in error. No person has a privacy right to their criminal convictions. With rare exceptions, when someone is convicted of a crime in a United States courtroom, it is a public event. The record of the conviction is a public record, and anyone can go to a court clerk's office and search the files for records of any conviction, especially felony convictions, for a certain person. These are publically available records; they are just not easily accessible public records. Additionally, the claimant affirmative waives their right to privacy when they make an application to the extent that the Agency believes is necessary to adjudicate their case. Further, the Agency itself on its application asks if the claimant has been accused of or convicted of a felony.[23]

The credibility of the claimant is a key component when evaluating a claim. Because so much of what the medical records contains are the subjective statements by the claimant, and the doctors' opinions resulting there from, the assessment of the claimant's credibility is usually the

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[21] The rules for conducting hearings are set for at 20 C.F.R. §404.944 *et seq*. These procedures are further restricted by the Agency's Hearings, Appeals and Litigation Law Manual (HALLEX). *See generally,* HALLEX, Chapter I-2-6.

[22] The one exception that I am aware of is if the case is referred to the Cooperative Disability Investigations Unit (CDIU). These units are comprised of OIG, SSA, DDS, and State or local law enforcement personnel. They investigate Social Security disability claims that come under suspicion for fraud or similar fault actions by claimants or current beneficiaries. However, an ALJ cannot merely ask the CDIU office for just a criminal history; criminal histories are generated as part of the CDIUs comprehensive investigation of a claimant. Because this organization is a scarce resource, ALJs must request their services with care. For an understanding of the consequences of a finding of fraud or similar fault, *see* SSR 00-2p.

[23] *See* the SSA electronic application form for Supplement Security Income (SSI). Ironically, the question is asked in the context of Title 16 applications when the exclusion for impairments committed in furtherance of a felony are limited to Title 2 claims only.

single most important factor in deciding a case. So evidence of a claimant's prior crimes may well be a key piece of evidence. Even a first year law student that has taken an evidence course understands that certain convictions are probative of that individual's credibility. *Crimen falsi* offenses by their very nature are probative of a claimant's credibility. Although the Federal Rules of Evidence do not apply to these proceedings, they are a guide we should consider when weighing the relevance of any evidence. If a criminal history is relevant and probative in criminal and civil trials with their more restrictive rules,[24] why are they less relevant and less probative in these informal administrative proceedings? In my short time on the bench, I have discovered claimant's with prior convictions for Medicare fraud, forgery, and false statements. Second, Congress has specifically directed that impairments resulting from injuries suffered while committing a felony are not to be considered in these proceedings.[25] Third, this information can be probative in drug and alcohol addiction cases because it aides the factfinder in understanding the extent of problem as well as the longevity of the problem. Finally, I find it valuable in understanding a claimant's prior criminal conviction history because I want to know if they'll tell me the truth about it. I frequently have claimant's minimize their criminal history when I ask them about it. Since I don't have access to their actual history, my inquiry is really limited to what doctors' report in medical records.

In a related but different issue, I routinely have witnesses or statements from witnesses about the claimant's activities of daily living. Frequently, there will be evidence that another person supposedly does all of the day-to-day activities for the claimant. Yet upon further inquiry I learn that this person is also on disability. Many times this creates a question about this other person's true condition. Yet we are precluded from getting access to statements made either by

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[24] *Compare* 20 C.F.R. 404.950(c) with Federal Rule of Evidence 609.
[25] *See* 20 C.F.R. §404.1506 as well as SSR 83-21.

the claimant before me, or by the witness before me, during the witnesses' social security disability file. In short, we cannot cross-check the credibility of their statements using files we already possess. We may be established as an inquisitorial hearing process, but in many respects the Agency doesn't allow us to inquire.

Second, the ALJ cannot establish procedural rules in their own hearings.[26] It is not at all unusual that I receive over 100 or more pages of new evidence the morning of the hearing, or at the hearing. *In a recent case, I received over 1800 pages of new medical evidence dating back to 2011, on top the current 1600+ pages in the record, over the weekend prior to the hearing.* The only remedy for such late submittal was a continuance which required that case being re-scheduled six months later. I have no authority to close the record, or to order all evidence be submitted in a timely fashion. Further, I have no authority to impose any kind of sanction for late submittals without good cause, failing to get evidence that may not support the claimant's application, or to even require a representative to submit a brief explaining with specificity where the evidence is within the file that substantiates their claim. This last point is important because I spend an inordinate amount of time reading duplicate records, or medical records that are not really germane to the decision. Unfortunately, I don't know that the document is duplicative until I see the exhibited documents. The Agency refuses to remove duplications, there is no advocate for the agency that allows me to focus on the key documents to make a decision, and I have no authority to require briefs from representatives prior to the hearing to help me focus on the issues. The "exhibits" are really nothing more than an assembly of a claimant's medical records from various providers. It is not at all unusual to have a 300-page "exhibit" merely described as "X hospital ER records". There is no effort by the staff to identify

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[26] *See* Chief Judge Bice's Memorandum 12-992, subj: Use of Prehearing Orders-**Reminder** (April 16, 2012); Memorandum 14-303-5128, subj: Prehearing Orders (Jan. 28, 2003). According to HALLEX I-2-5-85, ALJs cannot even require a claimant to complete a questionnaire to gather information they deem of potential value in a case.

key pages within these documents because it will slow down the process, thus leaving the judge to find the salient facts themselves by combing through the record.

The Agency policies limit access to certain evidence. For example, we are denied access to the Minnesota Multi-phasic Personality Inventory (MMPI), social media cites, a criminal history as mentioned above, or to request a urinalysis test in the appropriate case, as examples.[27] The MMPI is a peer reviewed, well recognized test, which can be an invaluable tool in helping to

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[27] *See* Disability Determination Services Administrator's Letter No. 866 (Jan. 26, 2012) and DAA SSR 13-2p. The recent guidance on the implementation of this letter and the prohibition on drug testing is contained in POMS Section: DI 22510.006 (eff. 4/8/13) which provides in pertinent part:

D. For the purpose of evaluating credibility or malingering
Do not purchase symptom validity tests (SVT) to address issues of credibility or malingering as part of a CE. Tests cannot prove whether a claimant is credible or malingering because there is no test that, when passed or failed, conclusively determines the presence of inaccurate self-reporting.
Examples of SVT include, but are not limited to:

- Rey 15 Item Memory Test (Rey-II),
- Miller Forensic Assessment of Symptoms Test (M-FAST),
- Millon Clinical Multiaxial Inventory,
- Minnesota Multiphasic Personality Inventory (MMPI),
- Malingering Probability Scale,
- Structured Interview of Reported Symptoms,
- Test of Memory Malingering, and
- Validity Indicator Profile.

EXCEPTION: The Office of Disability Programs may approve rare exceptions to this prohibition on a case-by-case basis (for example, testing ordered pursuant to a court order). When necessary, the Office of Disability Adjudication and Review will email ^ODP OMLI Controls for pre-approval.
REMINDER: Consider referring a case with evidence suggestive of fraud or similar fault to the Office of Inspector General for investigation. See DI 23025.015.
NOTE: When the results of SVT are part of the medical evidence of record, we consider them along with all of the relevant evidence in the case record.
E. For drug or alcohol testing
Do not purchase drug or alcohol testing to evaluate an issue of drug addiction or alcoholism (DAA). A single drug or alcohol test is not sufficient to establish DAA as a medically determinable impairment, nor does it provide pertinent information that can help us determine whether DAA is material to a finding of disability. For details on evaluating cases involving DAA, see SSR13-2p.

Within the past week I reviewed a case where the psychologist initially indicated that the claimant indicated significant mental health issues. However, for some reason, this doctor again evaluated this claimant and the doctor this time used TOMMs. Based on this new evaluation and the results of the TOMMs testing, the psychologist concluded that his own prior diagnosis and testing was no longer valid.

evaluate the credibility of a claimant, particularly when malingering is an issue. Ironically, the MMPI is even mentioned in the Agency's own regulations as recognized tool,[28] yet for some policy reason it chooses to perform informal rulemaking via policy as opposed to providing notice and comment to changes in its own regulations. The prohibition upon ALJs preventing access to a claimant's publically available social media is frankly without merit. We are not talking about asking for passwords or hacking into these forums, but looking at material that claimant's have put forth to the world. Information from these sites could be highly probative of one's physical abilities as well as mental abilities. The Agency precludes the ALJ from asking for a drug test purportedly because the test alone does not establish materiality of the impairment.[29] I agree with this point, but what this policy ignores is that it is a factor to consider given the longitudinal record. Any person that has dealt with a substance rehabilitation program understands two things: it is not unusual that a person with an addiction will misrepresent their sobriety and most rehabilitative programs trust but verify through the use of a urinalysis.[30] Just

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[28] 20 C.F.R. Part 404, Appendix I to subpt P, section 12.00D7 states:

> 7. *Personality measures and projective testing techniques.* Results from standardized personality measures such as the [MMPI], … , may provide useful data for evaluating several types of mental disorders. Such test results may be useful for disability evaluation when corroborated by other evidence, including results from other psychological tests and information obtained in the course of the clinical evaluation….

[29] *See, e.g.*, SSR 13-2p, fn 25 which states: We will not purchase drug screening or testing to determine the validity of psychological testing. The examining psychologist or other professional who performs the test should be able to provide an opinion on the validity of the psychological test findings without drug testing." So even if the psychologist suspects that the claimant may be lying to them about their drug use, or even if they suspect they may be under the influence, the Agency will not allow an objective test to corroborate this. *See also*, footnote 27, *supra*.

[30] The American Society of Addiction Medicine has the following in its Public Policy Statement On Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in other Clinical Settings the following:

ASAM recommends the following practices and procedures for drug testing:

A. The use of drug testing in diagnostic settings.

When patients are initially assessed to determine if there is a diagnosis of a substance-related disorder, it is essential for the health care professional to have objective evidence about the recent substance use status of the patient. Drug testing can provide evidence of current or recent exposure to intoxicants which could affect the patient's current last week I reviewed a consultative examination report prepared by a psychiatrist. He specifically recommended drug testing of the claimant to rule out whether the claimant was still using a powerful illegal drug. Such a recommendation is not at all uncommon, yet the Agency precludes the ALJ or the consultative examiner from acquiring this objective data.

Finally, the Agency has represented to the Senate Committee that the judges have resources to assist us in reviewing files. Frankly, that is a half truth. It is true that documents are exhibited with cursory titles such as X Hospital Health care records. However, as mentioned earlier, this one exhibit could be 300 pages long. These documents are not exhibited in any fashion like one would find in the typical adjudicatory format. VA records are notoriously thick and disorganized. These exhibits are filled with extraneous information and duplicates. The Agency makes little or no effort to remove duplicates. Has the Agency actually shown you what an Agency file looks like? I would invite you to come (preferably unannounced) and see for yourself how these files are presented to the field judges immediately prior to a hearing.[31] Unlike other judicial systems the Social Security ALJ has to find the relevant evidence within these files before they can even assess it. In every other system that I have been exposed to the judge is presented with the relevant facts upon which to make a decision. Senator Coburn's committee also heard testimony about access to senior advisory attorneys. They are advisors in name only. Unless they have reviewed a case for a possible On the Record (OTR) determination, we do not get an evaluation in a file by a senior attorney, and when we do there is no memorandum or brief focusing on exhibits.[32] The senior attorneys do help the writing staff;

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status, and can serve as an objective means of verifying the patient's substance use history as reported by the patient or collaterals.

[31] Obviously, the privacy issues of claimant's would have to be addressed in some fashion.

[32] Yet, in the senior attorney advisor position description, GS-905-13, Agency position number 672600, as amended on August 6, 2007, specifies that 25% of their time is to be devoted to advising the ALJs.

however, the ALJ does not even have supervisory oversight of the individuals that are drafting their decisions. Having said that, I have found that the staff writers in my office are very hard working conscientious individuals that try to produce a quality draft decision for me to review in the time they are allotted to draft a decision.

Senator Coburn was spot on in his questioning about how 500-700 decisions can be expected from the ALJs given the sheer volume of evidence. There is another field judge that has gathered data concerning how large his files are and how long it takes him to process a case. This information has been shared with Senator Coburn and I strongly encourage you to obtain that information for your review. The Agency's vague responses to the Senate Committee's questions about how this is accomplished should be really looked in to because it would be enlightening.

Conclusion.

Having identified several issues with the current system, I propose the following solutions to these identified shortcomings.

- I join Judge Hatfield in advocating that the Agency have a representative at these hearings. It makes no sense that one of the highest paid employees in the Agency have to sift thru a mountain of paper or electronic documentation to find the salient facts to make a decision. I am paid to make decisions and have no difficulty doing this. An Agency representative would return the balance to these proceedings. If this is not possible, then implement a regulation that states with clarity that the claimant's representatives are required to provide all evidence, not just favorable evidence, for review.

- Empower ALJs with more formal procedural rules, such as: requiring all documents be provided at least 5 days prior to the hearing; authorizing use of pre-hearing orders; if appropriate, requiring claimant's to complete questionnaires prior to the hearing; authorize judges when they deem appropriate to require briefs; authorize the use of other evaluative tools such as the MMPI, access to social media or to access to the claimant's criminal conviction history. However, also provide and require latitude in these rules when claimants are pro se.

- Require the Agency to validate this 500 to 700 quota by requiring it to keep track of not only the number of cases, but the actual size of the cases as well. The Agency should explain how

> it expects an ALJ to read and evaluate the volume of evidence before them in the time allotted for this quota. The Agency has set forth the task, but has not validated the time it actually takes to accomplish the task given the rules and procedures that currently exist, as measured against the size of these file.

In my limited experience with this Agency, it is my belief that the issue is not with the ALJs but with a culture of quantity over quality. The attitude is if a case gets reversed it's just an opportunity to get another bean towards making the quota. The Agency talks about increasing the quality, but there is zero consideration that an increase in quality may mean a decrease in quantity. The focus is on faster, and little focus on better. There is also no consideration for the diversity of the size of the files within each of the Agency's Regions.[33] For example, offices in States that have robust public assistance for health care, those files have much more medical evidence. How can you give a quota when you don't even know the size of the files? Finally, there is really no consideration for the burden placed upon each Region by the associated Court of Appeals.

As a public servant, I truly believe that we owe it to the public to provide quality service. However, quantity does not equal quality. In the Agency's commendable attempt to remove the backlog of claims, the Agency leadership has gone too far towards quantity at the expense of quality, and it has knowingly turned a blind eye to those that produce unusually large numbers of decisions per year; Huntington and the recent Senate Minority Report demonstrate this. Judges that conduct 15 minute hearings do a disservice to this Agency and the public. Like it or not, the ALJs are the face of the Agency in many respects. While I may not rule in a claimant's favor, I want that claimant to know two things when they leave one of my hearings. First, I want them to

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[33] There is also the issue of the types of cases. While I don't have hard data, a cursory review of Agency data does indicate to me that the ALJ in any given office that has the highest or one of the highest number of dismissals tends to be HOCALJ. For example, Chief Judge Bice testified that she had no trouble adjudicating 500 cases per year. However, I would encourage the Committee to look at the number of dismissals she issued while serving as a HOCALJ. This comment is not meant to be disparaging to the Chief Judge, but to point out that all files are not created equal.

know that I have taken the time to read their entire file. Second, I want them to have an opportunity to tell me their story. We owe them this just as much as we have an obligation to make a decision as best we can.

As I mentioned at the beginning, I really struggled with writing this letter. However, after serving 27 years in federal public service, I have come to the conclusion that someone has to step forward and tell you that with this organization, don't just talk with management. I am comforted by the fact that in discussions with fellow field judges across the country, they experience similar frustrations. To truly understand what is going on with this organization, you need to talk to the field judges, especially those that have not spent their career in this Agency's culture, and I'm talking about judges outside of the beltway. This pressure is resulting in erroneous decisions that are having a significant adverse impact on the expenditure of the public's funds.

Respectfully submitted,

Scott R. Morris

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Senator Orrin G. Hatch
104 Hart Senate Office Building
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Dear Senator Hatch:

I understand that you are to undertake an examination of the functioning of Administrative Law Judges (ALJs) in the Social Security disability hearings and review process. I have some issues I wish to bring to your attention; the views indicated in this letter and the attached document,[1] are my own as an individual and not as an employee of Social Security. I submit that the runaway expenditures and hearing workload in the disability program are the result of the Social Security Administration having ceded control of the program to the federal courts, through a decades-long accretion of court-made rules.

I have worked for Social Security for 38 years, since my second year of law school in 1972. I have served as a trial attorney (1974-1982) specializing in class action and appellate litigation, as an "Administrative Appeals Judge" (AALJ) on the Appeals Council (1982 -1987), and have been an Administrative Law Judge (ALJ) in the Seattle Hearing Office of the Office of Disability Adjudication and Review (ODAR) since November 1987. I have watched the erosion of Congressional intent for most of the past 38 years. In the agency bureaucracy there is no institutional memory, and consequently familiarity with Congressional intent has been lost.

From the outset of the disability program the courts have redefined it, step by step, from one where objective medical evidence and reasonable inferences based upon that objective medical evidence became secondary to subjective complaints of pain[2] and other symptoms, and subjective estimates of abilities by treating physicians. Over time the agency, rather than seek Supreme Court review of the appellate rulings, incorporated them into regulations and rulings.[3]

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[1] I have enclosed with this letter a paper regarding the courts' various glosses on the Social Security Act, which I wrote in 1993, addressed to the agency's "Disability Re-Engineering Project" (hereafter "Re-Engineering Paper").

[2] The Ninth Circuit legislated the "excess pain" standard, defined in 1986 in ***Cotton v. Bowen***, 799 F.2d 1404, 1407 (9th Cir. 1986) as follows: "(i)f the claimant submits objective medical findings that would normally produce a certain amount of pain, but testifies that she experiences pain at a higher level (hereinafter referred to as the claimant's "excess pain"), the Secretary is free to decide to disbelieve that testimony, ... but must make specific findings justifying that decision" (citations omitted).

[3] *Compare*, ***Polaski v. Heckler***, 739 F.2d 1320 (8th Cir. 1984), with Social Security Ruling (SSR) 88-13, *superseded*, SSR 96-5p, and see discussion, *infra*. The ***Polaski*** litigation precipitated an amendment to the Social Security Act, which was ignored by the courts. *See*, Note 14, *infra*, and Re-Engineering Paper pp 5-6.

The cumulative effect of this process is that the burden is now on the ALJ to disprove every subjective complaint and opinion. Consequently, rationalizing a denial decision is onerous, if not in many cases impossible, despite the underlying merits or lack thereof. This burden of *disproof*, together with constant hectoring for unrealistic production levels, is the reason allowance decisions have reached such an untenable magnitude.[4] Many ALJs are finding that favorable decisions are dictated by this court-designed system.[5] The allowance rate across the board, in my view, is indefensible in the context of the original legislative intent.[6]

To briefly summarize my position:

1: Around 1970, the Supplemental Security Income (SSI) disability program moved the responsibility for adult welfare benefits based on disability to the federal government from the former matching grant system. Social Security was charged with the responsibility for adjudicating disability for this new program, in partnership with the 50 states disability determination services. This dramatically changed the nature of the agency's clientele, from dealing with wage earners to dealing with welfare clientele, the majority with erratic work histories and marginal education. This is reflected in the number of cases which are either SSI only cases, or combined SSI – DIWC (disabled wage earner) (agency classification: SSDC) cases[7], as opposed to straight DIWC cases. I examined the next 37 cases I have set for hearing, the dockets for which happened to be on my desk prior to leaving work this afternoon. Only four

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[4] The uncomfortable result of the subjective nature of disability adjudication, which allowance and denial rate comparisons among ALJs will easily reveal, is that whether a claimant is awarded disability benefits depends on which judge he draws in the lottery of random case assignments. This fact in itself can prey on the comfort of people with relatively low allowance rates, with such doubt perhaps leading some ALJs to conform to what is touted as "normative." In addition, the illogically high pay rates of some ALJs in some degree has caused the growth of the hearing workload through the proliferation of appeals of insubstantial cases; whether a case is insubstantial is irrelevant, and attorneys pursue such cases because they may draw an ALJ who will pay it despite the lack of merit.

[5] The Commissioner is urging ALJs to hear and decide 500 to 700 cases a year, a number that is unreasonable. Several years ago, the Associate Commissioner for Hearings and Appeals, under another administration, acknowledged that as a practical matter, hearing and deciding around 40 cases a month was the maximum practical given the nature of the inquiry and the frequently voluminous records involved (ALJs in the early 70's averaged 14 cases a month, and we filed affidavits in litigation in the mid- to late 70's touting the accomplishment of raising this to 27). It is a simple matter for attorneys to paper files with medical opinions, non-medical practitioner opinions, and descriptions of limitations from friends and neighbors of the claimants. Each and every one must be refuted, or the case will be remanded to examine those which are omitted.

[6] The original Congressional intent, although I have years ago lost my citation, was such that it was expected that 80% of those who would be found disabled would be found so as a result of having such dire medical conditions that they would meet one or more of specific listings of impairments based on objective medical criteria alone. Such cases, in theory, would not have to proceed to the administrative hearing level.

[7] The implication from the combined cases is that even with these wage earners, either there is a remote date last insured issue, or the claimant's earnings are so low that his Social Security benefits will be less than the approximately $700 paid to SSI recipients in the State of Washington.

are DIWC.[8] This is representative of the division of cases generally. SSI was the beginning of the agency's inability to cope with the adjudication workload.

2: The Office of the General Counsel (OGC) has never sought Supreme Court review of the "substantial evidence" decisions of the appellate courts, which impose undue burdens on ALJs to *disprove* disability, in the guise of rationale requirements. The rules of evidentiary burden promulgated by the courts, and subsequently adopted by the agency, include the treating physician rule, which I believe you will find to be instrumental in the vast majority of cases paid by ALJs. Rather than seek appeals to the Supreme Court, the agency has historically adopted these complicating rules into even more complicated regulations and rulings, attempting to mitigate their effect with pages of confusing explanatory verbiage.

A: For example, the agency regulation on medical opinion *in 1990*, 20 CFR 404.1527, read as follows:

> We are responsible for determining whether you are disabled. Therefore, a statement by your physician that you are *disabled* or *unable to work* does not mean that we will determine that you are disabled. We have to review the medical findings and other evidence that support a physician's statement that you are disabled.

The federal courts early on decided that a treating physician's opinion should be accorded significant weight. In the Ninth Circuit, such an opinion must be accorded *controlling* weight absent *clear and convincing reasons* why it should not. Thus, an ALJ, to deny a case, bears a significant burden of justification, which amounts to a burden of proof. The practical effect is to displace the authority to dispense public funds from the agency to physicians, who are interested in the global well-being of their patients,[9] rather than the well-being of the public fisc.

The agency did not appeal to the Supreme Court any of the cases imposing on the ALJ the burden of refuting treating physician opinions. Rather, they attempted to write around it, by redrafting 20 CFR 404.1527 so that the subsequent, 1991, version comprises approximately *360* column lines (three pages) in the Code of Federal Regulations (CFR), as opposed to the original three sentence, nine lines.[10]

B: The agency regulation on symptom evaluation (credibility) follows the same course. 20 CFR 404.1529, predicated on a series of un-appealed circuit court opinions, expanded from 16 column

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[8] I do not know how the agency currently allocates costs in the appeals process, but I was told in the late 70's and early 80's that the Office of the General Counsel charged all the costs for litigation in SSDC cases to the trust fund rather than general revenue, from which SSI payments are made.

[9] There have been several studies indicating that treating physicians, as a general proposition, will freely provide opinions for purposes of insurance coverage. *See e.g.*, Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems, Novack, *et al.*, Journal of the American Medical Association, May 26, 1989.

[10] Subsequently, the Supreme Court in ***Black and Decker Disability Plan v. Nord,*** 538 U.S. 822 (2003), indicated, to my reading, that the only reason the treating physician rule existed in Social Security law was by dint of the 1991 regulation, *codifying* the line of court cases on the subject.. They rejected plaintiff attempts, and the Ninth Circuit ruling, extending the treating physician rule beyond the Social Security program.

lines in the Code of Federal Regulations, to three pages.[11] There is a lengthy discussion of the Ninth Circuit's "excess pain" standard for review of credibility in the attached Re-Engineering Paper. The agency never attempted insofar as I know to appeal any of the various circuit rulings imposing a burden on the ALJ of disproving each and every allegation made by the claimant. I believe that you will also find claimant's subjective complaints to be instrumental in the awards of benefits by ALJs regardless of whether the allegations regarding symptoms and limitations are reasonable.[12] As the Re-Engineering Paper indicates, the "reasonable man" standard which is the predicate for most of our laws, following the British system, has no place in the disability review process, at least once the courts take jurisdiction.[13] Of note, the Supreme Court, to which the issue of court-mandated rules on crediting subjective complaints has not been taken by government appeal, nonetheless observed in ***Mathews v. Eldridge***, 424 U.S. 319, 344-45 (1976):

> By contrast, the decision whether to discontinue disability benefits will turn, in most cases, upon "routine, standard, and unbiased medical reports by physician specialists," ***Richardson v. Perales***, 402 U.S., at 404, concerning a subject whom they have personally examined. In ***Richardson*** the Court recognized the "reliability and probative worth of written medical reports," emphasizing that while there may be "professional disagreement with the medical conclusions" the "specter of questionable credibility and veracity is not present." *Id.*, at 405, 407. To be sure, credibility and veracity may be a factor in the ultimate disability assessment in some cases. But procedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions. The potential value of an evidentiary hearing, or even oral presentation to the decisionmaker, is substantially less in this context than in ***Goldberg***. (Footnote omitted).

The Court further notes, *Id.*, N. 28, that with respect to the issues presented in a disability termination case, "(t)he value of an evidentiary hearing, or even a limited oral presentation, to an accurate presentation of those factors to the decisionmaker does not appear substantial." *Also see,* ***Bowen v. Yuckert,*** 482 U.S. 137, 149 (1987) (noting that 42 USC 423(d)(2)(A) "was intended to

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[11] Met with scant success in dissuading the courts from their continued reversal of ALJ decisions, the agency in 1996, supplemented the six pages of regulations on the issues of treating opinions and subjective evidence by issuing approximately 40 pages of rulings (SSR's 96-1 through 96-9), also in effect ignored by the courts.

[12] The Seventh Circuit, in ***Moothart v. Bowen***, 934 F.2d 114, 117 (7th Cir. 1991) indicated that "absent the requirement of objective medical findings, disability hearings would turn into swearing contests." This is precisely what has transpired.

[13] The agency's failure to appeal these cases resulted in what one appellate judge (***Stewart v. Sullivan***, 881 F.2d 740, 746 (9th Cir. 1989) Sneed, Circuit Judge, *concurring*) called the problem of "adjectival and adverbial enhancement," *i.e.*, the language used by the courts to describe the ALJs burden to refute credibility increased with subsequent decisions. Judge Sneed charts the progression of the rationale requirement on the issue of credibility from a "specific finding," to a "specific and justifiable" finding, to a "convincing" justification, and predicts that "convincing" will soon be joined by "clearly." Judge Sneed apparently had missed that the "clear and convincing" standard had been pronounced four months earlier in ***Swenson v. Sullivan***, 876 F.2d 683, 687 (9th Cir. 1989). The Court in ***Fair v. Bowen***, 885 F.2d 597, 603-05 (9th Cir. 1989), referred to this process as "continually shifting the target at which we ask ALJs to aim." As it happens, by 1996 the requirement had transmuted to "*specific*, clear, and convinging." ***Smolen v. Chater***, 80 F.3d 1273, 1281 (9th Cir. 1996) (emphasis supplied, citation omitted).

reemphasize the *predominant* importance of medical factors in the disability determination."[14] S. Rep. No. 744, 90th Cong., 1st Sess., 48 (1967), U.S. Code Cong. & Admin. News 1967, p.2882." (*emphasis supplied*). *And see*, S. Rep. No. 744, at 2295 N. 7, and at 2295-96, N. 8.

The considerable liberalization of the disability program by the courts, moving the program away from an objective-based system of adjudication with the burden of proof on the claimant, to what is, at the hearing level, a subjective-based program with the burden to disprove the claimant's every allegation on the ALJ, could have been, I believe, predictably, forestalled by recourse to an evidently perceptive and receptive Supreme Court.[15]

D. Subsequent to the treating physician rule and the "excess pain" standard, the Ninth Circuit imposed on ALJs the duty to refute clearly and convincingly lay opinions from practitioners such as social workers, and lay testimony from relatives and friends of the claimant.[16] These burdens of refutation have been incorporated into rulings, such as SSR 06-03p: Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies. These considerations also factor into making denial decisions either too much work or impossible to rationalize successfully. Many ALJs, I am convinced, rationalize their allowance rate on this basis.[17]

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[14] 42 USC 423(d)(5)(A) (added by The Social Security Benefits Reform Act of 1984) bolstered the emphasis on objective medical evidence by inserting into the Social Security Act the former regulatory requirement that:

> … there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could *reasonably be expected to produce the pain or other symptoms alleged* and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain or other symptoms which may reasonably be accepted as consistent with the medical signs and findings),…

(Emphasis supplied.) In a bizarre exercise, the Ninth Circuit subsequently read the legislative history of this amendment to mean the opposite of what the legislative history expressly stated, and found support in the amendment for the "excess pain" theory of adjudication pronounced by that circuit. *See*, ***Bunnell v. Sullivan***, 947 F.2d 341 (9th Cir. 1991). See discussion in Re-Engineering Paper, attached, pp 5-6.

[15] At one point in about 1979 at the weekly staff meeting in OGC one younger attorney expressed his dismay at the failure of the agency to timely pursue an appeal by providing the Appellate Section of the Civil Division at the Department of Justice with an appeal recommendation (colloquially referred to as a "yes-appeal."); DJ had already request two extensions of time to file the appeal (Third Circuit, if memory serves). The response was "It's not your merit pay at issue." My belief has always been that at least in this department, and at least with respect to litigation, merit pay precipitated a culture of no risk, which inhibited the government from protecting the disability program. Merit pay no doubt currently plays a role in the constant initiatives to increase production numbers at the cost of quality and consistency of adjudication.

[16] ***Dodrill v. Shalala,*** 12 F.3d 915, 918 (9th Cir. 1993).

[17] The confluence of all these rules long ago tolled the death of the "substantial evidence test" of judicial review (42 U.S.C. 405g), which is lip-serviced regularly by the circuit courts, but ignored in practice. In ***Bunnell v. Sullivan***, *supra*, 947 F.2d at 348, Kozinski, Circuit Judge, *specially concurring only in the judgment*, referred to the pattern of judicial rulemaking for social security adjudication, as "an exercise of common-law decisionmaking spuriously imposed on a complex regulatory scheme" and a failure to allow "the political branches to resolve the intractable policy conflicts

3. In 1980 the agency promulgated the Medical-Vocational Guidelines (MVGs, which was a misguided attempt to promote uniformity. The Commissioner in the past couple of years indicated an intent to revisit and recast the MVGs and caved in, according to rumor, to lobbying by disabled advocacy groups and the claimant bar,[18] with no changes being made. Over the years, as the baby-boomers have aged, those who have been uneducated and unskilled and have contributed the least to the trust fund (and the general fund) have benefited the most. If you examine the MVGs, found at Appendix 2 to Subpart P of 20 CFR, you will find that at age 50 a person who can perform only sedentary work and has no skills is presumptively disabled. A person age 49 is not.[19] More importantly, many in the baby-boomer population, who wish to retire at age 62 (or even 60), and do not have skills, may be found disabled if he or she has a history of unskilled work, or a history of skilled work with skills which will not transfer to other work, even if he or she is capable of *light* work, *i.e.,* standing and walking six hours a day out of eight, and lifting and carrying 20 pounds occasionally, ten pounds frequently.

4. Only tangentially related to my general points, perhaps, is the agency's implementation of The Contract with America Advancement Act of 1996, Pub. L. 104-121, 110 Stat. 847 (relevant

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that inevitably arise in the implementation of social welfare legislation." Occasionally, judges vent their frustrations in dissents, such as that in ***Holohan v. Massanari***, 246 F.3d 1195, 1211 (9th Cir. 2001), Fernandez, Circuit Judge, *Concurring* and *Dissenting*:

> As is common with triers of fact, the majority opinion marshals every bit of evidence that would support its decision that Holohan should get benefits, and denigrates the opinions of the doctors who do not agree with that. For example, Dr. Hsieh's opinion is accepted, though she wrote very little and had never seen Holohan, while other physicians are dismissed with the comment that they are wrong, or conclusory, or checked the boxes. None of that is unusual. We regularly engage in complex locutions as we rummage through records and reweigh each piece of evidence, with no real deference whatsoever to those who work with and decide social security disability cases on a day-to-day basis. That approach enables us to cast a brume over the fact that we are actually retrying cases. However, it is one thing to find error; it is quite another to decide that the trier of fact, the expert agency, and the district court have perceptions of the record so inferior to ours that benefits must be ordered with no further ado.

[18] One difficulty with the administration of the disability program is that the agency spends much of its time when it proposes reforms, dealing with "stakeholders." Dealing with "stakeholders," *i.e.,* lobbyists for disabled and claimant representative organizations, results in such anomalies as the agency position that fibromyalgia is a medically determinable impairment, while recognizing that there is no objective clinical or laboratory evidence which establishes this disease (there are currently clinical trials advertised on local television for "childhood fibromyalgia" medications, indicating that we can soon expect "childhood fibromyalgia" applicants under the SSI disabled children program). By contrast, once objective criteria for chronic fatigue syndrome, a similar primarily subjectively based impairment, were promulgated by ruling (SSR 99-2p), claims for disability on the basis of this impairment, once significant in numbers, all but disappeared, at least in the Seattle area. Similar considerations appear to play into the 2002 obesity ruling (SSR 02-1p), which indicates that "the goals of treatment for obesity are generally modest, and treatment is often ineffective. Therefore, we will not find failure to follow prescribed treatment unless there is clear evidence that treatment would be successful." This ruling, again, follows similar verbiage in Ninth Circuit and other circuit decisions. Thus, there is another impossible burden of proof on an ALJ who might deny benefits because the claimant's disinclination to diet and exercise complicates his medical condition.

[19] The exception is a person who is age 45 to 49 who cannot speak English. This person, limited to sedentary work, is disabled. This results in payment of benefits to people in Puerto Rico despite the fact the official language is Spanish.

portions codified in scattered sections of 42 U.S. C.), which made substance addiction disorder a non-qualifying medical impairment. Many people are awarded benefits while addicted to alcohol and drugs because the ALJ is not able to parse out what limitations would be present if there was no addiction. The Ninth Circuit has ruled along with several others that the burden is upon the claimant to establish that substance addiction is not material to the state of being "disabled." ***Parra v. Astrue,*** 481 F.3d 742 (9th 2007). The agency has taken the position that the burden is on the agency (*i.e.*, ultimately, the ALJ) to establish that the claimant would not be disabled if there was no addiction. In ***Parra***, 481 F.3d 749-50, the court indicates that the agency approach is contrary to Congressional intent:

> such an interpretation is unpersuasive because it contradicts the purpose of the statute. As noted above, Congress sought through the CAAA "to discourage alcohol and drug abuse, or at least not to encourage it with a permanent government subsidy." Appellant's proposed rule provides the opposite incentive. An alcoholic claimant who presents inconclusive evidence of materiality has no incentive to stop drinking, because abstinence may resolve his disabling limitations and cause his claim to be rejected or his benefits terminated. His claim would be guaranteed only as long as his substance abuse continues--a scheme that effectively subsidizes substance abuse in contravention of the statute's purpose.

This is another category of cases in which an untenable burden of proof is placed on the ALJ and renders him/her more likely to simply pay a case, and in which, in my opinion, Congressional intent has been thwarted.

I am certain that if you interviewed ALJs around the country you would find other issues with the disability system which contribute to the current lack of uniformity, lack of accountability, and virtual impossibility to please "management." Interviewing bureaucrats will not uncover the problems inherent in the current structure. Interviewing "stakeholders" will not elicit ways to tighten up the process. The people in the "trenches" are the people who understand the practicalities of the process.

I have no dog in this hunt, so to speak. I maxed out my pension under CSRS last August, but have not yet been able to bring myself to retire; I am, likely unreasonably, invested in the disability program. I would like to see Congress turn its attention to some of the problems I have raised.

As noted, the views indicated in this letter and the attached document are my own as an individual and not as an employee of Social Security.

Sincerely,

Cc: Sen. Max Baucus

Verrell Dethloff

To: SSA - Disability Reengineering Project
P.O. Box 17052
Baltimore, Maryland 21235

December 3, 1993

Fm: Verrell L. Dethloff, Jr.
Administrative Law Judge
Seattle, Washington Hearing Office (OHA)

Re: Reengineering Disability --- The Need to Reestablish the Original Definition of Disability

The burgeoning Social Security allowance rate at the administrative law judge level, and the concomitant growth of the payee roll itself, and the exploding workload for all adjudicators from the initial determination level through the federal courts, can all be traced to the departure of the program from its original precept. The disability program was originally defined as one which required that disability be objectively established. The statute, particularly as clarified after the 1967 Amendments, is clear on its face:

> For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (42 U.S.C. 423 (d)(3))

However, the federal courts early on declined to apply this strict test as it appears to have been intended. In Underwood v. Ribicoff, 298 F.2d 850, 854 (4th Cir. 1962), a germinative case in terms of disability substantial evidence review, the court declined to sustain the Secretary's decision, commenting that a finding of nondisability was possible on the record before it only if one adopted a highly technical and literal interpretation of the Act, which the Court declined to do.

This reluctance to strictly apply statutory provisions appears to follow, although the court does not cite, cases predating disability benefits which liberally construed old age and survivors benefits provisions of the Act. See, e.g., Schroeder v. Hobby, 222 F.2d 712, 715 (10th Cir. 1955) (mother's benefits); Wray v. Folson, 166 F. Supp. 390, 395 (W. D. Ark., 1958) (period of disability); Harper v. Flemming, 288 F.2d 61, 64 (4th Cir. 1961) (coverage issue). With scant exception the courts have followed this liberal construction in favor of the claimant (see, Schroeder, supra) without comment on the legislative history of the provision in question.

Disability insurance benefits were established by the Social Security Amendments of 1956 (P.L. 90-248) (90th Cong., lst Sess.).

By 1967 Congress was already concerned with the manner in which the definition of disability was being interpreted in the courts.

This Congressional concern was precipitated by cases such as Ber v. Celebrezze, 332 F.2d 293 (2nd Cir. 1964), reversing the Secretary in a case of questionable objective medical basis on the rationale that claimant's pain was "very real to her" and that pain "real to the sufferer" can constitute a disability regardless of the source. Id., at 294-297.

This Congressional concern was manifested in the enactment of new section 223 (d) (3) of the Social Security Act, set out above. Prior to that time the courts had been guided only by old section 223 (c) (2), paralleling current 223 (d) (3), defining disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable impairment..." The Senate Finance Committee notes that it "shares the concerns of the Committee on Ways and Means regarding the way this definition has been interpreted by the courts and the effects their interpretations have had and might have in the future on the administration of the disability program by the Social Security Administration." Discussing the courts' interpretation of this provision, the Finance Committee further notes:

> The studies of the Committee on Ways and Means indicate that over the past few years the rising cost of the disability insurance program is related, along with other factors, to the way in which the definition of disability has been interpreted. The committee therefore includes in its bill more precise guidelines that are to be used in determining the degree of disability which must exist in order to qualify for disability insurance benefits. S. Rep. No. 744, 90th Cong., 1st Sess., reprinted in (1967) U.S. Code. Cong. and Adm. News 2834, 2881.

The Finance Committee's concern with rising costs was voiced at a time when the number of disability recipients had risen from 455,371 in 1960 to 1,193,190 in 1966. The failure of Congressional efforts in 1967, and in 1984 (see discussion, below), is reflected in the fact that the disability recipient roll had risen by 1992 to 3,467,783. See, Social Security Bulletin, Annual Statistical Supplement 1993. The cost in dollars rose apace, from 40,668,000 in 1960, to 107,627,000 in 1966, to 2,171,080,000 in 1992. Id. These figures do not include auxilliary beneficiaries.

Among four primary concerns of the Senate Finance Committee in 1967 was "(t)he question of the kind of medical evidence necessary to establish the existence and severity of an impairment, and how conflicting medical opinions and evidence are to be resolved." In explaining what is meant by the enacted provision, section 223 (d) (3), quoted above, the Committee states:

> The impairment which is the basis for the disability must result from anatomical, physiological, or psychological abnormalities which can be shown to exist through the use of medically acceptable clinical and laboratory diagnostic techniques. Statements of the applicant or conclusions by others with respect to the nature or extent of impairment or disability do not establish the existence of disability unless they are supported by clinical or laboratory findings or other medically acceptable evidence confirming such statements or conclusions.... Id., at 2882-83.

To effectuate this legislative intent the Secretary promulgated 20 C.F.R. 404.1529 (1983) (compare, earlier, less explicit version, 20 C.F.R. 404.1526 (33 F.R. 11749, Aug. 20, 1968)) which provided:

> If you have a physical or mental impairment you may have symptoms (like pain, shortness of breath, weakness or nervousness). We consider all your symptoms, including pain and the extent to which signs and laboratory findings confirm these symptoms. The effects of all symptoms, including severe and prolonged pain, must be evaluated on the basis of a medically determinable impairment which can be shown to be the cause of the symptom. We will never find that you are disabled based on your symptoms, including pain, unless medical signs and findings show that there is a medical condition that could be reasonably expected to produce those symptoms.

There are three notable things about the 1967 Amendments beyond the issues discussed above. First, Congress was already concerned with the rising costs of the disability program (see discussion, Ibid, at 2880). Second, Congress expected that the majority of cases would be decided on the basis of medical considerations alone: "(I)n most cases the decision that an individual is disabled can be made solely on the basis of an impairment ... of a level presumed (under administrative rules) ... to be sufficient so that ... it may be presumed that the person is unable to engage (in substantial gainful activity)." Third, the new statute, its legislative history, and the Secretary's regulatory interpretation of the statute were largely ignored, as the federal courts continued to liberalize the interpretation of disability through the mechanism of substantial evidence review.

Administrative Law Judges came under increasing criticism for attempting to give meaning to the Secretary's regulation in the context of particular cases, for, in essence attempting to effectuate congressional intent that the program be administered on an objective, and therefore, more uniform basis. An atmosphere of rancor arose on the part of reviewing courts which constantly derided administrative law judges for failing to properly apply rules established in court decisions.

These rules created an increasingly subjective system of adjudication of disability, and displaced the burden of proof on the ultimate issue of disability from the claimant to the administrative law judge. This was accomplished by interpreting substantial evidence to require that a claimant's allegations of disabling pain or other symptoms be established to be non-credible, rather than requiring that the claimant prove on a medical basis, as required by statute, that the allegations were credible. Similar rules were posited and proliferated with respect to pronouncements of disability on the part of treating physicians; if a treating physician pronounced a claimant disabled, it became incumbent on the administrative law judge to provide clear and convincing reasons not to accept this opinion.

An example of this subjectivization of the disability adjudication process may be seen in the Ninth Circuit Court of Appeals. By 1986 the Ninth Circuit refined its position to the "excess pain" standard. In Cotton v. Bowen, 799 F.2d 1404, 1407 (9th Cir. 1986), the court stated "(i)f the claimant submits objective medical findings that would normally produce a certain amount of pain, but testifies that she experiences pain at a higher level (hereinafter referred to as the claimant's "excess pain"), the Secretary is free to decide to disbelieve that testimony, ... but must make specific findings justifying that decision" (citations omitted).

That this requirement of "findings justifying that decision" amounts to a burden of proof has been recognized by the courts. The Ninth Circuit in a subsequent case, Fair v. Bowen, 885 F.2d 597, 603-605 (9th Cir. 1989), discusses how the administrative law judge may "rebut" claims of "excess pain," and further notes the development in the circuit of an "intricate assortment of judicially-created rules" wherein the administrative law judge must "convincingly justify" his rejection of testimony, while the circuit rules on a piece-meal basis that the reasons offered in given decisions are insufficient.

Circuit Judge Sneed, concurring in Stewart v. Sullivan, 881 F.2d 740, 746 (9th Cir. 1989), notes his "belief that it is extremely difficult for the Secretary to refute successfully an excess pain claim." Judge Sneed further notes the unreasonable possibility of the Secretary enrolling the investigatory aid of the FBI to "ascertain the genuineness of these claims" and similarly dismisses the creation of the Secretary's own investigatory arm.

Judge Sneed appears to endorse the result reached in Stewart, a remand to pay the case rather than for further action, only because he questions the proper disposition in a case where the Secretary has "failed to carry his burden, whatever it may be, with respect to "excess pain" claims."

Both Judge Sneed, in Stewart, and the court in Fair, note the changing nature of the mark an administrative law judge must hit in rationalizing his cases. The crux of the difficulty with the subjective approach taken toward disability case adjudication by the courts, and the effect of this approach on both the disability roll (in terms of allowance rate) and the administrative process, is presaged by footnote 3 in the Fair decision, 885 F2.d, at 602:

> The growth in the number of excess pain cases may be a self-perpetuating phenomenom. As we decide more cases involving pain, the law regarding pain acquires more and finer refinements. The time lag between an ALJ's decision in a particular case and the day that case comes before us is often two years or longer; ALJs are thus often making excess pain determinations according to law that has been superseded by the time the cases are judicially reviewed. By continually shifting the target at which we ask ALJs to aim, we no doubt make it harder for them to hit it. The likelihood that an excess pain claimant will win reversal on appeal because the ALJ applied the wrong law accordingly increases, causing a corresponding increase in the number of excess pain cases appealed. And so on.

What is all the more troubling about the development of this line of cases and a similar line requiring the rebuttal of treating physicians' opinions of disability (see, e.g., Day v. Weinberger, 522 F2.d 1154, 1156 (9th Cir., 1975)), is that this line of cases persisted and gathered steam not only after the 1967 Amendments, but after the 1984 Amendments as well.

In 1984, Congress revisited the issue of the objective definition of disability and the activism of the courts in interpreting the statute. In a bizarre exercise, the Ninth Circuit subsequently read the legislative history of the 1984 Amendments (The Social Security Benefits Reform Act of 1984) to mean the opposite of what the legislative history expressly stated was the intent of the amendments, and exactly opposite of what the express language of the new statute stated:

> An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require. An individual's statement as to pain ... shall not alone be conclusive evidence of disability as defined in this section; there must be medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the pain ... alleged and which, when considered with all evidence required to be furnished under this paragraph (including statements of the individual or his physician as to the intensity and persistence of such pain ... which may reasonably be accepted as consistent with the medical signs and findings), would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain ... established by medically acceptable clinical or laboratory techniques ... must be considered in reaching a conclusion as to whether the individual is under a disability. (42 U.S.C. 423(d)(5)(A) (emphasis supplied)

The Senate Finance Committee report emphasized the explicit intent of section 423(d)(5)(A) as:

> a codification of the regulations and policies currently followed by the Administration. This rule prohibits basing eligibility for benefits solely on subjective allegations of pain (or other symptoms). There must be evidence of an underlying medical condition and (1) there must be objective medical evidence to confirm the severity of the alleged pain arising from that condition or (2) the objectively determined medical condition must be of a severity which can reasonably be expected to give rise to the alleged pain. S.Rep. No. 466 at 24, 98th Cong., 2d Sess. (1984) (emphasis supplied).

Again, this legislative action was precipitated by Congress' perception of misguided judicial activity: "if courts ignore the Secretary's regulatory authority and the expressed Congressional concerns for careful administration, national uniformity and verifiable evidence, the Committee has little choice but to draw the statute as narrowly as possible." Id., at 23-24. Indeed, Senator Long, Chairman of the Senate Finance Committee, specifically noted with reference to the district court opinion in Polaski v. Heckler, 585 F.Supp. 1004, 1008-09 (D.Minn., 1983), aff'd,739 F.2d 1320 (8th Cir., 1984, ordered remanded on other grounds, 751 F.2d 943 (8th Cir., 1984), vacated 476 U.S. 1167 (1986), which had held that medical evidence need not fully support a claimant's complaints of pain:

> On the basis of (the district judge's) finding that the Secretary was not obeying what he calls "Eighth Circuit law," this judge ordered the Secretary to substitute his policy judgment for hers (sic) (and that of Congress) in carrying out the Social Security Act in an area covering seven States.
>
> This case would not be so troubling if it were atypical. But apparently, it is almost the judicial norm. Courts do, of course, have the responsibility to carry out the law and resolve questions of interpretation. In so doing, however, they should be guided by the statute and its legislative history.... If the judge in this case had bothered to examine the statute and legislative history, he would have ample evidence of Congress' concern not that the law be more broadly construed, but that it be more narrowly construed. He would also have found great concern on the part of Congress that the law be administered more uniformly.... Circuit courts are not regional legislatures.

130 Cong. Rec. S6211 (daily ed. May 22, 1984). Senator Long further noted that the result of this judicial interpretation would be that "ultimately, ... eligibility would depend upon the subjective credibility judgment made by each individual adjudicator of claims." See, 130 Cong. Rec. S11458 (daily ed. Sept. 19, 1984.)

Considerable legislative comment to similar effect may be found discussed in Bates v. Sullivan, 894 F.2d 1059, 1067-68 (9th Cir., 1990) (Eugene A. Wright, and Wallace, Circuit Judges, concurring).

In the face of this considerable legislative criticism of the courts' historic approach to evidentiary matters under the Social Security Act disability provisions, and flying in the face of the new statute, the Courts maintained the position repudiated by Congress. One emphatic example of this is the Ninth Circuit's en banc revisiting of the issue of subjective evidence in Bunnell v. Sullivan, 947 F.2d 341 (9th Cir., 1991). In a majority opinion that defies logic and ignores completely the applicable regulations and the legislative record pertaining to the issue of pain (see, Kozinski, Circuit Judge, specially concurring only in the judgment) the Ninth Circuit finds support in the 1984 Amendment, 42 U.S.C. 423(d)(5)(A), for the "excess pain" standard it had judicially legislated in Cotton v. Bowen, 799 F.2d 1404, supra. The Bunnell opinion and its advocacy of the position scathingly rejected by Congress is, as noted by Judge Kozinski in his concurrence 947 F.2d, at 348, "an exercise of common-law decisionmaking spuriously imposed on a complex regulatory scheme" and a failure to allow "the political branches to resolve the intractable policy conflicts that inevitably arise in the implementation of social welfare legislation."

What is all the more troubling in the face of cases such as Bunnell, which have, as warned by Senator Long, supra, created a system wherein eligibility depends upon "the subjective credibility judgment made by each individual adjudicator," is that the political branches referred to by Judge Kozinski in Bunnell have failed in their responsibility to insure the integrity of the program. Notably, in Bunnell itself, the agency through its representative at oral argument essentially conceded the validity of Cotton's "excess pain" pronouncement. See, Bunnell concurrence, 947 F.2d, at 353. Congress has failed to address this pressing issue since the 1984 Amendments, and allowed the applicable "sunset" provision to take effect, rendering the provisions of 42 U.S.C. 423(d)(5)(A) inapplicable to adjudications made after January 1, 1987. Pub.L. No. 98-460, section 3(a)(3), 98 Stat. 1799-1800 (1984).

Further involvement by Congress in this area is clearly required, although perhaps not politically palatable. The constituency favorably disposed to taking the judicially created subjectivity out of the disability program is not so easily identifiable as the social security claimant bar, and indeed the social security claimant and recipient roll.

Congress has failed to further act or inquire into the issue of subjectivity in any organized or meaningful fashion, despite recommendations that it act to extend the 1984 amendment by the Commission on the Evaluation of Pain, which was itself established by section 3 of Pub. L. 98-460.

Moreover, the Pain Commission's report reflects the magnitude of the problem of subjective evidence: while filling three or four pages of its report with 13 recommendations, including extension of 42 U.S.C. 423(d)(5)(A) past its expiration rate pending further study of the issue, the Commission offers nothing to the adjudicator in terms of how to "judge" pain. The judgment of pain is left by the Commission, by the Social Security Administration, and by Congress, to the subjective judgment of the adjudicator; the adjudication of pain is left as the courts have established it, essentially a rebuttable presumption created by allegations, to be rebutted with no source for investigation, against a backdrop of ever changing judicially created rules.

In such a context, there is little reason to wonder at the multiplying number of claims and allowances, and the expanded roll of disability recipients currently exhausting the Disability Trust Fund, now estimated by some sources to dry up within five years. Litigation at all levels continues to grow as the subjectivity of the system and the changeability of the applicable rules encourages the pursuit of appeals.

Little effective guidance is provided either by Social Security Ruling 88-13 (codifying Polaski, supra) the basis for the government's essential acquiesence in the Bunnell case, or in more recently added regulations. Regulations on the issue of subjective evidence and treating physicians' opinions were drafted and went into effect in August and in November 1991. See, e.g., 20 CFR 404.1527, 1529 (56 FR 36960, Aug. 1, 1991; 56 FR 57941, Nov. 14, 1991).

The new regulation on subjective symptoms, which once was one brief paragraph, now covers six and a half columns of the Code of Federal Regulations with text which confuses more that it elucidates, and which has carried no discernible weight with reviewing courts. The administrative law judge remains fundamentally alone in assessing subjective evidence, without resources or black letter underlying philosophy to carry evidentiary burdens displaced to him by the courts.

In the face of this judicial redefinition of fundamental aspects of the social security disability program, the Social Security Administration, guided by the Department of Health and Human Services Office of the General Counsel embarked upon a questionable tactic of "non-acquiescence," with, apparently, either the active endorsement of the Appellate Division of the Justice Department, or with that Division's tacit approval.

In any event, rather than appeal much of the troublesome precedent which flowed from the courts, the agency proceeded to simply ignore such precedent in deciding similar issues in subsequent cases. This in turn was the cause of a considerable rift between political bureaucrats on one side and the Administrative Law Judges, who by vocational prerequisite for their positions came from a tradition of recognizing and honoring the controlling nature of judicial appellate decisions. The faceoff between the agency and the courts became rather bitter, and the ALJ's were caught in the middle.

The Office of Hearings and Appeals Handbook, published in 1976 stated: "(W)here a district or circuit court(')s decision contains interpretations of law, regulations, or rulings (that) are inconsistent with the Secretary's interpretations, the (administrative law judges) should not consider such decisions binding on future cases simply because the case is not appealed." Id., section 1-161, quoted in Steiberger v. Heckler, 615 F. Supp. 1315, 1351 (S.D.N.Y., 1985), vacated on other grounds, 801 F.2d 29 (2 Cir., 1986).

Prior to the appearance of this handbook provision, termed by one commentator to be SSA's "comprehensive nonacquiescence policy" (see, SSA Nonacquiescence, Kubitschek, University of Pittsburg Law Review, Vol. 50, No. 2 (Winter 1989)), SSA had issued individual "notices of non-acquiescence," directing that specific court decisions be disregarded. See, e.g., Social Security Ruling 66-23c, SSR 67-14c, and SSR 68-48c. Only these three nonacquiescence rulings were issued prior to 1976. Following the pronouncement of the 1976 OHA Handbook the agency nonetheless continued to issue individual rulings. See, e.g., SSR's 80-10c, 80-11c, 81-28c, 81-1c, 82-10c, 82-33c, 82-49c.

In 1985 SSA revised its approach and indicated it would henceforth issue Notices of Acquiescence. Interim Circular 185, June 3, 1985, reprinted in Steiberger v. Heckler, supra, at 1403. Under this procedure the agency now issues Acquiescence Rulings "identifying circuit court decisions which are at variance with established SSA policy" and "explaining how SSA will apply the decision within the circuit." Acquiescence rulings began in 1986 with 23 issuances and continue apace. For example, in 1992, SSA issued ten acquiescence rulings, three of which revised earlier acquiescence rulings (i.e., SSR's 86-2R(2), 86-18R(5), 86-19R(11)).

If an acquiescence ruling is in effect, the agency will follow the law of the circuit unless the Appeals Council identifies the case as one which on its facts will provide a good precedent to relitigate the holding at issue. See, again, Interim Circular 185. Administrative Law Judges are now dealing in a milieu wherein the agency has engaged in a process termed by Professor Carolyn A. Kubitschek (see, SSA Nonacquiescence, supra) "silent nonacquiescence."

An example of this is the agency's new subjective evidence regulation, 20 C.F.R. 404.1529, the six and one half column exercise previously referred to, which is largely an effort in attempting to circumvent the "excess pain" theory of Cotton v. Bowen, supra, and similar cases dating all the way back to Ber v. Celebrezze, supra, despite the apparent representation to the court in Bunnell of having effectively endorsed Cotton.

Paradoxically, prior to the issuance of the new regulations the Appeals Council persisted in remanding cases within the Ninth Circuit's jurisdiction for failure to conform to the "excess pain" holding of Cotton and requiring adherence in the same remand orders to SSR-88-13, which contrary to the "excess pain" approach, requires that there be an impairment which could "reasonably be expected" to cause the pain alleged.

The result of the failure to adhere to circuit court precedent has been an explosive growth in the number of disability cases filed in the federal courts. In fiscal 1984 18,968 disability cases were decided by federal courts; in 1985 26,487 decisions were issued. Of these decisions, the Secretary was affirmed only 2,676 times in 1984, and only 3,981 times in 1985. See SOC. SEC. ADMIN., Operational Report of the Office of Hearings and Appeals, 1984, 1985. These are the most recent figures I have available.

Congress has failed to address in meaningful fashion either the redefinition of disability through case law or the confrontation and resultant proliferation of such case law which has followed the nonacquiescence policy of SSA. Congress has recognized the confrontation between the agency and the courts noting "(t)he increasing number and intensity of confrontations between the agency and the courts as the SSA refuses to apply circuit court (precedent)." H.R. Rep. No. 618, 98th Cong., 2d Sess 25, reprinted in 1984 U. S. Code Cong. and Adm News 3038. However, Congress has failed to take steps to limit either this activity by the agency or the expansive and subjective approach toward disability taken by the federal courts since the 1984 Amendments.

Several notable issues were addressed by those amendments: 42 U.S.C. 423 (d)(5)(A), addressing the issue of pain was enacted and subsequently ignored by the courts, as explained supra; and Congress enacted the medical improvement standard for cessation of disability actions at 42 U.S.C. 423(f) (sec. 2(a), Social Security Disability Benefits Reform Act of 1984). The former is an effort to guide the courts, which the courts laboriously misconstrued (see, Bunnell v. Sullivan, Circuit Judge Kozinski concurring specially, supra), and the latter is a legislative endorsement of the "medical improvement" standard of Lopez v. Heckler, 572 F. Supp. 26 (C.D. Cal.), aff'd in part and rev'd in part, 725 F.2d 1489 (9 Cir., 1983), vacated on other grounds, 469 U.S. 1082 (1984), and similar cases.

Congress similarly enacted additional guidelines on the evaluation of mental impairments following legal challenges to the agency's standards and procedures. See, 42 U.S.C. 421 note; sect. 5, Social Security Disability Benefits Reform Act of 1984. A comparison of these developments results in the conclusion that while Congress can pass statutes to conform the agency to judicial precedent, Congress cannot pass statutes to cause the federal judiciary to follow Congressional intent, or give more than lip service to the concept of deference to agency interpretation of statutes.

Despite the aforementioned efforts to legislate acquiescence in two specific areas, the Social Security Disability Benefits Reform Act of 1984 failed to contain provisions reflecting either House or Senate proposals which would specifically address the issues of nonacquiescence, the Conference Committee failing to resolve major differences between the two offerings. See, H.R. 3755, 98th Cong., 1st Sess., 130 Cong. Rec. H1987, 1990 (daily ed., Mar. 27, 1984); S. 476, 98th Cong., 1st Sess., section 7(a)(1) (1984); and H.R. Conf. Rep. No. 98-1039, 98th Cong., 2d Sess. 37, reprinted in 1984 U.S. Code Cong and Adm. News 3080: "(b)y refusing to apply circuit court interpretations and by not promptly seeking review by the Supreme Court, the Secretary forces beneficiaries to re-litigate the same issue over and over again in the circuit, at substantial expense to both beneficiaries and the federal government. This is clearly an undesirable consequence." Compare, Administrative Conference Proposal, 53 Fed. Reg. 12,444 (1988), which would preserve nonacquiescence with wide dissemination to the public and relevant government officials and a statement of reasons for nonacquiescence.

Thus Congress and the political branches of the government have left unsettled resolution of the subjective nature of the disability program and the conflict this has created, exacerbated as are many other issues by the nonacquiescence policy currently employed by SSA. The administrative law judges remain in the position of fashioning hearing decisions which more and more frequently take on the aspect of a brief in support of a decision rather than the proper aspect of a judicial document.

The subjectivity of the process increases the workload in a continuing spiral and appears to many judges to result in undeserving and incorrect awards of benefits as the requirements to prove disability are displaced to judges who have no resources to disprove the allegations of claimants or the freely-given opinions of disability offered by treating physicians. See in this latter regard, Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems, Novack, et al., Journal of the American Medical Association, May 26, 1989 (indicating statistically a willingness of physicians to lie to insurers for the global well-being of their patients).

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