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

[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

[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

[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.

[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.

[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