COMMITTEE ON WAYS AND MEANS

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STATEMENT FOR THE RECORD

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

Thank you for this opportunity to discuss our partnership with the Office of the Inspector General (OIG) to root out disability fraud wherever it may occur.

My name is Carolyn Colvin, and I have served as the Acting Commissioner of the Social Security Administration (SSA) since February 2013. Prior to assuming my current position, I served as the agency's principal Deputy Commissioner. I also worked in several other positions, both inside and outside Government, in which I managed programs that help people with their healthcare and financial needs.

Throughout my career, I have met people from all walks of life who struggle to cope with severe disabilities. Whether their impairments are mental or physical, by birth or circumstance, these individuals face extraordinary challenges in providing for themselves and their loved ones. Little, if any, publicity documents the quiet struggle in the day-to-day lives of these remarkable individuals, but we must never forget them. They are the true face of disability in this country.

Unfortunately, the criminal mind knows no shame. While I am outraged whenever anyone attempts to commit fraud against the Social Security disability program, I am especially disgusted by the criminal conspiracy that our employees uncovered in New York. In this case, an attorney and several others fabricated medical history to defraud the U.S. Government of millions of dollars in disability benefits. Most of the false claims for benefits involved former fire fighters and police officers who claimed to be disabled in the line of duty, including disabilities claimed to arise from the tragic events of September 11, 2001.

As you can imagine, criminals invoking the memory of 9/11 to masquerade as disabled is deeply personal for our employees, especially those in the New York Region. Not only are the New York Regional Office and the New York Disability Determination Services (DDS) located within blocks of Ground Zero, but many of our employees were working at the time of the attack and were fortunate to escape with their lives. Soon thereafter, many of those same employees returned to work in emergency outposts throughout the city to accept survivor claims from the families of the deceased. One of those employees was Beatrice Disman, our Regional Commissioner for the New York Region. Bea led our agency's response to the aftermath of 9/11 and personally accepted a claim from a widow at Police Plaza. There, Bea met the father, a retired New York City fire fighter, and widows of two brothers who died in the attack—one a firefighter, the other a police officer. Bea joins me today to answer any questions you may have about our cooperation with the fraud investigation, which remains active and ongoing.

As the investigation unfolds and the perpetrators are brought to justice, I could not be prouder of our employees at SSA, the New York DDS, and the OIG. They worked cooperatively to flag the fraudulent cases, connect them to a criminal conspiracy, and build the cases for prosecution. Partnership with State and Federal law enforcement has also been essential.

Without question, we owe a special debt of gratitude to the diligent employees of the New York DDS, who are funded and trained by SSA to make disability determinations. These employees

referred fraudulent cases involved in the conspiracy to the OIG as far back as 1999.[1] After 9/11, the volume of the fraudulent claims increased significantly. Over time, the OIG began to notice patterns in the referrals. In 2008, as a result of a number of investigations stemming from referrals by the alert DDS employees, the New York Cooperative Disability Investigations (CDI) unit identified a potential conspiracy involving third-party facilitators and claimants submitting similar medical documentation that appeared to fabricate or exaggerate disabling conditions. As the CDI investigators and analysts, together with SSA's New York Region staff, began digging deeper, it became apparent that this was a vast and longstanding criminal conspiracy.

To date, the Manhattan District Attorney has indicted 106 individuals for their crimes. According to our estimates, the fraudulent payments total $23.2 million dollars to 102 disability beneficiaries and their auxiliaries, and we have already suspended these individuals' benefits. To provide some context on the scale of the fraud, over 1 million Social Security disability beneficiaries in the New York Region receive over $1 billion in monthly benefits. Nationwide, about 11 million Social Security disability beneficiaries receive about $12 billion in monthly benefits.

We will move aggressively to recover any overpayments we assess after re-determining the entitlement of those involved in the New York fraud case, using tools such as court-ordered restitution, wage garnishment, and the diversion of any future federal income tax refunds. In addition, SSA and the OIG have established a special toll-free fraud hotline where individuals can report additional information connected with this indictment or other fraud situations. That toll-free number is 1-877-441-6012. Reports of fraud also may be sent to the OIG using the link http://oig.ssa.gov/report.

If we are to keep the incidence of fraud in the disability program low, we need support from both the public and Congress. The continued success of the fraud detection and referral process that Congress established between SSA and the OIG requires constant vigilance and input from all of our stakeholders. Working with the OIG, we must continually enhance our processes to stay a step ahead of the criminals.

Continued success also requires a sustained commitment of resources to ensure the integrity of the disability program. Over the past 2 years, Congress has appropriated $421 million less for program integrity reviews than what it authorized for us in the Budget Control Act of 2011 (BCA). Over the past 3 years, we received an average of nearly a billion dollars less than what the President requested for our administrative budget. The net effect has been the loss of nearly 11,000 employees at Social Security—that means drastically fewer people standing watch for the next attempted theft and drastically fewer people available to serve those who truly need us. However, we are very pleased that the draft omnibus bill currently includes full funding of the fiscal year (FY) 2014 BCA level for SSA's program integrity reviews, which would allow us to significantly increase our continuing disability reviews (CDR), helping us save billions of taxpayers' dollars.

[1] Under the Inspector General Act of 1978, the SSA OIG is tasked with preventing fraud, waste, and abuse in SSA's programs and operations.

Fewer people at SSA to handle mounting workloads puts our record of exceptionally high payment accuracy at risk. In FY 2012, approximately 99.0 percent of all Social Security Disability Insurance payments were free of an overpayment, and approximately 99.8 percent were free of an underpayment. That same year, we also achieved high levels of payment accuracy in the Supplemental Security Income (SSI) program despite the inherent complexities in calculating monthly payments due to income and resource fluctuations and changes in living arrangements. We are proud of these results, and a sustained investment of resources in our workforce is essential for us to continue delivering them.

Anti-Fraud Initiatives

Because the investigation in New York is ongoing, my ability to discuss any more specifics of the case today is very limited. To the extent that providing more details would not jeopardize the investigation, both Ms. Disman and I will do our best to be responsive. I would also like to highlight for you the multiple anti-fraud activities that we have in place across the country.

As the dismantling of the fraud ring in New York has shown, our dedicated employees across the country are the first line of defense when it comes to combating fraud. They are highly trained professionals in the administration of the disability program, and they are in the best position to identify fraud, and refer any instances to our partners in law enforcement.

In fact, all of our front-line employees, including claims representatives in our field offices and disability examiners in the State DDSs, receive instruction in detecting potential fraud during their initial training program. Furthermore, all employees receive continuing training in the form of mandatory annual security reminders, programs and policy issuances, videos on demand, and office visits by executives from SSA and the OIG.

When our field office and DDS employees uncover potential fraud while performing daily responsibilities, we instruct them to report all (non-SSA employee) fraud allegations to the OIG Office of Investigations Field Division using the online electronic referral form, e8551. We provide periodic reminders to employees on how to complete the e8551, and maintain policy to instruct employees on its use.

Additionally, each region hosts a Regional Anti-Fraud Committee that meets to discuss and promote ongoing anti-fraud initiatives. The Committee sessions provide an opportunity to review the nature of the fraud referrals from SSA components and discuss techniques to encourage referrals and streamline our processes. Also, the Committees share ideas regarding areas that have potentially fraudulent activity that the OIG should examine.

On the back end, we support our employees' work with a series of anti-fraud initiatives that target the investigation and prosecution of fraud. Foremost among those initiatives are CDI units. Currently, there are 25 CDI units that investigate individual disability applications to identify beneficiaries and third-party facilitators who commit fraud. Each unit includes personnel from the OIG, SSA, DDSs, and local law enforcement. The value of these units is clear. If not for the New York CDI unit, which was among the first five units established in 1998, it may have been much more difficult to connect the individual fraud referrals from the

New York DDS to a criminal conspiracy. Moreover, according to the OIG, CDI units have produced SSA savings of more than $860 million over the last 3 years. With this record of results, expanding the successful CDI program, if adequate and sustained resources are provided, offers substantial benefits in the fight against fraud.

In addition, in cases where Federal prosecutors do not take action on fraud cases presented by the OIG, our Office of the General Council agency attorneys may prosecute these cases instead. These attorneys serve as Special Assistant United States Attorneys in our 10 regional offices and at headquarters. From FYs 2003 through 2012, our attorneys secured over $52.3 million in restitution orders and 921 convictions or guilty pleas. In FY 2013, they secured over $8.9 million in restitution and obtained 139 convictions. There are currently 12 attorneys assigned to these cases.

Another anti-fraud tool we recently developed addresses the growing problem posed by identity theft and direct deposit fraud. Beneficiaries can request a block to prevent changes to their records to optimize security and prevent criminals from re-directing payments to a fraudulent account. From November 2012 through September 2013, nearly 7,000 beneficiaries had taken advantage of this option. We will continue to devise ways to prevent fraud and collaborate with the OIG to protect our customers' payments and identities.

Simultaneously, we continue to ramp up our program integrity reviews, as well as our quality assurance (QA) and overpayment recovery activities, which can help us to detect fraud and remediate its effects. All of our efforts have resulted in a very low incidence of fraud in the Social Security disability program. In fact, in FY 2013, over 22,500 disability fraud referrals were made to the OIG, of which the OIG opened about 5,300 cases and to date has referred over 100 to the United States Attorney's Office for criminal prosecution. That compares with, in FY 2013, over 1.8 million people who applied for Social Security disability, and, as referenced earlier, about 11 million people who received benefits.

Increasing Program Integrity Reviews and Decisional Quality

We are committed to protecting program dollars from waste, fraud, and abuse. The recent arrests in New York demonstrate how seriously we take our responsibility to maintain the public's trust by effective stewardship of program dollars and administrative resources. While we recognize that not all improper payments result from fraud, we work diligently to correct them and pursue them wherever they may lead.

An important part of our program integrity activities are periodic medical re-evaluations, called CDRs, which we use to determine if beneficiaries continue to be disabled over time.

The FY 2014 President's Budget included a special legislative proposal that would provide a dependable source of mandatory funding to significantly ramp up our program integrity work. These mandatory funds would replace the discretionary cap adjustments authorized by the BCA. These funds would be reflected in a new account, the Program Integrity Administrative Expenses account, which would be separate, and in addition to, our Limitation on Administrative Expenses

account. The funds would have been available for 2 years, providing us with the flexibility to aggressively hire and train staff to support the processing of more program integrity work.

Over the past several years, the annual appropriations process has not provided us with the resources necessary to conduct all of our scheduled CDRs. We estimate that the money spent on CDRs saves, on average, $9 for every dollar invested, including savings accruing to Medicare and Medicaid, yet we have a backlog of 1.3 million CDRs due to budgetary shortfalls.

The draft FY 2014 omnibus bill, which was released earlier this week, would provide SSA with $11.697 billion for our Limitation on Administrative Expenses account, including $1.197 billion for program integrity work. The $1.197 billion for program integrity is the same level authorized by the BCA. If we receive this funding, we will be able to complete more CDRs, allowing us to save billions of taxpayer dollars, and set the stage to complete even more CDRs in FY 2015.

This funding level also would allow us to replace some of the staffing losses we incurred over the last 3 years. From FYs 2011 through 2013 we lost nearly 11,000 employees. We would have more staff for both our important service and stewardship work.

In addition to program integrity reviews, strict adherence to our program rules improves our adjudicators' ability to identify fraud and reduces the potential for an improper payment. Accordingly, we provide training and take steps, such as multiple layers of quality review, to ensure that all of our employees apply our program rules uniformly and correctly. This fiscal year, we established a new review process called the Continuous Quality Area Director Review Process. This review will help ensure the accuracy of work completed by field office technicians. One of the areas reviewed will be front-end disability accuracy in field offices, with a concentration on the accuracy of how we determine the applicant's disability onset date. We intend to use the results of these focused reviews to identify systemic issues; recommend training, policy, and systems enhancements; and provide direct feedback to employees regarding their compliance with existing policy.

Having a scrupulous QA operation is critical to ensuring programmatic compliance. We require all of the DDSs to have an internal QA function. In addition, our employees conduct QA reviews of samples of the initial, reconsideration, and CDR determinations of the DDSs. Between FYs 2008 and 2013, QA reviews showed that the DDSs improved their accuracy across the board. The DDSs increased their initial claims decisional accuracy from approximately 94.4 percent to 96.0 percent. They increased their reconsideration decisional accuracy from approximately 92.1 percent to 95.3 percent. Moreover, they increased their CDR decisional accuracy from approximately 96.8 percent to 97.2 percent.[2]

As required by the Social Security Act, we also perform a pre-effectuation review of at least 50 percent of all DDS initial and reconsideration allowances for Social Security and SSI disability for adults. We also review a sufficient number of DDS CDR determinations that

[2] The percent is based upon a statistically valid sample of cases reviewed. It reflects the percent of cases reviewed where we agree with the decision made by the DDS.

continue benefits. These pre-effectuation reviews, which are separate from the reviews mentioned above, allow us to correct errors we find before we issue a final decision. In 2011, they resulted in an estimated $751 million in lifetime program savings, including savings accruing to Social Security benefit payments, Medicare, federal SSI payments, and Medicaid. Based on our most recent data, the return on investment is roughly, on average, $13 for every $1 of the total cost of the reviews.[3]

To improve 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 we cite as deficient. In general, DDSs use the process to resolve the most complex cases. Our policy experts in headquarters thoroughly review these cases. We post all RPC resolutions and related data on our Intranet site, accessible to every disability examiner, medical consultant, and QA and supervisory staff. 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 2008, we have reviewed over 6,200 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 I believe will further improve the consistency and quality of disability determinations at all adjudicative levels.

At the hearings level, we have also taken aggressive steps to institute a more balanced quality review. Our first effort in this area was to develop rigorous data collection and management information for the Office of Disability Adjudication and Review. We then revived development of an electronic policy-compliance system for the Appeals Council (AC). Because the Office of Appellate Operations (OAO) handles the final level of administrative review, it has a unique vantage point to give feedback to decision and policy makers. OAO developed a technological approach to harness the wealth of information the AC collects, turning it into actionable data. These new tools permitted the OAO to capture a significant amount of structured data concerning the application of agency policy in hearing decisions.

Using these data, we provide feedback on decisional quality, giving adjudicators real-time access to their remand data. We are creating better tools to provide individual feedback for our adjudicators. One such feedback tool is "How MI Doing?" This resource not only gives administrative law judges (ALJ) information about their AC remands, including the reasons for remand, but also information on their performance in relation to other ALJs in their office, their region, and the nation. We develop and deliver specific training that focuses on the most error-prone issues that our judges must address in their decisions. This kind of data-driven feedback guides business process changes that reduce inconsistencies and inefficiencies, and simplifies rules.

In FY 2010, OAO created the Division of Quality (DQ) in OAO to focus specifically on improving the quality of our disability process. While AC remands provide a quality measure on

[3] Details can be found in the Annual Report on Social Security Pre-effectuation Reviews of Favorable State Disability Determinations at http://ssa.gov/legislation/PER%20fy11.pdf.

ALJ denials, prior to the creation of DQ, we did not have the resources to examine ALJ allowances. Since FY 2011, DQ has been conducting pre-effectuation reviews on a random sample of ALJ allowances. Federal regulations require that pre-effectuation reviews of ALJ decisions be selected at random or, if selective sampling is used, may not be based on the identity of any specific adjudicator or hearing office. Currently, DQ reviews a statistically valid sample of un-appealed favorable ALJ hearing decisions.

DQ also performs post-effectuation focused reviews looking at specific issues. Subjects of a focused review may be hearing offices, ALJs, representatives, doctors, and other participants in the hearing process. The same regulatory requirements regarding random and selective sampling do not apply to post-effectuation focused reviews. Because these reviews occur after the 60-day period a claimant has to appeal the ALJ decision, they do not result in a change to the decision.

Working alongside DQ is our Office of Quality Review (OQR), which provides another check on the quality of hearing decisions. OQR conducts an ongoing assessment of a national random sample of post-adjudication favorable and unfavorable decisions to determine and report on the accuracy of hearings at a national level. The findings from these OQR reviews provide additional data points to consider in improving the hearings operation.

Collaboration across all adjudicative levels is key to making high-quality disability decisions. The data collected from all of the quality initiatives that I have just described identify for us the most error-prone provisions of law and regulation. We use this information to adjust payments, strengthen business processes, improve training, spot trends, and clarify policy.

Overpayment Recovery

A major enforcement asset supporting our program integrity and QA activities is our debt collection program. It provides us many different avenues to make the taxpayer whole when a beneficiary is overpaid.

We collected $3.46 billion in Social Security and SSI benefit overpayments in FY 2013 at an administrative cost of $.07 for every dollar collected, and $16.12 billion over a 5-year period (FYs 2009-2013). To recover overpayments, we use internal debt collection techniques (e.g., payment withholding, billing, and follow-up), as well as the external collection techniques authorized by the Debt Collection Improvement Act of 1996 for Social Security debts and the Foster Care Independence Act of 1999 for SSI debts.

Since 2004, our cumulative recoveries are $27.66 billion for Social Security and SSI benefit overpayments. We suspend or terminate collection activity in accordance with the authority granted by the United States Code and the Federal Claims Collection Standards. Generally, when the debtor cannot repay, we are unable to locate the debtor, or the cost of collection is likely to be more than the amount recovered, we terminate or suspend collection action. Even though we terminate collection action by stopping our internal efforts, we continue to use our external collection techniques. Termination of collection action is a temporary or conditional write-off in that the debt remains on the person's record. If the debtor becomes re-entitled to benefits in the future, we will collect the debt by appropriate and available methods.

From inception in 1992 through September 2013, our external collection techniques have yielded $4.713 billion in benefits recovered through a combination of overpayment recovery and prevention improvements. We developed a system to handle the Department of the Treasury's (Treasury) Treasury Offset Program (TOP), credit bureau reporting, and Administrative Wage Garnishment. Because the system includes more than TOP and is the basis for any future collection interfaces with agencies or entities outside our agency, we call it the External Collection Operation (ECO) system.

In September 2013, we enhanced ECO to collect delinquent debts through Treasury's State Reciprocal Program (SRP). Treasury's SRP allows States to enter into reciprocal agreements with Treasury to collect unpaid State debt by offset of Federal non-tax payments. In return, the agreements allow the Federal Government to collect delinquent non-tax debt by offset of State payments. In May 2012, we enhanced ECO to collect delinquent debts through TOP beyond the current 10-year statute of limitations, as authorized by Public Law 110-246. Through FY 2013, we notified 310,000 former beneficiaries with debts 10 years or more delinquent of our ability to collect their delinquent debt through TOP. Continued improvement in our debt collection program is also underway. As resources permit, we will expand the Non-Entitled Debtors program, and implement the remaining debt collection tools authorized by the Debt Collection Improvement Act of 1996. These tools include charging administrative fees, penalties, and interest or indexing of debt to reflect its current value. In addition, we will assess the use of private collection agencies in debt collection.

We are in the process of developing a notice of proposed rulemaking that would propose increasing the Social Security monthly minimum repayment amount from $10.00 to 10 percent of the debtor's monthly benefit payment. This change would allow us to recover overpayments more effectively and better fulfill our stewardship obligations to the Disability Insurance Trust Fund. In addition, we will continue to expand our use of TOP by: 1) completing notification to all debtors with debts delinquent 10 years or more; and 2) continuing to notify debtors on a monthly basis of our ability to offset eligible State payments through Treasury's SRP to collect delinquent debt.

Conclusion

My testimony has laid out the uncompromising efforts and rigorous processes that we are employing daily to detect and prevent fraud against the disability program and maintain the integrity of the programs we administer. Unfortunately, as the deplorable situation we uncovered in New York shows, there are despicable people who will chase a dollar at any cost—whether illegal or immoral. To those people, my message is clear: We will find you; we will prosecute you; we will seek the maximum punishment allowable under the law; and we will fight to restore the money you've stolen to the American people.

Our highest priority at SSA is ensuring that benefits are paid only to the right person, in the right amount, and at the right time. This guiding principle is ingrained in our agency culture and repeatedly emphasized in training sessions and alerts to the field. Without question, our highly trained employees remain vigilant for the next attempted theft from the taxpayer.

The Congress can take steps to support our employees' efforts in keeping the incidence of disability fraud low. This includes providing a sustained commitment of resources to ensure the effective operation of the disability program and fully funding program integrity. We need the Congress' support in order to ensure that the disability program continues to well serve the American public in need of its benefits, while protecting the program from those who would attempt to defraud and weaken it.