HEARING BEFORE

THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

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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 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.