

**DETERMINING ELIGIBILITY FOR
DISABILITY BENEFITS: CHALLENGES FACING
THE SOCIAL SECURITY ADMINISTRATION**

HEARING
BEFORE THE
SUBCOMMITTEE ON SOCIAL SECURITY
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
FIRST SESSION

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**DETERMINING ELIGIBILITY FOR
DISABILITY BENEFITS: CHALLENGES FACING
THE SOCIAL SECURITY ADMINISTRATION**

WEDNESDAY, SEPTEMBER 6, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:03 a.m., in Room 2020, Rayburn House Office Building, Hon. Sam Johnson [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
Wednesday, September 6, 2017
SS-06

CONTACT: (202) 225-1721

Chairman Johnson Announces Hearing on Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration

House Ways and Means Social Security Subcommittee Chairman Sam Johnson (R-TX), announced today that the Subcommittee will hold a hearing entitled “Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration.” The hearing will focus on the Social Security Administration’s plan to reduce the hearing backlog and claimant wait times, other efforts to modernize and improve the disability determination process, and tools available to expedite decisions for those with certain severe conditions. **The hearing will take place on Wednesday, September 6, 2017 in room 2020 of the Rayburn House Office Building, beginning at 10:00 a.m.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments 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 make a submission, 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 document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, September 20, 2017.** For questions, or if you encounter technical problems, please call (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 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 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.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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 TDD/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 at <http://www.waysandmeans.house.gov/>

Chairman JOHNSON. Good morning to all of you, and welcome to today's hearing on the challenges Social Security faces when deciding if a person should receive disability benefits. Since I have been Chairman, we have held 18 hearings, including today, on the disability insurance program, on one topic or another. Now, that is a lot of hearings, but the disability insurance program is too important for Social Security not to get it right.

Americans pay taxes on their hard-earned wages for the promise of future Social Security benefits when the worker retires, is unable to work due to a disability, or dies. These benefits are an important part of a family's financial security, and Americans rightfully expect that when they apply for benefits, if they are eligible, that they will receive them quickly. But for those applying for disability benefits, that isn't the case.

Today, over 1 million people are waiting for a hearing with Social Security administrative law judges, and on the average these folks will wait around 600 days to get that hearing. That is nearly 2 years. And that is after waiting almost 4 months, on the average, for an initial decision, and more than 3 months for a second look, known as reconsideration.

While not all of them will qualify for benefits, all of these people deserve an answer in a timely fashion. And for those who don't qualify for benefits, these long wait times make getting back to work even harder.

With backlogs at record highs, it is more important than ever for Social Security to ensure that the Compassionate Allowances program is working as intended. The Compassionate Allowances program was created in 2008 as a way to help those with the most severe impairments jump to the front of the line. But as we will hear today, this program doesn't always work the way it should.

It is clear Social Security has serious problems when it comes to making sure people get the disability decisions as quickly as possible. But Social Security problems and the disability insurance program are more than just long wait times. Since 2003, Social Security's disability programs have been on the GAO's high risk list, in large part because of outdated criteria to determine eligibility for disability benefits. While some progress has been made, there is more work to be done to modernize Social Security's disability program.

As we know, more money isn't always the answer. This year, the Social Security Administration received \$90 million in dedicated funding to address a disability backlog. Yet, wait times continue to

grow. Social Security used some of this funding in much-needed information technology improvements that should pay dividends in the long run. The Social Security Administration must find ways to be more efficient and modernize the disability insurance program. And today, we are going to hear about how Social Security plans to do just that. This won't be easy work and there is plenty to do.

Social Security needs more than just a plan to fix this; it needs real leadership, and that is a large part of management's problem. Since 2013, Social Security has had an Acting Commissioner. In February, Ranking Member Larson and I, along with our colleagues from the Human Resources Subcommittee, sent a letter to President Trump, asking that he nominate a Commissioner without delay.

Social Security needs a Senate-confirmed Commissioner who can lead the agency and focus on providing the service Americans expect and deserve. Social Security provides important benefits that many Americans rely on. With the right leadership and a good plan, Social Security can get back on the right track, but until then, this Subcommittee will keep asking tough questions about how to get this done. The American people deserve nothing less.

And I am sure that my compatriot next to me agrees with that. With that, I will recognize Mr. Larson.

Mr. LARSON. Well, I thank our distinguished Chairman, and I certainly concur with that. And, most importantly, concur in saying your continued leadership to your country in every capacity is greatly respected. And I would say that we are in agreement on a number of the problems that Social Security is set with. As you know, Mr. Chairman, millions of Americans rely on Social Security for basic income when they retire, or if they are severely disabled or can no longer work. Social Security is also there to help widows and children who have lost a parent. There is no private plan on the market, simply put, that can compare to Social Security. That is just a fact.

And we are living that fact currently. And the people at Social Security deserve a lot of credit. In the midst of Harvey, and what is going on and the devastation and the people of Texas in the greater Houston area, and with Irma bearing down upon Florida now, I think it is heartening to know that Social Security hasn't missed a payment. And that on the ground, Social Security has people working with the Red Cross and other volunteer agencies. And even in the case where people do not have electronic transfers, that they are there to help and make sure that America gets what is America's number one program, the Social Security program.

Natural disasters remind us of how important it is to fight back against calls to cut Social Security, and instead, come together in a bipartisan way to make commonsense adjustments to strengthen Americans insurance plan and protect the benefits Americans have earned and rely on. Both the Chairman and I have offered comprehensive plans to address the long-term shortfall in the Social Security system so Americans can continue to count on these benefits, whether they become disabled or retired or they should die prematurely, leaving their young children behind.

By offering—while differing in our approaches, I hope we will be able to have a hearing. I keep on plugging for a hearing in Plano, Texas, with our distinguished Chairman, but anywhere in the country where we will have an opportunity to let the Congress work its will. Let the vitality of ideas come forward. We both share the same goals, we just have a different path of getting there.

But today's hearing is focused on a problem of record-high delays in processing disability applications. This is just simply unacceptable, and deplorable, at its very core, of what everyday average citizens in this country have to endure. As the Chairman pointed out, more than 600 days? It is unconscionable.

Since 2010, the number of beneficiaries, though, has grown by 13 percent as baby boomers reach retirement age, and especially as we saw after the Great Recession, a number of people who lost jobs and are scrambling for their positions. Social Security operating budget in this same period of time has fallen by more than 10 percent, after accounting for inflation. This has made it difficult, if not impossible, for Social Security to serve our constituents promptly when they need help the most. And that is where I think that money does matter, and that money in these budgets, so that we can get the front-line people who can handle these.

We have had many discussions about technology and there has been technological advances, but not on the grand scale that we need to address this, and nothing on a scale that will assist us in a way that that caseworker can—who can deal with an individual personally, like what these people are currently enduring and suffering through in Houston.

There are delays throughout the Social Security Administration. Today's hearing is focused on the lengthy waits, and the Chairman went over this, the administrative law judge who can decide on disability benefits appeal. These hearings are important. And for the first time, an applicant can get to meet face to face with an examiner, in many instances, these hearings are the first time the Social Security administrator has an applicant's complete medical evidence in hand, and the applicant can seek help from an attorney or a professional, which is important, given how complex the law is in this area.

But so far this year, the wait, as the Chairman underscored, is 600 days. I have several constituents in my district, and I am so glad that Ms. Ekman is here today, and we are going to get to hear from her. But when you find that people are committing suicide; when you find that, in many cases, they lose their homes; when you look at what happens to them mentally, and I am talking about people that have served in our armed services who have post-traumatic stress, who then find that their greatest post traumatic stress becomes dealing with the Social Security system that is there to help them.

And so, it is unconscionable that this goes on, and we have to solve this problem on behalf of the citizens we are sworn to serve, by correcting and making sure that America's primary insurance program for its citizens is there to provide them relief on a timely basis. I say "insurance program" because that is what it is. Citizens have contributed to this program. They deserve the best, as the

Chairman underscored in his remarks, from this Committee. I am looking forward to the testimony today. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. As is customary, any Member is welcome to submit a statement for the hearing record. And before we move on to our testimony today, I want to remind our witnesses to please limit your oral statements to 5 minutes. However, without objection, all of the written testimony will be made part of the hearing record. We have 5 witnesses today, and seated at the table are: Bea Disman, Acting Chief of Staff, Social Security Administration; Kathryn Larin, Director of Education, Workforce, and Income Security Issues, Government Accountability Office; Elizabeth McLaren, Bureau Chief, Iowa Disability Determination Services, on behalf of the National Council of Disability Determination Directors; Marilyn Zahm, President, Association of Administrative Law Judges; and Lisa Ekman, Director of Government Affairs, National Organization of Social Security Claimants' Representatives, on behalf of the Social Security Task Force Consortium for Citizens with Disabilities.

Ms. Disman, welcome. Thank you for being here, and please proceed.

**STATEMENT OF BEA DISMAN, ACTING CHIEF OF STAFF,
SOCIAL SECURITY ADMINISTRATION**

Ms. DISMAN. Thank you, Chairman. Chairman Johnson and Ranking Member Larson, and Members of the Subcommittee, I am Bea Disman, Acting Chief of Staff for the Social Security Administration. Before I begin, on behalf of the Social Security—

Mr. LARSON. Is your mic on, ma'am?

Ms. DISMAN. Yes. Before I begin, on behalf of the Social Security Administration, our thoughts are with those affected by the devastation in Texas and parts of Louisiana by Hurricane Harvey. We know Chairman Brady's district in Houston is especially affected by the storm, and that districts across Texas, like Chairman Johnson's, are providing disaster relief services.

Even though some of our field offices were closed, as Mr. Larson said, we were on-site with FEMA over the weekend at three sites in Texas, and two in Louisiana, where Social Security and Supplemental Security Income beneficiaries could request immediate payment in person if they did not receive their regular payment. We will continue to be on-site in three locations in Texas this whole week. And all but two of our field offices in Texas have opened again.

Thank you for inviting me to discuss how we are taking a systematic approach to modernize our disability policies and processes. We appreciate the Subcommittee for its ongoing oversight of the disability programs and your recommendations. With over 50 years of experience at Social Security, I can assure you that we are committed to serving the public effectively and compassionately, and to preserving the integrity of the Social Security programs. We are mission-focused, mission-driven, in developing disability policy and processes.

The Social Security Act defines disability as the inability to engage in any substantial gainful activity due to a medically determinable physical or mental impairment that is expected to last at

least 1 year or result in death. While this definition provides the statutory foundation of our Social Security disability insurance, and SSI income processes, our management of the program is also informed by both technology and policy advances.

Changes in healthcare delivery require us to rethink our use of medical source information and its supportability and consistency. With that in mind, the policy updates and revisions we have recently made establish the foundation for an integrated systematic approach to disability decisionmaking. For example, we have revised most of our listings of impairment criteria. After we finish the updates in fiscal year 2018, we will then update the listings on a flow basis using a 3- to 5-year update cycle. We have the expertise in place to meet this objective. We are developing an occupational information system that will be the primary source of occupational information used in disability adjudication.

We are committed to providing accurate, high-quality policy research in support of this initiative. And we have been working with the Bureau of Labor Statistics, which has been collecting data for us since 2015. We plan to implement this occupational information system in 2020, with the introduction of a vocational income tool that adjudicators will use to decide claims.

In January 2016, we developed our plan to improve hearing workloads and service delivery. We updated this plan in August of 2017 to meet our changing needs. We greatly appreciate the \$90 million anomaly funding that Congress has provided. The plan will permit us to enhance our business efficiencies, such as expanding our prehearing conferences. It will also allow us to increase our adjudicator capacity by hiring additional ALJs, decision writers, and other support staff. The plan also supports technological investments in our hearings process, such as using natural language processing to improve the quality of our decisions.

The quality of our decisions has always been a paramount concern to us. To this end, we are establishing the Office of Analytics, Review, and Oversight, which will improve coordination on the oversight of the disability adjudication process. This new office centralizes all agency offices that analyze data in our disability programs and conduct quality reviews of our DDS and hearings process.

We appreciate GAO's work in assessing our Compassionate Allowances, or CAL program. CAL delivers faster services by making policy compliant benefit decisions quickly to eligible individuals with the most serious disabilities. We are working to incorporate their recommendation to strengthen the CAL program. For example, we have updated our CAL website to be more transparent, and to include useful information for advocates to submit CAL conditions.

CAL will be the focus of our November National Disability Forum. We are looking forward to holding our outreach meetings again, with an eye to improving how we communicate about our CAL policies and updates. We are enhancing our internal processes as well as developing and updating CAL conditions, including the development of enhancements that would give us more flexibility to the program.

Thank you for your interest in discussing disability with us. SSA disability programs serve the most vulnerable segments of our society. Moving forward, we are and will continue to be mission-driven, mission-focused, as we serve the millions of individuals who need our help. We look forward to continuing to work with you and the Subcommittee.

[The prepared statement of Ms. Disman follows:]



**COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY
U.S. HOUSE OF REPRESENTATIVES**

September 6, 2017

STATEMENT FOR THE RECORD

**BEA DISMAN
ACTING CHIEF OF STAFF
SOCIAL SECURITY ADMINISTRATION**

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

Thank you for inviting me to discuss our administration of the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. I am Bea Dismar, acting Chief of Staff for the Social Security Administration (SSA) for the last seven months. For nearly 20 years, I served as the Regional Commissioner for our New York Region, working closely with State Disability Determination Services (DDS), and SSA's regional hearing offices. Prior to that, I served for over seven years as that region's director of program and integrity review. My first job at SSA was on the front line and included taking disability claims applications from members of the public.

We appreciate the Subcommittee's ongoing oversight of the disability programs, and input on possible regulatory changes, hiring, and backlog reduction. In addition to providing an overview of our disability decision framework and disability adjudication process, I am pleased to provide an update on recent efforts we have made to modernize our disability criteria and expedite decisionmaking, including our recent efforts to reduce the hearings backlog.

Background

Few government agencies touch the lives of as many people as we do. Social Security pays monthly benefits to approximately 61 million individuals. During fiscal year (FY) 2017, we expect to pay about \$935 billion to Social Security beneficiaries. In addition, in FY 2017, we expect to pay over \$54 billion in Federal benefits to an average of approximately 8 million SSI recipients. We continue to be mission-focused and mission-driven as we serve millions of beneficiaries, applicants, and other Americans who need services from us.

The Social Security Act (Act) provides for benefits to persons with disabling physical and mental impairments under the SSDI and SSI programs. SSDI provides benefits to workers who meet the Act's disability criteria, and to their dependents and survivors. On average, we pay SSDI benefits each month to approximately nine million workers with disabilities and two million of their dependents. Workers become insured for SSDI based on contributions to the Social Security trust funds through taxes on wages and self-employment income.

The SSI program provides monthly payments to people with limited income and resources who are aged, blind, or disabled. Adults and children under age 18 can receive payments based on disability or blindness. On a monthly average, we pay approximately six million blind and disabled adults and over one million blind and disabled children SSI benefits. General tax revenues fund the SSI program.

Evaluating Disability Claims and Recent Improvements to Our Disability Rules

Statutory Framework

The same statutory definition of disability is used to determine whether an adult is disabled under SSDI or SSI. The Act defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can result in death or has lasted or, can be expected to last for a continuous period of not less than 12 months. In making this determination, 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 significant numbers in the national economy.¹

To carry out this statutory definition, we have established regulations that, among other things, describe: (1) how we evaluate medical evidence; (2) medical conditions that we consider severe enough to prevent work; and (3) how we assess whether an adult can perform other work that exists in the national economy. Below, we describe the basic framework for adjudicating disability, as well as the important steps we have taken in recent years to modernize our regulatory criteria.

Regulatory Framework for Decisionmaking

For SSDI and SSI, we evaluate adult claimants using the following five-step sequential evaluation process:

Step one: We consider a claimant's work activity. We deny the claim if the claimant is doing "substantial gainful activity," or SGA (i.e., a certain level of wages or self-employment income). This year, earnings of \$1,170 in a month are generally considered SGA.²

Step two: We consider the medical severity of a claimant's impairment. We deny the claim if the claimant does not have a severe medically determinable physical or mental impairment (or combination thereof) that meets the statutory duration requirement.

Step three (Listing of Impairments): We consider whether the claimant has a severe impairment(s) that meets or medically equals a listing in the Listing of Impairments (listings), and meets the durational requirement, under our regulations. The Listing of Impairments describes for each major body system, impairments that we consider to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience. We find the claimant disabled if his or her impairment meets all of the criteria in one of the listings, or is medically equivalent in severity to a listing. A claimant whose impairment(s) does not meet or equal a listing may still be disabled.

Residual functional capacity (RFC): A claimant whose impairment(s) does not meet or medically equal a listing may still be disabled, because we must consider whether a claimant has the physical and mental capacity to perform his or her previous work or perform other work that exists in significant numbers in the national economy. Consequently, we assess what the claimant can still do despite his or her physical and mental impairments.

Step four: We consider whether a claimant can still perform past relevant work in light of his or her RFC. We deny the claim if the claimant can perform his or her past relevant work.

¹ The *Social Security Amendments of 1972* created the SSI disability program for children under age 18, using a definition of disability that was based on "comparable severity" to an impairment that would be disabling for an adult. The *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* amended the Act to create a separate definition of disability for children seeking SSI. To qualify for SSI disability benefits, a child must have a physical or mental condition that results in marked and severe functional limitations. This condition must have lasted, or be expected to last, at least one year or result in death. My testimony will focus only on the definition of disability for SSDI workers and SSI adults.

² This figure is for individuals who are not blind. For individuals who are blind, the SGA amount is \$1,950.

Step five: We consider our assessment of the claimant's RFC and the claimant's age, education, and work experience to determine whether he or she could perform other work that exists in significant numbers in the national economy. We deny the claim if the claimant could do so.

Keeping Disability Policy Current

We are dedicated to preserving the soundness of our disability programs, and our stewardship responsibilities make up-to-date policy a top priority. To that end, we strive to keep our rules and policies aligned with contemporary medicine, healthcare, and new technology, and to ensure policy decisions are evidence-based. We develop, in consultation with medical and other experts, new medical policies for the administration of the SSDI and SSI programs. These policy revisions reflect our adjudicative experience, advances in medical knowledge and treatment of disorders, recommendations from medical experts, and comments we receive.

Last year, we updated four listings and revised the way we evaluate treating source opinions. These changes were significant steps that aligned our disability programs more closely with contemporary healthcare. I will briefly describe those steps, and then discuss our efforts to revise our vocational criteria.

Updated Listings

We have taken significant steps in recent years to comprehensively update our Listing of Impairments for nearly all body systems. Between February 2013 and September 2016, we published 12 final rules that updated 11 of our 15 body systems listings. For instance, in 2016, we updated the listings for Neurological Disorders (prior comprehensive update, 1986), Mental Disorders (prior comprehensive update, 1985), and Respiratory Disorders (prior comprehensive update, 1993). We are currently working on completing the remaining comprehensive listings updates, including the Musculoskeletal System (prior comprehensive update, 1985 and minor updates, 2002).

When updating the listings for a body system, we consider current medical literature, information from medical experts, disability adjudicator feedback, public comments, and research by organizations such as the National Academies of Sciences, Engineering, and Medicine. Our objective is to revise the listings' criteria on an ongoing basis, using a three to five-year update cycle. We believe we now have a process, the staff, and expertise needed to meet this objective.

Evaluating Treating Source Opinion

In addition to updating our medical criteria in the listings, we have modernized our rules regarding how we evaluate medical evidence to reflect current healthcare delivery practices in this country—including how we consider opinions regarding a claimant's limitations offered by treating physicians.³ Under rules adopted in 1991, we established the "treating source" rule, which provided that a treating physician's opinion about the nature and severity of a claimant's impairment is entitled to "controlling weight" if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case. However, in the intervening years, the rule came under increasing scrutiny, as it was perceived to be outdated; eliminating or modifying the treating

³ Final rules, *Revisions to Rules Regarding the Evaluation of Medical Evidence*, 82 Fed. Reg. 5844 (Jan. 18, 2017).

source rule was considered to be a way to enhance the disability program's integrity and to prevent potential fraud. Further, a report by the Administrative Conference of the United States (ACUS) called into question whether controlling weight deference should be afforded to medical practitioners given changes in healthcare delivery. In our recently issued final rules, we stated that we are not retaining the treating source rule because:

the healthcare delivery system has changed in significant ways that require us to revise our policies in order to reflect this reality. Many individuals receive health care from multiple sources, such as from coordinated and managed care organizations, instead of from one treating [source]. These individuals less frequently develop a sustained relationship with one treating physician. ... [Instead], [t]he extent to which a medical source's opinion is supported by relevant objective medical evidence and the source's supporting explanation—supportability—and the extent to which the opinion is consistent with the evidence from other medical sources and nonmedical sources in the claim—consistency—are also more objective measures that will foster the fairness and efficiency in our administrative process that these rules are designed to ensure.

Occupational Information System and the Medical-Vocational Guidelines

We are also progressing deliberately on modernizing the occupational information we use to evaluate claims under steps four and five of our sequential evaluation process. Our main source of occupational information, the *Dictionary of Occupational Titles*, was last updated by the Department of Labor, (DOL) in 1991, and dates back to 1938. To ensure our decisions remain accurate, we are developing a new Occupational Information System (OIS) that will be the primary source of occupational information used in our disability adjudication process. We are working closely with the DOL's Bureau of Labor Statistics (BLS) and will have our first complete set of occupational data in 2019 after BLS completes its third year of data collection. We plan to implement the OIS in 2020 with the introduction of a Vocational Information Tool that adjudicators will use to decide claims. Working with us, BLS will immediately begin a new data collection cycle that will allow us to update the OIS at regular five-year intervals.

Parallel to our efforts to develop the OIS, we are working on updating our Medical-Vocational Guidelines, which were issued in 1978. At step five of our sequential evaluation process, we evaluate an individual's ability to adjust to other work that exists in the national economy. The Medical-Vocational Guidelines are a crosswalk used by adjudicators when considering an individual's RFC in relation to age, education, work experience, and work that exists in the national economy. We are currently considering potential evidence-based approaches to updating these guidelines to ensure we remain current with changes in medical and vocational practice, technology, and the workforce. We are closely coordinating any potential changes to how we consider vocational efforts with our development of the OIS.

Adjudicating Disability Claims and Steps We Are Taking to Decide Claims More Timely

In most cases, we decide claims for benefits using an administrative review process that consists of four levels: (1) initial determination; (2) reconsideration; (3) hearing; and (4) Appeals Council review. I will briefly describe each level of this process, as well as our efforts and proposals to improve our timeliness in deciding claims.

Initial Determination Level

At the initial determination level, claims are filed with us in field offices, over the phone, or via the Internet. Some claims may be denied for technical reasons—for instance, if a claimant is working and earning above SGA, or if a SSDI claimant is not fully insured to receive benefits. However, under the Act, most cases are sent to a State DDS, which is responsible for developing all medical evidence and initially determining whether a claimant meets our definition of disability. Nationwide, we expect to receive approximately 2.5 million initial disability applications in FY 2017. This is a decline from the level of applications we received in FY 2016 (approximately 2.6 million) and FY 2015 (over 2.7 million).

Generally, the disability examiner works with a medical or psychological consultant, or both, to determine whether the claimant is disabled. When deciding the claim, the disability examiner and medical or psychological consultant must consider all of the evidence in the file, both medical and vocational, to make a determination.⁴ For the past several years, the DDSs have allowed approximately 33 percent of the claims decided that year at the initial level. Our adjudicative teams that make disability determinations for us are highly accurate. Through July of this year, the performance accuracy rate of our initial level determinations for FY 2017 was 95 percent.⁵

We have developed several important programs to help expedite processing times, including for our most vulnerable claimants. For example, we established the Compassionate Allowance (CAL) process to quickly identify (through an automated process) and prioritize medical conditions that invariably qualify for disability under our rules. In addition, individual adjudicators also can flag an individual for CAL processing when the automated process does not identify the case. The CAL process helps deliver our services by making benefit decisions, often within days, to eligible individuals with the most serious disabilities. We currently have 225 CAL conditions, including certain cancers.

Today, we are also announcing that we have identified and vetted three new CAL conditions, and we are ready to proceed with their inclusion in our disability processing. Effective September 16, applicants afflicted with Congenital Myotonic Dystrophy, Vanishing White Matter Disease, also known as Childhood Ataxia with Central Nervous System Hypomyelination (CACH), and Kleefstra Syndrome will be quickly identified for CAL expedited review.

We maintain a public website explaining our CAL process. We are updating it to make it easier to suggest potential CAL conditions. It will also include information about our renewed outreach efforts and systematic details about how the CAL process works. We are also revising our communication plan to promote public engagement with this program. We appreciate the Government Accountability Office's (GAO) work in this area and their recommendations on how we can strengthen the CAL process.

⁴ In some States, experienced disability examiners, known as single decisionmakers, may make certain disability determinations alone under our current rules authorizing us to test, individually or in any combination, certain modifications to the disability determination procedures. However, under section 832 of the *Bipartisan Budget Act of 2015* (BBA), we are required to end the single decisionmaker test. In light of this recent legislation, we are in the process of requiring that an MC or PC review the medical portion of a DDS-level disability claim. We have phased in this requirement in over half of the States that used single decisionmakers, and we expect to complete this requirement by the end of FY 2018.

⁵ There are several reasons why a later appeal of a claim denied at the initial level may result in an allowance. For instance, a claimant's condition may worsen over time. Furthermore, a claimant may submit new medical evidence at the reconsideration or hearing level that was not previously available.

In addition to the CAL process, 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. Both of these programs have helped us better serve people who are so severely disabled and clearly meet our disability definition.

We are modernizing how we will collect medical evidence and will provide greater analytical tools for our adjudicators (at all levels). For instance, currently we gather most of our evidence by manually requesting it from providers. We are in the process of expanding the amount of electronic medical evidence we receive through computer-generated requests to expedite the receipt of the evidence and the processing of claims. Further, most of the evidence we currently gather is stored in fixed images (such as Tagged Image File Format (TIFF)), which is time consuming to process, review, and analyze. As we said above, we are planning to obtain additional evidence in a format that allows greater decision support, predictive analytics, and machine learning.

We created the National Disability Policy Cadre (NDPC) in the fall of 2015, consisting of DDS and Federal subject matter experts to address operational challenges associated with policy changes. NDPC input has helped with making disability policy more clear and concise, allowing us to strengthen the disability program and improve our service to the public.

These programs complement other recent initiatives to streamline the disability claims process. For example, we require our DDS examiners to use the Electronic Claims Analysis Tool (eCAT). 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.

Moreover, as required by the Act, we perform reviews of at least 50 percent of all DDS initial and reconsideration allowances for DI claimants before payment effectuation is made. These reviews, which we call preeffectuation reviews, allow us to correct errors we find before we issue a final decision, and to provide instructional feedback to our DDS adjudicators. These reviews help ensure consistency at all levels of the process.

We also created the National Disability Quality Cadre (NDQC) in the fall of 2016, consisting of DDS and Federal subject matter experts to identify methods to sustain and improve DDS quality. The NDQC focuses on quality reviews and identifying training needs based on data trend analysis, in an effort to identify problem areas before the DDS makes the final determination.

Certainly, our disability beneficiaries comprise one of the most vulnerable segments of our society. We remain committed to finding ways to serve them compassionately, while maintaining the trust of the American taxpayer.

Reconsideration Level

In most States, a claimant who is dissatisfied with our initial determination may request a reconsideration. However, many claimants denied at the initial level may choose not to appeal; in calendar year 2013, approximately 51 percent of claims denied at the initial level were appealed. A reconsideration involves a thorough review by a different examiner of all evidence from the initial determination and any new evidence provided at the reconsideration level. Nationwide, we expect to complete approximately 581,000 disability reconsiderations in FY 2017. In recent years, the DDSs have allowed approximately

12 percent of disability claims at the reconsideration level; in FY 2016, almost 77,000 individuals were allowed at the reconsideration step.

We are exploring potential proposals that could enhance the reconsideration level. Since 1999, ten States have participated in a pilot project that does not have a reconsideration level.⁶ In those States, an appeal of an initial determination goes directly to a hearing before an administrative law judge. The President's FY 2018 Budget request includes a proposal to reinstate reconsideration in those 10 States, which we also expect to alleviate the hearings backlog. This will bring these States back into conformity with the practices used in the rest of the country. The President's FY 2018 Budget also proposes, through a possible demonstration, an enhanced disability determination screening process; the intent of such demonstration would be to evaluate ways to possibly increase adjudicative consistency at each level of appeal and also to reduce the future hearing backlog.

Hearing and Appeals Council (AC) Review Levels

A claimant who is dissatisfied with our reconsideration determination may seek a hearing, which is held by an administrative law judge (ALJ). In FY 2017, we estimate we will receive approximately 632,000 requests for an ALJ hearing. However, in total, more than 1 million people are waiting for a decision on their hearing request, and the average wait time for a hearing decision in FY 2017 is currently around 600 days. Below is a description of the hearings process, but later in my testimony I outline our plan to reduce the number of pending hearings and the average wait time for a hearing decision.

The ALJ reviews a disability case *de novo*, including evaluating evidence that was not available to prior adjudicators. Generally, an ALJ will hold a hearing, at which the claimant may elect to appear in-person or consent to appear via video. Currently, approximately 30 percent of claimants opt to appear via video. The claimant may appoint a representative who may submit evidence and arguments on the claimant's behalf.⁷ The ALJ may call vocational and medical experts to offer opinion evidence, and the claimant or the claimant's representative may question these witnesses. Once the record is complete, the ALJ considers all of the evidence in the record and makes a decision.

A claimant may appeal an ALJ decision to the AC. The AC will grant review under certain circumstances specified in our regulations. After granting review, the AC may uphold part of the ALJ's decision, reverse all or part of the ALJ's decision, issue its own decision, remand the case to an ALJ, or dismiss the original hearing request. Finally, a claimant who completes our administrative review process and is dissatisfied with our final decision may seek judicial review of that final decision in Federal district court.

Currently, we have more than 1,600 ALJs on duty. We hire ALJs through a process established by the Office of Personnel Management, which administers the ALJ examination through which agencies make competitive service appointments of ALJs.

We have taken a number of steps to improve the efficiency and timeliness of our hearings process. For example, in December 2016, we published final rules that create nationally uniform

⁶ The following 10 States are currently without the reconsideration level of appeal: Alaska, Alabama, Colorado, Massachusetts, Michigan, Missouri, New Hampshire, New York, Pennsylvania and 2 California DDS offices.

⁷ A claimant may appoint a representative prior to the hearing level as well.

hearing and Appeals Council procedures. Under the rules, we provide claimants with a 75-day advance notice of the hearing, which provides claimants more time to obtain updated medical and other records before the date of the hearing. We coupled that 75-day advance notice with a requirement that generally requires claimants to submit written evidence at least five business days before a hearing. The changes we made in these rules, coupled with rules changes we made in 2015 that require claimants to inform us about or submit all evidence known to the claimant that relates to his or her disability claim, make our hearings process more efficient and effective. We expect that they will reduce the number of hearings that we need to reschedule or postpone.

The quality of our decisions is a paramount concern for us. It is our obligation to provide every person who comes before our agency – regardless of where they live – a timely, legally sound, policy-compliant decision. We took aggressive steps to institute a more balanced quality review in the hearings and appeals process.

For example, we created better tools to provide individual feedback for our adjudicators. One such feedback tool is "How MI Doing?" This resource not only gives ALJs 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 have developed training modules related to the most common reasons for remand that are linked to the "How MI Doing?" tool. ALJs are able to receive immediate training at their desks that is targeted to the specific reasons for the remand.

We also established several enhanced quality review initiatives. For example, we perform post-effectuation focused reviews of sampled ALJ decisions that look at specific issues. Subjects of a focused review may be hearing offices, ALJs, representatives, doctors, and other participants in the hearing process. 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. These reviews, though, help us identify the most error-prone provisions of law and regulation, which allows us to design and implement our ALJ training efforts.

We believe these steps have made an impact. The number of ALJs with extremely high and low allowance rates has dropped. While we do not set target allowance rates for our ALJs and always emphasize that an ALJ's allowance rate is not a proxy measurement of his or her policy compliance, we nonetheless believe that this phenomenon is a likely indicator of better, more standardized decision-making in our hearings process.

Most of our employees who receive feedback through tools like "How MI Doing?" welcome the opportunity to improve their skills. The vast majority of our ALJ corps is conscientious and thorough. That said, there have been some recent cases in which we hired an ALJ, and it later became clear the individual would be unsuccessful at the job. The President's FY 2018 Budget request includes mention of a proposal that would amend the Administrative Procedure Act to create a probationary period for newly hired ALJs. We are working with our colleagues at OPM to formulate the details of this proposal, and how it would impact our ALJ workforce.

Hearings Workload and CARES Service Delivery

Today, more than 1 million people are waiting for a decision on their hearing request, and the average wait time for a hearing decision in FY 2017 is currently around 600 days. To reduce the backlog, in January 2016 we developed our Plan for Compassionate and Responsive Service (CARES), which outlines business process, decisional capacity, and information technology (IT) improvements that we expect will reduce the average wait time for a hearing decision and allow us to achieve a reasonable

number of pending cases. Our CARES plan is a flexible, living document, which we recently updated in August 2017 to incorporate additional initiatives to address the backlog more aggressively. We appreciate the anomaly funding of \$90 million that Congress provided to aid us in reducing the backlog. I believe our initiatives with this funding will help us toward our goal of having a reasonable number of hearings pending. Due in part to additional ALJs, along with recent declines in hearings receipts, we are seeing initial signs of progress, as the total number of hearings pending has decreased in the last seven months. However, we recognize that reducing the hearings backlog will be a long-term challenge for the agency and that we will need to continue to refine and improve our efforts.

A complete copy of the CARES Plan is attached as Appendix A. However, I would briefly like to discuss our plans for the \$90 million anomaly funding, as well as some of our initiatives. We dedicated \$70 million of the \$90 million in anomaly funding to increasing our decisional capacity, which we are doing by hiring more ALJs and support staff while providing current staff with extra overtime hours to process critical workloads. Dedicating \$70 million of the anomaly funding to additional hiring will also allow us to rededicate staff to many of our most promising initiatives that are designed to make our business process more efficient. We plan to spend the remaining \$20 million on additional key IT projects that regular funding alone did not support.

Our updated CARES plan rests on three elements: 1) business process efficiencies; 2) increased decisional capacity; and 3) IT innovation and investments.

Business Process Efficiencies

We continue to look for opportunities to make the hearings and appeals process more efficient while ensuring decisional quality. We are also looking at ways to streamline our processes, eliminate duplication of efforts, and efficiently utilize our limited resources to provide better and faster service to the public. Our revised CARES plan includes 14 initiatives to improve business process efficiencies. Two of these initiatives are:

Pre-Hearing Conferences. We conduct pre-hearing conferences as a way to communicate with claimants to ensure they are prepared for their hearing. For this initiative, we focused on conducting pre-hearing conferences with unrepresented claimants beginning in FY 2015. Through this initiative, we aimed to reduce hearing postponements for unrepresented claimants

National-Based First-In First-Out (FIFO) initiative. This initiative involves sharing resources across the country and matching up resource availability to prioritize cases that have been waiting the longest. Through this initiative, we will pool available resources to help balance workloads and accommodate staffing shortages across offices.

Increased Decisional Capacity

We continue to advance our efforts to increase our decisional capacity through hiring strategies, while at the same time maximizing current staffing levels in order to address our wait times and backlog. In addition to ensuring the appropriate number of adjudicators, we are augmenting the size of our decision writing corps and other support staff to address and prevent bottlenecks in pre-hearing case preparation duties and decision writing. In addition, we are looking at ways to streamline the decision writing process, as well as strategies to increase productivity. We currently have eight initiatives to increase decisional capacity. Two of these initiatives are:

ALJ Hiring. We have hired almost 500 new ALJs since FY 2015 and now have more than 1,600 ALJs on duty. To reduce the backlog significantly, we will need to increase our decisional capacity even further. We hired 31 ALJs this year and we are planning to hire additional ALJs later this year. We currently project a need for an additional 300 ALJs by the end of FY 2019 to meet our backlog reduction goals.

FY 2017 Support Staff Hiring. We need to hire support staff employees to ensure that we can both prepare cases for hearing and draft ALJ decisions in a thorough and timely manner. We are currently in the process of hiring over 600 support staff for our hearings operation, including legal assistants and decision writers, so we can adequately support our ALJs and resume several CARES initiatives that we have paused. We plan to hire about 370 decision writers in FY 2017, to address delays in decision writing. Once our FY 2017 decision writers become fully productive, we expect them to begin to produce 80,000 decisions annually. We will also increase our decision-writing capacity by having headquarters, regional, management, and quality review staff with decision writing experience assist temporarily with the writing backlog. We expect to increase decisions written, leading to overall increase in dispositions using an all hands on deck approach by temporarily redeploying other staff, such as management and quality review staff, to assist in decision writing.

Information Technology Innovations and Investments

We designed our technology investments to provide faster, streamlined, and more efficient IT tools for our employees, external stakeholders, and the public. Specifically, we designed our IT improvements to help to remove inefficiencies in our case processing systems, drive policy-compliance and consistency across offices, and provide self-service options that allow us to provide customer choice and redirect staff away from manual workloads. We will measure the success of any IT investment we make in the hearings and appeals process by the extent to which that investment helps to reduce the wait time for the public and eliminate the number of backlogged cases. We have five initiatives under this category. Two of them are:

Duplicate Identifying Software. This is a CARES initiative, and will be supported by special anomaly funding. We will develop and pilot software that uses artificial intelligence technologies to automatically scan case files, identify duplicate medical evidence, currently a time-consuming manual task. We are piloting this software in three sites, Mobile, Alabama; Reno, Nevada; and Albany, New York. Assuming the pilot is successful, we would expect broader implementation to increase efficiency and decrease average wait times.

Expand Video Hearings Capacity. In FY 2016, we began replacing or upgrading old video hearing equipment and implemented a schedule to replace or upgrade equipment annually. In FY 2017, we made improvements and acquisitions for video hearing equipment, increasing our capacity to hold video hearings by adding over 200 additional units. We are also working with other agencies to use available hearing room space in their sites. We are implementing marketing efforts to promote Representative Video Project use, in which claimants can attend video hearings in their representatives' offices using special equipment.

In addition to the initiatives listed above and in our CARES plan, we are also exploring potential regulatory and other changes that would enhance our ability to manage the hearings process and deliver more timely hearings. For instance, we are exploring how we can expand the number of hearings we conduct by video, which we can offer more quickly to claimants.

Program Integrity

We have a number of program integrity and other initiatives to help ensure we are paying benefits to the right individuals. These activities include our continuing disability reviews and our Cooperative Disability Investigations (CDI) program. We periodically conduct continuing disability reviews (CDRs) to ensure we continue to pay benefits only to those who remain qualified to receive them. We estimate that the CDRs conducted in next fiscal year will yield net Federal program savings over the next ten years of roughly \$8 on average per \$1 budgeted for dedicated program integrity funding, including OASDI, SSI, Medicare, and Medicaid effects.

Our Cooperative Disability Investigations (CDI) program is a key anti-fraud initiative that prevents benefit payments from being made in cases involving fraud. CDI units consist of personnel from SSA, OIG, State DDSs, and state/local law enforcement, who review initial disability claims and post-entitlement activities when our front-line employees suspect possible fraud. CDI units obtain evidence of material fact to resolve questions of fraud.

Quality, Anti-Fraud, and Data Analytics

Our goal is to deliver more timely service to claimants using updated disability rules, while we remain committed to improving the quality of our decisions. I will provide a brief overview of our historical quality efforts, including recent efforts to improve the use of data analytics, as well as a recent organizational change that we believe will streamline and rapidly improve our oversight of the disability decision-making process.

Historically, we have established processes that provide information on, and work to improve, the quality of our decisions, and these efforts occur at all of our adjudication levels. For example, as explained earlier, we perform a review of at least 50 percent of all DDS initial and reconsideration allowances for DI claimants before payment is made. Conducted by our Office of Quality Review (OQR), these preeffectuation reviews allow us to correct errors we find before we issue a final decision, and to provide instructional feedback to our DDS adjudicators. Additionally, OQR uses a number of other types of quality reviews that monitor the accuracy of DDS decisions. We have a number of quality efforts relating to hearings decisions as well. For instance, a division within our Appeals Council conducts preeffectuation reviews on a random sample of ALJ allowances. Additionally, we perform posteffectuation, focused reviews looking at specific issues that help inform our training needs and potential policy changes.

More recently, we have begun incorporating the use of data analytics into our quality and antifraud efforts. For instance, one initiative under our revised CARES plan is expanding the use of a natural language quality assurance tool (called "Insight") to scan draft ALJ decisions for language that could result in error. We expect to see improvements in quality by ensuring legally sufficient draft decisions that will decrease the number of remanded decisions to the hearing level. Additionally, we are incorporating data analytics and employing technology to root out disability fraud. Earlier this year, we testified at a hearing before this Subcommittee that we are in the initial stages of implementing the Anti-Fraud Enterprise Solution (AFES), which relies on software, data, and technology to more accurately identify and take action on more difficult-to-identify high-risk transactions across our programs and processes, including in our disability program. Notably, in disability cases, we anticipate that AFES will help the agency identify fraudulent transactions before payments are made.

While we have achieved success through these quality and other efforts, these efforts are led in offices that are spread across our agency. Consequently, Acting Commissioner Nancy Berryhill announced a

recent organizational change at SSA that will enhance our continued efforts to modernize the disability programs. Effective October 1, we will have a new Deputy Commissioner-level organization – the Office of Analytics, Review, and Oversight. This organization will combine all agency offices that, among other things, are dedicated to institutionalizing and fostering data analysis in all of our disability programs, and improving coordination on the oversight of the disability adjudication system. For the first time, the offices that conduct quality reviews and other oversight of our DDS and hearings process, including OQR and the AC, will be contained within one Deputy Commissioner-level organization.

Conclusion

Our disability programs serve the American public by providing a vital safety net for those who are some of the most vulnerable members of society. We are firmly committed to the development of sound management practices like the ones we have discussed today. Moving forward, we will continue to be mission-focused and mission-driven as we serve the millions of beneficiaries and applicants with disabilities who need our help. We look forward to continuing to work with you and your subcommittee.



Chairman JOHNSON. Thank you, ma'am. Ms. Larin, you are recognized.

STATEMENT OF KATHRYN LARIN, DIRECTOR OF EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. LARIN. Chairman Johnson, Ranking Member Larson, and Members of the Committee, I am pleased to be here today to discuss GAO's report on the Social Security Administration's Compassionate Allowance initiative. This initiative, known as CAL, expedites the processing of disability claims for those with certain conditions, a process that could otherwise take months. While CAL has been effective in fast-tracking eligibility determinations for some applicants, questions have been raised about how the initiative has been implemented. Specifically, my remarks today will focus on three issues: how SSA identifies conditions for inclusion on the CAL list; how claims are designated for expedited processing under CAL; and how SSA ensures the accuracy and consistency of CAL decisions.

First, on identifying conditions for inclusion on the CAL list. We found that SSA lacks a formal and systematic approach for identifying CAL conditions. Since the CAL initiative began in 2008, the number of conditions included has grown from 50 to 228. Some conditions were added to the original list following a series of public hearings. But since 2011, SSA has relied primarily on advocates for certain diseases and disorders to bring conditions to its attention.

However, SSA has not provided guidance on its web page on how to make suggestions. It has not consistently communicated with those who suggested additions about the status of their recommendations. And has not conducted outreach efforts to help ensure that all advocates are aware of the initiative.

Relatedly, SSA does not have clear or consistent criteria that it uses to determine whether to designate a condition as CAL. As a result, SSA may be overlooking conditions that may be appropriate for inclusion.

Turning now to how claims are designated as CAL. We found that SSA's procedures do not ensure that all claims are accurately identified for CAL processing. SSA relies primarily on selection software that uses a word search of the impairment description to determine whether the claim refers to a CAL condition. But when the text provided by claimants is ambiguous, incomplete, or inaccurate, the software won't catch the condition as a CAL condition.

For example, we found that the software accurately flagged stage 4 lung cancer as advanced staged lung cancer, a CAL condition, but it did not flag a claim where the claimant described their condition as lung cancer terminal. Disability examiners have the opportunity to ensure that claims are correctly designated as CAL, even when the software makes errors, by manually changing a flag. But we found that staff vary in when or whether they add or remove CAL status from disability claims.

SSA does not have clear guidance on when to change CAL designations. And we found that some examiners didn't understand the importance of making such changes. For example, we found

that in 2016, over half of all disability offices did not manually add more than a single CAL designation to a claim.

Finally, on the accuracy and consistency of CAL decisions. We found that SSA uses detailed condition descriptions known as impairment summaries as a key tool to ensure accurate claims decisions. However, these summaries are not regularly updated. We found that a third of CAL impairment summaries are more than 5 years old. Even though medical experts we consulted suggested that given advances in medical research, summaries should be updated every 1 to 3 years.

In addition, while SSA collects data on things like denial rates for specific conditions and claims processing times, they don't leverage this data to inform improvements in the accuracy and consistency of CAL claims decisions.

In conclusion, CAL is viewed positively by SSA and many stakeholders, and appears to be effectively expediting the processing of disability claims with this designation. However, weaknesses in CAL have led to unintended consequences. Absent improvements in how they identify CAL conditions, designate CAL claims, and ensure the accuracy and consistency of CAL decisions, SSA is missing an opportunity to make needed improvements to this important initiative.

This concludes my prepared statement. I am happy to answer any questions you may have.

[The prepared statement of Ms. Larin follows:]



United States Government Accountability Office

Testimony

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Means, House of Representatives

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SSA'S COMPASSIONATE ALLOWANCE INITIATIVE

Actions Needed to Improve the Accuracy and Consistency of Expedited Processing of Disability Claims

Statement of Kathryn Larin, Director, Education,
Workforce, and Income Security Issues

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

I am pleased to be here today to discuss the Social Security Administration's (SSA) Compassionate Allowance initiative (CAL). SSA oversees two key federal programs for individuals with disabilities—Disability Insurance (DI) and Supplemental Security Income (SSI).¹ In December 2016, these programs provided about \$15.7 billion in disability benefits to nearly 17.4 million individuals. In order to be eligible for these programs on the basis of a disability, applicants must be determined to have a qualifying disability through a complex, multi-step process. As we have noted in our prior work, SSA has historically faced challenges with processing applications for benefits in a timely manner, resulting in significant backlogs and long waits for applicants to learn whether they qualify to obtain disability benefits.²

In light of these challenges, SSA in October 2008 implemented CAL, which fast-tracks through the disability determination process those applicants who are likely to be approved because they have certain medical conditions, such as specific cancers, Amyotrophic Lateral

¹DI is an insurance program that provides benefits to eligible individuals who have qualifying disabilities or who are blind and who have worked for a minimum amount of time in employment covered by Social Security, as well as their family members. SSI provides benefits to eligible individuals who are aged, blind, or have disabilities and have limited income and resources.

²For our prior work, see GAO, *High Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: Feb. 15, 2017); *Social Security Administration: Long-Term Strategy Needed to Address Key Management Challenges*, GAO-13-459 (Washington, D.C.: May 29, 2013); *Social Security Disability: Management of Disability Claims Workload Will Require Comprehensive Planning*, GAO-10-667T (Washington, D.C.: Apr. 27, 2010); *Social Security Disability: Additional Performance Measures and Better Cost Estimates Could Help Improve SSA's Efforts to Eliminate Its Hearings Backlog*, GAO-09-398 (Washington, D.C.: Sept. 9, 2009); and *Social Security Disability: Better Planning, Management, and Evaluation Could Help Address Backlogs*, GAO-08-40 (Washington, D.C.: Dec. 7, 2007).

Sclerosis (ALS), or early-onset Alzheimer's disease.³ Since 2008, SSA has expanded its list of CAL conditions from 50 to 225, resulting in increasing numbers of individuals qualifying for disability benefits through CAL. From the initiative's inception through the end of fiscal year 2016, SSA had approved more than 500,000 applications, or claims, for disability benefits through CAL. However, a few years after CAL began, concerns were raised that SSA had not identified all cases that qualified for CAL processing and processed some cases through CAL that did not qualify.⁴ More recently, concerns have been raised that SSA does not have a transparent process for identifying conditions for inclusion on the CAL list and its descriptions of certain CAL conditions may be medically out of date.

To apply for disability benefits through either of SSA's disability programs, individuals submit a claim, which includes the claimant's description of his or her impairment (or impairments), among other relevant information. SSA assesses the claimant's non-medical eligibility for benefits and sends the claim to a state disability determination services (DDS) office for a review of the claimant's medical eligibility and initial determination of disability.⁵ Although SSA is responsible for the programs, the law generally calls for initial determinations of disability to be made by state agencies.⁶ DDS examiners assess the applicant's medical condition against SSA's Listings of Impairments (medical listings), which contain medical conditions that have been determined by the agency to be severe

³CAL is one of several expedited processing initiatives SSA has implemented, consistent with SSA's focus on the timely processing of disability applications, or claims. For example, whereas CAL applies to claims of certain medical conditions, SSA's Terminal Illness initiative focuses on claims involving a terminal illness, which SSA defines as "a medical condition that is untreatable and expected to result in death." See SSA Program Operations Manual System (POMS) DI 23020.045. In addition, SSA's Quick Disability Determination initiative electronically identifies disability cases in which there is a high probability that the claimant is disabled, evidence of the claimant's allegation(s) is expected to be readily available, and the case can be processed in an expedited manner by the disability determination services office.

⁴SSA, Office of the Inspector General. *Compassionate Allowance Initiative (A-01-10-21080)*. August 2010.

⁵Non-medical eligibility requirements may include age, employment history, and performance of substantial gainful activity.

⁶See 42 U.S.C. § 421(a)(1). The work performed at DDS offices is federally financed and carried out under SSA disability program regulations, policies, and guidelines.

enough to qualify an applicant for disability benefits.⁷ Based on this assessment, a DDS examiner decides whether to medically allow or deny a claim for DI or SSI benefits.⁸

CAL claims may be processed more quickly than other claims, in part because they are given priority status. When a claimant submits a claim for disability benefits, it is flagged as CAL if the claimant's description of his or her impairment includes certain key words or phrases indicating the claimant has a CAL condition. These claims are given priority in disability examiners' and medical consultants' queues of incoming claims, and SSA guidance directs DDS offices to initiate development of CAL claims within one work day of receipt. Examiners may only require a minimal amount of medical evidence, for example, a biopsy report, to confirm the claimant's diagnosis of a CAL condition.

My testimony today summarizes findings from our August 2017 report on CAL that is being released today.⁹ This statement addresses the extent to which SSA has procedures for (1) identifying conditions for the CAL list; (2) identifying claims for CAL processing; and (3) ensuring the accuracy and consistency of CAL decisions. To address these objectives, we reviewed relevant federal laws, regulations, and guidance; analyzed SSA data on disability decisions for CAL claims from fiscal years 2009 through 2016 and on CAL claims flagged by staff for manual addition or removal of the CAL designation in fiscal year 2016; reviewed a nongeneralizable sample of 74 claim files with fiscal year 2016 initial determinations; and interviewed medical experts, representatives from patient advocacy groups, and SSA officials in headquarters and six DDS offices selected for geographic dispersion and varied CAL caseloads. Our work was

⁷However, an individual may still qualify as disabled even if his or her medical condition is not included in the medical listings. If the individual's impairment does not meet or equal the severity of at least one of those in the listings, DDS officials will assess the individual's physical and mental residual functional capacity. For adult disability claims, examiners follow a five-step sequential evaluation process. See 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4). Under that process, if the examiner finds that the impairment does not meet or equal a listing, the examiner assesses the claimant's residual functional capacity and determines whether the claimant can perform his or her past relevant work or other jobs that exist in significant numbers in the national economy.

⁸A DDS examiner may consult with a medical professional, psychological professional, or both as part of this assessment.

⁹GAO, *SSA's Compassionate Allowance Initiative: Improvements Needed to Make Expedited Processing of Disability Claims More Consistent and Accurate*, GAO-17-625 (Washington, D.C.: Aug. 11, 2017).

performed in accordance with generally accepted government auditing standards. More details on our scope and methodology can be found in the issued report.

In brief, although CAL appears to be effectively expediting benefit processing for disability claims receiving this designation, we found several weaknesses in SSA's procedures for identifying conditions for the CAL list and claims for CAL processing. We also found weakness in the agency's procedures for ensuring the accuracy and consistency of CAL decisions. My statement will highlight eight recommendations that SSA can implement to make the expedited processing of disability claims through CAL more consistent and accurate.

SSA Lacks a Formal and Systematic Approach for Identifying CAL Conditions

SSA has in recent years relied on advocates for individuals with certain diseases and disorders to bring potential CAL conditions to its attention. However, SSA has not clearly communicated this or provided guidance on how to make suggestions through its CAL webpage, which communicates information to the public. Without more explicit instructions, we noted that advocates may not present information that is relevant for SSA's decision-making or that most strongly makes the case for these conditions to be included on the CAL list. One representative from an advocacy organization, for example, described meeting with agency officials and being surprised by SSA's focus on cancer grades—an indicator of how quickly cancer is likely to grow and spread—as she was not accustomed to discussing the condition she represents in these terms. Federal internal control standards state that agencies should use quality information to achieve their objectives.¹⁰ We concluded that absent clear guidance to advocates on how to make suggestions through its CAL webpage, SSA is missing an opportunity to gather quality information to inform its selection of CAL conditions.

In addition, we found that relying on advocates to bring conditions to SSA's attention also introduces potential bias toward certain conditions and the possibility of missing others. Some conditions that are potentially deserving of CAL consideration may not have advocacy organizations affiliated with them, and some advocates may be unaware of CAL. As a result, some conditions may have a better chance of being considered

¹⁰GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 2014).

than other, equally deserving ones that are not proposed, and individuals with those conditions may have to wait longer to receive approval for disability benefits. Federal internal control standards state that agencies should collect complete and unbiased information and consider the reliability of their information sources.¹¹ According to some external researchers who work with SSA, an approach leveraging SSA's administrative data may help address the bias that is introduced by only using advocates. SSA has contracted with the National Institutes of Health and the National Academies of Sciences, Engineering, and Medicine for research using SSA administrative data, which has led to the identification of potential CAL conditions. However, we noted that to date, the research SSA has contracted has not been sufficiently targeted to generate more than a small number of additions to the CAL list.¹² In our August 2017 report, we recommended that SSA develop a formal and systematic approach to gathering information to identify potential conditions for the CAL list, including sharing information through SSA's website on how to propose conditions for the list and using research that is directly applicable to identifying CAL conditions. SSA agreed with this recommendation and has begun to make revisions to its website.

We also found that SSA has also not consistently communicated with advocates who have suggested conditions to add to the CAL list about the status of their recommendations, leading to uncertainty for some. SSA officials told us that they provide a written or oral response to advocacy organizations that have suggested a condition for inclusion on the CAL list to inform them whether the condition is approved. However, some of the advocates we spoke to had not received such a response from SSA and found it challenging to connect with SSA officials to obtain information about the status of their suggestions. For example, one representative from an advocacy organization told us that she was unable to reach SSA officials to obtain any information on the status of her suggestion despite repeated attempts. In the absence of a response from SSA, she had resubmitted her condition and supporting documents to SSA every six months for three years since her initial submission in 2014. Federal internal control standards state that agencies should communicate quality information externally so that external parties can

¹¹GAO-14-704G.

¹²SSA administrative data include information on disability claims, such as the number of allowances and denials for claims with certain conditions that were allowed or denied for benefits.

help the agency achieve its objectives.¹³ We concluded that without two-way communication between SSA and advocates, advocates are unclear on the status of their proposed CAL conditions and SSA may be missing an opportunity to improve the quality of the information it obtains from advocates. In our August 2017 report, we recommended that SSA develop formal procedures for consistently notifying those who propose conditions for the CAL list of the status of their proposals. SSA agreed with this recommendation.

Our review also found that SSA has not developed or communicated clear, consistent criteria for deciding which potential conditions will be included on the CAL list. Officials told us that they have informally considered criteria such as allowance rates—the percentage of claimants asserting a certain condition who are approved for benefits—when identifying potential CAL conditions. However, we reviewed 31 assessments of potential CAL conditions prepared by SSA medical consultants and found that they did not cite consistent criteria. There was no standard format used for these reports, and SSA does not have a template, checklist, or guidance—other than the medical listings—that its staff consult when preparing them. Further, SSA officials have cited different reasons for not designating conditions as CAL in communications with those who proposed conditions, which led to confusion regarding CAL condition criteria for staff from some advocacy organizations we interviewed. Federal internal control standards state that agencies should define objectives in specific and measurable terms so that they are understood at all levels of the agency and performance toward achieving these objectives can be assessed. To help achieve these objectives, the standards state that agencies should also communicate key information to their internal and external stakeholders. We concluded that absent clear criteria for designating CAL conditions, advocates and other stakeholders may be confused as to why some conditions are not included on the CAL list and SSA may miss conditions that could qualify for CAL. In our August 2017 report, we recommended that SSA develop and communicate internally and externally criteria for selecting conditions for the CAL list. SSA agreed with this recommendation.

¹³GAO-14-704G.

SSA's Procedures Do Not Ensure All Claims are Accurately Identified for Expedited CAL Processing

To identify disability claims for expedited CAL processing, SSA primarily relies on software that searches for key words in claims. However, because text provided by claimants may be ambiguous, incomplete, inaccurate, or misspelled, the software is hindered in its ability to flag all claimants with CAL conditions and may also flag claimants for CAL processing that should not be flagged.¹⁴ For example, officials we interviewed at 5 of the 6 selected DDS offices said that they have seen claims inaccurately flagged for CAL when the claim text included words like "family history of [CAL condition]" though the CAL condition was not asserted by the claimant. In addition, in our claim file review, we found a claimant asserting a leiomyosarcoma, a soft tissue cancerous tumor that may be found in organs including the liver, lungs, and uterus, who misspelled the term as "leiomysarcoma" on the disability claim, which resulted in the software not flagging the claim as CAL, although liver and lung cancers are CAL conditions.¹⁵

SSA officials told us that they have not established a feedback loop to capture observations from DDS officials on weaknesses in the software. However, DDS officials we spoke with have observed weaknesses in the software that, if shared, could assist SSA in improving its accuracy in identifying CAL claims. For example, an official at one DDS office noted that the software appears to identify CAL conditions using words from the claim text out of order or without regard to specific phrases. Specifically, the official stated that some claims with "pancreatitis" or "pancreatic pain" have been incorrectly flagged for the CAL condition "pancreatic cancer." According to federal internal control standards, quality information about the agency's operational processes should flow up the reporting lines from personnel to management to help management achieve the agency's objectives.¹⁶ We concluded that absent a mechanism to gather feedback from DDS offices nationwide, the agency may be missing an opportunity to obtain important information that could help improve the

¹⁴According to SSA officials, the software contains a master word dictionary developed by their contractor and looks at "catch all" terms in certain fields, including acronyms, alternative names, possessives, singulars and plurals, context mappings, word forms, and phrases to detect possible CAL conditions.

¹⁵In this case, officials manually added the CAL flag to this claim once it was at the DDS office.

¹⁶Management should also monitor performance measures and indicators, and design program and data controls that support the integrity of these performance measures and indicators. GAO-14-704G.

software. In our August 2017 report, we recommended that SSA take steps to obtain information that can help refine the selection software for CAL claims, for example by using management data, research, or DDS office feedback. SSA agreed with this recommendation.

We also found that DDS offices play an important role in helping to ensure that claims are accurately flagged for CAL by manually correcting flagging errors made by the software, but SSA's guidance on how to make such corrections does not address when they should occur. For example, instructions on the mechanical process for removing the flag based on the DDS examiner's review of the medical evidence in the claimant's file does not indicate how quickly this should be done after CAL status is clarified. Based on our discussions with officials in the 6 selected DDS offices, we found that some examiners did not understand the importance of making timely changes to a CAL flag designation to ensure faster claim processing and accurate tracking of CAL claims. For example, examiners at one DDS office said that they do not always add or remove a CAL flag when they determine a claim is erroneously designated because it adds another step to claim processing and the step seems unnecessary. Ensuring claims are correctly flagged for or not flagged for CAL is important because the CAL flag reduces DDS processing time by about 10 weeks on average compared to the processing time for all claims, according to SSA data.¹⁷ According to federal internal control standards, agencies should record transactions in an accurate and timely fashion, and communicate quality information throughout the agency. We concluded that without clear guidance on when to make manual changes, DDS examiners may continue to take actions that are not timely and may hinder expedited processing and accurate tracking of CAL claims. In our August 2017 report, we recommended that SSA clarify written policies and procedures regarding when manual addition and removal of CAL flags should occur on individual claims. SSA agreed with this recommendation.

In addition, our analysis of SSA's data shows that DDS offices varied in their use of manual actions to add the CAL flag to claims that were not

¹⁷Further, new medical evidence of a CAL condition can be discovered during DDS processing of a claim, which would require the manual addition of a CAL flag. Processing times refer to claims decided at the initial determination level. According to SSA officials, due to data limitations, they are unable to provide processing times for CAL claims separate from non-CAL claims; as such, the average processing time for all claims includes CAL claims.

initially flagged for CAL by the software. Specifically, we found that over half of DDS offices nationwide that processed disability claims in fiscal year 2016 had one or zero claims with a manually added CAL designation in that year.¹⁸ In comparison, 5 DDS offices together accounted for over 50 percent of all claims with a manual addition. Such variance could result in some claimants who assert a CAL condition not receiving expedited processing because their claims were not flagged for CAL by the selection software or DDS examiners.¹⁹ We found that because SSA had not undertaken a study of its manual action procedures on such claims, it was unclear why this variance existed among DDS offices. Federal internal control standards state that agencies should establish and operate monitoring activities to monitor operations and evaluate results.²⁰ In our August 2017 report, we recommended that SSA assess the reasons why the uses of manual actions vary across DDS offices. SSA agreed with this recommendation.

¹⁸This includes 64 of 103 DDS offices. For the purposes of this analysis, we focused on DDS offices in the 50 states and District of Columbia that had claims processed during fiscal year 2016.

¹⁹Although some DDS officials told us that they are able to informally expedite claims without applying a CAL flag, claims flagged as CAL have received quicker processing, as previously noted—2 weeks versus 12 weeks.

²⁰GAO-14-704G.

SSA Takes Some Steps to Ensure Accurate and Consistent CAL Decisions But Does Not Regularly Update Condition Descriptions or Leverage Data

In our August 2017 report, we found that SSA has taken some steps to ensure the accuracy and consistency of decisions on CAL claims, including developing detailed descriptions of CAL conditions, known as impairment summaries, but has not regularly updated the summaries. These summaries suggest specific medical evidence for the DDS examiner to obtain to verify the claimant's asserted CAL condition and help examiners make decisions about whether to allow or deny a claim. However, we found that because SSA has not regularly updated the impairment summaries, nearly one-third are 5 or more years old. Several advocates (4 of 6) and medical experts (2 of 3) we interviewed suggested that the impairment summaries should be updated every 1 to 3 years because medical research and advancements may have implications for disability determinations.²¹ In addition, federal internal control standards state that as changes in the agency's environment occur, management should make necessary changes to the information requirements to address the modified risks.²² We concluded that given the pace of medical research for certain CAL conditions, in the absence of a systematic and regular mechanism to update CAL impairment summaries, SSA potentially faces the risk of making inaccurate and inconsistent disability determinations based on outdated information. In our August 2017 report, we recommended that SSA develop a schedule and a plan for updates to the CAL impairment summaries to ensure that information is medically up to date. SSA agreed with this recommendation.

We also found that SSA does not leverage data it collects to identify potential challenges to accurate and consistent decision-making on CAL claims. SSA and DDS officials review some data to monitor CAL claims processing, such as the total number of CAL claims and claims flagged for CAL by the selection software, but these efforts do not address the accuracy and consistency of decisions on CAL claims. In contrast, our analysis of SSA's data on outcomes for claims with asserted CAL conditions suggested that a review of data on allowance and denial rates

²¹Representatives from two advocacy organizations we spoke with stated that a review every 10 years of the summaries for their specific diseases, which include genetic disorders and a hereditary brain disease, would be sufficient. Further, one medical expert stated that a review every 5 years would be adequate for a specific human immunodeficiency virus dementia disorder for which medical advancements are unlikely to occur.

²²GAO-14-704G.

for these claims may help identify conditions that are challenging to accurately and consistently adjudicate. For example, while the vast majority of claims asserting CAL conditions are allowed—about 92 percent were approved in fiscal year 2016—data we reviewed showed that there was a lower percentage of claims allowed for certain asserted CAL conditions. Specifically, SSA denied more than 30 percent of claims asserting 37 CAL conditions, and 17 of these conditions had denial rates that were greater than 50 percent.²³ Advocates we spoke to who represent some of these conditions explained why challenges adjudicating these claims may exist. For example, officials from one of these advocacy groups told us that the CAL condition they represent is frequently confused with a much more common and non-life threatening condition that is less likely to be allowed. According to federal internal control standards, management should obtain relevant data based on identified information requirements, process these data into quality information that can be used to make informed decisions, and evaluate the agency's performance in achieving key objectives and addressing risks.²⁴ We concluded that without regular analyses of available data, SSA is missing an opportunity to ensure the accuracy and consistency of CAL decision-making. In our August 2017 report, we recommended that SSA develop a plan to regularly review and use available data to assess the accuracy and consistency of CAL decision-making. SSA agreed with this recommendation.

Chairman Johnson, Ranking Member Larson, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have at this time.

²³CAL claims may be denied for various reasons, for example, if the claimant does not meet the applicable non-medical program requirements, if there is insufficient medical evidence in the file to adjudicate the claim, or if the impairment the claimant alleges does not reflect the claimant's actual diagnosis.

²⁴GAO-14-704G.

**GAO Contact and
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For questions about this statement, please contact Kathryn A. Larin at (202) 512-7215 or larink@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Rachel Frisk, Assistant Director; Kristen Jones, Analyst-in-Charge; and Michelle Loutoo Wilson.

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Chairman JOHNSON. Thank you very much. Ms. McLaren, welcome. Thank you for being here. You may proceed.

**STATEMENT OF ELIZABETH MCLAREN, BUREAU CHIEF,
IOWA DISABILITY DETERMINATION SERVICES, ON BEHALF
OF NATIONAL COUNCIL OF DISABILITY DETERMINATION
DIRECTORS**

Ms. MCLAREN. Chairman Johnson, Ranking Member Larson, and Members of the Subcommittee, thank you for this opportunity to testify on behalf of members of the National Council of Disability Determination Directors, or NCDDD, and the State administrators of the Disability Determination Services, or DDS, across the Nation.

Currently, we direct the work of over 16,000 employees, processing nearly 4.7 million disability cases a year. Today, I am here to provide you with the on-the-ground perspectives of the DDS community regarding the disability process. NCDDD recommends consistent policy application across the Nation. Therefore, we support the reinstatement of the reconsideration step, or the first appeal of the initial DDS denial to all States.

Introduced in 1999 in 10 States, the prototype pilot removes the reconsideration appeal level in State DDS's. In these 10 States, the first level of appeal is a hearing with an administrative law judge at the Office of Disability Adjudication and Review. The President's 2018 budget request includes a proposal to reinstate reconsideration in those 10 States. We believe the reinstatement would help alleviate the ODAR backlog.

Initially, this change would give those State citizens the same opportunity to get benefits sooner at less cost. NCDDD has previously supported this recommendation during testimony to this Committee in 2012. Then and today, we make this recommendation with the caveat that sufficient funding and additional resources must be included for DDS operations, chiefly related to staffing, funding, and infrastructure.

NCDDD is in favor of continuing refinement of the Compassionate Allowance, or CAL initiative, and the associated fast-track processes. In fiscal year 2016, the DDS has processed over 16,000 CAL-only cases, and nearly 62,000 CAL- and QDD-designated cases. While these numbers represent a small percentage of the millions of initial claims the DDS's will process in a year, NCDDD believes in the CAL process, and we believe it should continue to be supported, but with some improvement.

DDS's find that CAL is useful in identifying impairments and prioritizing cases that have a high potential for favorable determination. However, SSA's software has room for improvement, as it sometimes misidentifies cases as CAL, and at other times, fails to identify a CAL condition. We suggest refinements to the software to correct this issue.

We also propose that SSA continuously update both the condition list and the impairment summaries for CAL. NCDDD is concerned about eliminating the use of the disability examiner authority for QDD in CAL cases at the end of fiscal year 2018, as required by the bipartisan Budget Act of 2015. This authority currently allows a disability examiner to make fully favorable determinations in cer-

tain QDD or CAL cases without the approval of a medical consultant.

The DDS's give this authority to well-trained, seasoned adjudicators who can work independently without medical consultation. We believe the loss of this disability examiner authority will have detrimental impact on DDS operations and our service to those applicants who are most in need.

NCDDD supports and recommends the development of a new occupational information system to replace the outdated Dictionary of Occupational Titles, or DOT, and its companion volumes. In a large percentage of cases, disability determinations require assessment of an applicant's ability to perform their tasked work.

The 1991 edition of the DOT is a tool provided to the DDS's by SSA. This aged resource is a foundational piece of the disability determination process. We understand that SSA has been working with the Bureau of Labor Statistics on a solution, but the completion date is still years away. The lengthy timeline for this change is discouraging to the DDS community, as we now have to work through complex issues with outdated information and antiquated systems that are not aligned with the framework of determining disability. We advocate for haste in the development of a new tool.

In conclusion, NCDDD advocates that we retain and/or implement tools and policies that enable the DDS's to continue to provide compassionate service to the public with timely, cost effective, high-quality disability determinations.

On behalf of the NCDDD, thank you again for an opportunity to testify. I would like to thank our SSA partners for their collaboration, and commend the DDS staff across the Nation for their exemplary work for the American public. I would be glad to answer any questions you have.

[The prepared statement of Ms. McLaren follows:]

TESTIMONY OF
ELIZABETH MCLAREN, PRESIDENT-ELECT
NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS
TO THE
SUBCOMMITTEE ON SOCIAL SECURITY
OF THE
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
September 6, 2017

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

The National Council of Disability Determination Directors (NCDDD) is honored to submit this witness testimony to comment on issues regarding the eligibility determination process for the Social Security Disability Program. My name is Elizabeth McLaren. I am the current President-Elect of NCDDD and the Director of the Iowa Disability Determination Services (DDS).

NCDDD is a professional association composed of many of the Directors and managers of the DDS agencies located in each state. Collectively, members of NCDDD are responsible for directing the activities of approximately 16,000 plus employees who process nearly 4.7 million claims per year for disability benefits under the Social Security Act. NCDDD's goals focus on establishing, maintaining and improving fair, accurate, timely and cost-efficient decisions to people applying for disability benefits. The mission of NCDDD is to provide the highest possible level of service to persons with disabilities, to promote the interest of the state operated DDSs and to represent DDS Directors, their management teams and staff.

The DDSs work in partnership with the Social Security Administration (SSA) to provide public service to individuals applying for disability benefits and to help ensure the integrity of the disability program. The DDSs make complex medical determinations for the Social Security disability programs pursuant to Federal law and

regulations. The majority of DDS staff members are state employees subject to their individual state personnel rules, governor initiatives and state mandates, with the remainder of staff under state contract to provide services to the DDS. The DDSs adjudicate various disability claims including those for initial claims, reconsiderations, continuing disability reviews (CDRs) and disability hearings.

The Disability Determination Process

The DDSs provide high quality service at the front end of the process and for many applicants the front end is the entire process. For example, in 2016, DDS determinations at the initial and reconsideration steps accounted for 76.7% of all allowance decisions made that year (Title II, Title XVI and concurrent claims), while only 23.3% were made the Administrative Law Judge and Appeals Council steps. DDS allowance accuracy as measured by Social Security's review is very high at over 98.7% for all of the programs. In FY 2016, DDS processing time was 85.6 days for initial claims and 77.1 days for reconsideration claims.

"Quick Disability Determination" and "Compassionate Allowance" (QDD/CAL) claims are a small, but important subset, about 2.3% of the initial workload. Average DDS processing time for these claims is 18.5 days currently. Social Security's predictive modeling software identifies QDD claims by scoring each initial claim on factors related to probable, quickly processed allowances and flags those with the highest scores for expedited processing. In addition, Social Security's software identifies specific medical terms, key words or phrases that indicate a CAL condition and flags these cases for expedited processing.

DDS claim processing time overall is quite fast considering that processing them involves obtaining healthcare records, sending claimants as needed to consultative examinations, analyzing a large volume of medical, functional and vocational evidence, evaluating individuals' symptoms, addressing different medical opinions and determining individuals' remaining function and ability to perform work in the national economy. Determinations require applying complex law, regulations and policy in each claim and making correct denials as well as allowances. Outcome measures show that the DDSs have historically given the American public prompt, accurate and cost effective service. During fiscal year 2016, the DDSs provided 2,688,977 initial

disability decisions in this manner. The DDSs also provide stewardship oversight by determining continuing medical eligibility and by holding disability hearings for the appeals of those whose benefits are ceased.

The Challenges of staff and resources:

As always, NCDDD members and their DDSs strive to balance the demands of our varied budgeted workloads (initial, reconsideration, continuing disability reviews and disability hearings) with strained resources. The DDSs have historically provided the American public with timely, high quality service even during the hard times when resources are not available. Nationally, the DDSs lost 1,623 employees during the last fiscal year. Of that number, 1,238 were adjudicators, which equates to a lost capacity of over 736,610 claim determinations last year.

We provide this information to illustrate the very real impacts that lack of hiring resources creates in the DDS. Few hires have been available to the DDSs this year and for those that were- most of them have been for critical hires in the DDS where other staff cannot perform the work of the departing employee. Many DDSs are handling the challenges of increased workloads and constant attrition by shifting resources (such as training, mentoring, quality assurance, professional medical relations, consultative examination oversight, supervision and management) to claim processing. However, the DDSs cannot sustain these resource shifts for the long term without serious degradation of public service and program integrity.

NCDDD perspectives on disability process issues for this Subcommittee:

Reinstatement of the reconsideration step to all states

NCDDD recommends consistent policy application across the nation. Therefore, we ask that Congress consider reinstating the reconsideration step in the ten Prototype states. The cost in doing so would be an investment paid for in part by having fewer appeals for ODAR to process. For example, in FY 2016, over 79,799 claimants were allowed at the reconsideration step, an invaluable service to these claimants. Reinstating the reconsideration step in the Prototype states would give citizens in those states the same opportunity to get

benefits sooner at less cost to the system, while allowing the administrative law judges to focus on the claims that truly need their level of legal knowledge and expertise.

NCDDD previously recommended reinstating the reconsideration step during testimony to this committee in 2012. Then and today, we make this recommendation with the caveat that sufficient funding and additional resources must be included. Significant advanced planning, specifically related to the hiring of staff and medical consultants is also necessary for the DDSs to be successful in achieving this goal, as the DDSs are not able to effectuate such a change on short notice.

To illustrate this point, when the Bipartisan Budget Agreement mandated the elimination of single decision maker (SDM), the SSA brought the DDSs in for a face-to-face meeting in Baltimore to generate a plan to ensure the agency would meet the requirements of the Act and eliminate SDM on time. For the reinstatement of reconsideration to the ten Prototype states, NCDDD would recommend this same kind of face-to-face meeting for collaborative development of a plan and a reasonable time-period to reinstate reconsiderations.

Part of this plan must include advanced hiring authority for adjudicators. During fiscal year 2017, the DDSs have faced roughly 15% adjudicator attrition. With limited hires available this year, the DDSs have adjudicator vacancies that remain unfilled. As I am sure this committee is aware, DDS adjudicators are not quickly replaceable employees in the disability process. It takes time and resources to hire the right employees for the job and then a minimum of several years involving continuous training and mentoring before those employees have the knowledge and expertise to handle all claim types independently at full production levels.

In addition to the adjudicator hires, the ten Prototype states will also need to hire additional medical consultants to assist with the reconsideration claims. As with adjudicator hiring and training, sufficient time will be required in order for the DDSs to hire, train and ensure the programmatic accuracy of the medical consultants' assessments. Additional training will also be required for the existing DDS adjudicative staff and medical consultants, many of whom may not have worked a reconsideration claim before. Another factor to consider is the additional office space and equipment necessary to support these new hires. All of these concerns are very

real for the DDSs, specifically the ten Prototype states, and ones that we would hope to mitigate prior to the reinstatement of reconsiderations.

Continue the use of CAL conditions for claim processing

In FY 2016, the DDSs processed 16,636 CAL only claims and 61,712 claims with QDD and CAL. While these numbers represent a small percentage of the volume of initial claims the DDSs will process in a year, NCDOD believes that people with the most severe disabilities are well served by the Compassionate Allowance process therefore, it should continue to be supported, but with some improvements.

NCDOD recommends SSA pursue further refinement of the automated flag process. Social Security's software scans for specific phrases or words that claimants list as their medical conditions on their application for disability benefits, and those phrases or words generates the CAL flag or indicator on the claim. Currently the software sometimes misses a CAL condition due to the way claimants may spell their allegations or incorrectly use a medical term. Claims may come to the DDS marked as CAL incorrectly. As a benefit to the disability process, the resulting flags or indicators propagate claims to the top of an adjudicator's worklist, and this is especially helpful as it directs adjudicators to give those claims priority attention. When the DDS discovers the claim does not meet the criteria for a CAL condition, they then take the steps necessary to remove the flag. While DDS adjudicators do have policy guidance explaining how to add or remove a CAL indicator this is an additional step in the process, defeating the purpose of CAL as a claim processing "expedient".

Given the fact that in some DDSs, there may be claim backlogs or high adjudicator workloads, the flag or indicator will also push these claims to the top of the list for assignment to an adjudicator. The DDS may also use expedited requests for medical evidence from medical providers to receive relevant medical evidence to decide the claim. All of these factors help provide these claimants with faster service.

NCDOD recommends that SSA update the impairment summaries on a continuous basis to ensure the DDSs are using the most relevant, up to date information possible. These impairment summaries provide DDS adjudicators with the relevant information they need to know when making the medical decision on CAL.

claims. This is a helpful tool for adjudicators who may not be familiar with the often uncommon, complex medical conditions these claims present. The summaries provide further benefit as they can save the adjudicator time researching the impairments elsewhere.

Support for the updating of medical listings and regulations

NCDDD is supportive of the recent changes in the mental, neurological, immune/HIV and respiratory medical listings. However, the DDSs faced challenges from the impact of so many listings changes happening relatively close together in time. Rewrites and updates to policy instruction, updating training materials and changes to SSA and DDS legacy systems all must occur when the medical listings change. NCDDD recognizes the need to keep the disability process mirroring change in current medical care and treatment options- however, we would recommend that SSA use a more streamlined and phased in approach for medical listings changes in the future.

NCDDD also supports the March 2017 medical evidence regulation changes regarding acceptable medical sources. The additions of advanced practice registered nurses (APRNs), licensed physician assistants and audiologists to the list of acceptable medical sources are incredibly helpful to the disability adjudication process. These changes will save considerable time and money previously spent on sending claimants to consultative examinations to corroborate the evidence we may have received from their non-acceptable medical treating source. This is helpful to the program and to those claimants who reside in primarily rural areas, where extensive travel to and from the examination would otherwise be necessary.

The impact of SDM elimination on the DDSs

Due to the requirements of the Bipartisan Budget Agreement, the SSA is required to eliminate the use of single decision maker (SDM) authority in the nineteen DDSs that were previously using this authority. Several states have already made this change, and the remaining states are on track to complete their elimination of SDM on time. The nineteen DDSs have used this “tool” for more than 15 years, therefore this change was one that required planning and advanced hiring to handle the additional steps in their adjudication process.

The biggest component to successfully eliminating SDM was the hiring of additional medical consultants in advance to handle the increase in claims review. Some of the SDM states faced serious challenges in hiring these additional consultants due to the limited number of resources available in their states. The SSA ensured funding was available to the states as they were in the recruitment process for additional medical consultants and this has proven to be incredibly helpful.

NCDDD members have reported other varying impacts on the program from SDM elimination. They include delays in processing time due to the hiring and training of new medical consultants, increased costs from those additional medical consultants and the needs of additional workspace and equipment for them, negative impacts on morale and retention of adjudicators losing the SDM authority, as well as a decrease in job grades and salary.

DDSs need to retain disability examiner (DE) authority for QDD and CAL claims

Based on the language and direction of the Bipartisan Budget Act of 2015, SSA will be eliminating the use of the disability examiner (DE) authority for QDD and CAL claims at the end of FY 18. Currently, DDS adjudicators have the authority to decide fast tracked claims independently. The DDSs typically give this authority to those adjudicators who are seasoned, well trained and can work independently without medical consultation on many claims. As needed, adjudicators may request consultation from the DDS medical consultants, but in most cases, it is not required. NCDDD believes that independent disability adjudicator determinations have maintained high accuracy standards with a streamlined business process and cost-effective use of medical consultant time and expertise.

NCDDD believes that this loss of DE authority will have multiple detrimental impacts on the DDS operation. Since it will require significantly more medical consultant time and resources, longer DDS processing time and budget increases are to be expected. In FFY 2016, the DDSs processed roughly 58,763 QDD and CAL claims using the DE authority. Taking those 58,763 claims times the average costs of the medical consultation review costs of \$55.00 per medical review, you can quickly see the cost increases to the program.

Processing time delays are an important factor to consider due to the impact they have on the lives of the claimants we serve. Removing tools that enable the DDSs to provide timely, cost effective, high quality determinations does not serve the public in the best way possible. In addition, negative impacts to the disability adjudicator's morale, job classification and pay scales will affect DDS staffing capacity and quality across the country. We urge this subcommittee to consider a change to this requirement of the Bipartisan Budget Act.

The updating of the Dictionary of Occupational Titles (DOT)

NCDDD supports and recommends the development of a new Occupational Information System to replace the outdated Dictionary of Occupational Titles (DOT) and the Selected Characteristics of Occupations (SCO). Vocational documentation and analysis for the disability program are challenging for DDS adjudicators. Therefore, the updating of the old DOT and SCO to reflect current information about occupations in the national economy would be incredibly helpful for the DDSs. We understand that SSA has been working with the Bureau of Labor Statistics (BLS) but the completion of this update is still years away. BLS must do a great deal of data gathering and analysis and SSA must develop a modern electronic tool to support the vocational assessments required for disability determination. The long timeline for this change is discouraging to the DDS adjudicators who spend much valuable time working through vocational issues on claims supported only by outdated information and antiquated systems not aligned with the legal framework for determining disability.

Conclusion

The DDSs have a long record of partnership and collaboration working with SSA to provide timely, high quality service to the public. Policy changes and technology tools can further improve program efficiency and consistency of public service. As stated in this testimony, NCDDD supports the reinstatement of the reconsideration process in all states, the continued use of CAL conditions for claim processing, the updating of the medical listings and regulations, the continued use of the disability examiner authority for QDD and CAL claims, and the updating of the DOT. The DDSs need these tools to effectively and efficiently serve the needs of the American public, now and in the future.

We would also like to take this opportunity to acknowledge the support former Acting Commissioner Carolyn Colvin provided to the DDS community during her tenure. She was a collaborative partner, who listened to our perspectives and responded to the resource needs of the DDSs to support our mission of serving the American public. We also wish to acknowledge current Acting Commission Nancy Berryhill for her partnership and collaboration with the DDSs as we continue to strive to meet our public service mission.

Mr. Chairman, on behalf of NCDDD, I thank you again for this opportunity to provide testimony on the eligibility determination processes within Social Security's disability program. We will be happy to provide any additional information you need and answer any questions you may have.



Chairman JOHNSON. Thank you. Ms. Zahm, welcome. Thanks for being here. You may proceed.

**STATEMENT OF MARILYN ZAHM, PRESIDENT,
ASSOCIATION OF ADMINISTRATIVE LAW JUDGES**

Judge ZAHM. Thank you. Chairman Johnson, Ranking Member Larson and Members of the Subcommittee, thank you for this opportunity to address you who have the stewardship of this program in your hands. I am Marilyn Zahm, a United States Administrative Law Judge for 23 years and elected President of the Association of Administrative Law Judges.

The AALJ represents 1400 Federal administrative law judges located in 166 hearing offices across the country. I am speaking today on behalf of my judicial colleagues.

SSA judges have been doing triage work in hearing rooms across the country without adequate time, resources, or staff. We urge Congress to draft legislation to revitalize the adjudicatory system. Each of you has heard stories from your constituents, just as we judges hear stories in our courtrooms, of the hardship that waiting 2 years for a hearing and decision takes on those who appear before us.

However, there are some practical solutions to the problems that we face in the adjudicatory system. I will focus on four issues and our solutions: adopt an AALJ's recommended efficient adjudication procedures; protect and preserve the independent judiciary; provide judges with adequate support staff; and provide judges sufficient time to perform their work. I will briefly discuss each of these.

Since 2011, the agency has imposed an estimated 1,000 changes to its policies and procedures manual, most of which are unnecessary, and simply add to the time it takes to hear and decide cases. We have proposed a number of solutions to make the adjudicatory process more efficient and more effective. Streamlined fully favorable templates, which, if implemented, could save half a million work hours per year. An expedited dismissal process that has the potential to conserve 400,000 hours annually. Rules of procedure for those who appear before us: properly drafted regulations; elimination of the 10 regional offices for ODAR; and redeployment of their 400 staff to the hearings operation.

The American people are entitled to an impartial decisionmaker. The agency, however, continues to push an initiative that would disable all statutory protections to ensure that Federal agencies cannot improperly influence their adjudicators. It seeks to use in-house attorneys over whom it exercises control, instead of independent judges to hear and decide cases.

This is not a new initiative. The agency proposed this last year, but under pressure from Congress, backed away from the proposal. Nevertheless, the agency has again announced this plan. There should be a chart appearing on your TV screens, which highlights the differences between ALJs and the agencies attorney examiners. As you can see, ALJs have decisional independence; in-house attorneys do not. They are controlled by the agency. If you control the people who make the decisions, you can control their decisions.

The agency's probationary period proposal for newly hired ALJs with its argument for a judicial performance plan is also a well-

worn attempt to eliminate statutory protections for the American people. This idea should be unequivocally rejected. We Americans deserve an independent judiciary.

Judges are hamstrung without adequate support staff. Hiring freezes and attrition have eroded our clerical and attorney writing staffs. In many hearing offices, agency management has stripped judges of their assigned clerical support. In order to be efficient, judges need to work with the same staff. Each judge needs to have one clerical staff member and two attorneys assigned to us to work directly with us.

Each disability case involves a person who is likely to desperately need income. Each claim paid has an approximate value of \$300,000. Judges need to carefully and thoroughly evaluate each case, and we need sufficient time to do this job. The agency's quota, demanding judges dispose of 500 to 700 cases annually, was created by dividing the number of pending cases by the number of judges several years ago. This means that judges have an average of 2.5 hours to fully adjudicate a case. That means reviewing the entire file of hundreds of medical documents, sometimes thousands; holding a hearing at which the claimant and expert witnesses are questioned; drafting instructions for a decision and editing that decision; 2½ hours.

Judges who take the time to follow the rules, regulations, and policies——

Chairman JOHNSON. Can you finish pretty quickly because your time is up.

Judge ZAHM. Oh, I am sorry. Thank you for your attention.

[The prepared statement of Judge Zahm follows:]



**STATEMENT OF
JUDGE MARILYN ZAHM
PRESIDENT
ASSOCIATION OF ADMINISTRATIVE LAW JUDGES
BEFORE THE

HOUSE WAYS AND MEANS COMMITTEE
SOCIAL SECURITY SUBCOMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES**

SEPTEMBER 6, 2017

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

Thank you for this opportunity to appear before you to discuss the Social Security Administration's disability process.

I am Marilyn Zahm, an Administrative Law Judge assigned to the Buffalo, New York hearing office since 1994. I also serve as president of the Association of Administrative Law Judges (AALJ), a group of 1,400 Administrative Law Judges (ALJs, Judges) employed by the Social Security Administration across the country. The views I express today are those of the Association. I do not speak for the Agency.

The Social Security Administration (SSA) has an unprecedented number of cases pending at the hearings level. There are over 1.1 million people waiting for a hearing and decision. No one is more aware of the seriousness of this problem than the ALJs. Every day in our courtrooms, we see the toll that waiting up to two years for a hearing and a decision takes on those who appear before us.

I thank Congress for allocating an additional \$90 million to SSA in this year's budget. SSA leadership is using some of these resources under the CARES II plan for much needed technology improvements and hiring in the hearings operation.

However, the CARES II plan will not appreciably reduce the backlog of cases anytime in the foreseeable future. With the exception of the additional hiring, not one of these initiatives – either singly or in combination – focuses on the real reasons why we have a backlog crisis.

There are structural problems with the adjudicatory process that must be addressed if the disability program is to be efficient and effective. My goal today is to address these problems and offer constructive solutions that will improve service and reduce the backlog.

The culture of the organization must change if the system is to work well. The tension between the ALJ Corps and the Agency, while longstanding, has been exacerbated by the backlog crisis, as the Agency frantically tries to reduce the pending cases by improperly coercing Judges into issuing more decisions. The Agency's actions are counterproductive; management should be cooperating with its Judges rather than threatening and browbeating them.

The Agency's quota, demanding Judges adjudicate 500 to 700 cases annually, is not based on any study, not based on any rational analysis of the amount of work involved, and not based on anything other than the desire to have more decisions issued; it was created years ago by dividing the number of pending cases by the number of Judges. Please remember that each case involves a living, breathing person who is likely desperate after waiting up to two years for a hearing. And, it is important to understand that each claim paid has an approximate value of \$300,000 in government resources. Judges need to carefully and thoroughly evaluate each case before us.

A basic element of any adjudicatory system is that Judges have sufficient time and resources to do their jobs. Right now, SSA allots Judges an average of only 2.5 hours to adjudicate a case. This includes reviewing hundreds (sometimes thousands) of pages of medical documents, holding a full and fair hearing at which the claimant and expert witnesses testify, and issuing a decision which thoroughly addresses multiple complex medical and legal issues. I doubt there is anybody in this room who could read 1,000 pages of dense medical records, hold a hearing, write instructions, and edit the draft decision in 2.5 hours. I know I can't. Still, SSA insists ALJs adjudicate 500-700 cases per year.

Congress is rightfully concerned about accurate decisions being issued, and your inquiry must start with realistic dispositional goals for the ALJ Corps. AALJ commissioned a work analysis study (www.aalj.org) conducted by industrial experts that revealed that, if a Judge follows all of the Agency's policy dictates, it would take over seven hours to adjudicate an average case. The difference between the 7 hours to adjudicate a case and the 2.5 hours SSA allocates is serious.

This disparity has generated significant tension between the AALJ and SSA management. Judges who take the time to follow all of the rules, regulations, and policies are often bullied and harassed by SSA with threats of discipline and loss of benefits for not adjudicating more cases. As we all have learned from the Wells Fargo banking scandal, unrealistic quotas lead to bad results. The pushing of Judges to issue more decisions without adequately evaluating the claims created the environment that allowed the illegal actions in the Huntington, West Virginia hearing office to flourish.

SSA's adjudication procedures are upside down. ALJs have an average of 2.5 hours to fully adjudicate a case if they are to issue 500 dispositions annually, while SSA decision writers are allotted a minimum of 3 hours and up to more than 14 hours per case, depending on complexity, to produce a draft decision. Those in the Division of Quality who conduct reviews of

ALJ decisions spend multiple hours on their tasks. At the federal court level, the magistrate's law clerk can spend at least 8 hours reviewing an appeal from a single ALJ decision.

Why do those who evaluate our work have appreciably more time to spend assessing it than we have to complete it?

Simply ordering Judges to increase the number of hearings they schedule to 50 a month - as the Agency boasts it has done - does absolutely nothing to improve the system. Rather, it increases the chance that the decision issued will be neither well supported nor accurate, especially since the amount of medical evidence for each case has increased dramatically even as our support staff has shrunk and the Agency has placed more policy and procedural demands on the Judges. Furthermore, this dictate is insulting and ignores the fact that Judges are the hardest working group of SSA employees. In fact, at the insistence of our Judges, the AALJ negotiated the right to remain in the office after hours from 6:00 pm until 10:00 pm, without pay, to continue working.

So, what can Congress and SSA do? SSA must allow Judges sufficient time to adjudicate cases and must act to remove roadblocks that impede efficient adjudication. The Agency has burdened Judges with unnecessary policies and procedures and has hindered the smooth functioning of the system by poor management practices and poorly drafted regulations. These actions, together with the massive increase in the size of case files, the emphasis on quality - which the AALJ agrees with but notes that good work takes longer - and the reduction in staff assistance are what has driven down the number of decisions Judges can issue.

Modern corporate management seeks the advice of those who perform the actual work to solve problems, as they know best how to do the job. Unfortunately, the culture at SSA is top down, management-knows-best. SSA managers should listen to the Judges who perform the work that forms the core mission of the disability process. Hopefully, the new management team coming into SSA will bring a different attitude and will look to the AALJ as a partner in solving the backlog.

Let me outline a few changes that will help reduce the backlog while maintaining quality decisions. A normal adjudicatory system is organized to provide support to the Judge, as it is the Judge who is the point of production. Judges are most efficient when they work consistently with the same staff. In many hearing offices, management has stripped Judges of their assigned clerical support, causing them to have to spend time and energy following up on case-handling directives and searching for a staff member to provide needed assistance with such matters as equipment malfunctions, missing documents, phone numbers of experts who will be testifying at the hearing, etc. - in short, non-judicial work. Moreover, management has reduced the number of attorneys and decision writers assigned to the local hearing offices and placed this support in centralized locations. As a result, Judges do not know who is drafting their decisions, have little to no contact with writers, and at times must spend hours editing decisions. I note also that accountability decreases in direct proportion to the distance of the support staff from the Judges.

I see that the updated CARES II plan provides for a "virtual hallway" with writers in centralized writing units - communication between the writers and the local offices will be conducted via

Skype, email, instant messaging, or other electronic technology. Centralized writing units are not the best way to deliver service, but we acknowledge that, since they already exist, they should be made to work as efficiently and effectively as possible. The virtual hallway will be successful only if the writers are assigned to the Judges and have the ability to communicate directly with them. The AALJ has made similar suggestions over the past few years – however, while the Agency promises to implement the idea, nothing has been done to improve the process.

Because of hiring freezes and attrition, SSA lacks sufficient clerical and writing staff. With adequate staff providing necessary clerical and writing support, Judges can focus on their core function of hearing and deciding cases. The Agency should be hiring clerical employees and attorneys to assist Judges until we are adequately staffed.

AALJ has made numerous recommendations to the Agency to make the hearings operation more efficient. The Agency has taken some steps recently toward accepting one of our suggestions, the streamlined fully favorable template idea, which transforms the current, lengthy decision into a concise and legally sufficient shorter document by including only necessary information. For instance, there is no need to discuss all impairments, only the ones that are the basis for the disability. If management fully adopts our recommendations, we will be able to save half a million work-hours annually to spend working on the backlog.

There are many other suggestions that we have advanced that also can save time and money if implemented.

Another AALJ proposal is an expedited dismissal procedure. About 17% of Social Security disability cases are dismissed because the individual – usually unrepresented – has abandoned the case, having returned to work, lost interest, or moved and left no forwarding address. In many urban hearing offices, the dismissal rate is significantly higher. If, despite our best efforts and good intentions, we cannot find the claimant, then we cannot hold a hearing and adjudicate the case. Any work put into these cases – obtaining evidence, organizing the file, reading the file – is a waste of time and scarce resources. If these cases were to be resolved earlier in the process, before significant resources were expended on them, we could save almost 400,000 work hours annually. If the regulations and policies were changed so as to allow us to dismiss abandoned cases without scheduling a hearing, there is potential for even more savings.

SSA holds approximately 700,000 hearings a year – a staggering number – yet has no rules of procedure for those who practice in front of us. A lack of rules of practice impedes the smooth operation of the adjudicatory process. The submission of evidence in a timely fashion to permit the Judge and expert witnesses proper time to review the evidence and the closure of the record are two critical measures that are missing. Recently, SSA issued a regulation setting forth a rule for the submission of evidence five days prior to the hearing. This rule was based on a very lengthy and successful demonstration project in New England. The five-day rule, while better than the prior situation in the rest of the country (which allowed hundreds of pages of documents to be submitted at the hearing and post-hearing), is poorly drafted. The intent of the rule can be undermined, as it also indicates that it is sufficient if, five days before the hearing, the Judge is merely notified about what evidence is outstanding and the attempts made to obtain it. This “inform option” totally defeats the purpose of the 5-day rule, which is to ensure a fully

developed record prior to the hearing. A Judge is most efficient when he or she has all of the documents and can review them prior to the day of the hearing so that the decision can be made at the conclusion of the hearing, while the evidence is fresh in the Judge's mind. So, instead of taking what worked in practice in New England, SSA changed the rule and greatly reduced its impact.

In addition, rules need to be enacted to prevent the submission of duplicative documents or exhibits that are not organized in chronological order. Sometimes as much as 20% percent of the medical evidence consists of duplicate documents. Because medical evidence in a case may consist of thousands of pages, duplicates bulk up the record and lengthen the Judge's review. These rules will assist the claimants and the adjudicatory process by facilitating the Judge's review of the record and saving Judge and staff time.

Judges receive policy updates on a daily basis that set out changes that must be read, absorbed and applied – an impossible task. Many of these changes wind up as part of the Agency's Hearings, Appeals, and Litigation Law Manual (HALLEX) that Judges are required to follow. Since 2011, the Agency has imposed more and more policies and procedural requirements for case adjudication– we estimate 1,000 changes to HALLEX during this period - most of which are unnecessary and simply add to the time that it takes to hear and decide cases. For example, HALLEX I-2-5-13B requires the staff, once informed about medical evidence, to ask the claimant to obtain it, wait a mandatory 30 days before asking the claimant why it is not submitted, and then ask the ALJ if the staff should send for the documents. Since unrepresented claimants rarely obtain medical evidence, and when they do, it is often incomplete, the staff almost invariably has to obtain it. This HALLEX requirement, and many others, creates extra work and delay.

AALJ has presented the Agency with a significant number of specific changes to HALLEX to streamline procedures, with little result. HALLEX needs to be thoroughly reviewed and its dictates simplified so that the adjudicatory process becomes efficient. Moreover, Agency personnel crafting these changes could be better utilized to assist in the hearings operation.

This brings me to case record size. The size of our files has increased 55% from FY 2011 to FY 2016. While the Agency is developing software to identify duplicate evidence, which they expect will shrink the files by about 17%, and even if this initiative is as successful as predicted, this modest reduction in documents – in the face of the ever increasing file size - will not do much to reduce the backlog. Any real impact on the backlog will come from more staff and better policies.

As for more staff, technology facilitates direct dissemination of information without the need for bureaucratic middlemen. Eliminating the ten Regional Offices – most of which are located in expensive real estate – could deploy about 400 employees to the hearings operation to perform the real work of the Agency. Many of the functions performed by the Regional Offices are duplicative of those performed in the central office. The central office can more efficiently manage the hearing offices directly, rather than through the regions. Similarly, flattening the management structure in the hearing offices would allow for over 400,000 additional staff hours per year to be utilized directly in case adjudication.

There are a number of other measures that can improve the disability process, including establishing an SSA Medical Expert Corps, initiating an early continuing disability review upon the recommendation of the Judge, using social media and the internet, authorizing symptom validity testing, and reducing the occasions when closed cases can be re-litigated.

ALJs are required to adjudicate cases based on complex medical evidence without the timely benefit of medical experts. The Agency has a lack of experts in many specialties, which causes delay in adjudicating cases. A corps of medical experts will provide Judges with unbiased expert opinions that will assist in issuing medically and legally supported adjudications.

Having reviewed all of the medical evidence, Judges are in a good position to know the earliest time for SSA to conduct a Continuing Disability Review (CDR). SSA should implement ALJ recommendations for timing CDRs to determine medical improvement so that claimants can return to the work force as soon as they are able.

AALJ also recommends that SSA use social media and the internet to review an individual's activities prior to hearing (reports put in each file) so that Judges can question the claimant to better assess credibility. For example, in the New York City disability scandal, had the Agency reviewed Facebook postings, it would have discovered photos documenting claimants riding a motor scooter, fishing off the coast of Costa Rica, working as a martial arts instructor and holding a job as a helicopter pilot. A Judge should not be barred from asking questions about information that is disseminated to a wide audience.

Other federal agencies, including the Veterans Administration, use Symptoms Validity tests – psychological testing and assessment - in evaluating symptoms. SSA should also authorize such tests when requested by the ALJ so that the Judge can have access to an independent expert's opinion on malingering and exaggeration.

Regulatory changes to cut down on reopening closed cases and re-litigating periods of time for which the Agency has already made a determination should be implemented. It makes no sense and is unfair to make people wait in the queue for two years to have an initial hearing when others are permitted to have a second, third or fourth bite of the apple.

Finally, we must always keep in mind that workers have paid into the Social Security system and should expect to have that system treat them fairly when they have a need for its benefits. There are two recent developments that strike at the heart of the American public's entitlement to a full and fair due process hearing before an independent adjudicator.

First, the Agency plans to erode the right to an in-person hearing by restricting the ability of individuals to opt out of video hearings. While video hearings, under some circumstances, can be beneficial – such as providing timely service to those in remote areas – as a general rule, in-person hearings are preferable and ought to be the norm. When the Agency eliminates the right to an in-person hearing, community based hearing offices will likely be phased out over time. Besides avoiding the inevitable technology problems, in-person hearings have the benefit of allowing the Judge the opportunity to view individuals up close and interact with them directly

instead of on television. Furthermore, community hearing offices permit familiarity with local treatment providers. For claimants who are already under a great deal of stress, dealing with a screen rather than a human being can interfere with their ability to interact effectively with the Judge when making their case.

Second, the Agency continues to push an initiative that permits non-ALJs to hear and decide cases, which is inconsistent with the Administrative Procedure Act (APA) and its own regulations and is not in the best interests of the American people.

Last year, the Agency sought to hire 65 new Attorney Examiners (with the internal organizational title of Administrative Appeals Judges), together with almost 300 support staff, to augment the current 70 Attorney Examiners in the Appeals Council. These new appeals council attorneys, according to SSA, would hold hearings and issue decisions on two subsets of cases: non-disability and remanded cases. Non-disability cases are a specialized group of cases involving issues such as overpayments, underpayments, workers' compensation offsets, paternity, fraudulent retirement, selection of representative payee, and matters of income and resources. There are approximately 10,000 non-disability cases appealed to the hearings level annually, and about 30,000 remands pass through the Appeals Council each year.

Under pressure from Congress the Agency backed away from this proposal.

Recently, SSA has revived its interest in shifting hearings from Judges to Attorney Examiners at the Appeals Council, as the Agency has announced its plan to solicit public comment to "best utilize the Appeals Council to hold hearings to address the pending service crisis."

Using Appeals Council Attorney Examiners violates the Agency's own regulatory policy that evidentiary hearings on appeals from adverse Agency determinations are to be presided over by ALJs appointed pursuant to the Administrative Procedure Act (APA). Administrative law expert Dean Harold Krent has provided us with a legal analysis that concludes that this plan is *ultra vires* (www.aalj.org). Not only does SSA's agenda starkly depart from the law and regulations, it is poor public policy, as it strips the American people of their right to an independent APA adjudicator and also their right to an appeal before the Appeals Council.

For decades, and currently, ALJs have conducted evidentiary hearings on appeals made from adverse Agency determinations. SSA has over 1,600 ALJs located in 166 hearing offices throughout the country. ALJs are selected by federal agencies through the Office of Personnel Management (OPM) after a rigorous hiring process, the requirements of which include years of trial experience, a full-day written examination, and a structured interview conducted by, among others, sitting ALJs and law professors. The applicants' qualifying experience, together with the results of the test and interview, are scored and the names of the top candidates are sent to any Agency seeking to appoint an ALJ.

ALJs are appointed pursuant to the APA, the law passed by Congress in 1946 to ensure that federal agencies could not improperly influence their adjudicators. In order to assure judicial independence, ALJs are forbidden by law from having ex-parte communications with certain Agency personnel. They cannot receive bonuses or undergo performance appraisals.

Suspension and removal for good cause must be accomplished by filing charges at the Merit Systems Protection Board, where an independent Judge will preside over the hearing. All of these safeguards are imbedded in the law to protect the American people by ensuring that ALJs can exercise their judicial independence in applying the law.

The chart below highlights the differences between ALJs and the Agency's Attorney Examiners.

**INDEPENDENCE OF ADMINISTRATIVE LAW JUDGE COMPARED TO AGENCY
ATTORNEY EXAMINER**

	ADMINISTRATIVE LAW JUDGE (ALJ)	ATTORNEY EXAMINER/ ADMINISTRATIVE APPEALS JUDGE
HIRING PROCESS	<ul style="list-style-type: none"> • OPM recommended; • Rigorous screening, testing; and • A minimum requirement of 7 years trial experience 	<ul style="list-style-type: none"> • Agency determines qualifications; • No independent OPM review; • No required testing or trial experience
DISCIPLINE	Discipline imposed only for "good cause" determined by MSPB after formal administrative hearing	Subject to agency discretion
HEARING AUTHORITY	Statutory authority for formal hearing on the record under the Administrative Procedure Act (APA)	No APA statutory authority
AGENCY CONTACT	Statute prohibits Ex-Parte contacts	No statutory prohibition on Ex-Parte contacts
PERFORMANCE REVIEWS AND BONUS	<ul style="list-style-type: none"> • Ineligible for Agency Bonus; • Pay set by OPM and not tied to performance reviews; • Exempt from Civil Service Reform Act performance appraisal requirements 	<ul style="list-style-type: none"> • Agency awards bonus, reviews performance and sets employee pay
CLAIMANT'S APPEAL RIGHTS	<ul style="list-style-type: none"> • Appeal from an ALJ decision to the Agency's Appeals Council is accomplished by a letter. • The next level of appeal is to Federal Court 	<ul style="list-style-type: none"> • Loss of one level of appeal as no appeal to the Appeals Council. • Only appeal is to Federal Court

What SSA is again attempting to do is to divert a subset of cases from ALJs and have them heard by non-independent SSA employees. Instead of an ALJ presiding over the evidentiary hearing and issuing a decision, an appeals council attorney will be adjudicating the case. SSA argues that having appeals council attorneys hold regulatory evidentiary hearings is not a violation of the claimants' rights as, it contends, appeals council attorneys are equivalent to ALJs. This is simply not true.

These appeals council attorneys are directly selected by the Agency and promoted, demoted, and disciplined by their Agency supervisors. They receive bonuses and performance evaluations. In short, the Agency has direct control over these adjudicators who do not have statutorily-protected judicial independence.

These appeals council attorneys, who have never held SSA hearings or issued decisions after hearings, will have to undergo training to perform this work. Since the official learning curve for a new ALJ is nine months, this training will take at least several months even if the individuals involved are familiar with the disability program. Moreover, they will all be located in Baltimore, Maryland and Falls Church, Virginia, and time and travel costs will be required because these appeals council attorneys will be obligated to travel across the country to hold hearings for any claimant who declines a video hearing.

Last year, SSA asserted that it was too time consuming to hire more ALJs through the OPM process and that this new program would be a temporary measure, to end in one year. It is not productive or cost effective, however, to spend the time and money to train non-ALJs to hold hearings and issue decisions if they are going to only be assigned to handle this work for one year - unless, of course, SSA intends to continue to transfer more types of cases from ALJs to appeals council attorneys. Furthermore, it does not appear that there is an ALJ hiring crisis any longer. If the appeals council attorneys do not have enough work to keep them busy, the Agency should deploy them to write decisions, as there is currently an all-time high backlog of 73,000 decisions waiting to be written for Judges to review and issue.

Furthermore, under the SSA's plan, claimants who appear before these appeals council adjudicators will lose their right to a level of appeal. Currently, if a claimant is unhappy with the decision of the ALJ, an appeal can be commenced by a simple letter that will trigger the process of a complete review of the evidence, the hearing recording, and the ALJ's decision by the Appeals Council. Decisions of the Appeals Council are then appealable to Federal Court. A claimant having their case heard and decided by an appeals council attorney will not thereafter be able to appeal to the Appeals Council, but must seek redress directly in Federal Court, a much more expensive and difficult course. Moreover, claimants with non-disability cases, particularly overpayments, are often unrepresented as they do not have sufficient resources to hire an attorney and therefore would be particularly disadvantaged in filing an appeal.

The regulations relied on by SSA to justify its plan to divert these cases do not provide sufficient legal support for the Agency's position.

Title 20 Code of Federal Regulations, Part 404 §900 vests in all claimants:

- the right to a hearing before an administrative law Judge if dissatisfied with the determination of the state Agency, and
- the right to a review before the Appeals Council if dissatisfied with the decision of the administrative law Judge.

Sections 929 and 930 affirm the right to a hearing before an ALJ. Section 970 also provides that claimants may seek review of any adverse ALJ decision before the Appeals Council.

The Agency cites Part 404.956 for Title 2 cases, and the corresponding Title 16 regulation, 416.1456, for its authority to remove the non-disability caseload from ALJs. However, those regulations, which state that the Appeals Council may assume responsibility for holding a hearing by requesting that the Administrative Law Judge send the hearing request to it, give the Appeals Council only a limited power to hear particular cases. In fact, this is the manner in

which the Agency has interpreted these regulations in the past, as only individual cases, such as those involving novel issues, have been escalated from the ALJ level to the Appeals Council level. These regulations have not been used to subsume whole categories of cases to be heard by the Appeals Council. Any attempt to do so flies in the face of the longstanding regulatory scheme that clearly contemplates that individuals have the right to have ALJs hold their evidentiary hearings. Interpreting these regulations in the way SSA asserts would result in allowing SSA to replace ALJs with appeals council attorneys in any or all cases.

The Agency also argues that Parts 404.983 and 416.1483 authorize the Appeals Council to hold hearings on Federal Court remands. However, those regulations, which state that the Appeals Council may make a decision on the case or remand it to an ALJ to take action and issue a decision, including the holding of a hearing, make plain that the Appeals Council may act if it can make a decision without a further evidentiary hearing. SSA's initiative to remove the non-disability and remand hearings from ALJs and have the cases heard by appeals council attorneys is a dramatic change that is not contemplated or supported by the law or regulations.

With regard to remanded cases, the AALJ agrees that if the Appeals Council can make a determination on the record before them, it should do so; the existing regulations are clear in this regard. If an evidentiary hearing is necessary, it is more cost effective and efficient for the case to be sent back to the ALJ in the local hearing office to hold the hearing and issue a decision. Again, no additional travel costs or time will be required and no additional training is necessary. And, the right to an appeal of the ALJ decision to the Appeals Council would be preserved.

In conclusion, it is important for this Committee to understand the implications of SSA's initiative to supplant Judges with appeals council attorneys. This program is a thinly veiled attempt to eliminate APA protections for the American public in the name of reducing the backlog. Not only is this plan ill advised, it will barely impact the backlog of pending cases. More likely, it will result in a court challenge that will necessitate the rehearing of all of these cases by ALJs.

The Social Security Disability Program is an essential part of the safety net for the American people. And, it is likely to be the only opportunity they have to appear before a federal judicial official. We have a good system of providing full and fair in-person hearings to the public if it is properly managed. The Agency's difficulty with the backlog needs to be addressed with systemic changes that will result in an efficient adjudicatory process and good public service. Let us not erode this system by sanctioning poor management.

Thank you for the opportunity to address you, who have the stewardship of this vital program in your hands.

Chairman JOHNSON. Thank you. Thank you. You know, it is hard to quiz a judge. Ms. Ekman, you are recognized.

STATEMENT OF LISA EKMAN, DIRECTOR OF GOVERNMENT AFFAIRS, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES, ON BEHALF OF THE SOCIAL SECURITY TASK FORCE CONSORTIUM FOR CITIZENS WITH DISABILITIES

Ms. EKMAN. Good morning, Chairman Johnson, Ranking Member Larson, Members of the Subcommittee. Thank you for the opportunity to testify at this hearing. My name is Lisa Ekman, and I am the Director of Government Affairs for the National Organization of Social Security Claimants' Representatives, or NOSSCR.

I am testifying today on behalf of the co-chairs of the Social Security task force of the Consortium for Citizens with Disabilities, or CCD. The Social Security disability programs provide the modest but vital benefits to millions of people with disabilities so severe they are unable to perform substantial work, many of whom would live in abject poverty or be homeless without them.

Unfortunately, it took an average of 628 days for people who received an eligibility determination from an ALJ during the month of July to get access to these vital benefits. That wait time, which is far too long, is due, in large part, to chronic underfunding of the Social Security Administration's administrative budget since 2010. Prior to 2010, Congress invested resources in SSA, and SSA had been bringing the wait time down. SSA has shown what it can do when it is given adequate resources.

Having to wait that long for a hearing can have devastating consequences for an individual and his or her family. Some people lose their homes, some declare bankruptcy and some even die. Here is one such story. Ms. S was a resident of McKinney, Texas, Mr. Chairman. She led a comfortable life, a middle-class life while working as a property manager and inspector. However, she developed a number of conditions, including chronic pain syndrome, fibromyalgia, cervical spondylosis, thoracic and lumbar spine pain, migraine headaches, intracranial hypotension, and fibromuscular dysplasia. This was followed by ever-increasing depression and anxiety, especially after she could no longer work.

She tried every treatment doctors offered to reduce her pain and allow her to continue working, but by 2009, she just could not work anymore. She waited a long time for her hearing, which was finally scheduled in January of 2016, but she faced a terrible choice: miss an appointment for a test that might identify treatment to alleviate her pain that took months to schedule or postpone her hearing.

The hearing was postponed and rescheduled for April 2016, but unfortunately, Ms. S committed suicide several weeks before her hearing. She was 45 years old. She received a posthumous fully favorable decision, and her 15-year-old son now receives survivor's benefits.

My written testimony contains many other stories from—collected from claimants' representatives from all over the United States which highlight the hardship and debt pain inflicted on individuals with disabilities when they are forced to wait months, or

even years, for a hearing on their claim. And these heartbreaking stories are, unfortunately, becoming more commonplace.

During fiscal year 2016, 8700 people died waiting for a hearing for an ALJ. That is nearly one every hour. The hearing backlog must be addressed. The Social Security task force respectfully recommends the following actions for Congress and SSA to consider:

Congress should provide SSA with adequate funding to administer the Social Security Old Age Survivors and Disability programs. Only sustained, adequate funding, will allow SSA to reduce the time it takes to get a disability determination from an ALJ without negatively impacting customer service in its other core functions.

The task force appreciates the backlog reduction efforts that SSA is making within the inadequate budget it receives. And the CARES Plan obtained some promising initiatives, but more should be done to assist the nearly 1.1 million people facing this daunting wait.

SSA should work to ensure that a hearing is only held when necessary. And so first, SSA should do a better job of collecting full medical evidence at the initial application and reconsideration levels to ensure the decision is made on as complete and evidentiary record as possible.

Second, SSA should resume a robust program of reviewing claims for on-the-record decisions, cases where recent evidence clearly shows eligibility without requiring a hearing. I understand that this is part of the CARES Plan, but the attorneys who would conduct these reviews are not doing them because they have been pulled into addressing another horrible backlog, and that is, the writing of decisions after a hearing is held. This is yet another example of the consequences of inadequate funding and trying to shift things around to make it work within the budget that they have.

Third, Congress can assist to get the decision right the first time by facilitating reviews of more DDS denials, to ensure that these decisions are correct and prevent the need for an appeal. SSA should be permitted to use its dedicated program integrity funds to conduct these reviews, and they should increase the number of reviews.

Finally, SSA should consider revising some recently or finalized regulations the task force believes will harm applicants who are otherwise eligible for benefits and leads to increased appeals, including the Federal court.

One controversial rule regards the evaluation of medical evidence. The relationship between a person and their treating provider is unique, and opinions of treating providers deserve more weight than the opinion of someone who examines an individual once or reviews the claims file. The elimination of the treating physician rule is likely to lead to more appeals, more remands, and more delays as a result.

Thank you again for the opportunity to testify today, and I am happy to answer any questions you might have.

[The prepared statement of Ms. Ekman follows:]



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

**Hearing before the
House Ways and Means Committee
Subcommittee on Social Security**

**Determining Eligibility for Disability Benefits:
Challenges Facing the Social Security Administration
September 6, 2017**

**Testimony of Lisa Ekman, Co-Chair
Social Security Task Force
Consortium for Citizens with Disabilities**

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On Behalf of The Co-Chairs of the Social Security Task Force

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National Committee to Preserve Social Security and Medicare

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The Arc of the United States

TESTIMONY OF LISA EKMAN ON BEHALF OF THE SOCIAL SECURITY TASK FORCE,
CONSORTIUM FOR CITIZENS WITH DISABILITIES

Chairman Johnson, Ranking Member Larson, and Members of the Subcommittee, thank you for the opportunity to provide testimony for this hearing entitled "Hearing on Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration."

I am the Director of Government Affairs for the National Organization of Social Security Claimants' Representatives (NOSSCR). I am also a Co-Chair of the Consortium for Citizens with Disabilities (CCD) Social Security Task Force. Today I am testifying on behalf of the Social Security Task Force Co-Chairs. Testimony with a full listing of disability organizations supporting the testimony will be submitted after the hearing. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

The focus of this hearing is extremely important to people with disabilities. The Title II and the SSI disability programs provide modest but vital income support to individuals with significant disabilities and their families. More than 1 in 5 people with disabilities of working age lives in poverty in the US, nearly twice the poverty rate of their non-disabled peers.¹ That rate would be significantly higher without the modest benefits that the Social Security disability programs provide. Unfortunately, the chronic underfunding of the Social Security Administration's (SSA) administrative budget has undermined the ability of the agency to issue timely disability determinations and degraded customer service across the agency.

- The wait time to receive a determination from an Administrative Law Judge (ALJ) has reached an historic high of 628 days and this has devastating consequences for the claimants while they wait: some become homeless, some declare bankruptcy and some die.
- The past two decades demonstrate that when the Social Security Administration (SSA) receives consistently adequate funding it can reduce both the number of people waiting for a hearing and the time it takes to receive a determination from an ALJ. When SSA does not receive adequate funding, as it has not since 2010, the backlog and wait times grow. No search for efficiencies, reprioritization of tasks or technological improvements can substitute for adequate resources.
- SSA's CARES plan contains some promising initiatives but more could be done to reduce the hearing backlog and wait time for a disability decision.
- A number of SSA's recent regulatory changes are likely to increase the backlog and hearing delay and therefore should be reversed.

The CCD Social Security Task Force is pleased that SSA is examining every part of its disability determination process to implement backlog reduction measures within the inadequate budget it receives. However, the Task Force urges very careful consideration of increased use of technology in the hearing process or other initiatives that might threaten the ability of claimants to receive full consideration of their claims, undermine due process protections, or are not reflective of the ability of claimants (especially unrepresented claimants) to understand or comply with obligations created by new rules in the search for efficiencies. For example, while video hearings can be a useful option for certain claimants, SSA should not weaken claimants' ability to choose an in-person hearing when they believe it will be the most effective method of communicating with the decision-maker in their cases.

I. The Human Toll of the Hearing Backlog

The benefits provided by the Social Security disability programs are modest but vital to the Americans and their families who receive them. As of July 2017, SSDI benefits average only \$1,171.80 per month (\$14,041.60 annually) and SSI benefits average only \$564.16 per month (\$6,769.72 annually).² These modest benefits can mean the difference between keeping a roof over one's head and being homeless, being able to afford to eat and being hungry, affording a co-pay for needed medication and skipping doses, and getting needed medical treatment and letting conditions go untreated. The current wait time to receive a determination on an appeal to an ALJ is an average of 628 days. Waiting years to get a decision on a disability claim often leads to devastating consequences both for those waiting and their families. People lose their homes, exhaust their savings, declare bankruptcy and die while waiting on a hearing and decision on their disability claim. In fact, more than 8000 people died waiting for a hearing during Fiscal Year 2016.³ That is nearly 1 person per hour.

Here is a sampling of stories of the devastating consequences the hearing backlog has had on disability claimants that CCD has learned about from claimants' representatives:

Alabama: GH filed his claim while hospitalized in January 2016 for an infected heart valve. He had worked in construction but at age 56 he became homeless and was not receiving regular healthcare. He was denied in May 2016 and requested a hearing soon after (Alabama is a "prototype" state without reconsideration). Mr. H died in April 2017 of the same condition he originally alleged. He had severe sepsis throughout his body, requiring amputation of his arms and legs. Mr. H's condition while he awaited his hearing was also complicated by severe burns he endured when he lit trash on fire in an abandoned structure in an effort to cook food and warm himself. Unfortunately, Mr. H's claim has died with him since it was an SSI claim and he was never married. He spent the last year of his life waiting for a hearing that held the possibility of benefits and medical insurance that never came.

California: KL has a learning disability and is unable to read. Despite this obstacle, he worked for nearly 25 years at a grocery warehouse and there experienced a career-ending orthopedic industrial injury. While he was recovering, he experienced complications including two heart attacks and several seizures. He became homeless while going through the initial and reconsideration stages of the SSDI application process. As a result of being homeless, he lost custody of his teenage son. He became suicidal and was hospitalized on several occasions for this. Soon after requesting an ALJ hearing in September 2015, his representative filed a request for hearing and requested that it be flagged as critical because of Mr. L's dire need and risk of suicide. The request was granted—it took eight months for Mr. L to receive a favorable decision, rather than the 19 months average processing time at his local hearing office.

Connecticut: JE was a stay at home mother and homemaker. She applied for SSI when she began experiencing memory loss for which her doctors could not find a cause or a cure. Her application was denied, and approximately seven months before her hearing, she was finally diagnosed with early onset Alzheimer's disease. By the time her hearing was held, she was unable to state her address or her correct date of birth, and she did not know where she was during the hearing.

Connecticut: RS reached the rank of Captain in the U.S. Army and served in Afghanistan. He has worked with the FAA at his local airport to prevent dangerous items from entering planes. He also attempted work for the Department of Defense handling orders at a shipping and receiving department, and for the USDA processing grant applications for rural communities. However, he was no longer able to continue working as a result of his PTSD; he received an "Individual Unemployability" determination from the VA and his records repeatedly state that he is at high risk of suicide. Mr. S applied for SSDI in April 2012. He was denied and requested an ALJ hearing in May 2013. He received a denial almost two years later, in March 2015. He retained an attorney to

help him appeal to Federal Court and got a remand in December 2016. He is still waiting for a new hearing to be scheduled.

Connecticut: LMV was a preschool teacher. In February 2015, she was in an explosion that destroyed her home and burned half her body. In addition to the burns, the fire caused her to have PTSD and a severe facial pain disorder called trigeminal neuralgia. She filed for SSDI in March 2015 and sold her car to pay for expenses while she awaited a disability determination. Her church in Hartford and some of her relatives have helped her make ends meet. She was denied and requested a hearing in April 2016, which was held in June 2017. It took an additional two and a half months for the fully favorable decision to be issued. Ms. V is currently awaiting the start of her benefits.

District of Columbia: NJ's conditions, which include injuries to his elbow and shoulder, HIV, and anxiety, required him to severely reduce his working hours as a lighting designer. His SSDI application was denied at the initial and reconsideration stage, and he requested a hearing in September 2014. Mr. J's panic attacks increased over the next two years as he feared that his friend would stop paying for his housing and he would become homeless. When Mr. J and his lawyer arrived for his scheduled hearing in September 2016, Mr. J cried and shook in the waiting room for several hours before it was determined that the ALJ was not coming to work that day. Mr. J and his lawyer waived all notice requirements and assured the hearing office staff that they would return for a hearing at the first available opening. Still, Mr. J's depression deepened after this setback and his mental health team became worried he would commit suicide. The hearing was rescheduled for November 2016 and Mr. J was quickly awarded benefits. He can now afford housing and has started to pay off debts accumulated in the years he awaited a determination on his claim.

Florida: PC was diagnosed with a liver disease called Primary Biliary Cholangitis in the late 1990s. By April 2016, his health worsened to the point that he could no longer work. He applied for disability benefits the following month. Although he met a listing, he was denied at the initial level in August 2016 and at the reconsideration level in November 2016. He was hospitalized in January 2017 for the implantation of a dialysis shunt into his neck (TIPS procedure). After many complications, he was added to the transplant list. His lawyer made an "On The Record" request in May 2017 and Mr. C received a fully favorable decision shortly thereafter. Unfortunately, Mr. C passed away in late August without having received a transplant. In the past nine months, Mr. C's lawyer has had four other clients die while awaiting hearings.

Hawaii: MR worked as a mason all his life, but had to stop due to heart disease. He applied for benefits on February 1, 2015 and filed a request for a hearing on April 26, 2016. At a hearing on August 25, 2017, Mr. R's son testified that his father was stressed by not being able to support himself, and that his heart condition got progressively worse over time. Mr. R's son was the one testifying because Mr. R died of a heart attack in November 2016, eight months before his hearing. The ALJ issued a favorable decision from the bench.

Illinois: EB worked as a truck driver. When his declining health made that job impossible, he underwent a career transformation and became a cosmetology teacher. Then his health worsened further and he applied for SSI and SSDI. He was denied at the initial and reconsideration stages and lost his housing. Mr. B bounced between sleeping in his car and his friend's garage, when he wasn't hospitalized. Mr. B hired a lawyer to help him request a hearing in August 2016, who immediately requested that the claim be flagged as critical based on dire need. A supervisor at the Orland Park hearing office denied the critical case request, saying that living in a car did not qualify as dire need. At one point, Mr. B needed a colostomy, which became infected because he lacked running water and other necessities to care for himself. Eventually, a more senior supervisor allowed the claim to be expedited and Mr. B's hearing was held on May 11, 2017—approximately nine months after he made the request. He was awarded disability benefits.

Minnesota: CH worked with the clients of a center for adults with disabilities and also drove the bus that transported them to and from the center. She had a traumatic brain injury and applied for SSDI in April 2011. While she was waiting for her hearing, she was diagnosed with terminal cancer. She was unrepresented at the time of her hearing in November 2013 and did not attend it because she was hospitalized for cancer treatment. She subsequently hired a lawyer who asked the ALJ to reschedule the hearing. The ALJ instead dismissed the case and did not respond to a request to reopen it, so Ms. H appealed to the Appeals Council. She died in January 2014. In November 2014, the Appeals Council remanded the case for a hearing and Ms. H's widower attended a hearing in June 2015 to testify about his late wife. By that time, he was also suffering from Stage 4 cancer and died before the fully favorable decision was issued. Their three orphaned children, who ranged in age from 14 to 22 when their mother's case was finally resolved, received Ms. H's retroactive benefits.

North Carolina: JT applied for disability benefits in December 2015 because of congestive heart failure. He was denied at the initial and reconsideration levels during the summer of 2016, and requested an ALJ hearing on August 11, 2016. He died of congestive heart failure exactly one year later, never having a hearing scheduled.

Ohio: RW lives in Wooster. He requested a hearing in April 2016. A few months later, he became estranged from family and lost the housing they were providing. His lawyer requested his hearing be expedited based on dire need in October 2016 and despite repeated follow-ups, the request was not considered until March 2017. At that time, Mr. W was staying with his sister for a few weeks, so the dire need request was denied. Since then, Mr. W continues to struggle to find a place to sleep each night. Mr. W has made inquiries to his Senator and frequently calls and visits his lawyer in hopes that the case can move forward. It is scheduled for a hearing in October 2017, 18 months after the request was filed.

Pennsylvania: HW had worked as a Certified Nurse Assistant, but needed to apply for disability benefits after having a heart attack in May 2013. Her other impairments include Type 2 diabetes, chronic sciatica, atrial fibrillation, and obsessive compulsive disorder. She requested an ALJ hearing in March 2014 and had a hearing in March 2017. She received the notice of award in August 2017 – 1250 days after she requested a hearing - and is now eagerly waiting to receive benefits. She says "I am grateful for a fully favorable decision in my case, and I am grateful for a support network that enabled me to stay in my own home during that time, despite being unable to meet all mortgage payments in a timely manner. However, I cannot help but think how most people in my category might not be able to endure this seemingly interminable wait, at a time when they most need the benefit."

South Carolina: SB is 58 years old. He requested a hearing in December 2016 and one has not yet been scheduled. He has severe schizophrenia, bipolar disorder, and PTSD. He has been repeatedly hospitalized voluntarily and involuntarily in South Carolina and Nevada over the past five years because of these conditions. Without any income, it is difficult for him to get to the low-income clinic that treats him.

Texas: PS was a resident of McKinney. Until 2009, she led a comfortable upper middle-class life while working as a property manager and inspector. However, she developed chronic pain syndrome, fibromyalgia, cervical spondylosis, thoracic and lumbar spine pain, migraine headaches, intracranial hypotension, and fibromuscular dysplasia, followed by ever-increasing depression and anxiety, especially after she could no longer work. She tried every treatment doctors offered while caring for her son. She waited a long time for a hearing, but when it was scheduled in January 2016 she needed to postpone it because it was the same date as a medical test she had waited months to undergo. She hoped that the test would lead to treatment that would finally ease her pain, and that the hearing could be held quickly. The hearing was rescheduled for April 2016, but Ms. S committed suicide several weeks before it was held. She was 45 years old. She received a posthumous fully favorable decision. Her 15 year old son now receives survivor's benefits.

Texas: HW lived in the town of Pharr. He worked in construction and also harvested crops. He developed spinal problems, diabetes, and hypertension and applied for disability benefits in 2015. He requested a hearing in August 2016 and died from complications of his impairments in July 2017. At the time of Mr. W's death, his case had not yet been assigned to an ALJ or scheduled for a hearing.

Texas: LB was from San Antonio. She was a substitute teacher and school librarian until congestive heart failure, diabetes, and several white blood cell conditions (neutropenia, thrombocytopenia, myelodysplastic syndrome) made work impossible. She applied for disability benefits in 2015, requested a hearing in October 2016, and died from complications of her impairments in February 2017. At the time of her death, her hearing was still three months away.

Texas: IR lived in the town of Gonzalez. He drove oil and gas tanker trucks. After developing congestive heart failure, arthritis in his legs, and diseases of the kidneys and liver, he applied for disability benefits in 2015 and requested a hearing in March 2016. His attorney requested the hearing be expedited as a TERI (terminal) case but the request was still under review when Mr. R died in August 2016.

Utah: FP came to the United States as a refugee after the war in Bosnia, got a job as a product assembler in a factory, and became an American citizen. Many years later, after suffering an injury involving a conveyor belt at his workplace, he applied for SSDI. Mr. P was diagnosed with cancer while he was awaiting an ALJ hearing. He was able to attend the hearing, but he died during the long wait for a decision to be written. The ALJ denied Mr. P disability benefits, and a surviving family member is now appealing.

II. SSA Needs Adequate Resources to Administer the Social Security Programs

Administration of the Social Security disability programs is resource intensive. The processing and determination of initial claims and the adjudication of disability appeals require a significant amount of staff time to collect relevant information and fully develop the evidence required to make the correct determination. Unfortunately, SSA's Limitation on Administrative Expense (LAE) funding has not kept up with the agency's increasing workload. Although applications for SSI and Title II disability benefits have declined each year since 2010, there have been substantial increases in retirement, survivors, and Medicare claims, and the total number of people receiving Social Security benefits has risen. Chronic underfunding at a time of increased workloads has undermined SSA's ability to process disability applications and appeals in a timely manner.

Although processing times for initial disability applications and for completing reconsiderations of initial denials have remained relatively stable, the backlog in disability appeals at the hearing level has reached and stayed at historically high levels. As of the end of July 2017, claimants had to wait an average of 628 days from the time a hearing request was filed to receive a determination from an ALJ. There are just under 1.1 million people who have filed an appeal and face these daunting waits.

One cause of the hearings backlog is the chronic inadequacy of SSA's administrative funding. Between FY 2000 and FY 2007, the total funding shortfall exceeded \$4 billion and there was a concurrent and dramatic rise in the backlog. The backlog improved between FY 2008 and FY 2010 when Congress provided SSA with adequate administrative funding. In FY 2008, Congress appropriated \$148 million over the President's budget request, and in FY 2009 Congress provided SSA with \$700 million more than the previous year. The American Recovery and Reinvestment Act of 2009 (ARRA) provided SSA with an additional \$500 million to process the increasing number of retirement and disability applications, replace its aged National Computer Center, and hire thousands of new employees, including additional ALJs and hearing level support staff. These improvements undoubtedly assisted SSA in reducing the hearing level backlog. The FY 2010 appropriation of \$11.45 billion for SSA's LAE, a 10 percent increase over the FY 2009 appropriation, continued to provide SSA with the

resources it needed to meet its service delivery needs. Unfortunately, that trend did not continue and the inadequate funding since then has undone the progress SSA made between 2008 and 2011.

Although SSA has received a significant amount of additional funding for specified program integrity activities, core funding for SSA (LAE) has effectively been cut by about 10% since 2010 when taking inflation into account.⁴ This was during a time when the number of beneficiaries in all of the Social Security programs SSA administers (Old Age, Survivors, and Disability Insurance and Supplemental Security Income) has increased by about 13%.⁵ In addition, the funding of the Federal government through Continuing Resolutions led SSA to institute long hiring freezes (resulting in significant decreases in the overall number of staff due to attrition) and do away with overtime causing backlogs to grow in many workloads across the agency. The resulting deterioration in the ability of Social Security to serve Americans in all of its core functions is disappointing and Americans deserve better. For example, the average wait time on SSA's national 800 number is 18 minutes and nearly half of callers hang up before their call is answered. In addition, thirteen percent of callers receive a busy signal, due to the 450 fewer agents at the teleservice centers to handle the 37 million calls they receive each year.⁶ Nearly half of visitors to a field office must wait at least three weeks for an appointment and visitors without an appointment wait more than an hour for service because field offices have lost 1,400 field staff.⁷ More than 3.6 million actions were pending at the SSA Program Service Centers in January, more than double the normal pending workload at these components.⁸ This backlog leads to delays in the timely adjustment of benefits and the processing of claims once approved. Critical information technology maintenance and modernization is on hold due to a lack of resources as well.

Additional funding is required for SSA's LAE to reduce and eliminate the backlog in processing disability claims and to provide essential services to the public. CCD appreciates the \$90 million in anomaly funding Congress provided to SSA to address the backlog but a one-time increase in funding cannot make up for years of underfunding. The current situation is dire and without increased adequate, ongoing appropriations to fund SSA, the situation will continue to deteriorate. We strongly urge Congress to provide SSA with sufficient administrative funding so that there are enough personnel in SSA field offices and the stage agencies to adequately process, develop, and determine disability claims in a timely manner and so SSA to hire sufficient ALJs and support staff to reduce the hearing backlog and the wait time for disability hearing decisions. Additional funding is needed to ensure that SSA is able to provide all of its critical services to retirees, survivors and people with disabilities and their families. Reprioritizing activities is not an answer – when the funding pie is too small, a bigger piece of that pie going to one activity means a smaller slice goes to other activities and SSA's service to all Americans suffers.

III. SSA's CARES Plan: More Must Be Done to Reduce Wait Times

The CCD Social Security Task Force appreciates the efforts that SSA is making to reduce the number of people waiting for a hearing and the amount of time it takes to receive a decision on an appeal of a disability denial. The Task Force is aware that testing and implementing promising new initiatives and hiring and training new ALJs and support staff takes time. Many of the promising initiatives contained in the CARES plan are in the very early stages and wait times are increasing as we wait to see the impact these initiatives will have on the backlog. At the same time, despite the \$90 million in anomaly funding SSA received for FY 2017-18, many components of SSA's updated CARES plan have been suspended (for example, pre-hearing conferences, pre-hearing summaries, and the National Adjudication Team) with no indicated date for resuming those activities. Others are only at the pilot stage (e.g. shared scheduling services) and will not have a substantial impact on the backlog or processing time in the immediate or near-term. Because personnel have been reassigned away from the National Adjudication Team to assist with the extensive decision writing backlog, initiatives such as the Senior Attorney Program (where senior attorneys reviewed cases for the possible on-the-record decisions) that have proven successful at reducing the hearing backlog in the past are effectively not being utilized as part of

this effort. The CCD Social Security Task Force recommends the following actions be taken to assist with decreasing the backlog.

a. Getting the Decision Right at the Initial Level

It is the position of the CCD Social Security Task Force that ensuring that a disability claim file is as complete as possible before the initial decision is made is in the best interest of disability claimants, SSA, and the American public.

Better Case Development By Disability Determination Services (DDS): SSA regulations specify that the agency has the responsibility to “develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.”¹⁹ The regulations specify that SSA will make two attempts to obtain medical records and will proceed to make a decision without the records if not received after those requests. Claimants’ representatives routinely report that it takes multiple requests over weeks (and sometimes months) to obtain many medical records and those requests must be “higher touch” (with many calls or visits to medical facilities) than simply sending a written request. In fact, some representatives have hired staff whose entire job is dedicated to obtaining medical records for their clients. The two written requests required by current regulations are insufficient in many cases and cannot be considered “every reasonable effort” given the reality of how difficult it is to obtain medical records. Initial decisions on disability claims are often made without complete medical records as a result. Although the CCD Social Security Task Force appreciates the desire for timely issuance of initial determinations, it is concerning that doing so may come at the expense of obtaining complete medical records. This can lead to a denial that must be appealed to get a decision on a complete record, contributing to the hearing backlog and requiring the claimant to endure the extremely long wait for a hearing. The Task Force encourages SSA to implement an initiative to ensure more complete development of medical records at the initial level.

Information About Representation: Representatives play an important role in obtaining medical and other information to support their clients’ disability claims and helping SSA to streamline the disability determination process. They routinely explain the process and procedures to their clients with more specificity than SSA can. They obtain evidence from medical sources, other treating professionals, school systems, previous employers, and others who can shed light on the claimant’s entitlement to disability benefits. Given the importance of representation, the Social Security Act requires SSA to provide information on options for seeking legal representation, whenever the agency issues a notice of any “adverse determination.” This statutorily required information is typically provided only once the claimant has requested a hearing before an ALJ. SSA should provide claimants with more information on options for representation before and during the initial application process.

Expedited Screening Tools: The CCD Social Security Task Force supports the continued use and expansion of existing tools for expediting disability determinations. SSA already has in place several successful methods of expediting disability determinations for claimants whose conditions are so severe that they clearly meet the Social Security disability standard. These include Quick Disability Determinations (QDDs), Compassionate Allowances (CAL), and terminal illness (“TERI”) cases. CAL allows SSA to quickly identify claimants with extremely severe, often terminal conditions such as certain advanced cancers and life-threatening neurological disorders, that can be adjudicated quickly based on diagnosis without having to complete additional analysis of the impact of the condition on the ability to work. QDDs use a computer-based predictive model to identify cases where a medical eligibility is highly likely and medical evidence is readily available, enabling the state

DDS to expedite case processing. Initiatives such as QDD and CAL allow SSA to review cases more efficiently, while expediting approval for claimants with some of the most severe conditions and illnesses. These initiatives provide people with disabilities facing devastating illnesses the security of knowing that they and their families have income to rely on and removing one worry people face during a very challenging and scary time.

These screening initiatives appear to be identifying disability claims that clearly should receive awards and that involve conditions with a high chance of mortality, as they were intended to do. The SSA Office of Inspector General issued an informational report regarding the implementation of these initiatives last year.¹⁰ The report indicated that of the approximately 82,000 people whose cases were identified for CAL or QDD in Fiscal Years 2008 and 2009, over 96% were eventually awarded benefits. The vast majority, 76,000, were approved without having to appeal, and of those, one in four died within three months of application, more than seven in ten had died by June 2015, and another 20% were still receiving disability benefits.

The CCD Social Security Task Force supports continuation of these initiatives with two critical improvements:

1. SSA should adopt clear criteria for what constitutes a CAL condition. SSA should develop and implement clear, formal, and transparent criteria and procedures to add, continue, and remove CAL conditions.
2. The Task Force also supports improvement of the computer program used to screen cases for potential processing as a CAL claim to ensure all eligible claims are processed under expedited procedures and non-eligible claims are excluded.

To improve the development of cases at the initial level, the CCD Social Security Task Force additionally recommends SSA:

- Provide more assistance to claimants at the application level regarding necessary and important evidence so that all impairments and sources of information are identified, including non-physician and other professional sources. This is especially important for claimants with mental impairments and limited English proficiency.
- Ensure that questionnaires and forms are understandable to claimants and as free of jargon as possible, as well as appropriately tailored to specific types of impairments and probative of information that addresses the disability standard as implemented by SSA. This “language” barrier can lead to incomplete applications missing key details needed for full development of the claim.
- Provide better explanations to medical providers. SSA and DDS forms and questionnaires should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and should ask questions that are probative of evidence and information relevant to the standard. Unclear, hard to understand forms can result in incomplete responses as well as delays in obtaining medical evidence.
- Improve the quality of consultative examinations (CEs). Steps should be taken to improve the quality of the CE process. There are many reports of inappropriate referrals (e.g., to providers with the wrong specialty given the claimant’s condition(s)), short perfunctory examinations, and failure to provide an interpreter for people with limited or no English proficiency during the exam. In addition, there should be more effort to have the treating physician conduct the consultative examination, as authorized by SSA’s regulations.
- Increase reimbursement rates for providers. To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for CEs and for medical experts who testify at hearings, to ensure availability of qualified medical professionals. Appropriate reimbursement rates would also increase the frequency

with which treating physicians agree to conduct CEs at SSA's request, enabling adjudicators to obtain additional medical evidence from a treating source already familiar with the claimant's condition(s) and medical history.

b. Additional Screening of Denials Earlier in the Process

The CCD Social Security Task Force has two additional recommendations to reduce the number of claims appealing to the hearing level or reduce the number of appeals for which hearings are required.

Increased Targeted Denial Reviews: One way that Congress could help SSA eliminate its backlogs is by expanding the allowable uses of program integrity funding. SSA's Office of the Inspector General lists "reduce disability backlogs and improve decisional quality" among their top management issues for Fiscal Year 2017.¹¹ A disability benefits program with true integrity is one that allows claimants to obtain prompt and accurate determinations.

If Congress included Targeted Denial Reviews (TDRs) in allowable program integrity activities, the agency could increase program integrity while reducing the hearings level backlog. TDRs allow SSA's Office of Quality Review (OQR) to examine unfavorable decisions of disability claims issued by state agencies. Fewer than 3 percent of state agency denials receive TDRs; the number performed varies each year based on resources available to the agency. In comparison, Sections 221 (c) and 1633 (e) of the Social Security Act require SSA to review at least half of the favorable decisions issued by state agencies. In Fiscal Year 2016, 7.7 percent of TDRs resulted in a reversal of an unfavorable decision and the issuance of a favorable decision. That reflects nearly 3,400 individuals with disabilities who were spared the need to wait additional months and years to receive critical benefits. Since the program was fully implemented in Fiscal Year 2012, more than 17,000 cases have been kept out of the hearings-level backlog because of TDR. Allowing SSA to use program integrity funding to perform TDRs would increase the efficiency and accuracy of the disability programs.

Resume Issuing On-The-Record Decisions: It is sometimes the case that a fully favorable decision can be issued on a claim without needing a hearing. There are a number of reasons why an on the record decision is appropriate. For example, a claimant or representative might have been able to obtain additional evidence not available at the time of the DDS decision. Making such an individual wait until a hearing slot is available is cruel and holding a hearing on such a claim is inefficient for SSA. On the record decisions have been helpful in reducing the hearing backlog in the past. As recently as Fiscal Year 2010, senior attorneys issued more than 54,000 on-the record decisions, last year just over 1,000 were issued.¹² As of the end of July 2017, senior attorneys have issued only 686 on the record decisions this fiscal year.

The former Senior Attorney Program allowed senior staff attorneys in hearing offices to issue fully favorable on the record decisions in cases that could be decided without a hearing. Although the Task Force is aware that concerns have been raised regarding issues with the policy compliance of some on the record decisions, the Task Force is not aware of any publicly available study or data regarding these concerns. It is important to remember that a non-policy compliant decision is not necessarily an incorrect decision. SSA has never indicated that any on the record decisions issued by senior attorneys were incorrect (i.e. that they awarded benefits to someone not eligible) and to our knowledge has never used the avenues it possesses to review or reverse decisions they believe to be incorrect. If there have been on the record decisions in the past that did not comply with policy, SSA should provide the training and oversight necessary to ensure program integrity within these initiatives (as they do with ALJs who issue non-policy compliant decisions) rather than abandoning a successful initiative.

c. Recent Regulatory Changes Will Worsen the Backlog

In its revised CARES plan, SSA touts some recent regulatory changes as assisting with backlog reduction. The CCD Social Security Task Force believes some of these regulatory changes have actually had the opposite effect and are contributing to the backlog. The Task Force encourages SSA to consider rescinding these regulatory changes or offering better guidance and clarity on how to implement them, both because of the detrimental effects on claimants and the contribution of these regulations to increasing the hearing backlog.

i. Evaluation of Medical Evidence Rule (elimination of treating physician rule)

SSA issued a final rule revising the rules regarding the way medical evidence will be evaluated and weighed when making a determination of disability that took effect March 27, 2017.¹³ The revised rules eliminated the special weight given to the evidence provided by a claimant's medical treating source. Although the delivery of healthcare may have changed over the years, the relationship between a person and their treating provider remains unique and the opinions of treating providers deserve more weight than the opinion of someone who either examines an individual once or only reviews the claims file. The evidence from a treating source is generally more persuasive because treating providers treat. Providing effective treatment to a person typically requires a much greater depth of knowledge and information than that relied on by professionals merely performing an evaluative function. A provider would not prescribe medication, recommend tests, give advice, refer to a specialist, perform surgery, or provide other treatments unless they found the patient's reports and their own observations and conclusions persuasive enough to require these actions. By putting the evidence of a treating source on the same level of importance with someone who may never have examined the individual, this rule hurts claimants by devaluing the evidence received from treating sources with longitudinal knowledge of the claimant. This rule change, which is likely to be challenged in court, will not lead to more accurate decisions or decrease processing time. Rather, the elimination of the treating physician rule is likely to lead to more appeals, more remands, and more delays.

Similarly, we believe the parts of this final rule that allow SSA to disregard disability determinations of the Veterans Administration and other third parties and limits the explanation decisionmakers must provide when weighing evidence from different sources will also lead to more appeals and remands. The CCD Social Security Task Force raised these concerns in comments on the proposed rule but the final rule did not fully address the issues raised.¹⁴

ii. Program Uniformity or "5-day Rule"

SSA issued a final regulation requiring the submission of or informing the agency about all evidence at least 5 business days in advance of a hearing, subject to some good-cause exceptions.¹⁵ The CCD Social Security Task Force opposed this change for several reasons. SSA indicates in the preamble to the final rule that "a complete evidentiary record is necessary for us to make an informed and accurate disability determination or decision."¹⁶ The Task Force agrees and believes that creating an arbitrary deadline for the submission of evidence will hurt claimants, especially unrepresented claimants, who don't understand their obligations under this rule or have evidence inappropriately excluded in the name of efficiency. In addition, it is the Task Force's position that it is inconsistent with some provisions of the both the Social Security Act and other SSA regulations, as outlined in the Task Force's comments in response to the proposed rule.¹⁷ Finally, the Task Force is concerned that the exclusion of evidence under this rule is leading to more appeals to both the Appeals Council and Federal Court making the backlog worse.¹⁸ Although compliance with the rule was only required as of May 1, 2017, claimants representatives are already reporting significant issues with implementation of the rule and have appealed several ALJ denials as a result of the inappropriate exclusion of important evidence.¹⁹ The CCD Social Security Task Force submitted extensive comments in response to the proposed rule.²⁰

iii. "All Evidence Rule"

SSA revised its rules in 2015 to require claimants and their representatives to submit or inform SSA about all evidence related to the individual's disability. The CCD Social Security Task Force submitted extensive comments in response to the proposed rule which outline the Task Force's full concerns.²¹ Unfortunately, many of these concerns have come to pass.

One perhaps unintended consequence of this rule has been the creation of extremely large files which can require extensive amounts of time for SSA ALJs and support staff to review. In addition, SSA has not issued clear guidance to claimants, representatives, and ALJs on what constitutes a duplicate record that does not require submission. The preamble to the final rule indicates that claimants have "the duty to submit all evidence that relates to your disability claim received from **any source in its entirety**," (emphasis added). Different ALJs define a duplicate in different ways and no guidance has been provided regarding what constitutes a duplicate to clarify what is expected of representatives and claimants so files do not include unnecessary information. If such guidance were provided, an expensive and potentially problematic software program SSA is calling "De-Doop" currently being developed might not be necessary. We are concerned that DeDoop will remove records that should remain in the claimant's file, such as lab test results that may look similar from page to page but could contain minor but critical differences. Given that SSA's new rules on the valuation of medical evidence includes a provider's familiarity with the complete file as one determining factor determining the weight evidence from that provider is given, removing records from one provider that appear in another provider's records could reduce the weight given to that provider's opinions. We are also concerned about whether claimants and representatives will have access to the documents that are "DeDooped" and whether they will be part of the administrative record furnished in federal court cases. Advocates have made multiple requests for a demonstration of DeDoop and an opportunity to share these concerns, but SSA staff have rejected them.

Conclusion:

The number of people waiting for a hearing before an ALJ and the long waiting time is unacceptable. Claimants often experience incredible hardship during the delay in getting their claim decided – homelessness, bankruptcy, and sometimes death. SSA needs additional resources to be able to serve all its customers in a timely and accurate manner. The Task Force also urges SSA to take additional steps to ensure that eligible claims are awarded as early in the process as possible by improving the development of evidence earlier in the process and ensuring that claims that do not require a hearing to establish eligibility for benefits are processed without a hearing.

Thank you again for the opportunity to testify. CCD looks forward to continuing to work with the Subcommittee to protect this vital program for people with disabilities.

Endnotes

- ¹ Rehabilitation Research and Training Center on Disability Statistics and Demographics, 2016 Disability Statistics Annual Report, p. 8, https://disabilitycompendium.org/sites/default/files/user-uploads/2016_AnnualReport.pdf
- ² Social Security Administration, Month Statistical Snapshot July 2017, https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/
- ³ Email correspondence with Social Security Administration Office of External Affairs, September 23, 2016
- ⁴ Kathleen Romig, Center on Budget and Policy Priorities, "Cuts Weakening Social Security Administration Services Policymakers Can Address Through 2017, 2018", updated March 15, 2017/2018 Funding, <https://www.cbpp.org/research/social-security/cuts-weakening-social-security-administration-services>
- ⁵ Bonnie Kind, Associate Commissioner, Office of Budget, Social Security Advisory Board Budget Update, January 23, 2017, on file with author
- ⁶ Kathleen Romig, <https://www.cbpp.org/research/social-security/cuts-weakening-social-security-administration-services>
- ⁷ Kathleen Romig, <https://www.cbpp.org/research/social-security/cuts-weakening-social-security-administration-services>
- ⁸ Bonnie Kind, Associate Commissioner, Office of Budget, Social Security Advisory Board Budget Update, January 23, 2017, on file with author
- ⁹ 20 CFR § 404.1512(d)
- ¹⁰ Office of the Inspector General, Social Security Administration, Status of Compassionate Allowance and Quick Disability Determination Expedited Cases, March 16, 2016, <http://oig.ssa.gov/sites/default/files/audit/full/pdf/A-01-16-50051.pdf>
- ¹¹ <https://oig.ssa.gov/audits-and-investigations/top-ssa-management-issues>
- ¹² According to Social Security Administration data, there were 109,428 on the record decisions in FY2010, 55,261 issued by ALJs and 54,186 issued by senior attorneys. On the record decisions constituted 15% of all hearing level dispositions that year. In fiscal year 2016 (through 8/23/16) only 20,113 total on the record decisions were issued, 19,226 by ALJs and 1,187 issued by senior attorneys, constituting only 3% of dispositions. Source: Email correspondence with Social Security Administration Office of Disability Adjudication and Review, August 28, 2017; on file with author
- ¹³ 82 CFR 5844, <https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-00455.pdf>
- ¹⁴ Social Security Task Force, Consortium for Citizens with Disabilities, Comments on the Notice of Proposed Rulemaking on Revisions to Rules Regarding the Evaluation of Medical Evidence, 81 Fed. Reg. 62559, November 8, 2016, <http://c-c-d.org/fichiers/CCD-SSTF-Treating-Physician-Comments.pdf>
- ¹⁵ <https://www.federalregister.gov/documents/2016/12/16/2016-30103/ensuring-program-uniformity-at-the-hearing-and-appeals-council-levels-of-the-administrative-review>
- ¹⁶ 81 FR 45079
- ¹⁷ Social Security Task Force, Consortium for Citizens with Disabilities, Comments on Notice of Proposed Rulemaking on Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process, 81 Fed. Reg. 45079, August 26, 2016, p. 2-4, <http://c-c-d.org/fichiers/CCD-SSTF-Ensuring-Program-Uniformity-comments-final.pdf>
- ¹⁸ Social Security Task Force, Consortium for Citizens with Disabilities, Comments on Notice of Proposed Rulemaking on Ensuring Program Uniformity at the Hearing and Appeals Council Levels of the Administrative Review Process, 81 Fed. Reg. 45079, August 26, 2016, p. 4, <http://c-c-d.org/fichiers/CCD-SSTF-Ensuring-Program-Uniformity-comments-final.pdf>
- ¹⁹ See, for example, *Howe v Colvin*, 147 F.Supp.3d 5 (D.R.I. 2015), a case from Region I, where the federal court found that he ALJ abused her discretion in refusing to accept evidence submitted less than five days before the hearing, and remanded the case for consideration of this evidence years after the hearing was originally held
- ²⁰ <http://c-c-d.org/fichiers/CCD-SSTF-Ensuring-Program-Uniformity-comments-final.pdf>
- ²¹ Social Security Task Force, Consortium for Citizens with Disabilities, Comments regarding Docket No. SSA-2012-0068, Submission of Evidence in Disability Claims, April 21, 2014, http://c-c-d.org/fichiers/CCD_Comments_evidence_NPRM4-21-2014FINAL.pdf

Chairman JOHNSON. I thank all of you. As is customary, for each round of questions, I will limit my time to 5 minutes, and ask my colleagues to also limit their questioning time to 5 minutes as well.

Ms. Disman, as I said in my opening remarks, waiting almost 2 years to get a hearing decision is too long. Today, you have shown us Social Security's plan to get people hearings on time. But under that plan, people still aren't going to get a timely decision until at least 2022. Why is this plan taking so long?

Ms. DISMAN. Thank you.

Chairman JOHNSON. Turn your mic on.

Ms. DISMAN. Thank you, Mr. Chairman. Let me first say, in being with the Social Security Administration for over 50 years, and starting as an interviewer of disability applications, I share the concern, as do my colleagues, with the long wait for hearings as well as other issues that have been identified by the witnesses here. To listen and read the stories that were presented about people being deceased before a hearing took place is unacceptable to all of us.

However, we have to put everything on the table when we look at the hearings process. We have to look at all aspects of it. It is not just the hiring of human resources, it is being strategic; otherwise, you will have what happened before. We had an aggressive plan before. We reduced the hearings backlog. What happened was, baby boomers came of age, and they became disability-prone; the recession hit; the increased receipts of applicants were upon us. And, basically, we had not updated our business processes, or had the IT technology to really modernize where we are going.

So why does the plan take so long? We have to look at all aspects of it, in addition to making sure that we have sufficient staffing. I am pleased to say that this year, we are hiring 130 ALJs in addition to the 200-and-some-odd that we hired last year. We are also hiring over 600 support staff. Unfortunately, we hired more ALJs and didn't have the comparable support staff, because the agency had a self-imposed freeze. So we were able to hire one aspect, but it makes sense if you are hiring more judges, you need the decision writers, and you need the support staff to work with them.

So our commitment is to bring over 600 on before the end of the year, and that is with the help of the anomaly money. So it does take a long time to deal with systemic problems, but I want to assure you, for the Acting Commissioner and myself, all options are on the table. We are looking at all recommendations. As a matter of fact, Judge Zahm and I have met a couple of times, and I have actually looked at the 45 recommendations that she has made. One of them, which is a short form or template for the fully favorable, is something that the agency is looking at right now to move forward and to get agreement on a direction.

So, we ask you to work with us. Your Committee has come up with great ideas, and we appreciate your support for Social Security all these years.

Chairman JOHNSON. You have been working with us, and we have been working with you for the whole time I have been in the Congress, and I haven't seen much improvement. It wasn't that long ago that Social Security was facing a different disability back-

log, and telling our Subcommittee how that backlog was going to be tackled. Yet, less than 10 years later, here we are again with another disability backlog, and I don't know that your new plan is going to stop that cycle.

How can you assure us that in 10 years, we are not still talking about another disability backlog?

Ms. DISMAN. Well, my hope, Mr. Chairman, is that being strategic and looking at all aspects of the backlog will enable us to minimize the cycle. Now, we can't help what happens externally, whether there is another recession and more filings, or whether you have the issue—for example, there was a period of time where we couldn't hire administrative law judges because of the Office of Personnel Management, and thankfully, Congress helped us correct that situation.

But if we don't have a plan that is strategic and deals with the core of our problems, just giving us the budget won't stem the cycle that you have just referenced. For example, when I looked at the actuary projections of receipts for disability, they are going down now. Well, that is good news for us because that allows us to work on the backlog. By the way, the cases are averaging over 600 days, because we are working on the most aged cases now, and that means the processing time goes up.

But having said that, and working on the cycle that we are doing, we need to make sure we have fixes that prevent or minimize these swings in the workloads. And that is where we are all working very hard together.

Chairman JOHNSON. Thank you, ma'am. Mr. Larson, you are recognized.

Mr. LARSON. Well, I share the Chairman's concern, and 600 days is just flat out unacceptable. And we are the United States of America, these are our fellow citizens, this is a program that they have paid for. So I have heard a lot of discussion today, so what I am going to ask everybody is, you know—we cite the figure that there has been a 13 percent increase of baby boomers coming through the thing, but a 10 percent decrease.

If you have a 10 percent increase, could you turn this around? And what would that timeframe then be?

Ms. DISMAN. I would have to look at the particular statistics.

Mr. LARSON. Okay. That is not an answer.

Ms. DISMAN. But I want to give you an answer: Let me just say, for every \$100 million that is given in our budget—first of all, we want the President's budget because the President's budget commits a plan for us to balance the workload. But for every extra \$100 million, I will give you two examples: We can do another 100,000 of disability applications, or another 50,000 of hearing decisions. So I will take your question back—

Mr. LARSON. Why does that take so long, Ms. Larin? You have said there is a number of recommendations that don't seem to be followed. What would you say in this case? Would the additional money help or not help?

Ms. LARIN. I think where GAO's work—what GAO's work speaks to is, is SSA using the resources that they currently have as efficiently and effectively as they can?

Mr. LARSON. Are they?

Ms. LARIN. We found several instances where we don't believe that they are. Where they could be more effective and more efficient.

Mr. LARSON. So in a case where they are not, what is—what can the government then do? What does GAO then recommend?

Ms. LARIN. Well, we have several recommendations on how they can better use the information that they have, the administrative data that they are collecting, to inform how they can make quicker decisions, more accurate decisions, and more consistent decisions.

Mr. LARSON. Will that result in a savings of money and time and effort?

Ms. LARIN. Well, it certainly would save in the time and effort if they were more efficient and more effective in making their decision.

Mr. LARSON. Ms. McLaren, what would you say about additional resources, you very definitely indicated that in your remarks?

Ms. MCLAREN. Certainly. You know, the DDSs are always in need of more resources as well. You know, the work we do in the DDSs is similar to what they face in the ALJ courts. The disability examiners are stretched thin because we have a hiring issue as well there. If we had more adequate resources to take the time that is necessary to perform the reviews, there might be an impact. And we also, back to the statements that—

Mr. LARSON. That is a very troubling thing. We say, and my colleagues over here will say, look, more money isn't the answer. We just say to you, look, we recognize that you are down, if we give you more money and—you can't give us an answer. And so it is very disturbing to people that want to help and see the citizens get help. We hear Ms. Ekman talking about—putting a real face on this, and then we go round and round and round without the ability seemingly to help. Judge, you—

Judge ZAHM. Give me a clerk and two attorneys. Give my judges a clerk and two attorneys and we can go to town. We will be able to turn out a lot more decisions. And—

Mr. LARSON. What does that mean, "a lot more decisions"? We have a 600, you know, this backlog. What does that exactly mean?

Judge ZAHM. I would say that judges, if given proper staffing, could probably add another 50 to 100 hearings per judge, and we have 1600 judges, per year, if you gave us staffing, and if you change the procedures that are roadblocks.

Mr. LARSON. If we change the procedures, what is the number? Do you reduce it or do we just add more judges, more staff, more—

Judge ZAHM. No, no, no. We definitely can reduce the backlog.

Mr. LARSON. To what?

Judge ZAHM. Give me a minute and let me figure it out.

Mr. LARSON. Ms. Ekman, explain again what people are actually going through and how incompetent, in the face of that, we all seem.

Ms. EKMAN. Thank you, Mr. Larson. People are losing their homes, they are dying, and they are becoming bankrupt while they wait for a decision. I think, Mr. Larson, when you chronically underfund an agency, you can't expect a small increase in funding

in the short term to fix those problems. You need adequate funding sustained over a long period in order for SSA to get itself out of the hole that Congress has dug for them by giving them inadequate resources.

You can't fix your problems by shifting money from one place to another without expecting all of the service that SSA provides to America to suffer. And, unfortunately, it is going to take a number of years even if you were to give significantly increased funding for SSA to be able to dig itself out of the hole they have been put in by inadequate funding over the last 7 years.

Mr. LARSON. Well, it sounds like they could also make some changes that are being recommended by the GAO as well. I would be interested in finding out why it is that GAO can't get together with your group and come up with a comprehensive solution to this, that Congress can get its hands around, instead of these endless tastes-great/less-filling debates that we seem to have and nothing gets done.

Chairman JOHNSON. I appreciate your questions. I appreciate your questions, and I totally agree with what the Ranking Member said. I hope you all are listening to his questions. And some of the answers that we are getting are, you know, nebulous, fruitless, something. Mr. Rice, you are recognized.

Mr. RICE. Thank you, Mr. Chairman. I am looking at this chart of disability by wait times. It starts in 1986 and goes to 2016, 30 years, and the trend doesn't look very favorable. It is apparent that it is not a new problem. This is something that has been evolving over 30 years. But I also see that there are peaks and then there are valleys. And what I want to know is, what is the trend? Is this getting better or is it worse? Ms. Disman.

Ms. DISMAN. The trend is getting better. Over the last 7 months, we have reduced the pending. We are working on the aged cases. We have a number of initiatives that we started, but unfortunately, because of the decision writing backlog we had to stop. But with the hiring that we are going to do, there is some incredibly promising initiatives. We have to deal with—

Mr. RICE. Okay. Thank you. I want to ask, what is the trend, in your opinion, Ms. Larin?

Ms. LARIN. Federal disability programs have been on GAO's high risk list for many, many years. And—

Mr. RICE. Is the trend favorable today or not?

Ms. LARIN. We have not—

Mr. RICE. Is it going to get worse or get better?

Ms. LARIN. Well, we haven't seen much of an improvement.

Mr. RICE. Okay. Ms. McLaren.

Ms. MCLAREN. Initial disability applications are down, so are the appeals at the reconsideration level. So from a DDS perspective, we would see decreasing numbers in the front—

Mr. RICE. So you think the trend is good and we are going to start to see decreasing numbers?

Ms. MCLAREN. Some of those issues I couldn't speak to, those are SSA's issues.

Mr. RICE. Thank you. Ms. Zahm—Judge Zahm.

Judge ZAHM. The trend is down because applications are down.

Mr. RICE. So you see it getting better, Ms. Ekman?

Ms. EKMAN. Thank you, Congressman. We have not seen an improvement yet. I think—and the——

Mr. RICE. What would be your opinion? Do you see one on the horizon or not?

Ms. EKMAN. We see promising initiatives. It is going to take some time for them to——

Mr. RICE. Thank you. I want to know about the trend in claims. I know we had a huge upswing in claims as people talk about the baby boomers aging and the recession, which force people to look for alternative sources of income. You say that the claims are down 600,000 in the last year. Is that right?

Ms. DISMAN. What we were talking about—I can give you a figure of what they are down. The actuary shows they are down by about 100,000 from the prior year and 100,000 before that.

Mr. RICE. What are the total numbers of claims per year? Someone said 4 million. Is that right?

Ms. DISMAN. Well, the total number of claims per year that we are dealing with, I need to get back to you on that figure.

Mr. RICE. Roughly. Judge Zahm, do you know the total number of claims per year?

Judge ZAHM. No.

Mr. RICE. Okay. Do you know, Ms. McLaren?

Ms. MCLAREN. Yes, it is 4.7 million, but that includes all initial recon and CDR claims——

Mr. RICE. So we have a 100,000 drop out of 4 million?

Ms. MCLAREN. Right.

Mr. RICE. All right. What percentage of claims—you know, the whole reason we have to have hearings is to make sure people are eligible. Right? If we knew—if they came into the office and said, I am disabled, and we could just believe that they met all the qualifications, we wouldn't have to have the hearings, right? What percentage of hearing applicants, Judge Zahm, are approved versus rejected? Do you know that?

Judge ZAHM. At the hearings level it is approximately 45 percent of applicants are approved.

Mr. RICE. And ultimately, on appeals and on through, do you know the answer to that?

Judge ZAHM. No, probably not a whole heck of a lot different.

Mr. RICE. Ms. Ekman.

Ms. EKMAN. Overall, after all levels of appeal, it is about 4 in 10 that get approved. Initial claims, there is about 1 in 3 that are approved. So 2 out of 3 are denied at the initial level.

Mr. RICE. Wait a minute. She said 45 percent and you are saying 1 in 3.

Ms. EKMAN. Well, at the initial level. And it is 45 percent at the hearings level. And so once you go through all the levels of appeal, you have to remember, too, a lot of people drop out, so the number of initial claims, only a percentage of those go forward to request hearings.

Mr. RICE. The CAL program—I will go to you, Ms. Disman. I know it is expedited, so how much quicker is it than the regular program? How many more—what is the difference in wait times?

Ms. DISMAN. It is substantial. If you take a look at the CAL conditions.

Mr. RICE. Is it 200 days?

Ms. DISMAN. The average is about 39 days for a CAL condition.

Mr. RICE. Wow.

Ms. DISMAN. As opposed to the average processing time for initial applications which is somewhere between 110 to 114 days.

Mr. RICE. Wow. What percentage of people get approved in the CAL program?

Ms. DISMAN. Around 3 percent.

Mr. RICE. Three? So 97 percent are in the other?

Ms. DISMAN. Right. That is correct.

Mr. RICE. Okay. And then, finally, is there any mechanism even quicker than CAL? I mean, when you—when they meet with somebody, and there is no question they are clearly disabled, is there anybody that just gets an instantaneous approval?

Ms. DISMAN. Well, there is not instantaneous, but there are two other processes. One is TERI cases, where an individual has a disability which is likely to end in death and very seriously indicated as a TERI. The other is quick disability decisions. These were all implemented in the beginning of the rise of disability pendings over the years. So if it is not a CAL, it can be picked up as a quick decision case, it can be picked up as a TERI. They all work with each other.

Mr. RICE. Thank you, ma'am.

Chairman JOHNSON. Thank you for your questions.

Mr. Pascrell, you are recognized.

Mr. PASCRELL. Mr. Chairman, thank you. And I am interested in all the questions from all of our comrades here. Excellent. Maybe we should do this with Social Security, same approach, questions and answers.

I have a question for you, Ms. Disman, and thank you for all your service. I mean that sincerely.

We know that many initial SSDI applications are denied. Ms. Disman, let me ask you this, can you explain to me why that is? And is there anything we can do to try to reduce the inappropriate denials?

Ms. DISMAN. Well, thank you, first of all. And I just want to reminisce about you and I appearing together in New Jersey on radio when I was regional—

Mr. PASCRELL. We have the worst record in New Jersey. Did you know that?

Ms. DISMAN. I won't even talk about that. Those were my years as Regional Commissioner.

Mr. PASCRELL. I don't mean any inference to you. But I am saying New Jersey is way behind everybody else, it looks like, even though no State really stands out as getting a gold star. But go ahead, I am interrupting you.

Ms. DISMAN. But in any event, if you look at the initial disability application—I used to head the quality function of Social Security where we actually looked at these initial disability applications. They are, if you look at their accuracy, their net accuracy is at 97 percent. Their decisional accuracy is at about 95 percent. What happens between the time of the initial denial? Time passes. The condition worsens. There is also new medical evidence that is introduced that wasn't introduced at the beginning.

So where the DDSs on average have about a 35 percent allowance rate, you will see as it goes through its various stages, for example at the reconsideration stage when new evidence is submitted and the condition may change a little, another 12 percent get approved. And then you had, as Judge Zahm mentioned, you know, at the hearing level about 45 percent.

So it doesn't mean that the DDS's initial decision was incorrect, because they do look at 50 percent of the allowances, and there is a sample of denials as well, to see what is the quality of the decision.

Mr. PASCARELL. Now, let's compare that to other agencies in other departments when we see problems of responding to our taxpayers and constituents and our family. I have seen the tendency in some of those other departments and agencies that remain nameless right now, if they are cutting my budget so I cannot spend X amount of dollars on page 38 of the budget you refer to—I didn't refer to it, you referred to it—there is a \$64 billion cut in Social Security disability funds over the next 10 years.

Now, if I am the bureaucrat and the administrator, call us whatever you wish, making decisions about, well, if I have less benefit money to provide, I need to find a way to get rid of a lot of these applicants, because there may be less applicants this year, but there is a steady pace of increasing if you look back at it over the next—the last 15 years. And by the way, if we continue with the last 6 months, we will have the same amount as last year. I will tell you the numbers, and you know the numbers better than I do.

So I am saying, is there anything like that happening within the disability network of denying early on, let them appeal down the road?

Ms. DISMAN. I would say absolutely—

Mr. PASCARELL. Is that familiar to you, Ms. Disman?

Ms. DISMAN. I would say absolutely not. I will tell you that our employees—and I do want to talk about what is in the budget, but absolutely not.

Mr. PASCARELL. Yeah.

Ms. DISMAN. Our employees believe in the mission. That is to get the right decision to the right person on time. I was trained that way when I came in over 50 years ago.

Mr. PASCARELL. So we have less money over the next 10 years, according to the President's budget, which you talked about. We will find a way, if those people are eligible, to get them the assistance that they need?

Ms. DISMAN. Absolutely.

Mr. PASCARELL. Okay. Let me continue, please.

So there are no easy fixes. We know that. Making a proper SSDI eligibility determination is extremely complex. I feel like I am starting to sound like a broken record, though, lately, because I keep coming back to the same point that virtually all of the Social Security Subcommittee hearings we have had since I joined the Subcommittee, but many of the problems that this Subcommittee has been examining with the Social Security Administration are firmly rooted, I will contend, in the lack of resources the agency has been given.

Look, we don't want anybody to get Social Security disability that doesn't deserve it. You have changed the rules. And some of them I think are excellent so that we don't have to face that issue later on. So we are going to find a way to find the rules to have less people who are eligible because you have less funds to provide. I mean, the numbers are the numbers. I didn't make them up. And I don't think you made them up, Ms. Disman. I know your background.

So you can defend it all you want, but we are trying to get to some kind of agreement here so that we can move forward. And not everything is in, you know, stark white and black. We know that. And there is no easy answers. None. This is complex stuff. But I am looking at the history. I am looking at what is going to happen by the end of this year. And I don't see any improvement whatsoever, to go back to the gentleman's question before.

So, you know, no wonder why some of us are a little puzzled. I mean, I am always a little puzzled, but this is something that we need to take a much more serious look at, and I thank the Chairman for putting us together today.

Chairman JOHNSON. Thank you, sir. The gentleman's time has expired.

Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman. And I also want to thank Ranking Member Larson for both of you putting this together, and I want to thank the witnesses. And this won't be a pile-on, although it does seem like it is.

And I am going to go back to what my friend Mr. Larson said, because it is always easy to talk about money. And he said over here we are going to talk about money, and you are right because I was in business. And in my 30 years in business, when we were having troubles, people would walk up and say, well, we just need more money. And it is always easy to say, yup, we just need more money, and just give me more money, and if you keep giving me more money—the problem is here we don't have any more money.

In Washington, every day we are borrowing from China. We have enough issues already, and we just don't have the money, so we have to be more efficient. And that is what we used to do in the business world. That is what families are asked to do. We have to become more efficient.

So I want to talk about efficiency more than money. And we have to figure out how do we become more efficient, because there is just no more money. We can talk about it all day, but the American people are tired of talking about money when we have a \$20 trillion deficit, and it continues to grow.

So I want to talk about one example, because the trend line—I do like my friend's example of the trend. The trend is not good. I put the black line as the trend line. We can go up and down and up and down, but the trend is continually going up, so that is an issue.

What is troubling is that a constituent of mine—and I will just use one example. We have a constituent, John, from Parma, Ohio, who applied for disability in February of 2015, and who my office is still working on to get him a final decision. For John, this has really been a frustrating process for him and his family. This is

simply unacceptable. Unfortunately, I have many other constituents who are facing the same circumstances. That is February of 2015.

So what we did was we went out and we started to talk to some of the judges in our area to try to figure out what was going on. And our Social Security—when we talked to our judges, and my staff talked to them in northeast Ohio, they have told us that the rules—and I want to go back. Social Security recently finalized regulations that generally require all evidence to be submitted to the ALJ no later than 5 days before a hearing. The judges are stating, they told us that the rule fails to fully address the issue of ensuring that they as judges have all the information they need prior to the hearing.

So that is important in a timeline. That is important in a decision. And I think it is important that we look at at least that. So, basically, the rule is not working.

But I want to ask Judge Zahm, what are your thoughts on that? The judges are saying they need the information.

Judge ZAHM. Yes. The judges who spoke with you and your staff are 100 percent correct. This is the situation. Judges are most efficient when we have evidence submitted to us before the hearing so that the judge and the medical experts can review that evidence and be prepared for the questioning of the claimant at the hearing and for the questioning of the experts. Then when the testimony is over, we can make a decision right away right there. It is fast. It is efficient.

But what has happened is that the agency had a 10-year pilot program in New England that required evidence to be submitted 5 days in advance. By all accounts it worked well, so the agency decided to extend it nationwide. So far so good.

Then the rule was drafted, and the rule didn't require just the submission of evidence, it also said, and if you don't have the evidence you can just tell us what evidence is missing and your attempts to get it. So now, 5 days before the hearing I still don't have the evidence. What is worse is they have told me what evidence I don't have and it is too late to get it. So the intent of the rule was undermined by poorly being drafted.

We need a rule that says 5 days before the hearing get your evidence in. People get 75 days' notice before the hearing, so they have plenty of time. And if they can't get it, because sometimes providers are recalcitrant, let me know. I will subpoena it. I need the evidence the day of the hearing so I can be efficient.

Mr. RENACCI. I appreciate that. And again, that doesn't take more money, that just takes more efficiency.

Judge ZAHM. Exactly.

Mr. RENACCI. Ms. Disman, do you want to—

Ms. DISMAN. Yes. And certainly, we—the national uniformity rule was intended to do as you articulated. It was taking 73 days on average for the scheduling of a hearing, so this was giving 75 days for the reps to present the evidence. Unfortunately, we have had a few reps informing us before 5 days. These sources are medical.

So what we are in the midst of doing now is using a clarifying ruling to deal with those situations. We will also have our new Of-

Office of Quality and Review and Oversight do a study of these cases. The rule went into effect the beginning of May. We wanted to do some data analysis to see where it is. At the same time, the ruling that we will have will lay out factors of what does it mean when you are coming in front of us, what do you need to provide?

The one thing we don't want to do is prevent due process on behalf of our claimants. We want to make sure they are afforded the best while we are more efficient in what we do.

Mr. RENACCI. Well, I thank you. And I know I have run out of time, but again, this isn't more money, this is just a procedure and time and getting things done and getting things to the judges.

I yield back.

Chairman JOHNSON. Mr. Kelly, you are recognized.

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

As we listen to this, and again, it does come down, as Mr. Renacci was talking about, to the amount of money we have to work with and then the size of the Social Security Administration. So when we talk about not having enough people, and hearing you talk, Judge, what I don't understand is how did we figure out that we needed to hire more judges but didn't figure out that they needed to have support staff? How do those decisions come about?

Now, as a person who has always been in the private sector, it is hard for me to understand that money is the answer to this. As Mr. Renacci just said, it is efficiency that really drives us most of the time because we just don't have, in the private sector, large sums of money to work with. So I was really—I was puzzled. So we said, yeah, we need more judges, but nobody thinks that they need more support staff. That is almost incomprehensible, but that is the issue that you talked about.

Judge ZAHM. Yes. And to the extent that you give me no support staff, I cannot be efficient.

Mr. KELLY. Okay. And so I have to tell you what we face as Members of Congress in our offices. We have people coming to us with this problem. It is a very difficult system to navigate. Let me just read something to you, because we are talking about efficiency and effectiveness, and we are talking about making sure that we don't have unapplied time, because that is what drives everybody's model off the charts.

In looking over disability insurance statistics for my congressional district in western Pennsylvania, I noticed that the average processing time is much higher than the national average. In our Pittsburgh office, my understanding is the average processing time is 698 days. The national average is 599 days. Both are lengthy, but it takes almost 2 years for a claim to be processed with almost 8,200 cases pending in Pittsburgh alone. This is an incredible mountain we have to climb. That is thousands of western Pennsylvanians with their lives on hold for almost 2 years while their claim is being processed. Now, a constituent brought this up to me.

Meanwhile, I just read a report by the Social Security Commissioner's Office that last year, 2016, the agency spent over \$16 million on union representational activities. In fact, 16 employees spent 100 percent of their time solely on union activities. In addition to these 16 employees, almost another 1,500 used official time

on a part-time basis for a total of 255,000 official hours spent on union activities.

I have an extremely hard time explaining to my constituents that call our office seeking help with their disability claims that taxpayer dollars are being spent to the tune of \$16 million on union activities while they are waiting for a decision from a Federal agency.

Of course, this is not just an issue at the Social Security Administration. In 2014, government employees spent nearly 3½ million hours conducting union business, costing taxpayers, hardworking American taxpayers, \$162.5 million. That is not my number, that is OPM.

So when we are saying we don't have enough people and they don't have enough time, how do we find 255,000 hours to spend on union activity when we have people waiting to hear their claim being processed? Now, I know people say, well, you don't want to go down that road. I do want to go down that road because do you know who picks up the tab on this? Hardworking American taxpayers. They are asking us, how can you look the other way when this is going on, when we have people waiting over 2 years for a claim to be processed? This is not your problem. This is the problem with government.

Now, Ms. DISMAN, what is the average time it takes a Federal employee to process a disability claim nationally, just a ballpark average?

Ms. DISMAN. Well, I was going to give you an example of a decision writer.

Mr. KELLY. Just give me a ballpark, how much time does it take?

Ms. DISMAN. So one decision writer can write in a year 220 decisions.

Mr. KELLY. They can write 220 decisions. Okay.

Ms. DISMAN. So if you multiply that by the work years that you are talking about, you will have a sense of what can be done in writing decisions.

Mr. KELLY. Okay. Let me ask you then, if these 16 employees that spend 100 percent of their time dedicated to union activities could instead have been working on processing disability claims, do you think that would have helped reduce the backlog?

Ms. DISMAN. That would have contributed to more decisions being written.

Mr. KELLY. Okay. And if the 255,000 official hours spent on union activities funded by American taxpayers, by the way, were spent on processing disability claims, do you think this would further help reduce the backlog?

Ms. DISMAN. Well, I think you have to look at the whole program.

Mr. KELLY. No, I just want an answer. Would it reduce the backlog? I don't want to hear about things in totality, because that is how we always get lost in this government. We get so lost in the fact that we forget that every single penny came out of the pocket of a hardworking American taxpayer.

I know how Social Security works because I am from the private sector, and I know it is all based on wage taxes. But when I look

at this and I keep hearing all we need is more money, all we need is more people, and then I say to these people, "Well, what is everybody doing now?" I don't know, Judge, how you could look at more judges coming onboard but nobody being hired to the support staff. Maybe asking some of those other folks that spent 255,000 hours, do you want to really help out with claims and backlogs? Maybe that would be the answer.

Now, I get spun up about this because we keep chasing a rabbit we can't catch. And we keep talking about we need more money, we need more people, and I keep seeing the backlog keeps rising. And all we say to those people back home is just stay tuned, we are going to get to you eventually.

So I know my time is up. Mr. Chairman, I thank you. I yield back.

Chairman JOHNSON. Thank you. Thank you for your questioning.

And, Ms. Sánchez, you are recognized.

Ms. SANCHEZ. Thank you, Mr. Chairman.

You know, time and time we hold hearings criticizing the Social Security Administration for backlogs, technology issues, or fraud, and as Members of Congress we never end up doing anything about it. And there tends to be one common thing among all the concerns that we keep raising, and I think the line of questioning that just went down is sort of a red herring, but it all boils down basically to lack of funding. And I know people don't want to spend funding, but the Social Security Administration has been flat funded since 2011. Okay? In 6 years, you cannot buy the same amount of paper that you could 6 years earlier with the same amount of money. There is this thing called inflation that contributes to the cost of doing business.

In addition, we have an aging baby boomer population and an increased demand on limited resources. And I am just going to take a guess, and you all can correct me if I am wrong, but I am guessing that probably disability claims have been on the rise over the course of the 30-year history. I doubt that the number of claims has stayed flat.

So we can't expect Social Security, or any other Federal Government agency for that matter, to do more with less and less. As the increase in demand goes up, you need an increase in resources to deal with the issue. And there is no substitute for resources. No amount of congressional hearings and waving our arms and screaming into a microphone is going to make up for the fact that you guys are not receiving the funding that you should receive, that it is not keeping pace with the demand.

So here we are again one more time talking about the disability backlog, reprimanding Social Security, but not considering actual ways to fix it. And there is no doubt the backlog is unacceptable. Six hundred days is too long for people in need to wait for a decision. And as Ms. McLaren testified, the longer people wait, the greater the hardships that they face.

So it is imperative that Social Security has the number of ALJs it needs, the attorneys and support staff to process those reviews in a timely manner. Social Security is meant to be there when beneficiaries need it the most.

Now, I happen to have worked for a Federal district court judge, and I know what a lack of resources can mean for getting through case work. You know, we all want the Social Security Administration magically to be able to process these claims in a very quick turnaround, but heaven forbid, we don't want you guys to make a mistake. We want the decisions to be correct ones. Well, correct decisions mean that you need all of the information, and it takes time to get that information sometimes from the recipients themselves, from the petitioners themselves.

You know, we all want everything to work perfectly, and we live in an imperfect world. And certainly, if we don't allocate the resources needed, we are not going to see any trend reversal.

So I want to go to Ms. Zahm, because you were kind of interrupted by Mr. Larson. You were trying to do a back of the envelope calculation about how many cases could be taken out of that backlog if you had just one ALJ hired, one law clerk, and an attorney to help them. Can you give me a back of the envelope calculation?

Judge ZAHM. Yes. But let me just correct: one clerical employee, two attorneys.

Ms. SANCHEZ. My apologies.

Judge ZAHM. Because then if somebody implements it, and I don't get the other attorney—

Ms. SANCHEZ. Roughly how many cases?

Judge ZAHM. I think between 150- and 200,000 extra decisions a year. Now, we already put out 700,000 decisions a year. That will make a dent in the backlog.

Ms. SANCHEZ. Yeah. Nobody talks about what you are getting right, you know?

Judge ZAHM. Yes.

Ms. SANCHEZ. Everybody wants to focus on everything that is falling apart. Well, I happen to be a believer in government. I believe that government can do things competently, if they are given the right people for the right job and the right resources.

Ms. DISMAN, how big of an impact has level funding had on Social Security Administration's ability to process claims?

Ms. DISMAN. Well, I think if you look at what we have achieved, Social Security has managed to identify priorities and to establish the processing of claims for our constituents, and also has used technology to enhance services and to provide different ways of providing the same service.

Ms. SANCHEZ. But the question was how has level funding impacted the ability to write more decisions in a year? Has it positively impacted that or has it negatively impacted that?

Ms. DISMAN. Well, I think we can certainly say that with more funds we can do more.

Ms. SANCHEZ. Excellent. And how much funding would SSA need to bring the wait time down to the goal of 270 days, do you have an idea?

Ms. DISMAN. Well, I would actually like to come back with that for the record, because it makes a number of assumptions. I think you heard from our DDS community about the reintroduction of the reconsideration process. If we introduce that process, it means less cases will go to the administrative law judge. So let me send that back to you with a number of assumptions behind it.

Ms. SÁNCHEZ. I appreciate that. And do you think that with demand growing, you can keep level funding SSA and expect that somehow we are going to reverse the trend of this backlog?

Ms. DISMAN. I think that we have enough in the President's budget to be able to start the downward trend. It is taking longer than—

Ms. SÁNCHEZ. But could you get it to the recommended 270 days if you stay at a flat level funded? And that is not to say that there is no cuts, because we have even heard about cuts potentially.

Ms. DISMAN. Well, if the President's budget and the budget that we are going to be submitting to Congress for 2019 all assume that we will continue to get a specific funding level to allow us to reduce the backlog.

Ms. SÁNCHEZ. But would you get the—

Chairman JOHNSON. The time of the lady has expired.

Ms. SÁNCHEZ. Excuse me, but my last colleague was granted additional time, and I have one last question I would like to submit for the record and allow the witnesses to respond to in writing, not verbally.

Chairman JOHNSON. Sure.

Ms. SÁNCHEZ. My question is, with level funding, you said that you can start the downward trend in the backlog. How many years would it take you to catch up the backlog and get it down to the recommended 270 days? And I will allow you to submit that answer in writing.

And I thank the Chairman, and I yield back.

Chairman JOHNSON. Thank you.

Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman. Thank you for having this hearing.

Ms. Disman, could you tell me how many administrative law judges there were in 2011?

Ms. DISMAN. If my memory serves me correct, and I will change that for the record if it was wrong, there were about 1,100.

Mr. SMITH. Okay. And currently there is how many?

Ms. DISMAN. Over 1,600.

Mr. SMITH. So the lowest backlog we had was in 2011 in recent history. And it showed that it was like 350, around there somewhere, and now we are at 600. In fact, in Missouri, we are at 672, which is worse than the national average. Why have we almost doubled when we have almost doubled how many administrative law judges we have, according to those numbers?

Ms. DISMAN. Well, I think if you look at the issues, it is the composition of staff that we were able to hire over the years. It is the length of time it takes to hire staff. It takes time to train staff and have them be proficient. And the backlog was the increase in receipts that came in at the initial disability level and made its way through the ALJ level.

So this didn't happen overnight. If you look at a curve you will see each year it being incremental, and then we had problems over the years on actually hiring judges.

Mr. SMITH. I am just really confused. If in 2011 we had 11- or 1,200 people, whatever that is, administrative law judges, and

today we have 1,600, that is a sizeable increase. And I mean, does it take 5 years to train people so that they can go through the cases, or I just don't—I can't get—I can't comprehend that.

Ms. DISMAN. We had a period of time where we couldn't hire administrative judges, so if you look at it, about 245 were hired last year with another 130 this year. And we lose about 100 ALJs a year.

Mr. SMITH. So you hired about 350 new ones in the last year and a half. Okay. That is helpful. That is the kind of stuff you need to tell me.

Mrs. Zahm, in your testimony, you made the comment that there has been more than 1,000 new regulations. What were those regulations implemented from? Was it legislation or just that the Social Security Administration decided to come up with something different?

Judge ZAHM. It was the latter. The agency made changes to the Hearings and Appeals Manual that we use to adjudicate cases. Approximately 1,000 since 2011. They have complicated and made more time consuming our jobs, but also in that same period of time, since 2011, the size of our files have increased 55 percent, and that doesn't even count the increase from fiscal year 2017. So we have files increasing, numbers of applications going up since 2011 and—

Mr. SMITH. How much? What percent have they gone up since 2011? Do you have that number?

Judge ZAHM. That Ms. Disman would know.

Mr. SMITH. Okay. I will get to her again.

You said that out of those thousand rules, there is several that are not necessary. Could you give me a couple examples of not necessary rules that are costing the judiciary time?

Judge ZAHM. Yes. Okay. For instance, when a claimant tells us that they have new medical evidence, they send in documents saying Dr. Jones, Dr. Smith, whatever, I have been to the hospital, the clerk has to contact the claimant and say you need to get these documents. They have to wait 30 days. The documents won't come in. If it is an unrepresented claimant, they are not coming in. They have to recontact the claimant and say why aren't they submitted and then hear a story. They then have to go and say to the judge, what do you want us to do? And, of course, the judge will always say, I want you to get those documents.

With unrepresented people, why are we doing this? They are not going to get the documents. If they get them, they won't be complete. The clerk should simply, once they are notified that there is another medical provider, send for the documents. That would be less time consuming than this dance between us, the claimant, the judge, whatever. It takes time, it takes staff time, and at the end of the day, we are going to ask for those documents anyway, so why don't we just do it to begin with?

Mr. SMITH. Okay. Good point. You said that last year 750,000 claims were processed?

Judge ZAHM. About 700,000 claims, I believe, where dispositions were issued at the—that might be 690, whatever. About 700,000.

Mr. SMITH. And I just wanted to clarify Mrs. Sanchez' question and Mr. Larson's, I think. You said that by one new administrative

law judge and the appropriate personnel for their office would create a reduction in backlog by what amount a year?

Judge ZAHM. I estimate between 150- and 200,000 extra dispositions if you gave us staff.

Mr. SMITH. For each one administrative law judge or——

Judge ZAHM. No. Overall based upon—we already put out about 700,000. I think we could do an extra 150- to 200,000 if I had a clerk and two attorneys.

Mr. SMITH. With how many lawyers hired, though?

Judge ZAHM. I don't know exactly how many the agency has.

Mr. SMITH. Okay. All right.

Judge ZAHM. I don't know how many more.

Ms. SANCHEZ. If the gentleman would yield.

It sounds like you are saying not with additional judges but just getting the staffing for the current judges that exist.

Judge ZAHM. Right. Exactly.

Mr. SMITH. Oh, under the current administrative law judges to make sure that they are fully staffed?

Judge ZAHM. Exactly.

Mr. SMITH. Okay. Thank you.

Chairman JOHNSON. The time of the gentleman has expired.

I ask for unanimous consent to insert in the report Mr. Kelly's reference to the record. Without objection, so ordered.

[The submission of The Honorable Sam Johnson follows:]



SOCIAL SECURITY

The Commissioner

December 30, 2016

The Honorable Tom Cole
 Chairman, Subcommittee on Labor, Health and
 Human Services, Education, and Related Agencies
 Committee on Appropriations
 House of Representatives
 Washington, DC 20515

Dear Mr. Chairman:

I am writing to provide you with our agency's fiscal year (FY) 2016 report on official time and expenses for union representational activities. This annual report complies with the requirements in the House Committee on Appropriations' Conference Committee Report 105-205.

In FY 2016, the union representational activities total agency costs were \$16.0 million. As required by our annual appropriations acts, the general fund of the United States Treasury will reimburse the Social Security trust funds, with interest, for the portion of expenses attributable to the trust funds.

I hope you find the enclosed report informative. If there are any questions about this report, your staff may contact Michelle King, Deputy Commissioner for Budget, Finance, Quality, and Management, at (410) 965-7748.

Sincerely,

A handwritten signature in cursive script that reads "Carolyn W. Colvin".

Carolyn W. Colvin
 Acting Commissioner

Enclosure

Enclosure – The Honorable Tom Cole

Social Security Administration Report Concerning Expenditures for Union Activities

The Conference Committee Report accompanying the Departments of Labor, Health and Human Services, Education, and Related Agencies' fiscal year (FY) 1998 appropriations (Report 105-205) addressed the subject of support of union activities. The Committee requested that all departments and agencies report annually on expenditures for union representational activities. Our FY 2016 information is included in the table below:

Official Time for Union Representation Activities	Fiscal Year 2016
Hours of official time spent on union activities	255,481
Employees who used official time on a part-time basis	1,463
Employees who spent 100 percent of their time on union activities	16
	Dollars in Millions
Dollar Value of Official Time (e.g., salary and benefits)	\$13.7
Travel and Per Diem	\$0.7
Office Space, Telephones, and Supplies	\$1.4
Interest	\$0.1
Arbitration Expenses	\$0.1
Total Expenses	\$16.0

The Federal Service Labor-Management Relations Statute and Social Security Administration's labor contracts with the American Federation of Government Employees, the National Federation of Federal Employees, the National Treasury Employees' Union, and the International Federation of Professional and Technical Engineers obligate the agency to pay for certain costs. These costs include salaries, travel and per diem expenses, office space, telephone, and arbitration costs for union representational activities conducted on official time. Union representatives cannot use official time for certain internal union business (such as soliciting membership, conducting elections, or dues collection). Consistent with language in appropriations acts, the general fund of the Department of the Treasury will reimburse the Social Security trust funds, with interest, for the portion of these expenses attributable to the trust funds.

Chairman JOHNSON. As we have heard today, Social Security has a lot of work to do, and people are waiting too long to get a hearing, and that is simply unacceptable. The good news is that Social Security has a plan, but the bad news is it is going to take, according to them, until 2022 to get it done. Social Security needs to get their wait times under control and the American people deserve no less.

I want to thank our witnesses for your testimony and thank you for your patience out there. Thank you also to our Members for being here.

Mr. LARSON. Could I have just—

Chairman JOHNSON. Mr. Larson, you are recognized for a comment.

Mr. LARSON. Yes. I just also wanted to thank the panelists and the Chairman here. I would like to have Ms. Ekman—because you didn't get the opportunity to follow up on a number of the things that you heard from the only person here who is carrying the perspective of the individuals who are impacted by these excessive wait times. I think there is the desire from everybody here to get after this issue. And, Mr. Chairman, I thank you because we unearthed a lot of things.

What would you recommend, Ms. Ekman, that we do to take a number of the positive and constructive things that we have heard and turn it into a plan of action?

Ms. EKMAN. Thank you, Ranking Member Larson. I think everyone sitting at this table would agree that the earlier we can get a complete evidentiary record in the application process, the better and quicker decisions we can make. We would recommend that SSA maybe take a little bit longer at the initial decision to more fully develop the record. Many claimants are unrepresented, and as Judge Zahm said, unrepresented claimants can often not be very helpful because they are in dire medical straits often when they are going through their initial application in assisting in that process. Doing more reviews of denials, which less than 3 percent of denials are currently reviewed, to ensure that the decision is correct could assist in that.

I think one thing that does not help is creating arbitrary deadlines prior to a hearing for the submission of evidence. We all agree we want the evidence in, and if there are a few bad actors who are not getting the evidence in, Social Security has a lot of tools at their disposal to take care of those particular representatives. What we should not be doing is passing rules that arbitrarily exclude evidence based on a timeline that hits the claimant over the head instead of addressing any bad actions by representatives.

So I think what we need to do is figure out how to get the evidence in early in the process and have SSA assist claimants to do that so that we can avoid having to go through further stages of appeal.

Mr. LARSON. I want to thank you again. I want to thank all the witnesses and the Chairman.

I would just make one final comment about what we were discussing earlier, but we don't believe on either side that money in and of itself is the solution, but we cannot overlook the fact that we have had a large increase of baby boomers coming through this

process at this time either. So it is very helpful to find out how we can combine both what we like to think is technology's assistance but also then, with some of the very commonsense recommendations that the judge has made and with some of the recommendations of GAO, that perhaps we are well on our way to do a combination of both, and finding where it is where actual money in the system could best benefit and whether it is additional clerks or it is the streamlining of information, lesser regulations, or actually getting to some of these commonsense recommendations that we could actually make progress instead of just having hearings.

But, again, Mr. Chairman, thank you. This is a tremendous hearing.

Chairman JOHNSON. Thank you all for being here, and thank you for your testimony. Thanks also to our Members that are here.

With that, the Subcommittee stands adjourned.

[Whereupon, at 11:38 a.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

October 4, 2017

The Honorable Sam Johnson
Chairman
Subcommittee on Social Security
Committee on Ways and Means House of Representatives

Dear Mr. Chairman

Thank you for the opportunity to testify at the September 6, 2017 Social Security Subcommittee hearing entitled "Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration." My responses to your questions for the record are enclosed. If you or your staff have any questions, please contact me at (202) 512-7215 or larink@gao.gov.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Kathryn A. Larin".

Kathryn A. Larin
Director
Education, Workforce, and Income Security Issues

Enclosure

cc: Amy Shuart
Shaun Freiman
Matt Russell

**Questions for the Record from the September 6, 2017 Social Security Subcommittee
Hearing Entitled “Determining Eligibility for Disability Benefits:
Challenges Facing the Social Security Administration”**

- 1. Since 2003, the Government Accountability Office (GAO) has designated the Social Security disability programs as being high-risk. Why hasn’t this changed and what does the Social Security Administration (SSA) need to do to get off the list?**

As we reported in our 2017 High Risk List update, SSA’s disability programs continue to face significant challenges in addressing the needs of Americans with disabilities.¹ In particular, SSA has grappled with large workloads and struggled to make timely decisions on who is eligible for cash benefits, especially when individuals appeal their decisions. SSA has also struggled to make timely updates to the criteria used to determine whether individuals qualify for benefits. At the same time, as we noted in our 2017 High Risk List update, SSA has made continual progress in the areas we’ve identified.

Over the years, we have made multiple recommendations related to SSA’s management of its disability claims workloads and updates to its disability benefit eligibility criteria, and while SSA has made some progress in these areas, more remains to be done. Concerning SSA’s management of disability claims workloads, we recommended that the agency develop a long-term strategic plan for addressing its management challenges, which SSA has done. Further, SSA has taken steps to reduce the number of pending initial claims in each fiscal year since 2010—from about 842,000 in fiscal year 2010 to 621,000 in fiscal year 2015. However, the timeliness of its appeals workload worsened during that time period. Specifically, the number of appeal hearings pending as of the end of 2016 was over 1.1 million, and the average time needed to complete appeals increased from 353 days in fiscal year 2012 to 545 days in fiscal year 2016. SSA’s goal is to eventually reduce this time to 270 days, as articulated in its appeals reform plan. In 2017, we reported that SSA should continue to move forward in operationalizing its long-term strategic plan, as well as implement and monitor the success of its plans for addressing the growing appeals workload and improving appeals decision timeliness.

With regard to the criteria that SSA uses to determine eligibility for disability benefits, we previously reported that these criteria had not been fully updated to reflect medical and technological advances and labor market changes, and we made multiple recommendations for improvements. Since then, SSA has acted on our recommendations and made progress in this area. For example, SSA has made significant progress in recent years updating its Listings of Impairments, which contain medical conditions that have been determined by the agency to be severe enough to qualify an applicant for disability benefits. In addition, to gather updated information on technological advances relevant to disability determinations, SSA tasked the National Academies of Sciences, Engineering, and Medicine with studying the issue of how assistive technologies and workplace accommodations can affect disability determinations. Although the study was scheduled to be completed in 2017, it is unclear how SSA will consider incorporating its results into its decision-making process. As we noted in our 2017 high risk report, until the study is complete and SSA determines a course of action, we will not consider removing the area of updating SSA’s disability decision-making criteria from the High-Risk List.

¹GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, DC: Feb. 15, 2017).

2. GAO found that the software the SSA uses to flag Compassionate Allowance initiative (CAL) claims can fail to flag a CAL condition if a claimant misspells words or used ambiguous language. Did GAO find any evidence that the software's limitations could also intentionally be exploited to incorrectly flag a claim as CAL?

In our August 2017 report on CAL, we reported some claimants may purposely include certain words or phrases in their claims with the intent of having the software flag the claim as CAL, though that may not always be the appropriate designation.² Officials at 4 of 6 disability determination services (DDS) offices we spoke with said that they had processed claims in which they believe representatives or claimants coached by representatives added "please consider this case as CAL," or certain key words, to the claim in an attempt to get the claim flagged as CAL.³ While some of the key terms may have been added appropriately, others may have been added with the intent of having the software flag a claim as CAL though the claimant was not asserting a CAL condition. For example, officials with one DDS office said that they had seen evidence that representatives had coached claimants to include key words, such as "liver" and "cancer" in their claims in the hopes of getting them flagged for CAL and allowed for benefits quickly, though the claimants may not have had "liver cancer," which is a CAL condition.

SSA has a process for removing CAL flags for claims that are incorrectly identified as CAL, yet SSA's guidance does not clarify when removal of the CAL flag and other manual actions should take place during the process. We found that the point at which these changes occur during claim processing varies across DDS offices. Ensuring claims are correctly flagged for or not flagged for CAL is important because the CAL flag reduces DDS processing time by about 10 weeks on average compared to the processing time for all claims, according to SSA data. In our August 2017 report, we recommended that SSA clarify written policies and procedures regarding when manual addition and removal of CAL flags should occur on individual claims. SSA agreed with this recommendation.

(102259)

²GAO, *SSA's Compassionate Allowance Initiative: Improvements Needed to Make Expedited Processing of Disability Claims More Consistent and Accurate*, GAO-17-625 (Washington, D.C.: Aug. 11, 2017).

³Claimants may choose to appoint a representative—who may be an attorney or non-attorney—to assist them through the disability claim process and in their interactions with SSA. A representative may act on a claimant's behalf in a number of ways, including helping the claimant complete the disability claim. In our claim file review, we found one claim with "please expedite, is a CAL claim" in the allegation text, which was provided by a designated representative for the claimant and used key words to describe a condition that was flagged correctly for CAL by the selection software. GAO, *Social Security Disability Benefits: Agency Could Improve Oversight of Representatives Providing Disability Advocacy Services*, GAO-15-62 (Washington, D.C.: Dec. 3, 2014).



NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

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October 4, 2017

Amy Shuart, Staff Director
Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
2304 Rayburn House Office Building
Washington, D.C. 20515

Dear Ms. Shuart,

Thank you again for providing the opportunity for NCDDD to present testimony at the Committee on Ways and Means, Subcommittee on Social Security hearing relative to the determining eligibility for disability benefits. The following are our responses to your questions:

1. In your testimony, you expressed the National Council of Disability Determination Directors' (NCDDD) support of reinstating reconsideration nationwide. Why does NCDDD support this policy?

As we mentioned in our written testimony, NCDDD believes in providing the best possible customer service to the public as well as the consistent application of policy across the nation. Therefore, we believe Congress should both support and fully fund the reinstatement of the reconsideration step for the ten Prototype states.

The ten states began using the Prototype process on October 1, 1999. Since that time, the backlog of claims waiting for a hearing at the ODAR level has climbed, preventing these vulnerable citizens from receiving a timely decision. Given that the DDSs process reconsideration claims at a faster rate than ODAR can hold hearings and issue decisions, NCDDD believes the reinstatement of recons would allow claimants to receive their decision sooner. We support providing the opportunity for a reconsideration at the DDS level in all states, providing the answers the public so desperately need.

NCDDD believes in the consistent application of policy across the country. Reinstating reconsiderations in these ten states would then give all states' citizens the same opportunity to get benefits sooner. It is nonsensical to the DDSs that we have different processes for the appeals process, depending on where you live in the country. Eighteen years after the Prototype process began, we believe SSA should be using one universal process for claimants- either all states have recons, or none do. As we stated earlier, we believe the DDSs can provide these decisions quicker and at less cost than ODAR can, which will allow the administrative law judges time to focus on a smaller subset of cases that truly needs their attention.

Further, as we stated in our testimony, NCDDD would recommend SSA hold a face-to-face meeting for the ten Prototype states to allow for the collaborative development of a plan to reinstate reconsiderations. Part of this plan must include staff resources and funding. The DDSs will face the challenges of hiring staff and medical consultants, training them before reconsideration claims arrive at the DDSs, as well as developing a business processes for reconsideration claims. Addressing the needs of space and equipment in DDS offices will also be necessary. Simply stated, without ample time to plan and sufficient resources, the DDSs are unable to effect a change such as this successfully.

2. What challenges do the DDS employees encounter when using outdated tools such as the Dictionary of Occupational Titles or the Medical and Vocational Guidelines?

NCDDD advocates for continued funding and faster development of a new Occupational Information System, to replace the DOT with one that meets the specific needs of Social Security disability determination, and that provides current information about occupations in the national economy. We also support the simplification and modernization of the medical-vocational assessment as much as possible. We believe these changes can assist the DDSs in the production of disability determinations that are accurate, consistent, prompt and cost effective.

The Dictionary of Occupational Titles (DOT) is SSA's primary source of occupational information. Disability policy was developed around the DOT, yet there have not been significant updates to it in forty years. The use of this outdated information to process disability claims results in significant challenges. Disability adjudicators use the DOT to determine if applicants can do their past relevant work despite their impairments, and if necessary, determine the number and type of occupations than an applicant can perform despite their impairments. While the Social Security Administration contracted with the Bureau of Labor Statistics (BLS) in 2012 to produce occupational data for use as the main source of information about job demands in determining eligibility, the completion of the project is still years away – projected for 2020. The DOT's suitability for disability adjudication purposes given its growing age is a source of significant concern.

The following are challenges the DDSs face with use of the current DOT:

- Occupations are outdated and do not reflect the current state of the jobs that exist in the national economy.
- The electronic versions of the DOT that SSA supports are complex to use, difficult to navigate and not designed to support disability adjudication. The tools are simply a searchable database and do not assist with complex decision-making.
- Obtaining and evaluating a fifteen year work history is problematic, as claimants and even employers have difficulty remembering exactly how the work was done that long ago.
- Different ways of obtaining and evaluating this past work information may be one of the differences in decision making at the DDS and ODAR appeal steps, since DDSs do not have the same access as ODAR to vocational experts with knowledge of the current local and national economy.
- The DOT lacks job function data that matches the factors disability adjudicators must consider in comparing claimants remaining mental and physical residual functional capacity to their past relevant work.

The Medical-Vocational Guidelines were introduced in 1979 and are often referred to as the "grid rules". In promulgating the rules, administrative notice was taken of the numbers of unskilled jobs that existed throughout the national economy at the various functional levels as supported by the DOT and companion volumes, along with "County Business Patterns", "Census Surveys" and occupational surveys.

The following are the challenges with use of the current Medical-Vocational Guidelines:

- The rules do not take into account advances in technology and changes in workforce demographics since the current regulations adopted in 1978.
- Allowance rates based on medical and vocational factors has increased and this leads to increased adjudicative complexity and cost.
- Currently, substantial work that claimants have performed up to fifteen years ago is considered relevant when adjudicators determine whether claimants can do any of their past jobs. Given the rapid changes in technology, the relevance of work last performed more than ten years ago or the continued existence of the work in the national economy is very questionable.

Modernization of these rules has not occurred in any systematic way, nor has the data used to support the current approach. Given that DDS adjudicators use the rules to conduct an analysis of a claimants' age, education, work experience and residual functional capacity to determine if they are disabled, modern tools are necessary to assist in their work to produce the best determination possible.

Thank you for the opportunity to provide these answers for the record. We continue to offer our support for any efforts to improve the Disability Program for the public.

Sincerely,

Elizabeth McLaren
NCDDD President-Elect

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BRANDON CASEY,
MINORITY CHIEF OF STAFF

September 21, 2017

Bea Disman
Acting Chief of Staff
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Ms. Disman:

Thank you for your testimony before the Committee on Ways and Means at the September 6, 2017 Social Security Subcommittee hearing entitled "Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration." In order to complete our hearing record, I would appreciate your responses to the following:

1. The Social Security Administration's (SSA's) Compassionate and Responsive Services plan to eliminate the backlog has 27 initiatives. Which of these initiatives does the SSA expect to have the greatest impact on reducing the backlog? How will the SSA be able to tell which individual initiatives are working and which are not?
2. Currently, about 72,000 cases have been decided at the hearing level, but claimants haven't received these decisions because they still need to be written. How is the SSA addressing this decision writing backlog, and how is the SSA ensuring that these efforts do not create a backlog elsewhere?
3. How will the voluntary standby list help reduce the backlog? What else is the SSA doing to reduce delays due to postponements or no-shows?
4. Can the SSA implement the President's budget proposal to reinstate the reconsideration stage of appeal nationwide under its own authority, or does this require legislative action?
5. What is the SSA doing to improve the management of the Compassionate Allowance (CAL) initiative given the findings by the Government Accountability Office?
6. On September 5, 2017, the SSA announced three new CAL conditions. How did the SSA identify and evaluate these conditions?

7. The SSA is transitioning from using blanket purchase agreements with individual vocational experts who provide evidence at disability hearings to a more centralized vendor system. How does the SSA ensure the quality of the vocational experts it uses, and what quality measures will be used when the SSA transitions to a national vendor system? Does the SSA currently have enough quality vocational experts?
8. What information is required to be submitted for a claimant to request a hearing in writing? What information is required to be submitted for a claimant to request a hearing electronically through the SSA's iAppeals process? Do these requirements differ? If so, why?
9. In addition to answers for the questions above, please provide the following data updates:
 - Please provide the cost per case at each level of determination for Fiscal Years (FY) 2014 – FY 2016.
 - Please provide the post-effectuation quality review results for Administrative Law Judge (ALJ) decisions, specifically the number of decisions reviewed, number of decisions with disagreements, and disagreement percentage for ALJ allowances and denials, for FY 2012 – FY 2016.
 - What were the ALJ allowance rates by office for FY 2015 – FY 2016?
 - How many full-time equivalents were used for withholding and processing claimant representative fees in FY 2014 – FY 2016?
 - Please provide a list of the top fee earning representative firms for FY 2014 – FY 2016.

I would appreciate your responses to these questions by **October 5, 2017**. Please send your response to the attention of Amy Shuart, Staff Director, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, 2018 Rayburn House Office Building, Washington, DC 20515. In addition to a hard copy, please submit an electronic copy of your response in Microsoft Word format to mm.russell@mail.house.gov.

Thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Amy at (202) 225-9263.

Sincerely,



Sam Johnson
Chairman
Subcommittee on Social Security

**Post-Hearing Questions for the Record
Submitted to Bea Disman
Acting Chief of Staff
U.S. Social Security Administration
From Chairman Sam Johnson**

**“Determining Eligibility for Disability Benefits:
Challenges Facing the Social Security Administration”
September 06, 2017**

**United States House of Representatives, Committee on Ways and Means,
Subcommittee on Social Security**

- 1. The Social Security Administration's (SSA's) Compassionate and REsponsive Services plan to eliminate the backlog has 27 initiatives. Which of these initiatives does the SSA expect to have the greatest impact on reducing the backlog? How will the SSA be able to tell which individual initiatives are working and which are not?**

Our Compassionate and REsponsive Service (CARES) plan rests on three elements: business process efficiencies, increased decisional capacity, and IT innovations and investments. Based on these elements, we expect the following initiatives to have the greatest impact on reducing the backlog:

1. Hiring of (Administrative Law Judges (ALJ) and support staff
2. PATH (Proactive Analysis and Triage for Hearings)
3. Pre-Hearing Conference (PHC) Expansion
4. Duplicate Identifying Software (DeDoop)
5. Insight (Natural Language Processing quality tool)

We have established targets and expectations for each initiative and are monitoring them against those expectations. We primarily measure progress by service metrics, such as our level of hearings pending and wait times.

- 2. Currently, about 72,000 cases have been decided at the hearing level, but claimants haven't received these decisions because they still need to be written. How is the SSA addressing this decision writing backlog, and how is the SSA ensuring that these efforts do not create a backlog elsewhere?**

With fiscal year (FY) 2017 funding, we expect to hire approximately 600 support staff; final numbers will be available in November or December after all hires report for duty. This includes decision writers and legal assistants who can do both pre-hearing and post-hearing work. We will balance our workloads during the hearing process to minimize the creation of backlogs. As of September 29, 2017, we have hired approximately 300 new decision writers. The President's Budget calls for us to continue hiring decision writers in significant numbers in FY 2018.

Enclosure—The Honorable Sam Johnson

In addition to staffing, we are considering the following initiatives:

- focusing on accountability and ensuring our current corps of decision writers are meeting our performance expectations;
- negotiating assistance for decision writing from agency employees outside of the Office of Hearings Operations; and
- moving forward with tools that will ensure both quality and efficiency, such as an updated template for fully favorable decisions and the Insight tool, which uses a natural language process to check the quality of decisions.

3. How will the voluntary standby list help reduce the backlog? What else is the SSA doing to reduce delays due to postponements or no-shows?

The voluntary standby list offers an option for claimants and representatives to expedite the scheduling of cases by filling unexpectedly vacant hearing timeslots. This ensures that we maximize the use of our hearing rooms.

In addition to the voluntary standby list, we are reinstituting our pre-hearing conference program, which prepares unrepresented claimants for their hearings by explaining the hearings process. Additionally, we are reviewing our data on postponements and developing an action plan for both external communication and internal training. Our aim is to decrease no-shows through improved communication. For example, as we update our external websites and publications, we continue to include reminders about the importance of attending a scheduled hearing.

4. Can the SSA implement the President's budget proposal to reinstate the reconsideration stage of appeal nationwide under its own authority, or does this require legislative action?

Legislative action is not required to reinstate the reconsideration step of the administrative review process nationwide. Our regulations give us authority to test certain modifications to the disability determination process. 20 C.F.R. §§ 404.906, 416.1406. Using this authority, under the “reconsideration elimination model,” we modified the disability determination process by eliminating the reconsideration step of administrative review. 20 C.F.R. §§ 404.906(b)(4), 416.1406(b)(4).

We currently conduct the “reconsideration elimination model” in 10 states. Our case selections under the “reconsideration elimination model” will expire on December 28, 2018 unless we extend them beyond that date, or terminate them earlier, by publishing a notice in the Federal Register. 81 Fed. Reg. 58544 (Aug. 25, 2016). Thus, we could reinstate the reconsideration step of the administrative review process nationwide by publishing a notice in the Federal Register or rescinding the relevant regulatory provisions. If we decided to reinstate reconsideration, we expect we would phase in that decision, given our workload and resource constraints.

Enclosure—The Honorable Sam Johnson

5. What is the SSA doing to improve the management of the Compassionate Allowance (CAL) initiative given the findings by the Government Accountability Office?

Since we launched CAL in 2008, we have focused on expediting disability determinations for individuals with the most serious medical conditions. For example, we invested resources to develop an internal system to help us more readily establish CAL conditions on an ongoing basis. Since the GAO audit, we have undertaken the following activities to further improve the CAL initiative:

- We have formed an agency-wide workgroup to address GAO’s recommendations.
- We have revised our website to more clearly inform stakeholders about how to suggest a new CAL condition, and to state that we will keep them informed while we evaluate their suggestion.
- We are creating a formal business process for all of our CAL activities, including when we will update the CAL impairment summaries, and guidance for all adjudicators.
- We are seeking feedback from adjudicators on all aspects of the CAL process.
- We are developing a quality review to assess CAL case outcomes, which should help identify additional areas of improvement.
- We are holding a National Disability Forum (NDF) in November to hear from the public about the CAL initiative.

6. On September 5, 2017, the SSA announced three new CAL conditions. How did the SSA identify and evaluate these conditions?

The newest CAL conditions of “Congenital Myotonic Dystrophy” and “CACH - Vanishing White Matter Disease – Child” were suggested by advocacy groups, while “Kleefstra Syndrome” was identified internally by an SSA employee. Our medical officers researched and reviewed each condition to determine if it met our definition of disability. We also worked with our systems administrators to ensure that the CAL Services selection software could correctly identify these conditions. Both internal and external avenues for identifying potential CAL conditions continue to be effective in supporting CAL condition identification.

7. The SSA is transitioning from using blanket purchase agreements with individual vocational experts who provide evidence at disability hearings to a more centralized vendor system. How does the SSA ensure the quality of the vocational experts it uses, and what quality measures will be used when the SSA transitions to a national vendor system? Does the SSA currently have enough quality vocational experts?

We currently consider a combination of education, and type and longevity of work experience to determine if an applicant will succeed and provide quality service as a Vocational Expert (VE) under the Blanket Purchase Agreement (BPA). Areas of expertise include current knowledge of the following: working conditions and physical demands of various occupations; transferability of skills; knowledge of the existence and numbers of jobs at all exertion levels in the national economy; and involvement in or knowledge of placing adult, disabled workers into jobs.

Enclosure—The Honorable Sam Johnson

We rely on the ALJs use of VE testimony when determining whether the VE provides quality service through testimony or interrogatories. If a VE is not providing quality service, the BPA provides that unresolved, repeated occurrences of documented deficiencies may result in our discontinuing the contractor's services.

As we transition to a single provider contract, we are in the process of defining the necessary requirements for the VE. These requirements will incorporate expertise and experience, and define quality requirements for attracting the appropriate knowledge and number of VE contractors to support the hearing process.

We will continue to look to the ALJs for determining VE expertise, and will incorporate contract guidelines to address any issues that indicate non-compliance by the VE or the need for corrective action.

We currently have enough quality vocational experts. When we occasionally encounter issues with local VE availability, we provide support from other areas until we can recruit additional BPAs, or if necessary, we award single provider contracts. We are developing a centralized pool of VEs that will provide maximum flexibility for geographic locations where access to VEs is limited.

8. What information is required to be submitted for a claimant to request a hearing in writing? What information is required to be submitted for a claimant to request a hearing electronically through the SSA's iAppeals process? Do these requirements differ? If so, why?

As stated in the regulations, at 20 CFR 404.933, 405.722, 416.1429, 416.1433, and 418.1350, a claimant may request a hearing by filing a written request within 60 days of receiving notice of the previous determination or decision. A claimant should include the following information in his or her request:

1. the name and Social Security number of the wage earner;
2. the reasons for disagreeing with the previous determination or decision;
3. a statement of additional evidence to be submitted and the date it will be submitted; and
4. the name and address of any designated representative.

We recommend that form HA-501-U5, "Request for Hearing by Administrative Law Judge" be used as the written request as it collects the information on one form. We also request that the claimant submit a form SSA-3441, "Disability Report – Appeal" at the same time that he or she submits the written appeal request. The SSA-3441 collects updated information concerning the claimant's disability, medications, medical appointments, and procedures. If the claimant does not complete an SSA-3441 at the time of the appeal request, we contact the claimant and attempt to complete the document before processing the hearing request.

To file an appeal electronically, a claimant, appointed representative, or other third party completes and submits information on the electronic versions of the above forms, the i501, and the i3441. The difference in these processes, one requesting and one requiring the

Enclosure—The Honorable Sam Johnson

information on the Disability Report prior to submission of the appeal request, is the result of us establishing electronic efficiencies for collecting information needed to process appeals.

9. In addition to answers for the questions above, please provide the following data updates:

- **Please provide the cost per case at each level of determination for Fiscal Years (FY) 2014 -FY 2016.**

FULLY LOADED UNIT COSTS FOR DISABILITY CLAIMS AND APPEALS AT SSA			
	FY 2014	FY 2015	FY 2016
Initial Claims	\$ 1,081.00	\$ 1,192.00	\$ 1,187.00
Reconsiderations	\$ 724.00	\$ 771.00	\$ 837.00
Hearings	\$ 3,346.00	\$ 3,597.00	\$ 3,652.00
Appeals Council Review	\$ 1,231.00	\$ 1,244.00	\$ 1,219.00

- **Please provide the post-effectuation quality review results for Administrative Law Judge (ALJ) decisions, specifically the number of decisions reviewed, number of decisions with disagreements, and disagreement percentage for ALJ allowances and denials, for FY 2012 -FY 2016.**

We do not collect this data, as it is not within the scope of our post-effectuation quality focused reviews. The purpose of these reviews is to assess policy compliance. We tailor each focused review to the ALJ and, as such, we do not compile data for the universe of all the decisions we review.

- **What were the ALJ allowance rates by office for FY 2015 -FY 2016?**

Please see "Attachment A" for ALJ allowance rates from FY 2015 and FY 2016.

- **How many full-time equivalents were used for withholding and processing claimant representative fees in FY 2014 - FY 2016?**

The total work effort for processing the claimant representative fees is most accurately stated in workyears (WY). The system that collects and associates time/work effort to our agency's workloads is the Cost Analysis System (CAS). The CAS tracks all paid time/work effort in WY, which are a combination of full-time equivalents (FTE) and overtime. The CAS does not breakout FTEs from overtime by workload.

FULL-TIME EQUIVALENTS USED FOR WITHHOLDING AND PROCESSING CLAIMANT REPRESENTATIVE FEES			
	FY 2014	FY 2015	FY 2016
Estimated Workyears	1,258.63	1,306.75	1,081.70

Estimated workyears include all agency overhead.

Enclosure—The Honorable Sam Johnson

- **Please provide a list of the top fee earning representative firms for FY 2014 - FY 2016.**

Please see "Attachment B" for a list of the top fee earning representative firms for FY 2014-2016.

Attachment A

ALJ Allowance Rates for FY 2015 and FY 2016

ALJ Only Allowance Rate by Office FY 2015		ALJ Only Allowance Rate by Office FY 2015	
OFFICE	ALLOWANCE RATE	OFFICE	ALLOWANCE RATE
AKRON OH	44%	FT LAUDERDALE	41%
ALBANY	56%	GRAND RAPIDS	37%
ALBUQUERQUE	56%	GREENSBORO	60%
ALEXANDRIA	41%	GREENVILLE	47%
ANCHORAGE	15%	HARRISBURG	36%
ATLANTA	47%	HARTFORD	37%
DOWNTOWN		HATTIESBURG	39%
ATLANTA NORTH	49%	HONOLULU	64%
BALTIMORE	43%	HOUSTON NORTH	37%
BILLINGS	38%	HOUSTON-	32%
BIRMINGHAM	45%	BISSONNET	
BOSTON	42%	HUNTINGTON WV	34%
BRONX	40%	INDIANAPOLIS	50%
BUFFALO	46%	JACKSON	42%
CHARLESTON SC	39%	JACKSONVILLE	32%
CHARLESTON WV	46%	JERSEY CITY	39%
CHARLOTTE	47%	JOHNSTOWN	46%
CHARLOTTESVILLE	32%	KANSAS CITY	37%
CHATTANOOGA	55%	KINGSFORT	56%
CHICAGO	45%	KNOXVILLE	46%
CINCINNATI	46%	LANSING	46%
CLEVELAND	34%	LAS VEGAS	40%
COLORADO	37%	LAWRENCE MA	47%
SPRINGS		LEXINGTON	36%
COLUMBIA MO	39%	LITTLE ROCK	41%
COLUMBIA SC	52%	LIVONIA MI	50%
COLUMBUS	45%	LONG BEACH	51%
COVINGTON GA	46%	LONG ISLAND	58%
CREVE COEUR	56%	LOS ANGELES	46%
DALLAS	43%	DOWNTOWN	
DOWNTOWN		LOS ANGELES	42%
DALLAS NORTH	43%	WEST	
ODAR		LOUISVILLE	45%
DAYTON	38%	MACON	41%
DENVER	41%	MADISON	50%
DETROIT	50%	MANCHESTER	38%
DOVER	39%	MCALISTER	35%
ELKINS PARK	46%	MEMPHIS	46%
EUGENE	42%	METAIRIE	35%
EVANSTON	55%	MIAMI	42%
EVANSVILLE	44%	MIDDLESBORO	43%
FARGO	47%	MILWAUKEE	33%
FAYETTEVILLE NC	46%	MINNEAPOLIS	45%
FLINT	52%	MOBILE	51%
FLORENCE	37%	MONTGOMERY	43%
FORT MYERS FL	47%	MORENO VALLEY	45%
FORT SMITH	47%	CA	
FORT WAYNE	44%	MORGANTOWN	35%
FORT WORTH	41%	MT PLEASANT MI	45%
FRANKLIN TN	51%	NASHVILLE	46%
FRESNO	35%	NEW HAVEN	42%

Attachment A

ALJ Allowance Rates for FY 2015 and FY 2016

ALJ Only Allowance Rate by Office FY 2015		ALJ Only Allowance Rate by Office FY 2015	
OFFICE	ALLOWANCE RATE	OFFICE	ALLOWANCE RATE
NEW ORLEANS	50%	ROANOKE	46%
NEW YORK	45%	ROCHESTER	54%
NEW YORK	49%	SACRAMENTO	48%
VARICK		SALT LAKE CITY	52%
NEWARK	51%	SAN ANTONIO	34%
NHC	33%	SAN BERNARDINO	40%
ALBUQUERQUE		SAN DIEGO	51%
NHC BALTIMORE	45%	SAN FRANCISCO	47%
NHC CHICAGO	28%	SAN JOSE	41%
NHC FALLS	35%	SAN JUAN	67%
CHURCH		SAN RAFAEL	59%
NHC ST LOUIS	39%	SANTA BARBARA	41%
NORFOLK	41%	SAVANNAH	43%
NORWALK	48%	SEATTLE	30%
OAK BROOK	47%	SEVEN FIELDS	41%
OAK PARK	52%	SHREVEPORT	40%
OAKLAND	55%	SOUTH JERSEY	60%
OKLAHOMA CITY	43%	SPOKANE	54%
OMAHA	55%	SPRINGFIELD MA	42%
ORANGE	38%	SPRINGFIELD MO	30%
ORLAND PARK	40%	ST LOUIS	42%
ORLANDO	47%	ST PETERSBURG FL	48%
PADUCAH	52%	STOCKTON	40%
PASADENA	48%	SYRACUSE	45%
PEORIA	31%	TACOMA	50%
PHILADELPHIA	47%	TALLAHASSEE FL	48%
PHILADELPHIA	34%	TAMPA	49%
EAST		TOLEDO OH	41%
PHOENIX	40%	TOPEKA KS	31%
PHOENIX NORTH	32%	TUCSON	53%
PITTSBURGH	41%	TULSA	46%
PONCE	50%	TUPELO	42%
PORTLAND ME	51%	VALPARAISO IN	44%
PORTLAND OR	38%	WASHINGTON	42%
PROVIDENCE	37%	WEST DES MOINES	41%
QUEENS	50%	WHITE PLAINS	39%
RALEIGH	47%	WICHITA	35%
RENO	30%	WILKES BARRE	39%
RICHMOND	41%		
RIO GRANDE	37%		
VALLEY TX			

Attachment A

ALJ Allowance Rates for FY 2015 and FY 2016

ALJ Only Allowance Rate by Office 2016		ALJ Only Allowance Rate by Office 2016	
OFFICE	ALLOWANCE RATE	OFFICE	ALLOWANCE RATE
AKRON OH	45%	FRESNO	35%
ALBANY	54%	FT LAUDERDALE	41%
ALBUQUERQUE	51%	GRAND RAPIDS	38%
ALEXANDRIA	39%	GREENSBORO	54%
ANCHORAGE	21%	GREENVILLE	46%
ATLANTA		HARRISBURG	40%
DOWNTOWN	46%	HARTFORD	35%
ATLANTA NORTH	50%	HATTIESBURG	30%
BALTIMORE	44%	HONOLULU	64%
BILLINGS	37%	HOUSTON NORTH	34%
BIRMINGHAM	45%	HOUSTON-BISSONNET	30%
BOSTON	45%	HUNTINGTON WV	35%
BRONX	41%	INDIANAPOLIS	51%
BUFFALO	41%	JACKSON	42%
CHARLESTON SC	39%	JACKSONVILLE	36%
CHARLESTON WV	47%	JERSEY CITY	40%
CHARLOTTE	46%	JOHNSTOWN	45%
CHARLOTTESVILLE	32%	KANSAS CITY	38%
CHATTANOOGA	50%	KINGSFORT	61%
CHICAGO	43%	KNOXVILLE	47%
CINCINNATI	45%	LANSING	45%
CLEVELAND	32%	LAS VEGAS	40%
COLORADO SPRINGS	36%	LAWRENCE MA	44%
COLUMBIA MO	40%	LEXINGTON	38%
COLUMBIA SC	52%	LITTLE ROCK	41%
COLUMBUS	41%	LIVONIA MI	52%
COVINGTON GA	47%	LONG BEACH	51%
CREVE COEUR	47%	LONG ISLAND	59%
DALLAS		LOS ANGELES DOWNTOWN	50%
DOWNTOWN	43%	LOS ANGELES WEST	38%
DALLAS NORTH ODAR	46%	LOUISVILLE	46%
DAYTON	36%	MACON	41%
DENVER	41%	MADISON	52%
DETROIT	48%	MANCHESTER	40%
DOVER	38%	MCALESTER	38%
ELKINS PARK	48%	MEMPHIS	45%
EUGENE	41%	METAIRIE	37%
EVANSTON	53%	MIAMI	49%
EVANSVILLE	43%	MIDDLESBORO	41%
FARGO	48%	MILWAUKEE	36%
FAYETTEVILLE NC	46%	MINNEAPOLIS	46%
FLINT	53%	MOBILE	50%
FLORENCE	41%	MONTGOMERY	49%
FORT MYERS FL	47%	MORENO VALLEY CA	41%
FORT SMITH	53%	MORGANTOWN	37%
FORT WAYNE	44%	MT PLEASANT MI	44%
FORT WORTH	42%	NASHVILLE	48%
FRANKLIN TN	52%		

Attachment A

ALJ Allowance Rates for FY 2015 and FY 2016

ALJ Only Allowance Rate by Office 2016		ALJ Only Allowance Rate by Office 2016	
OFFICE	ALLOWANCE RATE	OFFICE	ALLOWANCE RATE
NEW HAVEN	43%	SAN FRANCISCO	48%
NEW ORLEANS	47%	SAN JOSE	44%
NEW YORK	48%	SAN JUAN	72%
NEW YORK		SAN RAFAEL	51%
VARICK	48%	SANTA BARBARA	44%
NEWARK	47%	SAVANNAH	43%
NHC		SEATTLE	33%
ALBUQUERQUE	38%	SEVEN FIELDS	41%
NHC		SHREVEPORT	44%
ALBUQUERQUE SO	39%	SOUTH JERSEY	52%
NHC BALTIMORE	46%	SPOKANE	50%
NHC CHICAGO	25%	SPRINGFIELD MA	45%
NHC FALLS		SPRINGFIELD MO	25%
CHURCH	40%	ST LOUIS	38%
NHC ST LOUIS	44%	ST PETERSBURG FL	49%
NORFOLK	45%	STOCKTON	45%
NORWALK	43%	SYRACUSE	46%
OAK BROOK	51%	TACOMA	51%
OAK PARK	54%	TALLAHASSEE FL	44%
OAKLAND	57%	TAMPA	44%
OKLAHOMA CITY	46%	TOLEDO OH	38%
OMAHA	50%	TOPEKA KS	33%
ORANGE	35%	TUCSON	54%
ORLAND PARK	43%	TULSA	48%
ORLANDO	49%	TUPELO	45%
PADUCAH	48%	VALPARAISO IN	46%
PASADENA	46%	WASHINGTON	38%
PEORIA	36%	WEST DES MOINES	48%
PHILADELPHIA	44%	WHITE PLAINS	43%
PHILADELPHIA		WICHITA	38%
EAST	37%	WILKES BARRE	39%
PHOENIX	37%		
PHOENIX NORTH	43%		
PITTSBURGH	39%		
PONCE	55%		
PORTLAND ME	53%		
PORTLAND OR	38%		
PROVIDENCE	38%		
QUEENS	52%		
RALEIGH	46%		
RENO	45%		
RICHMOND	41%		
RIO GRANDE			
VALLEY TX	38%		
ROANOKE	44%		
ROCHESTER	55%		
SACRAMENTO	48%		
SALT LAKE CITY	49%		
SAN ANTONIO	34%		
SAN BERNARDINO	39%		
SAN DIEGO	47%		

Attachment B

Top Fee Earning Representative Firms for FY 2014 - FY 2016

FY 2014

	FIRM NAME	TOTAL
1.	BINDER & BINDER -THE NATIONAL	\$ 61,490,373.82
2.	MYLER DISABILITY	33,827,326.77
3.	CITIZENS DISABILITY LLC	16,989,933.10
4.	ADVOCATOR GROUP LLC	16,280,678.24
5.	ALLSUP INC	11,887,950.08
6.	PREMIER DISABILITY SERVICES LLC	11,724,303.95
7.	SSC DISABILITY SERVICES LLC	11,620,718.10
8.	HEARD & SMITH LLP	9,926,436.62
9.	DISABILITY LAW CLAIMS P A	9,584,764.17
10.	HOGLUND AND CHWIALKOWSKI P L L P	9,010,231.97
11.	G STEVEN LARRY P FLESCHER & THOMAS	8,408,554.19
12.	ERIC A SHORE P C	7,729,704.86
13.	DOHERTY CELLA KEANE & ASSOCIATES	7,562,762.80
14.	JAN DILS ATTORNEY AT LAW LC	6,354,908.79
15.	ARRUDA & ASSOCIATES LLP	6,265,638.40
16.	FRANK W LATOUR	6,221,982.67
17.	SAMUEL H POND	6,133,992.02
18.	MIDWEST DISABILITY PA INC	6,080,493.77
19.	LAW OFFICES OF DANIEL A PARMELE P C	5,737,922.95
20.	GREEMAN & TOOMEY PLLC	5,640,004.22

Attachment B

Top Fee Earning Representative Firms for FY 2014 - FY 2016

FY 2015

	FIRM NAME	TOTAL
1.	BINDER & BINDER -THE NATIONAL	\$ 55,810,138.08
2.	MYLER DISABILITY	33,288,987.13
3.	CITIZENS DISABILITY LLC	27,509,157.52
4.	ADVOCATOR GROUP LLC	17,227,315.77
5.	PREMIER DISABILITY SERVICES LLC	15,124,904.63
6.	ALLSUP INC	11,015,817.34
7.	HEARD & SMITH LLP	9,775,272.91
8.	HOGLUND AND CHWIALKOWSKI P L L P	9,668,995.59
9.	DOHERTY CELLA KEANE & ASSOCIATES	8,705,692.07
10.	SSC DISABILITY SERVICES LLC	8,214,841.06
11.	DISABILITY LAW CLAIMS P A	7,766,689.10
12.	FRANK W LATOUR	6,786,552.35
13.	ERIC A SHORE P C	6,779,948.40
14.	G STEVEN LARRY P FLESCHER & THOMAS	6,549,653.62
15.	LAW OFFICES OF DANIEL A PARMELE P C	6,425,386.75
16.	BILL GORDON & ASSOCIATES PA	5,462,460.77
17.	JAN DILS ATTORNEY AT LAW LC	5,430,838.27
18.	PITTS & ZANATY LLC	5,387,140.75
19.	MIDWEST DISABILITY PA INC	5,328,445.70
20.	BROCK & STOUT LLC	5,283,492.16

Attachment B

Top Fee Earning Representative Firms for FY 2014 - FY 2016

FY 2016

	FIRM NAME	TOTAL
1.	BINDER & BINDER -THE NATIONAL	\$ 49,628,441.23
2.	CITIZENS DISABILITY LLC	33,832,649.46
3.	MYLER DISABILITY	32,521,749.33
4.	ADVOCATOR GROUP LLC	19,040,213.49
5.	PREMIER DISABILITY SERVICES LLC	18,791,255.53
6.	HEARD & SMITH LLP	11,604,719.58
7.	ALLSUP INC	9,736,749.10
8.	HOGLUND AND CHWIALKOWSKI P L L P	8,548,932.24
9.	DOHERTY CELLA KEANE & ASSOCIATES	8,450,923.26
10.	DISABILITY JUSTICE LLC	7,791,373.36
11.	LAW OFFICES OF DANIEL A PARMELE P C	7,737,506.22
12.	FRANK W LATOUR	7,244,646.58
13.	DISABILITY LAW CLAIMS P A	7,244,515.53
14.	SOCIAL SECURITY ADVOCATES FOR THE DISABLED	6,837,248.08
15.	MIDWEST DISABILITY PA INC	5,999,785.20
16.	BILL GORDON & ASSOCIATES PA	5,944,525.56
17.	THE MORGAN FIRM PA	5,928,398.47
18.	ERIC A SHORE P C	5,711,914.91
19.	CRUMLEY ROBERTS LLP	5,645,163.46
20.	LEVIN BENJAMIN P C	5,526,501.44



October 1, 2017

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Attention: Amy Shuart, Subcommittee Staff Director
Committee on Ways and Means
U.S. House of Representatives
2018 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Johnson:

Thank you for giving me the opportunity to testify before the Social Security Subcommittee.

You questioned whether Administrative Law Judges would need to manage assigned decision writers.

Administrative Law Judges do not want to manage or supervise decision writers; we simply want to work with the same writers for a period of time – such as a year – in order to facilitate efficiency in the drafting and editing of our decisions. Managing and supervising writers takes time that is better spent adjudicating cases. In the past, when ALJs have had clerical employees assigned to work with us for a year or so (before being rotated to another judge), ALJs have not managed or supervised them. ALJs managing decision writers has never been necessary nor is it desirable.

Please let me know if you have any other questions or concerns.

Very truly yours,

Judge Marilyn Zahm

President, AALJ

[Submissions for the Record follow:]



SOCIAL SECURITY ADMINISTRATION

Office of Hearings and Appeals
1441 Main St., Suite 450
Springfield, MA 01103
(413) 746-2770

September 30, 2003

Hon. E. Clay Shaw, Jr.
Representative in Congress
Chair – Subcommittee on Social Security of
the Committee on Ways and Means

RE: Hearing on Management of the Social Security Administration
Office of Hearings and Appeals

Dear Rep. Shaw and Honorable Members of the Subcommittee:

I am an Administrative Law Judge with the Social Security Administration [SSA], Office of Hearings and Appeals [OHA], and have served as such since October 1996. Since September 2000 I have had the additional responsibilities of a Hearings Office Chief.

The job of a judge in these proceedings is very challenging. We are required to wear three hats: [1] to provide full and fair hearings; [2] to assist claimants with developing the record and presenting their cases -- *even if represented*; and [3] last, **but definitely least**, to act as trustee for the Social Security Trust and General Tax Funds. The last two duties require a judge to, in essence, "represent" opposing sides.

I am elated at hearing that Congress will take a close look at the Social Security disability program management, and pray that the less than inspired changes implemented and in the works by its administrators, will be reviewed closely, but also broadly, so as

to encompass the larger goals of the disability program. I fear the administrators of the program have lost sight of the forest, having allowed it to be blocked by the minutia of the trees. I find it difficult to maintain faith in those the President has appointed to administer the Social Security Administration, particularly as pertains to due process disability hearings. They appear hell-bent on applying bureaucratic remedies to judicial problems, when the true impediment to due process and expeditious case movement is the latter. While having short term, and all too often short sighted, immediate effect, the bureaucratic remedies avoid dealing with the true problems of the disability program, and amount to being penny-wise and pound-foolish.

A big part of the complexity and time involved in disposing disability claims is the product of the Agency having succumbed to obfuscation in the definition of disability, as well as having ceded control of the process to the representative community. These representatives are generally paid on a contingent basis, with a success rate well in excess of 50%, not because reconsidered decisions are wrong, but due to factors addressed below. They are allowed a top fee of \$5,300.00, and, more often than not, work in a fast food restaurant fashion – i.e., high volume, doing a sloppy job and simply depending on the above noted success percentage, to collect \$10,000 to \$15,000 each month, doing little more than holding enough claimants' hands in a high number of hearings, and soliciting a few documents, as will be further addressed below.

An article, which appeared in the New York Times [*Laid-off Workers Swelling Cost of Disability Pay*, September 2, 2002] deals in general terms with a problem that could grow to the point of severely depleting the Social Security Trust and the General Tax funds. This is not just the product of baby-boomers coming of age, and the past Commissioner's loosening of the standards for mental disability. The general attitude that has developed is one by which this tribunal is not viewed seriously, and misrepresentation within these proceedings is regarded as the proverbial "white lie." This was virtually admitted by one representative, who took offense when I pointed out the inconsistency in his client claiming to have been "ready, willing *and able*" to work for purposes of collecting Unemployment Insurance Benefits, while claiming the opposite for the same period of time for purposes of SSA disability. This representative actually argued that disingenuousness, if needed to collect benefits, should not be viewed unfavorably in assessing the claimant's credibility.

The courts and the SSA Appeals Council have created and applied case law in a manner such as to have, effectively, shifted the burden of proof in contested disability cases to the Administration. This is primarily accomplished by having declared the opinions of treating physicians as controlling, unless the longitudinal record clearly overcomes those opinions [20 CFR §§404.1527 (d)(2), 416.927(d)(2)]. In a tribunal, in

which around 75% of the claimants are represented, and the Agency not represented, this permits easy solicitation of favorable reports from treating physicians, who are already naturally in sympathy with their patients. There are no countervailing forces in play, nor any incentives for these treating physicians not to succumb to their patients' entreaties for a favorable report. These reports are not sworn under the pains and penalties of perjury, as is generally done in Workers' Compensation tribunals. The treating physician is never subjected to cross-examination, let alone prosecution for misrepresentation. When the end "goal" of transferring wealth is thrown into the mix, such as to salve any guilt the treating physicians may have about exaggerating their patients' limitations, the flood gates are wide open to abuse. Thus an Administrative Law Judge [ALJ] is boxed into a corner, and forced to grant benefits, even when knowing the individual is not truly disabled. A very typical 40-year-old spine, with a sympathetic treating physician, can easily result in qualification for benefits, despite a claimant being fully capable of some type of work. The United States Supreme Court is to be applauded for not permitting the expansion of this foolish notion beyond the realm of Social Security hearings, and it should be reversed here [see: *Black & Decker Disability Plan v. Nord*, 538 US ____ (2003), No. 02-469. Argued April 28, 2003 – Decided May 27, 2003]. SSA should re-think the wisdom of this invitation to misrepresentation.

Administrative Law Judges dedicated to a diligent search for the truth, who take seriously the third duty noted above [i.e., to act as trustee for the SSA and General Tax Funds], are put into the awkward position of having to act as a contestant rather than a neutral in order to be true to the so-called "third hat." The alternative is to simply pay cases inappropriately, the road all too many are bludgeoned into by the Administration's constant push for numbers. As noted above, the solicitation of these highly suspect treating physician opinions is often the only thing a representative does, but it is sufficient to, effectively if not formally, transfer the burden of proof to the Commissioner.

The abuses of the disability system via the mental impairment route are even worse. Limitations imposed by amorphous diagnoses such as depressive disorders, anxiety, personality disorders and a plethora of other such impairments, leave the system literally at the mercy of a sympathetic treating professional, who is solicited by a representative to supply an opinion.

As I once suggested in a letter to the Commissioner, the law and regulations are the engine, which drives this agency, and must be reviewed and revised to respond to the factors making disability almost a presumed fact by the mere act of applying, with the Commissioner, through an ALJ ill equipped to investigate matters, then having to prove its absence. The law must be refurbished to return the burden of proof to the claimant, and to hold those claimants with representatives to a higher standard of duty to produce

truly probative evidence. As I stated in that letter to the Commissioner, which went unacknowledged, the actions to which she spoke for most of her testimony, are akin to working on only the transmission of a car with a leaky head gasket and sludge throughout the engine, and expecting it to perform well, and go faster. The engine cannot be ignored.

Honorable Committee Members, we are in a position much akin to that in the labor relations sphere decades ago. There Congress responded to the imbalance of power between employers and organized workers by passage of the Wagner Act in 1935, favoring only the rights of workers. By 1947 it was recognized that labor had come into its own, and that the balance of power had actually shifted in its direction. Thus, we saw passage of the Taft-Hartley Act, to even the playing field. Rest assured, claimants have come of age, and are very powerful. It's time to level the playing field for those who fund the programs.

As noted above, around 75% of the claimants in Social Security disability cases are represented, *and this in a tribunal with no opposition*. To say that the taxpayers are at a distinct disadvantage puts it mildly. The regulations that are presently in place to control the practice of these representatives do not require them to submit evidence, which would tend to disprove disability. Thus, if a representative comes into possession of information disproving disability, there is no requirement to present it. How one-sided can a program be?

We are charged to give the claimant every benefit of doubt. Superimpose the treating physician rules and the one-sided rules mentioned above upon this duty, and you can see how many people capable of working slip through the system. *Social Security Disability is quickly becoming the "wink and nod" with which President Clinton signed welfare reform.*

A few ideas for changes run along the following lines:

~ Tighten up the definition of disability, keying in on case law which has blurred that definition, and return the burden of proof to the claimant. I would suggest a "blue ribbon" committee of legal and medical experts, members of the disability and workers' compensation insurance industry, active and/or retired ALJs, personal injury lawyers from both sides, and representatives who practice in this tribunal regularly. The charge should be to clarify the definition of disability, such as to more closely reflect that in the collective mind of those who work to fund these programs. Somehow a person with a typical 40-year old spine, who simply doesn't want to work for a lower wage than obtained in a previous vocation, as may be dictated by his condition, is not that which the average taxpayer envisages when picturing a disabled person.

~ Eliminate Childhood Disability benefits [see: *Costs Soar for Children's Disability Program; How 26 Words Cost the Taxpayers Billions in New Entitlement Payments*, Washington Post, February 4, 1994]. Children are not generally sources of income in a household. The bottom line purpose of these benefits is to replace income that would, but for a disability, be coming into the household. There is simply no basis other than transfer of wealth for children's benefits. To make this change more politically palatable, I have suggested, through the Associate Commissioner, that we eliminate all cash payments, but provide Medicare coverage to *all* children below the poverty line, without regard to disability. This would eliminate that which has become a complicated and costly disability analysis, and clear up a plethora of frivolous cases engendered by the desire of parents to simply get another check in the mail. Since the vast majority of children found disabled are found so for learning disabilities and attention deficit hyperactive disorder, the amount expended by this trade-off would go down, as most of the services needed for these impairments are already provided gratis by the school districts. This would represent a direct response to a specific need, rather than simply throwing more money into the household, with no logical nexus between it and the need.

~ After five years living in those portions of United States of America in which English is the commonly used language, the inability to speak English should no longer be considered a vocational detriment in the disability assessment.

~ In the true sense of the SSA being part of the *Village* rearing the nation's children, psychiatric reports by which a primary caretaker of children is described as incapable of maintaining sufficient concentration, persistence and pace to perform even the simplest routine task, should be reported immediately to the local child protective service agency for investigation.

~ 20 CFR §§404.1527(d)(2) and 416.927(d)(2) should be rescinded

In a more esoteric sense, changes in the hearing process should be along the following lines:

~ The hearing process should be adversarial, similar to that in the Workers' Compensation system. Since there are no insurers to provide representation, a former President of the Hearing Office Chief Judges Association has suggested the Bankruptcy Court as a model, with an equivalent to the United States Trustee being assigned the role of representing the Commissioner's position. This office could be staffed by eliminating the present Appeals Council, allowing the ALJs to truly act as trial level fact finders without being second-guessed, and using the personnel from the Appeals Council to represent the Commissioner. Another alternative, which would more sensibly follow the

President's mandate for use of private contractors than the present delegation of clerical tasks [which has not helped us move cases], would be to replace the State Disability Determination Services [DDSs] with private insurers, and then have them provide investigative work and representation at the hearings.

An adversarial hearing process would likely resolve another source of consternation, specifically, the inconsistency of hearing results from hearing office to hearing office, and from region to region. Specifically, judges who do not take the third hat seriously are now able to stay under the proverbial radar screen by simply finding favorably, with the knowledge that only 7% of such decisions are ever reviewed, while a much higher percentage of unfavorable decisions are reviewed. Placing both favorable and unfavorable decisions on the same footing would, I believe, infuse much more consistency in the decision making process. All decisions should stand the same probability of being reviewed.

~ Once retained the claimant's representative should be primarily responsible for developing the record from the claimant's side, and the Commissioner's representative from that side. There should be strict rules for the timing of such development, and the availability of sanctions for poor performance by those representatives.

~ Strict rules of professional and judicial conduct should be implemented, along with rules for practice and procedure. It should be noted that such rules, as manifested in the Model Rules for both Professional and Judicial conduct, do have provisions for expeditious case movement, and would give the Administration a tool it presently lacks to encourage such. [e.g., see: *Model Code of Judicial Conduct*, Canon 3 (B) (8)].

~ The method of payment of representatives should also be revamped. The contingent fee method encourages representatives to drag out the proceedings as long as possible, so as to grow the back payments from which their fee is paid *and calculated*. A better method would be to pay representatives of both winning and losing cases, but at an hourly rate in line with the Federal Assigned counsel program, used in the Federal Article III courts. Indeed, I would take that suggestion a step further, by having fee payment administrated out of that program, rather than duplicating such administration at the agency level. In addition to discouraging procrastination, this would lower the incentive to engage in misrepresentation. ALJs should be allowed to assign counsel from a panel maintained by the Assigned Counsel program.

~ Eliminate the third step in the sequential analysis, by which disability determinations are made. The statutory definition of disability ties an impairment directly

to the limitations it imposes upon the ability to work; *it is a functional definition* [see: Social Security Act §§216(i), 223, 1614(a)(3)(A)]. The third step in the sequential analysis requires the judge to review the medical signs and symptoms, to see if they match a list of such signs and symptoms associated with specific maladies. The notion is that the presence of specific signs and symptoms will lead to a presumption that limitations precluding work exist. The problem is that medicine moves more quickly than law, and products ameliorating the limitations imposed by specific signs and symptoms are discovered daily. The presumptions simply do not hold up to medical progress. Furthermore, some of the signs and symptoms leading to the presumption of disability do not truly do so. I had at least one incident of an individual meeting a listing, whose treating physician opined as capable of working. I've had more than one vocational expert advise that the mental retardation listing is overly broad, and qualifies individuals capable of placement. Suffice it to say, the Listings impose a complicated analysis, often requiring the testimony of medical experts, and often provide that, to which I refer as a "black hole of obfuscation," into which representatives throw the truth.

Some of these ideas are along the lines of those proposed by the Social Security Advisory Board in its January 2001 publication, *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change*. Indeed, one of my greatest disappointments is the new Commissioner's tendency to engage in the diminution of due process, concentrating her efforts on the minutia of the ways in which files are handed off, despite her background with the Social Security Advisory Board. While honing down due process may give the illusion of streamlining the system, eventually it will have to be achieved, and having that take place at the level of Article III courts will certainly be much more costly and cumbersome in the long run. Putting off **real** due process, until a matter reaches a court of general jurisdiction and no specialized expertise, will be a disservice to the claimants and the taxpayers. Yet this seems the underlying theme to the constant bureaucratization of the Office of Hearings and Appeals.

The concentration of effort on the movement of cases, coupled with ignoring the substantive changes that need to be made to prevent abuse of the program, leads to many, many inappropriately paid cases. These have been estimated at a cost of \$200,000.00 to \$250,000.00 each. With over 1,000 judges, each pushed to dispose of about 50 cases per month, and ill equipped to get to the truth, you can see where inappropriately paid cases could mount up pretty quickly. Paraphrasing, I think it was Sen. Everett Dirksen, \$200K here and \$250K there -- pretty soon you're talking real money. The Administration seems to have lost sight of a notion once addressed by Woodrow Wilson, who said:

*We need laymen who understand the
necessity for law and the right uses of it too
well to be unduly impatient of its restraints.*

The present Associate Commissioner in charge of the Office of Hearings and Appeals has set a disposition goal for each judge to issue 2.72 decisions per day. When taking into account time off for annual leave, which is not considered in applying the above referenced “goal”, that actually calculates to a judge spending a total of 2 hours and 39 minutes on each case. This is to accomplish the following:

- ~ Development review, to see what additional evidence may be needed;
- ~ Thorough pre-hearing review of medical records, generally averaging the size of a phone book for a city of over 100,000 population [this usually takes me about 2.5 hours alone];
- ~ Conducting the hearing [generally about an hour];
- ~ Reviewing new submissions of evidence;
- ~ Deliberating the decisions and drafting instructions for the decision writers;
- ~ Editing the draft of the final decision.

I think it a sad anomaly that that which Congress sought, in first outlining the need for ALJs and what it hoped to achieve through them, has gotten lost in the flurry to bureaucratize this quasi-judicial body. Congress, and the Agency in its earlier stages, saw the value to seeking judges, whose experience was primarily attained in the day-to-day grind of arguing cases. The emphasis in terms of qualification for the position was placed on the development of an innate sense for the truth, developed through practice experience. It was understood that any lawyer could become familiar with specific statutes and regulations, but only those with a keen sense of fact-finding, honed by trial experience, could be entrusted with the practical application of the “three hats”, spoken to above. The appropriateness of that priority has recently been re-affirmed in *Meeker and James (OPM) v. Merit Systems Protection Board and Azdell*, decided February 20, 2003 by the U.S. Court of Appeals for the Federal Circuit. Indeed, the failure of a previously implemented “Senior Attorney” program, in which less than judges were actually given decision-making authority, underlines the importance of the experience of judges in this process. Having served as a Quality Assurance Review judge during the ending of this program, I had the opportunity to have reviewed many such decisions, and, as a taxpayer, felt literally raped at the ease with which cases were paid. This was the product of more than one factor, but primarily two: (1) the administrations adoption of a “could pay”

rather than “should pay” basis, meaning that, despite a claimant’s actual ability, if you can get the right blocks on your ticket punched [primarily by way of a solicited accommodation from the treating physician, with all the problems therewith noted above]; and (2) the fact that the Senior Attorneys making these decisions were only given production credit for cases paid. The philosophical change in the first of these two factors haunts us to this day, and must be addressed in the statutory and regulatory study I suggested above.

This was a mistake, which is rumored to now be reconsidered. I hope it isn’t, but, if indeed, the Administration wants to cede decision making powers to senior attorneys again, the more sensible way would be to limit such to overpayment and Medicare cases. These are cases dealing with finite amounts of money (disability payments often go on until the recipient dies), and, more importantly, are much less dependent on credibility determinations, which require the very experience and concomitant innate sense spoken to above. This would allow judges to give disability cases the time, analyses and deliberation they deserve.

The Administration’s constant emphasis on pumping out more and more cases, undermines the goals sought to be achieved via having experienced fact-finders applying the time and analyses necessary to arrive at just decisions. Its emphasis on the assembly line while ignoring the end product, has and will continue to lead to far more havoc than would the reverse. Undermining judges’ ability to properly hear and decide via unrealistic quantitative goals, leads to more and more inappropriately paid cases, which, in turn, attracts the filing of more and more specious claims, as the probability of winning increases with every short cut imposed upon judges. This vicious cycle makes achievement of the goal of expeditious case handling an impossible dream, while costing the taxpayers more and more in the way of inappropriately paid cases.

Your anticipated kind consideration of the points herein is appreciated.

Very truly yours,

/s/ *Peter J. Martinelli*

Peter J. Martinelli
U.S. Administrative Law Judge
Hearing Office Chief

Statement

Presented by

The National Association of Disability Examiners

Jennifer Pounds, President

Presented to the

Committee on Ways and Means

Subcommittee on Social Security

United States House of Representatives

September 6, 2017

Chairman Johnson, Ranking Member Larson and Members of the Subcommittee on Social Security, Committee on Ways and Means: The National Association of Disability Examiners (NADE) sincerely appreciates the opportunity to offer comment and insight regarding the Social Security Administration's management of the federal disability programs. The stated purpose of this hearing is, *"Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration."* NADE believes the challenges facing the disability programs are numerous and we commend the Subcommittee for convening this hearing to explore them.

Who We Are

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of our members work in the state Disability Determination Service (DDS) agencies where 15,000+ employees adjudicate claims for Social Security and/or Supplemental Security Income (SSI) disability benefits. Our members constitute the "front lines" of disability evaluation. Our membership also includes many SSA Central and Regional Office personnel, attorneys, physicians, non-attorney claimant representatives, and claimant advocates. The diversity of our membership, combined with our extensive program knowledge and "hands on" experience, enables NADE to offer a perspective on disability issues that is unique and which reflects a programmatic realism, which we believe, is a critical factor for Members of this Subcommittee to consider.

NADE members are deeply concerned about the integrity and efficiency of the Social Security and the SSI disability programs. Simply stated, we believe those who are entitled to disability benefits under the law should receive them; those who are not, should not. Many of the hearings held by this and other Congressional Committees and Subcommittees have, in recent years, focused on the challenges facing the Social Security disability program.

Program Scope

No other government agency has a greater impact on the quality of life in America as the Social Security Administration (SSA) and the American public will judge the ability of their government to meet their quality of life needs almost solely by the service provided by SSA. It is imperative that the services provided by SSA be of the highest quality. This includes the administration of the Social Security and SSI disability programs. SSA's mission, clearly stated, is: **"To promote the economic security of the nation's people through compassionate and vigilant leadership in shaping and managing America's social security programs."**

During FY 2017, SSA will pay approximately \$935 billion to nearly 61 million Social Security beneficiaries. SSA will pay an additional \$54 billion in Federal benefits to about 8 million SSI (Supplemental Security Income) recipients. The total annual payout of these two programs is nearly \$1 trillion! Every month in FY 2017, an average of 9 million workers and an additional 2 million dependents received Social Security disability benefits from SSA. SSA also paid monthly SSI disability benefits to 6 million blind and disabled adults and more than 1 million blind and disabled children in FY 2017. The vast enormity of the disability programs administered by SSA, and their impact on the lives of Americans, cannot be understated. Actuaries forecast 1 in 4 workers currently age 20 will become disabled prior to age 67. Among this group, 67% will have no private disability insurance and will depend on SSA as their only source of income.

The DDS Role in the Federal-State Partnership

Initial and reconsideration (first level appeal) claims for disability benefits are processed in the states by Disability Determination Services (DDSs). These are state agencies working in partnership with SSA to provide public service to individuals applying for disability benefits. The DDSs share a tremendous responsibility to help ensure the integrity of the disability program. Eligibility for disability benefits is difficult and determining eligibility for benefits is equally difficult. The DDSs make complex medical determinations for the Social Security disability programs pursuant to Federal laws and regulations. The vast majority of DDS personnel are state employees subject to their individual state rules and mandates, personnel practices and other issues specific to their respective states. The DDSs adjudicate disability claims at the initial, reconsideration, continuing disability review (CDR) and disability hearing levels. The adjudication of claims for disability benefits must adhere to SSA's stringent definition of disability* while following a 5-point Sequential Evaluation** approach that requires a determination to be made at each step before the adjudicator can proceed to the next step.

Throughout the 60+year history of the Social Security Administration's Disability Insurance Program, the disability claims adjudication process has been a Federal-State venture. In the DDSs, an adjudicative team composed of a Disability Examiner (generic title) and/or a Medical Consultant and/or a Psychological Consultant in the DDSs make the initial medical-legal-vocational determination. That initial or reconsideration determination must follow complex and frequently changing Federal rules and regulations and it is essential that those making the determinations possess unique and specific knowledge, skills, and abilities in order to fairly and timely administer the programs.

The Social Security definition of disability differs markedly from any other public or private industry definitions of disability. While other disability programs focus primarily, or even exclusively, on the degree of impairment, the Social Security and SSI adult disability programs are work and function oriented. The SSI child disability program is also function oriented. What this means is that an impairment is considered to be disabling only if it prevents an adult individual from working or a child from functioning in normal age-appropriate activities. The DDS adjudicative team is required, as a matter of routine, to deal with the interplay of abstract medical, legal, functional and vocational concepts.

In FY 2017, DDSs adjudicated over 2.5 million initial claims and about 600,000 reconsideration claims. DDSs also processed about 800,000 continuing disability review (CDR) claims. The DDS allowance rate was 33% at the initial level and 12% at the reconsideration level. The allowance decisions made by the DDSs account for nearly 77% of all allowances made in FY 2016 and the DDSs were able to achieve this level of service while maintaining an initial accuracy rate of 95%, including an allowance accuracy rate of 98.7%! The average processing time for an initial claim in FY 2016 was 85.6 days while reconsideration claims were processed in 77.1 days. SSA's Quick Disability Determination (QDD) and Compassionate Allowance (CAL) claims had an average processing time of just 18.5 days! The ability of the personnel within the DDSs to adjudicate these cases timely and accurately carries enormous consequences for SSA and the citizens who rely upon the Agency for assistance. Therefore, it is extremely critical the individuals tasked with this responsibility be highly trained and able to perform their job duties in a professional environment. The DDS adjudicators must be able to translate the medical concept of clinical severity into the legal concept of Social Security disability program severity and the resultant functional restrictions into vocational and/or age-appropriate assessments. In essence, the DDS adjudicators must appropriately and interchangeably, apply the "logic" of a doctor, a lawyer and a rehabilitation counselor.

The Need to Ensure Disability Policy Remains Current

In order for DDSs to make accurate and timely initial and reconsideration determinations on disability claims, it is essential that disability policy established by SSA be current and up-to-date. Until recently, SSA has struggled with this task. However, the Agency has made great strides since 2013 to correct this situation. In 2016-2017, SSA updated four of the medical listings and revised the manner in which disability adjudicators should evaluate treating source opinions. Between FY 2013 and FY 2017, SSA published final rules to update 11 of 15 body systems. These updates and revisions have been very significant. Consider the neurological listings were updated in the fall of 2016, followed by updates to the respiratory listings. These listings had their last comprehensive update in 1986 and 1993, respectively. The mental listings were updated in January, 2017, their first comprehensive update since 1985! SSA is expecting to release updated musculoskeletal listings in 2018. This will be the first comprehensive update for this listing since 1985. NADE is very appreciative of the effort SSA has made to update the medical listings, some for the first time in over 30 years. It is critical the listings should reflect current medical practices and SSA plans to ensure the listings remain current.

SSA has also prepared new policy for how adjudicators are to evaluate treating source opinions and added three (3) medical professionals to the list of "Acceptable Medical Sources." The updated policy and new additions to the list of acceptable medical sources should improve the service delivery of the DDS as well as the timeliness and accuracy of our determinations.

One update that is urgently needed is a replacement for the Dictionary of Occupational Titles. This source of vocational information used in making disability determinations at all levels was last revised in 1991 and had its last major update in 1977! In previous testimony before this Subcommittee, NADE stressed that the use of 40-year old information to process disability applications does not reflect well with regard to service delivery to claimants or taxpayers. We are pleased that SSA, in partnership with the Bureau of Labor Statistics (BLS) has made significant progress toward a D.O.T. replacement and the Occupational Information Systems (OIS) is expected to be implemented in 2020.

Reduced Budgets and Insufficient Funding

There are many challenges to ensuring that disability determinations are accurate and made in a timely manner. No challenge is more important to the DDSs than insufficient funding caused by reduced budgets. NADE is aware that many problems cannot be solved by throwing more money at the problem but, in the case of timely and accurate decision-making in the disability program, the lack of sufficient funding by Congress on a consistent basis has created a crisis of service delivery in the DDSs and SSA. Since 2010, SSA's administrative budget has remained static, even while the cost of service delivery has gone up. SSA responded initially to reductions in its budget in those areas that did not directly impact case production. That "luxury" is long gone and recent budget reductions have resulted in hiring freezes that have created a crisis of confidence in the Agency's ability to serve the public. Hiring freezes have contributed to higher caseloads, increased processing time and diminished accuracy. The resulting less than professional work environment contributes to increased attrition. The investment in time and resources to train a disability adjudicator to become proficient at making disability decisions is significant and the DDSs can't afford to allow this commitment of resources to continue to walk out the door. This is a program challenge caused by budget constraints imposed by Congress.

The attrition rate for DDS staff has been about 15% in recent years. What this means is that a DDS with 400 employees will lose 60 of them in any given year. Over the course of the past two years, that has meant a loss of 120 employees, nearly one-third of the DDS staff. New hiring has been minimal since the DDSs operated during the past two years with only critical hires being approved. As the attrition continues, the work environment within the DDSs can become nearly toxic as remaining staff have to assume almost unimaginable workloads. This, of course, feeds the attrition rate. The DDSs lost 1,623 employees in FY 2017 including 1238 adjudicators. It takes two to four years for most disability adjudicator in the DDSs to become proficient at making accurate and timely disability determinations. The DDSs cannot afford to expend the funds to train these adjudicators only to watch them walk out the door when higher paying, less stressful jobs in the private sector beckon to them.

The DDSs have had to shift personnel and resources from such positions in the DDS as training, quality assurance, professional relations, and even supervision and management and direct all their resources to claim processing to ensure that claims continue to be processed timely and accurately. This shift of resources within the DDSs cannot be sustained on a continuing basis without severe risk. How long, for example, can the DDSs continue to postpone ongoing training for their staff in order to ensure current decision-making is timely before future decision-making is not timely and not accurate because new training was never properly provided? How long can the DDSs allow its quality assurance personnel, trainers and supervisors process cases while abandoning their specific jobs that are critical to the DDS's ability to provide timely and accurate decisions? NADE would like to point out, for example, that while SSA made significant progress during the past year in updating the medical listings, many DDSs were unable to ensure their staff received anything more than the basic training package because subsequent training was deemed to represent a too costly investment of time away from case processing. It is critical to SSA's mission that sufficient resources be provided on a consistent basis to ensure the disability program is adequately funded at a level that will maintain the public's confidence in the program and the Agency's ability to serve its mission.

Reinstatement of Reconsideration

While about 80,000 claimants were allowed in FY 2017 at the reconsideration appeal step, this option was not available in ten DDSs that were part of the original Prototype redesign in 1997. NADE has repeatedly presented the argument that disability decision-making should be the same across the nation. We suggest Congress should explore the possibility of bringing the reconsideration step back to those DDSs where it has been absent for twenty years. While this will require a significant expense in new hiring and training of personnel, the expectation will be a reduction in the number of claims appealed to administrative law judges, helping to ease the backlog of claims pending at that level of appeal while also improving the processing time of ALJ decisions. With fewer claims to adjudicate, ALJs will be able to make their decisions faster.

NADE also observes that the inadequate hiring caused by insufficient funding plagues not only the DDSs but all components in the disability program, including the ALJ level where new hiring of ALJs has occurred in recent years but their support staff has not received new hires. SSA's Central Office and its many Field Offices have had to shift resources and reduce their hours of operation to absorb staff reductions caused by ongoing budget constraints. This level of service simply cannot continue for an Agency charged with service delivery to tens of millions of Americans every year, many of whom are our nation's most vulnerable citizens.

The Impact of Eliminating Single Decision-Maker and Disability Examiner Authority

The Bipartisan Budget Agreement of 2015 required that SSA eliminate the use of the single decision-maker (SDM) in the nineteen DDSs that had this authority. SSA imposed a staggered process to abide by this requirement with the result that the last DDSs using SDM will lose this authority on September 30, 2017. The SDM has been in use since 1997 and its resultant

elimination has contributed to higher processing times in the DDSs as well as lower morale and, in some cases, decreases in job grades and salary. This is not welcome news to DDSs who strive to maintain their staff in the face of heavy private industry recruitment. Also, the elimination of SDM means DDSs must have an increase in resources to hire sufficient medical staff to review the claims previously processed by SDMs.

The BBA also required SSA to eliminate Disability Examiner Authority (DEA) for Compassionate Allowance (CAL) and Quick Disability Determination (QDD) claims. These claims are, perhaps, the easiest cases to process in the DDS and they are fast-tracked accordingly. DDSs generally allowed their most experienced disability adjudicators to act with Disability Examiner Authority, ensuring CAL and QDD claims were processed correctly and timely. Statistical data show these claims were adjudicated with a high level of decisional accuracy and timeliness. It should not be necessary for DDSs to have to now impose an additional hand-off and require these claims to be reviewed and signed by a Medical Consultant. NADE believes the loss of DEA will have multiple negative impacts on DDS operations and the timeliness these claims can be produced as well as the cost of case production. Adding time delays to the processing of these claims for which timeliness can be considered essential is not in the best interest of the claimant or the disability program. We urge Congress to reconsider elimination of SDM and DEA and, at the very least, reinstitute DEA for CAL and QDD claims.

The CDR Claims Process and Impact of MIRS

When a claim is approved for disability benefits, a diary is established for that claim to be reviewed again after a certain period, usually three (3) to seven (7) years, to determine if the disabling condition continues. After the diary expires, the DDS conducts a Continuing Disability Review (CDR) during which the Medical Improvement Review Standard (MIRS) is applied to determine if the claimant's impairment has medically improved. MIRS was established in 1984 after a mandate from Congress and requires that benefits continue unless the beneficiary's disabling condition has shown medical improvement and the medical improvement is related to the ability to work. In effect, MIRS turns the tables on the federal disability program. During the initial application process, the burden is on the claimant to prove they are disabled. At the CDR level, the necessity to apply MIRS shifts the burden to SSA and the DDS to prove there has been significant medical improvement related to the ability to work. The MIRS standard is very stringent and, as a result, few claims are actually ceased by the DDS and many of the initial cessation determinations proposed by DDSs are reversed on subsequent appeal. The majority of cessations processed by DDSs are the age 18 redeterminations, claims processed for adults who have recently attained the age of 18 and were allowed benefits as children. These claims are re-examined by the DDS using adult criteria to determine if disability continues. MIRS does not apply to age 18 redeterminations. Instead, the DDS makes a new initial determination whether the claimant has an impairment that continues to be disabling based on adult criteria.

To process a CDR claim, the disability examiners are required to compare a beneficiary's current condition to the beneficiary's condition at the time of the most recent medical decision, whether that is the initial allowance decision or the most recent CDR continuance decision.

Because of MIRS it is not unusual to find a CDR claim where the disability examiner would not currently find the beneficiary disabled, but must continue benefits because significant medical improvement cannot be shown.

CDI and Other Anti-Fraud Initiatives

Every instance of fraud within the disability program has a negative impact on America's trust in the ability of SSA and its components to deliver on its promise to administer these programs in a manner that reduces the potential for fraud or similar fault. NADE is pleased SSA has moved forward to expand the continuing disability investigation units (CDIUs) in the DDSs. CDI and other anti-fraud initiatives are beneficial to the disability trust fund and to the public's perception that disability payments should be reserved for those who are truly disabled. We support SSA's ongoing efforts to ensure all DDSs have access to a CDI unit by 2020.

NADE would like to point out to the Members of this Subcommittee that SSA's Inspector General has previously commented on numerous occasions that SSA's best defense against fraud is the well-trained disability examiner. NADE would add the caveat that the well-trained disability examiner must also have a manageable caseload. We also wish to stress to the Subcommittee that the Inspector General has previously pointed out the majority of fraud in the disability program, to date, has been detected by the front line disability examiner in the DDS. Therefore, it is critical that adequate funds be consistently appropriated to ensure DDSs have sufficient staff and resources to not only produce disability decisions that are timely and accurate but that their caseloads be manageable and they have received sufficient training to perform their jobs so that they can continue to detect those instances when some individuals attempt to defraud the program.

Increased Efforts for Consistency Between DDSs and ALJs

NADE applauds SSA's recent efforts to bring consistency between the DDS and ALJ determinations. There has been improvement in documentation of rationales at the DDS level with the eCAT tool and the soon to be implemented Disability Case Processing System (DCPS) is expected to improve on this process. SSA has begun providing additional policy and medical training for ALJs, resulting in a decrease in the overall allowance rates by ALJs. When a claimant appeals a denial decision to the ALJ, they have the right to be represented at the hearing. NADE concurs with the right of representation, as this is a privilege granted under our country's system of justice. However, that system of justice is also predicated on the concept that both parties to a dispute are represented at a hearing before an impartial third party. Such is not the case in ALJ hearings where only the claimant is represented. The DDS decision must stand on its own and can be interpreted by the ALJ in whatever manner they wish to do so. Frequently, the ALJ must attempt to defend the DDS decision while attempting to remain an impartial judge. Such an effort can create the appearance of bias and NADE wonders whether it would be beneficial to have the DDS determination represented at the ALJ level.

SSA has also initiated Target Denial Reviews of DDS reconsideration decisions, using a predictive model to assess certain reconsideration denial claims that could likely be reversed by an ALJ

and returning these claims to the DDS for a subsequent re-assessment and possible reversal to an allowance. In recent years, this process has resulted in thousands of claims being reversed to an allowance by the DDS, thereby reducing the pending backlog of cases at the ALJ level.

Summary

NADE believes SSA's ability to provide timely customer service is critical. No other agency in government has the potential to impact so many people and the vast majority of Americans will judge the government's ability to serve their needs based on how effective and how efficient SSA is able to meet their needs. **SSA is America's "Window" to its government.** It can ill afford to fail in its mission. SSA and its DDS partners must be provided with the resources necessary for the Agency to achieve its mission in a timely manner. The growing complexity of the Social Security and SSI Disability Programs, coupled with the need to produce a huge volume of work, justifies even more the need for adequate resources in order to provide the service the American public has come to expect and deserve from SSA. We refer the Members of the Subcommittee to review the complex job of the Disability Examiner as published by NADE in 2004 at <http://www.nade.org/nade-board-approves-disability-examiner-position-paper/>.

In FY 2008, this Subcommittee held a hearing to address the challenges facing the Social Security disability program. The Subcommittee's Chairman in 2008 offered the observation that "constant under-funding of the disability program by the Congress over the past two decades had contributed heavily to the current crisis." NADE notes that another decade has passed and we do not dispute such wisdom! The past two decades have shown that when SSA receives consistently adequate funding, it can increase the timeliness and accuracy of disability decisions at all levels and reduce the backlog of claims pending for hearings. When SSA does not receive adequate funding, the backlogs and wait times grow. The timeliness of decision-making and the accuracy of those decisions are negatively impacted. Chairman Johnson noted in his opening remarks the amount of time from filing an initial application to getting a hearing is over two years. The Chairman commented, "All of these people deserve an answer in a timely fashion." NADE agrees. This is a problem in which Congress shares responsibility and Congress has the power to help resolve the problem. Congress must recognize the cost of doing business and serving the public cannot be ignored and Congress must appropriate adequate funding on a consistent basis so SSA and the DDSs can fulfill their mission.

Social Security can and must do better in fulfilling its promise to America. NADE stands ready, willing, and able to assist in fulfilling that promise. People with disabilities, already burdened by the challenges of their illness/injury, are often in desperate need of benefits to replace lost income. They deserve, and should receive, timely and accurate decisions through a fair and understandable process. The challenge to all of us – SSA, DDS and Congress – is to ensure the disability determination and appeals process fulfills its mission and this challenge must be met.

We commend the Subcommittee for exercising its oversight authority and we look forward to working with the Subcommittee to achieve the goals we have outlined in this statement.

*** Definition of disability for adults**

Under title II and title XVI, we consider a person disabled under Social Security rules if he or she has a medically determinable physical or mental impairment (or combination of impairments):

- that prevents him or her from doing any substantial gainful activity (SGA), and
- has lasted or is expected to last for a continuous period of at least 12 months, or is expected to result in death.

NOTE: The definition of disability also applies to persons applying for child's insurance benefits based on disability before age 22 and for disability benefits payable after December 1990 as a widow(er) or surviving divorced spouse.

Definition of disability for children under age 18

Under title XVI, we consider a child under age 18 disabled under Social Security rules if:

- the child has a medically determinable physical or mental impairment (or combination of impairments) that:
 - causes marked and severe functional limitations;
 - has lasted or is expected to last for a continuous period of at least 12 months, or is expected to result in death; and
- the child is not doing any SGA.

**** The steps of adult sequential evaluation of disability**

1. *Step one considers work activity – Is the claimant engaging in substantial gainful activity (SGA)?*
 - a. If **yes**, the claimant is **not disabled**.
 - b. If **no**, the sequential evaluation continues.
 2. *Step two considers whether the claimant has a severe impairment(s) – Does the claimant have a medically determinable impairment (MDI) (or combination of MDIs) that is **both** severe and meets the duration requirement?*
 - a. If **no**, the claimant is **not disabled**; and
 - b. If **yes**, sequential evaluation continues.
 3. *Step three considers whether the claimant's impairment(s) meets or medically equals a listing – Does the claimant have an impairment(s) that meets a listing, or is medically equal to a listing in appendix 1, and meets the duration requirement?*
 - a. If **yes**, the claimant is **disabled**; and
 - b. If **no**, the sequential evaluation continues.
- NOTE:** Before the sequential evaluation continues, we determine the claimant's residual functional capacity (RFC).

4. Step four considers whether the claimant's impairment(s) prevents performance of Past Relevant Work (PRW) – When comparing the RFC with the physical and mental demands of the claimant's PRW, we must consider two questions:

- a. Does the claimant retain the capacity to perform any PRW as he or she actually performed it?
- b. Does the claimant retain the capacity to perform any PRW as generally performed in the national economy?
 - o If the answer to either question is **yes**, the claimant is **not disabled**.
 - o If the answer to **both** questions is **no**, the sequential evaluation continues.

NOTE: Consider the Special Medical Vocational Profiles **after** evaluating step four and **before** evaluating step five. If one of the special medical-vocational profiles applies, the claimant is disabled and the sequential evaluation ends.

5. Step five considers whether a claimant can make the vocational adjustment needed to perform other work – Does the claimant have the ability to make an adjustment to any other work, considering the claimant's RFC, age, education, and work experience?

- a. If **yes**, the claimant is **not disabled**.
- b. If **no**, the claimant is **disabled**.



**Hearing
Before the
House Committee on Ways and Means
Subcommittee on Social Security**

**Determining Eligibility for Disability Benefits:
Challenges Facing the Social Security Administration
September 6, 2017**

**Statement for the Record
Submitted by
Philip B. Litteral, President
National Association of Disability Representatives
Director, Disability Claims Experts, Inc.**

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My name is Philip B. Litteral and I am President of the National Association of Disability Representatives. NADR is an organization of professional representatives who assist claimants in applying for disability income assistance from the Social Security Administration. Our members help individuals and their families navigate an often complex and lengthy process to demonstrate their eligibility for disability benefits. I am pleased to submit this statement for the record regarding the September 6, 2017 hearing entitled "Hearing on Determining Eligibility for Disability Benefits: Challenges Facing the Social Security Administration" on NADR's behalf.

NADR is a member of the Consortium for Citizens with Disabilities Social Security Task Force and a signatory to the testimony presented on behalf of the Task Force by Lisa Ekman of the National Organization of Social Security Claimants' Representatives. That testimony addressed the human toll that the hearings backlog is taking on claimants and their families. Here are some additional examples of the devastating consequences for claimants with severe disabilities who are forced to wait an average of 628 days for a determination before receiving the benefits to which they are entitled:

In Ashland, Kentucky, a man filed for disability in early 2013 because of debilitating migraine headaches. After initial claim and reconsideration denials, he waited 17 months for a hearing. During that time his home was foreclosed on. He moved in with his mother and filed for bankruptcy. At the hearing his representative asserted and provided evidence that his condition equaled a listing. Nonetheless, his claim was dismissed without comment and the decision upheld by the Appeals Council. A Federal District Court granted a remand for a new hearing. During this time his mother died and the claimant became homeless. He lived in homeless shelters and basements for ten months while awaiting a second hearing. After the second hearing was finally held, he waited another four months for the favorable decision - which ultimately agreed with the claimant's original assertion that his condition equaled a listing. During the period from filing his initial claim in early 2013 to receiving his first disability payment in late 2016, he lost his home, his vehicles, all of his possessions and most of what remained of his health and vitality.

In Atlanta, Georgia, a 57-year-old homeless man with multiple physical and mental impairments had his claim remanded for a second hearing. The ALJ denied it again, saying he could return to previous relevant work even though he could only do one part of a composite job. His representative appealed to the Appeals Council a second time, asking that the case be expedited due to dire need due to his eviction from his home. The case was so designated in March 2012, yet, the man died in January 2014 with the case still unreviewed at the Appeals Council. The storage unit he had been using that winter for shelter was flooded during a storm, ruining the few personal possessions he had as well as his place to sleep. A Good Samaritan took him out to dinner and paid for him to spend the night in a hotel room. During that night he passed away. An autopsy revealed that his heart gave out. Being

homeless wore him down physically with the constant stress of wondering where his next meal would come from and where he would sleep at night.

In Siren, Wisconsin, a claimant suffered from severe epilepsy following a traumatic brain injury. He had no access to health insurance and could not afford to see a doctor or pay for his seizure medication. In the middle of the winter, one year and six months after he filed his application, he suffered a seizure and was found dead in his home. He had been unable to afford to adequately heat his home, causing his pipes to freeze. His claim ultimately was approved posthumously, with benefits paid to his son.

In Brainerd, Minnesota, one year and five months after filing his application for disability benefits a young man with severe mental health impairments committed suicide in the community behavioral health hospital where he was being held. His claim was approved posthumously.

In order to assure that these tragic examples are not repeated, NADR urges Congress to provide adequate, sustained administrative funding in order to reduce the hearings backlog without compromising other workloads across the agency. In addition, by expanding the allowable uses of program integrity funding to include Targeted Denial Reviews, Congress could reduce the disability backlog and improve the decisional quality of disability determinations.

Among the steps SSA can take administratively to reduce the backlog are ensuring more complete development of medical records at the initial level; providing more information to claimants on options for representation before and during the initial application process; continuing to use screening initiatives such as Quick Disability Determinations and Compassionate Allowances to identify disability claims for expedited review; providing better explanations to medical providers when requesting medical evidence; and increasing reimbursement rates for medical providers. SSA can further address the hearings backlog by resuming its Senior Attorney Program to allow senior staff attorneys in hearing offices to issue fully favorable on-the-record decisions without a hearing.

Finally, NADR notes that recent regulatory changes have contributed to the hearings backlog and urges SSA to consider rescinding or clarifying the Evaluation of Medical Evidence Rule that eliminated the special weight given to evidence provided by a claimant's medical treating source; the Program Uniformity Rule that requires the submission of or informing SSA about all evidence at least five business days before a hearing; and the All Evidence Rule that requires claimants to "submit all evidence that relates to your disability claim received from any source in its entirety." These rules have contributed to the hearings backlog, causing delays and forcing claimants to wait additional months and even years to obtain the benefits they have earned.

Thank you for the opportunity to submit these comments for the record. NADR looks forward to continuing to work with the Social Security Subcommittee to improve the accuracy and integrity of the disability determination process.



**Testimony of
Anthony M. Reardon, National President
National Treasury Employees Union**

to the

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

**“Determining Eligibility for Disability
Benefits: Challenges Facing the Social
Security Administration”**

September 19, 2017

**USING SENIOR ATTORNEY ADVISORS AS ADJUDICATORS
A Proven Method to Reduce the Hearing Backlog, Expedite Decisions,
and Improve Public Service.**

Chairman Johnson, Ranking Member Larson and members of the Subcommittee, thank you for allowing NTEU to share its thoughts on methods to improve the Social Security Administration's disability process. NTEU represents 150,000 federal employees in 31 agencies including 1,900 attorneys and paralegals in the Social Security Administration's Office of Disability Adjudication and Review (ODAR). I appreciate the opportunity to discuss these important issues.

INTRODUCTION

The Social Security Administration's Office of Disability Adjudication and Review (ODAR) handles appeals of disability claims. ODAR strives to issue legally sufficient decisions and award benefits to disabled claimants "as early in the process as possible".¹ The decades-old disability hearings process, however, was not designed to process the unprecedented number of claims filed in the past ten years. The hearing process also was not designed to accommodate the increased participation of attorneys representing claimants. Adding to these challenges, the hearing process has been encumbered by insufficient resources, inadequate staffing, expanding case files, expansive changes in regulations, conflicting operational messages, and escalating internal tensions.²

These are some of the factors causing the most needy members of society to wait one to two years for a disability decision while they face life-altering medical and financial stressors. In September 2016, the Office of Inspector General (OIG) determined that almost half (45%) of pending disability claims languish in prehearing development.³ Due to the huge number of pending claims, currently more than 1.1 million, and lack of sufficient staff, a claim can sit in a hearing office queue for 6-9 months before it reaches an employee for processing. By the end of FY 2016, average case processing time rose to 540 days while Administrative Law Judge (ALJ) productivity declined nationwide even as the Agency hired more ALJs.⁴ Today, despite a host of initiatives outlined in the Agency's Compassionate And REsponsive Service (CARES) plan, ODAR does not expect average wait times to improve substantially until 2020.⁵

And yet, ODAR could begin to make a dent in the backlog immediately, reduce wait times, and bring relief to thousands of claimants simply by fully engaging its existing cadre of highly trained senior attorney advisors (SAAs). SAAs can screen, develop, and decide claims that do not require a hearing—and they can do it within a few months

¹ <http://odar.ba.ssa.gov/about-odar/what-we-do/>

² See Statement of Judge Marilyn Zahm, President, Association of Administrative Law Judges, Before the House Ways and Means Committee, Sept. 6, 2017.

³ Characteristics of Claimants in the SSA's Pending Hearings Backlog, A-05-16-50207, Sept. 2016.

⁴ OIG Sept. 2017 SAA Audit Report, A-12-18-50289.

⁵ SSA 2017 Updated Compassionate And REsponsive Service (CARES) and Anomaly Plan, submitted to The Hon. John Larson on Aug. 9, 2017.

rather than a few years. SAAs can meet with unrepresented claimants to advise them about the hearing process. SAAs can also identify evidentiary needs and develop the record as well as meet with claimants' attorneys to resolve cases without a hearing or obtain stipulations to streamline cases that require hearings. *Crucially, this cadre of skilled and experienced attorneys is prepared to act immediately and requires no additional funding or hiring.*

REINSTATING SAA ADJUDICATORY AUTHORITY
WILL INCREASE ODAR'S DECISIONAL CAPACITY

SAAs have regulatory authority to fully adjudicate fully favorable decisions. An SAA, “*instead of an administrative law judge,*” can conduct prehearing proceedings and issue fully favorable on-the-record (OTR) decisions, eliminating the need for a hearing.⁶ Even when SAAs determine that claims cannot be decided without a hearing, they play a pivotal role by initiating case development as soon as the claim enters the hearing office queue, significantly reducing the 6-9 month wait time. Further, SAAs can request additional evidence. They can hold conferences with claimants' attorneys to resolve procedural and evidentiary issues. SAAs also can hold conferences with unrepresented claimants to explain hearing requirements and procedures.

Unfortunately, SAAs are an underutilized resource at ODAR; most do not perform any of these roles in the hearing process. This was not always the case. In years past, when the Agency allowed full use of adjudicatory authority, SAAs contributed significantly to decreasing the number of pending claims and the extent of claimants' wait times.

- From 1995 to 2000, 475 SAAs adjudicated over 200,000 decisions with an average processing time (APT) of 100 days compared to 386 days for ALJ hearing decisions.⁷
- In 2007, when the Agency reinstated the SAA adjudication program, it acknowledged SAA adjudications conserved ALJ resources for more complex cases that required hearings, reduced the backlog, and increased adjudication capacity.⁸
- From 2007 to 2012, SAAs adjudicated a significant number of decisions. For example, in FY 2010 SAAs issued 54,000 decisions, 7% of all Agency dispositions.⁹

⁶ 20 CFR § 404.942; § 416.943 (emphasis added). SAAs can exercise this authority if: new and material evidence is submitted; there is an indication that additional evidence is available; there is a change in the law or regulations; or there is an error in the file or some other indication that a wholly favorable decision could be issued. The Regulation currently extends to February 2018. 82 FR 34400.

⁷ Statement of Jim Hill, NTEU President, Hearing Before the Subcommittee on Social Security, March 16, 2000, Serial 106-44. ODAR did not compile an official final study of this SAA program. OIG July 2011 SAA Audit Report, A-12-10-11018, Appendix H.

⁸ Chief Judge Bulletin 07-10.

⁹ OIG July 2011 SAA Audit Report, A-12-10-11018.

SAA disposition numbers from 2008 to 2013 were striking:¹⁰

<i>Year</i>	<i>SAA dispositions</i>
2008	24,575
2009	36,366
2010	54,186
2011	53,253
2012	37,422
2013	18,627

SAA decision processing time also improved claimant wait times. In FY 2010, SAA decisions took only 165 days to process compared with 462 days for all cases.¹¹

The value of the SAA adjudicatory program has been widely accepted. OIG acknowledged in its 2013 audit report that the “SAA program has contributed to both an increase in adjudicative capacity and improved average processing time.”¹² Hearing office managers reported that office goals were met or exceeded due to SAA dispositions. One manager reported that SAAs issued between 50 and 135 cases per month, and another reported that SAAs handled 20% of the office productivity goal.¹³ The OIG acknowledged that “SAAs’ additional adjudicatory capacity is especially important when the Agency is struggling to reduce its pending hearings backlog.”¹⁴ The OIG recommended that ODAR consider expanding the types of cases SAAs adjudicated and align SAA positions and promotions with predicted workloads.¹⁵

Nevertheless, in the face of surging hearing requests in 2014, ODAR eliminated SAA adjudicatory authority and imposed an arbitrary cap of 7,500 SAA decisions. Currently, ODAR prohibits its 550 highly experienced SAAs from independently screening pending claims or adjudicating fully favorable OTR decisions. Instead, hearing office supervisors (many of whom are not attorneys) select and assign cases to SAAs to review. If the SAA determines the case can be paid without a hearing, the SAA must write a detailed case analysis for an ALJ to review. If the ALJ agrees, the SAA writes the decision for the ALJ to review and sign (although the SAA has worked the case, the ALJ gets credit for the disposition). SAAs are allowed two hours to review cases assigned for OTR review, regardless of the size of the file or number of issues involved. SAAs may not independently obtain medical or vocational expert opinions or otherwise develop the claim. If the claim cannot be paid, the SAA completes a summary of the medical evidence and sends the case back to the queue—where the case will languish for 6-9 months before any development will be initiated. The case will not be scheduled for a hearing for another 2-3 months. By the time the hearing actually takes place, the claimant will have waited a year or more from the date he or she requested a hearing.

¹⁰ OIG July 2011 SAA Audit Report, A-12-10-11018.

¹¹ *Id.*

¹² OIG June 2013 SSA Audit Report, A-12-13-23002.

¹³ OIG July 2011 SSA Audit Report, A-12-10-11018.

¹⁴ OIG June 2013 SSA Audit Report, A-12-13-23002 (emphasis added).

¹⁵ *Id.*

The Agency's arbitrary refusal to allow SAAs to fully adjudicate favorable OTR decisions needlessly slows down the disability hearing process. From 2007 to 2013, when SAAs had full adjudicatory authority, they produced a high number of quality OTR decisions and significantly reduced claimants' wait times. Since 2014, the Agency has restricted this talented and dedicated cadre of legal professionals from resolving cases early in the hearing process. The Agency could improve the disability determination process and expand decisional capacity—immediately and at almost no cost—by fully using SAAs' legal, analytical, and programmatic skills.

SENIOR ATTORNEY ADVISORS ARE POISED
TO IMPROVE ODAR'S PUBLIC SERVICE

ODAR's senior attorneys deal with the intricacies of the legal-medical aspects of the Social Security disability program every day. They are experienced disability practitioners, well-versed in the law and possess a wealth of adjudicatory experience. Most have worked on thousands of cases and routinely advise ALJs. They are dedicated professionals who take pride in their work and are committed to the Agency's public service mission, a logical and reliable adjunct to the ALJ corps. The public would be better served if ODAR leveraged the skills of its SAAs to screen, develop, and adjudicate OTR decisions, conduct pre-hearing conferences, and work with claimants' representatives to simplify issues requiring a hearing. The public would be even better served if ODAR expanded the role of SAAs to include deciding unfavorable decisions on the record as claims examiners.

A. ODAR Should Restore SAA Full Adjudicatory Authority

Currently, there are 550 SAAs at ODAR.¹⁶ With full adjudicatory authority, this cadre would significantly streamline and expedite the disability hearing process at no additional taxpayer expense. Consider:

1. SAAs Increase Adjudication Capacity

The Agency has hired approximately 200 ALJs in the past few years at great taxpayer cost. Most of these ALJs are new to the Agency and require significant training (at significant cost) and initially work a reduced workload while they learn the job. SAAs, by comparison, are fully trained. Each SAA has at least three years' of experience at ODAR; most have substantially more. SAAs are a ready and reliable decision-making resource that can decrease the backlog and claim processing time without additional expensive hiring. They have regulatory authority to fully adjudicate certain cases without a hearing. They also would continue to write the more difficult ALJ decisions, thereby providing management

¹⁶ Although ODAR has 750 positions allocated for SAAs, instead of promoting GS-12 attorney-advisors, ODAR has kept 200 of these positions unfilled since 2009. As a consequence, skilled GS-12 attorney-advisors have moved into non-legal management positions, or left the Agency.

with flexibility to direct either decision-making or decision-writing resources, as needed.

2. SAAs Save ALJs Time

Under current regulations, ALJs are the only ODAR employees who can hold hearings. Allowing SAAs to screen and adjudicate OTR decisions in cases that do not require hearings leaves more time for ALJs to prepare for hearings, hold hearings, and make decisions in cases that require hearings. ALJs are under pressure to dispose of 500-700 cases per year. Allowing SAAs to fully adjudicate OTR decisions will conserve ALJ time and redirect staff resources to support ALJ dispositions and goals.

3. SAAs Require Less Staff Resources

Hearing office staff must conduct extensive development for ALJ cases. However, no such staffing is needed to process cases that a SAA adjudicates on the record, significantly reducing administrative costs. In OTR cases, the staff does not have to implement standing ALJ orders for case development, organize voluminous and often duplicative evidence, or schedule medical or vocational experts. And, because most hearing offices are significantly understaffed, preserving staff to support ALJ needs will produce greater efficiencies at the ALJ level.

Senior attorney advisors are trained to quickly recognize serious disabilities and analyze sophisticated and voluminous medical evidence. They do not require a cadre of support staff. They easily can identify gaps in the record. They can move cases in two months instead of two years.

To address the hearing backlog effectively and immediately, the Agency can and must:

- Restore full adjudicatory authority to SAAs, including signatory authority.
- Allow SAAs to independently screen cases, including cases assigned to ALJs.
- Allow SAAs to fully develop cases, including obtaining medical and vocational opinions.
- Promote more GS-12 attorney-advisors to GS-13 SAA positions.

These are tried and proven processes in adjudicatory proceedings. Indeed, a similar federal agency, the HHS Office of Medicare Hearings and Appeals (OMHA), has implemented many of them. Like ODAR, OMHA faces a daunting number of current pending claims. OMHA, however, recognizes the value of using its experienced attorneys to expand the pool of available adjudicators. To increase efficiency and streamline the appeals process, OMHA allows its attorneys to independently decide and issue OTR decisions.¹⁷ OMHA also allows attorneys to adjudicate claims on the record in which the

¹⁷ 82 FR 4974, January 17, 2017; 42 CFR § 423.2038. OMHA will also allow attorneys to issue certain dismissals and decide specific remands that are not involved in the SSA disability claims process.

claimant does not wish to appear at a hearing.¹⁸ OMHA expressly recognizes that attorneys are as capable of processing these appeals as ALJs, but faster and at a lower cost.¹⁹

Implementing the proposed measures at ODAR will optimize resources, increase adjudicatory capacity, increase dispositional productivity, and provide immediate and significant relief to claimants. These measures also will create a career ladder, and provide increased incentives and advancement opportunities for productive and valuable employees. Inexplicably, ODAR is the only disability adjudication component that provides no career ladder after the initial GS-11 or 12 attorney advisor entry level position. The Office of Inspector General, the Office of General Counsel, and the Appeals Council all provide a career ladder to a GS-14. Rather than create a career ladder and incentivize legal and professional excellence in its ranks, ODAR has told its skilled GS-12 attorneys who seek promotional opportunities that they can either find a managerial position or leave the agency. The practice of underutilizing and disincentivizing skilled attorneys in whom ODAR has invested years of training serves no one, least of all the claimants who need their services.

B. The Agency Must Allow Senior Attorneys and Attorney Advisors to Conduct Pre-Hearing Conferences.

In October 2016, ODAR began a pre-hearing conference pilot in some hearing offices. A few days per month, SAAs met with unrepresented claimants a few weeks prior to their scheduled hearings.²⁰ Following a uniform script, the SAAs told claimants about their right to an attorney and provided a list of attorneys and representatives. Because the SAAs had reviewed the cases prior to the conference, they were able to ask claimants specific questions about recent work activity and medical treatment. This enabled SAAs to resolve evidentiary gaps in the record and recommend specific additional development before the hearing.

ODAR's data shows that pre-hearing conferences were productive and successful. Hearing postponements decreased. According to the Agency's 2017 Updated CARES and Anomaly Plan, claimants who attended prehearing conferences went on to complete their hearings without postponement 56 percent of the time, compared to 28 percent for those who did not participate in a prehearing conference.²¹ Beyond this, claimants were happy to talk to someone about their case. Most were unaware they had a right to representation. Some withdrew their claims. ALJs benefitted from the pre-hearing conferences because claimants came to hearings informed about the right to representation and other procedural matters. SAAs reported that conducting pre-hearing

¹⁸ 42 CFR § 423.2038.

¹⁹ 82 FR 4974.

²⁰ The conferences were recorded.

²¹ Postponing and rescheduling a hearing wastes a hearing slot, ALJ time and staff resources, and costs associated with reserving medical experts, vocational experts, and hearing reporters (who are paid regardless of whether the claimant appears or the hearing is held).

conferences improved morale because they knew they were making a difference and providing a service that claimants appreciated.

Despite proven benefits to claimants, ODAR staff, and hearing office workflow, ODAR discontinued pre-hearing conferences in January 2017 and redeployed SAAs to focus on what the Agency termed a decision writing “crisis.”²² ODAR plans to reinstate pre-hearing conferences, but on a limited basis and only with unrepresented claimants.²³ Rather than restrict measures that yield proven results, ODAR should expand pre-hearing conferences to provide even greater efficiencies by allowing SAAs to meet with claimants’ attorneys and representatives to obtain stipulations and discuss evidence.

1. Stipulations.

SAAs and claimants’ attorneys and representatives can use pre-hearing conferences to reach written stipulations as to uncontested issues. For example, there often is little dispute as to the onset date of disability or whether the severity of a claimant’s impairments meets or equals a listing. These and other stipulations to facts not in dispute would simplify the ALJ’s case review, reduce the number of issues to be addressed at the hearing, and eliminate the need for decision writers to revisit the same issues again when they draft ALJ decisions.

2. Evidence and On-The-Record Decisions

A pre-hearing conference is the ideal venue for SAAs and claimants’ representatives to discuss and procure updated medical evidence and address gaps in the record. A pre-hearing conference is also the ideal venue to examine whether a hearing is needed, whether the claim can be decided on the record, what evidence would make that possible, and any other matters that might facilitate the expeditious processing of the claim, whether at hearing or on the record.

Again, OMHA has recognized the value of expanded pre-hearing conferences conducted by experienced attorneys. In OMHA’s FY 2018 budget request, the Chief Administrative Law Judge said:

OMHA will invest in the hiring [of] additional senior attorneys to support its administrative initiatives to address the pending workload. For example, the agency’s settlement conference facilitation program for interested appellants having multiple claims pending at OMHA was established in June 2014. OMHA has been encouraged by the results of the pilot program, *which has resolved*

²² ODAR has acknowledged that misaligned hiring practices (hiring judges without hiring support staff) is one reason for the burgeoning number of cases waiting to be written. However, we are not aware of any advance steps taken to mitigate the predictable increase in cases to be written. At the same time, ODAR continued to press a quality initiative in which attorneys reviewed (rather than wrote) decisions and sent them back to the writing queue for corrections to minor mistakes that had no material effect on the decisional outcome. The number of unwritten decisions climbed steadily each month, from about 34,000 at the beginning of the fiscal year to 73,000+ by September 2017.

²³ SSA 2017 Updated Compassionate And REsponsive Service (CARES) Plan.

10,383 appeals or the equivalent of one year of work for 10 ALJ teams (data as of February 28), and anticipates incorporating the program into its business model on a permanent basis.²⁴

To make good on the CARES commitment to benchmark with other agencies and learn about successful strategies, ODAR would do well to follow OMHA's example and expand its adjudicatory capacity by embracing its SAA cadre. ODAR's SAAs have the skills to conduct pre-hearing conferences and resolve claims that do not require expensive and time-consuming hearings, and the ability to narrow issues and streamline the hearing process for those claims that do.

C. The Agency Should Create a Claims Magistrate Program

SAAs can quickly recognize serious disabilities and analyze sophisticated and voluminous medical evidence. They do not require a cadre of support staff. They easily can identify gaps in the record. They can move cases in two months instead of two years.

These skills easily support a new Claims Magistrate Program. Under this program, SAAs would screen the hearing office queue to identify cases that have fewer than 300 pages of medical evidence. Represented claimants would waive their right to a hearing but preserve the right to appeal. Representatives would submit a brief in support of the claim. The SAA claims magistrate would analyze the case and the entire record and issue a decision. This model is similar to the OMHA Settlement Conference program, in which claimants can waive a hearing and allow attorneys to adjudicate claims on the record without any ALJ involvement.²⁵

Although a Claims Magistrate Program would require new regulatory authority, the Program would expand ODAR's adjudicatory capacity and streamline the hearing process by creating another adjudicatory avenue. Claimants who waive a hearing would get a faster decision without forfeiting their appeal rights. And, the Program would increase productivity, create a career ladder where currently there is none, and provide increased incentives and advancement opportunities for productive and valuable employees.

CONCLUSION AND RECOMMENDATIONS

Every claimant is entitled to a disability claim decision, but not every disability claim requires an expensive and time-consuming ALJ hearing. The current ODAR model, in which only ALJs can hold hearings and the Agency continually needs more ALJs, more support staff, and more funding, is not sustainable. Nor is the practice of introducing one

²⁴ The Office of Medicare Hearings and Appeals (OMHA's) Fiscal Year (FY) 2018 Congressional Justification (Budget Request) with attached Plan (emphasis added).

²⁵ OMHA Regulations 42 CFR § 405.1038 and § 423.2038 provide mechanisms for deciding cases without an oral hearing or ALJ involvement based on the written record under certain circumstances, including the claimant's waiver. OMHA takes the position that "... well-trained attorneys can review the record, identify the issues, and make the necessary findings of fact and conclusions of law when the regulations do not require a hearing to issue a decision in the appealed matter." 42 FR 4982.

initiative after another only to halt them in order to redeploy resources to address one workload crisis after another (many of them predictable and months, if not years, in the making). The only business model realistically capable of providing mission-critical services on a sustained basis is a *permanent expansion of adjudicatory capacity*—but without the costs associated with hiring and onboarding new ALJs and more support staff. ODAR would do well to recognize, as OMHA has, that the Agency has built-in capacity if only it would allow its talented and experienced senior attorneys to use their legal skills and program knowledge to process claims early in the hearing office process.

NTEU recommends:

1. Senior Attorney Advisors should be allowed to fully exercise their regulatory authority to screen, develop, and issue fully favorable decisions where the medical evidence supports disability.
2. Senior Attorney Advisors should be allowed to conduct comprehensive pre-hearing conferences with claimants and their attorneys with the goal of resolving cases as early as possible in the hearings process. Senior attorneys should be allowed to enter into wide-ranging stipulations with claimants' attorneys concerning procedural and evidentiary issues.
3. The Agency should establish a Claims Magistrate Program to allow Senior Attorney Advisors to review and decide claims without a hearing. In developing such a program, the Agency would have wide latitude to decide the types of cases suitable for magistrate decisions and the contours of the program.
4. Rather than hire more ALJs who require extensive training and additional support staff, the Agency should promote its trained and qualified GS-12 Attorney Advisors to fill all the available 200 Senior Attorney Advisor positions.

NTEU believes these recommendations will significantly increase the Agency's adjudicatory capacity, and thereby reduce the disability backlog, reduce case processing times, increase operational efficiencies, avert workload crises, and markedly improve the level of service the American public needs and deserves.

Thank you for the opportunity to provide our comments.