SECOND IN A SERIES ON SOCIAL SECURITY DISABILITY PROGRAMS' CHALLENGES AND OPPORTUNITIES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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SECOND IN A SERIES ON SOCIAL SECURITY DISABILITY PROGRAMS' CHALLENGES AND OPPORTUNITIES

TUESDAY, JUNE 11, 2002

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

The Subcommittee met, pursuant to notice, at 3:33 p.m., in room 1100 Longworth House Office Building, Hon. Mac Collins presiding.

[The advisory, revised advisory, and revised advisory #2, announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
June 4, 2002
No. SS–14

Contact: (202) 225–9263

Shaw Announces Second in a Series of Hearings on Social Security Disability Programs' Challenges and Opportunities

Congressman E. Clay Shaw, Jr. (R–FL), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing examining the Social Security Administration's (SSA's) disability determination and appeals processes. **The hearing will take place on Tuesday, June 11, 2002, at 10:00 a.m., and will continue Tuesday, June 18, 2002, at 2:00 p.m., in room B–318 Rayburn House Office Building.**

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

BACKGROUND:

Last year, the Subcommittee began a hearing series examining the challenges and opportunities facing Social Security's disability programs. In the first hearing of the series, the Subcommittee heard an overview of these challenges from key stakeholders. Recommendations generally focused on how to decrease processing times at all levels of disability claims adjudication.

Consistently managing our Nation's largest disability determination and appeals process and delivering timely, high-quality, and fair service to disability applicants has become one of the SSA's greatest challenges. The process of applying for Social Security and Supplemental Security Income (SSI) disability benefits is complex and fragmented, involving multiple State and Federal officials, and consisting of an initial decision and up to three levels of administrative appeals within the agency. Upon exhausting these administrative remedies, the claimant may file an appeal in Federal court. In addition, each step within the agency involves detailed procedures for collecting and reviewing evidence and for decision-making. Last year, it required an average of about 106 days to process and issue a final decision for an initial claim for disability benefits and about 308 days to process an appeal before an Administrative Law Judge.

Moreover, due to the aging of the baby boomers, Social Security's actuaries project that between now and 2010, the number of Social Security Disability Insurance beneficiaries will increase by nearly 50 percent and the number of SSI recipients who are disabled will increase by 15 percent. As a result, it is increasingly important for the agency to clearly identify the resources it needs to effectively serve the American people.

Aware of the long-standing problems within the disability determination and appeals process, SSA has spent more than $39 million attempting to develop and implement new initiatives to improve the timeliness, accuracy, and consistency of its disability decisions and spent an additional $71 million to develop an automated disability claims process. Many of these initiatives, however, have been ineffectual or have met with mixed results. Many reports, including those issued by the Social Security Advisory Board and the U.S. General Accounting Office, have outlined problems and provided recommendations for improving SSA's disability determination and appeals process.

In announcing the hearing, Chairman Shaw stated: "Individuals with disabilities, already burdened by the challenges of their illness or 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. Our challenge is to thoughtfully and carefully examine the disability determination and appeals process to ensure it meets the needs of individuals with disabilities and their families."

FOCUS OF THE HEARING:

The Subcommittee will examine the reasons for delays, complexities, and inconsistencies in the disability determination and appeals process and explore recommendations for change.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, by the close of business, Tuesday, June 25, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Social Security in room B–316 Rayburn House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

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

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

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

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

NOTICE—CHANGE IN TIME AND LOCATION

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
June 6, 2002
No. SS–14–Revised

Contact: (202) 225–9263

Change in Time and Location for Second in a Series of Hearings on Social Security Disability Programs' Challenges and Opportunities

Congressman E. Clay Shaw, Jr. (R–FL), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee hearing on the Social Security Disability Programs' Challenges scheduled for Tuesday, June 11, 2002, at 10:00 a.m., in room B–318 Rayburn House Office Building, **will now be held at 3:30 p.m., in the main Committee hearing room, 1100 Longworth House Office Building.**

In addition, the continuation of the hearing scheduled for Tuesday, June 18, 2002, at 2:00 p.m., in room B–318 Rayburn House Office Building, **will now be held at 3:30 p.m.**

All other details for the hearing remain the same. (See Subcommittee Advisory No. SS-14, dated June 4, 2002).

NOTICE—CHANGE IN DATE AND TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
June 14, 2002
No. SS–14–Revised #2

Contact: (202) 225–9263

Change in Date and Time for Second in a Series of Hearings on Social Security Disability Programs' Challenges and Opportunities

Congressman E. Clay Shaw, Jr. (R–FL), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee hearing on the Social Security Disability Programs' Challenges and Opportunities, previously scheduled for Tuesday, June 18, 2002, **will now take place on Thursday, June 20, at 10:00 a.m., in room B-318 Rayburn House Office Building.**

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, by the close of business, Friday, July 5, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Social Security in room B–316 Rayburn House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

All other details for the hearing remain the same. (See Subcommittee Advisories No. SS-14, dated June 4, 2002, and No. SS–14–Revised, dated June 6, 2002.)

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit 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.

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a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

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

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

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

Mr. COLLINS. The Subcommittee will come to order. Chairman Shaw is at the airport and is on his way into the Capitol now. So, he should be coming in most any time. We will enter his statement into the record, unless he just wants to go through it once he arrives.

[The opening statement of Chairman Shaw follows:]

Statement of the Hon. E. Clay Shaw, Jr., a Representative in Congress from the State of Florida, and Chairman, Subcommittee on Social Security

Today the Subcommittee will continue our in-depth examination of the challenges and opportunities faced by Social Security's two disability programs—Disability Insurance and Supplemental Security Income.

Americans should have a reasonable expectation that Social Security will fairly and efficiently process the more than three million applications for disability benefits each year. The problem: They don't.

In addition to hardships created by illness or injury, individuals with disabilities also face a long, complex, and confusing process in pursuing disability benefits for themselves and their families.

Sadly, this is not new. The agency has been working to get it right since 1994, when they introduced plans to redesign the disability claims process. The situation is now approaching the breaking point: both disability and retirement claim workloads will grow dramatically as baby boomers age. At the same time the agency expects to lose about half of its experienced workforce to retirement.

According to the bipartisan Social Security Advisory Board, "the projected growth in the number of disability claimants threatens to overwhelm a policy and administrative infrastructure that is already inadequate to meet the needs of the public."

An accurate and thorough analysis of how the disability programs are working is urgently needed so that we can consider effective changes in policy, resources, and administrative structure.

In our hearing series, we will focus in-depth on the disability determinations and appeals decisions made by State disability examiners and federal Administrative Law Judges. We welcome, for the first time, the new Deputy Commissioner for Disability and Income Security Programs, Martin Gerry. We will also hear from the Chairman of the Social Security Advisory Board, the GAO, a researcher, and several employee groups serving those with disabilities on the front lines every day.

Social Security Commissioner Jo Anne Barnhardt recently testified that the length of time it takes to process disability claims is unacceptable. We couldn't agree more, and look forward to hearing more about measures she has initiated to reverse this time lag.

If America's disabled workers must negotiate a morass of inefficient, complex and confusing bureaucratic processes to obtain benefits, then the essential safety net Social Security's disability programs offer has failed. Each of us has the opportunity and the responsibility to address existing problems within the disability determination and appeals processes so that individuals with disabilities and their families can receive the benefits so vital to their economic security.

Mr. COLLINS. We will call on Mr. Matsui and see if he has any words of wisdom for us.

Mr. MATSUI. I only have words of wisdom to thank you for holding this hearing.

Mr. COLLINS. I like that. Short and sweet.

Our first witness will be Mr. Martin Gerry, Deputy Commissioner for Disability and Income Security Programs. Welcome, Mr. Gerry, and we are glad you are here, appreciate your taking the time to come, and if you would like, your whole statement will be entered into the record, and if you would like to summarize your statement, we are ready.

STATEMENT OF MARTIN GERRY, DEPUTY COMMISSIONER, DISABILITY AND INCOME SECURITY PROGRAMS, SOCIAL SECURITY ADMINISTRATION

Mr. GERRY. Thank you very much, Mr. Chairman.

Mr. Chairman and Members of the Subcommittee, thank you very much for inviting me to testify today before this Subcommittee regarding the Social Security Administration's (SSA) efforts to improve the process used to determine eligibility for benefits under the Social Security Disability Insurance and Supplemental Security Income (SSI) programs. As you know, the monthly disability benefits provided through these programs represent an economic safety net for situations that any of us might find ourselves in at some point during our lifetime.

As Commissioner Barnhart testified before the Subcommittee last month, the length of time that the disability claims process can take is wholly unacceptable. The numbers of claims do not simply represent case counts. They represent people who need access to that safety net and are counting on the Social Security Administration for help.

We are committed to and actively engaged in improving the current disability determination process. To this end, my written testimony addresses our initial efforts to improve various aspects of that process. I would be pleased to elaborate on any of the initiatives described in that testimony and to answer any other questions, which you or other Members of the Subcommittee might have.

[The prepared statement of Mr. Gerry follows:]

Statement of Martin Gerry, Deputy Commissioner, Disability and Income Security Programs, Social Security Administration

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me today to discuss the Social Security Administration's (SSA) efforts to improve the Social Security and Supplemental Security Income (SSI) disability process. As you know, the monthly disability benefits provided through these programs represent an economic safety net for situations that any of us might find ourselves in at some point during our lifetime. Few individuals have private or employer-provided long-term disability insurance. But nearly all American workers have Social Security.

As Commissioner Barnhart testified before you last month, the length of time the disability claim process can take is unacceptable. The numbers of claims do not simply represent case counts, they represent people who need access to that safety net and also are counting on us for help. Today I will focus my testimony on a description of the disability determination process and our efforts to improve it.

The Disability Determination Process

Most disability claims are initially processed through a network of local Social Security field offices and State agencies (usually called disability determination services or DDSs). Favorable determinations (allowances) in most instances lead quickly to the payment of benefits. Appeals of unfavorable determinations may be decided in the DDSs or by administrative law judges or administrative appeals judges in SSA's Office of Hearings and Appeals.

Social Security Field Offices

SSA representatives in the field offices usually obtain applications for disability benefits, either in person, by telephone, or by mail. The application and related forms ask for a description of the claimant's impairment(s), names, addresses, and telephone numbers of treatment sources, and other information that relates to the alleged disability. (The "claimant" is the person who is requesting disability benefits.)

The field office is responsible for verifying necessary non-medical information requirements, which may include age, employment, marital status, or Social Security coverage information. The field office sends the case to a DDS for evaluation of disability.

State Disability Determination Services

The DDSs, which are fully funded by the Federal Government, are State agencies responsible for developing medical and other evidence and rendering the initial determination on whether the claimant is or is not disabled or blind under the law.

The DDSs follow SSA rules on how to develop and evaluate medical and vocational evidence. Usually, the DDS tries to obtain evidence from the claimant's own medical sources first. If that evidence is unavailable or insufficient to make a determination, the DDS will arrange for an independent medical examination, called a consultative examination (CE), at no cost to the claimant in order to obtain the additional information needed. The claimant's treating source is the preferred source for the CE; however, the DDS may also obtain the CE from an independent source.

After completing its case development, the DDS makes the initial disability determination. Generally, the determination is made by a two-person adjudicative team consisting of a medical or psychological consultant (who is usually a physician or psychologist) and a disability examiner. If the adjudicative team finds that additional evidence is still needed the consultant or examiner may recontact a medical source(s) and ask for supplemental information.

The DDS also makes a determination whether the claimant is a candidate for vocational rehabilitation (VR). If so, the DDS makes a referral to the State VR agency.

After the DDS makes the disability determination, it returns the case to the field office for appropriate action depending on whether the claim is allowed or denied. If the DDS finds the claimant disabled, SSA will complete any outstanding non-disability development, compute the benefit amount, and begin paying benefits. If the claimant is found not disabled, the file is retained in the field office in case the claimant decides to appeal the determination.

Appeals Process

A person who is dissatisfied with an initial determination may pursue an appeal through three administrative levels and the Federal courts. The Act requires the Commissioner to provide a claimant the opportunity for a hearing, and allows for filing of a civil action in Federal court after the Commissioner's final decision. SSA's regulations also provide a reconsideration review by the DDS prior to the hearing before the administrative law judge (ALJ) and an opportunity for final review by SSA's Appeals Council.

Generally, SSA's first administrative review for claimants—the reconsideration—involves a de novo, or fresh review of the claim (including any new evidence) by individuals who did not participate in the original determination. The reviewers consider all of the evidence and issue a reconsideration determination. There is no reconsideration step in the 10 States in which SSA still has in place the prototype of a revised disability process.

The second level of administrative appeal is a de novo hearing before an ALJ who can call on medical or vocational experts, if needed, to help evaluate the evidence. Usually the claimant obtains legal representation at this point. Frequently, new evidence is introduced by the claimant and his or her representative, often at the hearing itself. Claimants are allowed to appear before the ALJ and to call witnesses.

The final administrative appeal level is the Appeals Council, which may grant, deny, or dismiss a request for review of the ALJ decision. It will grant review if the ALJ decision contains an error of law, is not supported by substantial evidence, involves a broad policy issue, or if there appears to be an abuse of discretion by the ALJ. After an Appeals Council action, if the claimant is still dissatisfied, the next step is filing a civil action in Federal court.

Uniform Application of Policy

SSA strives to maintain and apply uniform standards at all levels of administrative adjudication and review. SSA takes every opportunity to emphasize to disability adjudicators in all locations and at all levels the importance of following SSA rules

to ensure that similar cases are decided in a similar manner throughout the country. The result of this program-wide emphasis has been, and continues to be, more consistent application of Agency policy throughout the nation. Without reservation, SSA remains committed to providing a fair and consistent disability determination process throughout the United States.

Efforts to Improve the Process

One of the first things that Commissioner Barnhart did after assuming office was to form a group to develop a service delivery budget to match up resource needs against the level of service we would like to deliver. The group mapped the disability determination process from the time a claimant first contacts SSA through the initial determination and all levels of appeal.

Our preliminary analysis shows us that there is no one way to make the disability determination process faster and better. It's going to take many improvements—some large, some small—to take us where we need to be. As the Commissioner testified last month, we have already announced a number of steps to address the causes of delay in the disability process.

Initial Determination Initiatives

As you are all well aware, SSA has engaged in a number of efforts to redesign and improve the disability determination process by testing a number of initiatives over the past several years. We carefully reviewed the results of these initiatives to identify the elements that show the most promise. Based on this review, we have decided to:

- Grant greater decision making authority to DDS disability examiners by extending single decisionmaker authority nationwide to all DDSs;
- Eliminate the formal claimant conference that was tested as part of the disability Prototype; and
- Extend elimination of the reconsideration step in the States that have been doing the Prototype, while SSA gathers additional information and considers alternative approaches to a second-level appeal step.

Appeals Initiatives

The amount of time it takes for an individual to make his or her way through SSA's appeals process has been a perennial concern. In an effort to address this concern, the Office of Hearings and Appeals (OHA) implemented a new workload process commonly referred to as the Hearings Process Improvement initiative or HPI about two years ago. Implementation of this initiative involved significant changes to the way SSA processed the hearings workload, and the organizational structure of our hearing offices. The initiative was intended to reduce case processing times, improve productivity, and enhance the quality of service to claimants.

However, while well intentioned, the initiative did not work. There have been concerns that the HPI project has created even more bottlenecks in the process that it was intended to fix. Simultaneously, SSA's past inability to hire ALJs to make decisions at the hearing level of the disability process compounded the unintended adverse impact that HPI had on our ability to provide timely service.

Last year, former Acting Commissioner Larry Massanari formed a group to look at the hearing process. Thanks to this timely analysis, this spring the Commissioner announced decisions on short- and near-term changes to the hearings process. We are required to bargain with employee unions before we can implement some of these changes. We certainly intend to meet that obligation in good faith and are working to implement these important changes as soon as possible.

On a short-term basis, the Commissioner immediately set aside $6 million in overtime and other costs to help expedite the processing of 30,000 to 35,000 backlogged cases in OHA. In addition to expediting the processing of these cases, this action signaled the importance the Commissioner was placing on making program improvements.

In the near term, the Commissioner announced decisions to make changes to the hearing process. The decisions include:

- Including ALJs in early screening for on-the-record decisions;
- Developing a short form for fully favorable decisions;
- Allowing ALJs to issue fully favorable decisions from the bench immediately after a hearing;
- Creating a law clerk position; and
- Expanding the use of technology in the OHA, including the use of video teleconferencing, speech recognition and digital recording of hearings.

Be assured, these are just the first steps that SSA will take to meet the challenge of providing a timely, efficient, and high quality hearing process.

Azdell Case

In regard to the hearing process it is important to remember that since April 1999, due to litigation pending before the Merit Systems Protection Board, (MSPB) SSA, with one special exception, has been unable to hire new ALJs to replace those who have retired.

The name of the case is Azdell v. OPM. It was brought by a class of individuals who have challenged the method that the Office of Personnel Management (OPM) used to compute the veterans' preference in the ranking of ALJ candidates. The MSPB has ruled in favor of the plaintiffs in the case and against OPM. The MSPB ordered OPM to revise the rankings.

With the interest of this subcommittee, we were able to bring on board 126 new ALJs last October from a list of candidates that has been (and continues to be) the subject of litigation. While these additional ALJs will certainly help in addressing the backlogs, the continued inability to replace ALJs who retire or leave has the potential to seriously affect our ability to decide cases in the hearing offices.

e-DIB

Before I close, I would like to note one final initiative that will improve the efficiency of both the initial determination and subsequent appeals process. Simply put, SSA must accelerate its transition to an electronic disability process (e-Dib), not just for the State Disability Determination Services but also for the appeals offices. As she stated here last month, Commissioner Barnhart is committed to the creation of an electronic system to support the disability determination and appeals process. I assure you that I share her commitment to bring the process into the 21st Century.

Accelerated e-Dib is a major Agency initiative that will move all components involved in disability claims adjudication/review to an electronic business process through the use of an electronic disability folder. When the process is fully implemented, the Agency will no longer create, mail and store paper disability folders. Through interfaces with their existing case processing systems, components will be able to work claims by electronically accessing and retrieving information that is collected, produced and stored as part of the electronic disability folder. Accelerated e-Dib will significantly change the business process and the ways that components interact with disability claims and will ensure that SSA has a robust platform to manage and control increasing disability workloads.

Conclusion

Finally, I thank you, Mr. Chairman, Mr. Matsui, and all the members of the Subcommittee, for your interest and offers to help as we move to meet the challenges facing the Social Security Administration. We are all aware that these go beyond our efforts to improve disability to providing the service that Americans deserve as the baby boomers age; ensuring the program's solvency; improving program integrity; and accomplishing all these goals with the quality staff we will need.

I look forward to working with you all in the future.

Mr. COLLINS. I like them short and sweet, but that was a little shorter and sweeter than I thought it was going to be.

In your opening statement, your remarks, Mr. Gerry, you elaborate on the State Disability Determination Services (DDS). We noticed that there is quite a variation from State to State across the country in approvals for disability. Can you elaborate on that some? I know they go from 31 percent in some States, as high as 65 percent in others. There is quite a variance. Can you elaborate on that some for us?

Mr. GERRY. Yes, Mr. Chairman. That is true. The current fluctuation actually runs from about 27 percent in the low State, which is Tennessee, to 61.3 percent, in the highest State, which is New Hampshire. The average is about 38.7 percent. So, you are absolutely right. There is a significant variation. This has been true for a substantially long period of time. I served on the Disability Advisory Council 15 years ago, and this issue was around at that point.

These variations have been with us for quite a few years in terms of the programs.

Part of the answer—and I want to stress part—has to do with the way in which we calculate these rates. Obviously the total number of people who apply has something to do with the total number of people who are allowed or disallowed. In some States, the percentage of people in the State that apply for benefits is quite a bit higher than it is in other States. That accounts for some of the difference in rates.

In other words, if you start with the assumption that for the most part disability is distributed evenly throughout the American population, you would assume the rates would be similar in every State. If, for example, twice as many people per thousand in a State apply for benefits, then it wouldn't be surprising that the rate of allowances might be lower in a State where more people apply.

Now, that accounts for some of the difference, but we are actively engaged. As the Commissioner testified last month, we are still engaged in analyzing these variations. I think she expressed some concern that the application rate won't explain all of the variations. Working with our quality analysis process and looking at the statistics we have—we are trying to isolate other factors, if there are other factors that account for these variations.

I can tell you from my own personal experience that some States have actually gotten into the habit of sending people to our offices for eligibility determinations as part of another eligibility process. That tends to, of course, artificially increase or decrease the rate of allowances by running people through our process just in case they might be eligible for benefits.

Again, I don't think that accounts for all the differences, but the numbers are not quite as obvious. They don't tell the whole story.

The other thing that is important, I think, is that accuracy affects allowance rates. The real issue is how accurate are the allowances made in different States? So really, in terms of what we would be looking at, it is the accurate allowance rate that we would want to explain any differences in. Sometimes if you have significant numbers of people who are being allowed or denied, and our review suggests that these are not proper decisions, then that would tend to influence data.

Mr. COLLINS. The States themselves are responsible for developing the medical and other evidence dealing with disability.

Mr. GERRY. Well, the States——

Mr. COLLINS. They draft their own guidelines, the States?

Mr. GERRY. No. We set forth the basic requirements for making the disability determinations through a series of documents, called the medical listings. There are other documents that provide instructions to the States on how to go about that. We do review the work of the States through our quality assurance (QA) process.

So, it is true that the day-to-day routine in State Disability Determination Services may vary somewhat, but it is a Federal process. The basic rules are set by the Social Security Administration. So, we should expect the process to be applied generally uniformly throughout the country. If it isn't, it is not because the States have separate rules for making disability determinations.

Mr. COLLINS. Okay. Well, that was the next point. There should be uniform standards.

Mr. GERRY. There should be and there are. Now, one of the things that Commissioner Barnhart has done—and I think it has been an important move in the right direction—is to change organizationally how we develop our disability policy.

Historically, we have collocated in the Office of Disability the rulemaking capability to develop the listings and the various rules that apply to the program. While that has had some direct linkage to the Disability Determination Services, it has been quite removed from the Office of Hearings and Appeals (OHA).

Over the last few years, under a title that I found particularly mysterious called "Process Unification," the Agency has been trying to make much more compatible and consistent the rules that are applied in the hearing and appeals process with the rules that are applied in the Disability Determination Service. They should be applying the same rules. It is the same law.

We are setting up a new unit. This unit will be part of the Agency component that I head, and that will set disability policy across the Agency. So, it would apply equally to the Office of Hearings and Appeals and to the DDSs. That is an effort to try to be sure that the rules are consistent. We shouldn't have to create a label, process unification, to describe implementing the law fairly and consistently. That is all it really means.

Mr. COLLINS. Moving on to another area, which I have had a lot of correspondence and input from people involved in this area in my district, or in Georgia, in particular. That is the administrative law judges (ALJ). How are we coming with giving them some assistance and helping with their processing of these cases?

Mr. GERRY. Well, we have a substantial amount of work for the administrative law judges, Mr. Chairman. We are providing training for the new administrative law judges, the 126 that we have hired. For the most part, we have an enormous amount of work to do, and we are under a lot of strain. The backlogs have grown, and productivity has not kept pace. I am not sure that it could fully have kept pace, although we have been making efforts to try to improve it. All in all, we are committed to making the system work and doing whatever we need to do to provide the resources that we can to support the process. The workload of the Office of Hearings and Appeals is growing, and because of the Azdell decision, we have had historically some significant constraints on hiring new administrative law judges.

We did have an initiative underway, covered in my testimony, called the Hearings Process Improvement (HPI) initiative. This initiative was an effort to try to speed up and improve the outcomes of the process. The Commissioner went through and reviewed a very careful analysis that was done by a group appointed by Acting Commissioner Massanari. We have made some major decisions to continue some portions of that initiative, to discontinue others, and to introduce some new elements to try to improve the hearing process.

We are now going through the process of meeting with the unions to discuss these changes, and we are hoping to implement

these initiatives this summer. I would be happy to discuss any of them, but they are pretty much outlined in my written testimony.

Mr. COLLINS. Well, I was going to get to and ask the question about the unions and how you are progressing with that—so we appreciate that volunteer comment and testimony. I think that shows some of the problems that the administrative law judges have had in the past and some of their concerns. Last year they moved toward organization. So, they need help. We are glad that the Commissioner and you are looking at helping those law judges. Mr. Matsui?

Mr. MATSUI. Thank you, Mr. Chairman.

Mr. Gerry, I want to thank you for taking this very difficult job that you have. I know your background is one in which you have been very involved with disability issues, almost your entire professional career. So, we appreciate the fact that you are there, and Commissioner Barnhart is where she is as well. I think both of you working as a team will hopefully solve this backlog of disability claims, and second, streamline the process.

Last month the Commissioner came before us, as you mentioned. She pretty much outlined her proposal. She wants to make this a major priority in her tenure as the Commissioner. You have outlined some of the recommendations that she intends to deal with in your written testimony. So, can you give me an idea of the timeline we are talking about—when she might be ready or you might both be ready to submit to us some legislative changes that you might think would be required in order to implement your proposals?

Secondly, in reference to the timeline, if it is within the next fiscal year, from October 1 on, would you be able to give us an idea what we are looking at in terms of additional dollars for both the transition and implementation? Then, lastly, in terms of the overall cost of this? If you are not prepared to do this, that is fine. Then obviously when you are, we would want to get that information from you. I don't want to have you make any recommendations or comments that are premature because obviously this is a subject that we are all concerned about. We are all interested in on the basis of doing this right.

Mr. GERRY. Well, thank you, and thank you for your kind comments, Mr. Matsui.

At this point, we don't have any specific legislative proposals. The Commissioner set a timeframe and has asked me to recommend changes that wouldn't necessarily involve legislation, but it might. The timeline is late fall, so I would expect that we will have something by December.

If at that point in time the Commissioner believes that we should go ahead with legislative proposals, then we would communicate those first, of course, to the Office of Management and Budget as part of our usual process. We then would try to move toward the Committee.

Of course, we don't have the details or any estimate of cost, but the Commissioner wants recommendations by late fall.

Mr. MATSUI. Okay. I would imagine if it requires additional sums of money, you probably would have to seek it in a supple-

mental. It could be very difficult as we are experiencing now, even with the current supplemental bill.

If you have any idea prior to that time before, obviously, we are completed with the appropriations process, it would help. Again, this is not to put you on the spot or anything of that nature. It is really in order to make sure everybody's job is easier, and we deal with these disability issues in the way that I think all of us want to. So, if you could look at that, and if it does make some sense that you can give us a better idea before the fiscal year begins and before the appropriations process is completed, it would be helpful.

Mr. GERRY. I would be happy to do that, Mr. Matsui. Again, we would very much like to work with the Committee and the staff on any proposals that we come up with. At this point, the fairly major task we have is to come up with the recommendations themselves.

Mr. MATSUI. Right. Thank you very much.

Mr. COLLINS. Thank you, Mr. Matsui.

You know, it is pleasing to hear that you are trying to come up with ways to better the process without doing it through legislation. I have often said that when you have to go through the legislative process, Congress has a tendency to mess up a two-car funeral. So, I know that it could probably make a real mess out of some legislative action. A little piece of advice: Do it within the budget that you already have funded and appropriated for you. We have no more money for additional funding. If you can't do it that way, do some rescissions and make your numbers work. Mr. Ryan?

Ms. RYAN. Well, thank you.

Mr. Gerry, I just have two quick questions. One, in the March 2002 Advisory Board Report, they stated that appealing decisions is very costly to claimants, the Agency, and ultimately to the taxpayer. In fact, their report states that in 2001 a decision made at the ALJ level costs $2,157, but the cost of an initial decision at a State Agency is about $583.

Many stakeholders have suggested closing the record at various stages, so that the case does not change at every level of appeal to save some dollars. I would just like your reaction to that proposal? What are your thoughts on that?

Mr. GERRY. Well, thank you, Mr. Ryan. For me it is not a new proposal. It has probably been around as long as the discussion of this program. It is one that I think has pluses and minuses, and that is what makes it difficult to answer.

There are a lot of advantages to closing the record, as you point out, in terms of getting a common set of facts where you could then get a more rapid decision about eligibility without the facts changing.

On the other hand, the question is to what extent would closing the record unfairly disadvantage an individual whose condition is changing, and in some cases changing fairly rapidly. That is the tradeoff.

In one sense, the record is closed probably now at the U.S. district court level in many cases. Even though in theory it might be closed at the administrative level, the district courts tend to reopen a lot of these cases. That is an awfully long time for the situation to continue without the record being closed, so I think it is logical

to try to close the record earlier. We are certainly looking at this issue as a major part of whatever we are going to recommend.

I just want to respond that if it were easy, I suppose other people—there have been many other people who have tried to solve these problems in the last 25 years—would have come up with an easy solution. It is a tradeoff. People can file separate claims. The other side of the closing-the-record issue is that if you go ahead and close the record, it doesn't preclude someone whose situation then changes fairly abruptly from filing a separate claim. I think the question is really how to do that? It is part of the larger question, I think, rather than a separate question.

Once you figure out how you want to streamline the process of reaching a decision, then maybe it is easier to discuss where and how you would close the record. We are very much aware that it has been studied not only by the Advisory Committee I was on, but by many others. It will have to be part of whatever we ultimately recommend to the Commissioner.

Ms. RYAN. Will you be recommending some changes to the Commissioner soon?

Mr. GERRY. I think, as I responded to Mr. Matsui, our plan is to have recommendations by late fall, so I would say by the end of November, early December.

Ms. RYAN. One other issue that I hope that you respond to is processing times. Claims to process, disability insurance (DI) claims, I believe, in 2000 took over 100 days to process, about 120 days for SSI claims. They have been going up since 1996. Those are the last data we have.

What are the processing times right now? How many applications are pending at this time? Do you think you are going to get these processing times down? Where are we right now vis-a-vis where we just were in 2000?

Mr. GERRY. Well, I am happy to say the processing time right now is 102.5 days, or lower than——

Ms. RYAN. On DI claims?

Mr. GERRY. That is right. The pending cases, 582,334. At least it was—it can't be quite 34 right now. It must be 35 or 33, depending on something in the last 15 minutes. But that is pretty close.

Ms. RYAN. Okay.

Mr. GERRY. I think we are doing better on processing times. As the Commissioner pointed out—and I know she presented the Subcommittee with that long chart showing all of the steps in the process. Without making any structural changes, there is only so much we can do on the processing times. I think we are getting closer to what we can do without changing the process itself. As she pointed out in her testimony, there are the larger changes. There are also a series of small changes that we are proceeding on that we think can get some of those days reduced. We are going to reach a natural limit that is imposed by the separate number of activities that are currently described in that chart.

Ms. RYAN. One-hundred days to 102 days is about the same. Clearly, the statute underlying requires you have so many stages to go through. Will you be bringing forward more of a comprehensive set of recommendations to get to both of these issues, which are obviously related, so we can streamline these things and save

a little money in the process? Do you think that within the existing statute you can come to us with some recommendations on how to accomplish those things?

Mr. GERRY. I think the Commissioner has made it clear that a major part of her mission and a major reason that she took the job was to do that. My job, of course, is to recommend some things to her, and what she ultimately goes forward with may be different than what I recommend. I am committed, as she is, to that process. That is why I took my job, the opportunity to work with her on this effort. So, I am hoping that by late fall we will have a set of recommendations for her. I am convinced that she will act on them as quickly as she feels is appropriate. I know it is a high priority for her.

Ms. RYAN. That is the point I am trying to make. We are eager to see what you have to recommend. We want to see progress made on these issues, and we are very much paying attention to these. I yield.

Chairman SHAW. [Presiding.] Thank you. Mr. Doggett?

Mr. DOGGETT. Thank you, Mr. Chairman, and I would just kind of continue the same line of questioning trying to understand the timetable. We appreciated the testimony of the Commissioner when she was here before previously. Of course, we are impressed by the very long delays that are occurring, recognizing that she has only been on that job for a relatively short period of time, and yourself also, but trying to get an idea of the timetable.

You are saying your recommendations on the short-term changes to address these lengthy delays will go from you to her by the fall?

Mr. GERRY. No. It wouldn't be the short-term changes. It would be the major changes. Those recommendations would be completed by the end of the fall. When she first took office, she mentioned short-term initiatives.

Mr. DOGGETT. I see.

Mr. GERRY. Those are the ones that are outlined in my testimony, so we are talking about the more significant, larger changes in the process.

Mr. DOGGETT. By what point do you think you will have determined whether significant additional moneys are necessary to reduce the delay?

Mr. GERRY. It would have to be after she reviews the options that are presented to her, and I know she will do that as expeditiously as possible. What is a little hard for me to at this point predict is how complex those will be.

Mr. DOGGETT. All right. Are you saying that you won't have any request for additional resources on your short-term solutions until she has reviewed all of your long-term solutions?

Mr. GERRY. No. Our plan is to implement the short-term initiatives that are outlined in the testimony as quickly as possible. We are meeting with union representatives right now to discuss implementation this summer. We are in the process—and I would be happy to provide sort of a status on each of them—of implementing each one of these changes. We have incorporated the resources that we need to implement all of those changes. They are part of the 2004 budget process, which is underway in the Agency, or we have already accounted for the resources for 2003.

So, we are not delaying any of the short-term changes. The only thing we are not in a position to do at this point, of course, is to look at the budgetary implications of recommendations for the larger changes, which the Commissioner hasn't seen yet.

Mr. DOGGETT. Do you believe any additional moneys will be necessary to meet your short-term concerns in this appropriation cycle?

Mr. GERRY. I don't believe so. I think we have certainly included in the budget documents that have gone forward, to my best knowledge, the resources that we need. I don't know of any unmet needs for the changes outlined in the testimony.

Mr. DOGGETT. So, you are not seeking any appropriations to address the delays that are occurring? You propose to deal with those in other long-range proposals that you will have?

Mr. GERRY. Well, of course, we are going through the process of submitting documents for the President's 2004 budget. In that budget we will reflect the resources that we need for that fiscal year. I mentioned in my testimony resource decisions and commitments that the Commissioner has already made. Those decisions are coming out of funds that are already available to us or that are part of the President's 2003 budget.

Mr. DOGGETT. Your best estimate at this point is that no further dollars will be requested for the next fiscal year, the one we are working on in the appropriations process?

Mr. GERRY. That is my best testimony at this point in time.

Mr. DOGGETT. Okay. With reference to other witnesses that will be testifying at this hearing and next week, is the Commissioner considering any of the proposals that they are advancing?

Mr. GERRY. Well, yes. The Commissioner is considering proposals from all sources. We are looking at recommendations that are being made from a variety of sources.

She hasn't ruled out any source of recommendations. I think she has laid out the general goals that she wants to accomplish in terms of expediting the process. The mission of the Agency historically has been characterized as getting the right amount of money to the right people as early as possible in the process. Obviously, we are not doing a very good job of getting that money to those people very quickly in the process that we currently have. So, the time delays are certainly a very high priority. The accuracy and quality of the decisions is an equal priority, and the Commissioner has various activities underway to be sure that we improve that as well.

Mr. DOGGETT. I would just ask, as you go through that process—that you continue in the coming months to consult with and keep advised some of those organizations that represent individuals with disabilities, as well as both majority and minority staff on this Subcommittee.

Mr. GERRY. I would be happy to do so.

Mr. DOGGETT. Thank you very much.

Chairman SHAW. I would point out, in furtherance of Mr. Doggett's questioning, that this appropriation process that we are about to go through is going to be long and painful. So, there may be some opportunities during the conference that, if there are some

immediate needs, there may be some tweaking that we are able to do for you. Mr. Brady?

Mr. BRADY. Thank you, Mr. Chairman, and thank you for holding the hearing on this very important issue.

The more I study disability, the more I am convinced that for us to have a fair and timely process, and to work off this growing backlog, it is going to take new reforms and new resources with a healthy dose of new technology in the middle of all that to bring this process into the 21st century. It is going to take a lot of work in a number of different areas to make this right.

One of those areas, just in the brief time we have, let's go back for a minute to the Azdell case. We all worked together to bring a special exemption that would allow us to hire 126 new administrative law judges. Hiring new ones alone won't solve this whole problem, but working off the backlog is critical.

The questions I have for you are: What is the status of this case? Are we making progress in resolving it? If not, at what point do you see Congress taking some legislative action to try to ensure this backlog and freeze on judges doesn't continue? It has really hurt the process terribly and needs to be resolved. If we can't resolve it through the courts, we may need to resolve it legislatively. What are your thoughts?

Mr. GERRY. First, I agree with your point about the importance of the case and the impact on the Agency. It has a substantial adverse impact on our ability to respond as we would like to.

My best understanding is that the case is on appeal to the Federal circuit. There is a stay currently in place from the Merit Systems Protection Board, which, of course, affects us directly. That hasn't changed as a result of the appellate status.

I don't have a very reliable estimate of how quickly the court will act on the case, unfortunately. I do agree with you that we need to get to a point where this case doesn't hinder us. We are very appreciative, by the way, of the assistance the Subcommittee has provided in the past in trying to help relieve the stresses that this has created.

I know that is probably not a very satisfactory answer, but it is the best one I have at this point. It is one of the factors contributing to the growing backlog of cases.

I wish I could say that even if we solved the staffing problem, which would be of great help, that the problem wouldn't continue to grow. As you pointed out, we have an increased rate of claims; we have an increased rate of appeals. Unless we make some more significant changes in the overall process, even if we were to solve the immediate problem, that isn't necessarily going to guarantee that we are not going to need to hire yet more administrative law judges. I think we have to do both, and we have to do them at the same time. We have to try to respond to the backlog and eliminate it, and solve the current problem. We also have to make some longer term systems changes that we can't just keep postponing that.

Mr. BRADY. It seems like even with the exemption to hire the new judges, if we were to double that and hire 120 more, we would still just be back up to where we were back in 1997 or 1998. Yet the growing number of cases, it just seems to me pretty obvious

that we just don't have enough trained up and running along with the other changes in the process that need to be made for us to be able to both work off that backlog and to handle the new cases that are being. A funnel is being created that is nearly impossible to avoid, although reforms earlier in the process could help that, no doubt. We still have a funnel that at some point just can't continue as it is today.

Mr. GERRY. I think you are right.

Mr. BRADY. I didn't expect that answer. I will take that while I have it. Thank you, Mr. Chairman.

Chairman SHAW. I have just one question. You state in your testimony that the SSA is striving for uniform policy and consistent application of policy throughout the Nation. Since 1994, the Agency has been talking about revamping its quality system, which is so critical in ensuring national consistency within and across disability decision makers both within and across States. It simply isn't fair when a decision can depend upon who makes the decision or which office processes the application.

What precisely is being done? Do you have a timetable that you might be able to share with us for taking action in this particular area?

Mr. GERRY. Well, the Commissioner has taken some pretty bold action on that by designating the former Regional Commissioner in Atlanta to head up the new quality work group. She is currently putting that work group together and will be preparing a report for the Commissioner. This is very high on the Commissioner's set of priorities, and it is on mine, too, Mr. Chairman. I have had a major concern. For one thing, we have had a process that has relied on appeals to protect people from erroneous decisions. Many people who I have worked with over the years—and I have been a pro bono lawyer for many people with disabilities—and others who have been around the program—agree that often the people who ought to appeal, don't appeal. We very much need the quality process to protect the entire program from becoming too much of a litigation-driven model. I think the Commissioner is very concerned about not losing that focus on quality.

I can tell you that the person she has appointed to this work group is a high-energy person who is very focused on producing a report. As I am sure you know, we had a study done by an outside contractor that made some fairly sweeping recommendations in changing the whole quality environment of the Agency. I know the Commissioner has read that report carefully and has paid a lot of attention to it. So, now we are into the process of trying to figure out what those changes should actually mean.

One of the recommendations of the report is that we institutionalize a quality environment at all stages of the process. That is a fine concept, but what this work group needs to do is to talk about how would we really do that. How would we go about providing the kind of management oversight that will be necessary to identify problems and solve them before they end up becoming backlogs or workloads? That is what the Commissioner wants to do.

So, that is going on right now. Along with the other Deputy Commissioners, I will be supporting that process. It is being spear-

headed by Myrtle Haberham, who was the Regional Commissioner in Atlanta. She understands our process from the field level and is probably the best person to lead that effort right now.

Chairman SHAW. Okay. Well, we thank you for your testimony—oh, Mr. Matsui has a question.

Mr. MATSUI. Thank you, Mr. Chairman. I appreciate your giving me one more opportunity.

Mr. Gerry, you were saying the recommendations would be made in the fall of this year. If at all possible—you know, I don't know when we are going to recess, probably around the second week of October, the first or second week of October, I would imagine. It would really be helpful if your recommendations and the Commissioner's recommendations came to us so that we would at least have a chance to review it before we adjourn for the year. Otherwise, it won't be until February or so that we would have that opportunity. I think given the backlog and given the number of people we are talking about, it would really be helpful if we had an opportunity to comment on it, work with you on it, during the regular calendar year. That is, in September, early October at the latest, assuming we are still in session. If, in fact, there is a short-term CR, continuing resolution, there may be an opportunity to help then with some of the funding requirements that may be necessary that Mr. Shaw had referred to. That to me would be at least a recommendation so that we would have a chance to vet it with you, obviously, before we adjourn.

Mr. GERRY. Well, thank you, Mr. Matsui. I will convey those sentiments to the Commissioner. What I know is that there will be a two-step process. What you would really want to see is what her recommendations would be. What we are doing is an internal process. I will certainly make her aware of that timetable and convey to her the important point you made about the involvement of the staff and the Committee.

Chairman SHAW. Well, I think an interim report would be welcomed if the Commissioner and you are comfortable in sharing them at any particular point.

Well, we thank you. I was reading your background. It is very impressive. We are delighted to have you, and thank you for appearing before our Committee.

Mr. GERRY. Thank you, Mr. Chairman.

[Questions submitted by Chairman Shaw to Mr. Gerry, and his responses follow:]

Social Security Administration
Baltimore, Maryland 21235
November 15, 2002

The Honorable E. Clay Shaw, Jr.
Chairman, Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your letter of July 24, 2002, which transmitted questions for the record from the June 11, 2002, hearing on the Social Security Disability Program's Challenges and Opportunities. Enclosed you will find the answer to your specific questions. I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me.

Enclosures

1. Judge Kathleen McGraw stated in her testimony that there are no performance standards for employees at the Office of Hearings and Appeals (OHA), except for the judges. Is this true? If so, why? How exactly is the performance of OHA employees assessed? Are there no performance standards beyond a "pass/fail" rating? Do you have plans to change this system? Why or why not?

Answer:

SSA employees, including those at OHA and those at the Office of Appellate Operations (OAO) with the exception of ALJs, have performance standards which are negotiated with SSA management and the unions which represent SSA employees. Each standard requires the successful performance of critical elements of the job. Employees are rated as performing at a "successful level" or as performing at an "unacceptable level." However, the standards do not include numerical requirements for critical or other elements and the appraisal system is based on a "pass/fail" rating.

Commissioner Barnhart has expanded the performance standards for members of the Senior Executive Service and is considering this change for other non-bargaining unit employees. The issue of returning to numerical requirements in the performance standards is under consideration for possible inclusion in SSA contract negotiations in 2004 for bargaining unit employees.

With respect to ALJs as independent decisionmakers, they are not rated in the same manner as other SSA employees. However, their decisions are still subject to the review of other ALJs (the peer review) and, if SSA becomes aware of a potential problem with a particular judge, it may refer the matter to the Merit Systems Protection Board to be investigated.

2. Several witnesses suggested improving the appeals process by allowing judges to manage their own offices, and to hold them accountable. What has been your experience with this management approach in OHA? Would you consider allowing judges to manage the personnel in their offices and hold them accountable? Why or why not?

Answer:

We have not tried this approach in the past because, with the exception of the Hearing Office Chief administrative law judge (HOCALJ), ALJs do not manage employees. They are part of a collective bargaining unit and, according to OPM's regulations, may not manage personnel in their offices. However, SSA may explore this concept as part of an overall initiative to improve the hearing process.

3. Much has been reported in the media and by the Advisory Board about the varying allowances rates across and within the States at the disability determination services (DDSs) and OHA offices. Can you provide more detail as to why these allowance rates vary? What is being done to address variances of allowance rates, including action taken, action planned, and the timeframe for completion of these actions?

Answer:

Variations in Initial Allowance Rates Among States

The variation in allowance rates among states and regions has been viewed by some as an indication that there may be a lack of uniformity in disability decisionmaking, but that greatly oversimplifies the issue. Enclosed is a study released in August [1] that helps to explain some of the variation in initial level allowance rates across states for adult disability applicants.

This study, like prior studies, will show that much of the variation in allowance rates can be explained by a number of socioeconomic and demographic differences among states. Using a regression analysis that predicts allowance rates based on the economic, demographic and health characteristics of states, the study estimates the portion of variation that can be explained by these differences. For example, states have different economic conditions, and economic conditions are correlated with the tendency to apply for benefits. When there are larger numbers of applications in a state, the rate at which those applications are allowed may be lower than the rate of allowance in a state that receive proportionately fewer applications. States also differ in their age and gender composition, and these groups have different tendencies to apply for benefits. For these reasons and others that are addressed in the study report, the composition and characteristics of the applicant pool

[1] Strand, Alexander, 2002, "Social Security Disability Programs: Assessing the Variation in Allowance Rates," ORES Working Paper No. 98, Social Security Administration, Office of Policy.

differ across states so that, even with no inconsistency in disability adjudication, allowance rates would properly be expected to vary among states and regions.

In view of the study results and our extensive experience with Federal consistency and quality assurance reviews of initial level determinations, we believe that most of the differences in initial allowance rates are not due to inconsistency in applying policy. The initial accuracy rate for the Nation through July 2002 is 94.6 percent. However, the study does show some differences among states that cannot be explained by the regression analysis (although these differences are much smaller than the simple allowance rates themselves suggest) and we will need to keep working to minimize them.

Variations in Administrative Law Judge Allowance Rates Among States:

We are not aware of any statistical studies that specifically address possible variations in state allowance rates based on decisions made at the administrative law judge (ALJ) level. Our Office of Quality Assurance monitors the quality of ALJ decisions and provides reports about quality at the regional and national levels, not for particular states or hearing offices. Hearing offices are not organized along state lines (e.g., the Evansville, Indiana hearing office handles claims from parts of Kentucky, Illinois and Indiana) and ALJs have decisional independence.

4. You stated in your testimony that implementation of the Hearings Process Improvement (HPI) initiative created bottlenecks in processing cases at OHA and in light of the initiative's failure, would not be continued in its current form. Commissioner Barnhart has announced short and near-term changes to the hearing process, but that SSA will need to bargain with employee groups before any changes are implemented. Please provide a status of the union negotiations relative to these changes.

Answer:

In March 2002, SSA Commissioner Barnhart announced a number of changes to the hearings process to remedy weaknesses in the HPI design in the short term and to promote greater efficiency in hearing office operations and better use of time and talents to reduce pending workloads.

OHA has begun to award folder assembly contracts to assist in eliminating the pending inventory of cases awaiting folder preparation. The contractors will perform the routine clerical tasks of numbering exhibits and pages, removing duplicate reports, and preparing exhibit lists. In May 2002, OHA and two employee unions, AFGE and NTEU, entered into memoranda of understanding regarding the impact and implementation of this initiative on bargaining unit employees. Despite assurances to the International Federation of Professional and Technical Engineers (IFPTE)/Association of administrative law judges (AALJ) that OHA would implement the folder assembly contracts in a way as to not directly or materially affect the conditions of employment of any judge, OHA's negotiations with IFPTE/AALJ did not culminate in a signed agreement. IFPTE/AALJ filed an unfair labor practice complaint on this issue.

In June 2002, OHA notified AFGE, IFPTE/AALJ, and NTEU of its intent to implement additional proposed initiatives for changes in the HPI design and afforded the employee unions the opportunity to discuss the impact and implementation of the initiatives on workers' conditions of employment. The initiatives were to:

- End the requirement that cases be certified as ready to hear;
- End rotational assignments for case technicians and senior case technicians;
- Extend early case screening and analysis to administrative law judges;
- Introduce a short form favorable decision format; and
- Promote the issuance of bench decisions by administrative law judges.

OHA and NTEU entered into a memorandum of agreement on these initiatives. Talks with AFGE and IFPTE/AALJ terminated without reaching agreement. AFGE negotiations stalled chiefly due to AFGE insistence on issues that are either non-negotiable or beyond the scope of the national collective bargaining agreement. AFGE required incorporation of previous "partnership" agreements and partnering rights in any new memorandum of understanding with OHA, contrary to the rescission of the Executive Order on partnering that was executed early in the current Administration. OHA adhered to the provisions of Articles 26 and 27 of the national agreement in effectuating the initiatives; however, AFGE insisted upon an expansion of the terms of the contract. AFGE grieved OHA implementation of the initiatives prior to reaching agreement. Discussions between OHA and IFPTE/AALJ also terminated without agreement. IFPTE/AALJ failed to recognize management's statutory right to assign work to employees.

Because of the importance of the initiatives to improve OHA's service for the American public, the initiatives were implemented in July 2002 despite the lack of agreement with AFGE and IFPTE/AALJ. Mindful of its labor management obligations, as well as the importance of the support of the employee groups in the success of any initiative, OHA invited both employee groups to return to negotiations in August 2002. Despite preliminary indications from the groups that they were amenable to continuing the discussion, neither AFGE nor IFPTE/AALJ returned to the bargaining table.

OHA has notified the unions of its proposal for video-teleconferencing of hearings. OHA will soon notify the unions of its proposals for expansion of speech recognition technology. The unions will be afforded the opportunity to discuss the impact and implementation of these initiatives. OHA will continue to bargain in good faith with the employee groups to ensure that the initiatives to improve the hearings process do not adversely affect the conditions of employment of any worker.

5. A number of changes to the disability appeals process were suggested at the hearing. Please provide your views as to the merits of each of the following and related issues the Subcommittee should consider as we examine each of these proposals:

- Limiting the review of the Appeals Council to clear error of law or lack of substantial evidence, as recommended by the American Bar Association.
- Following the current system of administrative hearings by review by an Article I Social Security Court, with a right of appeal on questions of law in the regular courts of appeals (as with the current Tax Court).
- Agency representation at ALJ hearings.
- Closing the record either after reconsideration or after an ALJ hearing.

Answer:

We believe it would be premature to advance an Agency view regarding any of these proposed changes. Commissioner Barnhart is committed to improving the disability process but the work is just beginning. In her testimony of May 2 before the Subcommittee on Social Security, Commissioner Barnhart announced decisions on a number of short or near-term improvements in the disability claims process but also indicated that mid- and longer-term improvements would be developed to improve the process. In her testimony Commissioner Barnhart emphasized that she "did not assume [her] duties as Commissioner to manage the status quo."

In his testimony of June 11 before that subcommittee, Martin H. Gerry, Deputy Commissioner, Office of Disability and Income Security Programs, reported that the Agency had determined that no single change would suffice to improve the process as needed and that many improvements (some large and some small) would be needed. The already announced steps were "just the first steps" that SSA would take to meet the challenge of providing an improved process.

Similarly, in his August 1 response letter to Ron Bernoski, IFPTE/AALJ President, Deputy Commissioner Gerry noted that the Commissioner had announced several improvements that were already being implemented, expressed no judgment regarding particular process changes that Judge Bernoski mentioned, and stated "our work on additional program improvements, however, is just beginning."

The above remarks of Commissioner Barnhart and Deputy Commissioner Gerry reflect a commitment to improving the process through mid- and longer-term changes, but this work on developing such changes is just beginning.

We agree with the comment in the Social Security Advisory Board's Report "SSA's Obligation to Ensure that the Public's Funds are Responsibly Collected and Expended", that there is no simple fix to the challenges facing the disability program.

6. You mentioned in your testimony that SSA has been hampered in hiring much-needed additional ALJs because of the Azdell v. OPM case challenging the method used to compute veterans' preferences in the ranking of ALJ candidates. What is the status of this case? Are there legislative changes the Subcommittee should be considering to provide the agency needed relief?

Answer:

The Azdell case is currently pending before the Federal Circuit. Oral argument was heard by a three-member panel on October 10, 2002. It is not clear at this time that legislative intervention is necessary.

7. You stated in your testimony that Commissioner Barnhart appointed a former Regional Commissioner to head up a work group to review SSA's quality assurance program and to prepare a report of their recommendations. Can you provide more detail about this group, including: who serves, the workgroup's mission, goals and objectives, and the timeframe for the

completion of its report. We would also appreciate a staff briefing as to the group's findings and recommendations, when ready.

Answer:

Commissioner Barnhart appointed the former Regional Commissioner for the Atlanta and Chicago Regions, Myrtle S. Habersham, as the Senior Advisor for Quality Management. A workgroup was established with 8 Members representing years of operational and administrative experience. The Members came from the following major components: the Office of Disability and Income Security Programs, the Office of Finance, Assessment and Management, the Office of Operations, and the Office for Human Resources. Permanent staffing plans are being finalized. Additionally the group has utilized a senior level Steering Committee composed of representatives from every component and members from SSA management and Disability Determination Services (DDS) administrators' organizations.

The group was tasked with developing a proposal on what quality should look like for each of the Agency's business processes (claims, post-entitlement actions, informing the public, enumeration, earnings) and all supporting activities. The proposal was presented to the Commissioner with initial implementation beginning in August 2002.

Initially, the workgroup was tasked with completing extensive research and fact finding for the necessary background on their assignment. They looked at five key areas: definition of quality, who is responsible for ensuring its presence, the identification of quality models, challenges that impede progress and solutions for those impediments. The following recurring themes emerged from this fact-finding and research process.

For SSA to improve its performance in this area, our Agency needs:

- leadership to drive the change;
- quantifiable measures where appropriate and sufficient resources for employees to provide services to the American public;
- identification of initiatives that are currently underway to improve processes;
- incentives to encourage ongoing identification of quality solutions;
- an evaluative tool for use at the start of every major initiative ensuring full consideration of quality; and
- more investment in leadership training that enhances the skills necessary to reinforce this quality environment.

To address the Agency's needs, the workgroup's proposal contains four phases that are running concurrently. The focus of the first phase was to re-emphasize the Agency's commitment to quality and increase visibility of quality issues. Many of the activities in Phase I such as a new Commissioner-level quality award and a Quality Matters website have already been completed. The website currently features initiatives that provide solutions to quality issues, i.e., changes in systems, policies, and processes. Phase II of the proposal involves defining quality for the disability claims process. The workgroup is continuing the research and fact finding needed to identify a quantifiable definition of quality. Beginning with Phase III, the workgroup has started to identify process changes that will streamline processes and procedures in order to free resources to focus on other priority workloads. Phase IV looks at how to build quality into new processes, i.e., the accelerated electronic disability process, online medical report for disability claims, online policy/procedures, etc. As new processes are developed, the workgroup will work with other components to identify up front needed policies, systems, and management information to ensure quality.

The above outlines the steps the Agency is taking to reinforce the expectation of quality in everything it does. However, fully integrating quality into each of the business processes that serve the needs of more than 40 million beneficiaries is both a lengthy and complex challenge. The Agency will continue to research, coordinate, and develop a quality process to meet that challenge.

8. GAO states in their testimony that SSA hired a contractor to evaluate their electronic disability strategy and make recommendations for options to ensure that all the business and technical issues are addressed to meet SSA's mission of moving the agency toward a totally paperless disability claims process. Has the contractor submitted their recommendations? If so, please provide a summary of the contractor's report and a copy of the report to the Subcommittee staff. If not, what is the timeframe for completion? What is the timeframe for implementation of e-dib? Once the contractor review is completed, we would appreciate a staff briefing as to the contractor's findings.

Answer:

SSA has contracted with Booz-Allen and Hamilton to support the overall eDib project. Rather than simply reviewing and reacting to SSA proposals, the contractor is helping us to formulate a strategy, define an architecture and refine implementation options.

Since that time, Commissioner Barnhart challenged the Agency to accelerate the eDib project. She directed SSA to be ready to start implementation of a "folderless" disability business process by January 2004. We have revised the eDib Project Management Plan to reflect the Accelerated eDib (AeDib) project.

9. GAO commented that, in the past, SSA has had mixed results implementing their information technology initiatives and that SSA must review the pros and cons of past efforts before they undertake new efforts. GAO also stated that SSA must identify, track, and manage the costs, benefits, schedule, and risks associated with the system's full development and implementation. In addition, they stated SSA must ensure that it has the appropriate ratio of skills and capabilities to achieve the desired results. Has the agency addressed these recommendations? How can the Subcommittee be assured that e-dib will succeed where other technology initiatives have not?

Answer:

SSA recognizes the inherent risks of any large-scale technology initiative such as eDib, whether at SSA or any other public or private organization. The success of the implementation of eDib is being managed on a twofold front at SSA: via the SSA institutional information technology (IT) management processes, and via process and architectural approaches unique to the eDib application.

SSA has already addressed recommendations made by GAO concerning reviews of past IT initiatives; including identifying the tracking and managing costs, benefits, schedules and risks associated with full system implementation and ensuring the availability of the appropriate human capital IT skills and capabilities. Some of the means addressing these various GAO recommendations are:

IT Capital Planning and Investment Control (CPIC)

SSA has had a documented and successful IT CPIC process in place for many years. The SSA Acting Chief Information Officer (CIO) is currently testing and evaluating promising changes to the already successful process. The process change recommendations being tested and evaluated address areas such as IT planning, value measurement for e-services, as well as IT cost allocation methodologies for IT security and other IT infrastructure costs. New guidance from the Office of Management and Budget, along with ongoing evaluations of new tools and recommendations for other process improvements from higher monitoring authorities and consultants, will be included in the final model of a new CPIC process guide. The anticipated process plus use of the Information Technology Investment Portfolio System (I–TIPS) as a repository for selection criteria as well as SSA's IT portfolios will facilitate objective analysis, comparison, prioritizations and selection of IT investments. SSA is also developing procedures to guide future post-implementation reviews (PIR) that include criteria for designated projects for PIR. Standardized input to SSA's review process will probably be through I–TIPS.

Information Technology Advisory Board (ITAB)

SSA is adopting an IT planning and portfolio selection process that includes predefined selection criteria. This new process includes the development of a documented prioritized IT plan based on predefined selection criteria. These plans will be provided to the CIO-chaired Executive-level Information Technology Advisory Board (ITAB). That board will perform enterprise-wide IT planning and prioritization using the established evaluation criteria to produce and regularly evaluate a single, integrated Agency IT project portfolio. The criteria will include qualitative and quantitative factors including strategic alignment, mission effectiveness, organization impact, risk and return on investment. ITAB and senior Systems managers will provide oversight of IT projects, comparing actual cost, schedule, and risk data with original estimates.

Information Technology Architecture Plan (ITAP)

The ITAP continues to be a core management tool within SSA to document and manage the existent IT portfolio and to ensure that IT assets will be well positioned to support the evolving future service delivery requirements of the agency, of which one example is eDib. The ITAP is used to manage the current and target physical and application architectures; link IT investments to essential operational requirements; ensure that the IT architecture will support the SSA vision of the future; ensure continually refined process management of application development and

operational IT management; ensure that security requirements are an integral part of all IT planning; and ensure the integration of IT capacity planning as part of the ongoing and future IT asset portfolio management.

Software Process Improvement (SPI) Program

SSA Systems has heavily invested in the IT SPI program. SSA has selected the Carnegie Mellon's Software Engineering Institute (SEI) Capability Maturity Model (CMM) as the methodology for conducting the SPI program. CMM is in wide use throughout the software industry and is well respected as a standard benchmark. In 2001, SSA was certified by the SEI as being at CMM level 2. Level 2 specifies that the management processes are in place and in use to track cost, schedule and functionality on a repeatable basis. In the history of evaluations of non-military public sector organizations conducted by the SEI, 33 have been evaluated. Of the 33, 29 are at level 1 and 4 are at level 2, including SSA. The SEI has not evaluated any organizations in either the state or Federal sector that have achieved level 3 or above. In June of this year, Bill Gray, Deputy Commissioner for Systems, set a goal for Systems to be level 3 compliant by the end of calendar year 2003.

Information Technology Human Capital Plan

SSA is currently in the process of developing a human capital plan for the agency, including the human capital requirements to support current and foreseeable IT requirements. Initial work has already been completed to identify current IT skills using the Skills Inventory Planning System (SIPS). SIPS information is being analyzed to assess the usability of the data collected to support a gap analysis. SIPS will be repeated once the Systems reorganization has fully stabilized. SIPS will ensure the data is available to link current competencies and requirements and future staff needs. Additional work is being undertaken to develop a human capital plan based upon the difference between foreseeable IT requirements, and the current and projected IT workforce structure. In the meantime in recognition of the substantial retirement wave over the next five to ten years, priority is being given to future needs by setting aside a percentage of all full-time equivalents for entry-level hiring.

eDib Specific Success Enablers

eDib is defined as a flexible IT framework to serve the complex SSA disability business process. A key tenant of eDib is that eDib is not viewed as just a successful demonstration of technology implementation, but rather as technology implemented in such as way as to clearly provide ongoing and increasing support for both the current and future disability business processes. eDib planning and implementation revolves around determining where automation might best make a contribution to significant operational needs in a cost effective manner. eDib IT development adheres to all of the SSA institutional IT management processes (some of which are described above) in order to ensure this rigorous connection between IT investment, IT development, and desired business outcomes. Business case documentation under development within SSA and with Booz-Allen & Hamilton is providing a foundation for ensuring linkage between the business case for disability processing improvements and the eDib IT structure to support the business case.

eDib has ongoing and regular review at the highest levels of the agency. A Deputy Commissioner workgroup has already been formed to review and guide project performance on a regular basis. The participants are the Deputy Commissioners from Systems, Disability and Income Security Programs, and Operations. Management decisions requiring prompt reconciliation and resolution are escalated to the Deputy Commissioner workgroup. The Deputy Commissioner for Systems meets weekly with senior Systems staff to review the progress of eDib on all fronts, be they organizational, resource, business process, or technical design and implementation.

Users and DCS are jointly framing requirements and implementation plans so that the functionality to be delivered is commensurate with available resources and timeframes. Extensive business process analysis, adherence to the systems development life-cycle, and use of CMM principles help ensure that the IT assets being developed in support of eDib clearly support the business process, and that system users and developers agree on clearly defined IT goals to support specific business process requirements.

eDib is not a monolithic single application. Rather, eDib is being architected to consist of a number of discrete components, many of which can be implemented independently of one another. With the individual eDib building blocks being for the most part loosely tied to one another, success can be achieved incrementally within and between separate eDib projects and without being hostage to a tightly integrated "grand design." Where eDib does introduce new IT components and architectures to SSA, these items are being positioned as core architectural components which will be used as part of the ongoing common IT architecture development.

eDib is being designed to make the best use of projects, analyses, and architectural components already in use or under development, to maximize the use of commercial products, and to use external consultative expertise where appropriate. For example, eDib is being built to leverage and enhance the capabilities of existing disability case development and management systems, such as those in the state Disability Determination Services and the SSA Office of Quality Assurance. eDib will not replace any of these systems, but will instead provide additional services working in conjunction with these systems to enhance the capabilities of these systems and improve the business process already in place, while simultaneously setting the stage for future business process enhancements.

As part of eDib planning SSA is making use of premier external consults such as Booz-Allen and Hamilton, Gartner, the Giga Information Group, Lockheed-Martin, and other select IT consultant and services groups. External professional services will also play an important part in eDib implementation in all areas, including design, development and implementation activities where necessary to provide expertise and to supplement the SSA IT workforce. Particular attention is being paid at both the design and systems operational levels to developing monitoring and modeling methodologies to proactively avoid potential performance issues both during design and upon implementation. A separate capacity planning and modeling activity is being undertaken to ensure that an appropriate physical architecture is procured and implemented which can support the operational business process and service level requirements. SSA will be making extensive use of prototyping, piloting, training, and phased and iterative deployment in order to introduce the various eDib IT components into the production environment in a carefully controlled fashion. This introduction will be quite granular permitting introduction by eDib component, SSA organizational entity type, and geographic location.

10. The Advisory Board has recommended strengthening the current Federal-State relationship. Their suggestions for doing that include requiring States to adhere to specific guidelines for educational, salaries for staff, training, carryout procedures for quality assurance, and other areas having a direct impact on the quality of States' employees and their ability to make quality and timely decisions. Do you agree with these recommendations? Are you pursuing any of these suggested changes?

Answer:

SSA considered the establishment of a standard for adjudicators along with a standardized test to establish a certain level of proficiency. However, some States did not want SSA involved in what they viewed as State personnel matters. Some States were also concerned such educational requirements would result in higher salary levels that would have a ripple effect on other positions in the State that were not fully federally funded.

In addition we have taken action to:

1. Increase the disability policy component's staff responsible for managing disability training to strengthen SSA's ability to deliver high quality and consistent program training to all adjudicators.
2. Focus user input regarding training needs and delivery through the Disability Training Steering Committee (DTSC), which has been operating for the last several years. The DTSC includes representatives from the DDSs, OHA, the Office of Quality Assurance, and Operations. Its primary role is to ensure that appropriate training is made available for all disability adjudicators.
3. Embark on mandatory national training on selected topics in which it is essential that every adjudicator, regardless of component, have the same understanding to promote consistency in decisionmaking. Training will be directed toward experienced adjudicators. As we start the process, we envision providing 3 to 4 mandatory training programs in the 1st year, with the first program in early mid FY 2003.

11. The Advisory Board also recommends establishing a system of certification for claimant representatives and establishing uniform procedures for them to follow. Do you agree with this recommendation? If so, what action has been taken or is planned? If not, why?

Answer:

We view the issue of establishing a system of certification and uniform procedures for claimant representatives as another possible structural change to the claims process. As we consider options and develop proposals for changes in the disability process, we will keep the Advisory Board's recommendation in mind.

12. Our hearings have reinforced the need for disability research in general, but specifically for comprehensive research in the area of return to work. Please provide a summary of related research that has been conducted in recent years, research underway, and research planned, including expected completion dates.

Answer:

Overview

SSA has conducted research in effective and efficient approaches to returning disability beneficiaries to work since the mid-eighties. Starting with the grants under the Research Demonstration Program and the Transitional Employment Training Demonstration, through Project NetWork, and continuing today with the State Partnership Initiatives (SPI), SSA has tested a wide range of work incentives, service provision techniques, and systems changes, designed to promote the employment of Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) beneficiaries. In addition, over the next few years, SSA plans to conduct several new demonstrations, including an early intervention demonstration and several projects under a Youth Employment Strategy.

Previously Completed Research

Research completed since the mid-eighties includes:

- Transitional Employment Training Demonstration: A randomized field experiment providing skills training and work experience to adolescents with mental retardation in the SSI Program. Participants in 8 sites nationwide were given up to 2 years of services. Program waivers were used to encourage participation.
- Research Demonstration Program: Three rounds of research grants and cooperative agreements to State agencies and private providers of vocational rehabilitation (VR) services to SSDI and SSI beneficiaries. Some projects included the use of program waivers to provide additional encouragement to disability beneficiaries who wanted to work.
- Project NetWork: A randomized field test of four models of case management for providing return-to-work (RTW) services to SSI and SSDI disability beneficiaries. This project included 2–3 years of services in 9 States and pre- and post-service interviews with participants to measure differences in outcomes between treatment and control groups.

Current Return to Work (RTW) Research

RTW research currently in progress includes:

- State Partnership Initiatives: A set of 12 projects (cooperative agreements), sponsored by SSA, and 6 projects, sponsored by the Department of Education. For the SSA-sponsored projects, awards were made for 5 years to State agencies, which proposed the most innovative consortia of State programs, designed to encourage SSDI and SSI disability adult beneficiaries and youth to attempt to work. Four of the projects are also testing waivers of SSI Program features, such as $1-for-$4 benefit offsets for earnings and suspensions of Continuing Disability Reviews during participation in the projects.

Expected completion date: September 2003 for the eight non-waiver projects; September 2005 for the four waiver projects.

- Adolescents with Special Health Care Needs Project: This cooperative agreement with Children's Research Institute is located in Washington, DC. It is a collaborative partnership between the Adolescent Employment Readiness Center, a model transition program; Health Services for Children with Special Needs, Inc., a managed care organization for SSI recipients; and the American Academy of Pediatrics, the nation's largest organization for pediatricians. The purpose of the project is to prepare transition age SSI youth with severe, chronic disabilities for post-high school employment by establishing, in an urban setting, an uninterrupted, coordinated, developmentally appropriate, psychologically sound and comprehensive model of transition services for SSI youth. This project is part of SSA's Youth Employment Strategy.

Expected Completion Date: September 2004.

Planned RTW Research

SSA has several RTW research projects planned to begin in FY 2003, spanning a broad range of topics.

- Youth Employment Strategy: Designed to assist individuals with disabilities between 11 and 30 years of age transition to the work force, this initiative will consist of several projects related to the delivery of services needed to assist these individuals in achieving independence. States and local communities will be awarded contracts, grants, and cooperative agreements for testing and delivering needed transition services to young SSDI and SSI beneficiaries with disabilities. Cooperative agreements will test integrated school-family community-agency models of transition planning, aided by assessments of employment potential and Vocational Rehabilitation services. SSA will be pursuing interagency youth transition projects with the Department of Education, the Department of Labor (DOL), and other interested Federal partners. Waivers of SSI and/or SSDI program features to support youth beneficiaries' transition to adult life will also be considered.

Expected Completion Date: September 2008.

- Mental Illness Treatment Demonstration: SSA will test models of services and treatment for SSDI and SSI beneficiaries with diagnoses of mental illness, such as, mood disorders or anxiety disorders and related co-morbid conditions. The objective of the tests will be to return these beneficiaries to productive activity and reduce program costs. Sites will be chosen scientifically in several States where the State and local mental health service system is interested in participating and wins a competitive cooperative agreement award. Participants will be randomly assigned to treatment or control groups. Program waivers will be considered if they are felt to be essential to supporting the work attempts of demonstration participants. Funding is initially scheduled for 5 years with the first year for setup and testing of procedures, followed by 4 years of enrollment of cases and service delivery.

Expected Completion Date: September 2008.

- Early Intervention Demonstration: The objective of the Early Intervention Demonstration is to assist title II (and concurrent title XVI disability) applicants, who have impairments reasonably presumed to be disabling, to secure the necessary support services that will help them to return to work. Applicants for disability benefits will be given the opportunity to put their applications "on hold" and participate in the demonstration. Providing the necessary support services before a benefit award is made may improve the applicant's chances of a successful return to work and possibly eliminate the need for disability benefits. Alternate models of service delivery will be tested to determine the interventions that will most likely encourage employers to hire and retain participants. Participants will be given a stipend to support them during the intervention as well as health care benefits. The demonstration will be conducted as a randomized experiment in several States nationwide.

Expected Completion Date: Sept. 2009.

- Comprehensive Employment Opportunities Demonstration: The Centers for Medicare & Medicaid Services (CMS) and SSA will solicit interested States for a demonstration entitled the "Comprehensive Employment Opportunities (chief executive officer)" demonstration that would combine resources and incentives from both Federal agencies and the States to promote the employment of people with disabilities. States will participate in this demonstration through cooperative agreements that would include pre-approved Federal waivers. Through this project, the Center for Medicare and Medicaid Services and SSA are promoting the ability of States to offer a coherent, comprehensive employment initiative. States will extend health coverage via the Medicaid Buy-In and related programs, and will bring State programs together to address all major barriers to employment— including health care, income support, housing, employer access, and transportation. As part of this demonstration, SSA will provide pre-approved waivers under the SSI and SSDI programs to successful applicants. These pre-approved waivers include additional disregards of income and assets/resources, as well as "hold harmless" provisions to ensure that an individual in the demonstration will not be worse off as a result of participation. The pre-approved waivers will be subject to State conformance with all applicable terms and conditions, operational protocols, and the cooperative agreement itself.

Expected Completion Date: September 2008.

- Benefit Offset Demonstration: SSA will test the impact on SSDI beneficiary employment through implementation of a $1-for-$2 benefit offset. This demonstration was mandated by section 302 of the Ticket to Work and Work In-

centives Improvement Act 1999. SSA will solicit the interest of States that wish to participate in this test. Sites will be selected to provide a diversity of settings nationwide. Participants in the demonstrations who work will have disability benefits reduced $1 for every $2 of earnings above a certain threshold, instead of having benefits eliminated completely, as in the current SSDI program. The extent of greater rates of employment and higher earnings of participants will be assessed relative to a control group.

Expected Completion Date: September 2008.

- Evaluation of the Ticket to Work Program: As mandated by section 1148 of the Social Security Act, SSA must evaluate the size and nature of the impact of the Ticket to Work and Self-Sufficiency Program on the employment and earnings of SSI and SSDI beneficiaries and on the payment of Employment Networks which provide services to those beneficiaries. SSA has awarded a contract to design the evaluation. SSA will award a competitive contract to a research firm to implement the research design during FY 2003.

Expected Completion Date: September 2007 with interim reports in FY 2003 and 2005.

- Benefits Navigator Demonstration: SSA is partnering with DOL on a test of a Disability Benefits Navigator in the nationwide network of One-Stop Centers. The Navigator will be an expert in SSA's disability program work incentives, the Ticket to Work program, and all SSA and non-SSA programs and benefits that could assist a beneficiary or non-beneficiary to start or return to work. SSA and DOL will test the efficacy of this new position in One-Stops in 6–8 States for 2 years and, based on the evaluation results, decide if this position should be made a permanent part of the One-Stop system nationwide.

Expected Completion Date: September 2004.

13. SSA created the Employment Support Representative (ESR) position to provide a specialist for work incentives. ERSs served as a single point of contact with beneficiaries, monitored beneficiaries' work progress, and processed work reports and work-issue continuing disability reviews. A final evaluation report on the ESR position was completed in November 2001 and recommended that SSA make the position permanent. SSA decided not to make the position permanent due to staff shortages and resources issues. Can you tell us what are SSA's plans for proceeding? Please provide a copy of the evaluation report to my Subcommittee staff. Additionally, we would appreciate SSA briefing Subcommittee Staff on this issue.

Answer:

SSA piloted the temporary Employment Support Representative (ESR) position in SSA's field operations structure consistent with the requirement of section 121 of the Ticket to Work legislation that SSA establish a corps of work incentives specialists within SSA. The ESR pilot began in late July 2000 and ended in September 2001. In late November 2001, the SSA ESR Pilot Evaluation Team presented its final report recommending adoption of the ESR position. SSA is concerned that all our beneficiaries receive the very best service that we can provide, and we are currently deliberating on how best to provide employment support programs-related information and services to our beneficiaries with disabilities nationally with our present resources. We provided Subcommittee staff with a briefing on this subject.

14. The National Council of SS Management Associations recommends that a Technical Expert for Disability (TED) position be created in field offices to focus on processing disability claims. Please comment as to your views regarding this proposal.

Answer:

The Technical Expert (TE) position was established to handle a broad range of complicated work in field offices. Managers in local offices have the flexibility to assign technical disability work to their TEs, and many do so. We feel that requiring all offices to have a TE dedicated to disability claims would limit our flexibility to keep all workloads in balance.

15. The National Association of Disability Examiners has proposed placing greater emphasis on claimant responsibility, expanding the single decisionmaker in DDS, providing for a due process hearing for the claimant in the reconsideration, closing the record after the reconsideration decision, eliminating the Appeals Council, and establishing a Social Security Court

to hear appeals of the ALJ decisions. Please comment as to your views regarding this proposal.

Answer:

We believe it would be premature to advance an Agency view regarding any of these changes.

16. The National Council of Disability Determination Directors provided recommendations for change in their testimony, including; providing adequate resources to handle the current and pending caseloads at the DDSs, improving policy and training to produce more consistent and accurate decisionmaking, making revisions of SSA's quality assurance system a high priority to unify the application of policy among all components, enhancing performance of electronic systems, strengthening the reconsideration phase to provide for a face-to-face de novo hearing between claimant and DDS reviewer, and establishing uniform quality assurance and case review systems to bring the DDS and OHA closer together in the determination process. Please comment as to your views regarding this proposal.

Answer:

SSA is actively considering broad changes to the disability claim process to improve service and efficiency, and we are moving forward with some process changes. Commissioner Barnhart has announced her intention to move aggressively to implement electronic disability processing (eDib) by January 2004. We have received suggestions regarding other changes from the public, Federal and State employees, and employee groups, such as the National Association of Disability Examiners and the National Council of Disability Determination Directors. It would be premature to react to specific aspects of these recommendations at this time. As we consider options and develop proposals for change, we will continue to work with interested groups and the Congress as we all strive to provide the best possible service in an efficient manner.

17. What is the average number of cases an ALJ hears per day?

Answer:

According to the FY 2002 Caseload Analysis Report, the national average number of hearings scheduled per ALJ per day was 2.32 through July 2002 and the national average of hearings held per day per available ALJ through July 2002 was 1.66. This latter statistic reflects postponements, continuances and no-shows.

18. To help us better understand how the process of disability determinations works at the OHA level, can you provide us with a step-by-step process of what happens to a case beginning when it is received in an OHA office until a decision is made? For each step, please include when evidence is requested and by whom, and how evidence is presented.

Answer:

The following is an outline of the step-by-step case processing at the Hearings level of administrative appeal:

- Case intake begins at the Master Docket level. The folder is stamped-in to acknowledge the receipt of the file.
- The case is screened to determine whether the claimant has had a prior claim(s) at the OHA level.
- The case is also screened through the Hearing Office Tracking System (HOTS) to determine whether or not the folder should be associated with a claim already pending at the hearing level or if it is a new claim.
- The case is the screened to determine if it is properly at the hearing level and whether the Request for Hearing is timely filed. Master Docket then enters the case into the HOTS tracking system, identifying the parties to the claim, the hearing type and the claim type. Master Docket also verifies the service area and the correct spellings of names and addresses.
- Following established guidelines, Master Docket screens cases for possible early dispositions. If the Request for Hearing is not timely filed or the claim is not properly at the hearing level, the case is referred to an administrative law judge (ALJ) for possible dismissal. Possible on-the-record decisions are referred to Senior Attorney Advisors for further review.
- If the case is properly at the hearing level, Master Docket then prepares an acknowledgement letter to the claimant and representative. Along with the acknowledgement letter, Master Docket sends the claimant hearing office worksheets requesting information regarding any recent treatment since the Reconsideration determination, medications and any updated work background information. Often the claimant will have submitted additional evi-

dence in connection with the request for a hearing. The case is then assigned to a Group within the hearing office. Within the Group, the case is first assigned to a Senior Case Technician (SCT).

- The SCT does a pre-hearing screening, including verification of claim type, hearing type, names, SSN and addresses.
- Proposed exhibits are selected in the case work-up process and the documents are stamped and numbered.
- The SCT reviews the file to determine the need to request updated medical information and information regarding work and earnings. If additional information is needed, the SCT requests this information from treating sources and employers or requests the claimant's representative obtain this information and submit it to the hearing office within a specified timeframe. At this point, the SCT may also suggest the need for medical or vocational expert testimony.
- The case is then assigned to an ALJ for his/her pre-hearing review. The ALJ will determine if further development is needed or whether the case is ready to schedule for hearing. The ALJ will also determine whether medical and/or vocational expert testimony will be required at the hearing.
- When a claim is scheduled for hearing, a notice of hearing is sent which requests the claimant/representative to send any and all additional evidence to the hearing office prior to the hearing. The acknowledgement letter to the claimant/representative explains that any additional evidence they wish to submit must be sent as soon as possible. Also, if they need help in obtaining evidence they should contact the hearing office for assistance.
- New evidence received prior to the hearing date is added to the case file by the SCT or Case Technician (CT) and the case is given back to the ALJ for review. The ALJ may decide that a hearing is not necessary because a fully favorable decision can be issued based on this additional evidence.
- The claimant/representative may submit written evidence on the day of the hearing. If this occurs, the ALJ may decide to reschedule the hearing for a later date if he/she needs additional time to re-review the file with the new evidence received at the hearing.
- There are times when the ALJ will need to request medical/vocational evidence subsequent to the hearing. This may include additional development from the treating source, a request for a consultative examination (CE), and/or a supplemental hearing.
- After the additional development/testimony is received, the ALJ will make a decision and complete the instruction sheet for the Attorney Advisor (AA) or Paralegal Analyst (PA) assigned to write the decision.
- The AA/PA prepares the draft decision.
- The ALJ is given the draft decision for review and edit.
- A Notice of Decision with appeal rights and a copy of the ALJ's decision are mailed to the claimant and representative.
- The claim file, containing the exhibits, audiotape of the hearing, Notice of Decision, and the ALJ Decision are mailed to the appropriate processing component of SSA.

The following is an outline of the step-by-step case processing at the Office of Appellate Operations (OAO) level of administrative appeal:

- When an unfavorable decision or dismissal is issued by an ALJ, the hearing office sends the claim file to the OAO Mega Site processing center for holding in the event the claimant or representative files a Request for Review of the ALJ decision or dismissal.
- When either a claimant or representative files a Request for Review it goes directly to an OAO Branch where receipt is documented by input into the case tracking systems. Branch staff requests the file from the Mega Site in order to process the claim. Often a claimant/representative will submit additional evidence in connection with the Request for Review or will request an extension of time in which to submit additional evidence or present statements or arguments in support of the claim.
- OAO does not routinely request evidence. However, in situations where a claimant/representative references additional evidence in connection with the Request for Review, the Council will routinely grant an extension of time to submit the evidence. Evidence of this nature is generally medical reports from treating sources, hospitals, examining sources, etc.
- Other pre-development activities may include obtaining all pertinent files; obtaining the audiotape hearing cassette, if missing; providing the claimant/representative with copies of exhibits and/or audiotapes; and time to submit evi-

dence and/or statements or arguments, and so forth. Once all pre-development activities are completed, an Analyst reviews the case and makes a recommendation to the Administrative Appeals Judge or Appeals Officer (signatory authority for denials only) for his/her action, i.e., deny the Request for Review; grant the Request for Review, vacate the ALJ decision and Remand to ALJ for further processing; grant the Request for Review, vacate the ALJ decision and issue an Appeals Council decision; or Dismiss the Request for Review.

- The Administrative Appeals Judge or Appeals Officer (denials only) review the Analyst's recommendation and sign the action documents, if he/she is in agreement with the recommendation. If there is no such agreement, the case is returned to the Analyst for further review, revision, etc.

19. Witold Skwierczynski's testimony focused on issues related to the Title II special disability workload. Please provide your comments regarding this testimony.

Answer:

We agree that the Special Disability Workload is complex and difficult. For that reason, SSA established cadres of specially trained employees to process the cases. The specially trained cadres will screen and "map" each case. ("Map" means that they identify the key issues to be covered during the interview and development of the claim.) They began processing cases in June 2002.

The cadres will send case-specific instructions, i.e., the "mapping" material, to the local field office that will obtain the application and develop the entitlement factors. Cases requiring medical determinations will then be sent to the disability determination services (DDSs). After all these steps have been finished, the field office will send the cases back to the cadres for quality review. Upon completion of the quality review, cases will be sent to the processing centers for payment.

In addition, SSA's Office of Quality Assurance will conduct independent quality reviews. They will conduct "early information" reviews at various steps in the process to ensure accuracy.

Due to much longer retroactive benefit periods than normal title II cases, the DDSs will need to develop much older medical evidence and it is estimated the special disability workload will take approximately 1½ times longer to adjudicate than regular cases. The disability determination services (DDSs) are not funded to do all initial receipts in FY 2003. Absent additional funding, the special disability workload will be worked along with other disability claims and add to the backlog.

20. In what percent of ALJ hearings is a medical or vocational expert present? Please provide this data totaled by year for the past 3 years.

Answer:

National data for Participants per Hearing Held is as follows:

Fiscal Year	Vocational Expert	Medical Expert
1999	47.4%	16.3%
2000	49.6%	17.8%
2001	51.2%	17.5%

21. Dr. Stapleton stated in his testimony that he arrived at a different conclusion regarding the findings of the Disability Claims Manager (DCM)—"SSA's evaluation of the DCM test concluded that it substantially reduced processing time, increased claimant satisfaction, and improved employee satisfaction, but at a somewhat greater cost than the current process. My interpretation of the evidence from that evaluation is more positive than SSA's; it appears to me that the DCM is cost neutral, and that it reduced processing time by more than the report indicates." Please provide your comments relative to Dr. Stapleton's conclusions.

Answer:

As Dr. Stapleton testified, SSA contracted the company he worked for (The Lewin Group) as consultants for the DCM evaluation. Based on the Lewin Group's recommendation, median processing-time was used as the assessment tool for the final report. The report recognized that the DCM cases had significantly faster median processing times for both Title II and Title XVI claims than the control group (on average 10 days faster for Title II and 6 days faster for Title XVI).

The DCM cost assessment considered the volume of cases processed, staff salaries including support staff and supervisors, medical development/evidence costs and

overhead. This analysis indicated that the DCM model cost at least 7% more to process an initial claim than the current process. The assessment did not factor in costs associated with creating an infrastructure to support the DCM process, extensive training and mentoring or productivity losses over the long learning curve.

Although there were some positive outcomes in the DCM test, the agency concluded that there was not a compelling business case for making resource commitments necessary to implement the process. The agency issued a decision not to pursue further testing or implementation of the Disability Claim Manager position, but to consider the valuable insights and experiences learned from this test in its longer-term planning efforts.

22. Please summarize the procedures requiring field office and DDS employees to instruct claimants and/or their representatives about how the process works and what information they need to provide to substantiate the claim. What quality review procedures are in place to ensure these procedures are followed? Do such quality reviews illustrate that these procedures are being followed?

Answer:

Field Office (FO) Responsibilities

- When a disability claim is taken, field offices explain to claimants and/or their representatives:
- That SSA will need to obtain medical evidence to support the claim;
- That timely and accurate identification of medical sources will assist the DDS in processing the case;
- That SSA will pay for the medical evidence of record;
- That the claimant will need to fully cooperate if a special examination is necessary;
- The estimated time it takes to get a determination;
- Available work incentive provisions;
- Available Vocational Rehabilitation Services; and
- Mandatory continuing disability review requirements.

Claimants are given the booklet "Disability Benefits". This booklet provides information on the definition of disability, how to apply for benefits and the role of the DDS. This pamphlet is available online at http://mwww.ba.ssa.gov/pubs/10029.html

Field office cases are reviewed for accuracy after they are worked. This is done by a quality review component located in the Regional Offices. Feedback is provided to the field offices on all cases found to be inaccurate, and these cases are sent back to the claims representative for correction.

Teleservice Center (TSC) Responsibilities

When a claimant calls one of our teleservice centers (TSCs) via our 800 number about applying for disability benefits, the TSC interviewer screens the caller for self-help and, if screened in, sends the caller a Disability Report form (SSA–3368–BK) and advises the caller that the:

- FO interviewer will provide any needed assistance to finish completing the form at the time of the interview, and
- Claimant should return the form along with any medical evidence (including prescription information) already in his/her possession:

1. when requested by the FO, or
2. in person at the time of the in-office appointment, or
3. by mail after the FO telephone interview.

The TSC interviewer also informs the claimant of the location of the SSA website, which explains each item on the Disability Report form.

The TSC interviewers receive quality review two ways. Their calls are monitored by management and/or technical staff onsite. Calls are also remotely observed by a quality component in the Office of Quality Assessment (OQA). Both service observation reviews look at the quality of service provided by the interviewer as well as the interviewer's accuracy of information provided to the caller. When needed, feedback is provided to the interviewer from their supervisors and/or technicians to ensure that correct information is given to the callers. The OQA provides feedback of their evaluations on a monthly and quarterly basis.

Disability Determination Services (DDS)

Many DDSs, as part of their initial development of every new claim, also mail the claimant an explanation of the disability process. This is in addition to the information provided by the FO and TSC. In addition, letters sent to the claimant by the

DDS for additional information, such as work history, consultative examinations, and activities of daily living, contain general information about why the DDS needs this information and how it relates to the disability process.

DDS Quality Specialists and frontline supervisors on an ongoing basis conduct quality reviews. Cases are reviewed at various stages of development to ensure that appropriate developmental practices and procedures are abided by. Worksheets are maintained on each case to verify that correct actions are being taken in a timely fashion. Recommendations are made to Disability Examiners if the reviewer feels that a more appropriate course of development should be pursued. A record is maintained of all case reviews for training purposes.

All quality review information for the FO/DDS/TSC is evaluated and, if it illustrates that procedures are not being followed, the necessary training is provided. All components provide ongoing training of new ad/or problematic procedures to insure that a high level of quality is maintained.

23. Judge Bernoski testified on June 20 that improving the quality of disability determination services (DDS) decisionmaking would improve the overall determination process. He stated (page 4 of his testimony), "rather than carefully develop and examine the claimants' case once, DDS often is making its initial determinations based on incomplete records and, upon reconsideration, rarely obtains significant additional medical evidence or changes the outcome of the case." What are your comments on this statement? [What] are the procedures for developing a case? Would you explain the process for reviewing a case for reconsideration, including under what circumstances a disability examiner obtains additional information? Are such processes checked and documented via DDS or Federal quality review?

Answer:

We believe that DDSs do carefully develop and examine cases.

A DDS is required by regulations to make every reasonable effort to develop an individual's complete medical history for the 12-month period preceding the month of filing before making any adverse determination (20 CFR 404.1512(d) and 416.912(d)). "Every reasonable effort," means an initial request for the evidence and, if not received one follow-up. (20 CFR 404.1512(d)(1) and 416.912(d)(1)). As part of the initial development of every new case, the DDS routinely requests evidence from medical sources identified by the applicant or discovered during development. The DDS may also develop medical evidence outside of the required 12-month period, if necessary.

If the DDS knows from past experience that a particular source either cannot or will not provide the necessary evidence, they will not request evidence from that source but will instead note this on the case development worksheet, which is part of the case file. Otherwise, the DDS develops evidence from all known sources.

However, that does not mean that the DDS receives responses from every source. It is common for some medical sources not to respond to the DDS's requests and follow-ups. Consequently, a case file can appear to be incomplete because of "missing" evidence, even though the DDS carefully developed the case by making every reasonable effort to obtain available evidence.

If a DDS is not successful in obtaining needed evidence from the individual's medical sources, then the DDS will ask the individual to go to one or more special examinations, called consultative examinations.

During the reconsideration process, the claimant has the opportunity to present additional evidence. The DDS makes a new determination considering all available evidence, including evidence considered at the initial determination and any new evidence. An adjudicator other than the one who made the initial determination makes this new determination.

Development and documentation requirements for reconsiderations are the same as for initial cases. At reconsideration, the DDS will request any new evidence since the initial determination, as well as any earlier evidence that is necessary.

Because reconsideration determinations are generally made soon after the initial determination, there is often no significant additional evidence available, and no reason to develop additional new evidence. This can contribute to a misperception that the DDS is not undertaking needed development at reconsideration. It also contributes to the comparatively low (but still significant) allowance rates at reconsideration of about 15%.

We continue to monitor DDS adherence to our development policies at both the initial and reconsideration steps through our quality assurance process.

24. Kathleen McGraw, the Chair of the Social Security section of the Federal Bar Association, testified on June 20 that State Disability Examiners

do not assess claimants' subjective complaints. She stated (page 2 of her testimony), "They were confounded by the task of assessing a claimant's credibility and subjective allegations and articulating a reasoned basis for their conclusion. Notwithstanding the clear message from the Process Unification Training that State Agency Examiners were expected to perform individualized assessments and rationalize their determinations, they have failed to do so. State agencies have balked at this requirement, and examiners' determinations continue to be devoid of rationale and are driven almost exclusively by objective medical findings." What are your comments on these statements? Would you explain what factors and criteria State disability examiner use to assess an individual's claim? Are such processes checked and documented via DDS or Federal quality review?

Answer:

Assessing subjective allegations and credibility is one of the most complicated and difficult parts of disability claims adjudication. This is true at all levels of adjudication—not just at the State agency (i.e., DDS) level. And dealing with these complex issues can confound not only DDS disability examiners, but also medical consultants, administrative law judges, and others involved in disability claim evaluation.

These issues present several particular difficulties for DDSs, even though DDSs consider the same factors and criteria as administrative law judges and other adjudicators. First, the volume of cases DDSs must deal with makes individualized assessment a significant challenge. However, our experience shows that the DDSs universally strive for, and for the most part, achieve, a very respectable level of performance. They provide individualized assessments and correctly apply our rules for evaluating subjective complaints and credibility, as shown in our quality review findings. However, their workloads make it increasingly difficult for them to document, through comprehensive and detailed rationales, how they have done so.

Despite these demands, however, we do not believe that DDSs have "balked" at the requirement to make proper assessments of disability claims. Indeed, DDSs have done the best job we could expect of them, while balancing enormous workloads with the need for comprehensive documentation.

We have been testing a different process in ten States, which includes the elimination of the reconsideration step from the appeals process, and DDS examiners making some disability determinations independent of medical and psychological consultants. Also included in this process is an enhanced rationale process that requires clear documentation of development actions as well as a clear explanation of the examiner's thought processes. Without the savings from the elimination of the reconsideration, however, the remaining States do not have the necessary resources to provide these more detailed explanations. This different approach among the States will be addressed as we consider longer term, broader changes to the claims process.

This new process was intended, in part, to help DDSs better meet workload demands, while providing the comprehensive decision rationales that we would prefer. Consequently, the rationales we have seen in these States are more extensive than those in other States in which the process was not tested. But, the same workload pressures exist in every State across the country.

Although DDS rationales are often less detailed than what we would like, it doesn't mean that DDSs aren't correctly applying our policies, including those we refer to as "Process Unification," such as policies related to medical source opinions, symptoms and credibility, and residual functional capacity. We believe that DDSs are doing so within the constraints imposed by budgets and workloads. Because their decisions are not always rationalized to the same extent as an administrative law judge's decision, it is a common misconception that that they consider only the "objective" medical evidence. That is because the evaluation forms and medical consultant analyses tend to reference readily available clinical information, and to give less emphasis to any complex discussion of the individual's complaints and credibility. But that doesn't mean the adjudicator did not consider those factors. It only means he or she didn't spend a great deal of time explaining them.

We continue to monitor and document DDS adherence to our disability adjudication policies through our quality assurance process. All DDSs are held to the same, strict quality standards, regardless of the level of explanation provided in their determinations.

25. James Hill made the following recommendations in his testimony. "1. All qualified OHA Attorney Advisers should be converted to Senior Attorney decisionmakers and given the authority to issue fully favorable on-the-record decisions. These Senior Attorney decisionmakers would review all cases coming into the hearing office. 2. SSA should establish a workgroup

to examine the implementation of additional attorney decisionmakers, such as Hearing Officers, in the OHA hearing offices to work in conjunction with the ALJs in processing the ever-growing workload that faces SSA. 3. SSA should establish a workgroup to examine the issue of introducing an Agency representative into the adjudication process." Please provide your comments as to these recommendations.

Answer:

See the response to question 5. Additionally, there is a proposal under development to establish an attorney decisionmaker position in OHA to help address the growing backlog of cases.

26. The Commissioner has stated she will implement reforms to the disability process this fall. Judge Bernoski indicated that SSA has not asked either he or his association, the Association of administrative law judges, to participate in identifying solutions to the problems associated with the disability determination process. Is this true? If so, why?

Answer:

Commissioner Barnhart has asked Martin H. Gerry, Deputy Commissioner, Office of Disability and Income Security Programs, to present suggestions for improvements in the disability process to her this fall. As Deputy Commissioner Gerry stated in his August 1, 2002 message to all hearing office employees, he plans to meet with Judge Bernoski as well as with representatives of OHA's other unions to solicit ideas for improvement. Deputy Commissioner Gerry is also looking into the possibility of obtaining input and feedback from other interested parties such as the Hearing Office Chief administrative law judge (HOCALJ) Association and the Federal Managers Association, and outside organizations such as NADE, NOSSCR, NCDDD and NCSSMA.

27. Judge McGraw believes a major failing of HPI was the promotion of clerical employees to the ranks of paralegals, who she states were promoted without having any legal training or demonstrating ability to write and communicate effectively. Their promotion reduced the number of employees trained in "pulling cases" in preparation for adjudication by ALJs, thus creating fewer cases ready for judges to hear. Compounding the problem is that the promoted employees are paid at the same grade and pay level as attorneys. Will you please comment as to Judge McGraw's concerns?

Answer:

The Memorandum of Understanding signed by management and AFGE on the implementation of HPI required the Agency to fill a large number of paralegal analyst positions, primarily through internal promotion of current OHA employees. The AFGE Partnership Agreement for HPI Phases II and III specified 350 paralegal analyst positions would be announced in July 2000 and filled before November 20, 2000. No one in a clerical position was promoted to the paralegal analyst position; however, the majority of the promotions were from the ranks of our technical positions, in particular the Senior Case Technician position.

All of the employees who were promoted met the basic qualifications of the position. However, as a result of the requirement to promote such a large number of employees in a relatively short time, there was a higher than usual incidence of employees requiring new skills training. Moreover, this occurred during a period when many of the employees supervising the new paralegal analysts were, themselves, also new to their positions, and all office staff was learning a new process.

Sincerely,

Martin H. Gerry
Deputy Commissioner for
Disability and Income Security Programs

Attachment:

ORES Working Paper Series
Number 98
Social Security Disability Programs:
Assessing the Variation in Allowance Rates

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August 2002
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Summary

The Social Security Administration (SSA) operates two programs that provide disability benefits: Social Security Disability Insurance (DI) and Supplemental Security Income (SSI). The Social Security Act and the regulations that implement it establish uniform national criteria for determining whether someone who applies for disability benefits under either of these programs is disabled. However, an agency of the state in which the claimant lives makes the initial determination under contract to SSA and using SSA guidelines.

Historically, states have allowed initial disability claims at rates that vary from one state to another, in some cases widely. On the surface, this variation seems to indicate that states apply the national disability criteria differently from one another. Over the years, this concern has prompted several congressional hearings and numerous analyses and reports. For example, the Senate Finance Committee report on the Disability amendments 1979 commented: "The assumption is that it is easier (or more difficult) to meet the disability definition depending on where you live" (Senate Committee on Finance 1979). Most recently, a report by the Social Security Advisory Board (2001a and b) showed geographic patterns of variation in allowance rates and expressed concern about SSA's ability to assess whether there is inconsistency and unfairness in disability decisionmaking.

Equity demands that claimants receive the same consideration regardless of their state of residence, but it does not require that states have the same or even similar allowance rates. Allowance rates depend in part on the economic and demographic characteristics of those who apply, which vary among states. For example, a state with an older population is likely to have a higher allowance rate because older claimants are more likely to meet disability criteria, on average.

This study estimates the amount of variation in allowance rates that is related to certain economic and demographic differences among states. The major findings include the following:

In 1997–1999, states with the highest and lowest allowance rates for DI, SSI, and concurrent applicationsdiffered by about 30 percentage points.

- States that have the highest and lowest allowance rates for DI or SSI tend to retain that status over time, although some changes in ranking do occur.
- States with high filing rates tend to have low allowance rates, and vice versa.
- Adjusting for economic, demographic, and health factors cuts the variation in allowance rates among states in half.
- The variation in the prevalence of disability beneficiaries in the population has only a minimal ability to explain allowance rates.
- The allowance rates in most states are relatively close to the rates predicted by demographic and socioeconomic factors.
- States that deviate from their predicted rates tend not to do so consistently.

* Social Security Administration, Office of Policy

Definitions

allowance rate: the number of allowances (or successful applications) as a percentage of the number of applications in a given year.

filing rate: the number of applications as a percentage of the working-age population.

predicted allowance rate: predicted values based on the statistical relationship between economic, demographic, and health characteristics of the states and allowance rates.

prevalence rate: the number of DI and SSI beneficiaries as a percentage of the population.

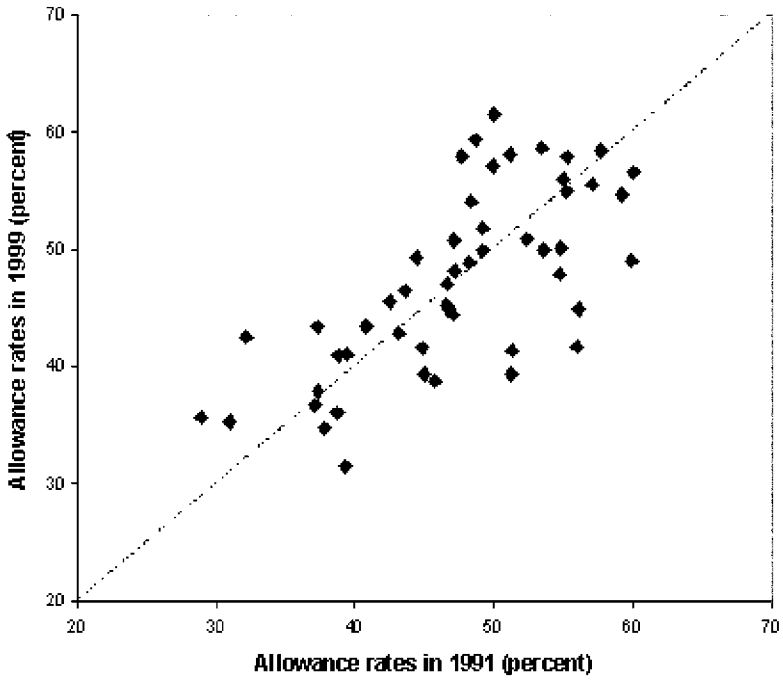
Concern about Variation in Allowance Rates

The variation in DI and SSI allowance rates across states has been substantial and persistent. Recently, the range between the states with the highest allowance rates and the ones with the lowest was around 30 percentage points.[1] In addition, the states with the lowest allowance rates tend to remain in this category in adjacent years. Over longer periods of time, the ranking of allowance rates remains fairly stable. For example, Chart 1 plots DI allowance rates that are 8 years apart. States tend to keep their position relative to the other states, as shown by the proximity of the data points to the diagonal line.[2]

[1] These allowance rates reflect initial decisions only (including pre-effectuation review) and exclude SSI applicants who are minors. The states with the five highest and lowest allowance rates for 1997 to 1999 are listed in Appendix A.

[2] The correlation of the rankings of allowance rates is around 0.7 for both DI and SSI between 1991 and 1999. It is somewhat lower for concurrent applicants.

Chart 1: The stability of state DI allowance rates across years, 1991-1999



Even though the differences between allowance rates are large and persistent, an internal Social Security Administration study (1988) showed that much of the variation is associated with economic and demographic differences in state populations. The analysis also concluded that more variation could have been accounted for had data on additional factors (such as health) been available. Numerous other studies have analyzed the relationship between allowance rates and economic and demographic factors.[3]

This study expands on the 1988 analysis by considering a wider range of possible explanatory variables. It differs from previous studies by analyzing 3 years of data and by conducting separate analyses for the DI and SSI Programs and for concurrent claims under both programs. It responds to concerns about differing allowance rates by reexamining the portion that is associated with external factors and, by extension, the portion that could be attributable to inconsistency. The analysis addresses the issue of whether a claimant in one state is less likely to be allowed than a claimant in another state, all other things being equal. By adjusting the allowance rates to account for demographic and economic conditions, this analysis moves toward making at least some important "other things" equal.

This study pertains to the average initial allowance rate for each state across all cases. Therefore, it does not reach any conclusions about the extent of variation across particular categories of disability or particular steps in the process. It also does not cover the important issue of possible inconsistency among decisionmakers within a state.

Factors Influencing Allowance Rates

This study aims to account for state-to-state differences in allowance rates using variables that are clearly external to the administration of the disability program.

[3] For a review of these studies, see Rupp and Stapleton (1995, 1998).

Variables that measure aspects of the economy or the population are in this category. An example is the age of the population; it is logical to expect higher allowance rates with an older population. The only variable used in the analysis that could be considered partially internal to the program is the percentage of applications based on physical (as opposed to mental) impairments. It is internal in the sense that it refers to a characteristic of the claimant rather than of the population. Although this variable is largely independent of the claims process, an element of subjective judgment exists in the classifying of disability cases. The analysis nevertheless uses this variable because there is no corresponding characteristic that can be measured in the state population.

One of the goals of this analysis is to separate the variation that can be influenced by administrative factors or policy from that which is attributable to external differences between states. Through controlling for the external factors for which data are available, the analysis can focus on the remaining differences in allowance rates.[4]

This study uses data for calendar years 1997, 1998, and 1999 to explain differences in allowance rates. It combines 3 years of data into a single analysis. In addition to allowing for greater statistical precision, combining the data permits an examination of whether anomalies recur in different years. Separate analysis is conducted for three different groups: DI claims, SSI claims, and concurrent claims under both programs.[5] DI and SSI allowance rates can differ greatly in a particular state. The states with the lowest DI allowance rates do not necessarily have the lowest SSI allowance rates. Furthermore, DI and SSI filing rates are correlated with different external variables. Concurrent applicants represent a unique population with labor force experience but little financial success. This group has enough work experience to be insured for DI but has meager enough assets and income to qualify for SSI. Because of these differences, we separated the programs for the purpose of this analysis.

Candidate Explanatory Variables

This section discusses the variables that were considered for inclusion in the analysis based on prior expectations about what variables might be important. Some variables that would be expected to be important are, nevertheless, not included in the analysis for reasons discussed below.

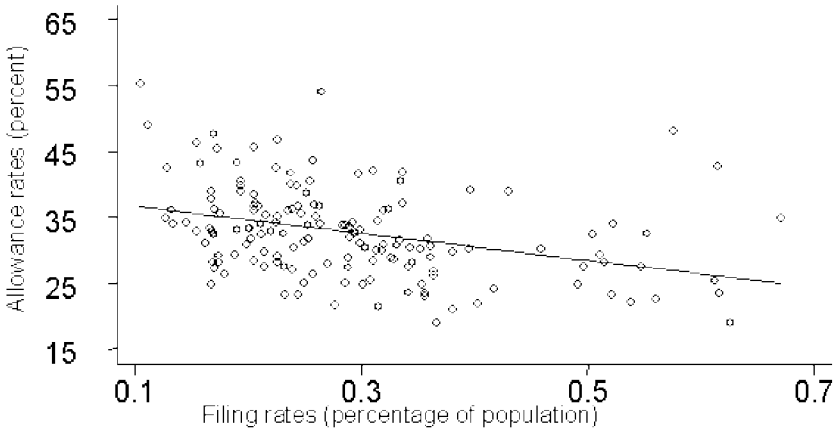
Filing Rates. Filing rates are the number of initial applications expressed as a percentage of the working-age population. Filing rates are negatively correlated with allowance rates; that is, the states with higher filing rates tend to have lower allowance rates, although not in all cases. Charts 2 and 3 plot data points for filing rates and allowance rates. The lines show the general relationship between the two.

It is not essential to include filing rates in equations explaining allowance rates because filing rates themselves are heavily influenced by economic and demographic factors. The influences on filing rates are shown by regression equations in Appendix B. Although these equations employ additional variables, they also use the same or similar economic and demographic variables as are used to predict allowance rates. Thus, the influence of filing rates on allowance rates is also captured by these other variables. Consequently, when predicting allowance rates, filing rates have only a marginal effect. Filing rates are rates on allowance rates is also captured by these other variables. Consequently, when predicting allowance rates, filing rates have only a marginal effect. Filing rates are, nevertheless, included in the equations explaining allowance rates because readers may be curious about their impact.

[4] It is important to note that while the degree of variation between states is less than it appears, that finding does not imply that inconsistency across adjudicators is not a concern. An earlier SSA study (Gallicchio and Bye 1980) found inconsistency in adjudicating sample cases.

[5] Concurrent applications are excluded from the DI and SSI equations.

Chart 3: SSI filing rates and allowance rates, 1997-1999



Economic Indicators. Although filing rates are influenced by economic factors, the economic indicators have an independent effect on allowance rates even when controlling for filing rates. According to economic theory, deteriorating economic conditions influence some people to switch from the labor market to disability insurance for their primary means of support as their probability of success in the labor market declines. Thus, poorer economic conditions are associated both with higher filing rates on an aggregate level and with an applicant pool containing people with less severe impairments. If the medical judgments are consistent, one would expect that more people in this group would be denied benefits, resulting in lower allowance rates. Thus, economic conditions affect both allowance rates and filing rates.

Different aspects of economic conditions can be captured by different variables. The available candidate variables are the unemployment rate, the labor force participation rate, the poverty rate, per capita income, and the proportion employed in retail or wholesale trade.[6]

Prevalence Rates. The proportions of DI and SSI beneficiaries in the population, known as prevalence rates, are related to the allowance rates for DI and SSI, as shown in Charts 4 and 5.

[6] Retail or wholesale trade is used as a cyclical indicator by Stapleton and others (1999).

Chart 4: DI prevalence rates and allowance rates, 1997-1999

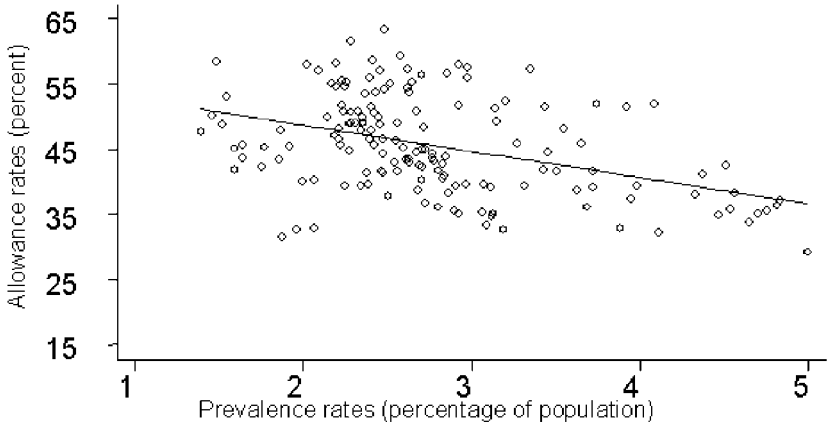
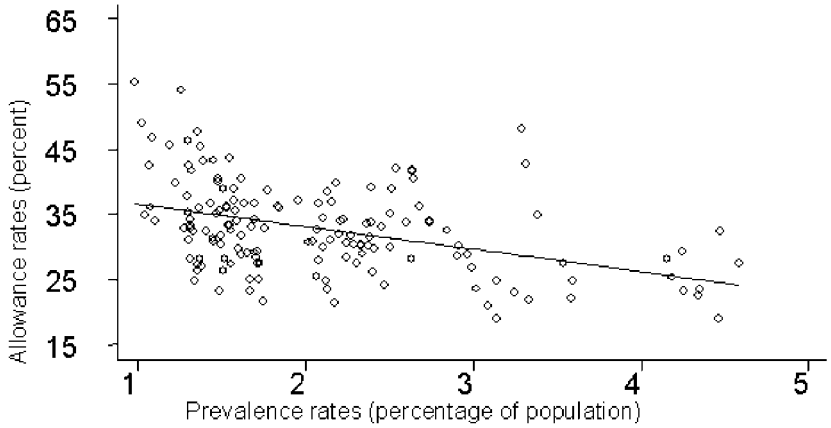


Chart 5: SSI prevalence rates and allowance rates, 1997-1999



Despite the apparent relationship, prevalence rates are not good explanatory variables for allowance rates when the other economic and demographic variables have been included. This is because both prevalence rates and allowance rates are influenced by economic and demographic factors. Also, the prevalence rate and the allowance rate are conceptually related measures. In an accounting sense, a prevalence rate is the sum of many years' allowances and rates of leaving the programs.

Demographic Indicators. Different demographic groups have different risks of disability. Demographic indicators include the median age, the proportion of the work force in ages most vulnerable to disability, the percentage of the work force that is male, and the percentage of the work force that has a high school education.

Health Indicators. Previous reports, including one by the Social Security Administration (1988), referred to average health status by state as a crucial but, at the time, unavailable piece of data. Such data are now available through surveys measuring self-reported health and disability levels. Indeed, these indicators are important variables in predicting filing rates but are not essential for predicting allowance rates. Other health-related variables that are useful for explaining allowance rates include the proportion of workers with health insurance and the rate of nonfatal work-related injuries and illness.

Predictive Equations. The sets of variables described above are used in a regression analysis to examine the variation in allowance rates. Regression analysis is a statistical tool that divides the variation in a variable into explained and unexplained portions based on a set of predictor variables. A subset of the candidate variables described above was used in each equation. A combination of variables was selected based on the proportion of variation that was explained and the relevance of the variables to economic theory. The equations that were selected are not uniquely superior by any one criterion but are among a number of equations showing similar results. More information about the equations is given in Appendix B and Table B–3.

The equation for allowance rates among DI applicants contains the following variables:

- the filing rate,
- the percentage of applicants claiming physical disabilities,
- the percentage of the work force with a high school education,
- the percentage of the work force that is male,
- the occupational illness and injury rate,
- the median age of the population,
- per capita disposable income,
- the poverty rate,
- variables capturing the percentage of employment in industries with high injury and illness rates, and
- a variable capturing differences between years in the data.

The equation for allowance rates among SSI applicants contains the following variables:

- the filing rate,
- the percentage of applicants claiming physical disabilities,
- the percentage of the work force with a high school education,
- the percentage of the work force that is male,
- the median age of the population,
- the unemployment rate,
- the percentage of employment in retail trade,
- per capita disposable income,
- the percentage of workers with health insurance,
- variables capturing the percentage of employment in industries with high injury and illness rates, and
- two variables capturing differences between years in the data.

The equations for SSI and DI are similar. Both equations include the filing rate, the percentage of applicants claiming physical disabilities, the demographic variables, and the variables representing the composition of employment by industry. The equation for concurrent applicants is similar to the ones for DI and SSI and resembles a combination of the two. It contains the following variables:

- the filing rate,
- the percentage of applicants claiming physical disabilities,
- the percentage of the work force with a high school education,
- the percentage of the work force that is male,
- the median age of the population,
- the percentage of workers with health insurance,
- the unemployment rate,
- the poverty rate,
- the percentage of employment in retail trade,
- variables capturing the percentage of employment in industries with high injury and illness rates, and
- a variable capturing differences between years in the data.

In assessing studies such as this one, there is frequently concern that some of the explanatory variables are internal to the claims evaluation process. For example, although filing rates may be expected to influence allowance rates, the inverse may also be true. Allowance rates may influence filing rates if the population in particularly lenient or stringent states changes their filing behavior. Thus, it is uncertain whether a variable measuring the filing rate captures differences in a state's population or differences in the application of the disability standards. Appendix B illustrates the impact of the variables to which this critique would most apply, presenting empirical analysis both including and excluding these variables. The primary result is that including variables such as the filing rate makes little difference in the explanatory power of the model equations and the overall conclusions of the report. However, the results for an individual state and the identification of an indi-

vidual state as a statistical outlier are affected by changing the variables of analysis.

The argument that certain variables measuring an aspect of the population may also capture variation in the claims evaluation process can potentially be extended to any of the explanatory variables. It is sometimes argued, for example, that adjudicators are more lenient during recessions. Following this logic, such variables as the unemployment rate or the poverty rate may capture an element of adjudicator judgment and may thus be internal to the claims evaluation process.[7] It is beyond the scope of this paper to address the issue of whether adjudicators are more lenient during recessions. Variables such as the unemployment rate and the poverty rate remain in the analysis. Retaining these variables would create a problem in the analysis only if adjudicator leniency varies with economic conditions in a way that creates differences across states. There is no problem if leniency varies only with national economic trends rather than with state-level economic conditions.

In summary, regression equations are used to divide the variation in allowance rates into the portion associated with external variables and a remaining portion. This remaining portion is the difference between the predicted allowance rates calculated from the equations and actual allowance rates. The remaining portion is examined in the next section. This remaining portion is of particular interest, since it represents the portion of variation that could contain the effects of inconsistency in evaluating claims.

Actual and Predicted Allowance Rates

A predicted allowance rate was calculated for each year of analysis for SSI, DI, and concurrent applicants and is presented in Appendix C. This allowance rate reflects the rate that is expected given the demographic characteristics, economic indicators, and other variables used in each equation. The difference between the predicted allowance rate and the actual allowance rate represents the unexplained portion of the variation in allowance rates.

States with the highest DI allowance rates in 1998 and their deviations are shown in the following tabulation:

State	Actual allowance rate	Predicted allowance rate	Actual less predicted	Actual less national mean
New Hampshire	56.4	57.0	-0.6	22.5
Nevada	56.9	47.1	9.8	23.0
Minnesota	57.1	58.8	-1.8	23.2
Vermont	57.4	54.0	3.4	23.5
Iowa	63.3	51.5	11.8	29.4

Although these states all have high actual allowance rates, only some of them differ substantially from the predicted rate. These differences from predicted allowance rates were examined from the perspective of their likely occurrence due solely to random variability and analyzed in terms of the standard deviation of the predictive model.[8] In Nevada, for example, there is a difference of 9.8 percentage points between the actual and predicted allowance rates for 1998. This difference exceeds two standard deviations (8.26 percentage points), so the Nevada allowance rate can be considered an outlier in 1998. The allowance rate for Iowa is also an outlier in 1998 whereas the other states listed here are not.[9]

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[7] Some studies have tried to quantify the feedback of disability policy on some economic measures. For an example of how disability policy can influence the unemployment rate, see Autor and Duggan (2001).

[8] The standard deviation is a measure of random variability of actual observations from the value predicted by the regression model. In general, due solely to random variability, an actual observation will be 1.96 standard deviations from the predicted value 5 percent of the time and will be one standard deviation away about 32 percent of the time. Actual observations that are far from the predicted value have a low probability of occurrence due solely to random variability. Observations that are more than 1.96 (roughly two) standard deviations away from the predicted value are considered to be outliers at the 5 percent level of statistical significance.

For the predictive allowance rate models for SSI, DI, and concurrent applicants, the standard deviations are respectively 3.90, 4.13, and 3.40 percentage points. Thus, for the SSI model, a state allowance rate that was more than 7.6 percentage points different from the predicted value would occur only about 5 percent of the time, due to random variability.

[9] These outliers are specific to a particular set of regression equations. Another set is shown in Appendix B, which produces a somewhat different set of outliers. Other variables that are not used here could explain a portion of the remaining variation.

Outlier Patterns

Three equations with 3 years of data for 50 states plus the District of Columbia provide 459 comparisons of actual and predicted allowance rates. Of these, 20 have differences from the predicted value in excess of two standard deviations, which is about 4.4 percent of observations; that is to be expected and is no cause for concern, in itself.

We now look for patterns of outliers in individual states. About half the outliers are a single occurrence for that state. In other words, the state is an outlier in 1 year of analysis but not in the other 2. A few states have more than one outlier. Out of a possible total of nine (three equations times 3 years), no state has more than four. The following tabulation shows states with more than one outlier:

State	Number of outliers	Direction of outliers
Nevada	4	+
Hawaii	3	+/–
Wyoming	2	–
Arizona	2	+

NOTE: (–) indicates that the actual rate is lower than predicted; (+) indicates that the actual rate is higher than predicted.

Other Patterns of Differences

No individual state is an outlier for all 3 years of analysis for any one set of applicants (SSI, DI, or concurrent applicants). In some states, however, there appears to be a pattern in the differences between actual and predicted allowance rates, even though the differences are less than two standard deviations. These patterns emerge when examining states that differ from their predicted value by at least one standard deviation.

The states that have differences that are greater than one standard deviation in all 3 years of analysis for one or more sets of applicants are listed in the tabulation below. A positive sign means the actual rate is higher than the predicted rate and vice versa. For example, the actual SSI allowance rate for Colorado is consistently lower than the predicted rate. The difference is 5.5, 6.5, and 11.0 percentage points for 1997, 1998, and 1999, respectively. Only the last figure is greater than two standard deviations, yet the available data consistently overpredict the SSI allowance rate for Colorado. States that differ from the predicted value by more than one standard deviation for one set of applicants for all 3 years of analysis are as follows:

SSI	DI	Concurrent applicants
Colorado –	Iowa +	Colorado –
Hawaii +/–	North Carolina +	Delaware +
	Wyoming –	Maryland –
		Utah –

NOTE: (–) indicates that the actual rate is lower than predicted; (+) indicates that the actual rate is higher than predicted.

Discussion

If all states were the same in terms of their population and economy, it might be appropriate to expect them to have allowance rates near the national allowance rate. In that case, a measure of the extent of inconsistency in the application of the national disability criteria would be the difference between state allowance rates and the national mean.

Given economic and demographic differences among states, however, it is not appropriate to expect allowance rates to be the same. The difference between a state's

actual and predicted allowance rates is a more appropriate measure of the extent to which the state might be applying national disability criteria differently than other states. Of course, this measure is dependent upon the quality of the available data as well as the choices made when constructing the regression equations. The measures are likely to capture the maximum difference that could be attributable to inconsistency since there are other aspects of the differences in caseloads that are not captured by the variables that were used.

Comparisons between actual and predicted allowance rates are given for each state and year in Appendix C. The differences are presented visually in Charts 6, 7, 8, and 9. The states are divided into categories, with darker shades representing categories with greater differences. Chart 6 shows the differences between allowance rates and the mean for DI. It shows a concentration of large differences in the South. By contrast, Chart 7 shows the differences between allowance rates and predicted allowance rates. When accounting for economic and demographic differences by using predicted allowance rates, the South no longer exhibits a concentration of large differences. Similarly, Charts 8 and 9 show the same information for SSI. For both SSI and DI, there are fewer states with the darkest shade representing differences greater than 10 percentage points when comparing allowance rates with predicted allowance rates. For example, 15 states fall into this category in Chart 6, while only 2 remain in Chart 7. The remaining states correspond in large part to the states that were described as statistical outliers in the previous section. Nevada, Wyoming, and Hawaii also appear in the category representing the largest differences for either DI or SSI.

Chart 6: Absolute difference between DI allowance rates and the mean, 1999

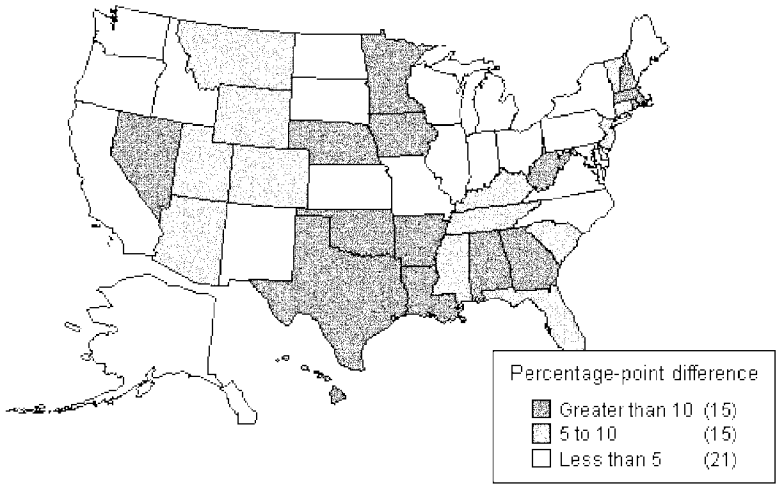


Chart 7: Absolute difference between DI allowance rates and predicted values, 1999

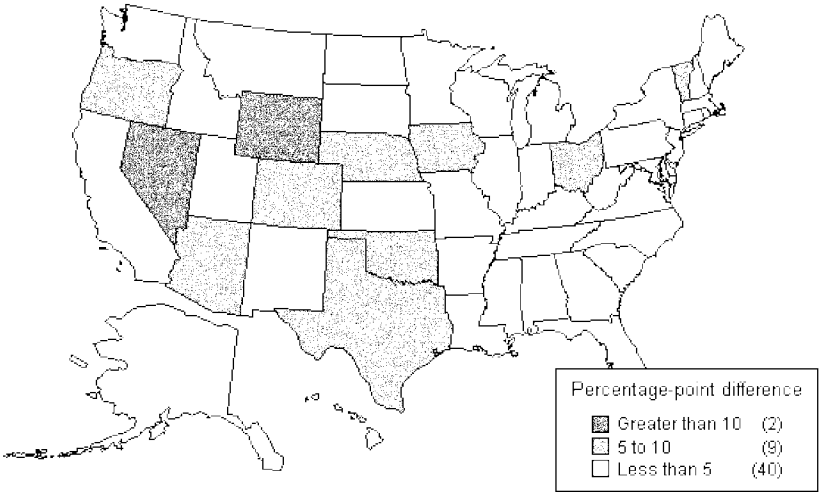
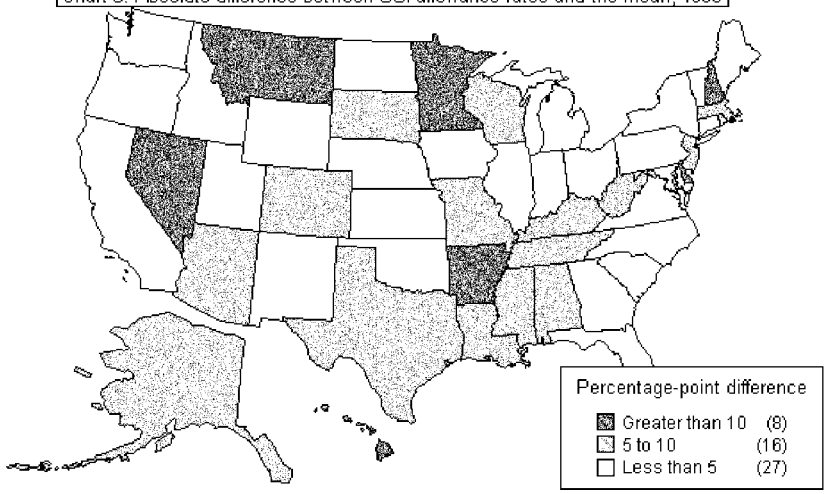
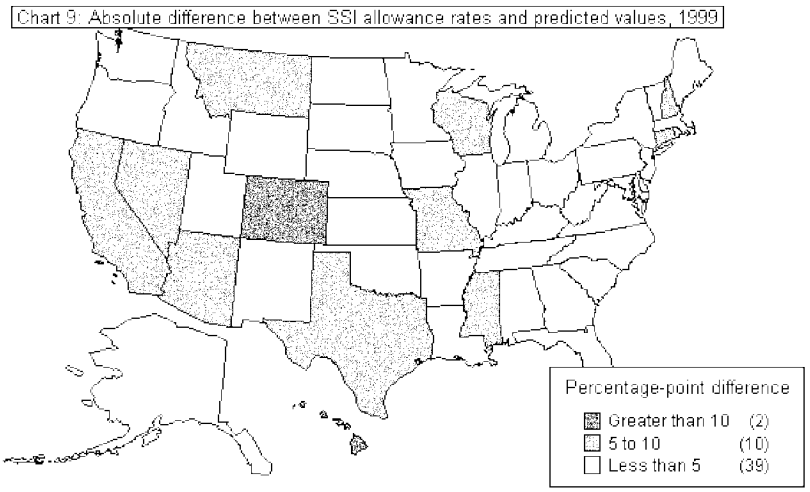


Chart 8: Absolute difference between SSI allowance rates and the mean, 1999





Because only a few states have large differences, a more representative picture of the magnitude of state variation emerges by examining differences for a typical state. The best way to show such differences is with the mean of the absolute differences. A typical state's DI allowance rate differs from the mean in either direction by 6.7 percentage points on average. It differs from the predicted rate by less than half that amount, however, only 3.1 percentage points. The reductions in allowance rate differences are not as notable for SSI or for concurrent applicants. These differences, in percentage points, are shown in the tabulation below, and more information is given in Appendix B.

	DI	SSI	Concurrent applicants
Difference from mean	6.7	5.6	4.5
Difference from predicted value	3.1	3.2	3.0

Conclusion

A major concern regarding the quality of disability adjudication has been the consistency of decisions. While no two cases are identical, SSA seeks to ensure that criteria are applied consistently and that like cases will have the same outcome. This study has focused on a subset of that issue—the variation in allowance rates across states. The difference between a typical state's allowance rate and its predicted allowance rate (for example, adjusted for economic, demographic, and health factors) is estimated to be about half the difference between a typical state's allowance rate and the national mean. Nonetheless, differences still exist, and a few states have DI or SSI allowance rates that are consistently above or below their predicted rates. By focusing on areas of real rather than apparent inconsistency, SSA can more effectively focus future examination of the issue of inconsistency.

Table A-1.
Allowance rate rankings, by state, 1997 (in percent)

State	Actual allowance rate	Predicted allowance rate
	DI allowance rates	
Lowest		
West Virginia	29.1	29.4
Alabama	32.2	35.7
Louisiana	32.5	27.3
Texas	32.9	33.2
Oklahoma	33.2	33.5
Highest		
Maine	51.9	46.5
Vermont	52.3	45.4
Minnesota	55.0	57.6
South Dakota	55.2	49.7
Iowa	57.2	50.8
	SSI allowance rates	
Lowest		
Arkansas	18.9	24.0
West Virginia	18.9	18.3
Missouri	21.4	24.8
Montana	21.6	22.4
Alabama	21.9	19.7
Highest		
Washington	36.2	33.5
Massachusetts	36.2	33.6
Delaware	40.5	35.5
New Hampshire	42.5	40.5
Minnesota	43.1	39.2
	Concurrent allowance rates	
Lowest		
West Virginia	16.6	19.5
Alabama	20.3	17.6
Oklahoma	20.4	21.7
Arkansas	20.5	24.7
New Mexico	20.7	24.9
Highest		
Washington	32.3	30.9
Nevada	33.4	32.4
New Hampshire	34.7	36.8
Delaware	38.4	32.9
Minnesota	38.7	35.9

Table A.2.
Allowance rate rankings, by state, 1998 (in percent)

State	Actual allowance rate	Predicted allowance rate
	DI allowance rates	
Lowest		
Texas	32.6	37.7
Alabama	32.7	39.6
Arkansas	33.7	33.3
Oklahoma	35.1	41.0
Louisiana	35.1	34.1
Highest		
New Hampshire	56.4	57.0
Nevada	56.9	47.1
Minnesota	57.1	58.8
Vermont	57.4	54.0
Iowa	63.3	51.5
	SSI allowance rates	
Lowest		
Arkansas	21.0	23.4
Alabama	23.0	26.4
Mississippi	23.1	23.1
West Virginia	23.4	25.1
Missouri	24.7	28.1
Highest		
District of Columbia	42.6	45.5
Delaware	43.2	40.4
Nevada	45.5	37.0
Minnesota	47.5	41.7
New Hampshire	49.0	47.7
	Concurrent allowance rates	
Lowest		
Arkansas	21.1	21.0
Alabama	21.4	24.4
Montana	21.6	25.5
West Virginia	22.7	25.1
Missouri	23.7	25.0
Highest		
Arizona	36.7	33.9
Delaware	39.3	34.5
Minnesota	39.9	37.5
Nevada	40.5	34.1
New Hampshire	42.5	41.0

Table A-3.
Allowance rate rankings, by state, 1999 (in percent)

State	Actual allowance rate	Predicted allowance rate
	DI allowance rates	
Lowest		
Texas	31.5	38.4
Arkansas	34.8	34.5
Louisiana	35.3	35.8
West Virginia	35.7	35.5
Alabama	36.0	38.6
Highest		
Nebraska	58.1	50.7
Hawaii	58.5	54.4
Iowa	58.6	52.9
New Hampshire	59.3	56.4
Nevada	61.5	48.5
	SSI allowance rates	
Lowest		
Montana	23.2	30.7
Arkansas	23.5	25.8
Alabama	24.7	25.3
West Virginia	25.3	24.7
Missouri	25.4	30.9
Highest		
Minnesota	46.1	41.7
Nevada	46.7	39.5
District of Columbia	48.1	46.9
Hawaii	54.0	43.3
New Hampshire	55.3	50.1
	Concurrent allowance rates	
Lowest		
Montana	20.9	27.3
Arkansas	21.9	24.7
West Virginia	21.9	25.9
Alabama	23.6	23.6
Texas	24.0	28.4
Highest		
Minnesota	41.1	37.0
District of Columbia	41.3	35.3
New Hampshire	43.1	39.8
Hawaii	44.2	36.5
Nevada	45.7	36.5

Appendix B: Technical Notes

This appendix presents the results of the regression analysis and discusses topics relevant to their interpretation. Interpretation of the influences on allowance rates is aided by discussion of the influences on filing rates; thus a discussion of filing behavior and an empirical analysis of filing rates is presented first. The analysis of allowance rates follows.

Filing Rates

Interpretation of the equations in this paper is aided by two assumptions about individual choice and the nature of disability. First, according to standard economic theory, people choose rationally between alternatives. In this case, the relevant alternatives are seeking work and filing for disability. It follows that the decision of those at the margin is affected by the return to each choice, in this case the size of the disability payment and the attainable wage from employment. Economic indicators serve as a proxy for the attainable wage, in aggregate.[10] Second, the analysis assumes that disability status itself is not affected by economic conditions, at least in the short run. Poverty and unemployment may affect the onset of disability through nutrition, safety, and other influences; however, this presumably happens gradually. Taken together, these two points portray filing behavior as more responsive to economic conditions and disability itself as less responsive. Therefore, when analyzing allowance rates, the effect of changing economic conditions is largely through changes in filing behavior and, it follows, in the composition of the applicant pool. The composition of the applicant pool is hypothesized to be one of the determining factors for aggregate allowance rates.

It follows that the interpretation of allowance rates rests in part on the interpretation of filing behavior. There is substantial empirical evidence that filing behavior changes in response to changing conditions. Leonard (1986) reviews the studies that examine whether changes in the DI benefit amounts affect the tendency to work. The consensus is that they do, although the magnitudes of the estimated effects vary widely. Conversely, various chapters in Rupp and Stapleton (1998) review and contribute to the literature on whether changes in the reward to work affect filing behavior. Again, the results point to substantial effects.

The results of this paper agree with most previous studies. Table B–1 shows some simple evidence about the influences on filing rates. The regressions describe filing rates for DI and SSI and include concurrent applicants. All the independent variables described in the text were made available for these regressions. Around 80 percent of the variation can be described with just a few variables, although different variables appear in the DI and SSI equations. Not surprisingly, the poverty rate appears only in the SSI equation since only that program has a means test. The DI equation uses the labor force participation rate. The negative sign is consistent with a discouraged worker effect; as labor force participation declines, DI filings increase. Demographic variables that capture some behavioral differences across age and educational attainment categories are also used, as are the self-reported health and disability averages from the Current Population Survey. Self-reported disability is strongly correlated with filing for DI. The industry variables that are included are also intended to measure an aspect of health. They capture the percentage of employment in various industries that have relatively high occupational injury and illness rates.

[10] Muller (1982) asserts that there is no additional relationship between aggregate economic indicators and individual outcomes beyond the incentives and constraints faced by the individual. The analysis uses economic indicators not to capture such an additional relationship but rather to proxy the composite of individual incentives in state-level equations.

Table B-1.
Regression estimates for filing rates

	DI	SSI
Percentage of workforce that is male	-0.01190 *	-0.02222 *
	(0.00439)	(0.00390)
Percentage of workforce completed high school	-0.00646 *	
	(0.00230)	
Median age of population	0.01571	
	(0.00807)	
Labor force participation rate	-0.00598	
	(0.00314)	
Poverty rate		0.03065 *
		(0.00274)
Disposable per capita income	-0.00555 *	
	(0.00276)	
Percentage of employment in construction	1.41154 *	
	(0.60388)	
Percentage of employment in agriculture		0.99811 *
		(0.27196)
Percentage of employment in three industries[a]	0.00532 *	
	(0.00185)	
Percentage who say their health is poor	0.03317 *	0.06733 *
	(0.00995)	(0.00641)
Percentage who say a disability prevents work	0.02396 *	
	(0.00677)	
Intercept	1.22678 *	1.18277 *
	(0.49366)	(0.20629)
R-square	0.7811	0.8488
Root MSE	0.07562	0.08083

NOTE: * = statistically significant at the 5 percent level. Blank cell = variable not included.

a. Agriculture, construction, and manufacturing.

Allowance Rates

Given these effects on filing rates, the pool of DI and SSI applicants changes with the economy and with demographic and health trends. The regression coefficients in the allowance rate equations are interpreted in this light. A procyclical economic indicator, for example, would be expected to have a positive sign. If per capita income falls during a recession, one would expect more marginal applicants to file for benefits. With the applicant pool diluted by these marginal filers, one would expect the allowance rate to be lower. Similarly, employment in retail trade is sometimes a good procyclical indicator of the low-wage labor market, but that is not borne out in these data. Countercyclical indicators such as the unemployment rate and the poverty rate are expected to have a negative sign.

The demographic variables have more straightforward interpretations. Disability is more prevalent at older ages and is associated with low educational achievement. The expected sign is thus positive for median age and negative for the percentage of the workforce that has completed high school. By contrast, there are no a priori expectations for the signs on the coefficients for percentage of the workforce that is male and percentage of applicants claiming a physical disability.

The remaining variables are related to health or occupational illness and injury. In general, one would expect health to be negatively associated with allowance rates. The variables representing employment in various industries capture employment in industries with high risk; agriculture, construction, manufacturing, and transportation are the one-digit Standard Industrial Classification codes with the highest rates of occupational illness and injury. These variables and the rate of occupational illness and injury itself are expected to have positive signs.

Tables B–2 and B–3 show two sets of regressions for the allowance rate equations. They differ primarily in terms of conceptual approach. The preliminary results shown in Table B–2 represent specifications reflecting a priori ideas about what variables should be included. By contrast, the final specifications in Table B–3 were chosen because they are among those that produce a good fit with just a few explanatory variables, within some limits. The fact that these two approaches produce quite similar results shows that the distinction between the two is not a crucial one. The regressions that are compatible with a *priori* ideas are close to the ones with a near-optimal fit. Similarly, the regressions with a near-optimal fit do not conflict with the a *priori* ideas. The results of the equations in Table B–3 were used for the analysis in the main text.

There were several *priori* considerations in the variable selection for Table B–2. Variables were selected corresponding to the nature of the SSI and DI programs. The poverty rate was employed as a predictor for the SSI equation corresponding to the SSI means test, whereas the unemployment rate has a rough relation to the work history requirement for DI eligibility.

Another consideration for Table B–2 was to exclude variables that contained possible endogeneity. As demonstrated above, most of the variation in filing rates corresponds to economic and demographic differences among states. However, it is possible that filing rates also respond to state differences in program administration. For example, states with more allowances could inspire additional people to file for benefits. It is also possible that some predictor variables are coincidentally correlated with adjudicative, administrative, or policy differences. Industry employment indicators, for example, could capture variations that correspond to such differences.[11] Because of this, the filing rate was excluded, and industry variables were included only in aggregated form in Table B–2.

[11] Variables indicating differences in state SSI supplements also fall into this category because state supplements are geographically concentrated.

Table B-2.
Preliminary regression estimates for allowance rates

	DI	SSI	Concurrent
Percentage of filings that are physical (not mental)	-0.89159 *	-0.69708 *	-0.57537 *
	(0.16965)	(0.09448)	(0.08411)
Percentage of workforce completed high school	0.28058 *	-0.25564	-0.24502 *
	(0.12211)	(0.13274)	(0.10804)
Percentage of workforce that is male	-0.00952	0.53465 *	0.43943 *
	(0.28680)	(0.26300)	(0.21561)
Median age of population	1.31307 *	0.19214	0.58091
	(0.50479)	(0.44618)	(0.37650)
Unemployment rate	-1.73610 *		-1.14526 *
	(0.49489)		(0.40036)
Poverty rate		-0.79708 *	0.53526 *
		(0.24673)	(0.21573)
Disposable per capita income	0.59555 *	0.83126 *	0.34152
	(0.21626)	(0.22507)	(0.18715)
Percentage of employment in retail trade	98.00137	1052.944 *	685.3652 *
	(388.051)	(353.679)	(294.989)
Percentage of employment in four industries[a]	-1.65705 *	-1.81342 *	-2.55525 *
	(0.64320)	(0.62828)	(0.53724)
Percentage of employment in four industries squared	0.02456	0.03271 *	0.04837 *
	(0.01409)	(0.01389)	(0.01162)
Nonfatal occupational injury and illness rate	1.70838 *	-0.27725	0.17414
	(0.48998)	(0.45141)	(0.37774)
Percentage of workers with health insurance	-0.07398	-0.58860 *	-0.52298 *
	(0.14250)	(0.14502)	(0.11904)
Year is 1997	-1.15364	-2.22333 *	-2.21296 *
	(1.05677)	(0.97163)	(0.82236)
Year is 1998	-1.15364	1.24468	-0.23165
	(1.05677)	(0.89852)	(0.73330)
Intercept	59.50867	112.2613 *	114.1173 *
	(37.3423)	(39.4099)	(33.6754)
R-square	0.6395	0.6485	0.6196
Root MSE	4.71286	4.27906	3.52434

NOTE: * = statistically significant at the 5 percent level. Blank cell = variable not included.
a. Agriculture, construction, manufacturing, and transportation.

Table B-3.
Final regression estimates for allowance rates

	DI	SSI	Concurrent
Filing rate (percent)	7.39238 (6.45851)	-18.6228 * (4.91978)	-0.02463 (4.15680)
Percentage of filings that are physical (not mental)	-1.20631 * (0.14799)	-0.81912 * (0.08777)	-0.72378 * (0.09362)
Percentage of workforce completed high school	-0.29838 * (0.14482)	-0.48208 * (0.12571)	-0.34014 * (0.11592)
Percentage of workforce that is male	0.47068 * (0.23106)	0.61456 * (0.23956)	0.40772 (0.22441)
Median age of population	1.29464 * (0.47063)	0.55066 * (0.41318)	0.81724 * (0.35558)
Unemployment rate		-1.31473 * (0.48700)	-1.87899 * (0.42773)
Poverty rate	-0.86872 * (0.19953)		-0.52263 * (0.20810)
Disposable per capita income	0.44462 * (0.20318)	0.91493 * (0.15657)	
Percentage of employment in retail trade		624.32458 (330.261)	180.07423 (264.372)
Percentage of employment in agriculture	122.2299 * (19.2863)		-86.0791 * (25.5015)
Percentage of employment in manufacturing			-82.0571 * (22.2779)
Percentage of employment in three industries [a]		-2.45914 * (0.45926)	
Percentage of employment in three industries squared		0.05121 * (0.01190)	
Percentage of employment in four industries [b]	-1.90453 * (0.58265)		-3.12508 * (0.43983)
Percentage of employment in four industries squared	0.02589 * (0.01291)		0.07648 * (0.01091)
Nonfatal occupational injury and illness rate	1.19549 * (0.42092)		
Percentage of workers with health insurance		-0.55047 * (0.13026)	-0.47814 * (0.11729)
Year is 1997	-2.61184 * (0.77473)	-1.62384 (0.90238)	2.08065 * (0.65209)
Year is 1998		-1.61386 * (0.81459)	
Intercept	120.7340 * (28.6846)	126.0639 * (32.7617)	150.8526 * (29.9893)
R-square	0.7213	0.7069	0.6457
Root MSE	4.12922	3.90767	3.40142

NOTE: * = statistically significant at the 5 percent level. Blank cell = variable not included.
a. Agriculture, construction, and manufacturing.
b. Agriculture, construction, manufacturing, and transportation.

The variables in Table B–3, by contrast, were selected with less regard for these issues. These equations were selected on the basis that they explain a large amount of the variation with relatively few variables. Variables were generally excluded if they did not contribute to the overall fit. The selection does not represent a complete disregard for endogeneity issues, however. The variables that are most likely to be endogenous have been excluded. For example, the average levels of self-reported health and disability were categorically excluded from these equations. The evidence indicates that the remaining variables are primarily exogenous but could be contaminated by some endogeneity.

The relevance of this issue is limited by the size of the differences between the two sets of equations. Given that the results are similar, including a few potentially marginally endogenous variables cannot undermine the results significantly. The results are similar in several ways. The signs and magnitudes of the coefficients that are included in both sets of equations are similar, with only one exception for both the sign (percentage completing high school) and the magnitude (percentage of employment in retail trade) in three equations. Also, the explained portion of the variation is similar, and the two sets of equations produce similar sets of outliers. The rank order correlations of the regression residuals are 0.83, 0.91, and 0.94 for DI, SSI, and concurrent applicants, respectively.

The outliers from the regressions in Table B–2 are shown in Charts 11 and 13. (To facilitate comparison, Charts 6 and 8 are repeated here as Charts 10 and 12.) In some cases, the two sets of equations produce different outliers. Thus, the results for any one particular state depend on the choice of specification; however, the overall results are independent of the choice of specification.

Chart 10: Absolute difference between DI allowance rates and the mean, 1999

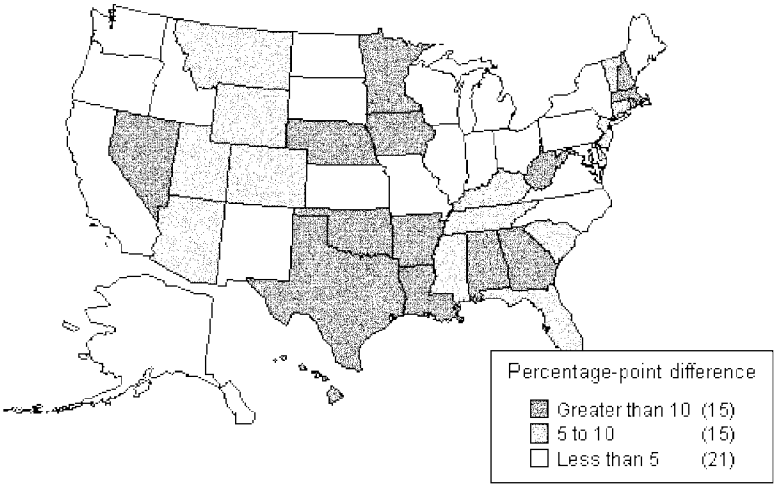


Chart 11: Absolute difference between DI allowance rates and predicted values, 1999

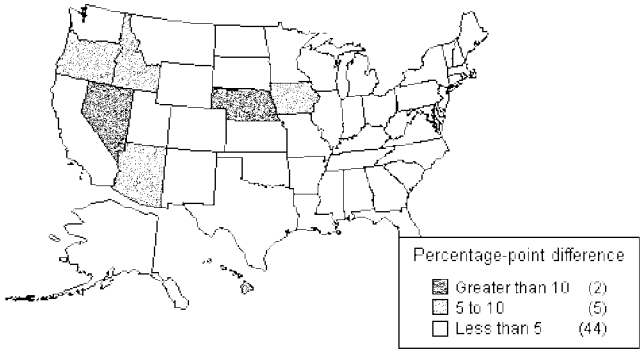


Chart 12: Absolute difference between SSI allowance rates and the mean, 1999

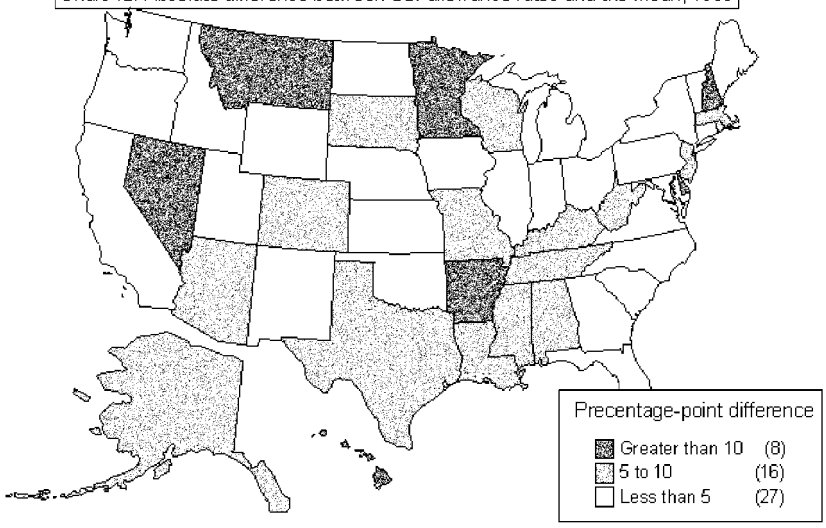
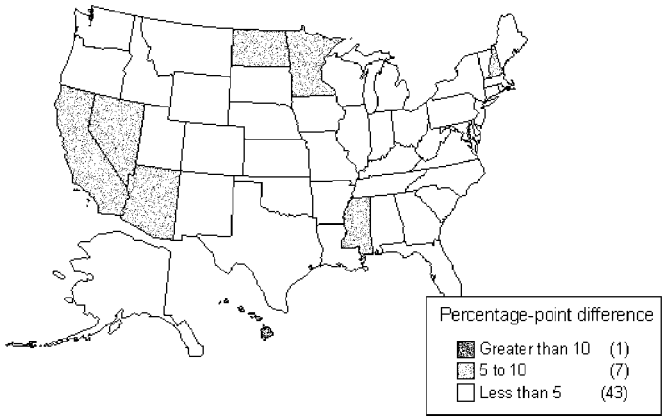


Chart 13: Absolute difference between SSI allowance rates and predicted values, 1999



The signs in Tables B–2 and B–3 are generally as expected. The coefficient on the percentage of filings that are physical is negative, indicating that physical claims have a lower allowance rate than mental claims. States with more males in the workforce and a higher median age have higher allowance rates. The coefficients for cyclical and health indicators have the signs discussed above. The coefficients for filing rates are negative but generally not statistically significant. It is not essential to include filing rates in the equation when the economic and health variables that are highly correlated with filing rates are included. Filing rates are included in Table B–3 because many readers may expect to see this effect.

Some other potential weaknesses of these equations should also be mentioned. The inclusion of filing rates illustrates that multicollinearity is present in these equations. Multicollinearity is a general problem not isolated to this variable. All

the variables are related to deprivation of either health or income, and health and income are also correlated. Thus, the accuracy of the standard errors and tests of significance is affected. The worst cases of multicollinearity have been removed. For example, self-reported disability has a correlation with the DI filing rate of around 0.8 and is thus excluded from the DI allowance rate equations.

The predictive value of the equations is not affected, however. The predictions are the product of the data and the regression coefficients summed for each observation. Table B–4 shows the quantile distributions of the difference between actual allowance rates and the predictions (based on Table B–3), as well as the distribution of the differences from the mean. It shows that the variation in allowance rates by states is lower when accounting for the variation due to economic and demographic factors.

Table B-4.
Distribution of differences from the mean and differences from predicted values, 1999 (percentage points)

	DI		SSI	
	Difference from mean	Difference from predicted value	Difference from mean	Difference from predicted value
Maximum	14.4	13.0	20.6	10.7
95th percentile	11.5	7.4	13.5	8.1
90th percentile	10.8	5.2	10.7	5.2
75th percentile	7.6	3.1	3.8	2.7
Median	0	-0.1	-1.3	0.2
25th percentile	-6.0	-1.9	-5.4	-2.4
10th percentile	-11.0	-3.9	-7.4	-5.1
5th percentile	-11.8	-6.6	-10.0	-7.6
Minimum	-15.6	-10.2	-11.5	-10.7
Mean	0	0.2	0	0
Mean of absolute value	6.7	3.1	5.6	3.2
Standard deviation	7.9	4.2	7.3	4.2

The figures give a sense of how much lower the variation is than when using the mean as a basis for comparison. The differences from the predicted rates have a smaller range and a more compressed distribution. At any point in the distribution (the 5th percentile, for example), the differences between allowance rates and predicted rates are smaller than the differences between allowance rates and the mean. This is a measure of the composite predictive power of the independent variables. Smaller average differences and a smaller variability of differences result from taking the independent variables into account. This result is robust with respect to choice of specification and the potential problems mentioned above.

It is also possible that using aggregate state-level data rather than individual-level data will introduce a bias in the estimates presented in this paper (see Robinson 1950 and Heckman 2001). Individuals within a state make the decision to apply for disability benefits, and individual adjudicators make a decision to award disability benefits. There is considerable within-state heterogeneity in economic and demographic factors. Aggregate-level data ignore this heterogeneity; thus the estimates presented in this paper may over—or underestimate the degree to which the variation is attributable to differences in environmental factors as opposed to the application of the SSA disability standard. Individual-level data may be examined in future work on this topic.

Appendix Table C-1.
Actual and predicted allowance rates for SSI, DI, and concurrent applicants, by state, 1997-1999

State and year	SSI allowance rate			DI allowance rate			Concurrent allowance rate		
	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)	Actual (percent)	Predicted (percent)	Deviation from predicted (Percentage points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)
Alabama									
1997	21.9	19.7	2.2	32.2	35.7	-3.5	20.3	17.6	2.6
1998	23.0	26.4	-3.5	32.7	39.6	-6.8	21.4	24.4	-3.0
1999	24.7	25.3	-0.5	36.0	38.6	-2.6	23.6	23.6	-0.1
Alaska									
1997	36.0	30.5	5.5	45.7	45.4	0.3	30.5	27.2	3.2
1998	41.7	39.8	1.9	48.7	51.0	-2.3	34.2	34.6	-0.4
1999	39.7	38.7	1.0	50.1	49.2	0.9	33.7	34.1	-0.4
Arizona									
1997	34.0	33.7	0.3	43.9	39.9	3.9	30.3	30.8	-0.5
1998	40.4	37.7	2.7	50.8	45.4	5.4	36.7	33.9	2.9
1999	43.7	35.6	8.1	54.9	46.6	8.3	39.1	34.1	4.9
Arkansas									
1997	18.9	24.0	-5.1	35.4	29.4	6.0	20.5	24.7	-4.3
1998	21.0	23.4	-2.4	33.7	33.3	0.4	21.1	21.0	0.1
1999	23.5	25.8	-2.3	34.8	34.5	0.3	21.9	24.7	-2.8
California									
1997	28.1	30.2	-2.1	40.3	42.4	-2.1	26.5	23.4	3.0
1998	38.8	30.9	7.9	45.3	46.0	-0.7	30.2	27.0	3.2
1999	39.0	32.6	6.4	47.9	47.1	0.8	32.9	28.2	4.7
Colorado									
1997	26.3	31.9	-5.5	39.6	42.8	-3.2	24.4	28.9	-4.5
1998	27.2	33.7	-6.5	39.2	45.6	-6.4	24.1	28.8	-4.7
1999	28.1	38.7	-11.0	39.4	45.5	-6.2	25.5	31.2	-5.8
Connecticut									
1997	26.4	30.1	-3.8	48.7	50.6	-1.8	24.6	27.0	-2.4
1998	31.7	39.5	-7.8	53.7	55.3	-1.6	30.2	35.2	-5.0
1999	35.0	40.1	-5.1	55.9	56.2	-0.3	35.2	36.1	-0.9
Delaware									
1997	40.5	35.5	5.0	51.7	49.5	2.2	38.4	32.9	5.5
1998	43.2	40.4	2.8	53.7	47.3	6.4	39.3	34.5	4.7
1999	45.4	43.6	1.8	54.1	49.6	4.5	41.0	32.4	8.6
District of Columbia									
1997	34.8	39.5	-4.6	48.9	50.6	-1.7	30.3	33.7	-3.4
1998	42.6	45.5	-2.9	54.7	54.8	-0.1	35.0	35.5	-0.5
1999	48.1	46.9	1.3	55.5	55.5	0.0	41.3	35.3	5.9

Continued

Appendix Table C-1.
Continued

State and year	SSI allowance rate			DI allowance rate			Concurrent allowance rate		
	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)
Florida									
1997	30.7	28.6	2.1	39.4	38.4	0.9	28.0	26.1	1.9
1998	37.1	31.6	5.4	39.5	41.0	-1.5	30.5	28.3	2.3
1999	36.0	32.6	3.4	40.9	41.6	-0.6	31.2	31.1	0.2
Georgia									
1997	27.4	24.7	2.7	34.7	34.0	0.7	23.8	22.5	1.4
1998	28.3	28.1	0.3	35.5	37.3	-1.8	24.6	24.2	0.3
1999	31.0	28.2	2.8	36.7	37.5	-0.8	26.5	25.7	0.7
Hawaii									
1997	27.0	31.5	-4.5	45.1	47.4	-2.3	22.3	29.8	-7.5
1998	42.4	36.1	6.3	53.0	50.0	3.0	32.6	29.8	2.8
1999	54.0	43.3	10.7	58.5	54.4	4.0	44.2	36.5	7.7
Idaho									
1997	31.6	30.0	1.6	41.3	43.9	-2.6	26.1	29.1	-3.0
1998	35.8	36.5	-0.7	46.5	48.0	-1.5	33.0	31.3	1.8
1999	36.6	35.4	1.3	50.8	46.1	4.7	33.7	32.0	1.7
Illinois									
1997	30.0	28.4	1.6	44.7	43.2	1.5	29.5	24.4	5.1
1998	34.4	34.1	0.3	46.6	47.3	-0.7	30.6	28.3	2.3
1999	32.6	35.2	-2.5	47.1	46.7	0.4	30.7	29.4	1.2
Indiana									
1997	29.6	31.1	-1.5	41.7	42.8	-1.2	27.3	27.9	-0.6
1998	34.0	36.8	-2.9	44.9	43.7	1.3	31.9	34.6	-2.7
1999	33.4	35.8	-2.4	43.5	45.3	-1.9	29.4	32.5	-3.0
Iowa									
1997	35.5	34.4	1.1	57.2	50.8	6.4	31.7	31.1	0.6
1998	39.0	37.8	1.2	63.3	51.5	11.8	34.7	32.1	2.7
1999	36.1	36.7	-0.5	58.6	52.9	5.8	31.1	32.4	-1.3
Kansas									
1997	23.2	28.8	-5.6	44.2	48.4	-4.2	20.7	25.0	-4.3
1998	30.7	30.2	0.5	53.5	48.2	5.3	26.9	26.0	0.8
1999	32.2	34.5	-2.2	48.9	49.7	-0.8	26.5	30.7	-4.2
Kentucky									
1997	27.4	28.5	-1.1	36.3	38.5	-2.2	24.2	25.6	-1.4
1998	32.3	33.1	-0.7	42.4	42.4	0.0	29.2	30.0	-0.8
1999	29.3	31.0	-1.8	37.9	41.3	-3.3	25.4	31.6	-6.2

Continued

Appendix Table C-1.
Continued

State and year	SSI allowance rate			DI allowance rate			Concurrent allowance rate		
	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)
Louisiana									
1997	22.0	22.3	-0.3	32.5	27.3	5.2	22.6	20.0	2.6
1998	24.7	26.7	-2.0	35.1	34.1	1.0	24.6	24.1	0.5
1999	27.4	29.7	-2.3	35.3	35.8	-0.6	26.1	27.2	-1.0
Maine									
1997	33.7	33.2	0.5	51.9	46.5	5.4	32.0	32.1	-0.1
1998	35.0	38.8	-3.8	51.4	50.9	0.5	31.0	33.3	-2.3
1999	33.7	36.7	-3.1	51.8	51.1	0.7	30.4	33.3	-2.9
Maryland									
1997	28.2	29.4	-1.3	40.0	46.5	-6.4	24.3	28.7	-4.4
1998	30.3	35.0	-4.7	43.3	49.0	-5.7	26.5	33.4	-6.9
1999	31.2	33.5	-2.3	45.3	48.5	-3.2	27.5	33.7	-6.2
Massachusetts									
1997	36.2	33.6	2.6	51.2	48.2	3.0	31.2	32.8	-1.6
1998	41.9	36.6	5.3	55.9	51.2	4.7	34.3	34.3	0.0
1999	40.4	39.2	1.2	57.9	54.7	3.2	34.7	37.2	-2.6
Michigan									
1997	30.4	28.3	2.1	40.5	44.3	-3.8	29.0	27.3	1.7
1998	31.7	30.8	0.9	40.2	46.3	-6.1	28.4	30.3	-1.8
1999	31.9	32.5	-0.6	43.4	47.3	-3.9	30.3	30.9	-0.6
Minnesota									
1997	43.1	39.2	3.9	55.0	57.6	-2.6	38.7	35.9	2.8
1998	47.5	41.7	5.8	57.1	58.8	-1.8	39.9	37.5	2.3
1999	46.1	41.7	4.5	57.9	58.4	-0.5	41.1	37.0	4.1
Mississippi									
1997	22.5	16.4	6.1	37.2	30.0	7.2	23.0	18.7	4.3
1998	23.1	23.1	0.0	38.2	39.5	-1.3	25.2	23.0	2.2
1999	28.1	20.1	8.1	41.1	38.0	3.1	27.6	21.9	5.7
Missouri									
1997	21.4	24.8	-3.3	41.8	40.7	1.1	21.0	24.0	-3.0
1998	24.7	28.1	-3.4	45.9	44.2	1.7	23.7	25.0	-1.3
1999	25.4	30.9	-5.4	49.3	45.7	3.6	25.5	27.5	-2.0
Montana									
1997	21.6	22.4	-0.8	39.1	38.5	0.6	21.7	21.1	0.6
1998	25.0	27.3	-2.3	39.5	42.6	-3.0	21.6	25.5	-3.9
1999	23.2	30.7	-7.5	39.4	43.1	-3.7	20.9	27.3	-6.3

Continuec

Appendix Table C-1.
Continued

State and year	SSI allowance rate			DI allowance rate			Concurrent allowance rate		
	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)
Nebraska									
1997	28.2	31.5	-3.3	50.5	53.7	-3.2	23.8	27.1	-3.3
1998	32.4	30.7	1.7	55.3	53.0	2.2	25.9	27.4	-1.6
1999	37.7	36.6	1.1	58.1	50.7	7.4	29.7	28.7	1.0
Nevada									
1997	35.2	33.9	1.3	48.3	48.3	0.0	33.4	32.4	1.1
1998	45.5	37.0	8.5	56.9	47.1	9.8	40.5	34.1	6.4
1999	46.7	39.5	7.2	61.5	48.5	13.0	45.7	36.5	9.1
New Hampshire									
1997	42.5	40.5	2.0	47.7	52.0	-4.2	34.6	36.8	-2.1
1998	49.0	47.7	1.3	56.4	57.0	-0.5	42.5	41.0	1.5
1999	55.3	50.1	5.2	59.3	56.4	2.9	43.1	39.8	3.3
New Jersey									
1997	33.2	35.9	-2.7	49.1	50.1	-1.0	31.1	30.5	0.6
1998	39.0	38.7	0.3	50.6	51.9	-1.2	33.7	32.9	0.8
1999	40.0	37.3	2.7	54.6	52.2	2.4	37.0	32.7	4.3
New Mexico									
1997	24.2	25.7	-1.5	38.2	38.7	-0.6	20.7	24.9	-4.2
1998	29.7	27.8	1.9	43.6	39.2	4.4	25.4	26.5	-1.0
1999	30.2	33.6	-3.4	42.5	40.3	2.2	26.7	31.0	-4.3
New York									
1997	30.1	31.7	-1.5	42.7	39.4	3.3	27.7	26.9	0.9
1998	32.5	34.2	-1.7	43.0	42.2	0.9	27.5	30.3	-2.8
1999	34.0	36.2	-2.2	44.9	42.7	2.2	28.7	31.4	-2.7
North Carolina									
1997	34.0	29.3	4.7	46.1	38.3	7.9	29.9	26.7	3.2
1998	36.9	31.5	5.4	45.8	41.0	4.8	30.3	27.4	2.9
1999	36.7	33.7	3.0	44.5	40.3	4.2	31.1	29.5	1.5
North Dakota									
1997	34.1	31.4	2.7	48.9	48.8	0.1	27.7	29.3	-1.5
1998	33.2	33.1	0.2	45.7	49.8	-4.2	30.8	27.9	2.9
1999	32.8	30.1	2.7	48.1	50.4	-2.2	31.0	29.6	1.5
Ohio									
1997	30.1	29.5	0.7	44.2	45.5	-1.3	29.3	24.9	4.4
1998	31.5	33.8	-2.4	44.5	48.8	-4.3	30.8	27.9	2.9
1999	30.4	34.7	-4.3	42.8	49.5	-6.6	29.0	29.1	0.0

Continued

Appendix Table C-1.
Continued

State and year	SSI allowance rate			DI allowance rate			Concurrent allowance rate		
	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percent-age points)
Oklahoma									
1997	23.4	23.0	0.5	33.2	33.5	-0.4	20.4	21.7	-1.3
1998	27.9	28.4	-0.5	35.1	41.0	-6.0	25.1	24.8	0.4
1999	30.7	30.2	0.5	36.1	41.8	-5.8	26.9	28.3	-1.4
Oregon									
1997	29.0	31.2	-2.1	45.1	43.9	1.2	25.5	26.8	-1.3
1998	32.5	33.9	-1.4	47.9	44.3	3.5	26.2	28.4	-2.2
1999	35.4	34.8	0.7	50.9	45.6	5.2	32.0	28.1	3.8
Pennsylvania									
1997	26.0	24.5	1.6	38.6	40.7	-2.1	24.6	24.6	0.0
1998	28.9	30.4	-1.5	41.5	44.8	-3.3	26.5	28.0	-1.5
1999	30.5	30.4	0.1	46.5	46.4	0.1	29.5	28.6	0.9
Rhode Island									
1997	33.6	31.5	2.1	48.1	49.8	-1.7	29.2	29.7	-0.4
1998	41.6	33.6	7.9	51.4	49.5	2.0	32.0	30.5	1.5
1999	41.9	40.4	1.5	57.1	59.0	-1.9	36.8	37.6	-0.8
South Carolina									
1997	29.9	29.3	0.7	39.3	39.8	-0.5	28.9	25.2	3.6
1998	33.1	33.6	-0.5	41.5	42.4	-0.9	30.8	27.0	3.7
1999	33.4	33.2	0.2	41.6	43.2	-1.6	30.3	28.8	1.5
South Dakota									
1997	27.5	20.8	6.6	55.2	49.7	5.5	26.4	23.8	2.6
1998	32.9	29.7	3.2	54.3	52.4	1.9	34.9	27.9	7.0
1999	27.4	23.6	3.8	49.0	50.3	-1.2	27.5	26.0	1.5
Tennessee									
1997	26.7	27.6	-0.9	37.4	41.3	-3.9	24.9	23.2	1.7
1998	28.8	32.8	-4.0	39.2	43.0	-3.8	27.0	28.1	-1.2
1999	28.6	30.9	-2.3	38.8	42.5	-3.7	27.0	28.7	-1.7
Texas									
1997	25.0	26.7	-1.7	32.9	33.2	-0.3	23.3	22.5	0.8
1998	28.7	32.0	-3.3	32.6	37.7	-5.1	25.2	27.5	-2.4
1999	27.3	32.5	-5.2	31.5	38.4	-6.9	24.0	28.4	-4.3
Utah									
1997	34.0	34.4	-0.5	42.2	42.5	-0.3	27.7	31.5	-3.8
1998	36.1	38.0	-1.9	43.5	45.5	-2.0	28.8	34.0	-5.1
1999	34.9	35.8	-0.9	41.7	43.4	-1.7	27.4	31.1	-3.7

Continued

Appendix Table C-1.
Continued

State and year	SSI allowance rate			DI allowance rate			Concurrent allowance rate		
	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)	Actual (percent)	Predicted (percent)	Deviation from predicted (percentage points)
Vermont									
1997	34.1	33.7	0.4	52.3	45.4	6.9	30.8	28.7	2.1
1998	39.7	40.4	-0.7	57.4	54.0	3.4	34.5	33.5	1.0
1999	38.5	37.0	1.5	56.6	51.4	5.2	35.1	35.7	-0.6
Virginia									
1997	33.0	34.7	-1.7	42.3	45.8	-3.5	29.2	27.8	1.3
1998	36.6	40.3	-3.7	42.8	48.1	-5.3	30.0	32.7	-2.7
1999	37.0	40.3	-3.3	45.5	47.4	-1.8	32.1	31.9	0.2
Washington									
1997	36.2	33.5	2.6	47.9	48.7	-0.8	32.3	30.9	1.4
1998	38.6	32.4	6.2	51.7	50.9	0.8	33.2	29.7	3.5
1999	36.6	35.7	0.9	49.9	50.4	-0.5	32.0	31.4	0.6
West Virginia									
1997	18.9	18.3	0.6	29.1	29.4	-0.3	16.6	19.5	-2.9
1998	23.4	25.1	-1.7	35.1	37.7	-2.6	22.7	25.1	-2.4
1999	25.3	24.7	0.6	35.7	35.5	0.1	21.9	25.9	-4.0
Wisconsin									
1997	28.3	29.8	-1.6	49.9	49.8	0.0	29.9	27.6	2.3
1998	29.3	35.6	-6.3	51.4	49.7	1.7	28.9	31.2	-2.3
1999	29.1	37.2	-8.1	49.9	50.0	-0.1	28.9	32.4	-3.5
Wyoming									
1997	24.7	31.3	-6.6	37.6	45.0	-7.4	25.5	25.1	0.4
1998	31.1	35.9	-4.8	41.5	50.3	-8.7	26.6	29.4	-2.7
1999	32.9	36.3	-3.3	41.4	51.6	-10.0	26.0	30.0	-4.0

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[Attachment is being retained in the Committee files.]

[Questions submitted by Mr. Matsui to Mr. Gerry, and his responses follow:]

Social Security Administration
Baltimore, Maryland 21235
July 24, 2002

The Honorable Robert Matsui
Ranking Member
Subcommittee on Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Matsui:

This is in response to your letter of June 27, 2002, which transmitted questions for the record from the June 11, 2002, hearing on the Social Security Disability Program's Challenges and Opportunities. Enclosed you will find the answer to your specific questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me.

1. What precisely are the consequences of filing a new application for benefits rather than appealing a denial—in terms of eligibility for past due benefits, maintaining insured status for Disability Insurance Benefits, and avoiding a denial on the second claim as a result of res judicata?

Answer:

The immediate consequence of filing a new application rather than appealing an unfavorable decision is the possible loss of past due benefits. A successful appeal would permit payment of retroactive benefits up to 12 months from the initial date of filing (starting with the date all eligibility factors are met). Conversely, a favorable determination on a subsequent application would have a maximum retroactivity to 12 months from the date the new claim is filed. Therefore, filing a new application instead of filing an appeal could reduce the amount of retroactive benefits payable. It is also possible for a person's insured status to expire between the retroactive period for the initial claim and the retroactive period for the new subsequent claim. Such cases could result in the person's new claim being denied for lack of insured status, while benefits would be payable upon a successful appeal of a medical denial.

There is no retroactivity for title XVI claims. Benefits are limited to the month after the date the claim is filed. A successful appeal would allow for benefits to be paid beginning the month after the month in which the initial claim was filed while filing a new subsequent application would limit benefits to the month after the month the new claim is filed. Thus, filing a new claim in lieu of filing an appeal could result in loss of benefits for the period between the month after the initial claim was filed to the month after the new subsequent claim was filed.

Administrative *res judicata* is a rule in civil law and an administrative policy. It means that SSA will not consider a claim again if it has already issued a determina-

tion based on the same facts, same issues, same parties, and same adjudicative period. In other words if a new application is filed with the same issue by the same party and no new facts or evidence is presented, the application may be denied on the basis of *res judicata*. (There are no appeal rights given in a notice determining *res judicata*.) However, if anything has changed, e.g., new evidence is presented, *res judicata* cannot be applied and a determination on the merits of the claim is made.

SSA's field office personnel explain the implications of res judicata to claimants who wish to file a new application rather than appealing a denied claim. However, if an individual insists on filing a new application, a new application must be taken. SSA has also revised its notices to inform claimants that filing a new application is not the same as requesting an appeal and that it could result in a loss of benefits.

2. What fraction of DI and SSI claimants have no treating physician, or no regular medical provider who can provide evidence of the claimant's impairment on thorough knowledge of the claimant's medical condition? Please provide separate estimates for DI and SSI claims.

Answer:

SSA has no records or data available on whether a claimant has a treating physician or regular medical provider.

3. Is the record ever closed during the agency's adjudicative process? Can the Federal courts consider new evidence? If so, under what circumstances?

Answer:

The record is never completely closed during the agency's entire adjudicative process. Claimants may submit additional evidence throughout the administrative review process including after the issuance of a decision by an administrative law judge (ALJ). However, the Appeals council considers new evidence submitted after the ALJ decision only if it is material and relates to the period on or before the date of the ALJ decision.

A district court may at any time order SSA to take or obtain additional evidence if the claimant shows that there is new and material evidence and there is good cause for failure to have the evidence entered into the record during the administrative reviews.

4. Does SSA have standards for the conduct of claimant representatives? What tools does it have available to sanction misconduct?

Answer:

SSA has standards for the conduct of claimant representatives that are published in our regulations at 20 CFR 404.1740. These standards include that:

The Representatives shall:

- Act with reasonable promptness to obtain the information and evidence that the claimant wants to submit in support of his or her claim, and forward it to SSA as soon as practicable;
- Assist the claimant in complying, as soon as practicable, with SSA's requests for information or evidence; and
- Conduct their dealings in a manner that furthers the efficient, fair and orderly conduct of the administrative decisionmaking process.

The Representatives shall not:

- With intent to defraud, willfully and knowingly deceive, mislead or threaten any claimant or beneficiary with respect to his or her rights under the Social Security Act;
- Knowingly charge or collect any fee not authorized by law;
- Knowingly make or present any false statement, representation, or claim about a material fact or law concerning a matter within SSA's jurisdiction;
- Unlawfully disclose any information SSA has furnished relating to the claim of another person.
- Through actions or omissions, unreasonably delay the processing of a claim.
- Attempt to influence the outcome of a decision by offering a loan, gift, entertainment or anything of value to a presiding official, SSA employee or witness; or
- Engage in actions or behavior prejudicial to the fair and orderly conduct of the administrative proceedings, including repeated absences or tardiness; willfully disrupting or obstructing hearings; and threatening or intimidating language, gestures or actions directed at a presiding official, SSA employee or witness.

If SSA finds that a representative has failed to comply with these standards, SSA may suspend the representative for a period of from one to 5 years, or disqualify the representative from further practice before the Agency. SSA will also notify an attorney's State bar disciplinary authority of any final decision finding that the attorney has violated SSA's law or regulations. Our rules for making decisions about violations of these standards are in our regulations at 20 CFR 404.1745–404.1795.

Other sanctions include:

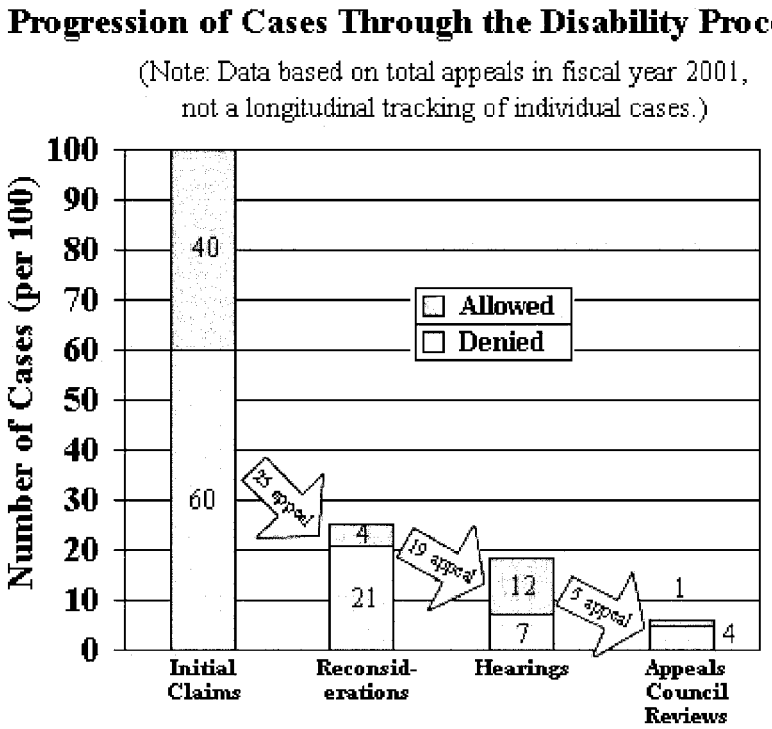
- If convicted of actions such as threatening a claimant or beneficiary with an intent to defraud or knowingly charging or collecting any fee in excess of the maximum fee prescribed by the Commissioner, a representative can be punished by a fine not to exceed $500 or imprisonment not to exceed 1 year or both.
- Civil and monetary penalties can be assessed against any representative who makes or causes to be made false statements or representations, or omissions of material fact, for use in determining the right to or amount of social security or supplemental security income benefits. The penalties may not be more than $5000 for each false statement or representation. The representative could also be subject to an assessment of not more than twice the amount of benefits or payments paid as a result of the statement or representation that was the basis for the penalty.
- A person can be excluded from representing claimants if they have been criminally convicted or determined to be civilly liable for committing fraud involving an SSA program. The minimum exclusion is for 5 years if the representative has no prior convictions, 10 years if the representative has one prior conviction, or permanently if the representative has two prior convictions.

The above listed sanctions are not mutually exclusive. Representatives may be subject to a misdemeanor prosecution, suspension or disqualification from practice before SSA and a civil monetary penalty. The components within SSA that have responsibility for each of the various types of sanctions coordinate their actions to ensure that all appropriate sanctions are imposed.

5. What fraction of cases are allowed at each level of the adjudicative process (at each level of agency decisionmaking and in the Federal court system)? What fraction of denied claimants appeal their denial at each level of the adjudicative process?

Answer:

The chart below, which is on SSA's website, represents aggregate data showing the number of claims, per 100, that are allowed at each step of the adjudicative process through the Appeals Council, and the number of appeals at each step. Most allowances are made at the initial level (40 out of 57 that are allowed overall for every 100 cases). Only about 5 cases out of 100 go beyond the administrative hearings level. At the Appeals Council level, 1 case in 5 is either allowed or remanded for further action. Less than 1 per 100 enter Federal court. The available data on Federal court decisions combines initial claims and continuing disability reviews, and shows that about 6% of the cases that reach Federal court are allowed, and 58% are remanded for further action.



6. What is the responsibility of personnel at SSA field offices, state Disability Determination Services and SSA Offices of Hearings and Appeals to develop the evidentiary record? What policies does SSA have in place to assure that each claimant's case if fully developed?

Answer:

Our policy for ensuring that each individual's case is fully developed is contained in our regulations (20 CFR 404.1512 and 416.912). Before we make a determination that the individual is not disabled, we are responsible for developing the individual's complete medical history for at least the 12-month period before the month in which application is filed, unless there is reason to believe that development of an earlier period is necessary or unless the individual says that his or her disability began less than 12 months earlier.

We make every reasonable effort to help the individual get medical reports from his or her own medical source(s). We request evidence from this medical source(s) and follow up with the medical source(s) if the evidence is not received.

When the evidence we receive from the individual's medical source(s) is inadequate for us to make a determination, we re-contact the medical source(s) for the evidence. If the information we need is not readily available, or we are unable to seek clarification from the medical source, we ask the individual to attend one or more consultative examinations at our expense (20 CFR 404.1517–404.1519n and 416.917–416.919n).

These policies are reflected in our operating instructions to field offices, disability determination services (DDSs), and hearings offices.

FIELD OFFICE (FO)

The FO is responsible for conducting the disability interview and completing the appropriate disability report forms for adults and children. The information that is provided by the individual to the FO during the disability interview is critical to the DDS's medical and vocational development.

Although the DDS is primarily responsible for developing the medical evidence, the FO will assist the individual in requesting medical evidence in special arrange-

ment situations, or when asked to do so by the DDS or other Social Security Administration component. In addition, FOs are authorized to request medical evidence from medical sources in certain Supplemental Security Income cases involving human immunodeficiency virus infection for which there is a strong likelihood that the individual will be found disabled. After initiating a request for medical evidence, the FO sends the file to the DDS. The DDS follows up on the request if necessary.

DDS

DDS examiners are responsible for making every reasonable effort to help the individual get medical reports from his or her medical sources. The examiners develop evidence, including diagnostic tests, from all sources identified by the individual or discovered during development who have treated or evaluated the individual for the alleged or documented impairment(s) during the applicable 12-month period. Examiners must also determine whether developing medical evidence outside of the 12-month period is necessary, based on the facts in each case.

The DDS is also responsible for obtaining additional vocational evidence not contained in the disability report form when it is necessary to determine the individual's ability do past relevant work or other work. The individual is the best source of information about past work. If this information is not sufficient, however, other possible sources of vocational information who the DDS may contact include family members, previous employers, authorized representatives, or anyone else with knowledge of the individual's work history.

HEARING OFFICE (HO)

The administrative law judge (ALJ) or HO staff under the ALJ's direction is responsible for reviewing the evidence before the hearing to determine whether it is sufficient for a full and fair inquiry in to the matters at issue. Development may be needed to:

- obtain additional medical evidence (for example, current evidence from a treating source);
- obtain technical or specialized medical opinion; or
- resolve conflicts or differences in the evidence.

If the ALJ or the HO staff decides that additional evidence is needed, the ALJ or the HO staff will undertake appropriate development before the hearing and arrange for any necessary witnesses to be present at the hearing.

If the ALJ obtains evidence after the hearing from a source other than the individual, the ALJ must provide the individual an opportunity to examine the evidence before entering it into the record as an exhibit.

APPEALS COUNCIL

The Appeals Council has responsibility for assessing whether the ALJ committed an error of law or abused his or her discretion with respect to the development of evidence or if the ALJ's decision is not supported by substantial evidence. If the Appeals Council determines that additional development of evidence is required, it typically remands the case to the ALJ to obtain the additional evidence.

Chairman SHAW. The next panel is made up of Robert E. Robertson, who is the Director of Education, Work force, and Income Security Issues, U.S. General Accounting Office (GAO); and Mr. Hal Daub, who is the Chairman of the Social Security Advisory Board (SSAB), a former Member of Congress, and former Member of this Subcommittee.

Welcome, gentlemen. We have your full testimony, which will be made a part of the record, and we invite both of you to proceed as you may see fit.

STATEMENT OF ROBERT E. ROBERTSON, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. ROBERTSON. Mr. Chairman, Members of the Subcommittee, thanks for the opportunity to discuss the challenges

that the Social Security Administration faces in improving its disability claims process. These challenges are among the more daunting that it faces. Before I go too much further, Mr. Chairman, I had better, as a concession to age, put on these glasses or who knows what words may come out of this mouth.

The written statement that I have submitted for the record basically addresses three areas: one being the results and the status of the five initiatives included in SSA's most recent plans to improve the disability process; another being SSA's current plans for developing an electronic disability system; and the last being the implications of SSA's past efforts for future success. What I would like to do this afternoon is concentrate pretty much on that last area because that gives a little bit more of a flavor of where do we go from here.

Mr. Chairman, here is the bottom line. In spite of the significant resources that SSA has dedicated to improving the disability process, the overall results have been disappointing. Now, before I go any further, I just want to emphasize something that I think is extremely important, which is simply that implementing the types of sweeping changes that were envisioned with the five initiatives I am going to be talking about is no easy task. This is because there are a number of factors that tend to make this very, very difficult, which include: the complexity of the disability decisionmaking process, the Agency's fragmented service delivery structure, and the challenge of overcoming an organization's natural resistance to change, inertia. However, the situation that led SSA to attempt these redesign initiatives—increasing disability workloads in the face of resource constraints—continue to exist today and will likely worsen as more baby boomers reach their disability-prone years.

This situation makes SSA's decisions on where to go with its disability initiatives crucial. In that regard, we agree with SSA that, because of its high cost and other practical barriers to implementation, the Agency should not continue to implement the disability claims manager initiative. If you will recall, that initiative basically combined the responsibilities normally divided between SSA's field representatives and the State DDS disability examiners under a newly created position of disability claims manager.

We also agree with SSA that the appeals council process improvement initiative which resulted in modest reductions in the processing times for certain types of appealed claims should continue, but with increased commitment to achieving the initiative's performance goals.

Deciding the future course of action on each of the remaining three initiatives, however, presents a challenge to SSA. For example, SSA continues to face decisions on how to proceed with the prototype initiative, which, as you know, experimented with significant changes to the initial claim process at State DDSs. Interim results were mixed, making decisions on the continuation of the initiative problematic. The SSA has recently decided to revise some features of the prototype in the near term and has also been considering some longer term improvements.

Of all the initiatives, we are most concerned about the failure of the hearing process improvement initiative to achieve its goals. Hearing office backlogs are fast approaching the crisis level of the

mid-1990's. We have recommended that the new Commissioner act quickly to implement short-term strategies to reduce the backlog and develop a longer term strategy for a more permanent solution to the problems. The new Commissioner has agreed with our recommendations and has announced her decisions on short-term actions. The challenge remains, however, to identify the longer term strategies to fix the longer term problems.

Similarly, we are concerned about SSA's lack of progress on its initiative for revamping its quality assurance system. Without such a system, it is difficult for SSA to ensure the integrity of its disability claims process. We are encouraged to see that the Commissioner has signaled the high priority she attaches to this effort by appointing a senior manager for quality who reports directly to her.

I would like to conclude my remarks by noting that, in addition to the changes that the Agency is currently considering to improve its claims processing, now may be the time for the Agency to step back and reassess the nature and scope of its basic approach. To date, SSA has focused, with limited success, on changing the steps and procedures of the process and on adjusting the duties of its decisionmakers. A new analysis of the fundamental issues impeding progress may help SSA identify areas for future action. This could include examining the fragmentation and structural problems associated with SSA's overall service delivery system.

Mr. Chairman, that concludes my statement, and I will be happy to answer questions at the appropriate time.

[The prepared statement of Mr. Robertson follows:]

Statement of Robert E. Robertson, Director, Education, Workforce, and Income Security Issues, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here to discuss the challenges the Social Security Administration (SSA) faces in improving the claims process for its two disability programs, Disability Insurance (DI) and Supplemental Security Income (SSI). Managing its disability caseloads and delivering high-quality service to the public in the form of fair, consistent, and timely eligibility decisions in the face of resource constraints has become one of SSA's most pressing management challenges.[1] In the last 7 years, SSA has spent more than $39 million in efforts to test and implement initiatives designed to improve the timeliness, accuracy, and consistency of its disability decisions and to make the process more efficient and easier for claimants to understand.[2] These efforts have included initiatives to improve the initial claims process as well as the process for handling appeals of denied claims. In addition, the agency has spent at least $71 million in an attempt to develop an automated disability claims process intended to provide support for its redesign efforts.

Today, I will discuss the results and status of five initiatives included in SSA's most recent plans to improve the process, SSA's current plans to develop an electronic disability system, and the implications of SSA's efforts to date for future success. The information I am providing is based primarily on recent work we did for this subcommittee.[3] (Also see Related GAO Products at the end of this statement.)

In summary, the results to date from SSA's redesign initiatives have been disappointing. The agency's two tests of initiatives to improve the initial claims process

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[1] U.S. General Accounting Office, Social Security Administration: Agency Must Position Itself Now to Meet Profound Challenges, GAO–02–289T (Washington, D.C.: May 2, 2002).

[2] The $39 million includes expenditures for contractor support, travel, transportation, equipment, supplies, services, and rent. It excludes personnel costs, most of which would have been incurred processing workloads regardless of redesign projects. it also excludes the costs incurred for all but one initiative tested or implemented after March 1999, when the commissioner ended disability process redesign as a separate agency project.

[3] U.S. General Accounting Office, Social Security Disability: Disappointing Results From SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Attention, GAO–02–322, (Washington, D.C.: Feb. 27, 2002) and GAO–02–289T.

produced some benefits; however, both initiatives as tested would have significantly raised costs, and one would have lengthened the wait for final decisions for many claimants. As a result, SSA is considering additional changes to one of these initiatives and has shelved the other. The situation is less favorable at the appeals level. One initiative to change the process for handling appealed claims in SSA's hearing offices has resulted in even slower case processing and larger backlogs of pending claims. A second initiative has reduced the processing times for a separate group of appealed claims, though far less than expected. Moreover, a cross-cutting initiative to update the agency's quality assurance program—a goal the agency has held since 1994—is still in the planning stage. Finally, SSA's plans to improve its disability claims process relied in part upon hoped for technological improvements; however, SSA failed to design and develop a new computer software application to automate the disability claims process after a 7-year effort.

On the basis of our recent work, we have recommended that SSA take immediate steps to reduce the backlog of appealed cases, develop a long-range strategy for a more permanent solution to the problems at its hearings offices, and develop an action plan for implementing a more comprehensive quality assurance program. SSA agreed with our recommendations and is beginning to make some short-term changes. In addition, SSA has recently announced plans to accelerate implementation of needed technological improvements. However, much work remains. The commissioner faces difficult decisions about long-term strategies for problems at the hearings offices and in the disability claims process as a whole. It will be important to both learn from the past and look to the future.

Background

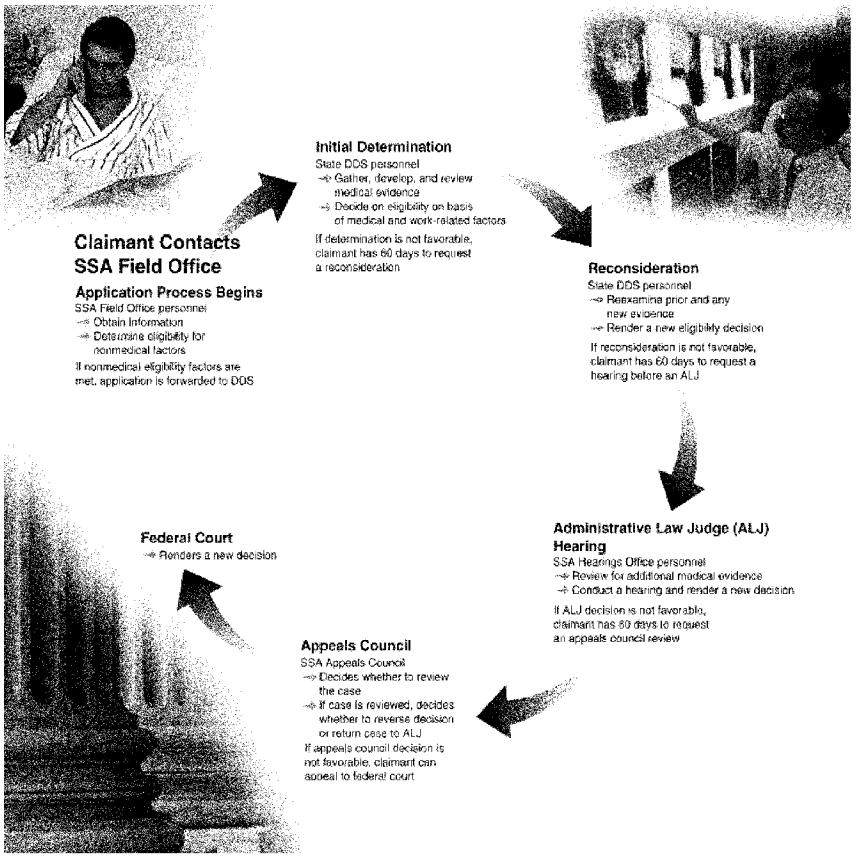
DI and SSI provide cash benefits to people with long-term disabilities. While the definition of disability and the process for determining disability are the same for both programs, the programs were initially designed to serve different populations.[4] The DI program, enacted in 1954, provides monthly cash benefits to disabled workers—and their dependents or survivors—whose employment history qualifies them for disability insurance. These benefits are financed through payroll taxes paid by workers and their employers and by the self-employed. In fiscal year 2001, more than 6 million individuals received more than $59 billion in DI benefits. SSI, on the other hand, was enacted in 1972 as an income assistance program for aged, blind, or disabled individuals whose income and resources fall below a certain threshold. SSI payments are financed from general tax revenues, and SSI beneficiaries are usually poorer than DI beneficiaries. In 2001, more than 6 million individuals received almost $28 billion in SSI benefits.[5]

The process to obtain SSA disability benefits is complex and fragmented; multiple organizations are involved in determining whether a claimant is eligible for benefits. As shown in figure 1, the current process consists of an initial decision and up to three levels of administrative appeals if the claimant is dissatisfied with SSA's decision. Each level of appeal involves multistep procedures for evidence collection, review, and decision-making.

[4] The Social Security Act defines disability for adults as an inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

[5] Some DI beneficiaries have incomes low enough to qualify them for SSI; therefore, they receive benefits from both programs.

Figure 1: SSA's Disability Claims Process



Source: SSA Documents

Generally, a claimant applies for disability benefits at one of SSA's 1,300 field offices across the country, where a claims representative determines whether the claimant meets financial and other program eligibility criteria. If the claimant meets these eligibility criteria, the claims representative forwards the claim to the state disability determination service (DDS).[6] DDS staff then obtain and review evidence about the claimant's impairment to determine whether the claimant is disabled. Once the claimant is notified of the medical decision, the claim is returned to the field office for payment processing or file retention. This completes the initial claims process.

Claimants who are initially denied benefits can ask to have the DDS reconsider its initial denial. If the decision at this reconsideration level remains unfavorable, the claimant can request a hearing before a federal administrative law judge (ALJ) at an SSA hearings office, and, if still dissatisfied, the claimant can request a review by SSA's Appeals Council. Upon exhausting these administrative remedies, the individual may file a complaint in federal district court.

Given its complexity, the disability claims process can be confusing, frustrating, and lengthy for claimants. Many individuals who appeal SSA's initial decision will wait a year or longer for a final decision on their benefit claims. In fact, the commissioner recently testified that claimants can wait as long as 1,153 days from initial

[6] DDSs are state agencies that contract with SSA to determine claimants' medical eligibility for DI and SSI disability benefits. Although federally funded and guided by SSA in their decision making, the DDSs hire their own staff and retain a degree of independence in how they manage their offices and conduct disability determinations.

claim through a decision from the Appeals Council. Moreover, the claims process can also result in inconsistent assessments of whether claimants are disabled; specifically, the DDS may deny a claim that is later allowed upon appeal. For example, in fiscal year 2000, about 40 percent of claimants denied at the initial level filed an appeal and about two-thirds were awarded benefits. This inconsistency calls into question the fairness, integrity and cost of SSA's disability decisions. Program rules, such as claimants' ability to submit additional evidence and to allege new impairments upon appeal, as well as the worsening of some claimants' conditions over time can explain only some but not all of the overturned cases. Other overturned cases may be due to inaccurate decisions by the DDSs or ALJs or to other unexplained factors.

In response to these problems, SSA first announced an ambitious plan to redesign the disability claims process in 1994, after a period of rapid growth in the number of people applying for disability benefits. This plan represented the agency's first effort to significantly revise its procedures for deciding disability claims since the DI program began in the 1950's. The overall purpose of the redesign was to

- ensure that decisions are made quickly,
- ensure that the disability claims process is efficient,
- award legitimate claims as early in the process as possible,
- ensure that the process is user friendly for claimants and those who assist them, and
- provide employees with a satisfying work environment.

The agency's initial plan entailed a massive effort to redesign the way it made disability decisions. SSA had high expectations for its redesign effort. Among other things, SSA planned to develop a streamlined decision-making and appeals process, more consistent guidance and training for decision makers at all levels of the process, and an improved process for reviewing the quality of eligibility decisions. In our reviews of SSA's efforts after 2 and 4 years, we found that the agency had accomplished little.[7] In some cases, the plans were too large and too complex to keep on track. In addition, the results of many of the initiatives that were tested fell far short of expectations. Moreover, the agency was not able to garner consistent stakeholder support and cooperation for its proposed changes.

In 1999, we recommended that SSA focus attention and resources on those initiatives that offer the greatest potential for achieving the most critical redesign objectives, such as quality assurance, computer support systems, and initiatives that improve consistency in decision-making. In addition, because implementing process changes can be even more difficult than testing them, we recommended that SSA develop a comprehensive and meaningful set of performance measures that help the agency assess and monitor the results of changes in the claims process on a timely basis. We have also pointed out the need for effective leadership and sustained management attention to maintain the momentum needed to effect change in such a large and complex system.

SSA's Recent Redesign Initiatives Have Had Limited Success

SSA's five most recent initiatives were designed to improve claims processing at all levels of the service delivery system. These redesign initiatives continue to experience only limited success. A brief summary of the status, results and problems experienced in implementing each of the five initiatives follows.

- The Disability Claim Manager initiative, which began in November 1997 and ended in June 2001, was designed to make the claims process more user friendly and efficient by eliminating steps resulting from numerous employees handling discrete parts of the claim. It did so by having one person—the disability claim manager—serve as the primary point of contact for claimants until initial decisions were made on their claims.[8] The managers assumed responsibilities normally divided between SSA's field office claims representatives and state DDS disability examiners. After an initial training phase, SSA tested the concept in 36 locations in 15 states from November 1999 through November 2000. While the test resulted in several benefits, such as improved customer and employee satisfaction and quicker claims processing, the in-

[7] U.S. General Accounting Office, SSA Disability Redesign: Focus Needed on Initiatives Most Crucial to Reducing Costs and Time, GAO/HEHS-97-20, (Washington, D.C.: Dec. 20, 1996); and SSA Disability Redesign: Actions Needed to Enhance Future Progress, GAO/HEHS-99-25, (Washington, D.C.: Mar. 12, 1999).

[8] The Disability Claim Manager initiative excluded claims for SSI children's benefits.

creased costs of the initiative and other concerns convinced SSA not to implement the initiative.

- The Prototype changed the way state DDSs process initial claims, with the goal of ensuring that legitimate claims are awarded as early in the process as possible. This initiative makes substantial changes to the way the DDS processes initial claims. The Prototype requires disability examiners to more thoroughly document and explain the basis for their decisions and it gives them greater decisional authority for certain claims. The Prototype also eliminates the DDS reconsideration step. It has been operating in 10 states since October 1999 with mixed results. Interim results show that the DDSs operating under the Prototype are awarding a higher percentage of claims at the initial decision level without compromising accuracy, and that claims are reaching hearing offices faster because the Prototype eliminates DDS reconsideration as the first level of appeal. However, interim results also indicate that more denied claimants would appeal to administrative law judges (ALJ) at hearings offices, which would increase both administrative and program costs (benefit payments) and lengthen the wait for final agency decisions for many claimants. As a result, SSA decided that the Prototype would not continue in its current form. In April, the commissioner announced her "short-term" decisions to revise certain features of the Prototype in order to reduce processing time while it continues to develop longer-term improvements. It remains to be seen whether these revisions will retain the positive results from the Prototype while also controlling administrative and program costs.
- The Hearings Process Improvement initiative is an effort to overhaul operations at hearings offices in order to reduce the time it takes to issue decisions on appealed claims. This was to be accomplished by increasing the level of analysis and screening done on a case before it is scheduled for a hearing with an ALJ; by reorganizing hearing office staff into small "processing groups" intended to enhance accountability and control in handling each claim; and by launching automated functions that would facilitate case monitoring. The initiative was implemented in phases without a test beginning in January 2000 and has been operating in all 138 hearings offices since November 2000.

  The initiative has not achieved its goals. In fact, decisions on appealed claims are taking longer to make, fewer decisions are being made, and the backlog of pending claims is growing and approaching crisis levels. The initiative's failure can be attributed primarily to SSA's decision to implement large-scale changes too quickly without resolving known problems. For example, problems with process delays, poorly timed and insufficient staff training, and the absence of the planned automated functions all surfaced during the first phase of implementation and were not resolved before the last two phases were implemented. Instead, the pace of implementation was accelerated when the decision was made to implement the second and third phases at the same time. Additional factors, such as a freeze on hiring ALJs and the ALJs' mixed support for the initiative, may also have contributed to the initiative's failure to achieve its intended results.

  SSA has recently made some decisions to implement changes that can be made relatively quickly in order to help reduce backlogs and to streamline the hearings process, and they are preparing to negotiate some of these changes with union officials before they can be implemented. These changes include creating a law clerk position and allowing ALJs to issue decisions from the bench immediately after a hearing and including them in the early screening of cases for on-the-record decisions. They also include decisions to enhance the use of technology in the hearings process, as well as other refinements.
- The Appeals Council Process Improvement initiative combined temporary staff support with permanent case processing changes in an effort to process cases faster and to reduce the backlog of pending cases. The initiative was implemented in fiscal year 2000 with somewhat positive results. The initiative has slightly reduced both case processing time and the backlog of pending cases, but the results fall significantly short of the initiative's goals. The temporary addition of outside staff to help process cases did not fulfill expectations, and automation problems and changes in policy which made cases with certain characteristics more difficult to resolve hindered the initiative's success. However, SSA officials believe that recent management actions to resolve these problems should enhance future progress. Improving or revamping its quality assurance system has been an agency goal since 1994, yet it has made very little progress in this area, in part because of disagreement among

stakeholders on how to accomplish this difficult objective. In March 2001, a contractor issued a report assessing SSA's existing quality assurance practices and recommended a significant overhaul to encompass a more comprehensive view of quality management. We agreed with this assessment and in our recent report to this subcommittee recommended that SSA develop an action plan for implementing a more comprehensive and sophisticated quality assurance program.[9] Since then, the commissioner has signaled the high priority she attaches to this effort by appointing to her staff a senior manager for quality who reports directly to her. The senior manager, in place since mid-April, is responsible for developing a proposal to establish a quality-oriented approach to all SSA business processes. The manager is currently assembling a team to carry out this challenging undertaking.

Problems Implementing Technological Improvements Have Long Undermined SSA's Redesign Efforts

SSA's slow progress in achieving technological improvements has contributed, at least in part, to SSA's lack of progress in achieving results from its redesign initiatives. As originally envisioned, SSA's plan to redesign its disability determination process was heavily dependent upon these improvements. The agency spent a number of years designing and developing a new computer software application to automate the disability claims process. However, SSA decided to discontinue the initiative in July 1999, after about 7 years, citing software performance problems and delays in developing the software.[10]

In August 2000, SSA issued a new management plan for the development of the agency's electronic disability system. SSA expects this effort to move the agency toward a totally paperless disability claims process. The strategy consists of several key components, including (1) an electronic claims intake process for the field offices, (2) enhanced state DDS claims processing systems, and (3) technology to support the Office of Hearing and Appeals' business processes. The components are to be linked to one another through the use of an electronic folder that is being designed to transmit data from one processing location to another and to serve as a data repository, storing documents that are keyed in, scanned, or faxed. SSA began piloting certain components of its electronic disability system in one state in May 2000 and has expanded this pilot test to one more state since then. According to agency officials, SSA has taken various steps to increase the functionality of the system; however, the agency still has a number of remaining issues to address. For example, SSA's system must comply with privacy and data protection standards required under the Health Information Portability and Accountability Act, and the agency will need to effectively integrate its existing legacy information systems with new technologies, including interactive Web-based applications.

SSA is optimistic that it will achieve a paperless disability claims process. The agency has taken several actions to ensure that its efforts support the agency's mission. For example, to better ensure that its business processes drive its information technology strategy, SSA has transferred management of the electronic disability strategy from the Office of Systems to the Office of Disability and Income Security Programs. In addition, SSA hired a contractor to independently evaluate the electronic disability strategy and recommend options for ensuring that the effort addresses all of the business and technical issues required to meet the agency's mission. More recently, the commissioner announced plans to accelerate implementation of the electronic folder.

Implications for Future Progress

In spite of the significant resources SSA has dedicated to improving the disability claims process since 1994, the overall results have been disappointing. We recognize that implementing sweeping changes such as those envisioned by these initiatives can be difficult to accomplish successfully, given the complexity of the decision-making process, the agency's fragmented service delivery structure, and the challenge of overcoming an organization's natural resistance to change. But the factors that led SSA to attempt the redesign—increasing disability workloads in the face of resource constraints—continue to exist today and will likely worsen when SSA experiences a surge in applications as more baby boomers reach their disability-prone years.

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[9] GAO–02–322.

[10] U.S. General Accounting Office, Social Security Administration: Update on Year 2000 and Other Key Information Technology Initiatives, GAO/T–AIMD–99–259, (Washington, D.C.: July 29, 1999).

Today, SSA management continues to face crucial decisions on its initiatives. We agree that SSA should not implement the Disability Claim Manager at this time, given its high costs and the other practical barriers to implementation at this time. We also agree that the Appeals Council Process Improvement initiative should continue, but with increased management focus and commitment to achieve the initiative's performance goals. Deciding the future course of action on each of the remaining three initiatives presents a challenge to SSA. For example, SSA continues to face decisions on how to proceed with the Prototype initiative. Although SSA has recently decided to revise some features of the Prototype in the near term, it also is considering long-term improvements. As such, SSA continues to face the challenge of ensuring that the revisions it makes retain the Prototype's most positive elements while also reducing its impact on costs.

We are most concerned about the failure of the Hearings Process Improvement initiative to achieve its goals. Hearing office backlogs are fast approaching the crisis levels of the mid-1990's. We have recommended that the new commissioner act quickly to implement short-term strategies to reduce the backlog and develop a long-term strategy for a more permanent solution to the backlog and efficiency problems at the Office of Hearings and Appeals. The new commissioner responded by announcing her decisions on short-term actions intended to reduce the backlogs, and the agency is preparing to negotiate with union officials on some of these planned changes. It is too early to tell if these decisions will have their intended effect, and the challenge to identify and implement a long-term strategy for a more permanent solution remains. It is especially crucial that the Office of Hearings and Appeals make significant headway in reducing its backlog quickly, as it faces in the next several months a potentially significant increase in Medicare appeals due to recent legislative changes in that program.

In addition to the changes the agency is currently considering, it may be time for the agency to step back and reassess the nature and scope of its basic approach. SSA has focused significant energy and resources over the past 7 years on changing the steps and procedures of the process and adjusting the duties of its decision makers, yet this approach has not been effective to date. A new analysis of the fundamental issues impeding progress may help SSA identify areas for future action. Experts, such as members of the Social Security Advisory Board, have raised concerns about certain systemic problems that can undermine the overall effectiveness of SSA's claims process, which in turn can also undermine the effectiveness of SSA's redesign efforts.[11] The Board found that SSA's fragmented disability administrative structure, created nearly 50 years ago, is ill-equipped to handle today's workload. Among other problems, it identified the lack of clarity in SSA's relationship with the states and an outdated hearing process fraught with tension and poor communication. As the new commissioner charts the agency's future course, she may need to consider measures to address these systemic problems as well.

Regardless of the choices the agency makes about which particular reform initiatives to pursue, SSA's experience over the past 7 years offers some important lessons. For example, sustained management oversight is critical, particularly in such a large agency and with such a complex process. We have found that perhaps the single most important element of successful management improvement initiatives is the demonstrated commitment of top leaders to change. In addition, some initiatives have not enjoyed stakeholder support or have contributed to poor morale in certain offices, both of which may undermine the chances for success. While it is probably not possible for the agency to fully please all of its stakeholders, it will be important for the agency to involve stakeholders in planning for change, where appropriate, and to communicate openly and often the need for change and the rationale for agency decisions. Moreover, because SSA has experienced problems implementing its process changes, the agency will need to continue to closely monitor the results of its decisions and watch for early signs of problems. An improved quality assurance process and a more comprehensive set of performance goals and measures can help the agency monitor its progress and hold different entities accountable for their part in implementing change and meeting agency goals. Thus, we are concerned about SSA's lack of progress in revamping its quality assurance system. Without

[11] See Social Security Advisory Board, How SSA's Disability Programs Can Be Improved (Washington, D.C.: SSAB, Aug. 1998); Selected Aspects of Disability Decision Making (Washington, D.C.: SSAB, Sept. 2001); and Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change (Washington, D.C.: SSAB, Jan. 2001). The Board is an independent, bipartisan Board created by the Congress and approved by the President and the Congress. Its purpose is to advise the President, the Congress, and the Commissioner of Social Security on matters related to SSA's programs.

such as system, it is difficult for SSA to ensure the integrity of its disability claims process.

Finally, because SSA has had mixed success in implementing information technology initiatives in the past, it is vital that the agency look back at its past problems and take the necessary steps to make sure its electronic disability system provides the needed supports to the disability claims process. It is imperative that the agency effectively identify, track, and manage the costs, benefits, schedule, and risks associated with the system's full development and implementation. Moreover, SSA must ensure that it has the right mix of skills and capabilities to support this initiative and that desired end results are achieved.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the subcommittee may have.

Contacts and Acknowledgements

For further information regarding this testimony, please contact Robert E. Robertson, Director, or Kay E. Brown, Assistant Director, Education, Workforce, and Income Security at (202) 512–7215. Ellen Habenicht and Angela Miles made key contributions to this testimony on the status of the five initiatives, and Valerie Melvin was the key contributor to the section on information technology.

Related GAO Products

Social Security Administration: Agency Must Position Itself Now to Meet Profound Challenges. GAO–02–289T. Washington, D.C.: May 2, 2002.

Social Security Disability: Disappointing Results From SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Attention. GAO–02–322. Washington, D.C.: February 27, 2002.

Information Technology Management: Social Security Administration Practices Can Be Improved. GAO–01–961. Washington, D.C.: August 21, 2001.

Social Security Disability: SSA Has Had Mixed Success in Efforts to Improve Caseload Management. GAO/T–HEHS–00–22. Washington, D.C.: October 21, 1999.

Social Security Administration: Update on Year 2000 and Other Key Information Technology Initiatives. GAO/T–AIMD–99–259. Washington, D.C.: July 29, 1999.

SSA Disability Redesign: Actions Needed to Enhance Future Progress. GAO/HEHS/99–25. Washington, D.C.: March 12, 1999.

Social Security Disability: SSA Must Hold Itself Accountable for Continued Improvement in Decision-making. GAO/HEHS–97–102 Washington, D.C.: August 12, 1997.

SSA Disability Redesign: Focus Needed on Initiatives Most Crucial to Reducing Costs and Time. GAO/HEHS–97–20. Washington, D.C.: December 20, 1996.

Chairman SHAW. Thank you. Mr. Daub?

STATEMENT OF THE HON. HAL DAUB, CHAIRMAN, SOCIAL SECURITY ADVISORY BOARD, AND FORMER MEMBER OF CONGRESS

Mr. DAUB. Mr. Chairman, nice to see you this afternoon. Mr. Matsui, thanks on behalf of the Social Security Advisory Board for continuing this very vital series of hearings on Social Security's disability programs. They have serious problems today calling for fundamental changes. The hearings that you are holding are an important step toward the reform that needs to be in a timely and appropriate way.

Over the past 5 years, the Board has spent a great deal of time studying the Social Security Administration's disability programs on a nonpartisan basis. The Board has consulted with Agency leaders and with hundreds of managers and employees in the field. The Board has examined data and listened to the views of many individuals and organizations in the disability community. I have a longstanding personal interest in this subject as well, both as a former Member of this Committee and Subcommittee as well as before that, well before that, an attorney representing claimants.

In my oral testimony today, I would like to focus on the issue of the quality of the decisions that are being made in the initial disability determination process. In my written statement, which I ask to be included in the record, I take a broader look at the process.

There are two items in the written statement which I would like to draw to your attention, and they allude a bit to what Mr. Ryan was saying in his questions a moment ago. They deal with the hearing level, but they have a definite impact on the initial process. The first is having the Agency represented at the hearing. Doing so would help clarify issues, provide useful feedback, which is sorely missing from the process, at the initial decision level. The second point is that it is time for serious consideration to be given to closing the record. Leaving the record open means that the case can change at each level of appeal, making it difficult for decisions at higher levels to improve the quality of the process at lower levels.

Organizations get what they measure, and the emphasis in the Social Security Administration disability programs has been on quantity and processing times. Last January, the Board issued a document entitled "Disability Decision Making: Data and Materials." The document presents extensive data indicating striking differences in outcomes over time from State to State and between levels of adjudication. I want to make it clear that these problems in the disability program are systemic. They are not the result of deficiencies in employee performance. In its visits to field offices, State agencies, and Offices of Hearings and Appeals around the country, the Board has met people on the front lines of the disability process. We have found that they work hard and care deeply. All parts of the process are under stress, severe stress.

The quality of the decisionmaking is a longstanding issue, but several things have happened since the mid-eighties to make the disability determination process even more subjective and more complex than previously. Over the same period of time, workloads have grown substantially, and resources have been constrained. The result is that disability policy and administrative capacity are now seriously out of alignment. There are also wide variances among States in areas that can have a major impact on the quality of work that is performed, such as staff salaries, hiring requirements, training, and quality assurance procedures. Turnover rates are high in some States. The result of lack of experience is especially troubling as SSA moves toward increased use of a single decisionmaker, examiners who can handle cases without much input from a physician.

So, I have three recommendations that I would like to make in my brief time remaining. They are crucial to improving the quality of decision making. I want to stress them.

The Social Security Administration's current quality assurance system relies on end-of-line reviews to check and report on the quality of the completed case. The Board believes that quality is something that should be built into the disability determination process, not something that should be graded at the end of the process. So, to make quality a central objective of the disability programs, the Administration needs to develop and implement a new quality management system that would apply to all levels of adju-

dication. Quality management is a process of ensuring that the right things are done well the first time at every level of the process.

Second, SSA should develop a single presentation of policy to guide all adjudicators. It should also enhance the medical and vocational expertise of its staff.

Last, there is a gap between what is required by policy and the administrative capacity to carry it out. The gap is large now and will grow as baby boomers age and become more likely to become disabled. The Administration's actuaries estimate that by 2012 the number of cases to be decided will grow by 9 percent, to 2.6 million per year. This growth threatens to overwhelm a policy and an administrative infrastructure that is already inadequate to meet the needs of the public. Bridging the gap between policy and administrative feasibility will require introducing changes in policy, institutional arrangements, funding, or most probably in all three facets of this interwoven process.

I have listed at the end of my statement, Mr. Chairman, the five publications that our Board has presented about SSA's disability program: an August 1998 on how SSA's disability programs can be improved; a September 2000 report on selected aspects of disability decisionmaking; a January 2001 report on disability decisionmaking; and the most recent one that was the subject of the hearings a couple of weeks ago, Mr. Chairman—a January 2000 report on charting the future of Social Security's disability programs and the need for fundamental change.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Daub follows:]

Statement of the Hon. Hal Daub, Chairman, Social Security Advisory Board, and former Member of Congress

Reforming the Disability Insurance and Supplemental Security Income Disability Program[1]

The Nation's two primary disability programs—Social Security Disability Insurance (DI) and Supplemental Security Income (SSI) disability—are a vital but complex part of our social insurance and welfare systems, requiring vigilant attention in order to keep their policy and administrative structures sound and up to date.

These programs have grown steadily over the years to the point where in fiscal year 2002 they are expected to account for nearly $100 billion in Federal spending, or nearly five percent of the Federal budget. They require a growing portion of the time and attention of Social Security Administration employees at all levels. In 2002, about two-thirds of the agency's $7.7 billion administrative budget, $5.2 billion, is expected to be spent on disability work.

As the baby boomers reach the age of increased likelihood of disability the growth in these programs will accelerate. The Social Security Administration's actuaries project that between now and 2012 the number of DI beneficiaries will increase by 37 percent. SSI beneficiaries are projected to increase by 15 percent. The projected growth in the number of disability claimants threatens to overwhelm a policy and administrative infrastructure that is already inadequate to meet the needs of the public.

In recent decades, disability policy has come to resemble a mosaic, pieced together in response to court decisions and other external pressures, rather than the result of a well thought out concept of how the programs should be operating.

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[1] For more information on this subject, see the Advisory Board's January 2001 reports, *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change and Disability Decision Making: Data and Materials, as well as How SSA's Disability Programs Can Be Improved,* issued in August 1998. The reports are available at the Board's website, www.ssab.gov.

Compounding the problem, the disability administrative structure, now nearly a half century old, has been unable to keep pace with the increasing demands that have been imposed upon it. Policy and administrative capacity are dramatically out of alignment in the sense that new and binding rules of adjudication frequently cannot be implemented in a reasonable manner, particularly in view of the resources that are currently available.

It has been more than two decades since either the Congress or the Administration has reviewed in a comprehensive manner the question of whether the administrative structure established nearly five decades ago should be strengthened or changed. Numerous regulations and rulings affecting how disability decisions are made have been implemented without review by policy makers. The question of whether the definition of disability for adults should be changed has not undergone close examination for more than 30 years.

Major Issues Need to Be Addressed

Are disability decisions consistent and fair?

There are substantial data that show striking differences in decisional outcomes over time, among State agencies, and between levels of adjudication, raising the question of whether disability determinations are being made in a uniform and consistent manner.

For example, in 2001 the percentage of disability applicants whose claims were allowed by a State agency ranged from a high of 66 percent in New Hampshire to a low of 27 percent in Tennessee. As another example, a strikingly large percentage of cases denied by State agencies are reversed upon appeal to an administrative law judge hearing, and, at least at the State level, there appears to be no correlation between high State agency allowance rates and low ALJ reversals of these decisions. Both State agency and hearing level allowance rates have varied substantially over the years. The hearing level allowance rates (allowances as a percent of all decisions) for both DI and SSI disability stood at 58 percent in 1985, grew to nearly 72 percent in 1995, fell to 63 percent in 1998, and grew again to 66 percent in 2000 and 68 percent in 2001.

For many years both Members of Congress and others who have studied the disability programs have expressed concern about variations such as these. Analysts have identified many factors which they believe contribute to inconsistencies in outcomes, such as economic and demographic differences among regions of the country, court decisions, the fact that the claimant has no opportunity to meet with the decision maker until the face-to-face hearing at the ALJ level, and that the record remains open throughout the appeals process.

But many who are knowledgeable about the programs—including disability examiners in the State agencies as well as administrative law judges—have long believed that there are also reasons relating to program policy, procedures, and structure that are responsible for some if not many of these inconsistencies. In a recent study of SSA's quality assurance processes, the Lewin Group found that although the information on current consistency of the disability programs is somewhat mixed and not as definitive as one would like, "The evidence of inconsistencies is compelling * * *."[2]

Despite the long-standing concern about consistency, the agency has no effective mechanism to provide the information needed to understand the degree to which the programs' own policies and procedures—including their uneven implementation—are causing inconsistent outcomes in different regions of the country and different parts of the disability system. As long as variations in decision making remain unexplained, the integrity and the fairness of the disability programs are open to question. These programs are too valuable and important to the American public for this issue not to be addressed.

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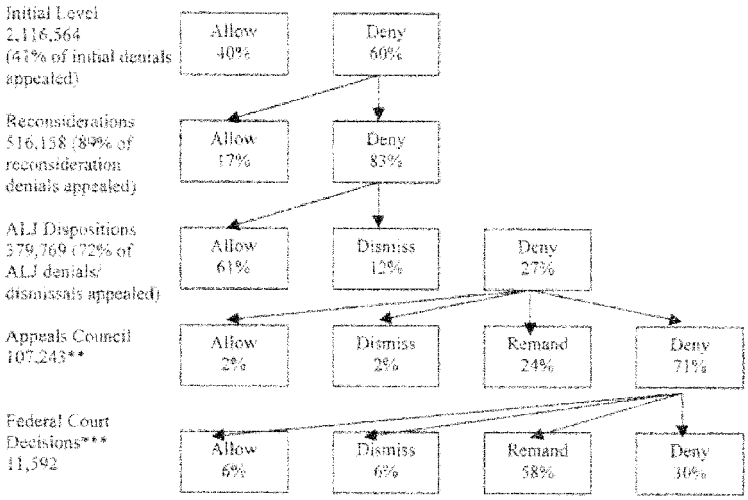
[2] The Lewin Group, Inc. and Pugh Ettinger McCarthy Associates, L.L.C., *Evaluation of SSA's Disability Quality Assurance (QA) Processes and Development of QA Options That Will Support The Long-Term Management of The Disability Program,* June 21, 2000, p. C–24.

DI and SSI Disability Determinations and Appeals*



Percentage of Allowances

Initial Decisions	72.5
Reconsiderations	7.5
Hearing Level	19.8
Appeals Council	.2

Note: Due to rounding, data may not always total 100%

** Data relate to workloads processed (but not necessarily received) in fiscal year 2001, i.e., the cases processed at each adjudicative level may include cases received at 1 or more of the lower adjudicative levels prior to fiscal year 2001. Not all denials are appealed to the next level of review.*

*** Includes ALJ decisions not appealed further by the claimant but reviewed by the Appeals Council on "own motion" authority.*

**** Remands to ALJs by the Appeals Council and courts result in allowances in about 60 percent of the cases. Court decisions include decisions on continuing disability reviews. Figures for other levels are for claims only.*

Is disability policy being developed coherently and in accord with the intent of the Congress?

Although Congress has not changed the law defining disability for adults for more than 30 years, the determination of what constitutes disability has changed in fundamental ways. For example, there has been a gradual but persistent trend away from decisions based on the medical listings to decisions that increasingly involve assessment of function. Today, many more decisions involve mental impairments than was the case in the past. In addition, changes in agency rules mean that now all adjudicators must adhere to more complex and intricate requirements regarding such matters as determining the weight that should be given to the opinion of a treating source and making a finding as to the credibility of claimants' statements about the effect of pain and other symptoms on their ability to function. All of these changes have made decision making more subjective and difficult.

These policy changes have been made through changes in regulations and rulings. A number of the most significant changes have grown out of court decisions, many of which have not been appealed. None of them have been reviewed by the Congress as to their effect on decision making or whether they are operationally sustainable for a program that must process massive numbers of cases.

Can today's administrative structure support future program needs?

When the DI program was enacted in 1956, the expectation was that the program would be relatively small. But over the last half century, the original Federal-State

administrative structure has had to accommodate a growth in program size and complexity that it has been ill equipped to handle. In addition to working within a fragmented administrative structure, employees at all levels have been buffeted by periodic surges in workloads and funding shortfalls.

At the present time, all parts of the applications and appeals structure are experiencing great stress with every indication that the difficulties each is facing will continue to grow unless changes are made. There are about 15,000 disability adjudicators throughout the disability system. Their qualifications and the rules and procedures they follow differ, sometimes dramatically. For example, adjudicators at the State agency and ALJ levels may receive vastly different training and draw upon very different resources. Factors such as these raise questions about how well the administrative structure will be able to handle the growing workload.

Is Social Security's definition of disability appropriately aligned with national disability policy?

There are many who believe that the Social Security Act definition of disability, which requires claimants to prove they cannot work in order to qualify for benefits, is inconsistent with the Americans with Disabilities Act and is at odds with the desire of many disabled individuals who want to work but who still need some financial or medical assistance. Recent Ticket to Work legislation is aimed at helping people who are already on the disability rolls to return to work by providing increased services and new incentives, but does not fully address these basic inconsistencies.

In recent testimony the Consortium of Citizens with Disabilities questioned whether the Social Security definition of disability adequately captures "the spectrum and continuum of disability today. Does it reflect the interaction of vocational, environmental, medical and other factors that can affect the ability of someone on SSI or SSDI to attain a level of independence?"

Reform Should Have Clear Goals and Objectives

Reform of the disability programs must be evaluated within the context of clear goals and objectives:

- All who are truly disabled and cannot work should receive benefits.
- Those who can work but need assistance to do so should receive it.
- Vocational rehabilitation and employment services should be readily available and claimants and beneficiaries should be helped to take advantage of them.
- Claimants should be helped to understand the disability rules and the determination process.
- The disability system should provide fair and consistent treatment for all.
- The disability system should ensure high quality decisions by well-qualified and trained adjudicators.
- The disability system should provide expeditious processing of claims. When cases are complex and require more time, claimants should be informed so that they will understand why there is delay.

The Elements of Reform

To build a disability system that can meet the challenges of the future will require changes in policy, procedure, and structure. The Board has proposed a number of changes that we urge policy makers in the Congress and the Administration to consider. These changes would represent fundamental reform. In summary, they include the following elements.

Strengthen SSA's capacity to manage

SSA's ability to manage the disability programs is undermined by three major shortcomings—

There is a lack of management accountability. Nearly every staff component of the agency has a role in administering the disability programs.

The policy infrastructure is weak. There are too many voices articulating disability policy. Adjudicators in different parts of the system are bound by different sets of rules.

Important policy elements are out of date. As the result of downsizing and lack of new staff to replace those who have left the agency through retirement or otherwise, the level of expertise in areas such as medical and vocational factors has declined.

The agency lacks a quality management system that can provide the comprehensive information that is needed for accurate and consistent decision making.

The Board recommends that SSA address these shortcomings by——

- organizing the agency so as to ensure greater accountability and
- unified direction for the disability programs, developing a single presentation of policy to guide all adjudicators and enhancing the medical and vocational expertise of its staff, and
- developing and implementing a new quality management system that will (1) provide the information that policy makers and administrators need to guide disability policy and procedures and (2) ensure accuracy and consistency in decision making.

Change the disability adjudication process

Strengthen the Federal-State arrangement.—Although the law gives SSA the basic responsibility for administering the disability programs, it requires that disability decisions be made by State agencies rather than by SSA itself. The Federal Government pays 100 percent of the cost.

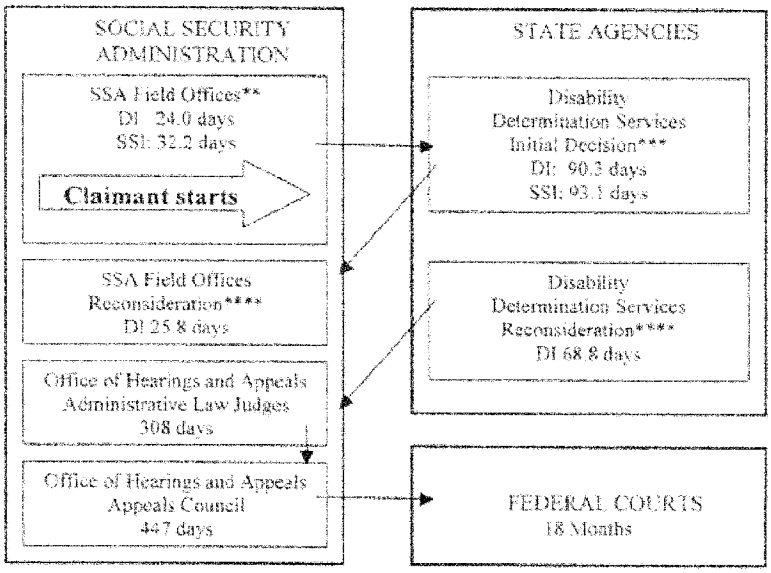
Whether the disability decision making authority should belong to the States or to SSA has been a subject of debate since Congress established the Federal-State arrangement nearly five decades ago. Proponents of federalizing the process argue that the present structure is inherently difficult to manage and that federal administration is necessary to ensure high quality, uniform administration throughout the country.

The issue of federalizing the disability determination process needs to be examined in the light of anticipated future needs of the disability programs. In the short term we believe it is necessary to strengthen the present Federal-State arrangement. Underpinning this view is the fact that SSA currently lacks the administrative and staffing capacity to take on the significant additional responsibility that federalization would entail. Nevertheless, the present arrangement is inadequate to meet the needs of the disability programs today, and problems need to be addressed as quickly as possible.

SSA's regulations should be revised to improve the agency's ability to manage State agency operations and to provide greater national uniformity. States should be required to follow specific guidelines relating to educational requirements and salaries for staff, training, carrying out quality assurance procedures, and other areas that have a direct impact on the quality of their employees and their ability to make decisions that are both of high quality and timely.

Reform the hearing process.—The formal right of claimants to a hearing was adopted in 1940 with only 12 "referees" to hear appeals. But with the enactment of the disability programs, the hearing process has become massive, with about 1,000 administrative law judges and nearly 7,000 other employees.

DI and SSI Claims Process: Steps and Average Processing Time* FY 2001



*Processing times shown must be added at each step to find the total time
**Field office processing time includes all components of the field office work, including taking the claim and processing it after the State agency makes a determination
***SSA reports DDS initial processing time by programs; average total processing time (DI and SSI) is not available

Along with becoming a much larger operation than originally envisaged, SSA's hearing process has also changed as the result of the fact that most claimants are now represented by attorneys or other representatives. Because the agency is not represented as well, many believe the hearing process has become too one-sided. We think that having an individual present at the hearing to defend the agency's position would help to clarify the issues and introduce greater consistency and accountability into the adjudicative system and, as in a more traditional court setting, would help to carry out an effective cross-examination. Consideration should also be given to allowing the individual who represents the agency at the hearing to file an appeal of the ALJ decision.

We also recommend that the Congress and SSA review again the issue of whether the record should be closed after the ALJ hearing. Leaving the record open means that the case can change at each level of appeal, requiring a *de novo* decision based on a different record. Many ALJs have told the Board that leaving the record open gives attorneys an incentive to withhold evidence in order to strengthen an appeal at a later stage, and provides an inherent incentive to withhold evidence in order to prolong the case and increase fees. Other ALJs do not believe that representatives hold back evidence for these reasons. If evidence is held back, they maintain, it is because the rules for presenting evidence are lax and representatives do not take the time or spend the money to obtain additional evidence unless required to do so as a result of an unfavorable hearing decision. Closing the record would heighten the need to develop the record as fully as possible before the decision is made in order to ensure that claimants are not unfairly penalized. Closing the record would not preclude filing a new application.

Third, we recommend that consideration be given to establishing a system of certification for claimant representatives and to establishing uniform procedures for claimant representatives to follow. The objective would be to provide for a more orderly and expeditious hearing procedure than currently exists.

Consider changes in the current provisions for judicial review.—Concerns about national uniformity in policy and procedure have led many to consider whether there is a need for change in the current provisions for judicial review. Under the current system, Federal courts frequently issue decisions that vary from district to district and circuit to circuit. Over the years a number of bills have been intro-

duced in the Congress that would create either a Social Security Court or a Social Security Court of Appeals that would specialize in Social Security cases, thus establishing a framework that could produce greater uniformity in decision making. The statutorily-established Commission on Structural Alternatives for the Federal Courts of Appeals, chaired by Justice Byron White, stated in its final report in December 1998 that Congress should seriously consider proposals that would place judicial review of Social Security cases in an Article I court. We believe that the question of whether existing arrangements for judicial review should be retained or replaced by a new court structure deserves careful study by the Congress and the Social Security Administration.

Align policy and administrative capacity

Nearly every part of the Social Security Administration has been affected by the downsizing and restraint on government hiring that has occurred over the last two decades. But for various reasons, the disability programs in particular have tended to suffer. As resources have been constrained, SSA has issued numerous regulations and rulings that require more time and expertise on the part of all adjudicators than was the case in the past and workloads have grown substantially. The result is that disability policy and administrative capacity are now seriously out of alignment and threaten to become more so as the agency moves toward national implementation of several new initiatives.

Of particular importance are the "process unification" rulings issued by SSA in 1996, which were aimed at bringing State agency and ALJ decisions closer together. Many State agency administrators claim that some of them are so complex that State agency employees cannot adhere to them without spending substantially increased time on a large percentage of the cases they are adjudicating. In addition, these new rules for adjudicating cases require analytical and writing skills that many employees do not have.

Both the Administration and the Congress will share the responsibility for making the changes that are needed to ensure that disability policy and administrative capabilities are properly aligned. This will likely involve a combination of changes in policy, processes, institutional arrangements, and funding. In addition, the Board has urged the agency to develop a comprehensive workforce plan and base its appropriations requests on this plan, as directed by the 1994 independent agency legislation. We also urge the Administration and the Congress to exclude SSA's administrative budget for Social Security from any statutory cap that imposes a limit on the amount of discretionary government spending.

Examine ways to improve incentives for early rehabilitation and employment

The issue of whether the present structure of assistance to the disabled provides sufficient help and incentive for employment needs careful review. Many experts believe that the most effective intervention is to help disabled individuals return to work as quickly as possible. More comprehensive research on ways to improve incentives for rehabilitation and employment early in a period of disability is needed. This may include new or different arrangements for cash or medical benefits or for rehabilitation and employment services. The experience of other countries and of both private and public employers in the United States should be taken into account.

Included as part of this comprehensive research effort should be a study of whether providing some type of short-term disability assistance, combined with rehabilitation services, would improve assistance for those who have disabilities while also relieving pressure on the permanent disability programs. The studies that are conducted should include cost-benefit analyses. Where needed, specific legislative authority and funding for these studies should be provided.

[Attachments are being retained in the Committee files.]

Chairman SHAW. Mr. Daub, what was your second recommendation?

Mr. DAUB. The second recommendation is on page 5 at the top of our oral presentation, which is to develop a single presentation of policy to guide all adjudicators.

Chairman SHAW. Is that adopting rules of procedure?

Mr. DAUB. So to speak. It would be. The Agency's regulations should be revised to require States to follow specific Federal guide-

lines relating to educational requirements and to salaries for: staff, initial and ongoing training, quality assurance procedures, and other areas that have a direct impact on the quality of their employees and their ability to make decisions. Regulations should also ensure that State hiring freezes will not apply to State Agency disability operations. These programs are national programs, and SSA has an obligation to ensure equal treatment for all claimants wherever they reside.

Chairman SHAW. Mr. Robertson, you expressed disappointment at the pace at which things are going. Could you frame that better for us and a position in time? The Commissioner was late coming online, and anyone who comes into a position like that, you don't want them to start making wholesale changes until they can get their sea legs, so to speak. Could you comment further or expand further as to exactly what you have seen since the new Commissioner has come online?

Mr. ROBERTSON. Well, let me just start by saying that we like a lot of what the Commissioner has done so far. She has taken actions that are very consistent with some of the things that we have been recommending for a long time. For example, she has elevated a senior manager to the position of a QA adviser. We have been emphasizing, as you know, the need to get a QA program underway and in place for quite a long time.

Likewise, we like the emphasis that she has placed on recognizing the importance of Information Technology solving some of the problems that the system is currently experiencing. Frankly, we like some of the short-term solutions that she has suggested for addressing the hearings office problems that we have seen.

Right now, it is just a little bit too early to get a good handle on how effective these actions will be. If I could just make an observation—I was sitting back earlier in the hearing listening to the discussion. Being relatively new to the area, it struck me that one of the fundamental differences that I see in discussions so far today is that there is agreement on what the problem is. There is inconsistency in the decisionmaking. There is a lengthy process. It is a costly process. There is also, it seems to me, some agreement on some of the actions that should be taken. Trust me, having looked at other areas, that agreement is not always there. So, I think this is a good thing. Again, being new to the area, it was a personal observation and it was kind of a nice thing to see.

Chairman SHAW. Mr. Robertson, are you saying that Mr. Matsui and I disagree on some things pertaining to Social Security?

Mr. ROBERTSON. Never, never.

[Laughter.]

Chairman SHAW. Mr. Matsui?

Mr. MATSUI. I won't respond to that, Mr. Chairman.

Mr. Robertson, your analysis actually goes back years and years in terms of the problems that we have had. I recall Mr. Daub does as well—in the early eighties we were having problems with both administrative law judges. Obviously the whole issue of disability claims and the backlog was significant then. It has obviously grown much larger now.

You have said that the short-term solutions by the SSA Commissioner and Mr. Gerry being implemented now are good short-term

solutions. Then you are basically saying where do we go from here? I think that is really the crux of the issue. Obviously time will have to be given to them to put together the long-term plan.

In your analysis—and perhaps I am asking a question that you won't want to answer, but is it a management problem in terms of how these things are being done? Is it a structural problem? Is it a lack of money? Or is it all three of those? If it is all three of those, or any one of those, could you kind of elaborate on that in terms of your analysis of the long-term problems? How we can really address these issues? Obviously, we are going to wait for the Administration to come up with their package, and we are all going to work with them because we all want to solve this problem. As you have said, we are all working in agreement here in terms of our goals. What is your analysis of the long-term approach that we need to be taking, in those three areas or any other areas that you might want to raise?

Mr. ROBERTSON. You have hit three areas that are all contributors to the problem. The one that maybe you didn't hit directly that I would like to re-emphasize—and I mentioned it in my short statement—is that, I think everybody should realize that we are dealing with an extremely complex process that involves complex judgments, multiple appeals levels, and lots of adjudicators. So, inherently, it is a difficult process to get your hands around, simplify and say here is the silver bullet that is going to fix everything. So, I would add that—the inherent complexity of the process—to your list of factors that have made the progress slow.

I would also add that the solutions—and I am going to say this carefully—the solutions, in my view, to the problems should not be narrowly focused. We should be looking very broad. We should be looking at some of the systemic problems, the fragmentation problems that are part of this overall problem that we are talking about this morning.

So, my only suggestion as we are looking for causes and for potential solutions to the problem, is that: we not look narrowly, that we look broadly, that at least everything gets on the table for discussion to begin with before we eliminate things, and that we look at things system-wide as opposed to one segment or another of the system.

Mr. MATSUI. Okay. I think I understood you. I am not sure if I did. I think I understand your initial part of your comments in terms of the length it takes. As somebody who practiced law before coming here, a normal case that goes through a superior court in California would take through the appeal process 4 or 5 years, perhaps. We are talking about something a lot simpler in terms of adjudicating a disability claim. We do have statistics that show that a claim actually is only seen for approximately 7 days or so. The rest is appeal time, or 500 days, 500-plus days, due to the fact that we have a backlog.

What do you think is an ideal time? Let's say that the backlog was cleared, and we had an efficient system going through the entire process. Could you make that estimate? Maybe you can't.

Mr. ROBERTSON. I can't make that estimate. I know that obviously we can do better than we are doing now, but I don't have an ideal time in mind. I think we are going to be talking—or you are

going to be speaking with some QA people later on this afternoon that have looked at benchmarking other organizations. They may be able to provide some insights into that question.

Mr. MATSUI. Could I ask you this question—and maybe, again, you think it would make some sense to try to figure out what should be the average time that a claim is adjudicated? The reason I ask that, how do we have a benchmark or how do we have some goals?

Mr. ROBERTSON. I think that is a very difficult question that you raise. I think that you can look to other organizations for benchmarking. Ultimately, you have got to look back at your process and say what is it that I want? What do I want to accomplish with this process? That is going to——

Mr. MATSUI. Process requirements, yes. Okay. Thank you.

Chairman SHAW. Mr. Brady?

Mr. BRADY. Thank you, Mr. Chairman.

Both the testimonies were excellent in different ways. Two of the statements that struck me were in Mr. Daub's testimony, but you addressed them a minute ago, Mr. Robertson. One of them was that it has been 30 years since Congress has changed the law defining disability. In that timetable, the intervening years, the disabled community itself sort of passed the process by with new technology and new approaches is able to do more in occupational areas than ever before. The decisionmaking is more complex with the determiners as a result of that. Also, as you would imagine, in 30 years a lot of complex and conflicting legal rulings—that have made it more difficult to consistently apply the decisionmaking across the way.

The second point you make is that it has also been about two decades since either Congress or the administration has really taken a fresh look at how the whole structure and process ought to work. I guess that is my question for both of you. Are you in different ways saying it is time for the administration to think outside the box in defining, in developing a system that really works? Is it time for Congress to step up to try to help remove some of the complexity or the conflicting legal decisions over the years that make it tough for the system to work? I would open it up to both of you.

Mr. DAUB. I would answer in this way: First, I think the Commissioner is very dedicated to summoning the resources of the administrative leadership of the Social Security program to try to make as many efficient decisions inside the system without legislative action, if that is possible. I think that the short-term goals she has established are starting to make sense and should produce some early results. I think that is an important point to emphasize.

In our testimony, you will recall, I talk on behalf of the Board about three things that we believe can be done by the leadership of the Social Security Administration, administratively. They deal with the quality of the decision making, not the quantity or processing. Focusing on the quality should lead to less confusion in the early period of the determination process, which can take 100, 106, 102, 115 days, according to various studies. If it just took 3 calendar months, to make a decision that wouldn't be bad for a very subjective judgment that is being made about assessing somebody's

degree of pain, their inability to take occupational therapy and to do alternative work to make a living. The Disability Determination Services are short of people who are well trained—it takes about 2 years to train these folks to be able to make those sound early judgments. We have high turnover coming, a very aging work force, and a crazy quilt of rules and regulations from the courts that have impacted the decision process. Many of them never appealed, so we don't have any consistency from region to region.

I think another important thing is that the administrative law judge system is just a paradise for extending matters as long as you can—especially if you hire a lawyer who is not forthcoming with the evidence or holds back or has something that may be a little damaging to your case. The administrative law judge wears two hats: the decisionmaking hat of having to decide the fairness of the Disability Determination Services decision, to adjudicate whether the appeal should be approved or not; and the interrogator representing the taxpayer and the system, sort of attacking the credibility of the witnesses and the claimant. So, the claimant and lawyer perceive the judge as almost being adversarial in a way.

So, part of the problem is attorneys take cases all the way through the court appeals process as long as they can because the record is not closed. Then the case gets up to the Federal district judge, where it gets remanded with an automatic $2,000 attorney's fee being paid for 30 seconds' worth of work. So, the longer the case is strung out, the more the lawyer makes. What is suffering is the process, the backlogs, and the claimants behind them.

So, I think that a fundamental reform can be accomplished by internally getting some of these things done that we are talking about today with the encouragement of this Committee. Second, I think Congress should legislate. I think it is time in the next year or so that this Committee take a strong look at things like: the record being closed, whether there should be an Article I court specialized in disability case matters, and whether there should be a process where there is a State's lawyer, a Federal Social Security lawyer, that represents the taxpayer side of the issue. Then after that hearing, close the record.

Those are things that I think need to be looked at by this Committee.

Mr. BRADY. Thank you. Mr. Robertson?

Mr. ROBERTSON. The short answer to your question, from my perspective, is that in looking for potential solutions to the problems that we are talking about today, yes, indeed, people should be thinking outside the box. Of course, that means, however, that those outside-the-box solutions are going to have to be discussed in terms of here are the pluses, here are the minuses, and there is going to have to be a lot of communication with you about the pluses and minuses of these types of solutions.

Mr. BRADY. Mr. Chairman, you need to know, in the questioning I am not suggesting that we have legislative solutions for all this, but neither do you want to abdicate responsibility. It seems that at some point this has gotten to such a critical situation. We all ought to be looking at ways that—roles we can play in helping solve this. Thank you, Mr. Chairman.

Chairman SHAW. Mr. Becerra?

Mr. BECERRA. Thank you, Mr. Chairman. Thank you very much for empaneling the witnesses and holding this hearing. Thank you for having come.

Let me go back to a question that Mr. Matsui raised. In preparation for this hearing, I asked my district staff to give me a sense of what we are encountering when it comes to these cases, these disability claims. I was told by the senior caseworker in my office that typically it takes someone in my congressional district 4 to 5 months to get an initial determination, about another 3 or 4 months to get a reconsideration, about a year to get a decision from the judge, an ALJ, and about 2 to 3 years to get a decision from the Appeals Council. Of course, there are a few who do go on to Federal court. I suspect that is pretty consistent throughout with other folks as well.

Given everything you have said, and having looked over some of the written testimony, is there some way that we can reduce that latter portion of time? It seems that when you have to appeal your case—and oftentimes, many of the claimants are—you are going to be waiting a lot longer the last steps, when you probably are most in need. Now you are starting to pay an attorney to help you take your case forward. So, is there any thought being given to how you reduce the wait between the decision by the ALJ and any decision that might be rendered by the Appeals Council, which at least in Los Angeles has resulted in, in some cases, 2 to 3 year waits?

Mr. ROBERTSON. Is that a question for me?

Mr. BECERRA. Mr. Robertson, Congressman Daub, either one.

Mr. DAUB. The Social Security Advisory Board has addressed it since 1998, and I think there are things that can be done. I think to Mr. Brady's question, I said that it is time for Congress to look at the process. Although I believe much can be done administratively, the administrative law judge appeals process, where you are focusing, is going to require congressional action in order to create a new process.

Mr. BECERRA. Yes, but I am not sure I would like to see the record closed.

Mr. DAUB. Let's talk about that for a minute, if I may. Closing the record is what proves the American system of jurisprudence. If you have any other type of court case of any complexity, for mental stress, pain, emotion, shock, whatever it is, at some point the record close. I am not saying when, now. The concept is that of closing the record so that the judge isn't at each next level considering new evidence, almost taking the case through a de novo new process as if you start all over. The fact is that the system currently is not cutting off one set of factual considerations, forcing the claimant to put his best evidence in at that point based on the disability claim to get a determination, knowing that they can come back and refile if there is further degeneration in the spine or other illnesses, or if they get dismissed at some level they can come back and refile, which you can do without prejudice in any other type of court case.

Mr. BECERRA. See, I would look at it differently. I would say that one of the difficulties we are having is that you are having claimants who, for the most part, are not versed in the law. They don't know how to best marshal the facts forward, and it is not

until they get to the ALJ stage that when they do finally hire an attorney because now it is getting pretty late in the process. If they do hire someone who can say, by the way, you should have raised these facts. To me that is two things. It spells out two solutions. One is we do a much better job—and principally that means putting more resources at the early stage so that these claimants do put forward all of their evidence——

Mr. DAUB. Well, that is what we should do. I agree with that.

Mr. BECERRA. If we do that, then I think you will have a fairly complete—without having to close the record, and ultimately I think what we have to try to do is figure out a way to get from the ALJ through the Appeals Council in a much faster way. To me that means if you put more resources in at the initial stage or you make that initial determination by someone at the Agency, that what you are going to do is you are going to prevent the difficulties that I think you raise rightfully, that a judge is having to consider new evidence for the first time, which should have been developed way at the beginning, at the first stage, and not depend so much on the claimant to try to marshal together his or her best case. I think we are wasting a lot of time in not allowing them to put their best foot forward. We shouldn't be adversarial in any way with them because if they have a legitimate claim, we owe them those benefits, and we should develop their case as much as possible.

Mr. DAUB. We should. We should make sure that it is a proper claim, that it is not fraudulent, that it is being paid properly. We have a system that also has a substantial insolvency issue. The oversight over claims paid and the redetermination process also lags dramatically.

So, it is complex, but to be sensitive to the disability claimant, that is truly, compassionately what we should have as our focus. On page 5 of the formal testimony that our Board has presented to you today, we list the objectives that reform of the system should have, that all who truly are disabled and cannot work should receive their benefits.

My testimony on behalf of the Board today emphasized administratively what we do to improve the quality of the determination to begin with. I couldn't agree with you more that that is where the emphasis on reform should be.

In the end, there will be those cases that will go into the system of appeal. That system, too, if it is reformed, will put pressure on more quality work up front early on. If you leave that system open-ended so you are not happy with the way things are going through the administrative process, knowing you are going to get a better deal from the court system, which is what is basically the result now, you will wait because you will get a better deal if you take it to court.

Mr. BECERRA. Mr. Chairman, I know you have been gracious with the time——

Mr. DAUB. So, I think that is the dilemma that you face.

Mr. BECERRA. Congressman Daub, I think the difficulty is the courts which have to finally dispense the justice are saying we see from the record, which should have been better developed at the beginning—that this claimant had a cause. The process didn't allow the claimant to fully develop at the initial stages, so the ALJ

or the Advisory Council could come up with a good decision. It is now left up to the courts. Instead of expending so much money and time and causing the claimant so much grief and loss of money, let's get our determiners to get out there and virtually tell these folks you are missing this piece of evidence. Get it out here, because the earlier we do it, the quicker we can dispense with those cases that are truly frivolous and deal with those that are really legitimate and come up with a solution. If there is an appeal, then you are going to have a good record because the ALJ will have all the evidence he or she needs. So will the Advisory Council, and you will never have to go to court to do that.

Mr. Chairman, you have been gracious with the time. Thank you to the two of you for your testimony.

Chairman SHAW. Thank you. I think this is insightful, and I think we need to do a little more work. It is difficult sitting here, never having tried such a case, and trying to figure out how we can solve the problems involved in the process.

Years and years ago, I was a municipal judge. What we would do is if the defendant was represented by counsel, we would always bring in the city prosecutor. If he were not, then it would just go forth almost as an administrative type of proceeding.

Maybe what we have here is a system that is a hybrid which really doesn't focus correctly in either instance. It is one size fits all, so it is like you are either a size 9½ or 10½. So, we will give you a 10. I think we need to maybe take a look at the process for people that have attorneys and people that do not to try to expedite the process.

Mr. DAUB. Mr. Chairman, Federal judges tell me—if I might just briefly comment, I have talked to a number of Federal judges in the last couple of months since I have been privileged to have this assignment. They commiserate with the administrative law judge. I say this kiddingly because I know that they are here today, they are listening, they are watching, and they are my friends. They ought to wear robes, but they don't. They have a tough job to wear both hats, almost, in that process.

So, if there is a way to force quality into that record on the way up, we all feel that is the better approach. There is a way—and you said it, when you were a municipal judge. There is a way that you get some balance in the system. You force it to come to the court better prepared so that the playingfield is level. The end result is that we want fair and uniform efficient determination. I think you are on to something.

Chairman SHAW. Who presents the case to the judge initially? Is it——

Mr. DAUB. The lawyer for claimant normally, on appeal in the ALJ system.

Chairman SHAW. Is there representation from the Social Security Administration who made the first determination?

Mr. DAUB. Just the file that has been submitted.

Chairman SHAW. So, you are counting on the judge having thoroughly read the file before the case.

Mr. DAUB. That is what you are counting on.

Chairman SHAW. I would assume that that is——

Mr. DAUB. I think most—I certainly think those judges make an effort to read every file, but there is also a backlog there. They are overwhelmed. They've got a huge load on them in many jurisdictions. As that Federal judge commented to me, these cases get to the Federal court just almost like they have been thrown into a shoe box. The Federal judge then has to feel compelled to go sort that case out from the beginning.

Chairman SHAW. How many cases a day would a typical judge hear?

Mr. DAUB. I am sorry?

Chairman SHAW. How many cases a day would the judge hear? A whole slew of them or——

Mr. DAUB. I don't know. It could be two or three. It could be 10. It depends on the——

Chairman SHAW. How long does the process usually take, the whole hearing process, typically?

Mr. DAUB. A typical case? I am going to ask a staffer because I haven't been in the courtroom in a long time. Forty-five minutes to an hour and a half?

Just the actual court experience itself, 45 minutes to an hour and a half. That would probably be the average.

Chairman SHAW. Okay. Well, thank you very much. I thank both of you. Perhaps this Subcommittee should go to court 1 day and watch one of these. It might not be a bad idea

Mr. DAUB. We are going to hold field hearings in Denver on Thursday and Friday.

Chairman SHAW. Well, I don't know that we have to go to Denver. Perhaps downtown would do. I don't know. Anyway, we thank you both.

Mr. DAUB. Thank you.

Mr. ROBERTSON. Mr. Chairman, thank you.

Chairman SHAW. We thank you both for your testimony.

Next we have Witold Skwierczynski. Boy, I am always challenged on difficult names, but I believe this one is the best one I have seen. He is the President of the National Council of the SSA Field Operations Locals, Chicago, Illinois, and a Representative in the American Federation of Government Employees, Social Security General Committee, AFL–CIO, Baltimore, Maryland. I apologize for crucifying the pronunciation of your name. If it was any longer it wouldn't fit on there. In fact, it barely fit on the placard there.

Anthony T. Pezza, who is the President of the National Coalition of Social Security Management Association; Jeffrey H. Price, who is the President of the National Association of Disability Examiners (NADE) from Raleigh, North Carolina; Linda Dorn, who is the Vice President of the National Association of Disability Determinations Directors, Lansing, Michigan; and David Stapleton, who is the Director of Cornell Center for Policy Research.

Welcome to all of you. We have your written testimony that will be made a part of the record, and you may proceed as you see fit. Thank you. Thank you all for being here. Mr. Skwierczynski, would you pronounce that for me, please?

Mr. SKWIERCZYNSKI. Witold Skwierczynski. Thank you.

STATEMENT OF WITOLD SKWIERCZYNSKI, PRESIDENT, NATIONAL COUNCIL OF SSA FIELD OPERATIONS LOCALS, CHICAGO, ILLINOIS, AND REPRESENTATIVE, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, SOCIAL SECURITY GENERAL COMMITTEE, AFL–CIO, BALTIMORE, MARYLAND

Mr. SKWIERCZYNSKI. I am with the union. We represent 50,000 bargaining unit Social Security workers.

The Social Security Disability Program is in trouble, and it is in deep trouble. Unfortunately, the Administration has not provided sufficient appropriations to allow Social Security to dig out of its hole. The Bush budget has cuts in our full-time equivalent staffing for fiscal year 2003. I do not see how we can absorb a cut when the Commissioner has already said that we are about 150,000 case backlog on our disability program. She has indicated to the Senate Finance Committee that in order to work off that backlog, the Agency is going to need 400 to 500 million additional dollars just to work off the backlog. I was shocked to hear Deputy Commissioner Gerry say that they are not going to ask for any more money when it is clear that the only way that the Agency is going to be able to cut down the backlog is to have additional employees do cases.

I am also disappointed that nobody is mentioning this terrible crisis that we are having on the special Title II Disability Workload. Unfortunately, what has happened is literally half a million of Title XVI Social Security beneficiaries, the Agency has finally determined, are due back Title II Social Security benefits. The Agency is going to have to take a half a million Social Security claims. Most of these claims are going to require additional disability decisions which is going to totally backlog the State agencies as well as the field offices that have to take those cases. These half a million Title XVI beneficiaries, who are due back pay benefits, have children and spouses who also may be due benefits on their record, which will mean additional claims that have to be taken. The union estimates that it will take a minimum of 22 to 25 hours per case to do these, which means that you're going to need about 6,000 work years in order to work off these cases. I think Congress needs to look very closely at funding the situation. This is a group of beneficiaries, by the way, that is the poorest of the poor. These are SSI recipients, who we have not paid properly and are due benefits, some of these cases date back to 1974. This is also an indication of mismanagement of the disability program. The Agency has known about this situation since the mid '90s and has not taken any action until recently to deal with it.

Another thing that the Agency hasn't done that nobody is mentioning today is work continuing disability reviews (CDR). People who are getting disability benefits, some of them to go back to work. If you are a Title II beneficiary, you get a trial work period. We get information that these people go back to work, but our employees in Social Security field offices don't have any time to take these work CDRs. The Agency doesn't track them. They don't track their processing time. They don't track their volume. They stack up in our offices and are overpayments that are not addressed. These overpayments continue to mount. We need additional staff to do address these CDRs. Now, the Congress did initiate a program

called Ticket to Work. The Agency hired 32 employment support representatives (ESR) for a pilot program. One of their functions was to do work CDRs, and they have done many of them and saved hundreds of thousands of dollars of trust fund dollars. We need to expand that program throughout the country. The ESRs pay for themselves and save taxpayer dollars.

Although Commissioner Barnhart has testified about some of the problems, it is funny that one of the big problems is the initial claim. Most people don't file appeals. About 47 percent of Title II beneficiaries are approved. A large percentage file appeals, but the average person that files a claim only makes it through the initial claims phase.

The Disability Claims Manager (DCM), which is a pilot that the Agency experimented with, cut the processing time of disability claims to 62 days. Right now you have heard testimony that the average case takes 102 days. The Agency goal is 120 days. The DCM did it in 62 days. Why did the Agency terminate that program? Why aren't we implementing the DCM across the board to save hundreds of thousands of disability applicants time in terms of the processing of these cases.

Not only that, but with regards to the ALJ, the Agency piloted the Adjudicate of Officer Program, which was a professional employee who was able to make favorable decisions upon reviews. They screened out about 17 percent of all cases that were sent to hearing, and in screening out those 17 percent cases, reversing them and approving them, the ALJs has less work. They had 20 percent less work. The Agency killed that program, too.

The Commissioner says let's have more litigation. By cutting out reconsiderations, what you do is you have more litigation. The claimants are forced to get a lawyer to deal with the hearings process. Even though reconsideration is only cut 17 percent, have a 17-percent reversal rate, that is a large group of people, along with 20 percent who don't pursue their claims, 37 percent of the people that don't have to get an attorney, don't have to deal with the hearings process and with the lengthy delays. So, I don't think it is the greatest idea to cut out the reconsideration process. I think what we need to do is, one, improve—I agree we need to improve the quality. I think the DCM does that. I think the wildly varing approval rates from State to State would indicate that there is something wrong with the system that we have now.

We ought to seriously look at Federalizing the Social Security Disability Program to ensure more uniformity and more consistency in decisionmaking. We should look at having a caseworker approach, like the DCM, which claimants love. The DCMs provided a quicker decisionmaking and quality product that produced high satisfaction rates. We need to have consistency. The problem today is that in the DDSs they are using one set of rules and the judges are using another set of rules. So, we need to unify the process to rectify the problems. It should be shocking to us that 60 percent of cases that are appealed to the ALJs are reversed, 60 percent. That means there is something wrong with the initial claims process, and that is the first thing that needs to be addressed.

Another problem is that we have 50 States with 50 different supervisors making the decisions using different rules. My suggestion

is that this Committee addresses the initial claims process and the lack of uniformity. The DCM and ESR have proven effective. Thank you Mr. Chairman and Ranking Member Matsui for holding this hearing.

[The prepared statement of Mr. Skwierczynski follows:]

Statement of Witold Skwierczynski, President, National Council of SSA Field Operations Locals, Chicago, Illinois, and Representative, American Federation of Government Employees, Social Security General Committee, AFL–CIO, Baltimore, Maryland

Chairman Shaw, Ranking Member Matsui, and members of the Social Security Subcommittees, I thank you for the opportunity to present this statement regarding Social Security's disability programs and the challenges that face SSA and Congress. As a representative of the AFGE Social Security General Committee and President of the National Council of SSA Field Operations Locals, I speak on behalf of approximately 50,000 Social Security Administration (SSA) employees in over 1400 facilities. These employees work in Field Offices, Offices of Hearings & Appeals, Program Service Centers, Teleservice Centers, Regional Offices of Quality Assurance, and other facilities throughout the country where retirement and disability benefit applications and appeal requests are received, processed, and reviewed.

In previous testimony before the Social Security Subcommittee, we have commended the Social Security Advisory Board (SSAB) for its continual perseverance addressing improvements necessary to strengthen SSA's capability to answer the demands of the public it serves. Prior to becoming SSA Commissioner, Jo Anne Barnhart was a member of the SSAB. The Social Security Advisory Board has confronted a number of important issues, including changes in the disability programs, the Agency's quality of service to the public, the need to safeguard the public's funds as well as the administration of the Supplemental Security Income (SSI) program. AFGE is committed to working with Commissioner Barnhart and Congress regarding these complex issues, as well as other issues continuing to present challenges to SSA and its employees.

Commitment to Staffing and Resources

The disability program is growing rapidly. Approximately 10 million Americans and their families depend upon SSA's disability programs. As baby boomers grow older, there is an increased likelihood of their filing for disability benefits. This causes the amount of resources dedicated to SSA disability programs to significantly increase. Last year, almost 70 percent of SSA's administrative budget was spent accomplishing disability work. Unfortunately, without serious changes in the current administrative process, along with additional staffing and resources needed to adequately receive and process this work, disability service to the taxpayer will deteriorate.

SSA will be unable to continue to timely and efficiently process disability claims unless the Administration and Congress provide additional resources. Absent appropriate financing for additional staff, SSA cannot guarantee providing timely payment of benefits, correct administration of complex regulations as well as training and mentoring both current employees and new workers. ***President Bush's FY 2003 budget request not only falls short of providing the resources necessary to begin addressing this crisis, but calls for a reduction in workyears***. AFGE believes a shortage of over 5500 positions currently exists in field offices and TSCs across the country. This shortage has already proven to be a recipe for disaster in providing adequate service. Backlogs of disability claims have created lengthier processing times. Callers are unable to get through on the toll free number and phones in field offices are frequently unanswered. The most recent example of last week's 800 number accessibility will demonstrate my point. Because of the tremendous backlogs in SSA's Processing Service Centers (PSCs), employees who assist our understaffed Teleservice Centers were unable to provide assistance during the busiest week of the month. This resulted in unacceptable levels of service. In fact, SSA has indicated that no PSC employees will be answering the 800 number for the rest of the fiscal year. This will cause 800 number performance levels to further deteriorate. The Government Performance Results Act goal for SSA's 800 number service is an overall 5-minute access rate of 92%. Last week, the 800 number 5 minute access rate slipped to an average of 82%. Occasionally last week the 5 minute access rate was as low as 68%. As I have previously testified, the public can expect to wait up to several hours in many SSA reception areas across the country before being

interviewed. Employees are forced to rush through the interviews, and stress levels have escalated to an unacceptable degree according to employee surveys.

Senior SSA officials have testified at various times to this Committee and other committees, that without process improvements, the Agency will need 20,000 additional Full Time Equivalent Employees (FTEs) to maintain previous service levels. Eighteen years of staffing cuts has been the primary cause for SSA's deteriorating service. During this time FTE levels plummeted from 86,000 to 62,000. Most of the cut was in direct service workers in the field. Recently the Social Security Advisory Board (SSAB) has issued multiple reports, which criticize SSAs inadequate staffing and resources. The Board has concluded that such resource deficiencies have adversely affected the Agency's ability to provide adequate service. In January 2001, the SSAB urged the President to provide sufficient funding for SSA to enable it to improve its service to the public. In September 2001, the SSAB contacted the House and Senate Appropriation Committees reiterating its concerns previously addressed to President Bush. It is unfortunate that those cries for help seem to have fallen on deaf ears.

Unless Congress acts to increase SSA's administrative budget, the Agency's service levels will continue to decline.

SSA's Disability Programs

AFGE believes that immediate attention needs to be given to three specific issues regarding the SSA disability benefit program: providing proper staffing and resource allocations, ensuring consistent disability decisions in a more expeditious manner and maintaining quality in person service and assistance at the field office level.

SSA's disability programs are at the heart of the Agency's many challenges. AFGE is just one of many voices that has insisted upon reform of SSA's seriously flawed disability structure.

However, institutional problems continue to be overlooked. SSA's ethos of discouraging open discussion of problems continues to exist. Communication between headquarters and operations in the field remains poor. Workgroups designed to address problem areas or workloads no longer include either the union or the employees who actually do the work. These employees in field offices and teleservice centers who have been working at SSA's frontlines serving the public, know what is wrong and what is needed. The open door policy between the Commissioner and the Union has does not exist. These actions have caused SSA employees to doubt Commissioner Barnhart's sincerity and will ultimately cause employees to mistrust any changes implemented without their participation and input. AFGE understands that long-lasting progress will only be achieved with the assistance of those who not only understand the problems, but also have the institutional experience and knowledge to repair SSA's disability programs. Certainly much more can be accomplished in a constructive manner with open two-way communications. The union remains committed to such a process.

SSA must develop and implement a new quality management system that will routinely produce information the Agency needs to properly guide disability policy. Equity and consistency in disability decision-making does not exist today. Claimant's chances of being approved for disability benefits depend on where they live and the amount of their resources.

For example, SSA records appear to suggest that those who have the resources to obtain medical attention early and often have a better chance of being approved for benefits than those who have a limited income or resources. (See Chart Below) Nationwide, those applying for Social Security disability have a much greater chance of being approved than those who may only apply for the Supplement Security Income (SSI) program. SSA records clearly expose the inconsistencies of the State DDS decisions. More than 70 percent of Social Security disability claims for benefits are approved in New Hampshire, while only less than 38 percent of those who file for benefit in Oklahoma are approved. Of those who applied for SSI benefits, New Hampshire soars with an allowance rate of over 63%. However, less fortunate are those from Kansas, Missouri, Louisiana and Georgia. Less than 35 percent of the SSI applications in these states are approved by the respective State Disability Determination service (DDS). The reconsideration process is fraught with inconsistencies. Reconsideration claims in Missouri and Pennsylvania result in a 40% reversal rate. Conversely, reconsiderations in East Los Angeles, Kentucky, New York and Oklahoma result in less than 15% approval rate. Reconsideration of an SSI application is less likely to be approved than TII cases.

As an illustration, following is a compilation of different states and the variance from state to state in allowance and denial rates:

	T2 Initial		T16 Initial		Concurrent Initial		T2 Recon		T16 Recon	
	Allow	Deny	Allow	Deny	Allow	Deny	Allow	Deny	Allow	Deny
NATIONAL AVERAGE	47.4	52.6	39.5	60.5	30.4	69.6	19.0	81.0	16.0	84.0
BOSTON Region	56.8	43.2	43.6	56.4	34.5	65.5	30.0	70.0	25.6	74.4
New Hampshire*	**70.3**	**29.7**	**63.6**	**36.4**	**56.2**	**43.8**	**33.3**	**66.7**	**33.3**	**66.7**
Connecticut	55.7	44.3	39.2	60.8	32.3	67.7	30.4	69.6	21.6	78.4
New York Region	48.5	51.5	40.8	59.2	34.5	59.2	15.1	84.9	13.5	86.5
New York*	**51.5**	**48.5**	**39.9**	**60.1**	**33.4**	**66.6**	**12.2**	**81.3**	**12.6**	**87.4**
Albany	55.0	45.0	36.2	63.8	32.6	67.4	22.0	78.0	19.4	80.6
Puerto Rico	34.6	65.4	–	–	–	–	16.3	83.7	–	–
Philadelphia Region	53.1	46.9	43.7	56.3	34.6	65.4	20.3	79.7	16.7	83.3
Maryland	49.8	50.2	38.6	61.4	30.4	69.6	25.3	74.7	18.0	82.0
PA*	**60.2**	**39.8**	**48.6**	**51.4**	**40.7**	**59.3**	**40.6**	**59.4**	**29.2**	**70.8**
Atlanta Region	40.3	59.7	35.8	64.2	27.0	73.0	16.3	83.7	14.0	86.0
Alabama*	**48.8**	**51.2**	**37.7**	**62.3**	**33.3**	**66.4**	**34.7**	**65.3**	**33.5**	**66.5**
Georgia	38.2	61.8	34.0	66.0	25.7	74.3	17.9	82.1	14.5	85.5
Kentucky	37.3	62.7	35.0	65.0	23.8	76.2	10.9	90.1	9.8	90.2
Birmingham	50.8	49.2	40.3	59.7	35.1	64.9	35.1	64.9	34.0	66.0
Florida	41.7	58.3	41.6	58.4	30.7	59.3	20.5	79.5	19.6	80.4
Miami	42.3	57.7	49.3	50.7	35.4	64.6	21.7	79.3	26.4	73.6
Chicago Region	47.3	52.7	36.4	63.6	30.1	69.9	19.8	80.2	15.0	85.0
Illinois	49.3	50.7	38.1	61.9	31.8	68.2	18.7	81.3	15.9	84.1

Michigan*	**49.8**	**50.2**	**35.3**	**64.7**	**31.9**	**68.1**	**32.3**	**67.7**	**24.7**	**75.3**
Wisconsin	52.0	48.0	37.2	62.8	30.3	69.7	31.7	68.2	16.8	83.2
Dallas Region	41.3	58.7	36.7	63.3	29.6	70.4	18.7	81.3	17.3	82.7
Louisiana*	**43.3**	**56.7**	**30.9**	**69.1**	**30.7**	**69.3**	**39.9**	**61.0**	**27.6**	**72.4**
Texas	40.0	60.0	40.0	60.0	30.5	69.5	18.7	81.3	18.5	81.5
New Mexico	49.1	50.9	41.3	58.7	32.2	67.8	23.2	76.8	20.9	79.1
Oklahoma	39.3	60.7	36.7	63.3	27.7	72.3	14.3	85.7	12.6	87.4
Shreveport	42.8	57.2	31.6	68.4	28.7	71.3	21.4	78.6	29.5	70.5
Kansas City Region	54.3	45.7	34.4	65.6	27.0	72.0	23.8	76.2	15.5	84.5
Missouri*	**56.8**	**43.2**	**33.0**	**66.0**	**28.6**	**71.4**	**44.8**	**55.2**	**35.3**	**65.7**
Kansas	47.2	52.8	34.7	65.3	22.1	77.9	23.5	76.5	14.6	85.4
Denver Region	43.6	56.4	41.1	58.9	25.2	74.8	14.2	85.8	9.7	90.3
Colorado*	**46.6**	**53.4**	**42.2**	**57.8**	**27.6**	**72.4**	**27.6**	**72.4**	**5.7**	**84.3**
N. Dakota	45.4	54.6	37.3	62.7	22.0	77.0	17.2	82.8	8.5	91.5
S. Dakota	48.2	51.8	36.5	63.5	23.0	76.0	18.8	81.2	12.8	87.2
San Francisco Region	52.8	47.2	46.2	53.8	37.1	62.9	25.2	74.8	22.5	77.5
Arizona	59.3	40.7	51.8	48.2	43.3	56.7	38.7	61.3	33.8	66.2
California	50.9	49.1	45.7	54.3	34.4	65.6	22.1	77.9	18.6	81.4
Bay Area	56.0	44.0	52.6	47.4	43.2	56.8	28.5	71.5	20.8	79.2
L.A. East	42.7	57.3	44.0	55.0	32.1	67.9	12.4	87.6	12.2	87.8
L.A. West*	**59.8**	**40.2**	**49.9**	**50.1**	**42.0**	**57.0**	**31.2**	**68.8**	**22.5**	**77.5**
L.A. North*	**58.7**	**41.3**	**49.3**	**50.7**	**40.0**	**60.0**	**31.8**	**68.2**	**42.2**	**57.8**
L.A. South	42.0	57.0	49.2	60.8	31.4	68.6	19.7	80.3	19.9	80.1

	T2 Initial		T16 Initial		Concurrent Initial		T2 Recon		T16 Recon	
	Allow	**Deny**	**Allow**	**Deny**	**Allow**	**Deny**	**Allow**	**Deny**	**Allow**	**Deny**
Sacramento	48.6	51.4	42.2	57.8	30.2	69.8	23.6	76.4	31.6	78.4
Seattle Region	50.0	50.0	43.6	56.4	21.2	68.8	22.2	77.8	16.1	83.9
Alaska*	**57.4**	**42.6**	**52.3**	**47.7**	**38.1**	**61.9**	**50.0**	**50.0**	**0.00**	**100.0**
Oregon	49.7	50.3	40.7	59.3	28.3	71.7	24.1	75.9	16.2	83.8
Washington	49.9	50.1	44.3	55.7	32.5	67.5	22.0	78.0	15.8	84.2
Seattle	50.1	49.9	49.8	50.2	36.6	63.4	24.3	75.7	16.1	83.9

***"Prototype" sites.**

In a system where contributions are made equitably, such wildly divergent allowance rates raise significant questions regarding the accuracy and fairness of the decision making process. The American taxpayers are entitled to quality consistent decisions whether they live in California or New Jersey. The significant differences between SSA and SSI disability approval rates leads one to conclude that wealth is a factor in the decision making process. We strongly encourage Congress to hold hearings in the near future to address these very important issues.

As long as inconsistent medical decisions continue to be made by the State DDSs, the backlogs at the hearing levels may never be completely resolved. In some areas, the rate of hearing reversals is as high as 60%.

SSA has spent millions of dollars testing new disability initiatives in an effort to address some of the serious problems with the disability process. One of those initiatives is the "Prototype" pilot. Approximately 25% of SSA's national initial disability claims workload was included in the Prototype, which was conducted in State DDS facilities for Alabama,

Alaska, California (Los Angeles North DDS & Los Angeles West DDS branches only), Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania. The Prototype features were designed to:

- Provide greater decisional authority to the disability examiner and more effective use of the expertise of the medical consultant in the disability determination process;
- Provide more complete development and improved explanations of how the disability determination was made in order to enhance the quality of decisions;
- Afford an opportunity for claimants to talk with the decision-maker if the evidence in the file does not support a fully favorable determination, and/or to submit further evidence before an initial determination is made.
- Simplify the appeals process by eliminating the reconsideration step.

Recently, Commissioner Barnhart announced her decision to expand the Single Decision Maker aspect of the Prototype pilot and to eliminate the Claimant Conference portion of the initial disability claims in the 10 Prototype states. These decisions were made prior to the completion of the pilot and before an analysis of final data regarding the pilot. The decision to eliminate the Claimant Conference appears to have been made solely due to the additional time that conducting such a conference adds to the processing time for initial disability claims. No data has been provided to the union which measures the impact of the claimant conference on the decision making process. Claimant conferences were intended to partially replace the loss of the Reconsideration appellate opportunity. Eliminating such conferences will, undoubtedly, result in additional hearings requests by denied claimants. Since there is a severe backlog of hearings cases, this is an undesirable result. The 2001 Interim Report on the Prototype indicated that claimant satisfaction was much lower than claimant satisfaction for the Disability Claims Manager (DCM) pilot. The interim report also indicated that Prototype productivity was less than the current process, employee satisfaction was not especially high and that, although final results were not available, the total program costs of the Prototype appeared higher than the current process and the elimination of the Reconsideration leads to more hearing requests than the current process. In addition, the Prototype did nothing to resolve the state to state disparity in the disability claims allowance rates.

The elimination of the reconsideration and the elimination of the Claimant Conference in Prototype states does not appear to be the solution to the disability problem in SSA. It is particularly puzzling that SSA leadership appears enamored with the Disability Prototype and its lukewarm results while it scuttled the DCM, which exceeded the current process in numerous respects, especially processing time.

As I emphasized in previous testimony before the Social Security Subcommittee in June 2001, the Disability Claims Manager (DCM) pilot (another SSA initiative) proved to be highly successful in addressing these problems in the disability program. Processing time was significantly better. In fact, the DCM processing time of 62 days was almost ½ of SSA's initial disability claim processing time goal of 120 days. Customer service dramatically improved. Claimants expressed record high satisfaction rates for the DCM. The public likes the DCM caseworker approach and wants it retained in the current process. Although SSA contended that the DCM would cost more than the current process, no valid data exists showing this conclusion. Also, the pilot was prematurely terminated before valid statistical data could be compiled regarding full program costs. It is unfortunate that, since the last time I testified before the SSA Subcommittee, then Acting Commissioner, Larry Massanari, decided not to implement the most successful new disability initiative, the DCM. The DCM was a positive step to ensuring the public that consistent and

equitable disability decisions are made. Tragically, no actions were taken to implement any of these successes, and the pilot was terminated. Congress should demand that SSA justify the elimination of this successful and innovative experiment. It is part of the answer to the disability problem.

It is apparent that the primary reason that SSA terminated the DCM pilot was due to State resistance. Such resistance certainly was not based on a poor pilot result. Instead the decision appears to be based on political considerations and the fear of losing work. Congress should be very concerned when SSA spends $ millions for a process that demonstrably improves the disability processing time yet is rejected for political reasons. The concerns of the states are understandable in view of their unacceptably poor performance regarding decision consistency from state to state and their poor processing time in comparison to the DCM. However, the only real criteria should be the level of service that is provided to the claimant. Using customer service as a measure, the DCM exceeds State DDS performance in virtually every category.

AFGE has recommended to Commissioner Barnhart that she reconsider former Acting Commissioner Massanari's decision and implement the position of the DCM at SSA as soon as possible. AFGE is willing to work with the Commissioner in an incremental approach to achieving this goal. AFGE understands that there will need to be changes in policy, processes and institutional arrangements, as well as funding to implement this very valuable and successful position at SSA. Legislative amendments to the Social Security Act would be necessary to allow SSA workers to make disability decisions; however the crisis in disability processing requires immediate, as well as long-term changes. When trained to make medical decisions, SSA employees can provide immediate relief to backlogged Disability Determination Agencies, and provide faster and better service to the public by serving as a single point of contact. The pilot demonstrates that the public loves the DCM, employees enthusiastically support it and that it provides substantially better service than the current disability product. It is the responsibility of Congress to take the necessary action to assure the DCM is part of the solution to the disability problem.

As a short term approach not requiring legislative change, AFGE is supportive of the "Technical Expert for Disability" position. This position would provide high quality, trained field office employees the tools to assist disability claimants in both programmatic and medical issues, provide professional personalized service to applicants, focus the disability interview, make or recommend disability decisions, and assist the DDS's in their development and backlogs.

Another tested initiative that would save considerable disability processing time is the Adjudicative Officer (AO). This position was intended to assist Administrative Law Judges to reduce the number of hearings and to prepare cases for efficient and expeditious hearings. AO's were empowered to gather additional evidence and to make favorable decisions without hearings when the evidence submitted indicated that such a decision was appropriate. The pilot indicated that many hearings requests were quickly adjudicated by AO's. These workers reduced the processing time for hearing requests. The AO's met the same fate as the DCM's. SSA cancelled the initiative. When processing time can be legitimately reduced, why is SSA terminating a methodology that achieves that objective? SSA should reexamine this position.

Ticket to Work

Another prominent challenge for SSA, as well as a legislative mandate, is complying with the provisions of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). SSA has, in fact, redefined its mission to include promoting the employment of Social Security beneficiaries with disabilities. By the year 2005, SSA's goal is to increase the number of beneficiaries who can attain steady employment and leave the disability rolls by 100%. Currently, less than one-half of one percent of Social Security Disability and SSI recipients return to work and whose benefits are terminated. If only an additional one-half of one percent of recipients were to cease receiving benefits due to employment, savings to the Trust Funds and Treasury would total $3.5 billion over the worklife of these beneficiaries.

Section 121 of this legislation directs SSA to establish "a corps of trained, *accessible* and *responsive* work incentives specialists within the Social Security Administration." As members of this subcommittee are well aware, this legislation mandating specialists within SSA is the result of many years of poor service on the part of SSA in providing accurate information on employment supports and failing to process cases timely or accurately. SSA created the Employment Support Representative (ESR) position as this work incentives specialist. The pilot of 32 ESRs testing models of how best to service the disabled community concluded in August 2001.

The final Evaluation Report of the ESR position was completed in November 2001. Findings of the report were clear that the ESR was most effective in serving organizations and beneficiaries when situated in field offices serving the communities. Beneficiaries and community organizations were overwhelmingly appreciative of the services the ESR performed, finding them to be compassionate, responsive, accessible, and highly knowledgeable. The investments of the ESRs in outreach programs have led to increased trust of SSA by the communities, and increased program knowledge on the part of professionals and consumers. There is a great deal of interest on the part of organizations for a further rollout to service every locality. The pilot proved that Congress was correct when it insisted that SSA improve its service to disabled beneficiaries seeking to return to work.

Furthermore, the ESRs were able to develop a single point of contact with beneficiaries, monitor their work progress in a timely and supportive manner, and process work reports and work-issue Continuing Disability Reviews (CDRs) timely, greatly reducing large benefit overpayments and anxiety on the part of the beneficiary. ESRs gave many examples of customers who, with ESR guidance, were able to reliably predict the outcome of their work activity and viewed benefit cessation as a mark of achievement.

Both SSA and AFGE agree that hundreds of millions of dollars in benefit overpayments would be saved nationally if work issues are reported and worked promptly. SSA projects a large increase in work CDR activity, especially in the early stages of the Ticket to Work implementation. Even discounting the potential effect of Ticket related workloads, work issue CDRs processed in field offices have been *increasing* at an average annual rate of over 35% for the past three years. Anecdotal evidence from employees throughout the country indicates that work issue CDRs are backlogged for up to several years in field offices. Overpayments on these cases can reach $250,000 for an office, and employees have encountered overpayments on individual records reaching $100,000. Unfortunately, the Union is unaware of any statistical data regarding the numbers of work CDRs processed, the number pending and the cessation rate due to work activity. SSA should be required to maintain and produce such data. In processing medical issue CDRs, SSA contends that for every dollar spent, seven to twelve dollars in benefits are saved. The cost savings are greater for "work" CDRs since the cost of medical decision making is eliminated. Investing in the ESR position is a perfect example of applying stewardship responsibilities effectively and investing resources in a cost effective manner.

The Evaluation Report recommends that the ESR job should be made a permanent position within SSA. The report also recommended that the ESR position be expanded to as many SSA offices as possible. The Report cautions: "Failure to institutionalize a position to perform the duties that the ESR has piloted could in effect deny the public and community the opportunity to interact with an accessible and responsive SSA specialist. This could eliminate an important element in SSA's plan to improve its employment support service delivery to the public. It could also negatively affect our ability to effectively train and advise other SSA staff in the provisions of the law, with implications for increased incorrect payments and the denial of benefits to beneficiaries."

Unfortunately, SSA is reluctant to implement the ESR position due to the shortages of staff and resources in field offices. These intolerable resource deficits leave SSA in the position of ineffectively implementing the Ticket to Work and continuing to provide the current level of service. This is an impossible situation.

AFGE believes an Agency decision not to implement the ESR would be a tragic mistake when the ESR has proven to be a winner for all parties. For SSA, it shows superb service to the public, provides stewardship in reducing benefits and overpayments, and results in SSA compliance with the legislative mandate for work incentive specialists within SSA. For the public, it provides stellar service, a single point of contact, and assists beneficiaries in leaving the disability rolls. For the taxpayer, it saves money and extends Trust Fund solvency.

Section 121 of PL 106–170 authorized $23,000,000 to be appropriated to establish a community based work incentives planning and assistance program for disabled beneficiaries, and to develop a corps of work incentives specialists with SSA, for each of the fiscal years 2000 through 2004. SSA allocated all of the appropriated resources to grants outside the Agency. AFGE requests that Congress direct SSA to appropriate additional funding to meet the requirements of the Ticket to Work and Work Incentives Improvement Act. This provision of the legislation also requires continuous adequate funding beyond FY 2004. Otherwise, the most effective method of providing consistent, accurate information and assistance on work incentive programs will not be accessible to disabled beneficiaries. It is outrageous that budget constraints for SSA's Administration Expenses will inhibit the success of the ESR, a Ticket to Work initiative, which is designed to generate Trust Fund Savings.

It would cost approximately 120 million to staff SSA's 1300 field offices with 1500 ESRs. The potential return of $3.5 billion indicates that this would be a prudent expenditure.

Special T2 Disability Workload

Inadequate staffing and resources influences SSA work priorities. While ignoring or putting off the inevitable can provide a temporary solution to a staffing and resource problem, the consequences can be severe and compromise the Agency's integrity. In addition to this being self-evident with the 800 number service, inadequate staff is also the cause for the "Special T2 Disability Workload." This resource shortage will be a great challenge for the new Commissioner, this Congress, and the employees of SSA as it begins to tackle the "Special T2 Disability Workload."

A study done by an SSA employee in the early 1990s revealed that a serious computer processing error existed in the Agency's software. At that time, SSA became aware that the Social Security and SSI programs were not properly interfacing, resulting in a failure to properly identify SSI recipients who may be eligible for Social Security and Medicare benefits retroactively to 1974. From 1974 until the early 1990's, the SSI application did not solicit information that would identify individuals who would be eligible for Social Security benefits. SSA officials neglected to take the necessary action to correct this problem until recently. As a result of this systems failure, hundreds of thousands of SSI recipients and their families were not paid the proper Social Security benefits. This placed the burden of benefits solely on SSI, Medicaid, and State and County welfare programs instead of the Social Security trust fund.

Under Title XVI of the Social Security Act, SSI recipients are required to apply for all benefits for which they are eligible. SSA is responsible for identifying and paying the recipient once they achieve insured status for Social Security benefits. Eligibility for Social Security benefits reduces the State's obligation to supplement the SSI and Medicaid programs. For example, in the cases SSA has identified, the average retroactivity is 8 years. This means that the states will be reimbursed an average of 8 years of past payments that States have made on SSI. In addition, using Social Security data, these individuals would have been eligible for Medicare retroactively for 6 years and Medicare would have been the primary insurance provider rather than Medicaid. Thus, the burden for paying for medical services would shift from State budgets to Medicare. Therefore, SSA owes millions of dollars in back payments to the States and the U.S. Treasury General Fund.

In March of this year, the AFGE National Council of Social Security Field Operations Locals made Congress aware of this very serious situation. This issue impacts not only the Social Security and Supplemental Income (SSI) beneficiaries in every state and/or Congressional district, but affects SSA reimbursements of revenue due states for erroneous SSI and Medicaid payments.

SSA has identified approximately ***505,000*** impoverished individuals to date who appear to be entitled to Social Security and Medicare benefits. Of those cases identified, some may have a retroactivity period that can date as far back as 1974; however, the average retroactivity involved is estimated to be about eight years. Because of the limited number of cases reviewed, we believe that a complete and thorough audit of all SSI cases should be evaluated for possible entitlement to Social Security benefits. It is important to notify you that these numbers do not reflect the countless thousands of spouses, widows and/or children that may be eligible for Social Security benefits due to the Agency's failure to correctly enforce the eligibility requirements for SSI beneficiaries.

The cases identified in the Special T2 Disability Workload are complex and require careful screening and diligent review by FO personnel. Development of trial work periods, substantial gainful activity, and workers compensation will be very time consuming. Most of these cases will require new medical determinations. If SSA's original medical file no longer exists, medical records will have to be redeveloped. Once approved for T2 benefits, the majority of these cases will require extensive manual computations. The complexity of these cases will be overwhelming. For example, all historic legislative changes that have occurred since 1973 will have to be considered to determine proper payment due to the disabled individual, spouse, widow, children, survivors and/or estates. Initial attempts to process these cases indicate that each case takes an average of 12 hours to properly screen. This time estimate does not include the time needed to make a disability decision and the time necessary to process and adjudicate auxiliary claims (e.g., mothers/father's and children).

Based on SSA's current work measurement system, the minimum amount of time to review and adjudicate the simplest of these cases will take 22–25 work hours.

This would result in a minimum of 2,400 work years to fully develop and adjudicate the first 210,000 cases. However, most cases will not be simple.

SSA's mission requires that the Agency pay each eligible beneficiary timely and accurately. Depriving poor SSI recipients accurate benefits adversely affects their struggle for survival.

Without additional resources, addressing this workload will have an enormously detrimental impact on service to current applicants and beneficiaries. AFGE recommends that SSA, with Congressional oversight, take immediate action to:

- Determine trust fund expenditures related to this workload;
- Identify state supplements and Medicaid reimbursements;
- Provide an analysis of when complete resolution can be expected, including reimbursement to federal and state treasuries;
- Verify that the processes are corrected, in an effort to rebuild the confidence of the public, Congress and the states;
- Identify the additional staffing and resources necessary to successfully process this overwhelming and complex workload;
- Earmark sufficient funds to process this work. This was done in the 1980's in order for SSA to process the "Zebley" litigation cases, which reversed case decisions on hundreds of thousands of cases involving children with disabilities. It is necessary to earmark such funds again, as in Zebley, to process this enormous complex workload.
- Utilize the former Disability Claims Manager (DCM) in processing this workload. DCM's are highly trained in SSA programmatic issues and experienced in making medical determinations. They would be able to process the entire complex case from start to finish and provide needed relief to the overburdened State DDS's regarding this workload.
- Utilize the skills of the Employment Support Representatives in developing and analyzing the many years of work activity present on these records, taking into account all work incentives and provisions, to insure accurate case development.

Summary

There will always be budget priorities, whether it's reducing the deficit or increasing our military opposition to terrorists. However, both workers and employers contribute to the self-financed Social Security system and are entitled to receive high quality service. It is entirely appropriate that spending for the administration of SSA programs be set at a level that fits the needs of Social Security's contributors and beneficiaries, rather than an arbitrary level that fits within the current political process.

Mr. Chairman, you and Human Resources Subcommittee Ranking Member Benjamin Cardin reintroduced the Social Security Preparedness Act of 2000 (formerly H.R. 5447), a bipartisan bill to prepare Social Security for the retiring baby boomers. AFGE strongly encourages each of your committees to reconsider introducing legislation that will provide SSA with the appropriate funding level to process claims and post-entitlement workloads timely and accurately. AFGE believes that by taking these costs OFF–BUDGET with the rest of the Social Security program, Social Security funds will be protected for the future. This will permit new legislation, such as Ticket To Work, to be fully implemented without comprising public service integrity. We believe this can be accomplished with strict congressional oversight to ensure that the administrative resources are being spent efficiently.

AFGE is committed to serve, as we always have in the past, as not only the employees' advocate, but also as a watchdog for clients, taxpayers, and their elected representatives.

Chairman SHAW. Thank you. Mr. Pezza.

STATEMENT OF ANTHONY T. PEZZA, MANAGER, SOCIAL SECURITY ADMINISTRATION DISTRICT OFFICE, HACKENSACK, NEW JERSEY, AND PRESIDENT, NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS, INC.

Mr. PEZZA. Chairman Shaw, Members of the Subcommittee, my name is Anthony Pezza. I am here as President of the National Council of Social Security Management Associations, which is an

organization of more than 3,000 managers and supervisors who work at SSA's field officers and teleservice centers in more than 1,300 locations throughout the United States.

I thank you for giving me the opportunity to come before you today to speak about the problems the Social Security Disability process is having from the perspective of SSA's frontline managers and supervisors, and make recommendations for change.

The managers and supervisors I represent deal directly every day with the folks applying for Social Security Disability and Supplemental Security Disability Payments. It is most often our Members with whom your local staff deal to resolve Social Security problems for your constituents. I must tell you, that more often than not those problems involve the disability program.

Since our organization was founded almost 34 years ago, we have been a strong advocate for locally delivered Social Security services nationwide. We work directly with those we serve, because they are our friends and neighbors, folks we know in our hometowns and local communities. We represent the very essence of citizen-centered government. Those of us who work in SSA's field offices spend a great deal of our time and effort on the disability program. We deal directly with disability applicants and recipients. We take their claims, initiate their continuing disability reviews and provide them and their representatives with information. We hear their stories and see firsthand the impact of their impairments and our procedures on their lives.

As we are all painfully aware, SSA's Disability program has been under severe stress for a number of years. I believe we all know about the processing delays. It takes too long to get an initial decision. The time it takes to get a decision on appeal is inexcusable. I think we all know that there are troubling variances in the allowance rates between State DDSs and between initial and appeals decisions.

Some 9 years ago, SSA embarked on an effort to re-engineer its disability process. After almost a decade of spending literally tens of millions of dollars on that effort, the sad fact is we are still talking about the same problems and discussing the same potential solutions today as we were then. It appears the more we discuss and study the problem, the less gets done. The bottom line is that after all of this effort, from the claimants' point of view nothing is changed.

In our written submission to the Subcommittee, we made a number of recommendations. I would like to tell you very briefly about one of them. In February 2001 and again in January of this year, the National Council of Social Security Management Associations made a recommendation to SSA that a new position be established in our local field offices. The position which we have called the Technical Expert for Disability, capitalizes on the success of the 3-year-long Disability Claims Manager program. That pilot demonstrated that field office personnel, given the same medical determination training as DDS medical examiners, can have a positive impact on the initial disability claims process. The new position would expand and strengthen the role and performance of the field office in the front end of the disability process.

Technical Experts for Disability would be responsible for the intake of applications for disability benefits under both titles. They would be responsible for developing both the medical and non-medical aspects of certain claims. They would be responsible for making the non-medical and making or recommending the medical decisions in predetermined types of cases in agreement with individual DDSs, for example, terminal cases and presumptive disability cases. They would be responsible for reviewing and taking where indicated the first action on disability claims being forwarded to the DDS for development and medical decision. This would ensure that the product sent to DDS for medical determination is of high quality and would often include supporting medical evidence. And finally, they would be responsible for training and mentoring other field office employees involved in the disability process.

The incumbents of this new position would be drawn mainly from SSA's current field office staff of claims representatives and technical experts, and within current FTE ceilings. We don't envision massive numbers. We are convinced that a 1,000 to 1,500 Technical Experts for Disability in field offices across the country could have a dramatic and positive impact on the timeliness and quality of the initial disability determination process. We urge the Subcommittee to join us in asking SSA to seriously consider this proposal.

Mr. Chairman, Members of the Subcommittee, I am ready to answer any questions you may have. Thank you.

[The prepared statement of Mr. Pezza follows:]

Statement of Anthony T. Pezza, Manager, Social Security Administration District Office, Hackensack, New Jersey, and President, National Council of Social Security Management Associations, Inc.

Chairman Shaw and Members of the Subcommittee, my name is Anthony Pezza, and I am here today representing the National Council of Social Security Management Associations (NCSSMA). I am also the manager of the Social Security District Office in Hackensack, New Jersey and have worked for the Social Security Administration (SSA) for 40 years. On behalf of our membership, I am both pleased and honored that the NCSSMA was selected to testify at this hearing on the problems and opportunities facing SSA in its administration of the disability program.

As you know, Mr. Chairman, the NCSSMA is a membership organization of more than 3000 Social Security Administration managers and supervisors who work in SSA's more than 1300 field offices and teleservice centers in local communities throughout the nation. It is most often our members with whom your staffs work to resolve issues for your constituents relative to Social Security retirement benefits, disability benefits, or Supplemental Security Income. Since our organization was founded almost 34 years ago, the NCSSMA has been a strong advocate of locally delivered services nationwide to meet the variety of needs of beneficiaries, claimants, and the general public. We represent the essence of **"citizen centered"** government. We consider our top priority to be a strong and stable Social Security Administration that delivers quality service to our clients—your constituents.

It is significant to note, that the number of people receiving Social Security or Supplemental Security Income (SSI) disability benefits is less than 20% of all those receiving Social Security or SSI payments. On the other hand, about two-thirds of SSA's administrative budget, around $5 billion this year, will be spent on the work generated by the disability program.

SSA's field offices must expend a great deal of their efforts on the disability program. Field offices deal directly with disability applicants and recipients. Field offices take disability claims, provide information to claimants and their representatives, initiate continuing disability reviews, and provide the public and third parties with information about the disability program. In dealing directly with disability claimants and recipients, we hear their stories and see firsthand the impact of their

impairments and our procedures on their lives. We are in a prime position to assess the challenges and opportunities presented by the current situation.

Challenges Facing the Disability Program:

SSA's disability programs have been under severe stress for a number of years. As reported by the Social Security Advisory Board in its January 2001 report entitled "Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change", SSA's actuaries project that between now and 2010 the number of Title II disability beneficiaries will increase by 50% and the number of SSI disability recipients by 15%. This tremendous increase in disability claims workloads will further strain a system that is already at the breaking point. Disability claims workloads are rising around the country. During one recent week some 60,000 initial disability cases were waiting to be assigned to Disability Examiners in the various Disability Determination Services. There were in all probability a like number of Continuing Disability Review cases awaiting assignment. This is just the "tip of the iceberg".

The most prevalent criticism field offices hear concerns the amount of time it takes to get a decision. Applicants wait an average of almost 4 months from filing to receipt of an initial decision. The almost half a million claimants who request a hearing before an Administrative Law Judge (ALJ) each year can expect to wait, on average, more than a year from the date of the initial filing for a decision.

Delay in the process may be the most pervasive problem, but it is by no means the only problem. Many claimants have no idea of how the process works or how decisions are made. They have little understanding of what is required to meet the definition of disability under the Social Security program, much less what is needed to document their claim. Unfortunately, limited resources have forced a reliance on self-help completion of forms and on telephone interviews. Claims Representatives rarely have the time to fully review all forms completed by applicants or to fully explain how the process works. Additionally, failure to see a claimant face to face increases the opportunity for fraudulent activity. It is also extremely important to note and understand that many claimants are suffering from mental impairments. This makes self-help and electronic service delivery extremely problematic for such individuals.

Other problems facing the disability program have been abundantly documented by reports of the Social Security Advisory Board, GAO, and others. There are, for example, wide variances in allowance rates and processing times from state to state. Court decisions have greatly complicated the disability determinations process and have resulted in a disparity between the criteria used to make initial and reconsideration decisions and criteria used at the hearing level. In addition, recent attempts to focus efforts on helping disability recipients return to work have not resulted in a promising response. The problem is probably rooted in the "all or nothing" statutory definition of disability and the application process that focuses on inabilities rather than abilities. These factors tend to discourage a return to work.

One of the most significant and sad points about the disability problems faced by SSA is that we've been discussing the same problems and talking about the same potential solutions for many years now. This is not a situation that materialized overnight. It's been a long time coming. But it appears that the more it gets discussed and studied, the less gets done to deal with the problem.

Unfortunately, from the claimant's perspective, after years of SSA's efforts to deal with its problems in the disability area, nothing has changed.

- There are reasons for this, among which are:
- The structure of the disability determinations and appeals process
- The competing interests of the various "stakeholders"
- The institutional bias toward the paralysis of analysis
- The limitations on resources

It is probable that we have now reached the point where all of the dire predictions about a "melt down" in the disability process will occur if action is not taken quickly and decisively to avert it. The final straw may be the recent emergence of an unanticipated workload in the form of literally hundreds of thousands of cases that have come to be termed Special Title II Disability cases. These cases involve situations wherein there was a failure to identify SSI recipients who, after becoming eligible for Title XVI (SSI) payments, subsequently became insured for Title II benefits. At that point an application for Title II benefits should have been solicited and processed. Having identified these cases, SSA is now obligated to secure and process applications. This will involve a very significant and unanticipated expenditure of SSA's frontline field office resources. But additionally, with specific reference to the disability issue, it is anticipated that more than half of these cases will require med-

ical determinations. This will further strain the already strained Disability Determinations Services (DDSs) with what could involve hundreds of thousands of additional medical determinations.

Potential solutions to the disability crisis can be divided into two broad categories: long-term and short-term. The long-term solutions generally require legislation. The short-term solutions require executive decision.

Long-Term Solutions:

The root causes of the disability dilemma were accurately described by the Social Security Advisory Board when it reported: **". . . the structural problems with the agency's disability determinations and appeals process . . . are at the heart of many of the agency's service delivery problems."** We believe that it is essential to reexamine the nature of the federal-state relationship in the disability process. What we have today is a system that produces wide variances in allowance rates, staff salaries, hiring and training practices, and quality assurance practices among the 54 different agencies making medical decisions. Because SSA's disability programs are national programs, there is an obligation to ensure that all applicants receive equal treatment. This does not appear to be the case today. Examination of the federal-state relationship may lead to recommended changes, which in all likelihood will require legislation.

Another long-term solution would be to change the nature of the disability program by changing the current definition of disability and modifying the program to provide for short-term as well as long-term disability payments.

Such a modified program could provide a smoother and faster initial disability determination process. It could also build into the provision for short-term disability the work incentive provisions currently available through "Ticket to Work".

Short-Term Solutions:

While it may be prudent and desirable to pursue the relatively long-term solutions described above, which would generally require legislation, there are actions that can be taken now to improve the current process.

Nine years ago, SSA embarked on an ambitious effort to improve the disability process by attempting to redesign the process. A number of pilots and other efforts were undertaken. While we haven't found a "silver bullet" much has been learned, and NCSSMA recommends that some of the positive findings from the efforts undertaken over the past nine years can and should be put to work now to help mitigate the problems with the current process. Our specific recommendations are as follows:

- Technical Expert for Disability: The three-year-long Disability Claims Manager (DCM) pilot undertaken by SSA was successful in proving the concept that one individual could handle both the program and disability determinations aspects of disability claims. Under this initiative, one individual in either an SSA field office or a DDS was given the responsibility for the complete processing, from initial application and interview to a final decision of an initial claim for disability benefits. The DCM served as the claimant's point of contact throughout the process. This pilot demonstrated reduced processing times, greater claimant and employee satisfaction, a level of accuracy at or above that of the traditional process, and at the peak of the pilot produced more work for the total number of staff hours involved than the traditional process. It is especially significant that claimants expressed high levels of satisfaction with the level of service provided under the pilot vis-a-vis the traditional process, especially claimants whose claims were denied. While the nature of the federal-state relationship presented difficulties preventing a general adoption of the DCM process, there were valuable lessons learned that can be put to immediate use to improve current service. The pilot established that, within the confines of the current federal-state relationship, the role of the field office could be strengthened and enhanced in the front-end disability process. Specifically, the NCSSMA has recommended to SSA that a new position be created in field offices whose focus would be on the processing of disability claims. This position, which we have termed "Technical Expert for Disability" (TED), would be fully trained in the same basic medical determination training received by new DDS Disability Examiners (DEs). Their responsibilities would include:
- Intake of initial applications for disability benefits under both the Title II and Title XVI programs
- Developing both the medical and non-medical aspects of certain claims
- Making the non-medical and making or recommending the medical decisions in predetermined types of cases, with individual state agreement

- Reviewing and taking, where indicated, the first action on disability claims being forwarded to the DDS for development and medical decision
- Training and mentoring other field office employees in the disability process

The TED position could help resolve one of the most pervasive problems in the disability process by improving the quality of the initial medical transmittals to DEs in the DDSs. Both the timeliness and accuracy of initial disability decisions should be improved. The TED could become the pivotal position in the disability process, providing the claimant with a single point of contact that can only be effectively accomplished by someone knowledgeable in both the medical and non-medical aspects of the disability claims process. Once again, we urge SSA to implement this position.

- E–DIB: SSA has recently embarked on a project to accelerate the conversion of the disability process to an electronic environment, eliminating paper files and mailings and permitting easier review and transfer of information in the disability claims process. We applaud the Commissioner's decision to move this project quickly.
- "Intelligent" front-end system: Field offices need to be provided with an intelligent front-end interview system that will allow the interviewer to obtain all relevant medical information. This would include "drop down" menus and an interview path with questions based on the specific impairment. This will result in a better front-end product and avoid unnecessary information by making the questions impairment-specific.
- Improving the appeals process: There are a number of changes to the hearings process that would make the process more efficient and reduce the length of time it takes to get hearing and appeals council decisions.
  - —Close the record after the ALJ decision
  - —Allow Agency representation at ALJ hearings
  - —Combine OHA and SSA field offices

The Need for Resources

Quality and service ultimately takes staff. SSA continues to struggle to keep up with its burgeoning disability workload. This situation will continue and probably worsen as the "Baby Boomers" age and file for disability in growing numbers if something is not done. Because of the nature of the disability process and program, it is not amenable to an Internet service delivery solution. Many people who file for disability are suffering from mental disorders. The complexity of the process makes it unlikely that this service population will be able to apply via the Internet. These individuals need the option of face-to-face, personalized service. The NCSSMA, in a survey released in March 2001, documented the finding that field managers felt the need for an additional 5000 employees simply to keep up with current service demands. The Special Title II Disability workload has added to this need. We cannot overemphasize the point that disability claimants need face-to-face, person-to-person service. This is the most effective way to ensure that these most vulnerable of our citizens, facing crisis situations in their lives, receive the timely and quality service they deserve.

Again, Mr. Chairman, I thank you for this opportunity to appear before this Subcommittee. I would welcome any questions that you and your colleagues may have.

Chairman SHAW. Thank you. Mr. Price?

STATEMENT OF JEFFREY H. PRICE, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, RALEIGH, NORTH CAROLINA

Mr. PRICE. Mr. Chairman, Members of the Subcommittee, the Social Security Administration faces critical choices regarding the direction the disability claims process should take, and the National Association of Disability Examiners appreciates this opportunity to present our perspective.

Our written testimony provides greater detail. Our oral testimony concentrates on our proposal for a new claims process that we believe will improve service to the claimant at an affordable cost.

Because of the extent of the increase in the number of disability claims over the next decade, improving the disability process in a way that is practical and affordable is critical. The SSA launched its most recent effort to redesign the disability process in October 1999. Spiraling administrative costs made it clear this design did not represent the future of the disability process. It was also clear that the attempt to reduce the four-tiered appeals step to two was not a viable solution. The ALJs were overwhelmed by the number of cases appealed. The need for an intermediate appeals step was clearly established. After more than a decade of redesigning efforts, SSA still does not have an acceptable new disability process to handle the significant increase and the number of claims. It does not have a new claims process that will reinforce the need for fair and timely decisions while awarding benefits only to the truly disabled.

The NADE accepted the challenge to develop a concept for a new process that would achieve these goals. What we hoped to achieve was to direct attention to a process based on what was fair for the claimant, and what could SSA afford. The highlights of our proposal include placing greater emphasis on: claimant responsibility, expansion of the single-decision maker in the DDS, enhancing the current reconsideration to provide a due process hearing, closing the record after the reconsideration decision, allowing administrative law judges to make the legal decisions they are trained to do, eliminating the appeals council, and establishing a Social Security Court.

Our proposal affords the claimant a right to the hearing regarding their eligibility for benefits, and a review to ensure that the medical decision correctly followed the law. Hearings conducted at the DDS level would follow the Administrative Procedures Act (APA) in the same way that appeals at State workers compensation agencies do at the present. Those hearings preserve claimant appeal rights, and have been tested in courts so that we know this process is viable. Under the APA claimants are entitled to a hearing to ensure that the government's decision follow the law. Our proposal does not alter this fact, but it does seek to reduce the 1,153 days that claimants now wait for a decision if they appeal their case all the way through the appeals council.

Our proposal recommends that the record be closed after the DDS hearing. Closing the record is critical to establishing consistency and affordability since appeals beyond the DDS are extremely expensive. It will also encourage cooperation with claim development efforts. The NADE's proposal required claimants and their representatives to cooperate with all components of the disability claims process. This Subcommittee was advised in March 1999 by the U.S. General Accounting Office that, "Frequent delays in disability proceedings are a significant problem and often attributable to the actions of some representatives. Decision makers are frustrated by disability program laws that provide numerous opportunities for claimant representatives to submit new evidence in support of their clients' claims throughout the entire process, but holding SSA primarily responsible for adequately developing the evidentiary record even when a claimant has representation."

The NADE believes this Subcommittee and SSA should consider holding claimants and their representatives accountable. Other as-

pects of our proposal call for the elimination of the appeals council and the creation of a Social Security Court. Eighty percent of the claims now heard before administrative law judges involve representation for the claimant. This process places an unfair burden on the administrative law judge who must remain fair and impartial while considering SSA's defense as if they had presented one.

In conclusion, NADE believes truly disabled citizens should be awarded benefits as early in the process as possible, and those who are not disabled should not receive benefits regardless of the process used. Our proposal has the potential for making this happen. We believe that it is time to establish a new process that reflects pragmatic reality and offers the best service to the claimant at the best price to the American taxpayer. Hon. Clay Shaw, Chairman of this Subcommittee, in announcing today's hearing, commented, "Individuals with disabilities, already burdened by the challenge of their illness or 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. Our challenge is to examine the disability process, to ensure that it meets the needs of individuals with disabilities and their families."

The NADE believes our proposal for a new disability process answer the Chairman's challenge. Thank you.

[The prepared statement of Mr. Price follows:]

Statement of Jeffrey H. Price, President, National Association of Disability Examiners, Raleigh, North Carolina

The National Association of Disability Examiners (NADE) commends the Subcommittee on Social Security for holding today's hearing. It is entirely appropriate and urgently needed that public and congressional attention be directed to *" SSA's Disability Determination and Appeals Process."* The Social Security Administration is bringing to a close this month the last of many experiments aimed at creating a new disability claims process. SSA now faces critical choices regarding the direction it must choose to go. NADE considers itself to be an expert on the disability claims process and we appreciate the opportunity to present our perspective on this topic.

Who We Are

NADE is a professional association whose mission is to advance the art and science of disability evaluation and to promote ongoing professional development for our members. The majority of our members work in the State Disability Determination Service (DDS) agencies and are responsible for the adjudication of claims for Social Security and Supplemental Security Income disability benefits. Our membership also includes personnel from Social Security's Central Office and its Field Offices, claimant advocates, physicians, attorneys, and many others. Our diversity, our immense program knowledge, and our "hands on" experience, enables NADE to offer a perspective on disability related issues that is unique and, more importantly, reflective of a pragmatic realism.

Current Process

The current disability claims process presents a four tiered approach that is challenging to the majority of claimants seeking help. An initial application is adjudicated by the DDS. If denied, the claimant may request a reconsideration of their claim. This is also adjudicated by the state DDS. Subsequent appeals would ask for a hearing before an Administrative Law Judge and review by the Appeals Council. Further appeals are made in federal court. Initial and reconsideration decisions are subject to quality review in the DDS and in SSA's regional offices. Counting waiting times, hand-offs, etc., claimants currently will wait an average of 1153 days, more than three years, for a final decision if their claim is appealed through the Appeals Council.

Is this the kind of service we should expect from our government? Do we really want to tell people, who believe they are disabled and unable to work, that if they can find a way to feed, clothe and house themselves, and their families, without an

income, for more than three years, we will then give them a decision? I doubt anyone believes this is the level of service we should be providing. Anyone who does should be made to wait three years for their next paycheck.

What's Wrong with the Current Process?

The current disability claims process presents many problems. These are the same problems that have been studied by the Social Security Administration and this Subcommittee for more than a decade. To date, affordable solutions have remained elusive. The complexity of the regulations and rules that govern the disability program and the multi-layer appeal process tends to discourage many claimants from utilizing all of their appeal rights. Consequently, SSA has been trying to redesign the disability claims process. For the most part, these efforts have been unsuccessful. The problems that persist are numerous:

- Timeliness of decisions
- Increasing administrative costs
- Solvency of Social Security disability trust funds
- Disparity in DDS and ALJ allowance rates
- Concerns regarding public confidence
- Poor customer service throughout the claims process
- Inadequate training of staff

Clearly, there is a need for the agency to move forward with implementing a new disability process that is practical and affordable. Because of the expected increase in the number of Social Security and Supplemental Security Income disability claims over the next decade, improving the disability process is critical to the agency's mission. SSA will also have to discover a way to incorporate into its assessment of eligibility for disability benefits a determination of what is actually needed to return the claimant to work. SSA will need to develop more aggressive and more comprehensive return-to-work strategies that focus on identifying and enhancing the work capacities of claimants and beneficiaries.

Redesign

SSA's most ambitious efforts to redesign the disability claims process were introduced in 1994. In the ensuing years, SSA tested many ideas, including the Full Process Model (FPM), the Disability Claims Manager (DCM), and others that, after lengthy testing, proved to be inadequate to meet the demands for service and affordability. NADE raised practical concerns about the feasibility of many of these proposals but we supported testing to establish whether or not the ideas would work. Our emphatic condemnation of the Full Process Model and concerns over the administrative costs of Prototype did cause SSA to step back from its plans to roll these designs out nationally.

SSA launched its most recent effort to redesign the disability claims process in October, 1999. In so doing, the Agency ignored warnings from NADE, from the General Accounting Office, and from others, that this test was too large and committed too much of the Agency's resources.

As the Prototype experiment was gradually refined in recognition of its spiraling administrative costs, it became clear that SSA had misjudged its data and that prototype did not represent the future of the disability process. It was clear that the attempt to reduce the four tiered appeal step to two was not a viable approach. Administrative Law Judges were not prepared for the tremendously heavy caseload that resulted from so many claimants choosing to appeal initial denials. Without an intermediate appeal step, Administrative Law Judges, already faced with a backlog of cases, were quickly overwhelmed. The Prototype experiment clearly established the need for an intermediate appeal step between the initial decision and the hearing before the Administrative Law Judge.

Prototype also produced one idea that did show promise for the future—the concept of a Single Decision-Maker (SDM). By eliminating the need for medical consultants to "sign off" on every case and allowing qualified disability examiners to make decisions on cases they felt comfortable deciding, the SDM became the one positive result of Prototype. It was successful in increasing employee satisfaction for the disability examiner and the medical consultant and, more importantly, there was no decline in the quality of the decision.

NADE Proposal For A New Disability Claims Process

After more than a decade of redesign efforts, SSA still does not have an acceptable new disability claims process that will enable the Agency to handle the expected significant increase in the number of claims it will receive in the next decade. It does not have in place a new process that will enforce the need for fair and timely decisions, coupled with the need to maintain public confidence that only the truly dis-

abled are awarded benefits. NADE accepted the challenge to develop a concept for a new disability process that would achieve these goals. A copy of our proposal, published over three months ago, is attached to our statement today. What we desired to achieve with this proposal was to direct attention on a concept for a claims process based on two ideas:

- What is fair for the claimant?
- What can SSA afford?

Our experience and expertise, as the only professional association with the membership base that enables it to view the entire disability process, was critical to our ability to develop this concept for a process that, not only would improve the service provided to the claimant, but would also be affordable. The major highlights of our proposal include:

- Placing greater emphasis on claimant responsibility
- Expansion of the Single Decision-Maker in the DDS
- Enhancing the current reconsideration to provide a due process hearing for the claimant
- Closing the record after the reconsideration decision
- Allowing Administrative Law Judges to make the legal decisions that they are trained to do
- Eliminating the Appeals Council
- Establishing a Social Security Court to hear appeals of ALJ decisions.

We firmly believe that the decision as to whether a claimant is disabled is a medical decision and should be made by those who are especially trained to make such decisions. Judging the impact that a heart attack or stroke has on a person's ability to function in a work setting is a medical decision and is best made by those who have been trained to do so.

Reviewing disability determinations to determine if the law was correctly applied is a legal decision and is best left to those who are especially trained to make those decisions. American jurisprudence would not accept a legal decision made by a lay person untrained in the law. Likewise, America's disability programs should not have to accept medical decisions made by individuals who are not trained to do so.

NADE's proposal affords the claimant the right to a medical hearing regarding their eligibility for disability benefits and a legal review to ensure that the medical decision correctly followed the law. We can hardly see where the argument that the claimant would lose appeal rights has any merit.

There have been arguments presented that hearings conducted at the DDS level would violate the Administrative Procedures Act and would restrict the claimant's right of appeal. This is clearly not true. The APA guarantees the claimant is entitled to a hearing to ensure that the Federal Government agency's decision was made in accordance with the law. This concept is reinforced in the NADE proposal. We fail see how it can be advocated that the right to a medical hearing much earlier in the process would restrict the claimant's appeal rights.

NADE's proposal asserts that the record should be closed after the DDS hearing. The Association of Administrative Law Judges has also supported closing the record after the claimant has received a hearing. Because each appeal beyond the DDS is extremely expensive and each new appeal level is looking at a new case, the decisions made on appeal cannot be used to reflect on the decision rendered by DDS adjudicators. There may be an incentive to not cooperate with the DDS. This is why we have proposed closing the record after the reconsideration level. It will add consistency and affordability to the program.

The proposal to close the record simply seeks to incorporate within the disability program a practice common to the American judicial system and most state workers compensation systems. Appeals are made on issues of law and not on a new case. In NADE's proposal, if claimants believe that new and material evidence does arise after the DDS hearing, this evidence can be reviewed in the DDS and, if necessary, the claim folder can be recalled and the file reopened. If the claim is not reopened, the claimant has the option of submitting a new application for disability and including this evidence. This process still provides claimants with faster processing times than currently.

NADE believes that a new disability process should place greater emphasis on the expectation that claimants, and their authorized representatives, must assume greater responsibility for cooperating with all components of the disability claims process. This Subcommittee was advised in March, 1999 by the U.S. General Accounting Office that, "frequent delays in disability proceedings are a significant problem and often attributable to the actions of some disability representatives." The GAO also reported it had found that disability decision-makers were frustrated

by, "* * * disability program laws that provide numerous opportunities for representatives to submit new evidence in support of their client's claim throughout the entire process and hold SSA primarily responsible for adequately developing the evidentiary record, even when a claimant has representation."

There is a growing problem in Continuing Disability Reviews where claimants refuse to cooperate with requests for information and to attend consultative examinations. This lack of cooperation is often encouraged by representatives and we are beginning to see the same lack of cooperation in initial and reconsideration claims, particularly when there is legal representation involved.

Claimants and their representatives should be required to cooperate fully with the decision-makers at each level in the disability process. Consideration should be given by SSA and the Subcommittee to holding claimants and their representatives accountable for their actions in failing to cooperate.

Other aspects of NADE's proposal call for the elimination of the Appeals Council and the creation of a Social Security Court. The Appeals Council is an unnecessary appeal step. The complexity of disability claims should require that a specialized court, similar to federal bankruptcy and military courts, be created to hear these appeals.

The DDS hearing decision should be defended in subsequent appeals by an individual who can present the merits of the decision. Many will, of course, advocate that this scenario will create an adversarial relationship between the claimant and the Social Security Administration at subsequent appeals. We do not believe this will be the case. Eighty percent (80%) of claims now heard before Administrative Law Judges involve legal representation for the claimant. There is no representation of the government's decision. Administrative Law Judges can be charged with bias if they are perceived as defending the decision while questioning the claimant. This process is unfair. The Social Security Advisory Board suggested in their September, 2001 report that the government should be represented at the hearing level. We concur with this opinion.

The Electronic Disability Claims Folder

The Commissioner of Social Security recently announced her intent to have an electronic disability claims folder fully operational in the field offices and DDSs by January 1, 2004. We believe this is an ambitious goal for an Agency that has struggled for the past ten years to develop an electronic folder. However, NADE is encouraged by the Commissioner's commitment to advancing this goal and we support this effort. We caution the Subcommittee, however, that the expected costs will be significant and funding must either be taken from other components within the disability program that are already experiencing financial strain, or be provided as new money. It would be unfair to expect the level of service that has been provided to be maintained if needed funds are diverted to other projects. We should also not forget that performance and training issues that would arise from this new way of doing business have not been addressed. This will require learning and using new tools and this usually has a negative impact on production, as it has for the past several years in Wisconsin where the DDS in that state has been working on a paperless folder pilot for five years.

Training and Resources

The NADE proposal should be tested to determine whether it can work and provide better service delivery to the claimant than the current process. Its success, however, will be contingent on the proper funding and training being made available to each component in the process.

The need for adequate training has never been more critical. Advances in technology make it likely that knowledge in the world will double every two months by the year 2010. Seventy-five percent (75%) of the technology we will use in 2010 has yet to be invented. It is critical that all components within the disability program be provided with the training that will enable them to discharge their responsibilities in the best interests of the claimants who come to us for help and the taxpayers who pay for the service delivery.

Conclusion

NADE believes that truly disabled citizens should be awarded benefits and that those who are not disabled should not receive benefits, regardless of the claims process used. NADE supports the goal of allowing disability claimants who should be allowed as early in the process as possible. Our proposal has the potential of making this happen in an affordable and expeditious manner.

In its September, 2000 report, the Social Security Advisory Board reported that, ". . . in recent decades, disability policy has come to resemble a mosaic, pieced together in response to court decisions and other external pressures, rather than the

result of a well-thought out concept of how the programs should be operating . . . Policy and administrative capacity are dramatically out of alignment in the sense that new and binding rules of adjudication frequently cannot be implemented in a reasonable manner, particularly in view of the resources that are currently available." NADE concurs with this observation. We believe our proposal for a new disability claims process achieves the goal of providing a well thought out concept that describes how the disability program should operate. It is time to move forward with a new disability claims process that reflects pragmatic reality and offers the best service to the claimant at the best price to the American taxpayer. It is equally important that the Commissioner be given the support necessary to make the appropriate changes that will recommit the Agency to its primary purposes of stewardship and service.

The disability program presently requires about two-thirds of SSA's operating budget ($8 billion in FY 2002–2003). To continue to allow the disability program to operate as described in the report from the Social Security Advisory Board would be a violation of the public's trust and the mission of SSA—**"To promote the economic security of the nation's people through compassionate and vigilant leadership in shaping and managing America's social security programs."**

At her confirmation hearing last year, the new Commissioner of Social Security asserted, *"I do not seek to manage the status quo."* NADE agrees that managing the status quo is no longer a viable option. While we do not support change for the sake of change, we recognize that the status quo has ceased to provide the level of service those who seek our help have a right to expect. The question we must all seek to answer is, "How will we respond to the need to improve service delivery while recognizing that financial resources have constraints?"

No other agency has a greater impact on the quality of life in this nation and the American public will judge the ability of their government to meet their needs by the quality of service provided by SSA. In announcing today's hearing, the Honorable Clay Shaw, Chairman of this Subcommittee, commented: "Individuals with disabilities, already burdened by the challenges of their illness or 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. Our challenge is to thoughtfully and carefully examine the disability determination and appeals process to ensure it meets the needs of individuals with disabilities and their families." NADE believes the proposal we have submitted for a new disability claims process addresses the Chairman's challenge.

NADE Proposal for New Disability Claims Process

February 26, 2002

1. Intake of new disability claims at the Social Security Field Office would not be significantly altered from the current practice with the following exceptions:
   a. Greater emphasis would be placed on the inclusion of detailed observations from the claims representative.
   b. The claimant would be provided with a clear explanation of the definition of disability by the claims representative. The definition would also appear on the signed application.
   c. SSA's web site should clearly indicate that this is a complex process that would be better served if the claimant filed the application in person at the Field Office.
   d. Quality review of the Field Office product would be added to demonstrate SSA's commitment to build quality into the finished product from the very beginning of the claims process.
   e. SSA's outreach activities would combine education with public relations. The Agency's PR campaign would remind potential claimants of the definition of disability with the same degree of enthusiasm as the Agency's efforts to encourage the filing of claims.
   f. Greater emphasis would be placed on claimant responsibility.
2. DDS receipts the new claim and assigns the claim to a disability examiner. The Disability Examiners initiates contact with the claimant to:
   a. The Disability Examiner will verify alleged impairments, medical sources and other information contained on the SSA–3368.
   b. The Disability Examiner will provide a clear explanation of the process and determine if additional information will be needed.

c. The Disability Examiner will inform the claimant of any need to complete additional forms, such as Activities of Daily Living questionnaires.

3. Expand the Single Decision Maker (SDM) concept to:
   a. Include more claim types
   b. Allow more disability examiners to become SDMs
   c. Standardize national training program for all components of the disability process
   d. Establish uniform criteria for becoming SDMs
   e. Standardize performance expectations for all components of the disability process
4. If the initial claim is denied by the DDS, the denial decision will include an appeal request with the denial notice that the claimant may complete and return to the DDS.
   a. The requirement for a clear written explanation of the initial denial will remain a major part of the adjudicative process.
   b. Process Unification rulings should be reexamined and, if necessary, modified to clarify how the initial disability examiners should address credibility and other issues.
   c. Claimant responsibility will be increased in the new process
5. The denied claim will be housed in the DDS for the duration of the period of time the claimant has to file an appeal. During this period of time, claims could be electronically imaged (with adequate resources—this would further the electronic file concept).
6. The appeal of the initial denial will be presented to the DDS. Upon receipt of the request for an appeal, the claim will be assigned to a new disability examiner. Under this proposal:
   a. This appeal step would include sufficient personal contact to satisfy the need for due process.
   b. The appeal decision, if denied, would include a Medical Consultant's signature.
   c. The decision would include findings of fact.
   d. There would be a provision to include an automatic remand to DDS on appeals for denials based on failure to cooperate.
7. The record should be closed at the conclusion of this appeal (including allowing sufficient time for explanatory process before the record closes).
8. Appeal to the Administrative Law Judge must be restricted to questions of law rather than de novo review of the claim.
   a. The DDS decision needs to have a representative included in the hearing to defend the decision.
   b. There must be an opportunity to remand to DDS but such remand procedures must be carefully monitored to prevent abuse and remands should only occur for the purpose of correcting obvious errors.
8. There needs to be a Social Security Court to serve as the appeal from OHA decisions.
   a. The Social Security Court will serve as the final level of appeal.
   b. The Social Security Court will provide quality review of ALJ decision.
   c. The Appeals Council would be eliminated, limiting the total number of appeal steps within SSA to three. Appeals beyond the ALJ level would be presented to the Social Security Court.
   d. The Social Security Court would be restricted to rendering only a legal decision based on the application of the law.

Explanation of New Disability Claims Process Proposed by NADE

NADE considered various alternatives to the current disability claims process before deciding on this process as representing the hope for a claims process that truly provided good customer service while protecting the trust funds against abuse. It was our intent to develop a vision for what the total program should look like and not just the DDS piece of the puzzle. We believe in the concept of "One SSA" and our proposal is submitted based on the belief that all components within the disability program should be united in the commitment to providing good customer service at an affordable price. Quality claimant service and lowered administrative costs should dictate the structure of the new disability program.

The critical elements identified in the NADE proposal are:

- The expansion of the Single Decision Maker concept to all DDSs and expanding the class of claims for which the SDM is able to provide the decision without medical or psychological consultant input. Continuing Disability Review cases (CDR's) and some childhood and mental cases can easily be processed by SDMs.
- More early contact with the claimant by the DDS to explain the process and to make the process more customer friendly. The Disability Examiner is able to obtain all necessary information while clarifying allegations, work history, and treatment sources. The claimant is educated about the process so they know what to expect.
- Housing the initial claim folder on denied claims in the DDS pending receipt of an appeal of that denial. This will effectively eliminate significant shipping costs incurred in transporting claims from the DDS to the Field Office and then back to the DDS. Costs of storage in the DDSs would be significantly less than the postal fees incurred by SSA in the current process. Housing the claims at the DDS instead of the Field Offices could save as much as $20 per claim in shipping costs. It will also reduce processing time by eliminating a hand-off.
- Closing the record after the appeal decision is rendered. NADE believes that closing the record prior to any subsequent ALJ hearing is critical to generating consistency, providing good customer service, restoring public confidence and reducing the costs of the disability program. Without it, there will continue to be two programs, one primarily medical and one primarily legal, with two completely different outcomes. We are unclear as to the degree of personal contact that would be required to satisfy the due process requirement at this appeal level and would defer to SSA the decision as to how much contact is needed and how the requirement could be met. Is a face-to-face hearing necessary or can a phone interview suffice? Even the former, conducted in the DDS, would be substantially less costly than the current hearing before the ALJ. The DDS hearing would allow the claimant to receive a much more timely hearing than the current process allows. NADE also believes that the role of attorneys and other claimant representatives would be significantly diminished as the opportunity for reversal of the DDS decision would be lowered substantially. The DDS hearing would be an informal hearing, lessening the impact attorneys have at this level.
- NADE believes that the current 60 day period granted to claimants to file an appeal should be reexamined in light of modern communication and greater ability of claimants to file appeals more quickly. Reducing the time allowed to file an appeal would produce cost savings to the program and aid the claimant in obtaining a final decision much more quickly.

The additional costs incurred by the DDSs in this new process would be paid for from monies reallocated from OHA and from the cost savings created by less folder movement between the DDSs and the Field Offices. Political decisions will have to be made to reallocate these funds and these decisions will not be popular. Because of turf guarding by the various components within SSA and a general unwillingness to accept change, NADE believes that the victim in past efforts to develop a comprehensive disability claims process has been the claimant. The question must be asked, "Who do we serve, ourselves or the claimant?"

NADE envisions a claims process that would reinforce the medical decision made by the DDS and limit the OHA legal decision to addressing only points of law. NADE believes this proposal would produce a high level of consistency for the disability decisions rendered by the DDSs while significantly reducing the opportunities for OHA to reverse DDS decisions. This would help restore public confidence in the system, provide good service to the claimant and reflect good stewardship since the entire process should prove to be less costly than prototype or the traditional process. The decision as to whether a claimant is disabled would rightfully remain primarily a medically based decision. Claimants who appeal the DDS decision to an ALJ would be entitled to hire legal counsel if they wish. Likewise, SSA would employ a legal representative to define the legal merits of the DDS decision. Each side would present legal briefs in support of their position, rather than appearing in person, and the ALJ would make the decision based on review of the claim file and the legal briefs. If necessary, the ALJ could be permitted to request that both sides appear in person but this should be only for rare circumstances. Unless the law was incorrectly applied, the DDS decision would be affirmed. Any appeal of the ALJ decision would be made to the Social Security Court and either side could appeal.

The proposal is predicated on the assumption that sufficient staffing and resources would be made available to the DDSs. It is also predicated on the need for SSA to clearly define the elements that will satisfy the process unification initiatives. It is critical that SSA should provide clarification of what steps must be followed and provide the funds necessary. To minimize the need for additional resources, we believe the process unification rulings should be modified in accordance with the recommendations that have been proposed by various workgroups. Failure to adhere to this recommendation could result in the likelihood of additional lawsuits throughout the country that will make it mandatory for DDSs to adhere to regulations for which they are not funded. Such a situation would have serious consequences for the ability of the DDSs to provide good customer service and also meet the requirements established by the courts.

Chairman SHAW. Thank you. Ms. Dorn?

STATEMENT OF LINDA DORN, VICE PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATIONS DIRECTORS, LANSING, MICHIGAN

Ms. DORN. Mr. Chairman, thank you for your invitation to participate in this hearing on the challenges and opportunities facing the Social Security Disability process. Our organization agrees with your statement that improvement in the disability determination function is among the primary challenges facing the Commissioner. The National Council of Disability Determination Directors (NCDDD) reaffirms all its previous commitments to participate in finding and implementing responsible solutions with accountability by all stakeholders.

The NCDDD is a professional association of directors and managers of agencies of the State government, performing the disability determination function on behalf of the Social Security Administration. The NCDDD's goals focus on finding ways to establish, maintain and improve fair, accurate, timely and economical decisions to persons applying for disability benefits.

Congress created the Federal/State relationship in response to the need for professional experts working effectively and efficiently with other community based services. It is through the State initiatives, work with the medical community, cost effectiveness in personnel usage, and working with individual State infrastructures to provide referrals to State agencies that serve the disability program and the American public well. This relationship should continue to be nurtured and supported to allow for alignment with other community-based services. The Federal/State relationship, while not perfect, is at its best when integrated with the administration's mandate of empowering States to act on behalf of and empowering our most vulnerable citizens.

We appreciate the recommendations of the bipartisan Social Security Advisory Board as stated in their January 2001 report in regard to strengthening the Federal/State relationship. Our recommendations today focus on six key issues in need of attention: adequate resources, clear concise policy, a quality culture promoting consistency, integrated technology systems, support for the interim decisions are post prototype, and consistency between the DDSs and OHA.

First in regard to resources. The complex task of applying the statutory definition of disability requires extensive development of medical evidence, expert analysis of evidence, and careful expla-

nation of conclusions. The process is therefore costly. Determining eligibility for disability benefits requires staff trained in making complex medical, psychological, vocational judgements. It is not done in any lab situation or a vacuum, but rather in the real world of mounting pressures. The DDS has continued to be the component performing the mission of Social Security disability programs productively, responsively, timely, consistently and cost effectively. Federal components have referred to the State agencies in the DDS as the best deal in government services. A clear relationship exists between the level of service we are able to provide and the resources available to provide that service. The recent history of downsizing, the attempts to implement multiple costly projects, pilots, prototypes, and the creation of new policies that are expensive to administer and other unfunded mandates have contributed to the current situation in which the program and the resources available to carry it out are seriously out of alignment. The task to resource deficit has resulted in an alarming situation about which we want to be very clear.

Presently our program has well over 125,000 disability cases nationally pending than we are able to process. These claims and disability application are awaiting assignment to caseworkers because the caseloads are at maximum capacity for the resources available. Worse, SSA has predicted that the current resource allocation, that this number will continue to grow. The NCDDD feels that this quality of service delivery is unacceptable and amounts to a failure to provide the level of service that the public deserves.

Second, improving policy and training as recommended in the Advisory Board report, the most important step SSA can take is to improve the process to develop ongoing joint training for all adjudicators in all components. The Board also noted that such training presumes the existence of a clear policy base, which is clear, concise and applicable in the real world setting. The NCDDD indicates much more remains to be done in the policy arena. Quality assurance, along with clear, concise policy, NCDDD recommends that SSA assign a high priority to revising the quality assurance system so as to achieve the goal of unifying the application of policy. The NCDDD endorses many aspects of the Lewin Report. We commend SSA and the Commissioner for their recent steps to appoint an executive lead to this important focus on quality. The NCDDD has a group ready, identified, to step forward and work with the Commissioner on this effort.

System support, the development and enhancement of effective performing electronic systems is critical to delivering a high level of service. Historically, the DDSs have an excellent track record of having worked together to develop system capabilities to support their business processes. The NCDDD wants to express our support for accelerated electronic technology initiatives. We recommend further and future development be accomplished with a greater reliance on DDS systems experts and personnel. By working together, the DDS systems experts and private sector and SSA will achieve the bold timeline announced by the Commissioner.

Our support for Post-Prototype and strengthening reconsiderations, we applaud the Commissioner's expeditious actions on prototype, ending years of testing and pilots. We want to acknowledge

the decisions are the beginning steps of the process improvements. We want the second level of a possible review at the DDS level need not be an extra step, but could be such that would provide a better product than those that do go on to the next step in the appeals. We see as the most important task consistency and bringing together reasonable, consistent decision making to the process and the outcomes between the DDS and the Office of Hearings and Appeals.

The DDS process initial and reconsideration level, in an average of about 70 days at a cost about $300 per case, according to data. According to SSA quality reviews we have a decisional accuracy of about 97 percent. Eighty percent of all allowances of those who receive disability benefits are allowed through decision made at the DDS. The NCDDD agrees that disability claims meeting the definition of disability should be allowed at the earliest step in the process.

In conclusion, there is not one single fix. There are challenges to the disabled citizens, the program, the policy, the quality assurance, the employees that make an effort to implement the policy, our Agency, as well as the taxpayer challenges, are in need of our collective attention. The NCDDD restates its desire to continue to work together with you during the continued evolution and improvement of the disability program. Thank you.

[The prepared statement of Ms. Dorn follows:]

Statement of Linda Dorn, Vice President National Council of Disability Determinations Directors, Lansing, Michigan

Mr. Chairman, thank you for your invitation to participate in this hearing on the challenges and opportunities facing the Social Security Disability process at the initial, reconsideration and continuing disability levels at the State Divisions of Disability Determination Services (DDS). Our organization agrees with your statement that improvement in the disability determination function is among the primary challenges facing the new Commissioner. The National Council of Disability Determination Directors (NCDDD) reaffirms all its previous commitments to participate in finding and implementing responsible solutions with accountability by all stakeholders.

Before commenting on specific issues on the topic of today's hearing, we would like to restate the purpose of our organization, explain the reasons for the federal state partnership, and describe our commitment to the identification of barriers to service improvements and to the search for solutions to the challenges facing the disability programs at the DDS adjudication levels.

The NCDDD is a professional association of directors and managers of the agencies of state government performing the disability determination function on behalf of Social Security. NCDDD's goals focus on finding ways to establish, maintain, and improve fair, accurate, timely, and economical decisions to persons applying for disability benefits.

Congress created the federal state relationship in response to the need for experts at the grass roots level working effectively and efficiently with other community-based services. The intention was that the DDS be the human face in government services to our disabled population. This still proves to be the case in most instances. State initiatives; cost effectiveness in personnel usage, and working within the individual state infrastructures to provide referrals to related state agencies have served the disability program and the American public well. This relationship should continue to be nurtured and supported to allow for alignment with other community-based one-stop services. In reality, the federal state partnership, while not perfect, is at its best when integrated with the Administration's mandate of empowering the states to act on behalf of and empowering our most vulnerable citizens.

The SSA/DDS partnership is held to a high standard by close contact with individual state governors, U.S. Congressional delegations and the American public. Serving the public requires close, collaborative teamwork. We appreciate the rec-

ommendations of the bipartisan Social Security Advisory Board (SSAB) as stated in their report of January 2001 and generally concur with their findings, particularly in regard to strengthening the federal state relationship in the short run.

The definition of disability has remained essentially unchanged in the past 30 years. It was always meant to be a more stringent standard compared to many other programs. Recent attention has been focused on allowance rates and other issues when, in fact, the program was never designed to allow every individual with any disability. Contrary to some statements contending the disability programs have not changed over the past years, the program has indeed experienced multiple changes in leadership, focus and direction. For example, mental, childhood, pain, treating source opinion, and credibility issues have engendered many changes which in turn impacted our ability to provide thoughtful, consistent, timely adjudication of Social Security disability cases.

Our recommendations today focus on key issues on which the Commissioner must take prompt and decisive action in order to improve public service for the programs that we jointly administer with SSA.

1. Adequate resources
2. Clear, concise policy
3. A quality culture promoting consistency and integrity
4. Up to date, integrated systems support
5. Support for the interim suggestions "Post-Prototype strengthened reconsideration"
6. Consistency between DDSs and OHA

1. Resources

The complex task of applying the statutory definition of disability requires extensive development of medical evidence, expert analysis of the evidence, and careful explanation of the conclusions. The process is therefore costly. Because determining eligibility for disability benefits are far more than a medical clerical function, the process requires staff trained in making complicated medical, psychological and vocational judgments. This is not done in a "lab" situation or vacuum but rather in the real world of mounting pressures. The DDSs continue to be the component performing the mission of the Social Security disability programs productively, responsibly, timely, consistently, and cost effectively. In fact, various SSA components have referred to the state agencies as being the "best deal" in government service.

A clear relationship exists between the level of service we are able to provide and the resources available to provide that service. The recent history of downsizing, the attempts to implement multiple costly projects, pilots and prototypes, the creation of new policies that are expensive to administer, and other unfunded mandates have contributed to the current situation in which the program and the resources available to carry it out are seriously out of alignment.

The task-to-resource deficit has resulted in an alarming situation about which we want to be very clear. Presently our program has well over 125,000 cases pending than we are unable to process. These disability applications are awaiting assignment to caseworkers because all the caseloads are at maximum capacity for the resources available. Worse, SSA has predicted that, with the current resource allocation, this number will continue to grow.

NCDDD feels that this quality of service delivery is unacceptable and amounts to a failure to provide the level of service that the public deserves.

2. Improving Policy and Training to Produce More Consistent and Accurate Decision Making.

As recommended by the Advisory Board in its report of August of 1998, "the most important step SSA can take to improve the process is to develop on-going joint training for all adjudicators in all the components that make and review disability determinations". The Board also noted that such a training program presumes the existence of a policy base, which is clear, concise, and applicable in a real world setting.

Presently, SSA policy for evaluating disability claims is fragmented, complex, conflicting, confusing, and sometimes obsolete. This compromises the ability of the DDSs to adjudicate cases consistently and accurately and is part of the reason that more than 60% of the applicants who appeal denial of benefits at the initial level receive those benefits after appeal.

While SSA should be commended for its recent efforts to introduce a greater degree of consistency into the process, much more remains to be done.

3. Quality Assurance

Along with clear, concise policy and guidelines, NCDDD recommends that SSA assign a high priority to revising its quality assurance system so as to achieve the goal of unifying the application of policy among all components. The present QA system is out of date, applies differently to the various components, and induces inconsistency of decision-making.

SSA presently is in possession of an independent consultant's report concerning changes in the QA system. NCDDD endorses many aspects of the Lewin report and recommends that it receive expedited attention by top management at SSA. We commend SSA for their recent steps to appoint an executive lead to this important focus on quality.

NCDDD is committed to work with SSA to help create a new quality culture and a new quality process.

4. Systems Support

The development and enhancement of effectively performing electronic systems is critical to delivering high quality service at a reasonable cost. Historically, DDSs have an excellent track record of having worked together to develop systems capabilities to support their business processes. In the last several years, SSA has embarked on various initiatives to develop, at the centralized level, alternative systems that would replace the equipment and software used in the DDSs. These initiatives have been extremely costly and have not produced advantages commensurate with their costs. While the available resources were diverted to the unsuccessful development of SSA systems, enhancement of the DDS systems has been curtailed due to lack of funding.

NCDDD wants to express our support for accelerated electronic disability technology initiatives.

NCDDD recommends that future development and enhancement of electronic systems be accomplished with greater reliance on the DDS systems experts and personnel.

We believe it is reasonable to consider system software development be a task for which the knowledge, skills and ability of the private sector should be better utilized. Only by working together with the DDS systems experts and private sector will SSA achieve the bold timeline announced by the Commissioner.

5. Support for the interim suggestions "Post-Prototype" and strengthened Reconsideration.

We applaud the Commissioner's expeditious actions on prototype issues ending years of testing and pilots. We want to acknowledge the decisions are the beginning steps of process improvements. Further the Social Security Advisory Board (SSAB) reported in January 2001 any plans to eliminate the reconsideration should be reviewed carefully. The rationale was that recon had become a meaningless step that only delayed the correct decision. But a second level of review at the DDS level need not be meaningless. Claimants could be provided the opportunity for a face-to-face de novo hearing conducted by highly trained and experienced DDS reviewers. This should enhance the reliability and accuracy of DDS decisions and reduce the need for claimants to go through the complex and lengthy ALJ hearing process.

NCDDD's position is an alignment of the SSAB's recommendation.

6. Consistency

We are concerned that by attempting to move on so many fronts simultaneously, SSA will sacrifice progress toward solving what we see as its most important task—bringing reasonable consistency to the decision making processes and outcomes between the state DDSs and the SSA Office of Hearings and Appeals (OHA).

We believe that variance in decision making between the two levels is a serious problem in the disability program. Without asserting which component is "right", the facts are as follows: DDSs process initial and reconsideration level decisions on average in about 70 days at a cost of about $300 per case. According to SSA quality reviews, DDS claims have a decisional accuracy of about 97%. Additionally, we believe that it is critically important to remember that eighty percent (80%) of all the individuals who receive disability benefits are allowed through a decision made by the DDS.

NCDDD agree that cases meeting the definition of disability should be allowed at the earliest step in the process.

There has historically been an absence of uniformity and stated clear policy instructions for adjudicators at the two levels. There has been no established ongoing common training for personnel.

Separate and opposite quality assurance and case review systems tend to drive the two components apart rather than to bring them together.

Mr. Chairman and members of the committee, thank you again for the opportunity to provide these comments on the challenges and opportunities facing the disability program. NCDDD restates its desire to continue to work together with SSA during the continued evolution and improvement of the program. We appreciate this committee's initiative in addressing and resolving barriers to improved service delivery.

Chairman SHAW. Thank you. Dr. Stapleton?

STATEMENT OF DAVID C. STAPLETON, PH.D., DIRECTOR, CORNELL CENTER FOR POLICY RESEARCH

Dr. STAPLETON. Mr. Chairman, Members of the Subcommittee, thank you for inviting me today.

Since 1993 the bulk of my professional career has been devoted to work on projects concerning SSA's Disability programs. My knowledge of the disability determination process comes from assistance that I provided to SSA in three evaluations of its efforts to improve the determination process, plus work on another project to review the quality assurance process. Martin Gerry referred to the report we produced today, which I have here in my hand, in his testimony. I am pleased that the Commissioner has followed our first recommendation in that report to appoint a quality work group at a very high level to study some of the options we developed and try to implement them.

My briefing paper presents my conclusions on the performance of the disability determination process and the key challenges that the Agency faces in trying to improve it. My oral remarks are confined to five recommendations that I see as key to making significant improvements

My first recommendation is to create a disability czar. This recommendation follows from the maxim that if it is everybody's responsibility, it is nobody's responsibility. Currently responsibility for the disability programs is divided among the deputy commissioners. Each deputy commissioner has responsibilities to go beyond the disability programs, and all of them interact with each other as equals. The Agency needs a single person whose sole responsibility is the disability programs, who has the authority needed to improve cooperation and coordination among the offices, and who is accountable to the Commissioner for all aspects of disability program performance. The senior advisor who has recently been appointed is not the disability czar I have in mind. It is possible that that position could evolve into a disability czar.

My second recommendation is to develop a modern performance management system for the disability programs. This is the thrust of our quality assurance report. Such a system will require improved information technology, improved performance measurement, consistent use of performance score cards in every day decisions, introduction of significance performance incentives, and use of management techniques that build a quality culture and support continuous improvement.

My third recommendation is to assign responsibility for each initial determination to a single office. This recommendation also follows from the maxim that if it is everybody's responsibility, it is

nobody's responsibility. Currently no office, let alone individual, takes ownership of an application. Each office involved blames the other for poor performance, and inter-office communications delay the process, use significant resources and result in duplication of effort. The substantial success of the Disability Claims Manager test demonstrates the gains to be made from single office responsibility. I think the DCM went too far, personally, by giving a single individual responsibility for adjudicating all aspects of all adult applications. In so doing, it also consolidated responsibility into a single office and gave a single individual ownership of each application. The SSA has concluded that the DCM, as tested, substantially reduced processing time, increased claimant satisfaction and improved employee satisfaction with no effect on measured accuracy, but at an increased cost.

My interpretation of the evidence—and let me tell you, I was intimately familiar with that evidence—is that it is actually more favorable than SSA's. It appears to me that the DCM is roughly cost neutral relative to the current process, as it was implemented in the test, and also that it reduced processing time by more than SSA's report indicates.

The most vexing question about assignment of responsibility to a single office is: whose office? There are really three options, SSA field offices, State run offices, and offices that are established by private contractors. All of these ideas have strengths and weaknesses, which I discuss in my briefing paper. I'm not ready to endorse any one of these approaches over the others, but I do think that one of them will have to be tried if significant progress is to be made.

The fourth recommendation is that the Agency should abandon the one-adjudicator-fits-all model. Currently each medical determination is the responsibility of just one disability examiner with some assistance from experts. This approach is probably efficient for a large majority of cases, but the complexity of the medical, vocational and legal issues involved in a significant number of cases requires a team approach. Such an approach is used for complex determinations conducted by private disability insurers, as well as for many other complex medical and non-medical determinations.

My final recommendation for improving the initial determination process is to address the problems with the appeals process, and in so doing I'm echoing the recommendation of Hal Daub. Current problems with the appeals process undermine the initial process because it is nearly impossible for SSA to obtain useful information from the appeals process and use it to improve the initial process. Defenders of the initial process allege that ALJs are out of control and they're undermining the initial process. Others allege that applicants help their representatives game the system by withholding evidence at the initial level so they can present it to an ALJ. If the ALJ denies their application, they shop for a new ALJ by filing a new application.

Given the lack of information about decisions at the appeals level, it is hard to know how much truth there is in these allegations, but it is clear to me that the initial process is being undermined by the lack of trust in the appeals process.

Those are my five recommendations. Thank you again for inviting me to testify. I would be pleased to answer your questions.

[The prepared statement of Dr. Stapleton follows:]

Statement of David C. Stapleton, Ph.D., Director, Cornell Center for Policy Research

This briefing paper is largely based on the knowledge I gained through work that was performed under contracts from the Social Security Administration to The Lewin Group and its subcontractors, Cornell University and Pugh Ettinger McCarthy Associates, LLC. I gratefully acknowledge the contributions of individuals in those organizations to the information contained herein and to my thinking on this subject. The views expressed in this briefing paper and my oral remarks to the Subcommittee are, however, my own, and do not represent the views of the Social Security Administration, Cornell University, or Pugh Ettinger McCarthy Associates.

Directions for Improvements to the Social Security Administration's Disability Determination Process

I. Introduction

I am an economist, with strong training and experience in the conduct of quantitative evaluations of social service programs. The bulk of my professional career since 1993 has been devoted to work on projects concerning the Social Security Administration's (SSA's) disability programs, Social Security Disability Insurance (DI) and Supplemental Security Income (SSI), and other disability programs and policies. My knowledge of the disability determination process comes from assistance that I provided to the SSA in evaluation of three of its efforts to improve the determination process—the Full Process Model (FPM), the Disability Claims Manager model (DCM), and the Prototype—and from a project to review and develop options for improvements to the Quality Assurance process for disability determinations. The product of the latter was a voluminous report, which included extensive background material, findings from our analysis, and numerous options for improvement.[1] My Cornell colleague Gina Livermore co-led the first three of these efforts, and Michael Pugh of Pugh Ettinger McCarthy Associates, LLC co-led the last.

This paper focuses on the initial determination process for all types of applications and continuing disability reviews (CDRs) (i.e., everything up to appeals to the Office of Hearings and Appeals), reflecting the Subcommittee's interest for this hearing. Some material concerning potential changes to appeals above this level is introduced because of its relevance to the initial determination process.

I begin by briefly summarizing my own conclusions about the performance of the disability determination process. I then describe challenges to improving the process that are posed by the nature of the determinations being made. It is critical to keep these challenges in mind as improvements are developed and implemented. I then describe five changes to the initial process that I believe are key to achievement of significant process improvements.

II. Performance of the Disability Determination Process is Poor

Performance of the process is poor. Mean processing times at the initial level are very long. Approximately one-third of all allowances are made to applicants whose applications are initially denied, including many applications that are allowed on the basis of the supporting evidence collected at the initial level. As a result, the administrative cost of appeals is very high. The cost to applicants whose awards are delayed, and who are often very vulnerable, is perhaps greater, although it is not a line item in the federal budget. Worse yet is the cost to an unknown number of applicants who should be found eligible, but whose claims are initially denied and who fail to appeal.

There is also substantial evidence that eligibility criteria are applied inconsistently across state Disability Determination Services (DDSs), and even across disability examiners within DDSs, although SSA does not currently have a good system to document it. We found one convincing indicator by looking at the spread of initial allowance rates across examiners within four DDSs. In each DDS, the examiners included were experienced, made several hundred decisions per year, and were drawing applications randomly from the same queue. We used statistical methods

[1] See D.C. Stapleton and M.D. Pugh, Evaluation of SSA's Disability Quality Assurance (QA) Processes and Development of QA Options that will Support the Long-term Management of the Disability Programs, to the Social Security Administration, 2001. http://www.quintiles.com / products and services / specialty consulting / the lewin group / lewin publications / detail / 1,1278,213,00.html.

to calculate that the luck of the draw would lead to a spread in allowance rates across examiners of about 10 percentage points within each of the DDSs, but we found that the actual spread in allowance rates was 10 to 19 percentage points greater. Thus, it appears that the examiner in a DDS that happens to get assigned to a claim could affect the chance of that claim's allowance by 10 to 19 percentage points. It is not hard to imagine that differences across DDSs are much greater, because of differences in management, training, examiner qualifications, expert consultants, the health care system in the state, and other factors.

Other evidence indicates that decisions are significantly influenced by incentives. Dramatic evidence of this occurred in the early 1980s. At that time, SSA, at the direction of Congress, started conducting pre-effectuation reviews of a large share of initial awards in response to low allowance accuracy identified through the quality assurance process; denial accuracy was much better. Over three years, allowance accuracy increased substantially, but denial accuracy fell by essentially the same amount. The most obvious explanation for this reversal in the two accuracy rates is that the pre-effectuation review process made it more costly for examiners to allow error-prone cases than to the deny them, tipping the balance in favor of denials. Although cause and effect cannot be proved, I have not heard a more convincing explanation.

People involved in the process are disgruntled about it. Applicants, adjudicators, managers, union leadership and others all have complaints that are difficult to dismiss. DDSs complain about the SSA field offices, and vice versa. Morale is low, leading to high turnover in many offices.

Some would say that the process is also very costly, but what is the benchmark against which we can say costs are high or low? In 1999, as near as I can tell, SSA spent about $1,400 per application adjudicated—including appeal costs, quality assurance costs, and any other costs that SSA associates with applications. The actuaries estimate that the present value of the average SSDI award, including Medicare benefits, is on the order of $100,000. Is $1,400 too much to be spending when this much money is at stake? One private disability insurer told us they were spending $2,400 per application when the amount at stake for the average claim was much lower. Putting more resources into the current process in a reasonably judicious manner, without any other changes, would clearly improve other aspects of performance, but it also appears that substantial improvements in performance could be achieved more efficiently by other means.

III. The Nature of Disability Determination Poses Significant Challenges to Performance Imporvements

Several features of disability determinations are significant challenges to improving process performance. The first is the highly complex and diverse nature of the medical, vocational, legal, and financial issues involved in making determinations. An impressive array of knowledge is required to make appropriate decisions in all cases.

The second is the high level of subjectivity involved in many decisions—assessments of severity of functional limitations, the credibility of evidence about pain and other symptoms, the weight to be given to source evidence versus a medical examiner's evidence, and the value of seeking medical evidence of record from certain providers, are all examples. It appears that there is room for well-trained, well-intended examiners to disagree on the "correct" decision in a substantial number of cases.

The third challenge is that the applicant has a substantial incentive—the potential benefit award—to mislead the adjudicator. The applicant's supporter, including the applicant's provider, might share that incentive.

The fourth challenge is that the program exists within an agency that, despite its fairly recent independence, is subject to the vicissitudes of the political process. Congressmen and governors attempt to influence the program in the interests of their constituents. While this can be a positive force for performance improvement in some circumstances, it can undermine improvement in others. Unions, professional organizations, and other groups can be expected to resist changes that are not in the interest of their members.

The fifth challenge is that major change takes time. The number of years needed is likely longer than a Commissioner's six-year term. Major change also takes extra resources during the transition period, and is likely to crowd out other agency priorities.

Perhaps the most significant challenge is that the concept of disability in the programs is out-of-step with current thinking. Advocates, researchers, policymakers, and others have embraced the idea that the inability to work results from the interaction of impairment, or functional limitations, with a person's environment, yet the

program is required to make determinations on the basis of the old notion that disability is "medically determinable." Policy is changing in ways that reflect the new thinking, albeit very slowly, and the determination process, as well as the broader operations of the disability programs, will need to change with it.

IV. Five Key Changes to Achieve Significant Process Improvements

There is much that can be done to produce small improvements to the initial determination process, but significant improvements require major change. I have developed a list of five changes that I think are key to making significant process improvements.

1. *Appoint a disability czar:* A single person who reports to the Commissioner must be given lead responsibility for all aspects of the disability programs. The recommended change follows from the maxim that "If it's everybody's responsibility, it's nobody's responsibility." Currently, responsibility for the program is divided among the Deputy Commissioners, each Deputy Commissioner has responsibilities that go beyond the disability programs, and all interact with each other as equals. The Agency needs a single person whose sole responsibility is the disability programs, who has the authority needed to improve cooperation and coordination among the offices, and who is accountable to the Commissioner for all aspects of disability program performance.

2. *Develop a modern performance management system.* The thrust of our quality assurance report is that SSA needs to develop a modern performance management system for the disability programs, including the determination process. Such a system will require improved information technology, improved performance measurement, consistent use of performance score cards in everyday decisions, introduction of significant performance incentives, and use of management techniques that build a "quality culture" and support continuous improvement. The job of the disability czar would be to develop and lead this system.

3. *Assign responsibility for each initial determination to a single office:* This recommendation change also follows from the maxim that "If it's everybody's responsibility, it's nobody's responsibility." Currently, SSA Field Offices and state DDSs share responsibility for disability determinations. The result is a system in which no office, let alone individual, takes ownership of an application, each blames the other for process problems, and inter-office communications delay the process, use significant resources, and result in duplication of effort.

The substantial success of the Disability Claims Manager model demonstrates the gains to be made from single-office responsibility. I think the DCM went too far, by giving a single individual responsibility for adjudicating all aspects of all adult applications, but in so doing, it consolidated responsibility into a single office and gave a single individual ownership of each application. SSA's evaluation of the DCM test concluded that it substantially reduced processing time, increased claimant satisfaction, and improved employee satisfaction, but at a somewhat greater cost than the current process. My interpretation of the evidence from that evaluation is more positive than SSA's; it appears to me that the DCM is cost neutral, and that it reduced processing time by more than the report indicates.

That SSA has decided not to pursue the DCM, despite the considerable success of the test, reflects the most vexing question about assignment of responsibility into a single office: Whose office? There are three options, and all have strengths and weakness. The first is to federalize the entire process, so that all decisions are made in field offices. This approach is favored by American Federation of Government Employees (AFGE), and likely has substantial support among SSA managers, but it is probably the most costly and it is also difficult to imagine a federal bureaucracy managing such a large internal process well. The determination process for Veterans' benefits provides a useful model.

The second approach is to give the responsibility to the states. This might be the least expensive approach, would provide a process that is more tailored to the needs of the state, and make state governments accountable to their voters for process performance. SSA's past management of the state DDSs has, however, been hampered by lack of political will; SSA does not have sufficient power to hold states accountable. Perhaps a deal that gives the entire process to the states in exchange for provisions that will make it possible for SSA to hold states accountable could be developed. Such a system already exists in the Food Stamp program, although it is imperfect.

The final approach is to contract the work to the private sector. Many would oppose such a change because of a fundamental distrust of entities that are driven by the profit motive. SSA might, however, be in a stronger position to ensure performance of local entities that are outside the political process than local entities that are either owned by states or internal to SSA. This approach also has the ad-

vantage that a successful firm could make determinations in multiple states. Every participating firm would be continuously threatened by competition from firms that are operating in other states. The Center for Medicare and Medicaid Services uses this approach in its effort to improve health care quality, with some success.

I'm not ready to endorse any one of these approaches over the others, but I think one of these approaches will have to be tried if significant progress is to be made.

4. *Abandon the "one-adjudicator-fits-all" model.* Currently, each medical determination is the responsibility of just one disability examiner. While expert consultation is available, and required in some cases, the decision rests on the shoulders of an individual. This approach is probably efficient for a large majority of cases, but the complexity of the medical, vocational, and legal issues involved in a significant number of cases requires a team approach. Such an approach is used for complex determinations conducted by private disability insurers, as well as for many other complex determinations, including medical ones.

5. *Address the problems with the appeals process.* Currently, the appeals process has significant performance problems of its own. Those problems undermine the initial process. The fact that the program is represented only by conflicted Administrative Law Judges (ALJs), and that performance management is limited, make it nearly impossible for SSA to obtain useful information from the appeals process and use it to improve the initial process. Instead, defenders of the initial process allege that ALJs are "out of control" and are undermining the initial process. Others allege that applicants, with the help of their representatives, game the system by withholding evidence at the initial level so they can present it to an ALJ, and by continuing to file whole new applications until they find an ALJ who will give them an award. Given the lack of information about the decisions at the appeals level, it is hard to know where the truth lies, but it is clear that the initial process is being undermined by the lack of trust in the appeals process.

Chairman SHAW. Mr. Brady?

Mr. BRADY. Thank you, Mr. Chairman. This was excellent testimony. While I have questions for each, I will limit it to three very brief questions.

Mr. Pezza, in your testimony you talk about the need for an intelligent front-end interviewing process. I would like to hear a little more about that.

Mr. Price, I was wondering about the relationship between the State groups and the Federal Agency, SSA, and how that helps or hinders the process?

Then to Dr. Stapleton, I would like to hear a little more about the revenue-neutral approach on the Disability Claims Manager because that seems like if we improve the information gathering and the intelligence up front, if we have good work relationships, consistent standards, and if we can process these claims more accurately and quicker, the whole process benefits in a big way. So, I would like to hear those real quickly.

Mr. PEZZA. Well, one of the things that we do in the initial disability application process taking in the field office, is we take what we call a background report which basically gives the nature of the impairment in the perspective of the claimant. In doing this background report, it would be very helpful if we had a system which would provide drop-down menus for our interviewers. So, that based upon the nature of the impairment, the individual interviewer would be able to tailor the questions and guide the claimant in giving us the information necessary to do a good background report and supply the folks in the DDS with complete medical information. This is something that I think the Agency's been looking into because each——

Mr. BRADY. By its nature, each impairment's going to have a unique set of—or some unique features that you ought to have laid out and gathered.

Mr. PEZZA. Absolutely, right. So, for example, if a person was talking about a heart condition there would be certain specific guidance that this system would provide in a series of drop-down menus which I think would be very beneficial. It makes good sense.

Mr. BRADY. Thank you. Mr. Price, relationship?

Mr. PRICE. Yes. The relationship, we would concur with the testimony of Mr. Daub and the previous reports by the Advisory Board. Strengthening the Federal/State relationship would greatly enhance the opportunity to reduce processing times, to give better service to the claimant. The current set up is such that NADE has encouraged the establishment of more uniform national training standards, for example, at the front end and strengthening the quality assurance process throughout.

Mr. BRADY. If you had to rank what could best be done to improve that relationship, would that increased training be the most important thing?

Mr. PRICE. I think it would be—yes, the training is absolutely essential, and having that availability, I think SSA needs to revamp, if you will, the way it does training, the way it mandates training. Right now in the DDS's initial disability examiners who are hired, receive training basically in compliance with whatever the State feels is their set up. The SSA has introduced a basic examiner training package which forms the basis of this new examiner training, but NADE has asked that there should be more than this because many States simply do what is minimum.

Mr. BRADY. Sure.

Mr. PRICE. Minimum doesn't give you good service.

Mr. BRADY. Good answer. Thanks, Mr. Price.

Dr. Stapleton, I like the idea of having accountability in one person. I like the idea of having teams evaluating these. I would imagine both between the sophisticated medical decisions and then ever-changing occupational standards and opportunities, that the would really help. Tell me about disability claims.

Dr. STAPLETON. Sure. Measuring costs in SSA's system is very difficult. They were doing a test where both the current process and the model they are testing. The DCM model were embedded in lots of other things that were going on in various offices.

I would say that—well, my recollection is that the result that SSA reported is that the DCM costs from 6 to 12 percent more than the current process. I would say that the margin of error in just trying to make that estimate is probably 5 to 10 percent. So, it is close to the margin of error.

The other thing, a couple other points though, when they did this they got the upper value by one method and the lower value by another method. It seemed to me that the upper value had some serious problems with it, and the other method was much more sound. So, I think 6 percent is a reasonable estimate given the whole period of the test which was 18 months. But if you look at the test results from month-to-month, you will see that productivity of the claims managers increases quite a lot over the first 12 months. By the time it gets to the peak, if you recalculated cost at that point,

it would be lower or at least about the same as the current process costs using SSA's methodology. The costs reported are reported for the entire 18-month period, and at the beginning there was startup time and at the end there was wind-down time. These people knew they were losing their positions and tried to wrap things up.

Mr. BRADY. Sure.

Dr. STAPLETON. So, that is the basis of my conclusions.

Mr. BRADY. Are your conclusions in detail on that in your report or can we get some information along those lines?

Dr. STAPLETON. It is not in this report, and in fact, it is not written in any report. I have detailed my thoughts in e-mails to people at SSA. I could provide those to you, I think.

Mr. BRADY. If you don't mind because I would like to learn about it. A final thought is that were the increased costs on that due to accelerated benefits, that we make decisions sooner and more accurately. Therefore, benefits occurred faster?

Dr. STAPLETON. Not really because the cost had to do with administrative cost, not programmatic cost, and my recollection is the allowance, the initial allowance rates were just about the same.

Mr. BRADY. Thank you, Mr. Chairman, very much.

Chairman SHAW. Mr. Pomeroy.

Mr. POMEROY. Mr. Chairman. this is one of the more challenging assignments we have given SSA. I appreciate you having this hearing to explore what they are doing to execute these duties as best as they can do, and I appreciate very much you holding this important hearing. I regret my own schedule prevented me from attending the bulk of it, and look forward to reviewing and having staff put a review of your written materials. It is obviously an area where Members of Congress on the Social Security program perhaps the most active interaction with their constituents. That is very important to us all. Thanks again, Mr. Chairman.

Chairman SHAW. Dr. Stapleton, you said something in your testimony regarding forum shopping to get the best administrative judge that you can get. If somebody's turned down at one, they can go ahead and refile, come up with another judge, and there is no way of bringing it back to the same judge?

Dr. STAPLETON. My understanding now is when somebody files a new application it just enters a process like any other application, and it can end up——

Chairman SHAW. Even though it may be from the same claimed injury?

Dr. STAPLETON. Yes, yes.

Chairman SHAW. Interesting.

Dr. STAPLETON. Actually, if I may go on, there has been some discussion earlier about closing the record. I know there is a lot of concern about if you close the record and somebody has got a new condition. Then that means filing a whole new application and a much longer wait for them, and that is a problem. It seems to me there is a fairly straightforward solution to that if new evidence is being introduced at the appeals level, at the ALJ level—to send the case back to the initial level basically and do another reconsideration by taking into account the new evidence.

Chairman SHAW. Can the court appoint its own doctor to examine the claimant? Does it ever do that?

Dr. STAPLETON. It can do that, yes.

Chairman SHAW. Is that done very often?

Dr. STAPLETON. I wouldn't be the best person to ask.

Chairman SHAW. I would guess, from the way I understand these things, that if you get the right doctor, the right lawyer and the right judge, and——

Dr. STAPLETON. Well, I would certainly expect that the advocates for the claimant get them to get medical examinations independently which are brought into evidence.

Chairman SHAW. I know going from tort law that different doctors are sought after depending on whether you are the plaintiff or the defendant. We remember one doctor that we didn't think he really believed in pain. He was one of the favorite of the defendants, but that was before he had a disc problem in is back. He now believes in pain.

All right. I want to thank all of you for being with us. It has been a very, very good hearing. I think the thing that comes out of this most is that I think this Subcommittee has to know more about this process. This is really our first venture into the details of this. We have looked at the process before as to the lack of electronics and the slowness of the movement, but now we are getting in a little bit into the actual process of the hearing process itself. It is something I don't think we have any expertise on this Committee—who really did any litigation in this area, even though a number of us are lawyers. Still, it is a very specialized area that most lawyers haven't even ventured into.

Thank you. Thank you all for being here. This hearing is adjourned.

[Questions submitted from Chairman Shaw to the panel, and their responses follow:]

National Association of Disability Examiners
Raleigh, North Carolina 27602
August 14, 2002

The Honorable E. Clay Shaw, Jr., Chairman
Social Security Subcommittee
Committee on Ways & Means
United States House of Representatives
2408 Rayburn House Office Building
Washington, DC 20515–0922

Dear Mr. Shaw:

The National Association of Disability Examiners (NADE) is pleased to provide the following response to your inquiry of August 1, 2002. NADE was asked to respond to several questions regarding our testimony, and the testimony of others, that was presented on June 11, 2002.

1a. Explain the process of developing a case.

Case development typically begins with a review of the disability application that has been forwarded to the DDS from the Social Security Field Office. In the vast majority of claims, the disability examiner must initiate contact with the claimant (either by phone or by mail) to develop or clarify issues regarding medical treatment, education, past relevant work and the impact the claimant feels that the alleged impairment has on their activities of daily living (ADLs). Frequently, the disability examiner must also contact an interested third party who is also asked to provide information about the impact the claimant's impairment has on these activities. If these reports include conflicting information then the disability examiner must resolve the conflicts by re-contacting the claimant, and third party source, or contact another source to resolve the conflicts.

All relevant medical sources listed by the claimant are then contacted by mail or fax and asked to either send copies of records or respond to questions specifically

tailored to the alleged impairment. *Information received from treating sources is reviewed as it is received to determine if a favorable decision is possible based on those records. If so, additional evidence is not pursued. If not, unless the treating source is a known uncooperative source,* appropriate follow up is made, either by telephone, fax, or by mail, to obtain any records or completed forms which have not been received.

SSA regulations (POMS DI 22505.001ff) mandate that treating sources be allowed thirty (30) days to respond and the DDS must initiate at least one follow up if there is no response.

If treating source information is incomplete, unavailable, or does not provide the specific documentation needed to determine eligibility under Social Security regulations, the DDS will schedule a consultative examination. This examination is at the government's expense. Every effort is made to assist the claimant in keeping any consultative examination, including arranging for responsible parties when the claimant has a mental impairment and providing the cost of transportation to the appointment. Once all of the medical and non—medical information, including ADL and work history forms, pain questionnaires, and so forth., has been received, the DDS will prepare a decision following the sequential evaluation process. This decision is based on an appraisal of the objective medical findings and consideration of the subjective non-medical findings such as pain allegations, claimant credibility, and treating source opinion.

b. Explain the process for reviewing a case for reconsideration, including under what circumstances a disability examiner obtains additional information.

Reconsideration claims are assigned to disability examiners who are more experienced than disability examiners who adjudicate only initial claims. Reconsideration claims are assigned to a disability examiner who had no part in the initial decision. If input from a DDS medical or psychological consultant becomes necessary at the reconsideration level, the consultant will also be one that had no part in the initial decision.

The reconsideration examiner reviews the claim file to determine both the accuracy of the initial decision and whether additional development is needed in view of the claimant's statements and allegations. The reconsideration examiner must determine if all impairments alleged by the claimant or diagnosed in the file evidence were fully developed initially. The reconsideration examiner must also determine if there are any new impairments alleged or diagnosed and/or whether the claimant has listed any new treating sources or has reported receiving additional treatment from previously identified sources.

If the prior decision was correct based on the information available at the time and the claimant has not alleged any worsening of the impairment(s) and has not reported receiving additional medical treatment, the initial decision can be affirmed "on the record" without the need to pursue additional development. However, such circumstances are unusual. If the claimant alleges worsening of the impairment(s) and/or reports receiving additional medical treatment, all relevant sources for more current records are contacted. The reconsideration examiner follows the same adjudicative requirements as the initial examiner in allowing an appropriate period of time to elapse for a medical source to respond and initiating appropriate follow up contact if the source does not respond. If the reconsideration examiner is unable to fully document all alleged or diagnosed impairments based on the medical evidence of record, a consultative examination will be scheduled. Once all requested information has been received, or it has been determined that the information is unavailable, the DDS will prepare a reconsideration decision, again following the sequential evaluation process.

c. Are such processes checked and documented via DDS or Federal quality review?

Any DDS decision is subject to review by internal DDS quality assurance staff and/or review by the Federal Disability Quality Branch (DQB) in the respective SSA regional office.

2a. Are determinations made by disability examiners in the DDSs, "devoid of rationale and—driven almost exclusively by objective medical findings."? What factors and criteria do State disability examiners use to assess an individual's claim?

NADE is very concerned with the erroneous statements contained in the testimony presented by Ms. Kathleen McGraw on June 11. We are equally concerned that such inflammatory statements are often left uncorrected, adding to the false perception the public already has of the decisionmaking process in the State Dis-

ability Determination Agencies. NADE is very appreciative of this opportunity to challenge Ms. McGraw's statements.

DDS decisions, by law and by SSA regulation, are based on objective medical findings, *coupled with consideration of the claimant's age, education and past work experience.* DDS decisions do take into consideration the subjective findings such as pain and fatigue and the impact the alleged impairment is said to have on a claimant's daily activities. However, DDS decisions are influenced to a lesser extent than decisions made by administrative law judges by these subjective findings. Where the disability examiner in the DDS is unable to conclude that there is an objective medical basis to support the claimant's allegations of pain or fatigue, the subjective complaints are often disregarded, as required by law.

The primary factor in adjudicating disability claims at the DDS level is that it must first be concluded that there is a medically determinable physical or mental impairment that can reasonably account for the subjective symptoms alleged by the claimant before any such symptoms can be factored into the decision.

As an example, NADE would like to offer the case of an individual who alleged disability due to severe burning pain in his hands. A physical examination failed to detect a significant medical condition. The claimant retained normal range of motion of all joints in the hands and there was no impairment of neurological functioning. The claim was documented with x-rays, nerve conduction studies, and a MRI, all of which failed to reveal any evidence of a significant medical condition. Without any objective evidence that could establish the existence of a medically determinable impairment the DDS would conclude that the alleged impairment was non-severe. This would be the correct decision under the law and any attempt to render a different decision would have resulted in DDS or DQB quality assurance reviewers returning the claim to the disability examiner with instructions to deny the claim.

The application of process unification rulings would not alter the DDS decision in such cases. By law, DDSs must first establish the existence of a medical impairment before determining that the claimant is functionally limited, even by pain alone.

An administrative law judge, hearing the same case and using the same evidence available to the DDS, could conclude that the claimant was under a disability. The decision by the ALJ would be based solely on the claimant's alleged pain and no other factors.

Herein lies the difference between DDS decisions and those made by ALJs—DDS decisions must have a medical basis that is defensible to subsequent quality reviewers. Such decisions are sometimes misinterpreted as if the DDS failed to consider the claimant's subjective symptoms. This perception is reinforced by subsequent ALJ decisions that do award benefits based only on such subjective complaints, even when the objective evidence clearly fails to document the existence of a significant impairment.

Such decisions by administrative law judges impact negatively on program integrity since such decisions will, in effect, place an individual on the disability rolls for life. All future continuing disability reviews of such cases will obviously fail to establish that there has been any significant medical improvement in the claimant's condition. Individuals whose claims are allowed on the basis of subjective symptoms alone will continue to receive benefits as long as they continue to allege the presence of such symptoms. Since there was no objective basis for the original allowance decision, there can be no objective basis for determining that there has been medical improvement.

NADE would contend that Ms. McGraw's testimony would have been more effective if she had devoted equal criticism to the administrative law judges who also have failed to adhere to the precepts of process unification.

b. Are such processes checked and documented via DDS or Federal quality review?

As noted earlier, any DDS decision is subject to internal DDS quality assurance review and/or review by the Disability Quality Branch in the regional SSA office. Not only do such quality reviews check for decisional accuracy, but also ensure that the procedures that define the adjudicative process that are outlined in the regulations are followed.

3. What is the status of implementation of Process Unification? What specific Process Unification activities were held last fiscal year? This fiscal year? What are the results?

Process unification was stressed extensively in the ten Prototype states and in those states under various court orders to follow the process unification rulings

without fail. It has been implemented to some extent in all DDSs, both in anticipation of the roll-out of the Prototype experiment and in an on-going effort to align DDS and ALJ decisions. However, there has been some inconsistent application of the process unification rulings in all DDSs because of a lack of necessary resources. DDSs have struggled to apply the process unification rulings in light of inadequate funding. For the most parts, the DDS application of process unification has been limited for cases in which the rulings would make a decisional difference. NADE strongly recommends that, in the future, adequate resources should be allocated to the DDSs whenever any changes are made in the adjudicative process that will require significant allocation of time and resources by the DDSs.

NADE also contends that the continued absence of ongoing training for *all* adjudicators and reviewers, and the lack of a consistent Quality Assurance review of decisions made at all levels, have contributed to the sporadic and inconsistent application of process unification.

4. Is the reconsideration, "little more than a rubber stamp of the original denial"? Should it be eliminated?

Current SSA statistics show a 16% reversal rate at the reconsideration level. NADE would like to challenge the testimony presented by others that point to only a 3% reversal rate at the reconsideration level. Such a misrepresentation of the facts could be viewed as an attempt to misguide the Subcommittee. Obviously, a reversal rate of 16% at the reconsideration level is not a "rubber stamp of the original denial." The reconsideration step in the appeal process has served to provide a needed intermediate appeal step between the initial decision by the DDS and the hearing decision made by the ALJ. This was effectively demonstrated in the Prototype experiment when the absence of a reconsideration step caused appeals to OHA to soar out of control. Even so, in recent years the reconsideration step has been weakened in the interest of increasing case processing efficiencies and reducing processing time. For that reason, NADE's proposal for a New Disability Claims Process, included as an attachment to our testimony of May 2, 2002 before the Subcommittee and the focal point of our testimony on June 11, 2002, proposes strengthening this vital step.

Consideration of affordability, timeliness and fairness issues would indicate that there is a need to strengthen the reconsideration step, rather than eliminating it. The reconsideration, especially an enhanced reconsideration, would provide claimants an opportunity to have their cases reviewed again much earlier than the current 1–2 year wait for a hearing before an ALJ. For thousands of people, an enhanced reconsideration would prevent lengthy waits and would reduce administrative costs.

5. Does the agency, ". . . consult the claimant's health care providers, and compensate them adequately for providing relevant medical information?" If so, how?

All relevant treating sources identified by the claimant on the initial and, if one is filed, reconsideration application, or who are subsequently identified in the course of DDS case development, are contacted. The majority of disability claims are adjudicated based on information obtained solely from the claimant's treating source(s). However, the reality is that, regardless of the level of compensation offered, some sources will to refuse to provide information, either because they don't feel the claimant is disabled or because they don't want to become involved with "government bureaucracies". Other sources provide little or no information as they have not seen the claimant for the alleged impairment or they do not have detailed records. Hospitals, clinics and other medical sources are frequently slow to respond due to the sheer volume of requests they receive for medical records.

In every case in which the DDS seeks to obtain medical records, compensation is offered. It is a subject of national debate as to whether the amount offered by the DDS is "fair and reasonable." DDSs continually face uphill struggles when attempting to obtain increases in the compensatory rates they offer for medical evidence of record.

6. In the case of continuing disability reviews, how common is it for claimants to refuse to cooperate with requests for information? Are claimant representatives a source for this lack of cooperation? What is your solution?

We are unaware of any factual data that would describe the incidence at which claimants and/or their representatives have refused to cooperate with requests for information from the DDS. To our knowledge, such data would be nearly impossible to collect because failure to cooperate or deliberate actions by the claimant or their

representative to delay the DDS in making a decision are nearly always concealed under false pretenses. However, we do have anecdotal information that would indicate this problem is increasing as claimants, and their representatives, become increasingly aware that benefits will continue until a final decision is made and that, by failing to cooperate fully with the DDS, such a decision can be delayed for years. There are few penalties for such actions as there are no administrative procedures in place that require the claimants to pay back any overpayments if the Agency's final decision is to cease benefits.

We further believe that anecdotal evidence suggests that the common perception that exists among the public that claimants have a better chance to "win" at the hearing level has caused some claimants and their representatives to elect not to "bother" with the DDS level, either at the initial or reconsideration steps. We believe that claimants erroneously believe that failing to cooperate with the DDS will force a quick denial of their claim and speed their case to the hearing level. This is rarely the case. Usually, the DDS spends weeks and months in an unsuccessful effort to document each case to show that the DDS has done everything in its power to document the claim for a medical decision before having to resort to denying the claim for failure to cooperate.

As at least a partial solution, NADE has proposed that the Regulations be revised to allow for the immediate suspension of benefits in CDR claims where the DDS proposed a cessation of benefits because the claimant has failed to cooperate or cannot be found.

NADE would also propose that administrative penalties should be enacted that would enable SSA to force the cooperation of claimants and/or their representatives when it can be clearly shown that there has been a failure to fully cooperate with the DDS or when the claimant and/or representative has engaged in actions designed to delay the development of the case.

7. Is the Federal/State relationship working? How could this be changed to improve this relationship?

NADE believes that the Federal/State relationship is working. However, we believe that this relationship could be strengthened by encouraging more open discussion between the DDSs and SSA to resolve issues as they occur. SSA must adopt a significant change in its culture to allow for the possibility that they are not always the experts in the development of policy for the DDSs. State governments must be more willing to accept the oversight requirements of SSA with regards to DDS training expectations and salary issues. Too often, the DDSs are asked to compete with similar state agencies in the formation of salary structure and training.

8. Should SSA's regulations be revised to require States to, "follow specific guidelines relating to educational requirements and salaries for staff, training, carrying out quality assurance procedures, and other areas that have a direct impact on the quality of their employees and their ability to make decisions that are both of high quality and timely."? What are the pros and cons, and the feasibility for making these changes?

NADE believes that the Federal/State partnership could be revised to allow SSA to stipulate minimum educational and training requirements for DDS staff, but only if such a mandate were accompanied by a similar mandate specifying minimum salary levels for DDS staff. NADE believes that a national disability program should have national minimum standards with regard to educational and training requirements for all adjudicative staff. NADE is committed to the concept of ongoing training and professional development. However, the ability to set minimum educational standards would carry an expectation that SSA would also set minimum salaries, an issue that will create problems in many states. Heretofore, SSA has been unwilling to face this political obstacle.

In recent years, we have witnessed frequent turnover in DDS staff. This is due both to an increase in the number of retirees as well as an increase in the number of employees who opt to leave the DDS for less complex work, often with an increase in pay. The salary levels in the DDSs have not kept pace with private industry and the ability of many DDSs to attract the most qualified job applicants has been compromised. At the same time, the DDSs have been forced to contend with the erosion of their experienced staff. These two factors will create a crisis of leadership and experience in the DDSs and contribute to an erosion of their ability to effectively administer the disability program. This will negatively impact on public confidence and the continued ability of the disability program to fulfill its mission.

NADE does believe that educational requirements must not take precedence over ongoing training needs. While we recognize there may be a need to establish some

degree of national uniformity in prescribing minimum educational requirements, we strongly suggest that *it is the need for ongoing training for all adjudicative staff that* will have a greater impact in achieving national uniformity in the disability program. Furthermore, while the ability to prescribe minimum educational standards for DDS staff would have to be coupled with the ability to prescribe minimum salaries, something that we do not envision as being possible in the near future, the ability to prescribe the need for ongoing training, and to be able to offer such training, either through its own resources or by utilizing the availability of training offered by such organizations as NADE, is certainly within SSA's ability. In this regard, we agree with the opinion expressed by the Social Security Advisory Board in its August, 1998 report, *"How SSA's Disability Programs Can Be Improved,"* page 19). *"The most important step SSA can take to improve consistency and fairness in the disability determination process is to develop and implement an on-going joint training program for all . . . 15,000 disability adjudicators . . . and the quality assessment staff who judge the accuracy of decisions made by others in the decision-making process."* The Advisory Board also asserted, *"We urge the Commissioner to make a strong ongoing training program a centerpiece of the agency's effort to improve the accuracy, consistency, and fairness of the disability determination process, and to see that the necessary resources are provided to carry it out."*

Recently, SSA explored the idea that the Agency would offer national disability examiner certification. This idea was abandoned because little interest was expressed in a program that came with few tangible rewards. We believe that an effort to prescribe minimum educational requirements, without the ability to prescribe minimum salary, would have a similar impact.

9. Do you have specific suggestions for changes in the law to better enable you to do your job?

NADE has long advocated review of an equal percentage of allowed and denied decisions by the regional DQBs. We are concerned with recent initiatives by SSA and the Congress that would require pre-effectuation reviews in 50% of State agency allowances of SSI adult cases. These initiatives are similar to existing legislatively mandated reviews of Title II allowances. Without additional resources, any increase in the percentage of allowance decisions reviewed will result in a corresponding decrease in the number of denial decisions reviewed. While we support the increased reviews as a means to improve decisional consistency, we also strongly suggest that reviews of decisions made *at all levels* should be increased. We are concerned that an increased focus on DDS *allowances* may reduce objectivity and compromise program integrity. *The decision regarding an individual's eligibility for disability benefits should be objective and unbiased.* Therefore, NADE supports requiring review of an equal percentage of DDS allowances and denials and an increased review of decisions at all levels.

NADE recommends allowing for the immediate cessation of benefits in failure to cooperate cases as a means of ensuring full cooperation from claimants and their representatives and to also ensure program integrity.

NADE believes that DDSs should be insulated from the particular circumstances that impact on state governmental agencies that tend to negatively effect the quality of service provided. For example, DDSs can be subjected to state hiring freezes, inadequate salary structures, and restrictions on out-of-state travel because of internal state budget problems. In many cases, DDSs are not exempted from such restrictions, even though their funding is provided in full from the Federal budget. Even when exemptions are granted, DDS Administrators are often required to exercise extraordinary measures to obtain such exemptions, wasting time and resources that would be better used in providing quality service to the people. The inability to hire new personnel, retain experienced staff, or offer employees opportunities to receive national training that may not be offered within their particular State, negatively impacts on the quality of service DDSs can offer. SSA needs to exert greater oversight in this regard.

Thank you for the opportunity to provide this additional response. Should you or any Member of the Subcommittee have any additional questions, please do not hesitate to ask.

Sincerely,

Jeffrey H. Price
President

National Council of Disability Determination Directors
Lansing, Michigan 48909
August 29, 2002

1. Judge Bernoski, the President of the Association of Administrative Law Judges, testified on June 20 that improving the quality of disability determination services decisionmaking would improve the overall determination process. He stated (page 4 of his testimony), "rather than carefully develop and examine the claimants' case once, DDS often is making its initial determination based on incomplete records, and upon reconsideration, rarely obtains significant additional medical evidence or changes the outcome of the case." What are your comments on this statement? Would you explain the process of developing a case? Would you explain the process for reviewing a case for reconsideration, including under what circumstances a disability examiner obtains additional information? Are such processes checked and documented via DDS or Federal quality review?

The National Council of Disability Determination Directors (NCDDD) agrees that improving the quality of disability determinations would improve the process. We agree that quality improvements are necessary for all steps in the process, including the appeals process. However, quality is a relative term when the Disability Determination Service (DDS) is the only component with regular, targeted and substantive reviews of their work. No other component, including Office of Hearings and Appeals (OHA) is held to this type of quality review standard. The DDSs' record of accuracy is well known as documented by the Federal Disability Quality Branches (DQB) of the Social Security Administration (SSA).

Additionally, we strongly disagree with the assumption that the DDS often makes initial determinations based on incomplete records and at reconsideration level rarely obtain significant medical evidence. We know of no study or report that factually documents these assertions and statements by the association of administrative law judges. The DDS follows the legal requirements for development of claimants' cases for the disability determination process.

The current process begins at the local SSA Field Office. The SSA Claim Representative, in person or via teleclaim, obtains the pertinent information from the claimant as to allegations, medical sources, types of tests, medications, work history information and daily activities. The claim file then moves to the DDS. Each case is assigned to a Disability Examiner. The Examiner does, in fact, carefully develop and examine the information provided by the claimant and/or representative. This would include requesting all medical evidence relevant to the claim within twelve months of the claimant's alleged onset (the day he/she indicates that disability precluded work at substantial gainful work activity). There are time constraints explained to each medical vendor and prescribed by law, including a series of follow up activities to providers slow in providing reports. Concurrently, Examiners send requests to collateral sources, including but not limited to relatives, friends, therapists, employers, teachers and special service providers. This is an attempt to supplement the objective medical evidence with additional evidence of functionality from a source that is more familiar with the claimant. Each DDS complies with state requirements for payment of medical reports. This entails, at the national level, literally millions of requests for medical evidence of record from various providers.

Throughout the entirety of the case, when an Examiner receives enough documentation for an allowance, development is ceased and a medical determination is made at the earliest possible time. After the legal requirements for requests and follow-ups are met, the Examiner reviews the evidence that has been compiled. The Examiner is required to have supporting documentation for all alleged impairments. In addition, if an impairment is discovered in the course of the development, the Examiner is required to fully and carefully document the new impairment(s). If there is enough evidence to support the medical determination, the Examiner finalizes the decision. If there is not enough evidence for one or more impairment, the Examiner requests a Consultative Examination (CE) from one or more sources including the treating physician, if appropriate. For the first 8 months of fiscal year 2002, nationally, over 42% of the DDS cases required more medical/psychological information. In these cases the DDS was required to purchase additional medical information. This is a significant administrative cost to the program. After the CE report(s) are received, the Examiner once again re-evaluates the case. In the statutory claims, both the DDS examiner and physician review the case for the thoroughness and completeness of the legally required documentation. In addition, all of the subjective information is synthesized into the decisionmaking process. This would also include credibility determinations and weighing treating source opinion.

After the DDS makes the medical determination, the case is subject to random sample review by the Regional Federal Disability Quality Branch (DQB). This review includes both allowances and denials. If the DQB concurs with the documentation and/or decision, the case is returned to the SSA Field Office for final processing. In unfavorable decisions the claimant has 60 days to file for reconsideration. At this time, the claimant may allege new impairments, new medical information, and/or question why the DDS did not obtain pertinent medical records. An Examiner is once again required by law to attempt to obtain the medical evidence from appropriate providers as updated by the claimant. The case is again subject to the same process as described above. This may include documenting a newly alleged or worsening impairment with a CE.

It is unfortunate that the reconsideration step may have been perceived as a "rubber stamp" of the initial decision. The DDSs have well known resource and time constraints in which to proceed with a case. When the medical provider does not provide reports in a timely manner (timely is considered in the range of 30 to 45 days), the case must be moved along in the process without the unavailable records. Many times these records do come in and are associated with the reconsideration claim. Again, if the lack of the medical information leaves an impairment "undocumented" a CE is purchased in most cases in order to meet SSA policy requirements.[1]

The DDSs have internal management reviews and/or quality assurance teams who check all legally required processes. This includes appropriate requests, follow-ups on these requests to the sources if the information has not yet been received and waiting the legally prescribed time for the medical providers to respond.

Since the appeal period on a denial is 60 days, many times the DDSs do not see a vastly different case at the reconsideration level. However reconsideration does validate that the claim was correctly adjudicated and, where conditions have worsened, results in an earlier allowance decision. Given the 12 month durational requirement for disability benefits, the DDS may agree that while the claimant is disabled at the time of the initial and reconsideration claim, their medical condition is not expected to remain severe for 12 continuous months. Because the DDSs have to make a medical/vocational projection of the claimant's recovery 12 months down the line, the DDS would be directed to deny the claim as a duration denial. This is a critical fact, but little known factor in the definition of disability under Social Security. Cases at the ALJ level are usually well beyond the 12-month duration requirements. Many ALJs in our communities tell the DDSs that they see a vastly different case when the case is a year or two older. These ALJs tell us that there is much new evidence in the file that the DDS was never told about or which occurred in months after the case left the DDS the claimant's condition has changed. However, these same judges tell us, given the DDSs' medical expertise, the DDS has laid the foundation for the medical evaluation.

The continuing challenge of the process in the DDS is to manage within the context of cost, resource, quality, and timeliness requirements. The historical underfunding of the program has a direct impact on our ability to balance the quality, timely adjudication of disability claims at the DDS level. Now is the opportunity for the Congress and Administration to find the supporting financial resources to move into the DDS environment. This would enhance the overall strength of the disability determination process.

2. Kathleen McGraw, the Chair of the Social Security Section of the Federal Bar Association, testified on June 20 that State Disability Examiners do not assess claimants' subjective complaints. She stated (page 2 of her testimony), "They were confounded by the task of assessing a claimant's credibility and subjective allegations and articulating a reasoned basis for their conclusions. Notwithstanding the clear message from the Process Unification Training that State Agency Examiners were expected to perform individualized assessments and rationalize their determinations, they have failed to do so. State agencies have balked at this requirement, and examiners' determinations continue to be devoid of rationale and are driven almost exclusively by objective medical findings." What are your comments on these statements? Would you explain what factors and criteria State disability examiners use to assess an individual's claim? Are such processes checked and documented via DDS or Federal quality review?

NCDDD disagrees with the perceptions stated in the testimony of the Federal Bar Association. In response to the allegation, ". . . examiner's determinations continue to be . . . driven almost exclusively by objective medical findings" we believe

[1] Redundant—stated in the 1st

this demonstrates a lack of understanding and medical expertise. We believe the DDSs are in compliance and alignment with the law for determining Social Security disability.

The foundation of each case is an objective medical impairment. "A medically determinable impairment (MDI) which must result from anatomical, physiological or psychological abnormalities which can be shown by a medically acceptable clinical and laboratory diagnostic techniques and be established by medical evidence consisting of signs, symptoms and laboratory findings . . ." The DDS is the only adjudicative component with the medical expertise, training and in-house medical staff to develop and evaluate the facts of the case. Our decisions are not based on bias, assumptions or unsupported allegations. Also, subjective complaints are just that—-subjective and, by nature, individualized. It is not an easy process to evaluate this information in the context of a medical determination, but it is considered in the final determination by the DDSs. Severe resource constraints do in fact place limitations upon the whole process.

We should be clear that most denial determinations have an individualized assessment and rationale. The DDS certainly admits that due to historical underfunding of the DDS process and workload volume, the assessment obviously is briefer than a detailed legal document. Most DDS cases that are appealed to an ALJ are rationalized on a Residual Functional Capacity form which addresses current functioning, subjective complaints, credibility and treating source opinion. As part of Process Unification, Social Security Ruling (SSR) 96–6p dictates that the DDS medical and psychological consultants' finding of fact may not be ignored and must be given weight. It appears the legal community might be reluctant to view this RFC as the individualized assessment and rationalization. However, this is the format prescribed by SSA, used consistently by the DDSs and should not be dismissed. The DDSs have participated in pilots and prototype initiatives, which provided for more detailed assessment, rationalization and explanation. It is our understanding that resource limitations are the basis for not including this detailed level of case explanation and documentation as part of the DDS determination.

All of these processes, including the assessment and rationalization, are subject to both DDS internal and Federal DQB quality review. In fact, the Examiner's assessment is subject to very close review by both quality review teams because it is a source of potential inconsistencies and deficiencies. The DDSs' review process reinforces the application of these concepts. The current national quality rating has not identified insufficient Process Unification application in the DDSs across the nation.

Given the DDS budgetary constraints, our organization believes that we are meeting the challenge, fulfilling the mandate and case compliance expectations set forth by SSA. We are in compliance with the training, and the feedback/monitoring by DQB.

The DDS stands ready to make further refinements and adjustments as required by the appeals process and SSA. The DDSs have been leaders on various pilots and projects to improve the adjudicative process. Unfortunately, resources have not always been commensurate with the mission and goals of the pilots and process improvements. In the future, it is crucial that both staffing and time extensions be built into the process and additional resources dedicated to these concepts, principals and requirements. The NCDDD believes that we need to continue strengthening training, learning from case examples, conducting cross reviews, and receiving component feedback.

3. What is the status of implementation of Process Unification? What specific Process Unification activities were held last fiscal year? This fiscal year? What have been the results?

The status of the Process Unification (PU) implementation at the current time is commensurate with the level of funding provided by SSA to DDSs. Activities continue and further refinements, training programs; case staffing and the collective understanding of the concepts outlined in the Process Unification guidelines are being pursued. However SSA policy for evaluating disability claims is fragmented, complex, conflicting, confusing and sometimes obsolete. This compromises the ability of the DDSs to adjudicate cases consistently and accurately.

NCDDD agrees with the recommendation by the Social Security Advisory Board in its report of August 1998, "The most important step SSA can take to improve the process is to develop on-going joint training for all adjudicators in all the components that make and review disability determinations". The Board also noted that such a training program presumes the existence of a policy base, which is clear, concise, and applicable in a real world setting.

Specific to your question about training, PU was the initial step in the direction of providing a consistent level of training. When PU was instituted there was a mas-

sive and mandatory intercomponent training. PU is the framework upon which the DDS makes determinations on a daily basis. This is not an added-on process. PU training is initiated in the DDSs as the order of business from day one when training the new Disability Examiner. This is supported in the following ways: Basic Examiner Training, in-house mentoring, trainer/supervisor/coach review, internal DDS Management Quality Assurance, SSA-provided Interactive Video Training, update training, and Federal DQB quality review.

As far as the specific training this past year, much of the PU training has been integrated into other training. For example, in January 2002, the DDSs had mandatory national training on the SSA changes in the musculoskeletal listings. PU was included into the training because it is the way we currently evaluate cases.

The DDSs continue to receive claims with ongoing feedback from the DQB for appropriate application of the PU concepts and principles. The DDS community does believe that there is a need for ongoing, intercomponent refresher training that should be provided by SSA for consistent presentation of policy similar to the original PU training.

It should be reiterated that this type of training and application of these concepts is resource-intensive and very time consuming. The DDS is not the only component with PU responsibilities. All components should share in the consistent application of these principles. Limited funding has compromised, in part, a comprehensive approach to the PU principles. We are aware of various pilots, and certainly the Prototype process, which have had success with these concepts when supported by adequate funding. With sufficient training and funding support, this regulatory language can continue to be refined and strengthened in the DDSs and throughout the disability determination process. Further cross component training, feedback and monitoring of PU concepts across all components would serve as a cost-effective method in our delivery of services.

4. Several witnesses testified at the Subcommittee's hearings recently that the reconsideration step should be eliminated. Ms. McGraw stated (page 8 of her testimony), "Reconsideration is widely—and correctly—viewed as little more than a rubber stamp of the initial denial." What are your comments on this statement and the recommendation of eliminating the reconsideration step? What are the pros and cons in your view?

NCDDD is in agreement with the Social Security Advisory Board that the reconsideration step should not be eliminated. We believe it should be strengthened and enhanced at the DDS. For the 86,000 individuals granted disability benefits at the reconsideration level last fiscal year (19% of those appealing), it should not be considered a rubber stamp for the initial decisions. This is particularly important when you consider how soon these decisions were made following the initial determination. The claimant does not have to wait for months for a hearing and it is exceptionally less expensive to process a case in the DDS. Per SSA Office of Disability, it costs on average $418.00 to process a claim at the DDS level. This is ⅓ of the cost of any case appealed subsequent to the DDS determination. Therefore, we believe it to be the most cost efficient part of the disability process.

In the debate over the value of the reconsideration we share the concern that the second step in the case process should be meaningful and value added. The rationale that the reconsideration has become a meaningless step, only delaying the correct decision, is not valid for the thousands of disabled citizens whose conditions continue to deteriorate. The DDS can and does step in to reverse an adverse decision to an allowance at the earliest possible time, including at the reconsideration. This is the right thing to do for the American public that the DDSs serve and is more cost-effective to the claimant and the taxpayer than sending the case to OHA.

The challenge as we view this process is in strengthening the reconsideration step. A second level of review at the DDS level need not be meaningless or have the appearance of a "rubber stamped" decision. Claimants could be provided the opportunity for a face-to-face *de novo* hearing, conducted by highly trained and experienced DDS staff. This "new" reconsideration would enhance the reliability and accuracy of the DDS decisions and reduce the need for claimants to go through the complex and lengthy ALJ hearing process. In addition, we recommend that the record be closed after this enhanced reconsideration in order to strengthen the consistency of the adjudicative process.

The opportunity, as we see it, is to target resources that achieve results in the component with a proven track record . . . the DDS. We would again reiterate, as in much of our earlier testimony, that our DDS organizations are the most cost effective and efficient. With proper funding and resource support, we are prepared to help establish and implement the program improvements that strengthen both the initial claim and the reconsideration appeals step.

5. Mr. John Pickering, Commissioner Emeritus of the American Bar Association Commission on Legal Problems of the Elderly, stated in testimony on June 11 (page 2) that to improve the initial quality of medical and vocational evidence and reduce the number of appeals, "the agency consult the claimant's health care providers, and compensate them adequately for providing relevant medical information." Isn't this done today? Can you explain how? What are your comments on this recommendation?

The NCDDD position is that the DDS organizations are under-funded in terms of appropriate financial support to pay medical providers. Medical evidence is the very foundation for our documentation in all disability claims. The states' ability to compensate health care providers has been compromised and weakened and has negatively affected their ability to deliver quality and timely service.

Each year many states request, as a part of their budget planning requests, increases in the Medical Evidence of Record (MER) and Consultative Examination (CE) fees paid by their state. This is typically the first line item in the funding authority that is eliminated or reduced as funds are being allocated to the State agencies. Further, many states do not even pay the Medicaid rate for retrieval of medical records and purchase of CE medical evaluations, laboratory tests and x-rays. By law, as previously stated, the DDSs are required to request the appropriate MER from the claimant's health care providers. This is not a matter of "picking and choosing" which piece of evidence to obtain. However, there are known timeframes to which all providers are expected to adhere in order to improve overall claims processing time.

Each state pays a predetermined amount for this MER. MER could be in the form of the physician's notes, diagnostic studies, and could include a narrative by the medical source in response to specific questions from the DDS. Nationally the DDSs send out millions of requests per year to document these cases. Mr. Pickering makes the case to ". . . compensate them [health care providers] adequately for providing relevant medical information". However, that would not appear to take into consideration the **millions** of dollars spent to document these cases in the current process. It also does not take into consideration that despite perhaps not "adequately compensating" the health care providers, the DDSs still manage to get the much of the Medical Evidence of **Record**. Again, this could be in direct contrast to Mr. Pickering's assertion that if we paid more for the medical records, we would get more "relevant medical information". We reiterate, the DDSs' don't dictate the relevancy of the record, it IS what is on the record. The challenge continues to be one of ever increasing administrative costs to the program.

We firmly believe that there are two options. These records could be made available to government agencies as belonging to the claimant. The other option would be to obtain available records and/or purchase evaluations with the ability to pay a fair market price, similar to what insurance companies and Medicare are paying, for existing medical records or examinations. This may also be an up front cost, saving overall dollars, resources, rework and costly appeals. The theory of "pay slightly more now or pay significantly more later" would seem to apply.

6. We have heard from the Advisory Board, as well as others, about the need for disability policy to be clear, concise, and applicable in real world settings. Can you give us an example of current policy that is not clear, concise, and applicable to real world settings? How can Social Security Administration (SSA) improve their policies to ensure they are applied consistently as they administer a national program?

The NCDDD organization believes that disability policy that is clear, concise and can be applied in real world settings is ultimately the most cost effective use of the limited resources in today's environment. Historically, there has been inaccurate analysis and insufficient funding associated with the implementation of operational policy changes. Policy effectiveness and its implications are not reviewed post-implementation. It is critical that decisionmakers at both levels (DDS and OHA) apply the same statutory definition of disability and the same regulations. The language in the regulation is far less specific than that of the separate vehicles used to convey policy to DDSs and to OHA. For DDSs there is a manual called the Program Operations Manual System (POMS). Adherence to POMS directives is required at the DDS level. The OHA appeals process has its own separate manual, which differs substantially from the DDS manual.

In addition to the different directives given to the DDSs and OHA, there are a number of unclear regulations and policies. A specific example is found in the newer "Musculoskeletal" listing regulation. One criterion for "loss of function," as required by the listings, is "The inability to ambulate effectively." This is defined as, "Inability to ambulate effectively, means an extreme limitation of the ability to walk; i.e.

an impairment(s) that interferes very seriously with the individuals' ability to independently initiate, sustain, or complete activities." Terms such as "effectively", "extreme limitation", "very seriously" "independently initiate", "sustain" or "complete activities" are nebulous and could lead independent reviewers to different conclusions.

Another example is found in the different approaches to the assessment of residual functional capacity by various decisionmakers. According to the law and regulations, decisionmakers must consider the effect of the medical impairments(s) on the applicant's ability to perform work-related tasks. The resulting conclusion is called the claimant's "residual functional capacity". This finding is based on the medical facts and any opinions that may have been provided by a claimant's treating physician. It is our understanding that OHA decisionmakers tend to place much greater weight on the conclusionary statements of treating physicians, often without supporting, objective findings. SSR 96–2p requires controlling weight to treating source opinions only when supported by objective findings. An extreme difference in decisional outcomes emerges from the conclusions reached about claimants' remaining ability to work.

A third example can be found in the way that SSA determines disability due to a mental impairment. Policies dictate that the claimant with a medically determinable impairment have two of the following: "Marked restriction of activities of daily living." "Marked difficulties in maintaining social functioning"; "Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere)". Or "Repeated episodes of deterioration or decompensation in work or work-like settings, which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors)." We suggest that these four areas are fraught with potential for inconsistencies in the application of policy. In addition, in spite of the allegation that "Disability Examiners do not assess claimants' subjective complaints" one should clearly see by evaluating the listing for a mental impairment, the way to establish any limitation is by assessing subjective complaints. Although data are not available, it is our understanding that at least half of the cases in each DDS involve mental impairments.

An additional example is the Speech and Language policy being applied in childhood disability claims. To some this is a very complex, comprehensive policy and appears to be heading beyond the real world operational boundaries.

A final example is in the way the DDSs and ALJ's assess vocational information. The DDS is required to assess and evaluate the claimant's past relevant work history for the previous 15 years. Then, using the Dictionary of Occupational Titles (DOT) produced by the Department of Labor, the examiner is required to make a vocational determination including transferability of skills to other jobs in the national economy. As an aside, the DOT has not been updated in many years; is not being continued as a research publication; but it is the only reference material available to the DDS. A finding of transferability of skills in most cases dictates a finding of "not disabled". This determination is done in the DDS by the Examiner who has been trained to apply the DOT.

The ALJ frequently contracts an independent a Vocational Expert (VE) to be present at hearings where a vocational determination is required. While the VE uses the same DOT he/she is frequently allowed to give testimony that the job as performed in the national economy (as the DDS is required to determine) is no longer available in the claimant's community. Therefore, there are no transferable skills used in the determination. This frequently results in an allowance decision at the ALJ level. This is inconsistent with the policy that the DDS Examiner would be "allowed" to use for determination purposes.

The challenge continues to be improvements and methods to ensure consistent application of policy. NCDDD and others in the disability community have consistently advised that updates and changes in regulations/policies should be carefully reviewed. There has been an ever-increasing move for including more subjectivity and 'functionality' in the medical listings, which has increased variation in the decision-making process. We acknowledge the current SSA Commissioner for essentially putting a hold on any medical listing updates that were being considered. It is our understanding that all of the proposed changes are being re-reviewed and reconsidered at least partly in response to NCDDD's expressed concerns.

The opportunity now is to review the many workgroup recommendations in which our organization has participated. We encourage SSA to again review the 30-Day Workgroup proposals, the Philadelphia Workgroup suggestions, Tri-Regional recommendations, the One-Agency session ideas and various subgroup proposals. All of these initiatives generated comprehensive strategies that would advance improved cost efficient policy development and operational efficiency.

In conclusion, a single presentation of clear policy for all components is required. In addition, the quality assurance system must be revised so as to achieve the goal of unifying the application of policy among all components.

7. You state your organization supports many aspects of the Lewin report. Would you describe which recommendations you specifically support and why?

NCDDD does support many of the key elements in the Lewin Report. First, NCDDD reiterates our commendation for SSA's recent steps in appointing an executive lead to focus attention on creation of a quality culture at all levels in the disability process. As one of the first recommendations of the Lewin report, we urged SSA to start a dialog. The SSA Executive Lead has already taken steps to include the NCDDD organization in early deliberations and movement forward on the findings of this report. We fully support this effort. The report recommends that the existing QA system be changed radically. It is very explicit that tinkering at the margins of the present system is not enough. The most fundamental precepts and processes must be changed.

The structure of the disability program is too fragmented with too many components responsible for the various pieces of the program and too little coordination among those units. We particularly agree with Lewin's recommendation that SSA develop a new organizational structure that clearly establishes responsibility and authority for the disability program across all SSA functions. This would not only include operations and quality review; but also policy development, budgeting, training and electronic data and tele-video systems design.

The current model is based on a decades-old industrial antiquated model for quality control in which end-of-process reviewers check a sample of the completed product and report and describe "errors". Quality reviews should assure a consistency across the nation. End-of-line quality review does not educate the front line workers or develop their abilities, but simply makes them fearful of being identified as error-prone workers. The SSA quality assurance system should place much more emphasis on in-line process improvement and much less emphasis on finding and reporting on defects.

The report recommends that SSA adopt a broader definition of what it means by quality outcomes in the disability program. At the present, quality, in the quality component, means only the extent of documentation, analysis, and explanation and the resulting "correctness" of the eligibility decision. Other important factors correlate with the quality of an operation—most notably case costs, case processing time and claimant satisfaction with the process—are not considered. This broader definition of quality **must be shared among all components.** Everyone must buy into it. Progress toward the objective is unlikely and is compromised if different components have different views of what quality means. Lewin also observes that leaders and managers in all components must commit to achieving all aspects of the quality objectives.

The frontline workers, the quality reviewers and OHA, should develop a shared definition of what "quality" means to replace the current process in which they view the concept much differently. Presently, frontline workers must always simultaneously balance concerns for the amount of documentation, the thoroughness of analysis and explanation, case processing time and case costs. The operations definition of "quality" includes all these elements. But at the case review level, "thoroughness" is the only consideration, cost and case processing time are entirely ignored. The result is that operations workers on the frontlines receive feedback from the quality reviewers, which is virtually impossible to apply in the real work environment. We recommended establishing a quality concept that all components can work toward rather than continue the present model, which places the components in adversarial positions to one another. The current process does not demonstrate reviews as a value-added step in the process, rather it is viewed as a costly, ineffective impediment.

Lewin recommends that DDSs be responsible for first level reviews (which would incorporate emphasis on in-line improvements) and that Federal resources be used to coordinate and develop the DDS QA units rather than to perform direct reviews of the DDS work.

NCDDD supports the following: creation of a strong link between the mission and goals of the disability programs. We support the refinement of the definition of goals and how they are measured. We also support the development and implementation of a communication plan that reinforces the understanding of the mission, vision, and quality definition for the disability programs at all levels of the organization. We especially agree with:

- Continuing the DDSs' internal quality management systems that meet SSA's disability program specifications;
- Case review and accuracy sampling conducted by **the DDS quality management unit** (whereby redundant [and costly] Federal and DDS end-of-line reviews are eliminated);
- Validation audits conducted by SSA on self-reported DDS accuracy and other performance metrics; and
- Using the findings to adjust state measures.

DDS performance monitoring, through use of a balance scorecard of key performance indicators, would serve as the foundation of the new Federal state relationship.

The opportunity and the reasons for our support of these key aspects are many. The DDSs have a proven track record of providing accurate, cost effective, and timely service to the disabled population that they serve. The DDSs have always been held accountable for a multitude of performance metrics. We support all the components being held to quality standards. A "balanced scorecard" approach would be an important step toward creating a quality environment for all components throughout the organization. This sets the stage for reducing variation in the decisionmaking process across the nation. Of critical importance in the quality process, are actions and steps throughout the process that would advance national quality consistency.

In conclusion, developing the broader definition and applying the definition to all the components can reasonably be expected to change the current environment into one here teamwork and collaboration flourish and adversarial behavior diminishes. The emphasis on quality must begin much earlier in the business process than in end-of-line review. Dedicating valuable time and resources to in-line quality culture is ultimately cost effective and efficient to a business process. The current environment costs the agency work and rework and is an ineffective way to assure quality and national quality consistency.

8. Much has been said by the Advisory Board and the media about decisional variance across states. Can you provide your opinion on why that is?

The NCDDD has historically recognized the issue of decisional variance across states. Reasons for variance include, but are not limited to demographics, urban, rural, age of population, education, poverty, economy, health care programs, employment base, insurance and corporate insurance policies, workers' compensation requirements and workload mix.

An SSA Office of Policy study last year determined allowance rate variance exists.

State supported programs, local economies, policies of large business corporations that require application for SSDI benefits when employees are in medical leave status and unemployment can all contribute to the variation. Access to health care and availability of public health and community mental health programs also add to the variance.

There have been no population-based studies to analyze the client population coming into the disability process. The questions of who is applying, what are the reasons, what are the disabilities, are there differences from state to state or among geographic areas, what are the influences of health care in select geographical areas have not been addressed.

In addition, we believe that the variance in decisionmaking between the DDS and OHA is a serious problem in the disability program. Realizing that time has passed and the claimant's condition may have changed, and without asserting which component is 'right', the facts are as follows: DDSs process initial claims with an average processing time of about 86 days, at a cost of about $418 per case. According to SSA quality reviews, DDS claims have a decisional accuracy of about 97%. Additionally, we believe that is critically important to remember that eighty (80%) of all the individuals who receive disability benefits are allowed through a decision made by the DDS at ⅓ of the administrative cost incurred at subsequent appeals steps. There has historically been an absence of uniformity and clearly stated policy instructions for adjudication at the two levels. There has been no established ongoing common training for personnel. Separate and opposite quality assurance and case review systems tend to drive the two components apart rather than bring them together. These challenges continue today.

In addition, there is clear variance in the decisionmaking between the ten DQB offices, again leading to inconsistencies across the nation. Although SSA has recently undertaken 'Consistency Reviews', SSA has reported that the review "Did not measure what we needed to measure".

Another demonstration of variances in the decisionmaking between components is 'Case Bank Studies'. This is an ongoing project to attempt to provide sample cases

to each component to get feedback on consistency in adjudicative application. In theory, the results were to come back to SSA and the 'correct' answer would be disseminated to all components. The results of this action did not provide clear case policy decisional direction.

The variance can be attributed to the very beginning of policy development and operational aspects of policy. There is variance in interpretation at various levels including the DDS, the DQB, as well as the OHA. The training, or lack thereof, also contributes to the variation. There is little opportunity for dialog, cross component feedback, retraining, and learning about the subjective areas of policy complexities.

The opportunity exists for further in-depth study to explain the variation. A national, not regional, review could minimize variance. Dedicating resources to assure the public confidence in the program and eliminate the concern of bias and unequal treatment of the disabled citizens of this country is absolutely necessary.

9. Do you have specific suggestions for changes in the law to better enable you to do your job?

NCDDD has recommended in several workgroups over the past few years many changes in policy and process to better deliver service and meet the mandated goals and objectives of the program. Adequate resources, administration and management support could better enable the DDSs to deliver improved service.

One specific suggestion is a change in the relevancy of past relevant work from consideration of a 15-year work history to a 5-year period. This is essential given the previous statement regarding the currency of the Dictionary of Occupational Titles and ever-changing job duties.

We have also recommended closing the record after an enhanced reconsideration decision performed by DDS personnel. We also suggest consideration be given to temporary and/or time-limited benefits. Temporary disability and short-term disability with new work incentive provisions and closing the record after the DDS final case review would be consistent with future goals and return to work initiatives for the future viability of the program. These kinds of changes in the disability laws, consistent with the Americans with Disability Act protections and provisions as a matter of general public policy, encourages successful efforts to have the disabled in the work force contributing to the national economy and productivity.

Decisionmaking between the initial (DDS) and appeals (OHA) level must be more consistent. It is our understanding that SSA management has historically permitted the development of an inaccurate view of the immunity from management control of administrative law judges under the Administrative Procedures Act. ALJs have successfully asserted broad decisional independence and freedom from management control and oversight. Our organization believes that this not only accounts for much of the difference in decisionmaking between DDSs and OHA, but also for the extreme difference in allowance rates generally. SSA has recently obtained an opinion for its General Counsel that declares management authority for requiring ALJs to attend training, apply the agency policy, conform to administrative rules, and so forth. As the administration establishes their authority as provided by law, a change in the law may not be necessary

Again our organization encourages changes and updates in laws that demonstrate cost effective public policy, protect vulnerable citizens, protect integrity of the trust fund and assure that resources and means to fund the program are consistent with these laws and initiatives.

Note: NCDDD is recommending regulatory changes that may not require a change in law.

10. Do you think the Federal/State relationship is working or not working? Please explain why, and what you would like to see changed?

The Federal state relationship is working, however the NCDDD organization believes that this unique relationship should be enhanced, nurtured and supported. We believe that the mission of the DDSs is to make accurate determinations of eligibility, to do so quickly, and to be economical.

In considering the effectiveness of the relationship, as well as some of the challenges, we encourage ongoing, open dialog on areas of concern. In reality, the federal/state partnership, while not perfect, is at its best when integrated with the Social Security Administration's mandate of empowering the states to act on behalf of and empowering our most vulnerable citizens. Our organization does recognize areas in need of attention and focus.

The NCDDD organization recommends changes including regulatory language that provides sufficient resources and appropriate funding to meet the mandates of the Administration. In addition, education of the DDS's parent agency and state entities supporting the DDS structure, improving the quality of staffing to deliver the

service of this complex process, training initiatives that support national consistency, and staff that are dedicated to systems support are vital.

Working together is cost-effective when both national and local governments understand the mission, goals and values of meeting the needs of vulnerable citizens. The time and effort to strengthen the relationship will, in the long run, serve both the states and nation.

11. The Social Security Advisory Board has recommended that SSA strengths the Federal/State relationship, including revising SSA's regulations to allow improving the agency's management of State operations. In his testimony of June 11 (page 6), Mr. Hal Daub, the chairman for the Advisory Board, suggested that these revised regulations require States to "follow specific guidelines relating to educational requirements and salaries for staff, training, carrying out quality assurance procedures, and other areas that have direct impact on the quality of their employees and their ability to make decisions that are both of high quality and timely." What are your comments on this recommendation? What do you believe are the pros and cons, and the feasibility for making these changes?

We agree with the Social Security Advisory Board (SSAB) in their report of January 2001 that "The agency's regulations should be revised to require States to follow specific Federal guidelines relating to educational requirements and salaries for staff, training, carrying out quality assurance procedures, and other areas that have a direct impact on the quality of their employees and their ability to make decisions that are both of high quality and timely. Regulations should also ensure that State hiring freezes will not apply to State agency disability operations." While many states have recognized the valuable, skilled professional staff in the DDS agencies, others are seriously impairing DDS and SSA to achieve their service goals. DDS organizations throughout the country have been impacted—as state budgets continue to be compromised by current fiscal conditions and the impact of revenue shortfalls and other local/state challenges. Hire freezes and downsizing of state government programs have all had a corollary impact on the DDS's business process. There is an urgent need for SSA to address in regulatory terms the DDS's ability to direct and control their data systems support staff, hardware and software assets. Therefore, there are many issues regarding staffing, staffing retention, training, internal DDS process issues, with a dramatic impact on the agencies' ability to meet the SSA service delivery goals.

We agree with Chairman Daub of the SSAB, that the regulations need strengthening. There are pros and cons to this challenge. The pros include language and strengthened abilities to minimize these mitigating effects on the DDS business and organizational process. The cons include the question of oversight and control issues. Carrying out the Federal mandate of the Social Security Administration should include flexibility in business processes, while protecting the integrity of the Federal funding.

The opportunity is now. The times call for an updating of the regulations that will instill public confidence and deliver the most cost-effective process for disabled citizens at the state and national levels. Together we can create the future of effective human service and efficient public policy.

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Kim Hildred
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Dear Ms. Hildred:

This letter is my response to a letter I received from Representative Clay Shaw, Jr., as follow-up to my testimony before the Subcommittee on June 11, 2002. He asked me to respond to the following question:

The results of your evaluation of the Disability Claims Manager test were more positive than the Social Security Administration's (SSA's) results. Would you explain why you disagree with SSA's evaluation of this test, including why they found higher costs and lower processing times than you?

First, I need to correct a misimpression that is reflected in the preamble to the question. I did not conduct a separate evaluation of Phase 2 of the Disability Claims

Manager (DCM) test—the phase on which SSA's conclusions are based. Instead, I interpret SSA's findings from Phase 2 differently than SSA does. That interpretation is based on a detailed knowledge of those findings, as well as the methods used to produce them. My colleague, Gina Livermore, and I evaluated the Phase 1 pilot, designed the evaluation of Phase 2, and provided technical assistance to SSA's Disability Process Redesign Team on their implementation of the Phase 2 evaluation.

Cost

The most critical issue is the interpretation of the cost data. SSA's report draws the following conclusion:

Dependent on the productivity and staffing models used, the DCM administrative cost to process an initial claim ranged from about 7 to 21 percent higher than the current process.[1]

The major component of cost is labor cost, which mirrors labor productivity. SSA drew the following conclusion about productivity:

DCM productivity ranged from about 14 percent less to 8 percent more than the current process.[2]

Based on the evidence provided in the same report, I think a more reasonable conclusion is that, apart from training costs, DCM cost per claim was about the same as cost per claim under the current process. DCM productivity is probably higher, but offset by higher salaries and expenditures for medical evidence. I would further conclude that opportunities for reducing DCM costs are substantial. My reasons follow:

- SSA's cost per claim and productivity estimates are based on the average performance of the DCMs over 13 months of the Phase II test. It is clear from other evidence in the report, however, that productivity increased substantially from the first month of Phase II through the 10th and 11th months, then declined somewhat in the last 2 months. In the peak month, SSA's estimates show that DCM productivity is no lower than current process productivity and possibly 20% higher. I think that peak productivity is a better gauge of actual DCM productivity than the mean over 13 months because the reasons for the gradual increase, followed by a decline near the end, have to do with the test situation. Although there was a substantial Phase I, the DCMs were still learning their jobs as Phase II started, and as Phase II ended their attention shifted to what they would be doing after the test ended. In fact, it is possible that productivity would have continued to increase had the test not ended when it did.
- Measurement of DCM productivity relative to current process productivity is very inexact, for two reasons. First, the current process has two components (state Disability Determination Service (DDS) and SSA field office (FO)), with two different productivity measurement systems, and these must be combined in some fashion for purposes of comparison to the DCM. Second, many activities other than initial adult disability claims processing occur in the DDSs and FOs, and it is problematic to accurately apportion labor effort into initial application processing and other activities. The problems are so substantial that we cannot be confident that the productivity (and cost) differences reported are real, rather than the result of measurement problems. SSA developed two approaches to measuring productivity, and the extremes of the range of both productivity and cost estimates reflect these two approaches. The range for measured DCM productivity relative to measured current process productivity is 22 percentage points. If I had to choose, I would prefer the approach that produces the relatively high productivity measures for the DCM, because it relies less heavily on work sampling. The more important point, however, is that the estimates are not sufficiently precise to draw firm conclusions about which process is less costly, given the differences observed for these measures.
- DCM costs could likely be lowered relative to current process costs through adjustments to the DCM process. Remember that the DCM process is largely new, while the current process has been in place for many years; SSA and the DDSs have had much more time to tinker with the current process in order to improve productivity. An important example is improvement in management information systems (MIS). Each DCM had to use both Federal and state MIS during the test. Combining the two systems would likely reduce costs substantially.

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[1] SSA, Disability Process Redesign Team, *Disability Claims Manager Final Evaluation Report,* October 2001, p. 29.

[2] *Ibid.,* p. 29.

- DCM salaries were an important determinant of DCM costs during the test, and it is quite possible that lower salaries would be sufficient to operate this process. The costs SSA reports reflect the salaries of individuals who actually participated in the test. With a few exceptions, the DCMs were a mix of former disability examiners (state employees) and claims representatives (federal employees). Almost all Federal DCMs received a promotion, and many state DCMs also did. One reason for the promotions was to encourage employees to accept temporary assignments, in many cases away from home. In general, state DCMs were paid substantially less than Federal DCMs.
- The cost estimates from the evaluation do not include training costs. Training costs under the DCM might be higher than under the current process because every adjudicator must receive training in both medical and non-medical adjudication. Lower adjudicator turnover, resulting from greater job satisfaction and higher pay, might substantially mitigate this increase.

Processing Time

SSA concludes that the median processing time for DCM Title II claims was 10 days shorter than under the current process; for Title XVI the median was 6 days shorter. These estimates understate the reduction because of the way the samples used to calculate the medians were selected. While it is not possible to determine exactly what the corrected values would be from data in the report, it is possible to make a good estimate. My calculations indicate that median DCM processing times were shorter than those for the current process by about 19 days for Title II (compared to SSA's 10), and by about 15 days for Title XVI (compared to SSA's 6).

The report states: "Any claim filed before Phase 2 began (11/1/1999) or that was adjudicated after the evaluation phase ended (11/30/2000)" is excluded.[3] Exclusion of claims filed before Phase 2 is fine. Exclusion of claims adjudicated after the evaluation phase ended is necessary, but by itself introduces a downward bias in processing time for both DCM and control (i.e., current process) claims, because claims filed late in the evaluation phase are included if they are adjudicated quickly, but omitted if they are not. The bias is greater for control claims, for two reasons. First, longer processing times for control claims means that for all claims filed during any month, the share of "slow" control claims excluded is larger than the share of slow DCM claims excluded. Second, due to an initial problem in the assignment of control claims, a larger share of the control claims is initiated in the last few months of the evaluation period.

It is possible to produce unbiased estimates of the medians for claims in each group that were filed in the first 10 months of the evaluation period, because more than half of all claims filed in each of these months had been adjudicated by the end of the evaluation period, for both the DCM and control processes and for both Titles. SSA provides enough information in the report to approximate the median processing time for all claims filed in the first 10 months of the test by process and Title.[4] My estimates of the reductions in median processing time are based on those claims only.

Conclusion

Based on the evaluation, I think that the DCM, if fully implemented in a reasonable way, would produce substantial improvements in processing time, applicant satisfaction, and employee satisfaction without an increase in cost, a decline in accuracy or a change in the initial allowance rate. However, as indicated in my testimony, I do not recommend implementation of the DCM as it was tested. Based on discussions with many people involved in the test, I think that much of the success of the DCM occurred because a single person in a single office took ownership of the claim and also served as the point of contact for the claimant. That feature of the DCM can be preserved without requiring the person to be qualified to adjudicate all aspects of the claim. The complexity of many claims makes it inefficient to have

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[3] *Ibid,* p. 18.

[4] *Ibid,* p. 23. The table on this page of the report shows the percentage of claims filed in each month that were processed as of each 30 day interval after filing, from 30 to 180 days, plus the number of claims filed in each month, by Title and DCM versus control. From these data I calculated the percent of each type of claim completed at 60, 90 and 120 days for those claims filed in the first 10 months. My estimates of the medians were obtained by interpolation between these percentages. For example, I found that 39.0 percent of DCM Title II claims were completed within 60 days and 62.7% were completed within 90 days. The median must, therefore, be between 60 and 90 days. I used linear interpolation between these two points to estimate a median of 74 days for DCM Title II claims. Note that this value is actually greater than the median reported by SSA, but this is because of the bias in SSA's estimate caused by; the fact that SSA included claims that were filed after the 10th month if they were adjudicated by the end of the 13th month.

a single person have the expertise needed to fully adjudicate any claim. A system that preserves the most positive aspects of the DCM, but includes more specialization of expertise and functions, would be better.

I hope this information is useful to the Subcommittee.

Sincerely,

David C. Stapleton, Ph.D.
Director

[Whereupon, at 5:30 p.m., the hearing was adjourned, to reconvene on Thursday, June 20, 2002, at 10:00 a.m.]

THURSDAY, JUNE 20, 2002

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

The Subcommittee met, pursuant to notice, at 10:21 p.m., in room B–318 Rayburn House Office Building, Hon. E. Clay Shaw, Jr. (Chairman of the Subcommittee) presiding.

Chairman SHAW. We are going to go ahead and get started. I am advised that we should be left alone for an hour before they call us back across the street. I am told Mr. Matsui will be here in just a moment. So, I am going to go ahead and read my opening statement.

Today the Subcommittee will continue our examination of the challenges and opportunities faced by Social Security's two disability programs, Disability Insurance and Supplemental Security Income.

Last week we examined the disability and appeals process. Today, we will focus in depth on the disability appeals decisions made by Federal Administrative Law Judges, the Appeals Council and the Federal District Courts.

We will hear from stakeholder groups who can provide their perspectives on the major issues their constituents face as well as their recommendations.

Americans that apply for disability benefits and those who appeal the Agency's decision expect to receive accurate fair decisions within a reasonable period of time.

This is not happening now. Individuals with disabilities who pursue disability benefits for themselves or their families by appealing an unfavorable decision face unconscionable delays. On average, according to the Commission of Social Security, wait time from initial applications to decisions from an Administrative Law Judge averages 495 days.

Add appeals and the court's processing time, the average is nearly 3 years. Worse yet, this broken system has persisted for years with little improvement. Individuals with disabilities face tremendous obstacles every day and an enormously frustrating process of applying for and obtaining Social Security benefits shouldn't contribute to this challenge.

Changes must be made to improve this process to ensure that Americans with disabilities and their families can depend on Social Security to provide the economic security that they deserve.

This morning we have one panel, and it is a large panel. We have Marty Ford who is Co-Chair of the Social Security Task Force, Consortium for Citizens with Disabilities (CCD). We welcome you back.

We have Nancy Shor who is Executive Director of the National Organization for Social Security Claimants' Representatives from Midland Park, New Jersey.

We have James Hill, who is President of the National Treasury Employees Union (NTEU), Chapter 224.

We have the Honorable Ronald G. Bernoski, who is President of the Association of Administrative Law Judges. He is from Milwaukee, Wisconsin.

We have the Honorable Kathleen McGraw who chairs the Social Security Section of the Federal Bar Association (FBA).

We have John Pickering who is the past Chair of the Senior Lawyers Division, Commissioner Emeritus, Commission on Legal Problems of the Elderly, American Bar Association (ABA).

We have Paul Verkuil, who is Professor of Law, Benjamin N. Cardozo School of Law at Yeshiva University in New York. He is accompanied by Jeffrey Lubbers, who is a Fellow at the Washington College of Law, the American University.

We welcome all of you. We have your full statements which will be made a part of the record and you may summarize as you see fit. Ms. Ford.

[The opening statement of Chairman Shaw follows:]

Opening Statement of the Hon. E. Clay Shaw, Jr., a Representative in Congress from the State of Florida, and Chairman, Subcommittee on Social Security

Good morning. Today the Subcommittee will continue our examination of the challenges and opportunities faced by Social Security's two disability programs—Disability Insurance and Supplemental Security Income.

Last week we examined the disability determination and appeals process. Today, we will focus in-depth on the disability appeals decisions made by Federal Administrative Law Judges, the Appeals Council, and Federal District Courts. We will hear from stakeholder groups who can provide their perspectives on the major issues their constituents face, as well as their recommendations for change.

Americans that apply for disability benefits, and those who appeal the agency's decision, expect to receive accurate, fair decisions within a reasonable amount of time. This isn't happening now.

Individuals with disabilities who pursue disability benefits for themselves and their families by appealing an unfavorable decision face unconscionable delays. On average, according to the Commissioner of Social Security, wait time from initial application to decision from an Administrative Law Judge averages 495 days. Add appeals through the courts plus processing time and the average is nearly 3 years. Worse yet, this broken system has persisted for years, with little improvement.

Individuals with disabilities face tremendous obstacles every day—the enormously frustrating process of applying for and obtaining Social Security benefits shouldn't contribute to their challenges. Changes must be made to improve this process to ensure that Americans with disabilities and their families can depend on Social Security to provide the economic security that they deserve.

STATEMENT OF MARTY FORD, CO-CHAIR, SOCIAL SECURITY TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES

Ms. FORD. Chairman Shaw, thank you for this opportunity to testify.

For people with disabilities it is critical that the Social Security Administration significantly improve the process for determining disability and the process for appeals. The CCD Social Security Task Force strongly supports efforts to reduce unnecessary delays and to make the process more efficient—so long as those efforts do not affect the fairness of the outcome.

I will highlight three points from my written statement. First, regarding technological improvements: The current system requires a great deal of manual labor. Using electronic folders could allow much faster processing.

However, it is critical to establish from the outset that electronic files must contain all of the claimant's evidence in an exact, unalterable electronic copy of the original.

In addition, nothing should preclude the claimant from presenting available evidence in any format. Important details and nuances in handwritten and typed reports must not be lost. We do not consider summaries or partial documents acceptable substitutes for inclusion in a folder.

Advances in technology will allow the Commissioner to ensure protection of this evidence by requiring that exact, unalterable, electronic copies of all originals be permanently maintained in the folder.

Second, keeping the record open for new evidence: We strongly support the development and submission of evidence as early as possible in the process. However, there are often factors beyond the claimant's control which contribute to delay. Claimant's conditions may worsen over time and diagnoses may change. Claimants may undergo new treatment. They may be hospitalized or referred to different doctors. Some conditions take longer to diagnose. Some claimants misunderstand their own impairments.

By their nature, these claims are not static and a finite set of medical evidence does not exist. At what point can a individual say that he now has all of the information about the condition and how it will affect his life?

How sensible is it to refuse to receive new information, especially if the process itself creates such a delay that changes in condition are possible?

If the record is closed earlier in the process, individuals will be forced to file new applications merely to have new evidence reviewed. However, filing a new application may severely jeopardize, if not permanently foreclose eligibility for benefits.

Individuals applying for Title II Disability Insurance could lose their entitlement to benefits if they are unable to reapply before their recent connection to the workforce ends.

Contrary to statements made in oral testimony during last week's hearing, great harm could be done to an individual who is forced to reapply and who, due to the Title II time limits, loses his or her eligibility.

We believe that it is important to work on the front end of the process instead and figure out how to get the best possible evidence as soon as possible.

Third, the Agency role in adjudication. An important issue underlying many of these discussions is the role of the Agency in determining disability and paying benefits. There seems to be a sentiment among some that SSA is not being fairly represented in the determination process.

We believe that it is important, however, to note that SSA and the claimant are not parties on opposite sides of a legal dispute. The SSA already has a major say in what goes on. The SSA develops and publishes the regulations, including the medical listings. The SSA provides guidance to claims workers and DDS staff through its program operations manual system. The SSA contracts with the States for determinations based on its own regulations and Program Operating Manual System (POMS) and SSA hires the ALJs.

The claimant's role is to show that she has an impairment with limitations that fit within the parameters constructed by Congress and implemented by SSA. Very few claimants would have the wherewithal to know and understand all of the things that could or should pertain to their cases.

The SSA's role is not to oppose the individual's claim, but rather to ensure that people who are eligible, as contemplated by Congress, are enabled, as a result of the claims process, to receive the benefits to which they are entitled.

Where an individual has representation, SSA is not placed in a weaker or unfair position. The SSA still controls the process. Rather, SSA should see the individual's representative as an ally in facilitating the collection of relevant evidence and highlighting the important questions to be addressed in making the disability determination.

Again, I thank you for this opportunity to testify on these important issues. The CCD Social Security Task Force looks forward to working with the Subcommittee and the Commissioner in meeting the challenges to improve the disability determination and appeals processes.

[The prepared statement of Ms. Ford follows:]

Statement of Marty Ford, Co-Chair, Social Security Task Force, Consortium for Citizens with Disabilities

Chairman Shaw, Representative Matsui, and Members of the Subcommittee, thank you for this opportunity to testify regarding the disability determination and appeals process.

I am Director of Legal Advocacy for The Arc of the United States. I am testifying here today in my role as co-chair of the Social Security Task Force of the Consortium for Citizens with Disabilities (CCD). CCD is a working coalition of national consumer, advocacy, provider and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force focuses on disability policy issues in the Title XVI Supplemental Security Income program and the Title II disability programs.

For people with disabilities, it is critical that the Social Security Administration address and significantly improve the process for determining disability and the process for appeals. We are pleased to see Commissioner Barnhart take on this task as a major goal of her tenure as Commissioner. We support her view that this is a vitally necessary course of action for the agency and we look forward to working with the Commissioner and this Subcommittee in meeting the challenges

The backlog of cases waiting for ALJ and Appeals Council decisions is clearly unacceptably long, as so vividly and visually illustrated by the Commissioner at this Subcommittee's hearing on May 2, 2002. People with severe disabilities who by definition have limited earnings from work are often forced to wait years for a final decision from the time of application through the final Appeals Council decision. This is damaging not only to the individual with a disability and his/her family, but also to the public perception of and integrity of the program.

We strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as they do not affect the fairness of the process to determine a claimant's entitlement to benefits.

Technological Improvements

We support the Commissioner's efforts to make technological improvements at SSA. Whatever funds are necessary should be appropriated to ensure that the process works as intended by the law.

Much of the delay in the current process is caused by a system that still requires a great deal of manual labor. If the system is not upgraded, from a technological standpoint, some of the process reform changes discussed below will not improve the system. Several initiatives have been announced recently that, we believe, could reduce delays, provide better service to the public, and would not require fundamental changes to the current process. They include: electronic folders (eDIB); digital recording of hearings, and video teleconference hearings. We support such modernizations where they are used to ensure a full and fair evaluation of a claim and ensure the claimant's access to a full and fair hearing on appeal, where necessary.

We believe that using electronic folders will allow much faster processing, eliminating delays while folders are moved from place to place, avoiding loss of valuable records, and allowing immediate recording of updates, new evidence, or other actions regarding the file. However, we believe that it is critical to establish that electronic files contain all of the claimants' evidence in an exact, unalterable electronic copy of the original, including complete copies of originals that are received electronically. In addition, nothing should preclude the claimant from presenting available evidence in any format.

In the past, we were skeptical about the use of electronic folders due to concerns about how evidence, such as handwritten or typed doctors' reports, would be included in an electronic file. We do not consider summaries or partial documents acceptable substitutes for inclusion in a folder. Important details and nuances in the paper reports must not be lost. However, technology is now commonly available to allow such "paper" evidence to be fully included in the electronic folder without alteration. We urge the Commissioner to ensure protection of this valuable, sometimes irreplaceable, evidence by requiring that exact, unalterable electronic copies of all originals be permanently maintained in the electronic folder. Otherwise, we could not support this move toward a fully electronic record.

Gathering Evidence

It is critical that SSA collect the correct information at the earliest possible time in the process to ensure that correct decisions are made the first time. SSA must improve the collection of medical and non-medical evidence by explaining what is needed and asking the correct questions, with appropriate variations for different treatment sources.

Claimants should be encouraged to participate to the extent they are able. To that end, SSA should assess, as early in the process as possible, the claimant's need for special assistance and provide it. Such assistance could be triggered when applicants are unable to read, show evidence of cognitive or other mental impairments, or give other indications of being unable to maneuver the process alone.

As noted below, it may be difficult for claimants to obtain evidence for various reasons, e.g., state laws limiting release, reluctance of providers to release information, inadequate payment for records. Providing DDSs with adequate funds to obtain evidence would assist greatly at an earlier part in the process.

Eliminating Reconsideration

We support the concept of eliminating reconsideration and providing the opportunity for a pre-denial interview. The Commissioner recently announced in April 2002 that the elimination of the reconsideration step would be extended in the ten "prototype" states while SSA gathers additional information, but will not be extended nationwide at this time.

However, the Commissioner also announced the end of the "claimant conference" in the prototype states, upon publication of a notice in the Federal Register. We believe that an in-person interview would be beneficial to many claimants. In addition

to identifying further information, these interviews would also allow claimants to provide information and explain the limitations caused by their impairments.

The Right To A Full And Fair Hearing Before An Administrative Law Judge

The key aspect of the adjudication process for a claimant is the right to a full and fair hearing by an Administrative Law Judge (ALJ), who is an independent decision-maker, providing impartial fact-finding and adjudication. The ALJ asks questions of and takes testimony from the claimant, may develop evidence when necessary, and applies the law and agency policy to the facts of the case. Claimants have the right to present new evidence in person to the ALJ and to receive a decision from the ALJ that is based on all available evidence. This right should be preserved.

Keep the Record Open for New Evidence

Many recent proposals to change the disability determination process recommend that the record be closed to new evidence either after the DDS or, at least, after the ALJ level. In the past, both Congress and SSA have recognized that such proposals are neither beneficial to claimants nor administratively efficient for the agency.

We strongly support the submission of evidence as early as possible. Full development of the record at the beginning of the claim means that the correct decision can be made at the earliest point possible. The benefit is obvious: the earlier a claim is adequately developed, the sooner it can be approved and the sooner payment can begin.

Despite the obvious benefit to claimants, the fact that early submission of evidence does not occur more frequently indicates that factors beyond the claimant's control contribute to this problem. In attempting to find a solution, Congress and SSA should be careful not to make the process less "user-friendly" or more problematic for SSA.

There are several reasons why closing the record is not beneficial to claimants:

(1) Conditions change over time. Claimants' conditions may worsen or improve over time and diagnoses may change. Claimants may undergo new treatment, be hospitalized or referred to different doctors. Some conditions, such as multiple sclerosis, take longer to diagnose. Some claimants mischaracterize their own impairments, either because they are in denial or lack judgment or understanding about their illness.

By their nature, these claims are not static and a finite set of medical evidence does not exist. Think for a minute about your own and your family's situation. How often has someone received a diagnosis, only to have it change later as more tests are conducted or as more symptoms begin to appear? How often has the original assessment of a condition's severity changed, for the better or the worse? At what point can the individual affected say that he/she now has all of the information about the condition and how it will affect his/her life? And how sensible is it to refuse to receive new information, especially if the disability determination process itself creates such a time lag that changes in condition are possible, if not likely?

If the record is closed, individuals will be forced to file new applications merely to have new evidence reviewed, such as reports from a recent hospitalization or a report that finally assesses and diagnoses a condition. Closing the record to such evidence does not serve either the claimant or the agency well. It would merely ensure that a decision will be made based on a snapshot that may be significantly out of date.

Finally, the system already imposes restrictions on new evidence submitted after the initial DDS decision. These limitations prevent the process from being entirely open-ended and serve to encourage claimants and their representatives to gather as much relevant information as possible as early in the process as possible.

(2) The ability to submit evidence is not always in the claimant's control. Claimants always benefit by submitting evidence as soon as possible. However, there are many reasons why they are unable to do so and for which they are not at fault. Closing the record punishes them for factors beyond their control, including situations where:

- DDS examiners fail to obtain necessary and relevant evidence.
- Neither SSA nor the DDS explains to the claimant what evidence is important and necessary for adjudication of the claim.

- Claimants are unable to obtain medical records either due to cost or because state laws prevent them from directly obtaining their own medical records.
- Medical providers, especially treating sources, receive no explanation from SSA or the DDS about the disability standard and are not asked for evidence relevant to the claim.
- Medical providers delay or refuse to submit evidence.

So that claimants are not wrongly penalized for events beyond their control, the current system provides a process to submit new evidence if certain conditions are met. This exception should not be eliminated in the name of streamlining the system.

(3) The process should remain informal. For decades, Congress and the United States Supreme Court have recognized that the informality of SSA's process is a critical aspect of the program. Imposing a time limit to submit evidence and then closing the record is inconsistent with the legislative intent to keep the process informal and inconsistent with the philosophy of the program. The value of keeping the process informal should not be underestimated: it encourages individuals to supply information, often regarding the most private aspects of their lives. The emphasis on informality also has kept the process understandable to the layperson, and not strict in tone or operation. SSA should be encouraged to work with claimants to obtain necessary evidence and more fully develop the claim at an earlier point.

Further, filing a new application is not a viable option because it does not improve the process and may in fact severely jeopardize, if not permanently foreclose, eligibility for benefits. A claimant should not be required to file a new application merely to have new evidence considered where it is relevant to the prior claim. If such a rule were established, SSA would need to handle more applications, unnecessarily clogging the front end of the process.

Worse yet, individuals applying for Title II Disability Insurance benefits could permanently lose their entitlement to benefits if they are unable to re-apply before their recent connection to the workforce ends (DI beneficiaries must have worked 20 out of the last 40 quarters). Contrary to statements made in oral testimony during last week's hearing, great harm could be done to an individual who is forced to re-apply and who, due to the Title II time limits, loses his/her eligibility permanently.

Many people will wait some time before applying for benefits as they try to see if their impairments can be overcome or if they can make it in their changed circumstances. Added to the delays in the process as described by the Commissioner, the individual could be beyond the 5-year "recency of work" test before facing the need to re-apply. Those who do not have problems with recency of work may still lose benefits for the time period between the first and second applications. Forcing re-application merely to consider new evidence is clearly unfair to the claimant.

The Agency Should Not Be Represented at the ALJ Level

We do not support efforts to have SSA represented at the ALJ hearing because past experience shows that it does not result in better decision-making and reducing delays, but instead injects a level of adversity, formality and technicality in a system meant to be informal and non-adversarial. In the 1980's, SSA tested, and abandoned, a pilot project to have the agency represented. It was terminated following Congressional criticism and a judicial finding that it was unconstitutional and violated the Social Security Act. In the end, the pilot did not enhance the integrity of the administrative process.

Agency Role in Adjudication

In the discussions above regarding maintaining an informal process and representation of SSA in the ALJ hearing, an important underlying issue is the role of the agency in determining disability and paying benefits. There seems to be a sentiment among some that SSA is not being fairly represented in the determination process.

We believe that it is important, however, to note that SSA and the claimant are not parties on opposite sides of a legal dispute. SSA already has a very heavy say in what goes on: SSA implements the law through development and publication of regulations, including the medical listings; provides guidance to claims workers and Disability Determination Services staff through its Program Operations Manual System (POMS); contracts with the states for determinations made in accordance with its regulations and POMS; and hires the ALJs. The claimant's role is to show that he/she has an impairment with limitations that fit within the parameters constructed by Congress and implemented by SSA.

Very few claimants would have the wherewithal to know and understand all of the things that could or should pertain to their cases. SSA has a vital role in helping the claimant through a very complex process. SSA's role is not to "oppose" the individual's claim; but rather to ensure that people who are eligible as contemplated by Congress are enabled, as a result of the claims process, to receive the benefits to which they are entitled. Where an individual has representation, whether legal or lay representation, SSA is not placed in a weaker or unfair position requiring its own representation. SSA has still written all the regulations and POMS and contracted with the DDSs and hired the ALJs. Rather, SSA should see the individual's representative as an ally in facilitating the collection of relevant evidence and highlighting the important questions to be addressed in making the disability determination.

We believe that all the discussions about the formality/informality of the process and whether SSA should/should not be represented should be viewed from this perspective.

Retain Review by the Appeals Council

We oppose the elimination of a claimant's right to request review by the Appeals Council. The Appeals Council currently provides relief to nearly one-fourth of the claimants who request review of ALJ denials, either through outright reversal or remand back to the ALJ. Review by the Appeals Council, when it is able to operate properly and in a timely manner, provides claimants, and SSA, with effective review of ALJ decisions. Given the low percentage appealed to federal court, it appears that claimants largely accept decisions by the Appeals Council as the final adjudication of their claims. As a result, the Appeals Council acts as the initial screen for ALJ denials, a position for which the district courts are ill equipped, given their other responsibilities.

Retain Access to Judicial Review in the Federal Court System

Both individual claimants and the system benefit from the regular federal courts handling social security cases. Given the wide variety of cases they adjudicate, federal courts have a broad background against which to measure the reasonableness of SSA's practices.

Reasons given for establishing a Social Security Court include creating a uniform body of case law and guaranteeing that the claims of similarly situated claimants are treated without regional disparity. Creation of a Social Security Court is not the most effective, efficient, or fair manner in which to accomplish these goals.

Intervention by the federal courts has played a vital role in protecting the rights of claimants. The courts have halted illegal practices by SSA and have provided standards and guidance where SSA has failed to articulate clear policies. The current federal court system has contributed to national uniformity. The process of federal court review has not led to significant regional variation. In general, the courts have reached agreement on core issues concerning SSA programs. As a result, extensive circuit case law has provided guidance to SSA in developing uniform standards. Two examples in major areas include: (1) rules describing the weight to be given all medical evidence, including reports from treating sources; and (2) rules to evaluate subjective symptoms, including pain. Overall, there is substantial benefit to be derived from different courts thoughtfully considering different cases on the same issue to shed light on the many aspects of any particular position.

The courts should be readily accessible to all claimants, and should allow everyone, including people who are poor, disabled or elderly, an equal opportunity to be heard by judges of the high caliber we expect. A Social Security Court located in Washington, DC, would severely limit access to the court for those who most need it—people with disabilities or who are elderly and who have limited financial means. Currently, claimants and their attorneys have relatively easy access to the federal courts and un-represented individuals are able to file appeals without the assistance of counsel. If Social Security Courts were not located in as many locations as the federal district courts, many people would be unable to file cases because of distance and the cost of travel. These individuals would likely feel that the system had utterly failed to provide a fair opportunity for review. In light of geographical distances and high caseloads, the court might be forced to forego oral argument altogether, as has been the case with the Appeals Council.

There are high financial and administrative costs in creating the court. The court would involve expenditures for judges, staff, courthouse space, etc. The financial cost of creating the court must be weighed against the questionable effectiveness of the court to achieve its stated objective, especially given the limited resources available.

Remove Limitation on Administrative Expenses

Reducing the backlog and processing time must be a high priority. We urge commitment of resources and personnel to resolve the exorbitant waiting times and make the process work better for people with disabilities. First, SSA must be provided with the resources to fully meet its administrative responsibilities. This can be accomplished by removing SSA's Limitation on Administrative Expenses budget authority from the domestic discretionary spending category.

SSA workloads are projected to begin increasing rapidly within the next decade as the baby boom generation begins to reach its peak disability years just prior to reaching early retirement age beginning in 2008. In addition, the SSA workforce is also aging and will begin to lose significant numbers of staff, including senior and leadership staff. About 3,000 employees are expected to retire per year from 2007 through 2009. SSA is also taking on new or more complex responsibilities such as providing increased rehabilitation and employment services for people with disabilities, completing and maintaining an appropriate schedule of continuing disability reviews and other eligibility reviews, and new approaches to prevent fraud and abuse. In FY 1985, SSA's staffing levels were 80,844 FTEs and 83,406 workyears. The President's budget requests for FY 2003 include 63,464 FTEs and 64,730 workyears, for a reduction of 17,380 FTEs and 18,676 workyears over the last 18 years.

The CCD Social Security Task Force has voiced concern for some time over the continued long-term downsizing of the SSA workforce. We believe that failure to conduct appropriate and timely CDRs and other eligibility reviews could lead to decreased trust in the integrity of the Social Security and SSI programs. In addition, the new efforts to assist people with disabilities to go to work, through the Ticket to Work and Work Incentives Improvement Act of 1999, require new and expanded approaches for SSA interaction with beneficiaries. Adequate staffing levels are critical for these and other efforts to be successful, especially given the coming disability and retirement years of baby boomers.

For these reasons, we strongly support removing the Social Security Administration's Limitation on Administrative Expenses (LAE) budget authority from any domestic discretionary spending caps. Even if the LAE were removed from the domestic discretionary caps, SSA's LAE would still be subject to the annual appropriations process and Congressional oversight. Currently, SSA's administrative expenses total less than 2% of benefit payments paid annually. Congress would still maintain its role in ensuring continued administrative efficiency.

Most importantly, removal of the LAE from the domestic discretionary spending caps would remove it from competition with other health, education, and human needs programs for limited funds. It would allow for growth that is necessary to meet the needs of the coming baby-boomer retirement years (including the retirement of SSA and state DDS personnel); continue the efforts to improve the processing time for initial applications and appeals, particularly through technological improvements; continue the efforts to ensure integrity in the program through CDRs and other redeterminations; and allow for replacement of staff in a timely manner and to provide for adequate training and mentoring.

Again, thank you for this opportunity to testify on these important issues. The CCD Social Security Task Force looks forward to working with the Subcommittee and the Commissioner on improving the disability determination and appeals processes.

On Behalf Of:

American Association on Mental Retardation
American Congress of Community Supports and Employment Services
American Network of Community Options and Resources
American Occupational Therapy Association
Brain Injury Association of America
National Alliance for the Mentally Ill
National Association of Protection and Advocacy Systems
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Research Institute for Independent Living
The Arc of the United States
Title II Community AIDS National Network
United Cerebral Palsy Associations, Inc.

Chairman SHAW. Ms. Shor?

STATEMENT OF NANCY G. SHOR, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES, MIDLAND PARK, NEW JERSEY

Ms. SHOR. Chairman Shaw, thank you for inviting us to testify today about challenges and opportunities in the administration of the Social Security Disability Programs.

Collectively, Members of the National Organization of Social Security Claimants' Representatives (NOSSCR) have many, many years of experience in representing claimants at every level of the disability determination process. We appreciate this opportunity to share some observations and recommendations with you.

Today's hearing focuses on the challenges facing the disability programs, two extremely important criteria for such review are certainly efficiency and timeliness. They are not the sole criteria. Today's hearing should be directed to ensure the fairness of the process for determining whether or not a claimant is entitled to benefits.

Without hesitation, NOSSCR strongly supports efforts to reduce unnecessary delays for claimants and to make the process much more efficient as long as these efforts do not impair the fairness of the process to determinate a claimant's entitlement to benefits.

First, it is certainly necessary to State without elaboration. It is crucial to provide the Social Security Administration with adequate resources to meet current and future needs. To improve delays, better develop cases and implement technological advances, SSA requires adequate staffing and resources. The NOSSCR supports removing SSA's administrative budget from discretionary domestic spending caps.

Secondly, very briefly, but it is certainly necessary to improve full development of the record earlier in the process. Unfortunately, very often the files that denied claimants bring to our Members show that inadequate development was done at the initial and reconsideration levels.

Often claimants are denied at those levels, not because the evidence establishes that the person is not disabled, but because the limited evidence gathered there cannot establish that the person is disabled.

Often, a properly developed file is before the ALJ because either the claimant's representative has obtained the necessary evidence or because the ALJ has. Not surprisingly, these different evidentiary records can easily produce different results on the issue of disability.

To address this, the Agency needs to emphasize the full development of the record at the beginning of the claim. The benefit is obvious. The earlier a claim is adequately developed, the earlier it can be correctly decided.

We have set out several recommendations to improve the development process in our written testimony.

Third, I want to speak to processes to streamline the disability determination process without impairing the claimant's right to a full and fair hearing.

First, we support elimination of the reconsideration level. It appears to be a step that requires a lot of time and produces very little.

Secondly, with the focus on the Office of Hearings and Appeals, clearly current processing times at the ALJ and Appeals Council levels are unacceptably high. We strongly agree with the Commissioner that reducing the backlog and processing time is a high priority. We urge commitment of resources and personnel necessary to reduce delays and make the process work better for the public.

We believe that features of a full and fair process include the following: retain the right to a de novo hearing before an Administrative Law Judge. This is the right to a full and fair administrative hearing by an independent decision maker who provides impartial fact finding and adjudication, free from any agency coercion or influence for claimants. This means the right to appear in person to provide testimony and new evidence to an ALJ.

Keep the record open for new evidence and understand that there are currently regulatory and statutory limitations on what can come into a file once an ALJ has issued an opinion.

The NOSSCR strongly supports the submission of evidence as early as possible, but we know there are often many legitimate reasons that evidence cannot be presented at the time of the ALJ hearing. I would certainly offer a cautionary observation that telling a claimant to file a new application in lieu of submitting new evidence on appeal can be significantly disadvantageous to that claimant.

We believe that the Social Security Administration should not be represented at the ALJ level. In the eighties, SSA tested and abandoned a pilot project to have the Agency represented. The government representation project, which I guess works out to GRP.

The GRP caused extensive delays in a system that was overburdened even then and injected an inappropriate level of adversity, formality and technicality into a system meant to be informal and non-adversarial.

We support continued review by the Appeals Council. I will note very briefly, appropriately 25 percent of claimants who have requested review of an unfavorable ALJ decision find relief at the Appeals Council. We also note that the processing times are significantly improved at that level in the past year.

Finally, we support continuation of the current system of access to the Federal courts for judicial review of Social Security claims. Thank you for the opportunity to testify.

[The prepared statement of Ms. Shor follows:]

Statement of Nancy G. Shor, Executive Director, National Organization of Social Security Claimants' Representatives, Midland Park, New Jersey

Chairman Shaw, Representative Matsui, and Members of the Subcommittee:

Thank you for inviting me to testify about challenges and opportunities in the Social Security disability programs. I commend you for holding this hearing since millions of people with disabilities depend on these programs.

For the past twenty years, I have been the Executive Director of the National Organization of Social Security Claimants' Representatives (NOSSCR). NOSSCR's current membership is approximately 3,450 attorneys and others from across the country who represent claimants for Social Security and Supplemental Security Income (SSI) benefits. Collectively, we have many years of experience in representing claimants at every level of the disability determination process and welcome this opportunity to share some observations and recommendations with you.

During my tenure as the NOSSCR Executive Director, SSA Commissioners and other officials at the Social Security Administration have been willing to meet with us and other groups to discuss issues important to our membership and to claim-

ants. This has proven to be an effective way of addressing our concerns before they become serious problems requiring other types of intervention and we look forward to continuing this dialogue with Commissioner Barnhart and her staff regarding the disability programs.

Today's hearing focuses on the challenges facing the Social Security and Supplemental Security Income disability programs. Two extremely important criteria for such a review are efficiency and timeliness. But these are not the only criteria. Today's hearing should be directed to ensure the fairness of the process for determining whether or not a claimant is entitled to benefits. We share SSA's goal of providing accurate decisions for claimants as early in the process as possible. Further, changes at the "front end" can have a significant beneficial impact on improving the backlogs and delays throughout the hearings and appeals process.

The vast majority of cases handled by NOSSCR members are claims for Social Security and SSI disability benefits. NOSSCR strongly supports efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as these efforts do not impair the fairness of the process to determine a claimant's entitlement to benefits.

Provide SSA With Adequate Resources To Meet Current And Future Needs

NOSSCR is concerned about SSA's readiness to deal with the impending increase in its workload as the "baby boom" generation approaches the peak age for onset of disability and, subsequently, retirement. At hearings held by this Subcommittee in 2000, testimony painted a bleak picture regarding SSA's ability to deal with the increased work, at the same time that its own workforce will reach peak retirement numbers. To exacerbate this problem, SSA's budget continues to be cut from levels that would allow it to adequately address current and future service delivery needs.

Most cases handled by NOSSCR members are at the ALJ hearing and Appeals Council levels, where current processing times are unacceptably high. A claimant cannot proceed with an appeal in federal district court until the Appeals Council has acted. Thus, while their medical and financial situations are deteriorating, claimants are forced to wait for many months, if not years, before receiving a decision.

To improve delays, better develop cases and implement technological advances, SSA requires adequate staffing and resources. NOSSCR supports removing SSA's administrative budget, like its program budget, from the discretionary domestic spending caps. Legislation such as H.R. 5447, a bipartisan bill introduced in 2000 by Chairman Shaw and Representative Cardin, would accomplish this by allowing Congress to approve funding for SSA to address current service delivery needs and planning for the future.

Improve Full Development Of The Record Earlier In The Process

Developing the record so that relevant evidence from all sources can be considered is fundamental to full and fair adjudication of claims. The decisionmaker needs to review a wide variety of evidence in a typical case, including the medical records of treatment; opinions from medical sources and other treating sources, such as social workers and therapists; records of prescribed medications; statements from former employers; and vocational assessments. The decisionmaker needs these types of information to determine the claimant's residual functional capacity, ability to return to former work, and ability to engage in other work which exists in the national economy in significant numbers. Once an impairment is medically established, SSA's regulations envision that all types of relevant information, both medical and nonmedical, will be considered to determine the extent of the limitations imposed by the impairment(s).

The key to a successful disability determination process is having an adequate documentation base and properly evaluating the documentation that is obtained. Unless claims are better developed at earlier levels, the procedural changes will not improve the disability determination process. Unfortunately, very often the files that denied claimants bring to our members show that inadequate development was done at the initial and reconsideration levels. Until this lack of evidentiary development is addressed, the correct decision on the claim cannot be made. Claimants are denied **not** because the evidence establishes that the person **is not disabled**, but because the limited evidence gathered cannot establish that the person **is disabled**.

A properly developed file is usually before the ALJ because the claimant's representative has obtained evidence or because the ALJ has developed it. Not surprisingly, these different evidentiary records can easily produce different results on the issue of disability. To address this, the agency needs to emphasize the full development of the record at the beginning of the claim. The benefit is obvious: the earlier a claim is adequately developed, the earlier it can be correctly decided.

NOSSCR supports full development of the record at the beginning of the claim so that the correct decision can be made at the earliest point possible. Claimants should be encouraged to submit evidence as early as possible. However, the fact that early submission of evidence does not occur more frequently is usually due to reasons beyond the claimant's control.

Our recommendations to improve the development process include the following:

- SSA should explain to the claimant, at the beginning of the process, what evidence is important and necessary.
- DDSs need to obtain necessary and relevant evidence. Representatives often are able to obtain more relevant medical information because they use letters and forms that ask questions relevant to the disability determination process. DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. The same effort should be made with nonphysician sources (therapists, social workers) who see the claimant more frequently than the treating doctor and have a more thorough knowledge of the limitations caused by the claimant's impairments.
- Improve provider response rates to requests for records, including more appropriate reimbursement rates for medical records and reports.
- Provide better explanations to medical providers, in particular treating sources, about the disability standard and ask for evidence relevant to the standard.

The Disability Determination Process: How to Streamline Without Impairing the Claimant's Right to a Full and Fair Hearing

I. Initial And Reconsideration Levels

In ten "prototype states" [AL, AK, CA, CO, LA, MI, MO, NH, NY, PA], SSA currently is testing two significant changes at the pre-hearing levels of the process: elimination of the reconsideration level and adding a predecision interview, also known as a "claimant conference." Originally scheduled to be implemented in 2002, SSA published proposed regulations in January 2001. 66 Fed. Reg. 5494 (Jan. 19, 2001). However, SSA announced in mid-2001 that the nationwide rollout would be deferred pending further analysis. In April 2002, the Commissioner announced that the claimant conference would be eliminated after notice is published in the Federal Register.

NOSSCR has supported elimination of reconsideration and adding the predecision claimant conference. We have had concerns about the conduct of the claimant conference based on reports from NOSSCR members such as: brief and pro forma conferences held by telephone; variations in content of the conference, depending on the particular DDS adjudicator involved; claimants not being informed of their right to be represented at the claimant conference; and claimants possibly being discouraged from pursuing an appeal if the decision is denied.

We have long advocated the value of providing claimants with a face-to-face meeting with the decisionmaker and hope that the Commissioner will find a way to incorporate the most beneficial features of the original objectives of the claimant conference. When she announced that the conference would be eliminated, the Commissioner stated that SSA would encourage early and ongoing contacts with claimants during the development process. As discussed above, these are goals that NOSSCR strongly endorses. Many NOSSCR members would like to participate earlier in the process since they are able to assist the disability examiners in obtaining medical evidence and focusing the issues.

II. The Hearings And Appeals Levels

Current processing times at the ALJ and Appeals Council levels are unacceptably high. We agree with the Commissioner that reducing the backlog and processing time must be a high priority. We urge commitment of resources and personnel necessary to reduce delays and make the process work better for the public.

Recently, a number of proposals to change the disability determination process have been put forward. However, these proposals contain some recommendations that we believe would undermine a claimant's right to a fair adjudication process. We believe that features of a full and fair process include the following:

- **Retain the right to a *de novo* hearing before a Administrative Law Judge.**

A claimant's right to a hearing before an Administrative Law Judge (ALJ) is central to the fairness of the adjudication process. This is the right to a full and fair administrative hearing by an independent decisionmaker who provides impartial fact-finding and adjudication, free from any agency coercion or influence. The ALJ

asks questions of and takes testimony from the claimant, may develop evidence when necessary, and considers and weighs the evidence, all in accordance with relevant law and agency policy. For claimants, a fundamental principle of this right is the opportunity to present new evidence in person to the ALJ, and to receive a decision from the ALJ that is based on all available evidence.

- **Keep the record open for new evidence.**

Many recent proposals to change the disability determination process recommend that the record be closed to new evidence either after the DDS or, at least, after the ALJ level. In the past, both Congress and SSA have recognized that such proposals are neither beneficial to claimants nor administratively efficient for the agency.

Under current law, an ALJ hears a disability claim *de novo*. Thus, new evidence can be submitted and will be considered by the ALJ in reaching a decision. However, **the ability to submit new evidence and have it considered becomes more limited at later levels of appeal.** At the Appeals Council level, new evidence will be considered, but **only** if it relates to the period before the ALJ decision and is "new and material."[1] At the federal district court level, the record is closed and the court will not consider new evidence. However, the court may remand the case to allow SSA to consider new evidence, but only if it is "new and material" and there is "good cause" for the failure to submit it in the prior administrative proceedings.[2]

As noted earlier, NOSSCR strongly supports the submission of evidence as early as possible. Full development of the record at the beginning of the claim means that the correct decision can be made at the earliest point possible. The benefit is obvious: the earlier a claim is adequately developed, the sooner it can be approved and the sooner payment can begin. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record is not beneficial to claimants including: (1) worsening of the medical condition which forms the basis of the claim; (2) the fact that the ability to submit evidence is not always in the claimant's or representative's control, e.g., providers delay sending evidence; and (3) the need to keep the process informal.

Proponents of closing the record note that claimants could file a new application. This does not improve the process and may in fact severely jeopardize, if not permanently foreclose, eligibility for benefits. By reapplying rather than appealing: (1) benefits could be lost from the effective date of the first application; (2) in SSDI cases, there is the risk that the person will lose insured status and not be eligible for benefits at all when a new application is filed; and (3) if the issue to be decided in the new claim is the same as in the first, SSA will find that the doctrine of *res judicata* bars consideration of the second application.

In the past, SSA's notices misled claimants regarding the consequences of reapplying for benefits in lieu of appealing an adverse decision. Congress addressed this serious problem and, in legislation enacted in 1990, required SSA to include clear and specific language in its notices describing the adverse effect on possible eligibility to receive payments by choosing to reapply in lieu of requesting review.[3]

Apart from these harsh penalties, which have been recognized and addressed by Congress, a claimant should not be required to file a new application merely to have new evidence considered where it is relevant to the prior claim. If such a rule were established, SSA would need to handle more applications, unnecessarily clogging the front end of the process. Further, there would be more administrative costs for SSA by creating and then developing a new application.

- **SSA should not be represented at the ALJ level.**

We do not support proposals to have SSA represented at the ALJ hearing. In the 1980's, SSA tested, and abandoned, a pilot project to have the agency represented, the Government Representation Project (GRP). First proposed by SSA in 1980, the plan encountered a hostile reception at public hearings and from Members of Congress and was withdrawn. The plan was revived in 1982 with no public hearings and was instituted as a one-year "experiment" at five hearing sites. The one-year

[1] 20 C.F.R. §§ 404.970(b) and 416.1470(b).
[2] 42 U.S.C. § 405(g).
[3] 42 U.S.C. §§ 405(b)(3) and 1383(c)(1).

experiment was terminated more than four years later following congressional criticism and judicial intervention.[4]

Based on the stated goals of the experiment, i.e., assisting in better decision-making and reducing delays, it was an utter failure. The GRP caused extensive delays in a system that was overburdened, even then, and injected an inappropriate level of adversity, formality and technicality into a system meant to be informal and nonadversarial. In the end, the GRP experiment did nothing to enhance the integrity of the administrative process.

- **Retain review by the Appeals Council.**

In the ten prototype states, SSA also is testing the elimination of a claimant's right to request review of a hearing decision by the Appeals Council. We oppose the elimination of a claimant's right to request review by the Appeals Council. The Appeals Council currently provides relief to nearly one-fourth of the claimants who request review of ALJ denials, either through outright reversal or remand back to the ALJ. As the Commissioner noted in her testimony at this Subcommittee's hearing on May 2, the Appeals Council has made significant improvements in reducing processing times and its backlog. Based on this progress, she stated that by the end of the year, the Appeals Council pending caseload could be at a workable level.

The Appeals Council, when it is able to operate properly and in a timely manner, provides claimants with effective review of ALJ decisions and acts as a screen between the ALJ and federal court levels. In addition, elimination of Appeals Council review could have a serious negative impact on the federal courts. As long ago as 1994, the Judicial Conference of the United States opposed elimination of the claimant's request for review by the Appeals Council prior to seeking judicial review in the district courts, stating that such a proposal was "likely to be inefficient and counter-productive."[5] Since most ALJ denials did not then result in federal judicial review, as is currently the case, the Judicial Conference stated: "Claimants largely accept the outcome of Appeals Council review." Further, the Conference expressed concern that allowing direct appeal from the ALJ denial to federal district court could result in a significant increase in the courts' caseloads. As a result, the Judicial Conference concluded:

> From the perspective of both unsuccessful litigants and the federal courts, the present system of Appeals Council review as a precondition to judicial review is sound. The right of judicial review by Article III courts for all claimants remains intact under the present system. To the extent that the process of Appeals Council review is thought to be too time-consuming, despite the high degree of finality that results, it would be wiser to seek to streamline and expedite the process of review rather than to bypass it as a precondition to federal judicial review.[6]

We agree with the conclusion of the Judicial Conference of the United States. Access to review in the federal courts is the last and very important component of the hearings and appeals structure. Court review is not de novo, but rather, is based on the substantial evidence test. We believe that both individual claimants and the system as a whole benefit from federal court review. The district courts are not equipped, given their many other responsibilities, to act as the initial screen for ALJ denials.

- **Retain access to judicial review in the federal court system.**

NOSSCR supports the current system of judicial review. Proposals to create either a Social Security Court to replace the federal district courts or a Social Security Court of Appeals to provide appeal of all Social Security cases from district courts have been considered, and rejected, by Congress and SSA over the past twenty years.

We believe that both individual claimants and the system as a whole benefit from the federal courts deciding Social Security cases. Over the years, the federal courts have played a critical role in protecting the rights of claimants. The system is well-served by regular, and not specialized, federal judges who hear a wide variety of federal cases and have a broad background against which to measure the reasonableness of SSA's practices.

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[4] In *Sallings v. Bowen*, 641 F. Supp. 1046 (W.D.Va. 1986), the federal district court held that the Project was unconstitutional and violated the Social Security Act. In July 1986, it issued an injunction prohibiting SSA from holding further proceedings under the Project.

[5] Comments dated May 26, 1994, of Chief Judge John F. Gerry, Chairman of the Judicial Conference of the United States, in response to SSA's April 1, 1994 "Disability Reengineering Project Proposal."

[6] *Id.*

Creation of either a single Social Security Court or Social Security Court of Appeals would limit the access of poor disabled and elderly persons to judicial review. Under the current system, the courts are more geographically accessible to all individuals and give them an equal opportunity to be heard by judges of high caliber.

Rather than creating different policies, the courts, and in particular the circuit courts, have contributed to national uniformity, e.g., termination of disability benefits, denial of benefits to persons with mental impairments, rules for the weight to give medical evidence, evaluation of pain. The courts have played an important role in determining the final direction of important national standards, providing a more thorough and thoughtful consideration of the issues than if a single court had passed on each. As a result, both Congress and SSA have been able to rely upon the court precedent to produce a reasoned final product.

Finally, the financial and administrative costs of creating these new courts must be weighed against their questionable effectiveness to achieve the stated objectives. The courts, if created, would involve new expenditures. We believe that limited resources should be committed to the front end of the process. Further, from an administrative perspective, the focus should not be on the end of the appeals process but, rather, on the front end. Requiring claimants to pursue an appeal to obtain the justice they are due from the beginning will only add to the cumulative delay they currently endure.

Other Hearing Level Improvements

Recently, the Commissioner decided that the Hearings Process Improvement plan (HPI) would be discontinued as a nationwide initiative and that she would move forward, based on what was learned from that initiative. We support her decision.

From the inception of HPI, NOSSCR members raised numerous, critical concerns about the current state of affairs in hearing offices around the country. These concerns were shared last year with the Executive Task Force established by former Acting Commissioner Massanari to evaluate HPI. The main problems included: processing times after the Request for Hearing is filed; development; lack of on-the-record decisions; conduct of hearings; and processing times after the hearing. Specific concerns included duplicate requests for medical evidence; inability to speak to a "point" person on the case; mail not being associated with the file prior to the hearing; organization of files; preparing cases for hearing; and confusion over when a case was ready for hearing.

Some of the recommendations NOSSCR presented to the Task Force included: (1) creating the same claims folder earlier in the process; (2) reinstating senior attorney authority to issue decisions in certain cases; (3) identifying a "point" person who is available to ensure that the case is ready for hearing; (4) a better mechanism for review of requests for on-the-record decisions; (5) single requests for information; and (6) advance notice of hearings so that submission of evidence can be targeted. We hope that the Commissioner will consider these recommendations as she determines the future organization of the hearings process.

In addition, the Commissioner and the Associate Commissioner for Hearings and Appeals recently announced an initial series of initiatives to improve the hearings and appeals process which include:

- Early screening and analysis of cases, including possible on-the-record decisions
- Short form favorable decisions
- Bench decisions
- Expansion of videoconference hearings
- Digital recording of hearings

We are generally supportive of these initiatives so long as they do not impair the claimant's right to a full and fair hearing. The technological improvements are discussed below.

Technological Improvements

At the Subcommittee hearing on May 2, 2002, Commissioner Barnhart expressed her strong support for moving forward to improve the technology used in the disability determination process. NOSSCR fully supports the Commissioner in this effort, as we believe that much of the delay in the system could be rectified with improved technology.

For example, the Commissioner has committed herself to development of the electronic disability folder, "eDIB," as soon as practicable in light of available resources. This would reduce delay caused by moving and handing off folders, allowing for immediate access by whichever component of SSA or DDS is working on the claim. Further, this would allow adjudicators to organize files to suit their preference.

In terms of preparing a record for the district court, it would allow for electronic filing of the administrative record, which is consistent with the Judicial Conference of the United States' policy and initiative to move towards electronic filing of documents and pleadings. The Appeals Council has had difficulty reproducing copies of the record, whether needed by the claimant or for federal court filing. Files are too often lost or difficult to locate, leading to delays at the Appeals Council and district court levels. Our members report increasing delays and government requests for extension while cases are pending in court, in order to locate files and prepare transcripts. In many cases, after more lengthy delays, the files cannot be found and the court must remand the case for a new hearing. The electronic folder would certainly ease the workload in this regard and consequently, reduce delays. However, we urge the Commissioner to ensure that the eDIB folder contains complete copies of the paper records, rather than summaries or otherwise reduced copies, and that claimants would be able to submit evidence in any format, including paper records.

Another important component of technological improvement is digital recording of ALJ hearings. Currently, hearings are taped on obsolete tape recorders, which are no longer even manufactured. If copies are needed, they must be transferred to cassette tapes, which is time-consuming. Tapes are frequently lost because they are stored separately from the paper folder. Given the age of the taping equipment, the quality of tapes is often quite poor, which also results in remands from the Appeals Council or the district court. A digitally recorded hearing would not only be of high audio quality but would be easy to copy or transfer to the district court as part of the administrative record.

The Commissioner also has announced an initiative to expand the use of video teleconference ALJ hearings. This allows ALJs to conduct hearings without being at the same geographical site as the claimant and representative and has the potential to reduce processing times and increase productivity. NOSSCR members have participated in pilots conducted by SSA and have reported a mixed experience, depending on the travel benefit for claimants, the quality of the equipment used, and the hearing room set-up.

In 2001, SSA published proposed rules on video teleconference hearings before ALJs. 66 Fed. Reg. 1059 (Jan. 5, 2001). In general, we support the proposed rules and the use of video teleconference hearings so long as the right to a full and fair hearing is adequately protected and the quality of video teleconference hearings is assured.

Conclusion

We commend the Subcommittee for holding this hearing today to look at the challenges and opportunities for the Social Security disability programs. NOSSCR is committed to working with Commissioner Barnhart to improve these programs which are so vital to millions of people in this country. I would be glad to answer any questions that you have.

STATEMENT OF JAMES A. HILL, ATTORNEY–ADVISOR, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, CLEVELAND HEIGHTS, OHIO, AND PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION, CHAPTER 224

Mr. HILL. Good morning, Mr. Chairman. I thank the Subcommittee for inviting me to testify today.

I have been employed as an attorney advisor in the Cleveland, Ohio hearing office for nearly 20 years. I am also the President of Chapter 224 of the National Treasury Employees Union, which represents attorney advisors and other staff Members in approximately 110 hearing offices and regional offices across the United States.

The crisis in disability adjudication of the mid-1990s has returned. The OHA is once again failing to provide quality service to the American public. Commissioner Barnhart and her staff are currently in the process of planning long-term initiatives. Implementation of those initiatives is years into the future.

To address the current problems, SSA has announced a series of short-term initiatives. I regret to inform you that these initiatives

are utterly inadequate for the task. Some of the initiatives resulted from recommendations of the HPI Executive Steering Committee, which was tasked by Acting Commissioner Massanari with finding short-term initiatives to combat the growing case backlog at OHA. I was a Member of that Committee. Many Members of that Committee were bitterly disappointed that we failed to address the primary problem with OHA disability adjudications, that being the lack of a sufficient number of decision makers.

We were well aware that the initiatives we advised would have only a minimal impact. I seriously doubt that feeling was conveyed to the Commissioner during the briefing she received regarding the Committee's recommendations.

Despite the plethora of problems caused by the implementation of HPI, the most fundamental problem at OHA remains the lack of a sufficient number of decision makers. The SSA must quickly recognize that the current initiatives are inadequate and quickly augment them by reinstituting the Senior Attorney Program.

The GAO recently issued a report which emphasized the success of that program. Its recommendations to SSA clearly contemplated a return to that program. However, SSA did not follow that advice. While recognizing the value of early screening of cases by a decision maker, SSA is instructing its ALJs to perform that role.

Having ALJs perform the time-consuming task of reviewing "unpulled" cases significantly reduces the time they can spend conducting hearings and deciding cases in which a hearing is required.

While the Senior Attorney Program produced a substantial number of dispositions in addition to those produced by ALJs, the current program only redirects ALJ time. It does not increase the number of decision makers and will not significantly increase the number of dispositions.

The lack of sufficient decision makers must be addressed on both a short term and a long-term basis. However, the answer is not hiring vast numbers of ALJs, as was acknowledged last week by Deputy Commissioner Gerry in his testimony before this Subcommittee. Hiring the number of ALJs needed to efficiently adjudicate the entire OHA workload is cost prohibitive and operationally unnecessary.

Many of the cases that come to OHA do not require the participation of an Administrative Law Judge in the adjudicatory process. The ALJs must remain the backbone of the OHA process. The SSA should investigate the utility of introducing an Agency representative into the hearings process and the feasibility of using other attorney adjudicators, such as a magistrate or hearing officer, to assist the administrative law judges and Senior Attorneys in adjudicating the OHA caseload.

The NTEU makes the following recommendations for actions necessary to ensure OHA delivers quality service as demanded by the American people now and in the future:

One, all qualified OHA attorney advisors should be converted to Senior Attorney decision makers now and given the authority to issue fully favorable on-the-record decisions. These Senior Attorney decision makers would review all cases coming into the hearing office, as well as provide decision-writing support for Administrative Law Judges.

Two, SSA should establish a work group to examine the implementation of additional attorney decisionmakers such as a magistrate or hearing officer who would work in conjunction with ALJ's and Senior Attorneys in adjudicating the ever growing disability work load that faces SSA.

Three, SSA should establish a work group to examine the issue of introducing Agency representatives into the adjudication process at the hearing level. Thank you very much.

[The prepared statement of Mr. Hill follows:]

Statement of James A. Hill, President, Attorney-Advisor, Office of Hearings and Appeals, Social Security Administration, Cleveland Heights, Ohio, and President, National Treasury Employees Union, Chapter 224

Chairman Shaw and Members of the Subcommittee:

My name is James A. Hill. I have been employed by the Office of Hearings and Appeals (OHA) of the Social Security Administration (SSA) for more than 19 years as an Attorney-Advisor. I am also the President of National Treasury Employees Union (NTEU) Chapter 224 that represents Attorney-Advisors and other staff members in approximately 110 Hearing Offices and OHA Regional Offices across the United States. I wish to thank the Subcommittee for inviting me to testify regarding the challenges and opportunities facing Social Security disability programs today.

The crisis in disability adjudication at the hearing level of the mid-1990's has returned. Case backlogs and average processing time have increased at an alarming rate, severely diminishing the quality of service provided to the American public. SSA must immediately address the current backlog problem and devise a system that will adequately serve the needs of the future. At the request of the Social Security Subcommittee, the United States General Accounting Office (GAO) conducted a study of the initiatives that SSA developed and the results that have been obtained. GAO stated that:

> SSA's current backlog is reminiscent of a crisis-level backlog in the mid 1990's, which led to the introduction of 19 temporary initiatives designed to reduce OHA's backlog of appealed cases . . . Among the most long-standing of these initiatives was the Senior Attorney Program. Under this program, selected attorneys reviewed claims to identify those cases in which the evidence already in the case file supported a fully favorable decision. Senior attorneys had the authority to approve these claims without ALJ involvement. The Senior Attorney Program took effect in fiscal year 1995 and was phased out in 2000. During its existence, the program succeeded in reducing the backlog of pending disability cases at the hearing level by issuing some 200,000 hearing-level decisions. . . . SSA management has expressed concern that the Senior Attorney Program is a poor allocation of resources as it diverts attorneys from processing more difficult cases in order to process the easier cases. (GAO Report 02–322, February 2002, Page 23–24, (hereinafter "GAO"))

GAO recommended implementing "short-term strategies to immediately reduce the backlog of appealed cases in the Office of Hearing and Appeals. **These strategies could be based on those that were successfully employed to address similar problems in the mid-1990's"**. (GAO at Page 28) (Emphasis added.)

Unfortunately, SSA has chosen to evade the clear advice of the GAO and has not implemented strategies based on those that worked in the 1995 to 1999 time period. The misuse of ALJs to screen and analyze unassembled cases off the master docket is the only short term change proposed by the Commissioner that bears any resemblance to the changes that successfully brought down the backlog by more than 250,000 cases. It will not succeed because every minute an ALJ spends on screening and analyzing unassembled cases is a minute that that ALJ will not spend preparing for a Hearing, holding a Hearing or deciding a case after the Hearing, tasks that no other SSA employee can assume. It robs from Peter to pay Paul. It actually reduces the time ALJs will have to spend on the great majority of cases that go to Hearing, the ones where the claimant waits the longest. This initiative will have the unintended consequence of actually making most claimants wait longer for their Hearing. Additionally, if each ALJ does not produce a decision for each 4 hours he or she spends on this program, ALJs will actually produce fewer decisions with this initiative than they would have without it. To be sure, some deserving (and lucky) claimants will get their decisions and benefits significantly earlier than they would under the present process, but it will come at the expense of other claimants who

have been waiting much longer. Further, these claimants would receive the same benefits from a Senior Attorney program that has none of the adverse consequences of this initiative. The Senior Attorney program would not divert any ALJ time from the Hearing workload. No one would wait longer for a Hearing because of the Senior Attorney program. Rather than the possibility of fewer cases going out each month, the Senior Attorney program will result in as many as 5,000 to 8,000 more cases going out every month. Based upon previous experience the average processing time for these cases would be approximately 100 days. We asked the Agency how many cases they expected their initiatives to produce and we were told that they did not have that data.

Deputy Commissioner Martin Gerry recently testified before this Subcommittee and stated that short term initiatives are being implemented that are intended to alleviate some of the current problems at the Office of Hearings and Appeals. Mr. Gerry testified that these initiatives were recommended by the HPI Executive Steering Committee impaneled by Acting Commissioner Massanari and charged with finding short term initiatives to solve many of the problems associated with HPI. I was a member of the Executive Steering Committee as was Judge Bernoski. I regret to inform you that many members of that Committee were bitterly disappointed that we failed to address the primary problems associated with HPI, and we left the final meeting with a pervasive feeling that we had failed. We were well aware that the initiatives we advised would have only a minimal impact. I seriously doubt that feeling was conveyed to the Commissioner during the briefing she received regarding these initiatives.

In light of the GAO analysis and recommendations, NTEU makes the following recommendations for action necessary to ensure that the Office of Hearings and Appeals delivers the quality of service demanded by the American people currently and in the future:

1. All qualified OHA Attorney Advisers should be converted to Senior Attorney decision makers and given the authority to issue fully favorable on-the-record decisions. These Senior Attorney decision makers would review all cases coming into the hearing office.
2. SSA should establish a workgroup to examine the implementation of additional attorney decision makers, such as Hearing Officers, in the OHA hearing offices to work in conjunction with the ALJs in processing the ever-growing workload that faces SSA.
3. SSA should establish a workgroup to examine the issue of introducing an Agency representative into the adjudication process.

Since the mid-1990's SSA's disability program has been in crisis. In the mid-1990s the disability backlog rose to over 550,000 cases and processing time climbed to nearly 400 days at the hearing office level. In 1995 SSA introduced the Senior Attorney Program that was instrumental in reducing the disability backlog to approximately 311,000 cases by September 1999 and reducing processing time to approximately 270 days at the end of fiscal year 2000. Since the termination of the Senior Attorney Program the pending case backlog has risen to approximately 491,350 and SSA projects by the end of FY 2002 the backlog will rise to 546,000 cases.

The Senior Attorney Program was replaced by HPI, a program which was implemented without testing. HPI includes a triage system in which Attorney Advisers screen profiled cases (the same profiles used by the Senior Attorney Program) and recommend cases to ALJs that could be paid on the record. This still requires a significant commitment of ALJ resources. However, this process has resulted in a considerable decline in on-the-record decisions emanating from this profiled workload leading to fewer overall dispositions. The average rate of ALJ dispositions has not increased; in fact, it has declined, leading to a substantial decrease in total dispositions. We are in the midst of an emerging disaster precipitated by the demise of the Senior Attorney decision maker and fueled by HPI. The situation continues to deteriorate. Any hope of significant improvement without bold and decisive action is unreasonable. OHA has traditionally maintained a roster of 1000–1100 ALJs. Hiring substantial numbers of additional ALJs to meet future needs is fiscally irresponsible. SSA recently hired approximately 130 new Administrative Law Judges (returning to the norm) but readily admits that this addition will not solve today's problems.

The loss of efficiency caused by HPI, the elimination of the Senior Attorney Program, the precipitous decline in the number of on-the-record decisions, the staggering increase in "unpulled" cases, the expected increase in disability receipts, and the imposition of a new and increased Medicare workload spell disaster. The Social Security Administration must act quickly to deal with the current disability backlog.

It must also realistically assess its future workloads and devise processes sufficient to meet the decision-making needs of the future.

SSA Must Immediately Re-introduce the Senior Attorney Program

The fundamental problem at OHA is that the number of decision makers is insufficient to meet the workload. There is widespread agreement that it is unreasonable to expect an Administrative Law Judge to produce more than 500 dispositions in a year if an acceptable level of quality is to be maintained. If ALJs are the only decision-makers, unless the Agency is prepared to accept a much greater number of ALJs than currently are employed, the simple arithmetic mandates an ever increasing backlog and skyrocketing processing times. The solution is more decision makers.

In 1995 the Social Security Administration faced a disability caseload backlog and processing time crisis very similar to that existing today. In order to reduce the backlog and decrease processing time, SSA instituted the Short Term Disability Program. The primary element of that program, designed to reduce both the backlog and processing time, was the Senior Attorney Program.

That program continued until the advent of the HPI Program. The authority to make and issue fully favorable decisions on the evidence of record, with minimal development, was delegated to the Agency's experienced Attorney Advisors. The Senior Attorney decisions combined with ALJ decisions resulted in a substantially higher level of total dispositions than would have occurred if ALJs had been the sole decision-makers. In addition to performing the "Senior Attorney work", the Senior Attorneys also continued to draft ALJ decisions. This arrangement utilized the knowledge, skills, and abilities of these attorneys to issue fully favorable decisions to those claimants whose case did not require a hearing, and to continue to draft the more difficult ALJ decisions. This afforded, on an individual hearing office basis, the flexibility to direct decision making and decision writing resources as necessary to achieve maximum productivity.

Senior Attorneys issued approximately 220,000 decisions during the course of the Program. The average processing time for Senior Attorney decisions was approximately 105 days. During its pendency the OHA backlog fell from over 550,000 to as low as 311,000 at the end of FY 1999. The correlation is obvious. During the same time period there was also an increase in ALJ productivity demonstrating that dual decision makers was a viable concept. It is readily apparent that processing a large number of cases in such an expeditious manner materially reduced the average processing time for all disability cases at the hearings level in OHA.

While the Senior Attorney Program resulted in a substantial increase in on-the-record decisions, there was not a corresponding increase in the OHA payment rate. In fact the overall payment rate at OHA declined during the course of the Senior Attorney Program.

In July 1998 the Senior Attorney Program was significantly downsized with approximately one-half of the senior attorneys returned to the GS–12 attorney adviser position. The remaining Senior Attorneys spent 100 percent of their time doing "Senior Attorney work". This lack of flexibility doomed this arrangement which lasted only four months before the remaining Senior Attorneys were also assigned ALJ decisions drafting duties. Unfortunately, the number of Senior Attorneys was not increased which led to a significant decline in the Program's productivity. This decrease in productivity led to the rise in unpulled cases and the beginning of the increase in the backlog and average processing time.

The Senior Attorney Program benefited more than just those claimants who received their disability payments far earlier than would otherwise have been the case. Staff and ALJ time was not spent needlessly on cases that could be paid without a hearing and they could more timely attend to the other cases, thereby reducing processing time for those cases as well. Another benefit was that cases paid by a Senior Attorney were not "pulled" (prepared for hearing). Had the Senior Attorney Program not been downsized, and then eliminated, there would be about 90,000 fewer cases waiting to be "pulled".

The processing of Senior Attorney cases involved a very limited amount of hearing office staff time. This resulted in the expenditure of far fewer work years devoted to processing Senior Attorney cases than would have been the case had ALJ adjudication been required. This resulted in a significant reduction of administrative costs for those cases. The former Chief Administrative Law Judge stated that OHA may receive as many as 100,000 cases a year that with minimal development could be paid without a hearing. The savings in administrative costs arising from the reinstitution of the Senior Attorney Program would be substantial.

One of the criticisms of the Senior Attorney Program involved decisional accuracy. Of course that is also one of the chief complaints regarding ALJ decisions. The Ap-

peals Council review of Senior Attorney and ALJ on-the-record decisions found no difference in quality. I am convinced that the formulation and implementation of an effective quality assurance program at the hearing level should be of the highest priority

The success of the Senior Attorney Program ultimately rests on the competence of the legal professionals who can serve as adjudicators. These individuals are experienced OHA Attorney Advisors who have many years experience dealing with the intricacies of the legal-medical aspects of the Social Security disability program. They are attorneys well versed in the law, and they are experienced disability practitioners with a wealth of adjudicatory experience in the Social Security disability system.

The conversion of OHA Attorney Advisers to Senior Attorney decisionmakers as described above will result in an immediate and substantial improvement in OHA service to the public at minimal additional cost. Based upon the Agency's experience with the original Senior Attorney Program, and with the full cooperation of hearing office management (lacking during the original Senior Attorney Program), this measure could produce as many as 75,000–100,000 decisions a year without diminishing ALJ productivity.

The original Senior Attorney Program was a resounding success. It materially improved the quality of service provided to the public, especially for those individuals who were disabled and entitled to receive their disability decision and benefits on a timely basis. In addition, it resulted in administrative and program cost savings. Senior Attorney decisionmakers have proven by their performance that pre-ALJ decisionmaking in the OHA hearing office significantly improves the quality of service provided to the public.

SSA's Proposed Changes

Instead of following the advice of GAO, SSA has once again decided to implement additional permanent untested changes to the Appeals process. These include requiring ALJs to perform early screening and analysis of unassembled cases from Master Docket; implementing a short form favorable decision; and, authorizing ALJs to issue bench decisions. While current Senior Attorneys will continue to screen and analyze some cases, they will not have the decisionmaking authority that they had in the original, successful, Senior Attorney Program. Also contrary to the advice of GAO, SSA did not involve this Stakeholder, NTEU, in any predecisional planning for these changes.

The agency has stated that both the ALJs and Senior Attorneys will generally be expected to complete their early screening and analysis of cases within five work days. This will not permit ALJs or Senior Attorneys to develop the record. The system will allow ALJs to do little more than cherry pick the easy cases and second guess the DDS decision. The review of a lesser profile of cases by Senior Attorneys who have neither the authority to decide the case, nor the time allocated by management that is necessary to develop the case, will largely be a waste of resources. These short-term strategies will not reduce the backlog, in fact, it is unlikely that they will significantly slow the rate of growth of the backlog. (Other changes, such as ending certification of cases as ready to hear, simply recognize the reality that many offices never implemented this change, and most of those that did have already stopped the practice. Similarly, many offices no longer rotate clerical employees. Neither of these changes will have a measurable affect on the backlog.)

Without a doubt the biggest problem with the plan is the decision to have ALJs perform screening and analysis. This adds significantly to the workload of SSA's most expensive and most limited resource, ALJs. The time they spend on screening, analyzing, deciding and writing these unassembled cases is time that they cannot spend preparing for a Hearing, holding a Hearing, deciding a case after a Hearing or editing and signing the final decision, functions that no other SSA employee can perform. Even if the program worked, most claimants would have to wait longer for their decision. ALJs will have less time to review, hear and decide those cases already in the 500,000 case backlog while critically limited ALJ time is spent cherry picking payments as they come into the office. This is supremely unfair to those claimants already waiting almost a year at OHA for their decision. The critical difference between the Senior Attorney Program and this current SSA plan is that the Senior Attorney Program did not divert any ALJ time to produce 50,000 or more decisions a year. NTEU does not believe that a process that reduces the number of Hearings that an ALJ can hold and the number of Hearing decisions that an ALJ can issue is a fair or effective way to increase production or reduce processing time. SSA needs a program where decisionmakers can pay deserving claimants at the earliest possible time in the appeals process, but not at the expense of those longer suf-

fering claimants whose cases require a Hearing. That program is the Senior Attorney Program.

The Senior Attorney Program is a real life tested program that demonstrated it could produce 50,000 to 60,000 on the record decisions a year without the use of any ALJ time. It can be instituted quickly with minimal cost to the Agency using current Agency personnel. If it were implemented with the strong support of the Commissioner, OHA could, for the first time since the original Senior Attorney program was eliminated, actually decide more cases in a month then it received and begin to reduce the backlog.

As indicated by Acting Commissioner Larry Massanari, in response to questions from the Chairman following your June 28, 2001, Hearing:

> The Senior Attorney Program was established in 1995 as an initiative of the Agency's Short Term Disability Project to rapidly reduce the number of pending disability cases at the hearing level. Under this program, some 200,000 fully favorable decisions were issued without the need for approval by an ALJ, thus saving the ALJ's time for hearings and decisions on the rest of the hearing workload. In general, the Senior Attorney Program had a positive impact on hearing process efficiency and productivity.

I note that rather than saving the ALJ's time for hearings and decisions the current plan reduces the time that ALJs have for hearings and decisions on the rest of the hearing workload. Acting Commissioner Massanari continued:

> However, by the beginning of FY 2000, pending hearing workloads had declined and fewer cases lent themselves to on-the-record fully favorable decisions primarily because of process unification improvements at the initial claim level. Thus, it was decided that an adjudicator in addition to the ALJ would not be a useful element of the workflow and staffing structure and that the signatory authority of the Senior Attorney would be terminated in each office.

Note that pending hearing workloads are now higher than they were during most of the existence of the Senior Attorney Program and they continue to increase. The anticipated improvements from "process unification" have not materialized and thus the conditions that now exist are remarkably similar to the conditions that led to the first Senior Attorney Program in 1995. Acting Commissioner Massanari further stated:

> At the time the decision was made to terminate the Senior Attorney Program, the full implementation of prototype in the DDSs was believed to be imminent. These process changes would further reduce the pool of possible on-the-record decisions at the hearing level by ensuring more allowance decisions made correctly at the DDS level and by sending fully developed and "fresher" cases to the hearing offices for adjudication.

Clearly, this did not take place.

> The Senior Attorney Program was never a part of HPI. However, the HPI plan institutionalized key positive aspects of the Senior Attorney Program, like early screening and analysis of cases and early identification and fast-tracking of potential on-the-record decisions.

Unfortunately, HPI was unsuccessful in its attempt to screen, analyze, identify and fast-track on-the-record decisions. HPI proved that taking a few, but not all, key aspects of a successful program like the Senior Attorney Program, does not guarantee success in a new untested program. HPI had too many handoffs and still required the ALJ to review the potential on-the-record decision, and make the decision. This cumbersome process is what remains in place for most of the cases that will be screened and analyzed in OHA. It did not work well when it was called HPI and it won't work any better with whatever new name they put on it.

NTEU doubts that Bench decisions will add significantly to ALJ productivity or decrease processing time. We do believe, however, that they will increase the rate of cases remanded to ALJs as these decisions are likely to be less well reasoned and drafted than those decisions where an ALJ can review the entire record after the Hearing and make a thoughtful reasoned decision with the advice and counsel of Hearing Office attorneys and program experts. Even without the screening and analysis initiative, many ALJs (who generally have hundreds of cases on their docket at any one time) have insufficient time to fully evaluate and consider all of the nuances of each case prior to the Hearing. We are concerned that ALJs are being pressured into making premature decisions.

NTEU also has serious concerns about the short form for favorable decisions format (FEDS) that the Agency proposes that ALJs and other employees use in drafting decisions. We are unimpressed that a number of Agency components have re-

viewed the format for legal sufficiency and quality as formats do not have to be legally defensible, disability decisions do. Decisions such as these, long on conclusions and short on facts, will fuel the complaint that the ALJ decisions are not supported by the evidence.

Long Term Changes

NTEU believes that it is time for the Social Security Administration to seriously consider fundamentally altering the nature of ALJ hearings by introducing an Agency representative, the Social Security Counsel, who will be responsible for presenting the Agency's case to the Administrative Law Judge. The Counsel would be responsible for developing the record and presenting it at the hearing. It is the responsibility of the Counsel to present the adjudicator with a balanced and complete record upon which a fair and just decision can be based. The Counsel, in concert with the claimant's representative, will resolve issues and propose settlement agreements that would be presented to the adjudicator for approval.

The role of the adjudicator would be reduced to oversight of the pre-hearing process, conducting hearings, and preparation of written decisions based on evidence presented at hearing. The ALJ would be relieved of the responsibility of representing the agency and the represented claimant, and would act as a trier of fact.

In its report dated January 2001, Charting the Future of the Social Security's Disability Programs: The Need for Fundamental Change, the Social Security Advisory Board also noted that Administrative Law Judges have been required to balance three roles. They are obligated to protect the interests of both the claimant and the government, and to serve as an objective adjudicator. The Board further noted that approximately 80 percent of disability insurance claimants are now represented by an attorney. The Board also noted that because of the massive increase in the disability appellate workload, SSA has periodically made efforts to increase ALJ productivity which many in OHA believe has impacted adversely on the quality of decision-making. The Social Security Advisory Board recommended that the agency be represented at hearings. The Board stated that having a representative present at the hearing to defend the Agency's position would help clarify the issues and introduce greater consistency and accountability into the adjudicatory system.

The extent of the quality assurance problems in the current system is underlined in the report of The Lewin Group, Inc, which stated that the adjudication process at OHA is almost unique. The Lewin Group reported, "We have not encountered good examples of non-adversarial processes." The Lewin Group suggested that one way to improve the non-adversarial system is to make it more adversarial. It suggested that the mechanism for such a change would be to introduce a representative from the Social Security Administration into the adjudication process. This would relieve the Administrative Law Judge of the responsibility of representing the agency, and if the claimant were represented by outside counsel, the responsibility for representing the claimant.

In conclusion, NTEU makes the following recommendations:

1. All qualified OHA Attorney Advisers should be converted to Senior Attorney decisionmakers and given the authority to issue fully favorable on-the-record decisions. These Senior Attorney decision makers would review all cases coming into the hearing office.
2. SSA should establish a workgroup to examine the implementation of additional attorney decision makers in the OHA hearing offices to work in conjunction with the ALJs in processing the ever-growing workload that faces SSA.
3. SSA should establish a workgroup to examine the issue of introducing an Agency representative into the adjudication process.

Chairman SHAW. Thank you, Mr. Hill. Mr. Bernoski?

STATEMENT OF THE HON. RONALD G. BERNOSKI, ADMINISTRATIVE LAW JUDGE, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, MILWAUKEE, WISCONSIN, AND PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, MILWAUKEE, WISCONSIN

Mr. BERNOSKI. Thank you, Mr. Chairman for inviting us to testify here today.

Based on the testimony of this hearing and other hearings that you have conducted so far this year, it is clear that the Social Secu-

rity Disability System is under severe distress. It is also clear that the Agency-imposed process of HPI is at the center of the problem.

Immediately before the start of HPI, both case backlogs and case processing times were being reduced. For fiscal year 1998 and 1999, we averaged about 600,000 cases each year. After HPI, both case backlogs and case processing times have increased and for fiscal year 2001, we produced about 450,000 cases.

As found by the Social Security Advisory Board, the Agency has not properly administered the hearing process. Therefore, we believe that active Congressional oversight is needed at this time.

I will discuss three major issues this morning.

First, if the entire case processing time is to be reduced, the steps in the process should also be reduced. This can be done by having one complete review at the DDS level, which is based upon the same legal standard that is used by the Administrative Law Judges.

The issue of the variance between the DDS allowance rates should also be addressed.

Second, the hearing process must be restored and the problems caused by HPI corrected. As stated in some detail in our written statement, we believe the corrections should include both short range and long-term objectives.

Some of the reforms that we consider vital include restoring the Administrative Law Judges to the primary position in the hearing process; assigning staff and attorney writers to each judge; adopting a government representative to help develop the record and to represent the Agency at some hearings before the Administrative Law Judge; closing the record after the ALJ hearing and as of the date of the decision; defending decisions of the Administrative Law Judges before the Appeals Council and in the Federal courts; clarifying the disability law by either statute and/or case law; and adopting rules of practice and procedure for claimant representatives and for our hearings.

The Commissioner has stated that she will announce reforms for the disability system this fall. We have not been asked to participate, despite our effort to do so.

Thirdly, the hearing system and the hearing system should be strengthened. A bill has recently been introduced into Congress within the last week. It is H.R. 4932. This bill will place the Administrative Law Judge hearings of SSA under the operational control of a Chief Judge who reports directly to the Commissioner. This is an important first step for reform and this bill deserves the support of this Committee.

We have also suggested a more comprehensive reform that would make the hearings function a separate component within the Agency. The hearings component will report directly to the Commissioner. The plan eliminates the Appeals Council and it creates local administrative law judge appellate panels that are based upon the Bankruptcy Court model.

We testified in detail on this change before this Committee, and the plan is part of the record of a prior hearing of this Committee.

Whichever reform the Congress adopts, we believe that it is now time for the Congress to act. We know the problems. We have been discussing them for many years. We have also identified several so-

lutions. We think that the Congress should begin moving along these lines and begin some type of reform effort.

We think that it is now time to bring together a work group consisting of legal scholars, judges, attorneys and claimant groups and start crafting a plan for reform. We believe that we should also give the recommendations of the Social Security Advisory Board considerable credit and use them as a guide.

We believe that the American people must have a hearing system that is timely, accurate, fair and understandable, and is protected by the Administrative Procedure Act.

Mr. Chairman, our request as judges is simple. We ask that we be given the responsibility and authority and we be held accountable for our work.

Mr. Chairman, we look forward to working with you and the Committee on this important project of reforming the Social Security disability system. Thank you.

[The prepared statement of Mr. Bernoski follows:]

Statement of the Hon. Ronald G. Bernoski, Administrative Law Judge, Office of Hearings and Appeals, Social Security Administration, Milwaukee, Wisconsin, and President, Association of Administrative Law Judges, Milwaukee, Wisconsin

Mr. Chairman and Members of the Subcommittee:

I. INTRODUCTION

Thank you for the opportunity to testify before you today. My name is Ronald G. Bernoski. I am an Administrative Law Judge ("ALJ") who has been hearing Social Security disability cases at the Office of Hearings and Appeals ("OHA") of the Social Security Administration ("SSA") in Milwaukee, Wisconsin, for over 20 years.

This statement is presented in my capacity as the President of the Association of Administrative Law Judges ("AALJ"), which represents the ALJs employed in the SSA OHA and the Department of Health and Human Services ("DHHS"). One of the stated purposes of the AALJ is to promote and preserve full due process hearings in compliance with the Administrative Procedure Act for those individuals who seek adjudication of program entitlement disputes within the SSA.

I will address the challenges and opportunities for the Social Security Disability Programs in improving the disability determination appellate process at the ALJ hearing and Appeals Council administrative review levels. First, I will list the challenges at the DDS agencies that affect the appellate levels and at each of the appellate levels. Then I will offer short and long term solutions that may be implemented to resolve these challenges. The table of contents is an outline of the challenges and proposed solutions that I present for the Social Security Disability Programs. This discussion presumes familiarity with the structure of the SSA OHA and the initiatives by the SSA management to change or improve the functioning of OHA, including the Process Unification Training ("PUT"), the Hearing Process Improvement Plan ("HPI"), and the Appeals Council Improvement Plan ("ACPI").

II. CHALLENGES FOR THE SOCIAL SECURITY DISABILITY PROGRAMS

A. **Challenges at the DDS Level:**

1. **The Need to Reduce the Number of Cases that Require an ALJ Hearing by Getting the Claimants a Correct Final Administrative Result Sooner:** The reversal rate of the DDS decisionmakers' determinations by the ALJs remains high. In order to reduce the number of ALJ reversals of DDS determinations, in 1996, the SSA conducted the PUT training to have the DDS decisionmakers use the same rules to decide cases as the ALJs. This has not resulted in fewer cases requiring an ALJ hearing because DDS decisionmakers are required to apply a medical standard set forth in the SSA POMS manuals when determining disability, which is not the standard used by the ALJs. ALJs use a legal standard when determining disability that is based upon the Social Security Act, the SSA regulations and rulings, and the federal case law that interpret them.

Although Congress has expressed concern about the different benefits allowance rates between the DDS agencies and OHA, there also is a concern about the wide discrepancy in the benefits allowance rates among the different states' DDS agen-

cies. The latter discrepancy cannot be explained by the use of a different standard for decisionmaking, since all of the DDS agencies use the same medical standard.

2. **The Need to Reduce Processing Time for the Initial and Reconsidered Determinations Levels:** Rather than carefully develop and examine the claimants' cases once, DDS often is making its initial determinations based on incomplete records, and, upon reconsideration, rarely obtains significant additional medical evidence or changes the outcome of the case. SSA recently reported that only about three percent of initial determinations are changed at the reconsideration level.

There are steps that SSA can take that do not require legislation to (1) improve the quality of DDS decisionmaking, which will reduce the number of ALJ hearings, and (2) reduce the DDS case processing time. They are enumerated in Section III below.

B. **Challenges at the ALJ Hearing Level:** In brief, the Social Security Disability Programs' challenges at this level is to have a large and growing volume of cases heard and decided by SSA's ALJs in a timely and high quality manner that preserves the claimant's due process rights under the Social Security Act and Administrative Procedure Act ("APA"). Several specific challenges that now confront the new Commissioner are as follows:

1. The Need to Reduce the Number of Cases that Require an ALJ Hearing by Getting the Claimants a Correct Final Administrative Result Sooner: The burgeoning caseload at the ALJ hearing level has been growing unabated in recent years. Prior to HPI, the SSA OHA heard and decided over 500,000 cases annually, and surpassed 600,000 in one recent year. SSA is projecting that the annual caseload will climb to about 726,000 by 2005. This has strained the current structure of OHA to timely handle the volume with quality because nothing effective has been done to either reduce the number of cases that require an ALJ hearing or change the structure of OHA to better address the huge caseload:

(a) OHA's structure and process for hearing cases has not changed significantly to adjust to the large scale of the operation since the APA went into effect in 1947. There is no mechanism for settling cases without a hearing, other than granting a claim on the record, because SSA has no representative to assert its interests at the hearing level.

(b) Cases endlessly are remanded back to the ALJ level for rehearing because the record remains open without limits, new issues may be raised at all levels of appeal, and the quality of the Appeals Council review is poor.

There are several steps that SSA can take that do not require legislation to reduce the number of ALJ hearings. They are enumerated in Section III below.

2. **Challenges from the ALJ Level HPI Reorganization of OHA:** There is a consensus that HPI, which SSA implemented in 2000, has both exacerbated the case disposition time problems that it was intended to solve and created new problems that have caused work flow bottlenecks, reduced the quality of decision drafts by some decision writers, and increased the case backlog. The several HPI challenges are as follows:

(a) One purpose of HPI was to reduce the amount of processing time it takes to obtain the evidence for the record by doing it more completely before the ALJ hearing, so that fewer cases would need post-hearing development. The practice of HPI did not result in a reduction of cases that require post-hearing development.

(b) HPI also was expected to reduce overall case processing time, ostensibly by reducing the need for post-hearing development. Instead, case processing time steadily has lengthened under HPI beyond what was considered to be unacceptable at the time that HPI was implemented. The creation of teams to handle cases was intended to decrease the number of people who have to work on each case and increase individual responsibility for the quality of work within the group, which were expected to reduce case processing time and increase work quality. Instead, HPI process has resulted in an increase of the "hand offs" of the files and the sense of individual responsibility for work quality has vanished. The cases are assigned to judges later in the process and the responsibility for early pre-hearing case development has been transferred to the staff.

(c) The quality of decision drafts has declined because, as part of the HPI plan, SSA has promoted to Paralegal Specialist positions as ALJ decision writers clerical staff members, many who do not have the skills to perform the job adequately. HPI created promotion opportunities for the clerical staff, which boosted the morale of those receiving the promotions. However, the implementation of HPI resulted in the promotion of clerical staff to approximately 350 writer positions without the need to show that they have the skills to do the job. This

promotion process resulted in positions being filled by clerical staff, some of whom who have not been successful in performing the job.

(d) A huge backlog of case files that need to be prepared for hearing has accumulated as a result of the SSA promoting about 350 clerks to writer positions and about 300 clerks to case technician positions as part of the HPI plan without replacing the vacated clerical positions. (The process of organizing and marking exhibits to prepare a case for hearing is called "pulling," which is a clerical task.) As a result, the backlog of unpulled cases has ballooned from about 34,000 to 216,000 since HPI has been implemented. The shortfall in "pulled" cases has resulted in an insufficient number of cases being scheduled for ALJs to hear in many offices and adds to the case processing time.

(e) The lack of acceptance of the failure of HPI by the SSA administrators is a challenge that the new Commissioner confronts. At a hearing before the House Subcommittee on Social Security in June 2001, Mr. Stanford Ross, Chair of the SSAB, testified that the HPI did not improve the hearing process and in some circumstances it had made the situation worse. Without acknowledgment of the failure of HPI, new strategies will not be considered seriously and implemented by SSA administrators.

3. **The Challenge of Preserving Due Process While Achieving Greater Efficiency:**

I have a strong concern with recent information that AALJ has received relating to three proposals to transfer the SSA administrative law judge hearing and final adjudication of Social Security Act claims to non-ALJ claims personnel within the District Offices, non-ALJ claims personnel within the District Offices the Departments of Disability Services, and/or non-ALJ hearing officers within OHA. A brief summary of the facts about these proposals that are known to AALJ are as follows:

Transfer of SSA Hearings to non-ALJ Technical Personnel in the District Offices: Recently, AALJ learned that the SSA is creating a "Special Title II Disability Workload cadre" ("ST2DW") to make final determinations of Title II Social Security Act claims. The jobs are for a detail of one year that may be extended in upstate New York (Buffalo, Schenectady, Albany) that will consist exclusively of GS–12 level claims personnel employed in the District Offices in that local area, whose title is "Technical Expert ("TE")." No OHA personnel reportedly will be considered for this position. The SSA New York Region Personnel Operations already has issued solicitations for Technical Experts to apply for the position that was to close on May 1. There reportedly will be a two month training period for this one year detail. The training was to begin in New York City on May 13. The solicitation provided as follows:

> TEs will perform a pre-interview assessment of each ST2DW case and complete a development sheet. This sheet will be used to conduct interviews with the claimant and to obtain complete development of the case. **TEs will be responsible for final adjudication of developed cases,** and/or pre-effectuation reviews of cases developed by others. TEs will use all available tools and controls associated with the ST2DW.

The position reportedly will be at the GS–12 level and no position description has been prepared. This is a proposal that already is being translated into action. The use of the words "final adjudication" of cases in this job announcement is telling, since only ALJ and Appeals Council decisions may become final decisions of the SSA Commissioner pursuant to the Social Security Act and APA.

Transfer of SSA Hearings To DDS: Since February, information has surfaced that report that the Agency may attempt to change the Social Security hearing process and move the administrative law judge hearing to the reconsideration level at the DDS. The National Association of Disability Examiners ("NADE") has published its detailed proposal for such a change and the fact that its executive officers met with the SSA Commissioner in February 2002 to discuss the proposal. NADE also has submitted its proposal in a written statement that is part of the record of this Subcommittee's May 2, 2002, hearing on the Challenges Facing the New Commissioner of Social Security. The DDS proposal would restrict appeals to the administrative law judge to questions of law, rather than the de novo review of the claim that is mandated by the Social Security Act and the APA.

In mid-January, the New York DDS director sent a letter to the Commissioner that includes suggested reforms of the Social Security disability system that is like the NADE proposal. The letter contains the recommendations that the administrative law judge hearing be abandoned and that the hearing be changed to a "fair hearing" conducted at the state level by the DDS. At the end of Janu-

ary, the Commissioner attended a meeting of DDS personnel at which the attendees agreed to continue to investigate this change.

AALJ has learned that a small committee had been appointed by the SSA Commissioner to look at alternative hearing methods. There also is an existing SSA Commissioner's Committee on Disability that is looking at various aspects of the disability program. AALJ learned that the Committee soon will send a report to the Commissioner that contains a recommendation to conduct the de novo Social Security hearing at the Reconsideration level of the DDS. Under this proposal, administrative law judges would have jurisdiction only to review cases for errors of law. If error is found, the case would be remanded to the DDS for hearing. The Commissioner apparently has not made a policy decision on the transfer of the due process hearing to a lesser DDS hearing, but this issue clearly is on the table for consideration.

Any such change would have a profound effect on the rights of the American people and would deny them a constitutional due process hearing and decision of their claims as now is protected by the APA. The DDS proposal also would markedly restrict the claimants' access to judicial review, since few cases would reach ALJs and thus be subject to the Appeals Council review that is a necessary predicate to judicial review.

Transfer of SSA Hearings to Non-ALJ Hearing Officers: AALJ has learned from a reliable, well-placed source that SSA is planning to budget for hiring of hearing officers at the GS–14 and GS–15 level. However, AALJ does not have information on the timing or implementation of the plan. This information is consistent with a proposed hearing officer job description for a position to handle "small claims" that the National Executive Board became aware of at the time of its October 2002 meeting. This news is of considerable concern because it is a natural "spin off" from the discussions to transfer the hearings to the DDS. This type assault on the hearings system goes to the very heart of the purpose and function of administrative law judges.

Any plan to deny Social Security claimants the right to a full due process hearing under the APA before an administrative law judge will result in a denial of basic constitutional rights to the American people. The preservation of APA due process for the claimants, including the hearing and decision of their claims by ALJs who are appointed pursuant to the APA, is essential as the new Commissioner devises ways to more efficiently address the agency's large and growing caseload.

The APA was adopted by Congress in 1946 to ensure that the American people were provided hearings that are not prejudiced by undue agency influence. The securing of fair and competent hearing adjudicators was viewed as the heart of the Administrative Procedure Act.

The APA was enacted primarily to achieve reasonable uniformity and fairness of the administrative process in the Federal Government for members of the American public with claims pending before Federal agencies. The APA sets forth a due process administrative procedure for the hearing and decision by administrative law judges of cases brought before the Federal agencies to which the APA applies. The APA provides the minimum standards for federal administrative due process in the Executive Branch, and delineates procedures for adjudicative administrative proceedings, namely individual case decisions about rights or liabilities as an agency's judicial function. This includes uniform standards for the conduct of adjudicatory proceedings, including the merit appointment of administrative law judges. U.S. Justice Dept., *Attorney General's Manual on the Administrative Procedure Act 9* (1947) (the "Manual"). The APA, Pub. L. No. 79-404, 60 Stat. 237 (1946), *as amended*, is codified at 5 U.S.C. §§ 551-559, 701-706, 1305, 3105, 3344, 4301(2)(E), 5335(a)(B), 5372, and 7521.

By APA mandate, the administrative law judge is an independent, impartial adjudicator in the administrative process and there is a separation of the adjudicative and prosecutorial functions of an agency. The administrative law judge is the only impartial, independent adjudicator available to the claimant in the administrative process, and the only person who stands between the claimant and the whim of agency bias and policy. If SSA returns to using subordinated employees who would be an instrument and mouthpiece for the SSA, we will have returned to the days when the agency was both prosecutor and judge.

There is a close relationship between the APA and the Social Security Act. In the case of *Richardson* v. *Perales*, 420 U.S. 389 (1971), the U.S. Supreme stated that the APA was modeled upon the Social Security Act.

It is clear that Congress intended the APA to apply to hearings conducted under the Social Security Act. The Attorney General's Manual on the Administrative Procedure Act, which is recognized by the U.S. Supreme Court to be part of the legisla-

tive history of the APA, states that "the residual definition of "adjudication" in section 2(d) was intended to include. . . . [t]he determination of . . . claims under Title II (Old Age and Survivor's Insurance) of the Social Security Act. . . . " Manual at 14–15 (emphasis added), *citing*, Senate Judiciary Committee Hearings on the APA (1941) at 657, 1298, 1451 and S. Rep. No. 752 at 39; 92 Cong. Rec. 5648. (The other programs did not then exist.)

The U.S. Supreme Court defined the role of a federal Administrative Law Judge in *Butz* v. *Economou*, 438 U.S. 478, 513–514 (1978), as follows:

> There can be little doubt that the role of the modern hearing examiner or administrative law judge within this framework is "functionally comparable" to that of a judge. His powers are often, if not generally, comparable to those of a trial judge. He may issue subpoenas, rule on proffers of evidence, regulate the course of the hearing, and make or recommend decisions. . . . More importantly, the process of agency adjudications is currently structured so as to assure that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency. Prior to the Administrative Procedure Act, there was considerable concern that persons hearing administrative cases at the trial level could not exercise independent judgment because they were required to perform prosecutorial and investigative functions as well as their judicial work . . . and because they were often subordinate to executive officials within the agency. . . . Since the securing of fair and competent hearing personnel was viewed as "the heart of formal administrative adjudication," . . . the Administrative Procedure Act contains a number of provisions designed to guarantee the independence of hearing examiners. They may not perform duties inconsistent with their duties as hearing examiners. When conducting a hearing under the APA, a hearing examiner is not responsible to or subject to the supervision or direction of employees or agents engaged in the performance of investigative or prosecution functions for the agency. Nor may a hearing examiner consult any person or party, including other agency officials, concerning a fact at issue in the hearing, unless on notice and opportunity for all parties to participate. . . . Hearing examiners must be assigned to cases in rotation so far as practicable. . . . They may be removed only for good cause established and determined by the Civil Service Commission after a hearing on the record. . . . Their pay is also controlled by the Civil Service Commission.

The Supreme Court recently reaffirmed its holdings in *Butz* that a federal ALJ's role is similar to that of a trial judge and that administrative adjudications are similar to judicial proceedings when it held that state sovereign immunity bars the Federal Maritime Commission from adjudicating a private party's complaint against a non-consenting state. *Federal Maritime Commission v. South Carolina State Ports Authority*, _____ *U.S.* _____, slip op. 1, 10–14 (2002).

The Congress has reviewed the function of the administrative law judge in the Social Security Administration. In 1983, a Senate Subcommittee on Oversight of Government Management of the Committee on Governmental Affairs conducted a hearing that inquired into the role of the administrative law judge in the Title II Social Security Disability Insurance Program. S. PRT. 98–111. The Committee issued its findings on September 16, 1983, which provided in part as follows:

> The APA mandates that the ALJ be an independent impartial adjudicator in the administrative process and in so doing separates the adjudicative and prosecutorial functions of an agency. The ALJ is the only impartial, independent adjudicator available to the claimant in the administrative process, and the only person who stands between the claimant and the whim of agency bias and policy. If the ALJ is subordinated to the role of a mere employee, and instrument and mouthpiece for the SSA, then we will have returned to the days when the agency was both prosecutor and judge.

The decisionmaking independence provided by the APA is not for the benefit of the judge, but instead is provided for the protection of the American people. The protections are intended to ensure that the American people receive a full and fair due process hearing with a decision based on the evidence in the hearing record. This is a right protected by the constitution. "The APA creates a comprehensive bulwark to protect ALJs from agency interference. The independence granted to ALJs is designed to maintain public confidence in the essential fairness of the process through which Social Security benefits are allocated by ensuring impartial decisionmaking." *Nash v. Califano*, 613 F.2d 10, 20 (2nd Cir. 1980). Despite these protections, the Social Security Administration has a history of attempting to assert undue influence on the decisionmaking of its administrative law judges. This abuse

occurred in the 1980's after the agency had implemented the *Bellmon Review Program*. The Senate Subcommittee on Oversight of Government Management (referred to above) issued findings on September 16, 1983, on this improper agency conduct that provided in part as follows:

> The principal findings of the subcommittee is that the SSA is pressuring its ALJs to reduce the rate at which they allow disabled persons to participate in or continue to participate in the Social Security Disability Program.

The Bellmon Review Program also was challenged in the courts in Association of *Administrative Law Judges v. Heckler*, 594 F.Supp. 1132 (1984). In that case, a Federal district court judge found in part as follows:

> In sum, the Court concludes, that defendant's unremitting focus on allowance rates in the individual ALJ portion of the Bellmon Review Program created an untenable atmosphere of tension and unfairness which violated the spirit of the APA, if no specific provision thereof. Defendants' insensitivity to that degree of decisional independence the APA affords to administrative law judges and the injudicious use of phrases such as "targeting", goals and "behavior modification" could have tended to corrupt the ability of administrative law judges to exercise that independence in the vital cases that they decide.

The efforts of the administrative law judges of the Social Security Administration to protect the Social Security hearing process and the rights of Social Security claimants was recognized in an award presented to the judges of the agency by the President of the American Bar Association in August 1986. The award acknowledged the efforts of the Social Security administrative law judges in protecting the integrity of the hearing system. The award specifically stated:

> That the American Bar Association hereby commends the Social Security Administrative Law Judge Corps for its outstanding efforts during the period from 1982–1984 to protect the integrity of administrative adjudication within their agency, to preserve the public confidence in the fairness of governmental institutions and uphold the rule of law.

On January 9, 2001 Commissioner Kenneth S. Apfel affirmed the relationship between the Administrative Procedure Act and the Social Security Act for Social Security hearings. He stated as follows:

> The Social Security Administration (SSA) has a long tradition, since the beginning of the Social Security programs during the 1930s, of providing the full measure of due process for people who apply for or who receive Social Security benefits. An individual who is dissatisfied with the determination that SSA has made with respect to his or her claim for benefits has a right to request a hearing before an Administrative Law Judge, an independent decisionmaker who makes a *de novo* decision with respect to the individual's claim for benefits. As the Supreme Court has recognized, SSA's procedures for handling claims in which a hearing has been requested served as a model for the Administrative Procedure Act (APA). Congress passed the APA in 1946 in part to establish uniform standards for certain adjudicatory proceedings in Federal agencies, in order to ensure that individuals receive a fair hearing on their claims before an independent decisionmaker. SSA always has supported the APA and is proud that the SSA hearing process has become the model under which all Federal agencies that hold hearings subject to the APA operate. SSA's hearing process provides the protections set forth in the APA, and SSA's Administrative Law Judges are appointed in compliance with the provisions of the APA.

In a recent study prepared for the Social Security Advisory Board by Professors Paul Verkuil and Jeffrey Lubbers, entitled *Alternative Approaches to Judicial Review of Social Security Disability Cases,* the authors recommended the establishment of an Article I court for Social Security cases. The report favorably refers to the over 1000 administrative law judges in the Social Security Administration as an objective source of decisionmaking that can be effectively integrated into an article I court review structure. This recommendation seeks to improve and strengthen the Social Security disability process, not to diminish the system as would result from abandoning the administrative law judge hearing. In fact, articles recently have been published that recommend that the Veterans disability appeals system be improved by modeling it after the Social Security administrative law judge hearing process. James T. O'Reilly, *Burying Caesar: Replacement of the Veterans Appeals Process Is Needed to Provide Fairness to Claimants,* 53 Admin. L. R. 223 (2001); William F. Fox, Jr., *A Proposal to Reform the VA Claims Adjudication Bureaucracy: One Law Professor's View,* FBA Veterans Law Sec., Tommy: A Lawyer's Guide to Veterans Affairs, 1 (Issue 3, 2001).

Any retreat from this long and proud tradition of the Social Security Administration with regard to the manner in which it conducts hearings will have a substantial adverse effect on Social Security claimants and will deny them basic constitutional rights. American citizens will have less rights than they had prior to the enactment of the APA.

We urge Congress to protect the constitutional rights of the American people and to continue to provide the Social Security claimants the full range of due process rights for a Social Security hearing under both the APA and the Social Security Act.

C. **Challenges at the Appeals Council Level:** Several specific challenges that now confront the new Commissioner are as follows:

1. **Long Case Processing Time:** The long case processing time at the Appeals Council often is measured in years, rather than months.

2. **Poor Decision Quality:** The chronically poor quality of the Appeals Council decisions has declined further in recent years. The decisions rarely have legal citations of authority or rationales for the positions taken, and often are factually inaccurate regarding what the record shows. The informality of the decisions does not give the impression of the careful deliberation to which the claimants are entitled.

3. **Excessive Number of Lost Hearing Record Tapes and Files:** The chronic loss of hearing record tapes and files by the Appeals Council requires a lengthy rehearing process for the claimants. Anecdotal evidence suggests that thousands of hearing tapes and files have been lost. SSA recently reported that there are about 5,000 remands per year for lost or inaudible hearing tapes, most of which are for lost tapes. The loss of tapes and files reportedly is caused by three problems: (a) the repeated crashing of the Appeals Council's antiquated computer case tracking system and loss of case names from the database that are not recoverable, (b) a large backlog of cases that have not been entered into the case tracking system but instead are stored on shelves without being alphabetized, numbered or coded, and (c) separating hearing tapes from the hearing file to save storage space and prevent jamming paper shredder machines when the files ultimately are destroyed.

4. **Achieving Acceptance of the Failure of the Appeals Council Level ACPI Reorganization of OHA:** Acceptance by SSA administrators of the failure of the ACPI that was implemented in 2000 to correct these three chronic challenges of the Appeals Council operation also is a challenge that the new Commissioner confronts. Without acceptance of the failure of ACPI, new strategies will not be considered seriously and implemented by SSA administrators.

III. PROPOSED ACTIONS TO MEET THE CHALLENGES FOR THE SOCIAL SECURITY DISABILITY PROGRAMS

A. **Overview of Needed Reforms for the SSA Hearing Process**

1. **Reorganize the Hearing Office Process:** Because of the failure of HPI, SSA should reorganize the hearing office process. The reorganization should correct the defects in HPI. We propose that the recommendations of the Commissioner's HPI Steering Committee be used as a guide for the reorganization. The reorganization should consist of both short term and long term changes. The short term changes should be structured in a manner that permits easy transition to the long term reforms. The objective should be to immediately return to the efficiency and level of case production that existed in the hearing offices immediately before the introduction of HPI (over 500,000 cases a year). The long term reform should then build on that base. There is no single change that will accomplish this objective. It instead must be accomplished by a series of coordinated changes in several different areas. The changes will allow the agency to improve the service provided to the American public.

We recommend that the short term changes should include the following elements:

(a) The process must be simple, and administrative law judges should be assigned to cases from master docket according to law.
(b) Each administrative law judge should have adequate and properly trained support staff. The support staff should include a clerical worker, paralegal and attorney/writer.
(c) The support staff should be assigned to perform the work product of a particular administrative law judge according to the instructions and guidance of the judge.
(d) The administrative law judge should have control of all case development.
(e) The administrative law judge should have the responsibility to determine when a case decision is legally sufficient and the judge should have the authority to return the decision for rewrite to achieve the same.
(f) Case files of each administrative law judge should be maintained separately.

(g) The assigned support staff of each administrative law judge should be under the supervision of the hearing office management staff for personnel actions.
(h) Staff members should be accountable for their work product. Case work should be assigned on an individual basis to support staff to provide for accountability and enhance the employees' sense of ownership.

We recommend that the long term changes should include the following elements:

(a) Close the hearing record after the administrative law judge hearing as of the date of the ALJ's decision.
(b) Assignment of Social Security Administration representatives to represent the agency at administrative hearings. Such representatives would be responsible to defend the position of the agency at the hearing, recommend favorable cases, exercise settlement authority, and assist unrepresented claimants. When most claimants were unrepresented, having a non-adversarial process made sense to keep the benefits process simple and not intimidating. However, now, approximately 82% of the claimants who have an ALJ hearing are represented, according to recent statistics assembled by the SSA OHA Office of the Chief ALJ.
(c) Create a case manager and law clerk position for the support staff of each administrative law judge (as recommended by the Commissioner's HPI Steering Committee).
(d) Allow administrative law judges to issue bench decisions and short form decisions.
(e) Adopt regulations for issue exhaustion as suggested by the United States Supreme Court in the case of *Sims v. Apfel*, 530 U.S. 103 (2000), if SSA representatives are available to assist the unrepresented claimants.
(f) Reform the Appeals Council to issue decisions in some cases, limit the scope of appeal for claimants who have received the requested relief from the administrative law judge, and support the administrative law judge in "no-show" dismissals.
(g) Implement a sustainable agency policy on the issue of pain and the treating physician rule and defend the same if challenged.
(h) Require the DDS to follow the same legal standard as the ALJs when determining disability, which is based upon the Social Security Act, the SSA regulations and rulings, and the federal case law that interpret them.
(i) Improve the use of technology in the hearing process (i.e. an improved case processing and management system, and electronic file, voice to print software, improved equipment for recording hearings, etc., most of which already is in the planning and pilot stages).
(j) Adopt rules of procedure for the hearing process.
(k) Reorganize the Office of Hearings and Appeals.

B. **Strategies to Reduce the Number of Cases Heard at the ALJ Hearing Level that May Be Effected in the Short Term by Regulation Changes and Preserve Due Process**

1. **Require DDS Decisionmakers to Follow the Same Legal Standard as the ALJs, not a Medical Standard:** SSA should issue regulations that require DDS decisionmakers to adjudicate cases pursuant to the Social Security Act, the SSA regulations and rulings, and the federal case law that interpret them. This can be implemented on a short term basis and immediately would serve to reduce the number of cases appealed to the ALJs.

2. **Have the DDS Do One Thorough Case Development and Determination to Increase the Accuracy and Quality of the DDS Determinations:** If the DDS were enabled to do one thorough development of the medical record and carefully considered determination, rather than two incomplete reviews of incomplete files, the accuracy and quality of the determinations would rise and result in fewer appeals to the ALJ level. Either eliminate the reconsideration level to save processing time at the DDS level or make it into a meaningful decision level in which evidence is further developed and a meaningful second look is taken at the claimants' files that has a realistic chance of a more accurate outcome for the claimants than at the initial level.

3. **Close Record as of the Administrative Law Judge decision date:** The amendment of SSA's regulations to close the record after the ALJ hearing and as of the date of the ALJ decision would reduce the number of cases that ALJs must hear upon remand from the Appeals Council and courts based upon new evidence. New evidence is one of the most common reasons for remand of cases. This adds to the ALJ caseload and greatly delays a final administrative decision for the claim-

ants. This change will place the responsibility upon the claimants' representatives for producing all relevant and material evidence at the hearing.

By SSA regulation, the hearing record in the Social Security disability system is not closed at any stage in the appeals process. This system precludes administrative finality and allows the claimant to introduce new evidence at each step of the process, including the Appeals Council level. 20 C.F.R. §§ 404.900(b), 404.976(b). This is true even when the evidence was in existence and available during the prior stage of the appeal. The reason the SSA keeps the record open at the administrative levels is that the Social Security Act authorizes the courts to remand a case to SSA when a claimant shows that there is material new evidence and there is good cause for not including it in the record earlier. 42 U.S.C. § 405(g).

In a recent report, the Social Security Advisory Board ("SSAB") stated that "Congress and SSA should review again the issue of whether the record should be fully closed after the ALJ decision." *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change, January 2001,* p. 20. This change will bring administrative finality to the Social Security disability case and will encourage all known relevant and material evidence to be produced at the hearing.

New documentary medical evidence of disability based upon treatment that occurred before the date on which the ALJ hearing closed should be admitted into evidence by the Appeals Council only upon a showing that the new evidence is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding. This standard is in keeping with the standard that the Social Security Act allows for the courts. Unrepresented claimants should be excepted from the requirement to show good cause.

4. **The SSA Should Have a Representative at the ALJ Hearings:** After conducting a pilot program to work out the details in practice, the SSA should amend its regulations to provide for a government representative at the ALJ hearing. This change would permit SSA to complete the documentary record faster, enter into settlements without the need for a hearing in some cases, and present the government's position on each case. SSA representation will allow the SSA to present its evidence, present the type of expert witnesses it deems necessary, and advance its legal theories in the case. The government representative also should provide assistance and advice to claimants in unrepresented cases.

In order to meet the requirements of due process, the APA provides that "[a] party is entitled to appear in person or by or with counsel or other duly qualified representative in an agency proceeding." 5 U.S.C. § 555(b). Therefore, the SSA, as a party, has the right to appear on its own behalf at the proceedings before the OHA. However, the Social Security Administration is not represented at the disability hearing before an administrative law judge. SSA regulations long have stated that it "conducts the administrative review process in an informal, nonadversary manner," 20 C.F.R. § 404.900(b), so SSA thus has waived its right to appear at the ALJ hearings. The present system worked well when most claimants in Social Security cases were not represented at the hearing. However, there has been a dramatic rise in the number of claimants who are represented at the hearing. Presently, well over 80% of the claimants are represented at the hearing. The Social Security Advisory Board has noted that "[t]he percentage . . . of claimants represented by attorneys at ALJ hearings has nearly doubled [between] 1997 [and 2000]." SSAB, *Disability Decision Making: Data and Materials,* Chart 56 Attorney and Non-attorney Representatives at ALJ Hearings Fiscal Years 1997–2000, p. 73 (January 2001).

In its recent report, the SSAB recommended that the SSA have representation at the Social Security disability hearing: "We think that having an individual present at the hearing to defend the agency's position would help to clarify the issues and introduce greater consistency and accountability into the adjudicative system." *Charting the Future of Social Security's Disability Programs: The need for Fundamental Change, January 2001,* p. 19.

The SSA had a pilot program for its representation at the hearing in 1982. This pilot program was discontinued after an unfavorable court decision on the project. *Salling v. Bowen*, 641 F. Supp. 1046 (W.D.Va. 1986). The past pilot program on the government representative project was not an adequate test of this system. The SSA should implement a new test program for agency representation at the hearing. This pilot project should be implemented in coordination with the claimants' bar, SSA employee organizations, our Association, and other interested groups. The pilot program should address the issues raised by the court in *Salling.* The objective is to establish a hearing process that provides a full and fair hearing for all parties who have an interest in the case.

In addition, in the current non-adversarial setting, the SSA ALJ has the legal responsibility to "wear three hats" in each case. The ALJ legally is bound to ensure that all of the claimant's relevant and material evidence is made part of the record

and the claimant's interests are protected, to protect the interests of the government in the hearing, and to make a fair decision which is based on the evidence in the record. Additionally, the judge must take care to not become overly protective of the interests of the government for fear that the case will be reversed on appeal on a claim of bias against the claimant. The inherent conflict in all of these roles is patent and would be resolved by having the government represented at the hearing.

5. **If the SSA Provides for a Government Representative at the Hearing, Require Issue Exhaustion at the Appeals Council Level for Represented Claimants:** As the Supreme Court stated in *Sims v. Apfel*, 530 U.S. 103, 120 S.Ct. 2080, 147 L. Ed. 2d 80 (2000), there is no statute or regulation that requires that a claimant must list the specific issues to be considered on appeal on the request for review by the Appeals Council of an ALJ's decision, in order to preserve those issues for judicial review. Although agencies often issue "regulations to require issue exhaustion in administrative appeals," which are enforced by the courts by not considering unexhausted issues, ". . . SSA regulations do not require issue exhaustion." *Id*. at 2084. The Supreme Court refused to impose a judicially inferred issue exhaustion requirement in order to preserve judicial review of the issues upon a claimant for Title II and Title XVI Social Security Act benefits because the issues in SSA hearings are not developed in an adversarial administrative proceeding and the "[Appeals] Council, not the claimant, has primary responsibility for identifying and developing the issues." *Id*. at 2086. However, the Court, deferring to the agency, noted that ". . . we think it likely that the Commissioner could adopt a regulation that did require issue exhaustion." *Id.* at 2084. The Supreme Court thus explicitly invited SSA to draft new regulations.

Unrepresented claimants should be excepted from the requirement to show good cause. Expecting unrepresented claimants to bear the burden of preserving specific legal issues for judicial review does not comport with a sense of fair play and keeping the claims process claimant-friendly.

Issue exhaustion would bring finality to the administrative process and it is consistent with the general principles of administrative law and the procedure of other agencies in the Federal Government.

C. **Strategies to Reduce Case Processing Time and Increase Quality of Service at OHA While Preserving Due Process**

1. **Administratively Reform the HPI Process:** SSA should change the HPI process by assigning cases to ALJs at an earlier point in the process, such as when the cases are entered into the computerized master docket. This would return the control of pre-hearing case development to the ALJs, leave the ALJ in control of the hearing, and support the ALJ's responsibility for determining when a draft decision is legally sufficient. SSA also should return individual accountability for work product to the employees by assigning staff employees to work with each ALJ, which should consist of a clerical person, paralegal, and staff attorney. This will enhance morale through a sense of ownership by employees working on particular cases for an individual judge. These changes are needed to permit the ALJs to provide full and fair hearings for the American public in an efficient and timely manner. SSA may effect these changes administratively on a short term basis.

2. **Redefine Paralegal Specialist Job To Include Clerical Duties:** SSA OHA may redefine the GS-0950 Paralegal Specialist ALJ decision writer job across a broad band of General Schedule levels to permit the assignment of appropriate clerical duties to the people promoted to this position who have not performed the ALJ decision writing function well. The clerical work could include the case pulling and other clerical work that has been accumulating. This permits the necessary clerical work of the agency to get done while permitting the promoted staff to stay at their new grade levels and experience satisfaction from a job well done.

3. **Enhance the Appeals Council Case Tracking System by Including it in the First Phase of the Accelerated e-DIB Project:** SSA should install a modern computerized case tracking system with bar coding for the Appeals Council as expeditiously as possible to prevent loss of files and tapes by the Appeals Council. SSA is in the process of developing a new Case Processing and Management System ("CPMS") for OHA that is part of the Accelerated e-DIB project, the first phase of which will be implemented in January 2004. Although both the ALJ-level offices and the Appeals Council are expected to have the capacity to read an electronic file by January 2004, senior SSA management reportedly is including only the ALJ-level offices in the implementation of the CPMS by January 2004. Implementation of the CPMS for the Appeals Council reportedly is being deferred to a later phase of the Accelerated e-DIB project, despite the chaos in its case tracking system. If 140 OHA offices can be brought into the CPMS by January 2004, the Appeals Council, with its one location, also can be included in the first phase of implementation.

4. **Reorganize the Office of Hearings and Appeals**

(a) **Proposed Legislation to Reform the Office of the Chief ALJ and Create an Office of Administrative Law Judges within SSA:**

Current Status:

The adjudication of administrative claims by the SSA currently is done by administrative law judges who are part of the OHA. The function for both administrative law judge hearings and the appellate process for the review of administrative law judge decisions by the Appeals Council are located in the OHA. The OHA is under the dual leadership of a Chief Administrative Law Judge and an Associate Commissioner. The position description of the Chief Administrative Law Judge places the Chief Judge in charge of the hearings function and hearings field operation of the agency. The Associate Commissioner is placed in charge of the Appeals Council and major policy-making and policy-implementation responsibilities of the OHAs. The Chief Judge reports to the Associate Commissioner, who in turn reports to the Deputy Commissioner for Disability and Income Security Programs ("ODISP"), who in turn reports to the Commissioner.

Problems with Current System:

In the current organization of SSA, the Office of Hearings and Appeals is buried in the bureaucracy and is far removed from the Commissioner. This structure prevents the Commissioner from having effective oversight of the agency hearing process. The administrative law judge adjudication function should not be treated as a staff responsibility in the agency. The administrative law judge adjudication function is a major program of the agency with every individual in this nation being a potential claimant within the system. The SSA Administrative Law Judge hearing system protects a constitutional right of our citizens and provides a constitutionally protected due process hearing to the American public. This vital process should have direct oversight from the Commissioner and the Chief Judge should have direct interaction with the Commissioner.

Another major defect in OHA is created by the dual leadership responsibilities of the Chief Judge and the Associate Commissioner. Frequently these two leaders are competing for power to control the administrative and/or policy decisions for this component of SSA that has deprived OHA of strong effective leadership. The lack of effective leadership and direction of the Office of Hearings and Appeals has resulted in an organization that has been deteriorating. During the past 10 plus years several reforms have been imposed on the SSA hearing process. Each attempt has resulted in failure. Subsequent to a recent change in the hearing office process that was implemented in January 2000 (HPI), the number of case depositions have dropped while the case processing time and the case backlog have increased. The result has been poorer service for the American public. Within the past several years, the Associate Commissioner attempted to reorganize the responsibilities of the Chief Judge and divest the Chief Judge of most of the powers of that office leaving the Chief Judge with some minor duties relating to judicial education and staff support for the Associate Commissioner. This scheme was thwarted by the efforts of interested individuals and organizations together with the oversight action of the Congress.

The problem has now returned with the present Associate Commissioner of the Office of Hearings and Appeals. He has striped most of the power from the Office of the Chief Judge. He treats the Chief Judge as a staff person instead of a vital policy maker who is in charge of the field operations for the hearings function of the agency as provided for in the Chief Judge's position description. This action of the Associate Commissioner has led to a crisis within the Office of Hearings and Appeals with the last Acting Chief Judge leaving the position last March after having served for only a few weeks in office. The Chief Judge position was vacant until June 3, when a new Acting Chief Judge was appointed. This position has not been filled permanently since the last Chief Judge left over a year ago.

Proposed Reform:

This system requires basic reform that places an established Chief Judge in charge of the agency hearing process with reporting responsibility directly to the Commissioner. We propose legislation that separates the agency hearings function from the Appeals Council and places the hearing component in an Office of Administrative Law Judges under the control of a Chief Judge who reports directly to the Commissioner. Our bill to effect this reform imminently will be introduced in the House.

The following improvements in service to the American public will result from the proposed legislation:

a. The Commissioner will have direct oversight of the hearing component of the agency that is necessary to effectively administer this important program which provides constitutional due process hearings for the American public.
b. Improved leadership and efficiency in the hearings component will permit the SSA to provide better service for the American public by increasing case dispositions, reducing processing times and reducing case backlogs.
c. The change will improve the SSA hearing process and will continue to ensure that the American public receives a fair constitutional due process hearing.
d. The proposed legislation creates an Office of Administrative Law Judges ("Office") in the SSA. The national ALJ hearings function and hearings field operation that presently is within the OHA would be transferred to the Office by the proposed legislation.
e. The Chief Judge would be in charge of the Office, would report directly to the Commissioner, be appointed by the Commissioner for a term of six years that is renewable once, and be subject to removal only upon a showing of an enumerated cause.
f. The administrative law judge hearing component of SSA is regarded as an organization that is responsible for administering a major agency program which reports directly to the Commissioner. It will be no longer organized as a staff function within the agency.
g. The Office of Administrative Law Judges will have one individual, the Chief Judge, responsible for administrative operations and policy making. This will result in effective leadership of the administrative law judge function.
h. The Associate Commissioner of OHA will continue to head the Appeals Council.
i. The change is a reorganization within the agency and will not result in any additional costs to the agency.

This change is endorsed by the SSAB. The SSAB recently prepared a report on the Social Security disability system that states that "[m]any believe that the Office of Hearings and Appeals is buried too low in the agency and should be elevated so that the head of the office would report directly to the agency leadership. Others believe that there should be independent status for an administrative law judge organization." *Charting the Future of Social Security's Disability Programs: The need for Fundamental Change, January 2001,* p. 19.

(b) **In the Alternative, Reorganize OHA to Have the Chief ALJ Report Directly to the Commissioner and Replace the Appeals Council with a Right of Appeal to Appellate Panels Staffed by ALJs that Would Be Administered by the Chief ALJ:** This proposal is identical to AALJ's proposal for an independent adjudication agency that would provide a hearing before an ALJ with a right of appeal from the individual ALJ's decision to an appellate panel staffed by ALJs, which is explained in suggestion 6(b) below, except that the Chief ALJ would report to the Commissioner rather than be the head of an independent agency. Such a reorganization may be effected by the SSA without legislation.

(c) As an Alternative to Reorganizing OHA, Create A New Independent Agency within SSA to Issue the Final Administrative Decisions of Social Security Act Claims, Including Medicare Claims: A consensus has formed that the SSA's administration of OHA and its efforts to bring DDS decisionmaking into accord with ALJ decisionmaking have failed and that fundamental change is needed. Management initiatives such as process redesign, process unification, prototype, and, most recently, the Hearing Process Improvement Plan ("HPI") and Appeals Council Process Improvement Plan ("ACPI"), have not achieved their goals. The Appeals Council, which originally was intended as a policy making body, is universally recognized as a failure in its function as the final step in the administrative review of Social Security claims.

OHA performs an adjudicatory function in an executive agency that was created by Congress, and handles the largest appellate administrative caseload of any agency in the world. SSA's many misguided efforts to implement policy through OHA's adjudication function, some of which are described in this statement and AALJ's Statement that is published in the Report for the June 28, 2001, First Hearing in the Series on Social Security Disability Programs' Challenges and Opportunities, House Subcommittee on Social Security, No. 107–35, 107th Cong., 1st Sess., pp. 80–93, reveal the nature of the change in the Social Security claims process the American public needs: Separation of OHA's appellate administrative adjudication function into an entity that is independent of the political policy making and implementation portions of SSA. An independent adjudication agency would provide members of the American public who file claims for Social Security Act entitlement program benefits that have been denied by the SSA timely adjudications that give due proc-

ess, including a timely and fair hearing free of policy implementation and political pressure.

The rationales that have justified Congressional separation of the appellate administrative adjudication function from Executive Branch agencies include an efficient and low cost process for the claimants, high case volumes, expertise, and decisional independence of adjudicators. The maintenance of a reasonably efficient, orderly and low cost adjudication system in the traditional domain of public rights is in the public's interest, especially for programs that distribute benefits on a large scale. Specialized tribunals are more likely to make correct decisions in subject areas that are legally complex or have technical facts. The large increase in the administrative case volume also supports the use of specialized adjudication agencies. The most important rationale is the experience that effective protection of individual rights before agencies through independent decisionmaking cannot take place unless adjudications are separated from the agency's rulemaking/policy, prosecutorial/enforcement and investigatory functions.

These rationales, particularly the need to separate the adjudicatory function from other conflicting agency functions, led Congress to create the Occupational Safety and Health Review Commission ("OSHRC") in 1970, 29 U.S.C. § 661, and the Federal Mine Safety and Health Review Commission ("FMSHRC") in 1977, 30 U.S.C. § 823, as independent Executive Branch agencies outside the Department of Labor with only adjudicative authority. The OSHRC determines whether regulations promulgated and enforced by the Occupational Safety and Health Administration have been violated. The FMSHRC adjudicates violations of standards promulgated and enforced by the Mine Safety and Health Administration.

Therefore, when an agency, such as SSA, exclusively uses rulemaking proceedings to set policy, rather than also using adjudications to set policy, there no longer is any rationale for keeping the adjudicatory function within the agency. The Congressional interest in providing a check on SSA's enforcement powers, *i.e.*, to withhold disability and other program benefits, is best served by having entitlement determinations decided by an independent adjudicatory agency based on the benefits entitlement standards set by SSA. Hence our proposal that the independent agency be an adjudicatory body that is self-administered by the ALJs with a right of appeal from an individual ALJ's decision to an appellate panel staffed by ALJs.

There are additional reasons why an independent adjudication agency administered by ALJs would provide a more efficient and higher quality of due process for Social Security benefits claimants than the current SSA Appeals Council or an independent but politically appointed Commission or Board structure. First, a small body, such as the current Appeals Council, or a Commission or Board, cannot be of sufficient size to do meaningful administrative review of appeals from the ALJ decisions, which now number near 100,000 per year. The SSA ALJs are a large group of highly qualified judicial professionals who are capable of administering themselves and the appellate administrative process in a competent and effective manner. Second, creating an independent agency would eliminate political oversight by appointees (ie., Commissioners or Board members) who do not have due process and adjudicative independence as their foremost goal in agency administration. Finally, if the SSA ALJs administer themselves, they will draft and issue the procedural regulations and rules of the new agency based upon their experience and needs of the process, rather than expediency and other policy concerns as they are now. There now is no coherent set of procedural regulations and rules for the SSA appellate administrative process.

For all of these reasons, the Social Security Act hearing process should be reformed by the transfer of the authority to make final administrative adjudications of Social Security Act claims, which currently are made at the ALJ and SSA Appeals Council levels, from the Social Security Administration to a new ALJ-administered independent adjudication agency within SSA. This agency may be called the United States Office of Hearings and Appeals ("USOHA").

The USOHA would have the exclusive jurisdiction to make the final administrative decisions of Social Security Act Title II and XVI claims. The USOHA would have permissive jurisdiction over other classes of cases, including Medicare cases under Social Security Act Title XVIII. [On December 4, 2001, the House passed the Medicare Regulatory and Contracting Reform Act of 2001, H.R. 3391, section 401 of which authorizes the transfer of the ALJ function from SSA to the Department of Health and Human Services by October 1, 2003, to hear and decide Medicare cases pursuant to Title XVIII of the Social Security Act. AALJ's proposal advocates placing all of the ALJs hearing Social Security Act cases into one independent agency, including Medicare cases.]

AALJ recommends the creation of a new ALJ-administered independent adjudication agency for Social Security Act claims that would provide a hearing before an

ALJ with a right of appeal from the individual ALJ's decision to an appellate panel staffed by ALJs. The panels would consist of three ALJs who would review the cases locally. This Social Security Appellate Panel Service within the USOHA would replace the Appeals Council, a failed appellate review step that already exists and is funded.

The ALJ appellate panels would be akin to the Bankruptcy Court appellate panels and is one of the key features that makes the ALJ self-administration model superior to the current SSA Appeals Council model, which is a small body that cannot timely and effectively handle a heavy caseload. Based upon the Bankruptcy Court experience, the appellate panel model (1) is an appellate system that can handle a large caseload, (2) results in a shorter disposition time because the large pool of about 1,000 ALJs throughout the United States permits the timely determination of appeals that cannot take place with a small body such as the Appeals Council or a Commission or Board, (3) results in higher quality decisions because of expertise, (4) results in substantially fewer appeals to the courts and a substantially lower reversal rate by the courts because of the confidence in the high quality of the decisions, which reflects a higher degree of decision accuracy, (5) results in a substantially reduced federal court caseload, and (6) affords the claimants access to a local administrative appellate process.

This proposal would provide the claimants with timely, high quality, impartial and fair decisions of their claims pursuant to the Social Security Act and APA by adjudicators who are in an agency independent of, but within, the SSA.

The USOHA would be located within the SSA for logistical reasons, but its officers and employees will not be supervised by any other part of SSA. The USOHA will be accountable only to Congress and the President. Placing the USOHA within SSA results in no new costs for office space and information systems and is a practical necessity, given the USOHA's substantial space needs that currently are in place at SSA, the need to share the SSA's information services and data bases, and the need to use the same case files.

A Chief ALJ appointed by the President for a term of years would administer the agency.

The final decisions of the USOHA that are made by its appellate panels would be appealed only to the federal courts, with the District Courts as the first step in the judicial review. A District Court appeal step is essential for several reasons: (1) The huge size of the Social Security appellate caseload would overwhelm the Circuit Courts if the District Court step is removed. An Article I court as a substitute for the District Courts would suffer from the same problems of being too small to effectively handle the case load that the Appeals Council does. (2) Retaining District Court judicial review keeps local decisional generalists in the appeals chain who are sensitive to due process concerns, including adherence to the Administrative Procedure Act. (3) Social Security claimants have come to rely on the availability of the District Courts as a part of the judicial review due process. (4) Congress has a demonstrated preference for local control and decisionmaking with Social Security programs. (5) It is desirable to retain local access to the judicial review process for the often indigent Social Security claimants.

The appeals from the District Courts will remain with the regional Circuit Courts of Appeal, as they do now, rather than go only to the D.C. Circuit or the Federal Circuit. Even with District Court review, placing all of the Social Security Circuit-level appeals in either of these courts would increase their workload by over 50%. The SSAB's recent suggestion of a specialized Social Security Court of Appeals superficially may sound attractive as a device to have one national interpretation of the Social Security Act. However, the SSAB does not demonstrate a strong need for such a specialized court. First, as SSAB points out, the Supreme Court already serves the function of providing a national interpretation of the Social Security Act, and having the regional circuits address the issues allows for legal debate that would otherwise not occur. Second, continuing to have the appeals go to the regional Circuits allows somewhat local access to the claimants. This is the same procedure as for appeals from both Bankruptcy Court decisions after District Court review and Tax Court decisions, which are appealed to the regional Circuits, which makes sense since they also serve individual claimants throughout the country who often have limited means. (Although the Tax Court is based in Washington, D.C., it sits throughout the country.) Regional circuit review has worked for tax and bankruptcy cases, despite the obviously strong argument that a single standard for construing the tax and bankruptcy laws is desirable so that they are applied the same to everyone. Finally, the regional circuits are not being overrun with Social Security cases. During the years that ended on September 30, 1999, and September 30, 2000, only 891 and 845 Social Security cases respectively were filed with the regional Circuit Courts of Appeals. *Judicial Business, 1999 and 2000 Reports*, Table B–1A. This is

less than two percent of the 54,693 cases that were filed in 1999 and 54,697 cases filed in 2000 in the regional Circuit Courts. *Judicial Business, 1999 and 2000 Reports,* Table B.

Thus, no substantive changes in the process of judicial review after the final administrative decision are recommended by AALJ, other than to amend the Social Security Act to reflect that judicial review will be from the final decisions of the new agency, not the SSA. Our recommendations pertain only to the appellate administrative adjudication process that results in a final administrative decision of the claimants' entitlement to Social Security benefits, since that is where the problems lie.

This proposal requires legislation that would amend the Social Security Act.

A detailed version of the features of the proposed new agency and the rationales for such a new agency is presented in the AALJ's Statement that is published in the Report for the June 28, 2001, First Hearing in the Series on Social Security Disability Programs' Challenges and Opportunities, House Subcommittee on Social Security, No. 107-35, 107th Cong., 1st Sess., pp. 80-93. A very detailed version of the features of the proposed new agency and the rationales for such a new agency, including legislative language, is presented in the AALJ's "Report and Recommendations for the Transfer of the Authority to Make Final Administrative Adjudications of the Social Security Act Claims from the Social Security Administration to a New Independent Regulatory Agency," which is available upon request or on the AALJ website, www.aalj.org.

The AALJ proposal for a new adjudication agency is a detailed and practical blueprint to improve the Social Security disability process. The AALJ proposal would improve the timeliness and quality of ALJ and final administrative review decisions that, at the same time, likely will reduce the claimant's need to resort to federal court review and thus reduce the federal court Social Security caseload. The process AALJ is proposing is realistic in terms of handling the large caseload, which I respectfully submit is not the case for the other proposals in this area. All of the agencies and academicians who comment on the disability process correctly recognize the need for change, but rely on the creation of small bodies, such as a Review Board or Social Security Court, that would suffer from the same problems of low decision quality and untimely action as the SSA Appeals Council, another small body, has had for years.

(d) **As an Alternative to Reorganizing OHA, Create A New Independent Agency outside SSA to Issue the Final Administrative Decisions of Social Security Act Claims, Including Medicare Claims:** Another alternative is to create a separate adjudication agency to hear Social Security Act claims, including Medicare claims. This agency would have the same organization structure as is described in section 4(c) immediately above, but it would be a separate agency outside the SSA.

(e) **As an Alternative to Reorganizing OHA at the ALJ Level, Create a Unified Corps of ALJs outside SSA:** A more comprehensive reform of the ALJ hearing process may be achieved through the House Judiciary Committee by creating a unified corps of ALJs outside SSA and other agencies that includes SSA ALJs and ALJs from other agencies in any one of the following three configurations:

1. a unified corps of all ALJs from the agencies that hear benefits cases, including SSA,
2. a unified corps of all ALJs from SSA and the Cabinet-level Executive Branch agencies, and
3. a unified corps of all ALJs in the Executive Branch, including all of the independent agencies.

Chairman SHAW. Thank you, Judge. Ms. McGraw?

STATEMENT OF THE HON. KATHLEEN MCGRAW, ADMINISTRATIVE LAW JUDGE, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, ATLANTA, GEORGIA, AND CHAIR, SOCIAL SECURITY SECTION, FEDERAL BAR ASSOCIATION

Ms. MCGRAW. Chairman Shaw, thank you for convening this hearing on an issue of vital importance to millions of Americans.

I am pleased to be here on behalf of the Social Security section of the Federal Bar Association. Although I am an ALJ with Social

Security, I am not here in my official capacity and my remarks are solely those of the Social Security section of the Federal Bar.

As you know, the FBA represents a broad array of stakeholders working at all levels of the disability adjudication process. The primary concern of the FBA is the integrity, independence, fairness and effectiveness of the disability hearing process. Clearly, the effectiveness of the process is front and center in this hearing today.

Two years ago, I testified before this Committee and not much has changed. We are faced with the same problems, only they have gotten worse. In my limited time I want to address two of those problems. First, the fundamentally different approaches to disability of DDS and OHA, and second, the unacceptable delays at OHA.

The SSA's process unification initiative was intended to have everyone using the same legal standards to decide the issue of disability. That still is not happening. At the DDS, decisions are driven solely by the objective medical findings with mere lip service being paid to the requirements of the law that a claimant's subjective complaints such as pain and fatigue be assessed. No two people with the same objective findings have identical functional limitations. The law requires an individualized assessment.

While there has been some good faith effort in prototype States to apply the law and assess subjective complaints, the testimony before this Committee 1 year ago of Sue Heflin, then President of NADE, is illuminating. She made the point that it is expensive and time consuming to gather the evidence necessary to make an individualized assessment. Moreover, doing individualized assessments leads to inconsistencies in decisionmaking. Consequently, DDS prefers to base decisions purely on objective medical findings. That, however, is not what the law requires.

The NADE has proposed to move the claimant's hearing to the DDS level. Based on the DDS response to process unification, it is clear the DDSs are not capable of providing claimants the due process hearing they are entitled to consistent with the requirements of the law.

At a minimum now, DDSs need to do a better job of collecting relevant evidence; they need to contract for higher quality consultative examinations; and, they need to provide claimants with rationalized decisions that explain the standards for disability and the reasons claimants don't meet those standards.

The Commissioner recently announced an initiative to have ALJs screen cases as they come in the door from DDS. The purpose is to pay those that should be paid on the record and to identify those that need more development. If this initiative can be productive, then clearly claimants are not being allowed as early in the process as they should be and cases are not being properly developed at the DDS.

That said, the delays at OHA are unacceptable. You no doubt want to know why and what can be done about the situation. As for the "why," the culprit is poor management practices at OHA. Mr. Bernoski referenced the number of cases ALJs used to produce. We are dealing in large part here with a management-induced crisis.

Two years ago we raised with this Committee a warning about management problems within OHA. The HPI was conceived and implemented without meaningful input from judges. It was not designed for the needs of an organization that delivers judicial services.

Under HPI, employees were organized into groups servicing groups of judges. Instead of more accountability, there was none. Claimants and representatives found themselves unable to identify any one employee who had responsibility for or knowledge of their cases. Judges didn't even know which employees were handling the cases on their own dockets. There was chaos in the office.

In addition, there was wholesale promotion of employees into jobs they weren't prepared for or qualified to perform. The OHA was without a support staff that could effectively process cases. Judges who routinely issued 40 to 60 decisions a month no longer had enough cases pulled and scheduled to enable them to maintain that level of production. Added to this organizational debacle is the inscrutable decision of SSA not to impose performance standards on its employees. The only people in OHA who have production expectations are judges. The employees that both claimants and judges rely upon for case preparation, scheduling and decision drafting have no quantifiable standards. They operate on a pass-fail basis. In my experience, no one, no matter how little they do or how poorly they do it, has ever failed or suffered any adverse consequences.

The simple act of imposing quantifiable performance standards would produce immediate improvement in OHA's productivity and timeliness.

Finally, in the view of the FBA, OHA is a judicial entity. It needs to be led by a Chief Judge and it needs the support and services of attorneys. While there is a legitimate place for paralegals, the massive promotion under HPI of 350 clerical staff to the paralegal position with no legal training and no demonstrated qualifications for the job of drafting decisions is inexplicable. These so-called paralegals are at the same pay and grade as attorneys. This decision flies in the face of effective judicial administration.

With this, I am afraid time deserts me. So, I thank you for this opportunity to testify on behalf of the Social Security section of the FBA.

Chairman SHAW. Thank you.

[The prepared statement of Ms. McGraw follows:]

Statement of the Hon. Kathleen McGraw, Administrative Law Judge, Office of Hearings and Appeals, Social Security Administration, Atlanta, Georgia, and Chair, Social Security Section, Federal Bar Association

INTRODUCTION

Chairman Shaw and Members of the Subcommittee:

I am Kathleen McGraw, Chair of the Social Security Section of the Federal Bar Association. I am an administrative law judge in the Office of Hearings and Appeals of the Social Security Administration in its Atlanta North office. As an Administrative Judge for the U.S. Merit Systems Protection Board for 13 years and as an Administrative Law Judge for Social Security for the past seven years, I have heard and decided well over 2,500 appeals. I am very pleased to be here today representing the Social Security Section of the Federal Bar Association (FBA). My remarks today are exclusively those of the Social Security Section of the Federal Bar

Association, not the FBA as a whole. Moreover, they in no way reflect the official views of the Social Security Administration.

Thank you for convening this hearing this afternoon on a matter of critical importance to the Federal Government's delivery of effective services to the American people. As you know, the Federal Bar Association is the foremost professional association for attorneys engaged in the practice of law before federal administrative agencies and the federal courts. Fifteen thousand members of the legal profession belong to the Federal Bar Association. They are affiliated with over 100 FBA chapters in many of your districts. There are also over a dozen sections organized by substantive areas of practice, such as the Social Security Section, of which I am the Chair.

Unlike other organizations associated with Social Security disability practice that tend to represent the narrow interests of one specific group, the Federal Bar Association's Social Security Section encompasses all attorneys involved in Social Security disability adjudication. Our members include:

- Attorney Representatives of claimants
- Administrative Law Judges (ALJs)
- Administrative Judges at the Appeals Council
- Staff Attorneys at the Office of Hearings and Appeals
- Attorneys at the Social Security Administration's Office of General Counsel
- U.S. Attorneys
- U.S. Magistrate Judges, District Court Judges and Circuit Court Judges

The greatest interest of the FBA's Social Security Section is in the effectiveness of the adjudicatory process associated with hearings in the Office of Hearings and Appeals (OHA), the appeal process at the Appeals Council and judicial review in the federal courts. Our highest priority is to assure the integrity, independence, fairness, and effectiveness of the Social Security disability hearing process for those it serves—both Social Security claimants themselves and all American taxpayers who have an interest in assuring that only those who are truly disabled receive benefits.

It is the Section's collective view that the Social Security disability program is under considerable strain. Current delays in the processing of claims are unacceptable and the quality of decisions at all levels is less than ideal. The Commissioner is faced with a daunting task. It is with that in mind that we offer the following comments.

Full Implementation of Process Unification at All Levels of Adjudication

Process unification is essential to an efficient, timely and accurate disability adjudication system that ensures disabled claimants will be paid as early in the process as possible.

In the mid-1990's the Social Security Administration (SSA) acknowledged the inconsistency created by the Disability Determination Services (DDS) applying one set of rules for determining eligibility through the Program Operations Manual (POMS), and its Administrative Law Judges, Appeals Council, and the federal courts applying another through statute, regulations, rulings and case law. Consequently, in 1996 SSA initiated Process Unification Training for all DDSs, ALJs, and the Appeals Council. The training was based on a set of rulings—the "Process Unification Rulings"—that were designed to guide all adjudicators at every level. It was anticipated that the DDSs would no longer rely exclusively on POMs, and that they would begin to write an analysis of their decision-making. This rationalized determination, in turn, would be granted some deference by reviewing ALJs and Appeals Council.

As a facilitator for this training, I traveled across the country and interacted with all components being trained. It became clear to me during this training that State Agency examiners, although hardworking and well-trained in the medical area, were not assessing a claimant's subjective allegations. Moreover, they were overwhelmed by the prospect of having to do so. They were confounded by the task of assessing a claimant's credibility and subjective allegations and articulating a reasoned basis for their conclusion. Notwithstanding the clear message from the Process Unification Training that State Agency Examiners were expected to perform individualized assessments and rationalize their determinations, they have failed to do so. State agencies have balked at this requirement, and examiners' determinations continue to be devoid of rationale and are driven almost exclusively by objective medical findings. It is the only way they can maintain the production expected of them.

These observations were confirmed by Sue Heflin, President of the National Association of Disability Examiners, who testified before this Subcommittee on June 28, 2001. In her answer to the Subcommittee's question on the prototype initiative, she

confirmed that it is only in the 10 prototype states that Process Unification initiatives have been really implemented. In those states, while the implementation of Process Unification enabled examiners working as Single Decision-Makers to allow claims they might have otherwise denied—something they found to be a positive and fulfilling professional experience—examiners also learned that it takes longer to process a claim and costs more to do the additional development required to comply with Process Unification requirements. Ms. Heflin astutely observed that evaluating subjective factors such as pain, fatigue, credibility and treating source opinions is more time consuming for examiners and therefore more costly.

The evaluation of the claimant's subjective complaints is an everyday occurrence for ALJs deciding Social Security disability cases. Under Process Unification, it should have been an everyday occurrence at the DDS level as well. The failure to fully implement Process Unification at the DDS level implicates the due process rights of the claimant because the evaluation of subjective complaints is an integral part of the process that is due the claimant. The evaluation of subjective complaints should not be postponed until the case reaches OHA. Postponement in the review of subjective complaints represents one of the core problems that Process Unification was intended to address.

Social Security regulations and rulings mandate an individual assessment of each and every claimant's subjective complaints and their impact upon that claimant's ability to function. Yet, as candidly acknowledged by Ms. Heflin, the DDS examiners do not consider subjective complaints. We have all heard the stories about people walking around with herniated discs, documented by MRI, who suffer few or no symptoms, while others with the same MRI findings suffer from debilitating pain. At the DDS, both would receive the same decision based on the objective findings the individual level of pain alleged would not matter. That certainly makes for consistency, but unfortunately does not make for accuracy in decision-making. One can only imagine how the claimant who suffers with a subjective condition such as fibromyalgia or chronic fatigue syndrome will fair at the DDS level. Only at OHA, will the claimant's subjective complaints be fully evaluated.

The failure to implement Process Unification has led to a new agency initiative to identify cases shortly after arriving at OHA offices from the DDS. The new initiative would have been wholly unnecessary had Process Unification been implemented at the DDS. The Commissioner recently announced that, in an effort to deal with the backlog and delays at OHA, ALJs will begin to review raw, unpulled files as they arrive from DDS. The purpose of the review is twofold: to grant those claims that can be allowed on the record without a hearing; and to undertake immediate development of cases requiring additional expansion of the record. While this initiative is commendable from the viewpoint of claimants who should have been paid earlier in the process, it attests to the failure of process unification. If such an initiative yields significant results and productivity, then the cases were either: (1) not decided correctly under the law at the DDS; or (2) not adequately developed at the DDS.

We submit that SSA had it right the first time when it recognized the need for process unification. Fairness requires that all adjudicators assess a disability claim using the same legal standards and requirements. A fundamental premise of the SSA process unification effort was that disability benefits should be awarded to claimants as soon as their disability has been determined under the law. The burden of long delays to claimants before the statute, regulations, rulings, and case law are applied is unacceptable and does not serve the interests of justice. Quite simply, it can wreak havoc in the lives of deserving claimants.

Preservation of the Due Process Hearing Before an Administrative Law Judge

It is our understanding that various proposals are being made that would eliminate a hearing before an Administrative Law Judge. The Social Security Section of the FBA strongly opposes any such effort.

In 1983, the Senate Governmental Affairs Subcommittee on Oversight of Government Management conducted a hearing on the role of the ALJ in disability hearings. The report provided in part:

> The principal finding of the Subcommittee is that the SSA is pressuring its ALJs to reduce the rate at which they allow disabled persons to participate in the Social Security Disability Program. . . . [The Subcommittee found that the SSA was limiting the decisional independence of ALJs through its Rulings, its non-acquiescence to federal court decisions, and its increasing of case quotas that reduced the time an ALJ could spend on each case to develop additional evidence that may support an allowance decision, among other things.] The APA mandates that the ALJ be an independent, impartial adjudicator in the

> administrative process and in so doing separates the adjudicative and prosecutorial functions of an agency. The ALJ is the only impartial, independent adjudicator available to the claimant in the administrative process, and the only person who stands between the claimant and the whim of agency bias and policy. If the ALJ is subordinated to the role of a mere employee, an instrument and mouthpiece for the SSA, then we will have returned to the days when the agency was both prosecutor and judge.

Sen. Rep. No. 98-111 (September 16, 1983).

The Administrative Procedure Act requires that independent administrative law judges be selected on a merit basis and insulated from agency bias and pressure in performing the adjudicative function. *See Butz v. Economu*, 458 U.S. 478, 513 (1978). Regretfully, as noted in the Senate Report, SSA in the past has attempted to subvert the statutory independence of its administrative law judges. It has sought overtly, and at other times more subtly, to influence the decisions of its ALJs to achieve some predetermined acceptable allowance rate or altogether cease payment of benefits to a particular class of disabled beneficiaries. In one well-publicized episode in 1982, SSA attempted to terminate benefits to thousands of Americans with mental disabilities, triggering the reversal in many cases of that policy decision by SSA ALJs who applied the law and restored the benefits. The American Bar Association in fact honored the SSA ALJ corps for their outstanding efforts during the period from 1982-84 to protect the administrative adjudication within their agency, to preserve the public confidence in the fairness of governmental institutions and to uphold the rule of law.

A due process hearing conducted by an ALJ is a protection against potential agency bias and policy that may at times run contrary to the law as mandated by Congress. Disability claimants should not be deprived of this step in the disability process. Moreover, as noted earlier, given the constraints on DDS's, it is the first opportunity for claimants to have their subjective complaints meaningfully considered as mandated by the law. That being said, there remains the critical issue of unacceptably long delays at OHA. The causes of these delays are many, but most obvious is the abject failure of the Hearing Process Improvement (HPI) initiative. Prior to HPI, in FY 1998, ALJs issued 618,578 decisions. In FY 2001, with full implementation of HPI, that figure plummeted to 465,228.

The defects in HPI, both in design and implementation, are legion and need not be enumerated here. Suffice it to say, a fundamental problem was the de-legalization of the adjudicative process, which included the removal of judges from the case development function. Over 350 employees, primarily from the clerical ranks, were promoted to the position of "paralegal". Their promotion left OHA bereft of employees trained in "pulling cases" in preparation for adjudication by administrative law judges. This created fewer cases ready for judges to hear and fewer cases for judges to decide—a crisis induced by an ill-advised management decision. To make matters worse, the employees who have been promoted to the "paralegal" position, in almost all cases, have had no legal training whatsoever and in their promotion were not even required to demonstrate an ability to write; yet, they were and remain tasked with writing draft decisions for the judges—decisions that are subject to judicial review in U. S. District Court. Attorneys could have filled the positions encumbered by these "paralegals" as the two positions are at the same grade and pay level. Instead, SSA made the conscious choice to fill these slots with clerical workers rather than trained lawyers. It goes without saying that under this new arrangement the review time required for judges to edit and revise their decisions has increased exponentially further delaying disposition of claimants' cases.

OHA performs an adjudicative function and its procedures and support systems need to be designed and implemented to facilitate that function. Clearly, with proper and adequate support, ALJs are capable of timely adjudicating the cases before them while providing claimants with due process.

OHA Adjudicative Support Functions Should be Reorganized

OHA fundamentally is a judicial operation. Therefore, it should be under the direction of a Chief Administrative Law Judge, who is provided appropriate administrative assistance in carrying out the adjudicative function. Contrary to the current situation, the administrative and support system should not dictate to OHA's judges how the adjudicative function should be accomplished.

The foremost problem within the Office of Hearings and Appeals is that the judges have no managerial authority over the staff who work for them. It may come as a surprise to members of this Subcommittee, particularly those who may have practiced in federal or state courts, how different the delivery of judicial "services" is in Social Security cases. In federal district courts, as well as in most state courts,

judges have secretaries and law clerks whose work they direct on a day-to-day basis. Theses employees are ultimately responsible to the judge and practitioners can readily identify them as the employees who support the work of the judge.

This is decidedly not how the Social Security Administration has chosen to deliver its judicial services. A pooled staff is available to assist judges, but without direction or supervision by the judges themselves. Judges, as well as claimants' representatives, are often at a loss to know what staff member to talk to about specific case problems. Miscommunication abounds, leading to processing and scheduling problems that impede the timely adjudication of cases. The situation is further compounded by staff working at home—a complicating factor that in some cases further diminishes the effectiveness of the office. On a daily basis, evidence that needs to be associated in a timely manner is not. In fact, the evidence may even be lost. Messages do not reach the right person to avert scheduling problems. Ultimately claimants' cases are delayed as a result of this administrative chaos.

Added to these problems, and probably chief among them, is the fact that within OHA there are no quantifiable standards by which employee performance is measured. Appraisals are done on a pass/fail basis, and no one ever fails. Employees can nominate themselves for awards and too often the worst of employees reap the same rewards as their hardworking coworkers who are picking up the slack for their shoddy performance. Morale is understandably low. Other components of SSA have employee performance standards and it is difficult to see why a component such as OHA would not utilize a system of individual employee accountability.

Like it or not, OHA is drawn into a numbers game. Yet, the only persons in OHA for whom there is a stated numerical expectation are the judges who are supposed to produce a certain number of cases per day. There is no comparable expectation for the employees upon whom the judges must rely for support, such as the case technicians who "pull" cases or the attorneys and paralegals who draft decisions. Competitive and excepted service employees in other federal agencies are subject to objective performance standards both for quality and quantity of work. For some unexplained reason, that is not the case at OHA. As a result, substandard performance is routinely tolerated and claimants suffer as a result. There could be no more single effective improvement at OHA than the imposition of quantifiable performance standards and the willingness on the part of management to enforce those standards.

Establishment of a Comprehensive Quality Assurance Program Throughout the Disability Program

The General Accounting Office has repeatedly reported that SSA needs to implement a comprehensive and meaningful quality assurance system. SSA announced a plan to revamp its existing quality assurance system in 1994. Yet, in 2001 SSA acknowledged that its quality assurance system needed to more effectively promote uniform and consistent disability decisions across all geographic and adjudicative levels. GAO has made specific recommendations as to the content of such a plan.

The Commissioner has appointed a Regional Commissioner to lead an effort to establish a quality assurance program. We commend the Commission for undertaking this action, and we encourage the development of a comprehensive quality assurance program that establishes quality standards at all levels of the claims process. The disability program is a nationwide program, and it is not acceptable to have disparate allowance rates at the initial DDS level on disability claims in FY 2001 ranging from a low of 27% in one state to a high of 65% in another state.

A quality assurance plan should, for example, set the standard for the collection of evidence at all levels of review, including DDS. Much of the delay in the life of a disability claim is due to the time needed to collect relevant evidence. For example, if a claimant alleges disability due to severe injuries in an automobile accident and DDS obtains the primary care physician records of general care, but fails to obtain the records of the trauma surgeon and hospital, DDS will not have the relevant evidence needed to make an accurate determination. While a denial based on the primary care physician records may be technically correct, given the record as developed, that record is wholly inadequate. The claimant is then forced to appeal the denial until someone develops the complete and relevant record. If the correct record were obtained at the DDS level, the accuracy of the DDS decision could be realistically measured. It is a meaningless statistic to say the DDS made the right decision, when it was rendered on an inadequate record.

Similarly, delays at the ALJ level occur while the relevant evidence is obtained and the file is assembled. One of SSA's redesign initiatives, the Adjudication Officer (AO), sought to accomplish the generation of evidence and file assembly at the DDS level. The AO developed the record and granted eligible claims, forwarding the ineligible claims to an ALJ for further review. In those cases that were denied, the AO

prepared a summary of the evidence, and certified that the record was complete. The case was then heard by an ALJ generally within 60 to 90 days of its receipt and little or no further development of the record was required. Concerns were raised about the AO project because a higher percentage of claims was paid at the DDS level, and administrative costs for assembling a complete record and providing a summary were high. The project, however, resulted in correct decisions earlier in the process and savings of administrative costs and time at OHA.

A Quality Assurance Program should measure the adequacy of the file, the quality of the analysis, and the correctness of decisions at all levels. It should also undertake to measure the accuracy of both allowances and denials of claims. At the DDS level, quality review work currently performed by SSA's Disability Quality Branch focuses on allowances of claims rather than denials. This creates systemic pressure on the DDS examiner to avoid erroneous allowances, but not necessarily erroneous denials. Since an erroneous denial is much less likely to be scrutinized by quality control, a denial represents a far more attractive and safer decision option for the DDS examiner. At the ALJ level, the opposite is true. To be effective, without subtly influencing the outcome of decision-making, a quality assurance program should be neutral and refrain from pushing the process toward allowing or disallowing claims. The QA program must measure the accuracy of both allowances and denials.

The Electronic Folders Initiative (E–DIB) must be adequately funded, closely monitored, and not viewed as the complete answer to disability adjudication problems

The Commissioner has announced that the entire record at all levels will be contained in an electronic folder (E-DIB) by January, 2004. The E-DIB initiative has the potential to provide significant improvement in the speed of claims adjudication. However, given SSA's track record in the conceptualization and implementation of HPI and other redesign initiatives, we strongly encourage the application of significant care and attention to the testing and introduction of E-DIB.

Very few details concerning the plan have been announced, and there are innumerable questions relating to the implementation of this initiative. We urge extensive testing at the pilot stage and vigilant monitoring of its rollout. Given the shortage of personnel within DDS and OHA to handle the current caseload, careful attention also should be devoted to staffing plans for those who will maintain the systems and scan the documents included in the electronic folder. Attention should also be devoted to whether E-DIB coverage will extend to claims pending at the time of conversion or whether this will include only claims filed after January, 2004. The Social Security Administration needs to work with the representative community to insure the confidentiality of the claimant's record, while also assuring safety and security of the internet system itself. Access to the claimant's record by those on the other side of the digital divide, who lack compatible equipment, also should be considered.

Elimination of Reconsideration and Reorganization of the Appeals Council

The Social Security Section of the FBA seriously questions whether the current processes of DDS level reconsideration and Appeals Council review are serving their intended purposes. Thoughtful scrutiny should be devoted to whether the time spent on these two review processes contributes to the effective adjudication of disability claims and the interests of justice.

A claimant who is initially denied benefits may request DDS reconsideration of the denial decision. Reconsideration is widely—and correctly—viewed as little more than a rubber stamp of the initial denial. During FY 2001, of an average 100 claims processed by DDS, 40 were approved at the initial level and 4 at the reconsideration level. Time spent at the reconsideration level was 69 days. Given the few requests for reconsideration that ultimately are successful, concerns can be deservedly raised whether reconsideration represents a meaningful step in the disability process. The Social Security Section of the FBA supports the elimination of reconsideration and redirection of that portion of DDS budgets into the initial level of decision-making.

Attention should also be devoted to the role and effectiveness of Appeals Council review. Upon receipt of an adverse claims decision by an ALJ, a claimant may appeal to the Appeals Council, which then undertakes a review on the record. While the Appeals Council serves a valuable purpose in screening out many cases that should not reach federal court due to deficiencies in the ALJ decisions, the Appeals Council is overwhelmed by its staggering workload. It has taken steps to shorten its appeal time, and according to the General Accounting Office, reduced the amount of time to process an appeal from 458 days in FY 1999 to 447 days in FY 2000. This is still an unduly long period of time. There can also be no excuse for the number of cases in which a remand occurs for no reason other than a lost or defective hearing tape. Technology needs to be improved to eliminate this needless delay for claimants.

The substantive legal correctness of the decisions of the Appeals Council has also been frequently challenged. In a mounting number of cases appealed to U.S. District Court after denial of review by the Appeals Council, the Office of General Counsel and U.S. Attorneys have asked the Appeals Council to agree to a "voluntary remand." These requests are prompted by concerns over the ability to defend the underlying ALJ decision—the decision that had already been affirmed by the Appeals Council. The frequency of such "voluntary remands" indicates that in its rush to process appeals, the Appeals Council may not be getting it right the first time. The record the Appeals Council agrees to take back in a voluntary remand is usually identical to the record it initially reviewed. If the ALJ decision is indefensible, it should have been caught before the case proceeded to federal court. That, after all, is the role of the Appeals Council in the request for review process.

Therefore, we believe that the Commissioner should review and study the role and responsibility of the Appeals Council, with special attention devoted to: the usefulness and necessity for the request for review function; the merits of redesign of the Appeals Council mission to focus on quality review; and the establishment of a time-limit for the processing of requests for review, permitting cases not reached within the allowable time to go directly to court.

Conclusion

This concludes my prepared remarks. Thank you once again for the opportunity to appear before you today. The Social Security Section of the Federal Bar Association looks forward to working with you and the Social Security Administration in improving disability process. I would be happy to answer any questions you may have.

STATEMENT OF JOHN H. PICKERING, PAST CHAIR, SENIOR LAWYERS DIVISION, AND COMMISSIONER EMERITUS, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION

Mr. PICKERING. Mr. Chairman and Members of the Subcommittee, it is a privilege to appear before you this morning to present the views of the American Bar Association to discuss the important issue of improving the Social Security disability appeals system.

The American Bar Association as a representative of our legal profession, is particularly concerned with making access to justice available to those persons who are most in need and are least able to protect their rights: the poor, the elderly and persons with disabilities.

Accordingly, we have had a longstanding interest in the Social Security disability review process and we have worked actively to promote increased efficiency and fairness. Over the years we have developed numerous recommendations for improvement, which are appended to my written statement. We have filed an amicus brief in the landmark Bowen case in the Supreme Court for the disability claimants who had been unlawfully deprived of their rights.

Our first recommendation for improvement builds on what you have previously heard. To reduce the number of appeals, we need to improve the initial stage of the process by providing applicants with a clear statement of eligibility requirements, a list of claimant responsibilities, and a description of the administrative steps in the process, and explanation of relevant medical and vocational evidence and a notice of the availability of legal representation.

The SSA should take affirmative steps to make a better record at the initial stage by compiling accurate documentation and by supplementing medical reports that are not sufficient.

Next we recommend that before denying a claim, SSA should notify claimants of the pending adverse action, inform them of the reasons for the finding, ensure that they have access to all the evidence in their file, and provide them with an opportunity to submit further evidence.

We recommend that the SSA advise claimants' health care providers of deficiencies in the medical evaluation and give them an opportunity to cure those deficiencies.

If the claim is denied after full development of the file, we recommend additional steps to ensure the integrity and efficiency of the appeals process and to guarantee due process. To do that, claimants should be provided with a clear and detailed statement of the reasons for denial, their opportunity to appeal, the availability of legal representation, and the consequences of failing to appeal.

We support the elimination of the reconsideration level. In the present scheme it serves no purpose. Instead, you should go right to a due process hearing on the record before an Administrative Law Judges whose authority as an independent fact finder is assured.

That ALJ should have the opportunity to take testimony from the client, develop evidence when necessary, consider and weigh the evidence and evaluate vocational factors in order to reach an impartial decision free from Agency coercion. I emphasize the need for independence because we must never forget past history when SSA tried to eliminate the backlog of disability cases by threatening the ability of the ALJs to ensure due process. That sorry experience must not be repeated.

We also urge that the proposals to close the record be carefully considered. We think the record should not be closed until the conclusion of the hearing at the very earliest and that it could be reopened upon a showing of good cause. Denying the opportunity to reopen and requiring the applicant/claimant to submit a new application is simply a waste of time and resources.

Recent proposals have again raised questions about the role of the Appeals Council. We have recommended that this issue be studied in the past. We caution that any changes should not compromise the independence and the impartiality of the ALJs. We therefore urge that the scope of the Appeals Council review be limited to clear errors or law or lack of substantial evaluated.

The ALJ findings of fact should not be reversed without specific documentation and review of the hearing tapes.

We recommend that if the Appeals Council fails to act upon a request for a review within a specified period of time, claimants should be deemed to have exhausted their administrative remedies and be permitted to seek Federal court review if the decision is adverse.

Finally, there is the issue of creating Article I courts to hear Social Security appeals. The ABA has consistently opposed legislation to create such Article I review courts. It may be timely to revisit this issue, but the important factor is that it is not court review that has resulted in delay. It has been defects in the administrative process itself.

Accordingly, we think that the improvements have to be made at the front end, not at the back end of the review. Simply shifting appeals to another court system is not a practical solution.

We are confident that our recommendations will improve the disability system and alleviate the backlog by reducing the number of appeals and the number of reversals when cases are appealed.

We commend the Subcommittee for holding these hearings on these important issues. We appreciate the opportunity to testify. We look forward to working with the Subcommittee and with SSA on these issues in the future. Thank you very much.

[The prepared statement of Mr. Pickering follows:]

Statement of John H. Pickering, Past Chair, Senior Lawyers Division, and Commissioner Emeritus, Commission on Legal Problems of the Elderly, American Bar Association

Mr. Chairman and Members of the Subcommittee:

My name is John H. Pickering. I serve as Commissioner Emeritus of the American Bar Association Commission on Legal Problems of the Elderly, which I chaired for a number of years. I am also a past chair of the ABA Senior Lawyers Division. I appreciate the opportunity to appear before you today on behalf of the Association, to discuss our views on the Social Security disability appeals system.

As representative of the legal profession in the United States, the American Bar Association is particularly concerned with equal access to justice for those members of our society who are generally least able to protect their own rights—low-income persons, individuals with disabilities and older people. We have a long-standing interest in the Social Security Administration's disability benefits review process, and have worked actively for many years to promote increased efficiency and fairness in this system. We have followed the agency's efforts over the past decade to improve the timeliness, accuracy, and consistency of its disability decisions, and we commend those attempts, although we recognize that they have met with mixed results. It is clear that they have not alleviated backlogs in the system. It still takes the agency as long as one year to reach a determination on an initial appeal; some claimants must wait years for a final Appeals Council decision. These delays have a profound effect on public confidence in the agency, on agency staff, and most significantly, on claimants who desperately need the benefits.

Almost seventeen years ago, the ABA joined with the Administrative Conference of the United States (ACUS) to sponsor a national symposium to examine Social Security's administrative appeals process. In 1986, the Association filed an *amicus curiae* brief in the landmark U.S. Supreme Court case, Bowen v. City of New York, in which we argued successfully that the Social Security Administration should reopen the cases of thousands of mentally disabled claimants who were denied disability benefits because they failed to meet sub rosa requirements and appeal deadlines. Brief for the American Bar Association, *Amicus Curiae*, in Support of the Respondents, Bowen v. City of New York, 476 U.S. 467 (1986). More recently, the Association adopted a set of recommendations for strengthening safeguards and protections in the representative payee program. Over the years, we have drawn upon the considerable expertise of a membership with backgrounds as claimant representatives, administrative law judges, academicians and agency staff to develop a wide ranging body of recommendations on the disability adjudication process that encourage clarity in communications with claimants, due process protections, and application of appropriate, consistent legal standards at all stages of that process.

It is with this background that we offer some recommendations to the Subcommittee for consideration. We believe that implementation of these recommendations will help to alleviate the backlogs and delays that are overwhelming the current system, and will lead to the development of a disability determination and appeals process that is timely, efficient and fair, and that meets the needs of individuals with disabilities and their families.

The first step toward increasing the speed and efficiency of the appeals process is to reduce the number of appeals. According to the General Accounting Office, of the 40% of claimants who appealed initial denials in fiscal year 2000, approximately two-thirds were awarded benefits upon appeal. In all too many cases in the system today, claims that could have been decided at the initial stages are awarded at the hearing level simply because the evidence of disability is more complete by the time it is presented to the administrative law judge. We recommend that the Social Secu-

rity Administration improve the front end of the process by providing applicants with a clear statement of eligibility requirements, a list of claimant responsibilities, a description of the administrative steps in the process, an explanation of relevant medical and vocational evidence, and notice of the availability of legal representation.

To improve the quality of medical and vocational evidence at the initial stages of the process and to reduce the need for appeal, we suggest that the agency consult the claimant's health care providers, and compensate them adequately for providing relevant medical information. We encourage SSA to take affirmative steps to compile accurate documentation and to supplement medical reports (particularly those from treating physicians) that are not sufficiently detailed or comprehensive. We are pleased to note that the SSA website includes information for the medical community about eligibility criteria used in the disability program. We encourage the agency to go further by assisting claimants in compiling necessary documentation and in supplementing incomplete reports. We also urge the agency to establish a single standard for the determination of disability at all levels of decision-making making.

We recommend that, prior to denying claims, the Social Security Administration notify claimants of the pending adverse action; inform them of the reasons why the finding of disability cannot be made; ensure that they have access to all the evidence in their file, including medical reports; and provide them the opportunity to submit further evidence. We also recommend that SSA advise claimants' health care providers of deficiencies in the medical evidence and give them the opportunity to supply additional information. Disability claims managers should be encouraged to consult with legal as well as medical resources in their evaluation of a claim. We encourage the vesting of initial decision-making authority in two-member teams composed of a disability examiner and a medical or psychological professional, and we support face-to-face interviews between claimants and agency decision-makers before a final decision is made.

In the event that the claim is denied after this full and complete development of the file, we suggest certain additional steps to enhance the integrity and efficiency of the appeals process while guaranteeing the claimant due process.

Claimants whose applications are denied should be provided a clear and detailed statement of the reasons for denial, the opportunity to appeal, the availability of representation, and the consequences of failing to appeal. The ABA supports elimination of the reconsideration level. If the quality of intake and development of evidence at the early stages is improved, there is little reason for reconsideration, particularly given the historically low reversal rate and substantial delays involved at this level. Instead, claimants whose applications are denied should have the right to a due process hearing on the record before an administrative law judge whose authority as an independent fact-finder is assured. The administrative law judges should be appointed pursuant to the Administrative Procedures Act. This hearing is essential to a full and fair review of the claim, and administrative law judges should have the opportunity to take testimony from the claimant, develop evidence when necessary, consider and weigh the medical evidence, and evaluate vocational factors in order to reach an impartial decision free from agency coercion.

In 1995, in response to the Social Security Administration's efforts to eliminate the backlog of cases that threatened the ability of administrative law judges to assure due process at the hearing level, the ABA House of Delegates endorsed additional reforms at the hearing and pre-hearing stages. We recommended the designation of adjudication officers with supporting staff who, immediately following the initial denial of a claim, would work with the disability claims manager to develop the evidence, assemble a file and, where appropriate, allow the claim. The adjudication officer could obtain additional evidence necessary to establish a change in medical condition, or evidence that the claimant was unable to procure due to cost or other circumstances beyond the claimant's control. Should the case proceed to a hearing, the adjudication officer could be a "presenter" responsible for drawing attention to salient facts in the record and calling witnesses where appropriate. However, concerned about the disadvantage such a system might pose to unrepresented claimants, we also recommended that administrative law judges have access to investigative sources and be permitted to assert direct control over the development of the record. Those recommendations still have value today.

Several proposals over the past few years have suggested closing the record at some point during the administrative appeal process to provide a measure of finality. While we hope that evidence would be submitted as early in the process as possible, we urge that proposals to close the record be carefully considered. Certainly, the record should not be closed until the conclusion of the hearing at the earliest. Even then, claimants who show good cause, such as newly discovered evidence or a material change in condition, must be permitted to reopen the record within one

year of an adverse decision. To close the record without allowing reopening under those circumstances would penalize claimants who may have been unable through no fault of their own to gather the evidence necessary for a full and fair hearing. It would also create additional costs for the agency, because claimants would file new applications simply to submit new evidence.

Recent proposals have raised anew questions about the role of the Appeals Council. In 1986, the ABA advocated for a complete study of Appeals Council procedures and functions to determine whether Appeals Council review is necessary and to explore possible changes in the Council's role. We are cognizant of past agency attempts to control the rates at which administrative law judges allowed claims, so we caution that any changes to the role of the Appeals Council not compromise the independence and impartiality of administrative law judge decision-making making. We therefore urge that the scope of Appeals Council review be limited to clear errors of law or lack of substantial evidence. Administrative law judges' findings of fact should not be reversed without specific documentation and review of the hearing tapes. Finally, we recommend that if the Appeals Council fails to act upon a request for review within a specified period of time, claimants should be deemed to have exhausted their administrative remedies and permitted to seek federal court review.

Finally, we consider the issue of Article I courts to hear Social Security appeals. The ABA has consistently opposed legislation to create Article 1 courts to hear appeals from final decisions of the SSA. When we testified before this Subcommittee in 1991, we observed that efforts to establish a separate court appeared to have been motivated by three concerns: increasing numbers of appeals, issues too technical for courts of general jurisdiction; and the need for uniformity of decision-making making. More recent arguments have included the potential for more cases in the system as a result of baby boomer claim filings, and the parallels to be drawn with the Veterans Court of Appeals and other specialized courts. We have posited in the past that Social Security appeals are not drains on federal court resources since they are considered by magistrates in many if not all jurisdictions, and are on the record reviews using a substantial evidence test. While it may be time to revisit this issue in light of the more recent arguments, the more significant problem remains the failure of the Social Security Administration to make accurate determinations on claims in the earlier stages of the process. Simply shifting appeals to another court system is not a practical solution, and indeed could overwhelm a single court.

We attach copies of relevant ABA policies for your reference.

The Social Security Administration has made great strides in improving access to information, particularly on the Internet, but there continues to be room for improvement in the appeals process itself. We are confident that our recommendations would improve the disability system and alleviate the backlog by reducing the number of appeals and the reversals upon appeal. We commend the Subcommittee for holding hearings on these important issues, and appreciate the opportunity to submit this testimony. We look forward to working with the Subcommittee and with the Social Security Administration on these issues in the future.

Chairman SHAW. Thank you.

STATEMENT OF PAUL VERKUIL, PROFESSOR OF LAW, BENJAMIN N. CARDOZO SCHOOL OF LAW, YESHIVA UNIVERSITY, NEW YORK, NEW YORK, ACCOMPANIED BY JEFFREY LUBBERS, FELLOW, WASHINGTON COLLEGE OF LAW, AMERICAN UNIVERSITY

Mr. VERKUIL. Thank you. Mr. Chairman and Members of the Committee, I am pleased to be here this morning to discuss the findings and conclusions of a recent study for the Social Security Advisory Board that evaluates various proposals for changes in the judicial review structure relating to disability determinations.

The study was conducted for the SSAB by Jeffrey Lubbers and myself. Mr. Lubbers is here. It was submitted on March 1, 2002.

Of course, in our testimony we do not speak for the SSAB, but I believe that the Committee has copies of the study. It should be made generally available. It was submitted both to Members of Congress and also to Members of the Judiciary.

In the last few decades there have been several legislative proposals to modify the current system of judicial review, including one model that would change the review structure after the ALJ stage by creating a new Article I court, a so-called Social Security court, and give it limited Article III review power to legal and constitutional issues.

There is another proposal that would maintain the current district court review structure, but centralize court of appeals review in a special Article III court, the Social Security Court of Appeals.

While these and other alternatives are not themselves new, they have become increasingly relevant in light of recent events. The number of disability claims is expected to rise in the future for several reasons. One is the impending retirement of baby boomers; two, the downturn of the economy in the last 2 years; three, the resumption of CDRs by the SSA; and four, the increasing tendency of private insurance companies to require as a condition of payment that claimants pursue their offsetting SSA benefits.

These caseload realities create pressure on the SSA to achieve more uniform, fair and efficient decision-making and will likely increase the present time-consuming nature of that review, which varies between 12 to 18 months.

In addition, during the last decade, a possible model for Article I and Article III shared review of disability cases has become a reality with the emergence of a program for the review of the U.S. Department of Veterans Affairs disability claims.

Finally, in 1994 Congress also made a significant structural change in the Social Security program by separating SSA from the U.S. Department of Health and Human Services to "ensure that policy errors resulting from inappropriate influence from outside the Agency such as those that occurred in the early 1980s do not occur in the future." I believe Mr. Pickering referred to those incidents in his testimony.

As a result, the Agency is now independent and better able to assist in a restructuring of the decision process. After the SSA signs off on a disability case, either as a result of an ALJ decision or after Appeals Council review, the losing claimant has an opportunity to appeal to the District Court. While traditionally known as a trial court, the District Court serves an appellate function in connection with disability review. In this role it is called upon not to hear matters in a trial de novo, as it usually does, but to apply the substantial evidence test to the record before it.

Over the years, substantial evidence review of disability cases by District Courts and even subsequent review by Courts of Appeals has been a heavily contested matter.

Modification in the role of a District Court was made necessary because of the size of the disability caseload, which makes the usual practice of direct review in the Court of Appeals to create administrative adjudication impractical.

For example, during the decade 1990 to 2000, the number of new disability cases in the Federal District Courts nearly tripled from 5,000 to 15,000. In terms of impact upon the court system, during the 1-year period ending September 30, 2000, Social Security cases represented 5.86 percent of all civil District Court cases.

It seems clear that the substantial judicial resources allocated to disability determinations are not used in the most cost effective manner.

I do not wish to minimize the significant, symbolic role, as well as a corrective one that the District Courts play in our judicial system. Over the years the theoretical advantage of Article III oversight in SSA cases has become more limited in practice. District judges increasingly review disability cases not by themselves directly, but through surrogates. Article I, magistrate judges take evidence, decide on summary judgment or remand to the Agency. In fiscal year 1999 magistrates decided over 40 percent of disability cases throughout the Federal courts and, in some jurisdictions over 50 percent.

In addition to caseload concerns within the District Courts, there are genuine concerns as to uniformity of decisions around the country, not only because of widely varying reversal rates, but also in terms of the need for better development of the law. A Social Security court would be a remedy for both of these problems.

Opponents of such a court counter these arguments on a variety of fronts: the new court would be inconvenient to claimants; it would produce a windfall of appointments to the current President; or it might become captured by the SSA or those that tend to favor a higher rate of denial of claims.

I respect these concerns, but believe that the caseload and uniformity problems are acute enough to warrant serious consideration of the changes to the current system.

The current system of administrative hearings with a somewhat revised system of administrative review, followed by review in an Article I Social Security court with a right of appeal on questions of law to the regular courts of appeals, as with the current Tax Court, is, in our judgment, the best approach.

This doesn't mean that class actions and facial constitutional challenges would be heard in this Article I court. They could still be reserved to the District Courts, as well as, challenges to SSA rule making which could be heard directly in the Courts of Appeals.

Concerns about the convenient problem can be addressed by having regional offices for the SSA disability court. Concern about politicized appointments to the court would, of course, be ameliorated by the Senate confirmation process, but could be addressed more directly by requiring judges to be appointed like commissioners of independent agencies, with one political party limited to a bare majority.

Down the road one could foresee the combination of such a court with the current Court of Veterans Appeals to produce a Federal disability court with a broader experience and expertise.

Well, next steps to consider: Whatever happens with the Judicial Review Proposal, we believe that several steps can and should be taken at the SSA level. First, the use of attorneys for the government requires further consideration, as has been mentioned.

Second, consideration should be given to a long pending suggestion to closing the file after the ALJ stage.

Third, amending the good cause remand provision in the current law, section 205(g), should also be considered to reduce the ease

with which District Courts simply remand cases back to the SSA. These remands fail to produce an effective feedback loop.

Finally, we believe that much can be done to better utilize and improve the performance of ALJs in the current process, separate and apart from the Article I idea. An ALJ appeals process, which has been mentioned, is something worth looking at. We have made some initial analyses of that idea and if it works it could assume the correction and quantity review functions now performed by the Appeals Council.

By the side of my statement was written "explain." In connection with the ALJ appeals process idea, I gather that note is from the staff. I will reserve further explanation for the comment period.

I would like to thank you and praise the Committee for their efforts in this hearing.

[The prepared statement of Mr. Verkuil follows:]

Statement of Paul Verkuil, Professor of Law, Benjamin N. Cardozo School of Law, Yeshiva University, New York, New York

I am pleased to be here this morning to discuss the findings and conclusions of a recent study for the Social Security Advisory Board (SSAB) that evaluates various proposals for changes in the judicial review structure relating to Social Security disability determinations. The study was conducted for the SSAB by Professor Jeffrey Lubbers of American University, Washington College of Law and myself, and was submitted on March 1, 2002. Professor Lubbers is with me today. I believe the Committee has copies of the complete study.

Background

In the last few decades, there have been several legislative proposals to modify the current system of judicial review of Social Security Administration (SSA) disability cases, including one model that would change the review structure after the administrative law judge (ALJ) stage by creating a new Article I court structure (a "Social Security Court") with Article III review limited to legal and constitutional issues; and another that would maintain the current district court review structure but centralize court of appeals review in a special Article III court (a "Social Security Court of Appeals").

While these and other alternatives are not themselves new, they have become increasingly relevant in light of recent events. The number of disability claims is expected to rise in the future for several reasons: (1) the impending retirement of Baby Boomers, (2) the downturn of the economy in the last two years, (3) the resumption of continuing disability reviews ("CDRs") by the SSA, and (4) the increasing tendency of private insurance companies to require as a condition of payments that claimants pursue their offsetting SSA disability benefits.

These caseload realities create pressure on the SSA to achieve more uniform, fair, and efficient decisionmaking and will eventually add to the caseload of the federal courts on judicial review. In addition, during the last decade, a possible model for Article I/Article III shared review of disability cases has become a reality with the emergence of a program for review of the Department of Veterans Affairs disability claims.

Finally, in 1994, Congress also made a significant structural change in the social security program, by separating SSA from the Department of Health and Human Services to "ensure that 'policy errors resulting from inappropriate influence from outside the agency such as those occurring in the early 1980s do not recur in the future.'" As a result, the agency is now independent and better able to assist in a restructuring of the process.

The Current System of Judicial Review

After the Social Security Administration signs off on a disability case, either as a result of an ALJ decision or Appeals Council consideration, the losing claimant has an opportunity to appeal to the federal district court. While traditionally known as a trial court, the federal district court serves an appellate function in SSA disability review. In this role, it is called upon not to hear matters in a trial *de novo* as it traditionally does, but to apply the substantial evidence standard to the record before it. Over the years, substantial evidence reviews of disability cases by district

courts (and even subsequent review of such decisions by courts of appeals) have remained a heavily contested matter.

This modification of the role of district courts is made necessary because of the size of the disability caseload, which makes the usual practice of direct review of formal administrative adjudication in the courts of appeals impractical. For example, during the decade 1990 to 2000, the number of new disability cases in the federal district courts nearly tripled from 5,000 to 15,000. In terms of impact upon the court system, during the one-year period ending September 30, 2000, Social Security cases represented 5.86 percent of all civil district court. It seems clear that the substantial judicial resources allocated to disability determinations are not used in a cost-effective manner

I do not wish to minimize the significant symbolic role (as well as a corrective one) that federal district courts play in our judicial system. But over the years, the theoretical advantage of Article III court oversight in SSA cases has become more limited in practice. District judges increasingly review disability cases not by themselves, but through surrogates: Article I magistrate judges take evidence, decide on summary judgment, or remand to the agency. In FY 1999, magistrates decided over 40 percent of disability cases.

In addition to caseload concerns within the district courts, there are genuine concerns as to uniformity of decisions around the country not only in terms of widely varying reversal rates, but in terms of development of the law. A Social Security Court would be a remedy for both of these problems.

Possible Concerns

Opponents to such a court counter these arguments by saying that the concerns are overstated and that a new court would be inconvenient to claimants, would produce a windfall of appointments for the current President, and might become "captured" by the SSA or those that tend to favor a higher rate of denials of claims.

I understand those concerns, but believe that caseload and uniformity problems are acute enough to warrant serious consideration of changes in the current system. I believe that the current system of administrative hearings (with a somewhat revised system of administrative review), followed by review by an Article I Social Security Court, with a right of appeal on questions of law in the regular courts of appeals (as with the current Tax Court) is the best approach.[1] Concerns about convenience can be addressed by having regional offices for the SSA Court. Concern about politicized appointments to the court would, of course, be ameliorated by the Senate confirmation process, but could be addressed more directly by requiring the judges to be appointed like commissioners of independent agencies, with one political party limited to a bare majority.

Down the road, I could also foresee the combination of such a court with the current Court of Veterans Appeals to produce a Federal Disability Court.

Next steps

Whatever happens with the judicial review proposal, we believe several steps can and should be taken at the SSA level. First, the use of attorneys for the government requires further consideration, and we are currently looking at this issue for the SSAB. Second, consideration should be given to the long pending suggestion of closing the file at the ALJ stage. Third, amending the "good cause" remand provision in the current law (section 205(g)) should also be considered, to reduce the ease with which district courts simply remand cases back to SSA.

Finally, we believe much can be done to better utilize and improve the performance of ALJs in the disability decision process, separate from the Article I court idea. An ALJ appeals process (using two or three ALJs to review their colleagues' decisions in precedential or other selected cases) could aid uniformity and correctness, and, if it works well, could take over the error correction and quality review functions now performed by the Appeals Council.[2] The resources currently spent on the Appeals Council (reportedly over $64 million in FY 2000) could be used to cover the additional ALJs needed for the two tier review. Additionally, some Appeals Council members might be considered for positions as ALJs or as members of the Social Security Court. Moreover, the SSA should use some of these resources to improve its policymaking through rulemaking.

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[1] Class actions and facial constitutional challenges could be preserved in district courts, with challenges to SSA rulemakings going directly to the courts of appeals.

[2] If the ALJ stage were to be made the final stage, then SSA should also be entitled to appeal such decisions to the Social Security Court.

I compliment the Committee for giving its consideration to these ideas and others for improving our vital but overly stratified SSA disability appeals process and would be happy to try to answer any questions about our proposals.

Chairman SHAW. Thank you, Professor. Ms. Ford, you made reference in your testimony and I believe Mr. Pickering also made reference that when someone is going through the appeals process and their condition changes, that this is sort of an unamendable process.

An example: Starting out the process, the claimant is partially blind. He is denied. During the appellate process in the days that are going by the claimant becomes totally blind. I would gather from your testimony that the process would require that claimant to start the process all over again and claim total blindness. Is that what you are saying?

Ms. FORD. Well, as I understand the process, after the ALJ hearing new evidence would be allowed only if it related to the period before the ALJ hearing. So, depending on when that total blindness occurred, it might require him to start over, if I get that correctly.

Chairman SHAW. I see. So, it would be like regular court process. Once a judgment is made, if you are appealing an ALJ process, that the record would stay intact. Is that correct?

Ms. FORD. It is closed somewhat. The period of disability before the hearing is what is being looked at. If you have new evidence that relates to that period, as I understand, you can bring that evidence in at that point. We think that is important because people keep on seeing doctors.

Chairman SHAW. I think it is important to that point. I would like to get the judges to comment on that because I want to be sure this Committee fully understands the process here. Would either one of you judges comment on that?

Mr. BERNOSKI. The current process is that the record is not closed after the Administrative Law Judges hearing. In theory, the Appeals Council is not to receive new evidence, but in fact it is done routinely.

The record isn't ever really closed. Even before the Federal court evidence is submitted to the Federal court. It is usually attached to the brief. The judge considers the new evidence as part of the brief.

I understood Marty Ford's comment to be addressed to closing the record, the proposal to close the record after the Administrative Law Judges hearing. Now the record is not closed.

Chairman SHAW. When the appeal is made to the Federal District Court from the Administrative Law Court, does it go up as a record or does the Appeal Court take testimony?

Mr. BERNOSKI. No. It is certiorari. It is on the record.

Chairman SHAW. So, it is simply, it is as any other court process?

Mr. BERNOSKI. Yes, Mr. Chairman.

Chairman SHAW. I'm glad you cleared that up. Another point that I would like to explore here for just a moment is how long do these cases usually take in the courtroom?

Mr. BERNOSKI. Before the Administrative Law Judges?

Chairman SHAW. Yes, sir.

Mr. BERNOSKI. I would say a case before an Administrative Law Judge ranges from 45 minutes to an hour and a half, maybe 2 hours on the outside.

Ms. MCGRAW. Yes. In my experience, on average it is about 1 hour. That brings me to that other question. In 2000, last year, there were two cases that were disposed of per day as an average. This would go from a high of about four and a half cases that were heard down to slightly less than one per day.

What is the variance and how do you spend the rest of your day and how many cases do you all hear per day on the average?

Ms. MCGRAW. I would say that on average I hear about two cases a day. I think it is important to realize Social Security is looking for numbers here, but I think it is important to realize that each claimant is entitled to a full and fair hearing.

I think when you get up over two to three cases a day, because you have to prepare for these hearings. I do not go into a hearing without reading all the evidence concerning that claimant. I then hold the hearing and have to write directions and actually review the decision.

So, I think there is an outside limit on what a judge can do effectively and in my view two to three cases a day is that limit.

Chairman SHAW. How thick are those files when you receive them?

Ms. MCGRAW. They range from a half an inch to a foot high, depending on how much treatment the claimants have. That is a very good point. Across the country you have different sized files based on the medical treatment that is available to citizens in particular parts of the country.

Chairman SHAW. Do you have clerks working for you?

Ms. MCGRAW. I have no one directly working for me. We are in a pooled system. I believe that if I had someone that I was working with it would be more efficient.

Chairman SHAW. You have, as you say, a pool system. Are they reviewed by staff for you, are the files reviewed for you and summarized when they come to you or are you just given the raw file?

Ms. MCGRAW. When the file is given to me it is what we call "pulled." The exhibits have been put in chronological order. That is all that has been done to the file. I personally go through and read every piece of evidence in the file. I don't think it is fair to a claimant not to have done that.

Chairman SHAW. Are there depositions in the file or is that part of the process?

Ms. MCGRAW. No. By and large, depositions do not occur in these cases. We are dealing with medical evidence, physical therapy, statements of activities of daily living. There is rarely a deposition unless there has been a workers comp case or something like that that the claimant has been involved in.

Chairman SHAW. We have heard about incomplete medical records that sometimes show up. Do you order the claimant to go back and do you bring the doctors in? How do you handle that?

Ms. MCGRAW. If the claimant is unrepresented, the claimant has filled out a form that States his medical sources. If a claimant

is unrepresented, I ask someone on the staff to write to the sources that the claimant has identified.

If a claimant is represented, then I expect the representative to go out and get that evidence.

Chairman SHAW. Is there any sworn evidence that comes before you?

Ms. MCGRAW. At the hearing the testimony is sworn.

Chairman SHAW. It is all sworn in at the hearing. These medical records can come into consideration without sworn testimony. Is that correct?

Ms. MCGRAW. Absolutely. They are almost never sworn.

Chairman SHAW. Do you find in your experience that—and this is getting in the area of represented and non represented claimants—I would assume that if someone has a serious claim and represented by a lawyer, that perhaps the lawyers screen their cases somewhat. So, if somebody is just unhappy with the decision but without legal grounds, I would assume that probably if a lawyer is representing the claimant—the claimant probably has some grounds or the lawyer probably wouldn't have taken the case.

Do you generally find that when the lawyers are involved that there are stronger grounds on the average?

Ms. MCGRAW. I don't think that is necessarily so because I think there a lot of claimants out there who simply don't know how to go about getting an attorney. They may have a very good case. Some lawyers screen. There are other lawyers who are willing to take the cases of almost any claimant.

On average I would say that cases where the claimant is represented, there has probably been more preparation of that case and a greater understanding of what is necessary to meet the disability standards.

Chairman SHAW. I would assume that most of the State bar associations would represent this as a specialty, representing claimants for Social Security, and they could actually list that as qualified.

Ms. MCGRAW. Yes, and when a claimant files we send out a form that gives them information about sources of legal representation.

Chairman SHAW. A list of lawyers?

Ms. MCGRAW. Not specific lawyers, but places to go to look for lawyers.

Chairman SHAW. That is interesting. What is the general quality of the lawyers who practice before you? That is not a fair question, but I am going to ask it anyway.

Ms. MCGRAW. By and large, it is good, although in any forum like this there are those that don't do such a good job. I think that Social Security takes the view that the job of developing the record is the Judge's. There are some lawyers out there who do take the view, "Judge, it is your job. We will let you do it. Ultimately, it is your responsibility."

Unfortunately, that happens sometimes, but it is not the normal course of events.

Mr. MATSUI. Thank you very much, Mr. Chairman. I want to thank all of you for your testimony.

Let me follow up with Ms. McGRAW. on the questions that Mr. Shaw was asking. My understanding is that there are groups of lawyers in various communities, Sacramento, for example, where I represent, in which they kind of specialize in Social Security claim issues or workmen's comp claim issues.

We have a law school in Sacramento. It is McGeorge School of Law. Oftentimes the lawyers will recruit some of the law students to participate in this. I would imagine that law students can come before you as well. I have gone through the process with some of the professors and some of the lawyers and some of the students over the years.

I find, as you suggest and I think that Mr. Shaw was suggesting, some are really good and some are not so good. You get all kinds of variations here. Do the Administrative Law Judges? They come to know this over time, they are more careful in some cases than they need to be in others, I would imagine.

How does that affect the issue of closing the record, which obviously is the big issue in terms of the point of view of the ALJ judges in terms of why the case never closes? That is why you have somewhat a backlog here.

Can you discuss that with us a little bit? Go ahead, and then I will follow up.

Ms. MCGRAW. Generally, when someone is represented, I leave it up the representative to develop the record. I will often identify pieces of evaluated that I feel are missing and need to be obtained. I leave it to the representative to do that.

So, the closing of the record, if a representative is not doing their job, it might disadvantage a claimant. I agree with you. Representatives are being paid a lot of money, and I think they have an obligation. I think it is part of the process that they should be held to that obligation to properly develop the record.

Mr. MATSUI. It is so difficult to know when that happens and when that doesn't happen. Obviously Mr. Pickering——

Ms. MCGRAW. I can honestly say, there is discussion that there are some attorneys who hold back evidence and then they spring it on the Appeals Council. I don't see that happen very often. I don't believe attorneys are doing that and representatives are doing that. I think what sometimes happens is a claimant loses and then a representative will say, "Well, I am going to send this claimant to another doctor and have another opinion."

Then that opinion gets offered at the Appeals Council level and as a result the case gets remanded because it raises a question about the decision. That is a somewhat frustrating situation for ALJs.

Mr. MATSUI. I can appreciate that.

Chairman SHAW. If you would yield to me just for a moment, I want to develop this line of questioning a little bit because I am confused. I am hearing an inconsistency which probably isn't there.

Do you mean after you rule in a case that the claimant can go get another opinion from another doctor and that would be admitted at the appeal level at the District Federal Court?

Ms. MCGRAW. I have had that happen on multiple occasions. That is not unusual.

Chairman SHAW. Well, then the record is kept open as it goes up the appellate process.

Ms. MCGRAW. We do not close the record. We have no authority right now to close the record.

Chairman SHAW. So, you can get reversed on evidence you never saw?

Ms. MCGRAW. I won't get reversed. I will probably have the case sent back to me, and that happens a lot.

Chairman SHAW. Okay. Thank you.

Mr. MATSUI. On the contrary side of that, and I have a totally open slate on this because this is kind of like Groundhog Day to me. This has been like a lot of times we have had discussions on this and the caseload. The backlog just keeps growing more and more and we really need to solve it.

I really appreciate the Chairman holding these hearings and really trying to come to grips with it. In your opinion, and of course I am asking you to speculate and I am somewhat reluctant to do this kind of—in a formal hearing, because I don't want to create a bias for you. Is it in your opinion that the lawyers or representatives of the claimants—do you think they are gaming the system when they do this?

I mean I know that there are a lot of doctors in various communities that specialize in these areas. You know, you can cherry pick, I guess, and pick and choose. You see, probably, the same doctors in the reports over and over again.

Tell me, is that a gaming of the system? Do you think there is some of that going on? Again, if you don't want to answer it, that is fine, because you do have to maintain your independence here.

Ms. MCGRAW. I think our representatives are putting their best foot forward for the claimants, trying to get the case allowed. I do see doctors who are used repeatedly by particular representatives. The system allows that. I am not sure how to correct that, to tell you the truth.

Chairman SHAW. Mr. Lewis.

Mr. LEWIS. What is your opinion, the panel, of continuing to keep the record open or closing the record? Are you in favor of closing the record?

Mr. BERNOSKI. The Association of Administrative Law Judges, and I believe most administrative law judges in the field, are of the opinion that the record should be closed because this provides administrative finality to the adjudication process.

In my opinion at some time the record has to be closed and the case has to come to an end. We believe that the best point for that is at the conclusion of the ALJ hearing when the decision is actually signed and issued. At that point the case record should be closed.

There should be at that point a process for an appeal on the record, a certiorari appeal on the record that has been compiled.

Mr. LEWIS. On the question of employment representatives, should there be a system of certification for these claimant representatives or some standard procedures that are set forth for these representatives?

Mr. BERNOSKI. Well, our association hasn't taken a position on that issue, but I will offer my opinion. I would say yes. It is not

uncommon in the government system of administrative hearings to have some type of a certification process by the government Agency. I think it would be appropriate for the Social Security Administration to do that.

We have a system in place, but it is not very well developed. I think there could be work done in this area. It would provide protection to the claimant to have the government, the Social Security Administration, certify the claimant representatives.

Hopefully we would have better quantity representation. You must understand that not all of the representatives are required to be attorneys. We have people representing claimants before Administrative Law Judges who are not attorneys and do not have the skill and training of an attorney.

In my personal opinion, that is probably where most of the trouble is, in that area as opposed to attorney representatives.

Mr. LUBBERS. If I could add a quick point on that. With respect to attorneys, under the Agency Practice Act, all attorneys are deemed to be qualified to participate in Agency proceedings. So, a special law would be needed to allow certification of attorneys in SSA cases. With respect to the non-attorney representatives, however, it is a different matter.

Mr. PICKERING. On the closing of the record, the American Bar Association takes the position that if you do close the record, it should not be until after the ALJ hearing, but there should be a good cause exception for claimants who have been unable through no fault of their own to gather necessary evidence.

The alternative, if there is no additional evidence, is for the claimant to start a new proceeding. There is no res judicata here and I would like to emphasize, even though representation is desirable, we are not dealing with an adversary process.

The Social Security Program is a social insurance for the benefit of the people of this Nation. Consequently, they are entitled to some help. That is one of the reasons why we suggested that the ALJs be able to take a more active role in questioning and in trying to assist people to get a full record so that rights are not arbitrarily or without reason denied.

Mr. LEWIS. Just following up on the adversarial role, you know, there has been some that believe that the Social Security Administration should be represented at the hearing. What is your feeling on that?

Mr. VERKUIL. Maybe I can offer something on that score. In the study that Jeff Lubbers and I are doing for the SSAB, we will explore this more fully. The following case serves as a basis for government representation.

The first assumption is that when this process started out there were no representatives for either side. The ALJ in the Richardson v. Perales case in 1971 was approved by the Supreme Court as having a three-hat role: represent the claimant, represent the United States, Foreign Sales Corpration, and be an objective decider.

Now, over the years one of those hats has dropped off, since the claimant is now represented in 80 to 90 percent of the cases. That is the reality. So, now the judge has got two hats, is that right? This puts the judge in an awkward position vis-a-vis the claimant

because by trying to question the claimant the judge often feels, he or she may be showing a kind of bias against the claimant.

Now, the process looks imbalanced. So, the notion would be to give the judge the independent role, keep the one most important hat, but give the other one over to a government representative. This representative could also serve in preparing the case. Importantly, if there are two lawyers, or even if there are two non-lawyers, before a hearing, cases can get decided without having to go to a hearing. That happens frequently in other settings. Certainly in our criminal justice system it happens all the time. So, there is that opportunity and that is the case for it, I think.

Mr. LEWIS. So, obviously, you feel like this would speed the process up.

Mr. VERKUIL. It could have that effect. I don't want to be committed to a precise definition because we really haven't finished the study. But, of course, that is one of the issues that would be explored, i.e., whether it would have a positive effect.

Mr. LEWIS. Thank you.

Chairman SHAW. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. Thank you again for this second of two hearings on this matter.

Thank you all for your testimony.

Let me ask a series of questions, and I will try to go through them quickly. Do disability examiners follow precedent in reaching their decisions on whether or not a claimant deserves or does not deserve benefits?

Ms. MCGRAW. Well, they have objective medical standards that they use. Court precedent is not really a part of their world. They follow the POMS. In my experience from reviewing these cases, I would say that they are driven by the objective medical evidence in the record.

Mr. BECERRA. So, it is principally a fact-finding mission that these examiners undertake.

Ms. MCGRAW. What is critical is developing the record properly, getting the medical evidence that relates to the claimant's impairments.

Mr. BECERRA. Now, do the examiners have any interaction with the claimants?

Ms. MCGRAW. By and large they do not. They may call them on the phone. I see phone contacts asking questions of the claimants. If you are familiar with the prototype, with the 10 States where there has been some change at the DDS. The idea was to have a face-to-face contact at the DDS level. The Commissioner has now eliminated that face-to-face contact with the claimant, even in prototype States.

Mr. BECERRA. Is that working well?

Ms. MCGRAW. It has just started. I can't tell you. I think that most people believe that face-to-face contact assists in deciding a case.

Mr. BECERRA. That would be my gut reaction as well, that you are trying to make a judgment on someone's disabilities which in many cases is emotion. To not have a face to face, to have a paperwork administrative act occur which could be life or death for an

individual probably doesn't help that individual feel comfortable with the final decision if it is adverse.

It just seems to me that you add to the mounting number of days and delay that occurs. It is kind of horrific to see that at the very final stage of this process at the Federal court level, there is a 64 percent, nearly a two-thirds result of either remand or granting of the claimant's case. Two-thirds, if we had that in our judicial process, we would be swamped from here until eternity. It just doesn't make any sense that 64 percent of all the cases by the Federal court have to be in some way returned to the system to be reviewed.

It seems to me we don't do enough at the initiative stage and if it is accurate that most of these claims that have some difficulty take up to 3 years to complete——

Chairman SHAW. At what level is that? Is that from the District Court?

Mr. BECERRA. You are correct, Mr. Chairman. The numbers that I am showing from the Social Security Administration show that 6 percent of the cases presented to the Federal court are allowed and 58 percent of the cases are remanded, which could mean at the end of the day the ALJ still dismisses the case or finds adversely to the claimant.

The fact remains, it has to go through the process again. So, you are adding additional time, delays, grief for the claimant. Even in our court system, which most people complain about to begin with, I guarantee you, two-thirds of the cases that go to the court on the appellate level do not have some type of positive or recurring activity.

So, we have got to deal with that. If it takes that long, it just seems to me that we have to do a lot more up front and that principally means, not just at the examiner level, I would hope, and I know there have been some recommendations, that we talk about the collection of evidence.

I would think that we could do a much better job at the administrative level of telling claimants, who are not claimants at that point, they are just hoping to be beneficiaries, what they need to do to get the process running. That means give them a better sense of what kind of evidence you all look at so they understand what they need to provide in terms of medical records; they understand that certain evidence that may be provided by non-medical individuals could be helpful in their case.

It just seems that as you try to prepare a better record that we can do a lot more through the administration, on the government side, of helping prepare the case and giving claimants the information they need. Perhaps it is a brochure that tells them, "Get ready if you think you are qualified. This is also what you will have to go through if you have to appeal."

So, they know what they need to keep so they can remember the name of that one physician who said this or that, who never really did a document at a particular visit to an office or something along those lines.

Time and complexity of cases. I wouldn't go into because I think I just did. It seems to me that if you can't get it resolved well at the examiner stage, you are in real trouble. It just seems that for

most of these folks, many of whom are on fixed incomes, it is a travesty to expect them to now try to find an attorney and in many cases go without an attorney and make it through the process.

Mr. Chairman, I see my light is on. Let me just have one last question.

Should the government be a party in these ALJ proceedings? I know that has always been a question that is out there. I guess if you have a process in the sense that the government prosecuting its case and being seen as an opposing party to the claimant, it creates an adversity and it makes it difficult.

At the same time, perhaps if we help rid ourselves of the frivolous cases because now you have the government prosecuting this matter to try to engage the claimant in a more robust collection of evidence.

Perhaps what we do is also make the claimant better develop the case. Of course, if you have a claimant who is not prepared or doesn't have good representation, you are now facing Goliath in the government.

Is there any thought on what we should do in terms of that?

Mr. HILL. Yes, I think at OHA one of the problems and one of the things that takes a lot of time is developing the case. The simple fact of the matter is cases are not as well developed as they should be coming up.

Now, a lot of that may be due to the extreme time constraints the DDSs, the State agencies are under. The fact of the matter is, we get a lot of cases in OHA office that are not well developed. We also have a lot of cases that come in that when you have worked in the business long enough you look at it answer say, "This is probably a pay."

The evidence isn't there. You have to go get it. There are a couple of ways to get it. One of the things that was done in the past, when we had the Senior Attorney Program, we reviewed these files. If it looked like a pay and the people were reported, we could make a call to the representative. When the representative at that point recognizes that these cases that we were looking at as probably pays, you would be surprised how fast evidence can come in under those circumstances.

Mr. BECERRA. I agree.

Mr. HILL. That is one way to handle it. One of the advantages to having somebody represent the government is they will be responsible for developing the case. Very quickly, I think what is really wrong with OHA is that cases sit and sit and sit. They are either in line, we are waiting for evidence or there are some time periods that have to run.

The basic problem is they are sitting there waiting for somebody to do them. The quicker we get through them, the quicker we have somebody who can make a recommendation, "We should go after this real quick because it looks like pay," the better off we are.

Mr. BECERRA. In that regard, don't we have funding that is going in the opposite direction of caseload? The SSA has less money today to administer these cases than it did before and its caseload is ballooning.

Mr. HILL. It is going up and we need a better way of triaging those cases that don't need to go to the judges because that is time

consuming. Necessarily, it involves all kinds of assets. There are a lot of cases that they really shouldn't be involved in.

Ms. MCGRAW. I would suggest, if that case can be paid when it comes in the door, DDS didn't do its job. It never should have gotten in the door. It should have been allowed earlier in the process.

Mr. BECERRA. Thank you, Mr. Chairman.

Mr. BERNOSKI. On the government representative, as Mr. Verkuil indicated, there is a definite probability that this could speed up the process.

During last week's hearings, it was demonstrated quite conclusively that the case doesn't get active until the attorney from the claimant gets involved in the case. That unfortunately happens most generally at the Administrative Law Judge level. If the government also had an attorney involved in the case at that level, these two attorneys could more completely develop the case at an earlier time. There could be a resolution of the case, as Mr. Verkuil said, on a compromise basis or on a settlement basis as is normally done in the court system.

I think that would be a beneficial aspect that would help the claimant in the process.

Chairman SHAW. I think Ms. Ford wants to jump in here.

Ms. FORD. Yes. We are opposed to having SSA represented. I think that changes the entire dynamic and the relationship between SSA and the claimant.

Chairman SHAW. Yes.

Ms. FORD. The SSA is supposed to be helping the claimant get that evidence. To put SSA in a position of being in an adversarial role against the claimant totally changes things. I think it would have to change the nature of an ALJ hearing. You couldn't have SSA in two roles in that hearing.

I think the perception of unfairness of the process would be tremendous. This Subcommittee actually has testimony, significant amounts of testimony from the government representation project in the early 1080s that was submitted on behalf of claimants.

I would be happy to dig that out and resubmit it as it stands, but it is in the record, documenting the problems that claimants encountered in these types of very adversarial hearings.

Mr. BERNOSKI. Mr. Chairman, I think a point has to be made that having the government represent itself helps expedite the case, but if it becomes a prosecutor, then Ms. Ford is correct. It becomes not only an adversarial process, but a process where most claimants won't be able to hold their own. It would cost them additional money for the new attorneys that they would have to hire.

We are trying to figure out a way to promote the full and expeditious development of the record without turning it into a strong prosecutor process.

Mr. VERKUIL. Excuse me. Maybe the word "prosecutor" crept in when I drew an analogy to the criminal process. If so, Mr. Becerra, I withdraw the word. That is an inappropriate reference. Social Security attorneys do not do a prosecutorial function. There is a claimant helping function. It would still be that.

We should focus on the fact that Social Security is the only ALJ setup where there is no government representation, or one of the few I can think of.

In most cases, an ALJ presides over a formal hearing. So, that to bring an attorney in would not be an extraordinary act in terms of the ALJ's experience. But surely, even if that happens, the nature of the process still would be different from formal ALJ proceedings. It wouldn't be as adversarial. It might be more so in some contexts, but it would still be a claimant helping process and the statute wouldn't change in that regard.

Chairman SHAW. I want to refine a point. Mr. Becerra brought out a statistic which, on its face, appears to be startling, but it may not be as startling as it appears to be. That is that 58 percent of the cases appealed to the District Court are remanded back. That, by the way, is up from 48 percent in the year 2000.

What percentage of the cases are appealed? We have to know that figure first before we know how startling that 58 percent is.

Mr. VERKUIL. I think I can help you with that. There are approximately 120,000 decisions at the Appeals Council level and about 75 percent are denied, so that leaves you about 90,000 cases that come to the Appeals Council and have not been paid. Of that 90,000, the Federal court only gets, say, 15,000. So, the percentage would be—we can do the math. It is 15 or 16 percent.

Chairman SHAW. About 15 percent.

Mr. VERKUIL. There is a lot of drop out.

Chairman SHAW. Mr. Brady.

Mr. BRADY. I agree with Mr. Becerra's observations about improving the initial decision-making in this whole process. As to the panel, I really appreciate your testimony today because it seems like this process is just ripe for a major overhaul. Not only because between this and SSI we are talking about 5 percent of the Federal budget, not just because there are very tragic individual consequences for not doing this right, for cases.

There are so many areas of improvement open in this whole process, it just cries out for a major change in how we handle all this. The more homework I do, the more I am becoming convinced that the process is legally top heavy in the sense that we have an emergency room full of non-emergency cases. All important, but many which could have been treated accurately, faster, better and sooner in the process.

By its nature, the legal process in the courtroom is deliberate. It is complicated and it is expensive. My thought is that it ought to be reserved for, not only as part of our due process, but reserved for the cases that are the most complex, where the decisions of fact and prospective really are difficult. They require the expertise of a legal mind in going through that.

The only way that works is if we dramatically strengthen the initial process.

Many of you offered good ideas on how to do that. As to the issue of how do we create an appellate model that works well, that really applies those legal resources to those truly legal cases. What appellate models would you suggest we look at that this Committee or the Social Security Administration look at if we are to undertake a major overhaul in the appeals process?

Mr. VERKUIL. Well, we have several alternatives. One, as an appellate model in the court system, Mr. Brady.

Mr. BRADY. Well, within the whole process.

Mr. VERKUIL. Oh, within the whole process.

Mr. BRADY. Whether it is equivalent to the U.S. Department of Veterans Affairs (VA) or Workman's Compensation.

Mr. VERKUIL. We have a VA system which now has become much more formalized where there is a Court of Veterans Appeals and it reviews decisions. Then there is appeal on legal questions to the Federal circuit.

We also have a Tax Court which as an Article I court, resolves most cases involving taxpayers even though there is a District Court option. That is, the taxpayer has a choice between an Article I or an Article III determination. The Article I is vastly preferred. About 90 percent of the cases go through an Article I court and then on to an appellate review in the Federal court system. So, that is another model.

Mr. BRADY. Well, which one, in your opinion, works better in the whole process of fair, timely, accurate decisions as early in the process as possible, and then the legal system really gets to the heart of the more complicated matters?

Mr. LUBBERS. It is a very hard question because there are so many levels in the process. I think that most of the comments from the panel today were that you want to try to resolve as many cases as you can at the beginning, when the stream of cases is at its widest. So, there are a lot of recommendations that have been made to improve the initial disability determination service review of cases.

Then the stream narrows a little bit at the reconsideration level. Some people have suggested getting rid of that. You have the ALJ process, Appeals Council and court. So, you have a multi-stage process and when you change one process, it affects all the other processes.

Mr. BRADY. Back to the question of which, in your opinion, which model ought we look at for significant improvement.

Mr. LUBBERS. I think the basic structure of having an initial determination process at the State level is sound. I will consider perhaps not having a reconsideration level before going to the Administrative Law Judge system for the full hearing. Then the question is, do you need further review at the Social Security Administration Appeals Council?

The panel has differed on that. I think the basic structure of maintaining an Administrative Law Judge hearing is something we can all agree on.

So, I don't have a major structural change of the process, but I think you have to look at each step and make changes. We think a Social Security Court could help.

Mr. VERKUIL. The reason why, and I would say in response that we came out favoring an Article I, Social Security Court, precisely because in the current system, in the Article III system, there is no feedback loop.

These Federal District judges get 15,000 to 20,000 cases a year. They remand more than half, as was pointed out. That remand is a total disconnect. It doesn't even go back necessarily to the same

decider. Nothing is learned and there is no education and uniformity gained from that kind of a process.

An Article I process, however, with a Social Security Court who are experts in the field, could be more closely tied to educating what was wrong. If you have to remand a case, you want the decider to learn why the case was remanded and to get it correct the next time.

An Article I system has a feedback loop that doesn't exist in Article III because it is just two different worlds. If you create an Article I court with rule making and other powers that would be provided through the Agency, you could define issues more clearly. You could have more accountability at the administrative system, and there would be connections.

So, that is the argument in favor of it. That is why we would say we think the case for Article I is worth reconsidering.

Mr. PICKERING. The view of the ABA on this is that it may be time to revisit whether we change the system or judicial review between Article I and Article II courts.

The real problem here, as you have identified, is getting the system right at the beginning. Everything else will fall into place if we have a much better intake system, much better development of the record and help given to these people, many of whom are not represented by attorneys and need the help of the tryers of fact as to what are the deficiencies in the record. The better the product is from the beginning, the more likely it is that everything else will fall in place.

Mr. BRADY. Thank you.

Mr. BERNOSKI. It is our opinion, as we indicated in our written statement and during the testimony, and I agree with the other panelists, that the first thing that must be improved is the initial intake, review and decision. It should be based upon the legal standard that the ALJs use.

The case is then appealed to the next level, and that is where the government representative is important. The government representative would develop the case as needed and would compromise or settle the cases that could be settled at that point.

After the Administrative Law Judges hearing, we are of the opinion that the next level of appeal, if there is going to be one in the Agency, should be, to a three judge Administrative Law Judge panel. That panel is based on the Bankruptcy Court model, which is working well. That would give a higher and more careful level of review.

After that, we believe the case should go into the Federal District Court because that seems to be the preference of the bar. Congress also seems to be very comfortable with the Federal District Court review of Social Security cases. Although there seems to be an interest in exploring a change at that level.

Mr. BRADY. Okay. Thank you, Mr. Chairman.

Chairman SHAW. Ms. Ford, go ahead and then Mr. Matsui has some questions.

Ms. FORD. First of all, I am in an agreement with the other witnesses who have said that the front end is the important place to be putting our time and effort—in case development and evalua-

tion. From our perspective, the process needs to remain informal for the claimant because this is a very difficult process.

Not all medical evidence may be available at all points along the process. We have to help that claimant put as much forward as possible.

I think one point that keeps getting missed is the fact that submitting a new application is not a valid choice for many people. If you are applying for Title II benefits, you must apply for benefits for a certain period of time to keep your connection to the recency of work—you must have worked 20 out of the last 40 quarters before the period applied for.

So, if your case has been denied, and then you are forced later to reapply, you may in fact lose eligibility permanently (res judicata) for benefits that you in fact should have been found eligible for.

I am not sure that the question at higher levels of appeal should be, "What was wrong in the earlier decision so much as the question might be, what more do we know about the claimant now at this later stage of the process?" Thank you.

Chairman SHAW. Well, Ms. Ford, just to expand on that 1 second, though, let's assume none of these guys get into the case and the claimant is settled very, very quickly to everybody's satisfaction and then several years later, perhaps someone who was 50 percent disabled becomes 100 percent disabled. They can go back, can't they, at any time on that?

Ms. FORD. The date of application is going to be important for the back benefits for a lot of folks. Also, in Title II their claim of when disability began has to be within that time period of having worked 20 out of the last 40 quarters.

In Title II, there is the potential for waiting too long and losing benefits or losing eligibility.

Mr. LUBBERS. I want to make a quick point, Mr. Chairman.

Chairman SHAW. I am confused by that.

Mr. LUBBERS. You mentioned a 50 percent disability. My understanding is that in the VA system you can be partially disabled, but in Social Security, you are either disabled or you are not.

Chairman SHAW. That's correct.

Mr. HILL. There is another real misunderstanding, when you file an application for disability insurance benefits, you allege an onset date. That onset date is not the date you file the application. I could file an application today alleging I was disabled December 1, 1988. If I have the evidence to show that I was disabled December 1, 1988, I will be awarded benefits, provided my case is approved.

Chairman SHAW. One of the disadvantages that we have, and it probably is obvious from some of the questions that we are asking. We are trying to help reform a system that we have never seen before, even though you are a lawyer, aren't you?

Mr. BRADY. No.

Chairman SHAW. No? You plead not guilty?

Mr. BRADY. Not guilty.

Chairman SHAW. Bob and I are reformed lawyers, but neither one of us have been through this process. Most lawyers haven't. Mr. Matsui?

Mr. MATSUI. May I ask, Ms. Ford, because I did ask the Administrative Law Judges about the closing of the record, I would like your thoughts? Perhaps, Ms. Shor, if you want to add to it, if you have any new thoughts on this.

Ms. FORD. Well, we think the record should remain open as it is allowed to be now. There are some limitations. I understand what has been said earlier, but as I understand it, there are some limitations on what new evidence could come in after the ALJ level or the appeals level. It depends on whether the new evidence relates to the period of time before the ALJ hearing.

There are some limits on new evidence. There is, therefore, some pressure on the claimant and the representative to get evidence in early.

This is so important for the claimant, I don't think that we should be closing the record before it is absolutely necessary.

If it can be handled by remanding—as it is now—or otherwise taking a look at the evidence, whatever is available that tells us more about that claimant and whether or not they have an impairment that is disabling ought to be looked at.

Chairman SHAW. Did you want to add to that?

Ms. SHOR. I think with the discussion earlier about Federal court, the statute provides that there has to be good cause and evidence has to be not cumulative and has to be new and material. The evidence that is going into Federal court cases is already quite tightly restricted.

I don't think you would want a situation where someone with perhaps diverse symptoms and an undiagnosed case at the time they appeared before an ALJ, and was subsequently given a diagnosis of Multiple Sclerosis, for example. This happens quite frequently because it is a condition that is so difficult to diagnose. It seems more administratively efficient to deal with that case on remand when in fact the policy of the Social Security Administration is to send Federal court case remands back to the ALJ who heard the case in the first place; rather than to tell that person to file a new application and go back to the front of the line.

That is the important reality. People with new evidence are not going to disappear. If the door were slammed in their face immediately and they were told, "Under no circumstances and for any reason new evidence will not be accepted" the Social Security Administration is not free from dealing with that person. They will go back to the front of the process, file a new application and frequently will find themselves disadvantaged by that choice.

Mr. MATSUI. Thank you.

Chairman SHAW. Well, we have learned about a lot of problems. I think it is going to take, a lot of independent study. Professor, perhaps you will come in with some answers that we will have a hearing on at a later date with your study. Perhaps the American Bar Association might come in with some study and suggest recommendations.

The problem really is going to have to be looked at by the people who are in the system and know the system well as to how to streamline it.

One further question I do have, though, and I would like to ask this of both the judges. What is your current case backlog? I am concerned exactly as to where the delays are.

Ms. MCGRAW. It varies widely from office to office. Within my office I am now processing cases, requests for hearing that have come in our office in February of this year. We are pretty caught up. Then there are other offices around the country that are woefully backlogged.

Chairman SHAW. Is that because of the—I will try to put it delicately, but I am not sure I can—about the work ethic of the judge involved?

Ms. MCGRAW. No, I can't really tell you why that is. Mr. Bernoski, you may have a better understanding of it. I don't know the reason. I know that that is the situation in our office.

Chairman SHAW. In Federal courts the work ethic of the judge has a lot to do with it.

Ms. MCGRAW. It does, there is no doubt about that.

Mr. VERKUIL. It varies greatly at all levels, administrative law judges and District judges.

Chairman SHAW. Some judges have a huge backlog just because they are not working enough.

Mr. BERNOSKI. The overall backlog in the Agency, as we indicated, has grown. I believe it is around 490,000 cases or in that neighborhood at this point.

As Ms. MCGRAW. indicated, that backlog does vary between individual offices for various reasons. Some offices just have more cases coming in. Some have more Administrative Law Judges. Some have more staff. So, to some extent, it is particularized in the offices.

But the overall backlog for the Agency is growing. The HPI has hurt us to the extent that, as Ms. MCGRAW. testified, the confusion that has been caused by the API process has allowed fewer cases to be set up for hearings. That has caused backlogs to grow, together with the filings of more cases.

Chairman SHAW. What is the average backlog in your area?

Mr. BERNOSKI. In our office, we were relatively current, but it is growing now. There seems to be more cases coming in.

Chairman SHAW. What is current—February?

Mr. BERNOSKI. For us current is about 6 months.

Chairman SHAW. I see. Thank you all very much. We very much appreciate it. It has been very enlightening. We are trying to build some knowledge in this area, which I think is tremendously important to the people we serve.

Thank you very much.

[Questions submitted by Chairman Shaw to the panel, and their responses follow:]

Consortium for Citizens with Disabilities
Washington, DC 20006
August 9, 2002

The Honorable E. Clay Shaw, Chairman
Subcommittee on Social Security
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Shaw:

This is in response to your letter of August 1 requesting additional information regarding the Social Security disability programs' challenges and opportunities. Specifically, you asked:

1. There have been suggestions that to improve the entire disability determination process, the claimant's record needs to be better developed at the disability determination services (DDS). This would involve obtaining more complete medical evidence earlier in the case. SSA's procedures include field office and DDS personnel advising claimants of the information needed to determine their eligibility for disability benefits. Are these procedures not being followed? Is the information that is now provided not adequate? If not, what else can be done to better gather and develop the evidence?

I suspect that the ability of claims representatives and DDS staff to properly collect evidence would depend on a number of factors, including the workload of the individual and the tools available to assist in the process. Collection of better evidence earlier requires that SSA look carefully at all of the factors that currently hinder the effort. Applicants come to SSA with varied backgrounds. Some will not understand the process or the importance of the evidence; some may not have consistent treating medical sources in their history; and still others may not fully grasp their own impairments. SSA should look at all of the relevant factors, such as: whether the claimant needs assistance in understanding the process and the nature and importance of the material to be collected; whether the field offices and DDSs have adequate staffing and resources to thoroughly carry out evidence collection functions, including necessary follow-up with treating sources; whether physicians and others from whom evidence is sought are given enough guidance about what documentation is needed and the importance of a speedy response; whether consultative exams should be purchased earlier in the process for those without adequate medical treatment histories; and whether payment rates for consultative exams are adequate.

It would be valuable for SSA to work with claimants' representatives, including attorneys, who have proven their ability to collect otherwise unavailable evidence. SSA should identify the key differences in the approach to evidence collection between these claimants' representatives and the SSA and DDS staff who have the statutory responsibility for evidence collection. It may be that the overall elements are the same (letters of request, follow-up phone calls, and etc.), but that the details or implementation differ (initial interview with claimant, content of the letter to physicians, number of follow-up calls, and etc.). I believe that such an effort could only result in useful, valuable information for SSA to use in assessing its own procedures.

2. In your testimony of June 20 (page 4), you state that you believe a claimant's record should remain open so they are not wrongly punished for events that may be beyond their control. Could your concerns regarding closing the record be mitigated if claimants were provided sufficient protections? If so, what protections would be needed for you to support closing the record?

Some of my concerns regarding closing the record could be mitigated if claimants were provided sufficient protections. These protections would have to include a hold-harmless provision for claimants whose late evidence is not accepted for purposes of reaching a decision. The claimant would have to be protected against application of the doctrine of *res judicata*—the period of time covered by a decision would need to be open for further decisionmaking in the future should late evidence become available. This must protect the claimant in at least two ways. The claimant should be able to apply again for the same time period and be able to receive any back benefits for that period without being negated by *res judicata*. Further, those claimants whose coverage has expired due to application of the recency of work test (insured status requires 20 quarters of coverage out of the last 40 quarters) must be able to apply again for that same time period, should late evidence be available, without being negated by *res judicata*. It is interesting to note that, in 1990, when Congress addressed the notices which SSA sends to beneficiaries and claimants, there was a clear recognition that re-application, under current policy and accepted legal doctrine, does not equate to an appeal.

Another way to address this issue might be to allow a case to be reopened. However, the current regulations on reopening a case place time limitations on the reopening, leave the decision to reopen to the discretion of the Commissioner, and do not allow appeals on the decision regarding reopening.

Even if the above concerns were addressed, I would be concerned about the potential delay in the process. Claimants with late evidence would be forced to begin

again and go through the entire process. I would expect this to increase, rather than decrease, administrative burden. In addition, from the claimant's perspective, the refusal to accept late evidence and the insistence on making a decision on a less-than-complete record would create the appearance of arbitrary decisionmaking and government waste.

As the process currently stands, late evidence is accepted under certain conditions, avoiding the appearance of arbitrary decisions and allowing a common-sense result of a decision made on the basis of all available evidence. Existing statutory and regulatory provisions recognize the need for the system to be flexible enough to admit such evidence on a limited basis. I believe that if the acceptance of late evidence were viewed in a common-sense way, there would be no problem with ensuring that all available evidence is brought into a decision. I believe part of the problem with late evidence is the perception that a remand to the ALJ from the Appeals Council or the district court is indicative of a bad or wrong decision. In many cases, it is merely indicative of late-arriving, but relevant, evidence. Quality assurance mechanisms should take this into account.

3. The Social Security Advisory Board, in their testimony of June 11 (page 8) recommended that the Social Security Administration (SSA) consider establishing a system to provide certification for claimant representatives and establishing a system to provide certification for claimant representatives and establishing uniform procedures for them to follow. What are your comments on this? What are the pros and cons of implementing these suggestions?

I do not believe that certification is necessary, given the tools already available to SSA for ensuring proper behavior by representatives and the bureaucracy it would be necessary to establish for a certification process. The limited administrative funds available to SSA can be put to far better use in improving the disability determination process.

In 1998, SSA issued final rules governing the conduct of all claimants' representatives, "Rules Of Conduct And Standards of Responsibility for Representatives". 20 C.F.R. 404.1740. These rules include both affirmative duties and prohibited actions, addressing, among other things, the duties to obtain and submit evidence and to comply with requests to submit evidence. The rules establish a procedure for filing complaints against representatives which are handled by SSA's Office of Special Counsel. In addition, SSA has the capacity to reduce attorneys fees in any case.

Thank you for this opportunity to provide comment on these issues. I would be happy to respond to any further questions.

Sincerely,

Marty Ford
Co-Chair
Social Security Task Force.

National Organization of Social Security Claimants' Representatives
Midland Park, New Jersey 07432
August 21, 2002

Hon. E. Clay Shaw, Jr., Chairman
House Ways and Means Subcommittee on Social Security
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Shaw:

I am responding to your letter dated August 1, 2002, requesting additional information for the June 20, 2002 hearing on the Social Security disability programs' challenges and opportunities. Specifically, you asked for a response to the following question:

1. The Social Security Advisory Board, in their testimony of June 11 (page 8) recommended that the Social Security Administration consider establishing a system to provide certification for claimant representatives and establishing uniform procedures for them to follow. What are your comments on this? What are the implications of implementing these suggestions?

For the following reasons, I do not believe there is a need for certification of claimants' representatives.

First, the bureaucracy involved in establishing and maintaining a certification system would be a significant expenditure of limited agency resources. In any meaningful certification program, required tasks include:

- defining the area of practice

- devising the applicable standards
- writing the examination
- administering the examination
- grading the examination
- providing an appeal mechanism for aggrieved certification candidates
- maintaining the certification roster, and
- providing for future re-certification.

Second, SSA already has adequate procedures to govern the conduct of representatives. All claimants' representatives are subject to the agency's Rules of Conduct and Standards of Responsibility for Representatives, which have been in effect since 1998. 20 C.F.R. §§ 404.1740, *et seq*., and 416.1540, *et seq.* These rules include both affirmative duties and prohibited actions. They were designed to clarify the obligations of representatives by promoting competence, diligence, and timeliness. The rules establish a procedure for filing complaints against representatives with the Office of Special Counsel (OSC) at the Office of Hearings and Appeals. OSC has the responsibility to investigate complaints and to administer discipline (suspension or outright disqualification) where warranted. Should, for example, an Administrative Law Judge (ALJ) wish to file a complaint about the conduct of a representative, the procedures set forth in the regulations on the Rules of Conduct would address the ALJ's concerns.

Third, certification is not necessary because most representatives are attorneys and their conduct is already governed by state bar organizations. Each state bar promulgates rules of conduct and codes of professional responsibility. To the extent that a problem of misconduct by a claimant's attorney exists, SSA has the discretion to address each instance by referring it to the state bar which holds the license of the attorney involved.

Thank you for the opportunity to provide this information.

Very truly yours,

Nancy G. Shor
Executive Director

Federal Bar Association
Washington, DC 20037
January 10, 2003

Hon. E. Clay Shaw, Jr., Chairman
House Ways and Means Subcommittee on Social Security
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Shaw:

1. The Social Security Advisory Board has stated that the Federal-State relationship should be strengthened. Do you agree? If so, why do you agree? How can that relationship be strengthened?

Out of concern for the variations in State Agencies in areas such as staff salaries, hiring, qualifications, training and quality assurance procedures—all of which have a major impact on quality of work product—the Advisory Board has asserted that the Federal-State relationship needs strengthening. While the Advisory Board has not advocated Federalization of the State programs, it has recommended implementation of guidelines for disability examiners vis-á-vis experience, training, background and salary.

The Social Security Section of the Federal Bar Association (FBA) appreciates the point being made by the Advisory Board. The Social Security disability program is a national program and a person living in New Hampshire should expect his claim to be adjudicated in a comparable manner to the person living in Texas. While Federal guidelines in the areas mentioned above are a good idea, it is more important that the Social Security Administration (SSA) strengthen its oversight of the quality of State Agency decisionmaking. It can do so by implementing a strong and consistent quality assurance (QA) program within SSA that monitors State Agency work. The component that currently does this job is known as the Disability Quality Branch (DQB). It wields significant power over the States' work but it does not appear to have effectively fulfilled its mission. As GAO indicated in its report "Social Security Disability: Disappointing Results from SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Attention" (GAO–02–322), SSA needs to develop a quality focused culture and it needs to implement a comprehensive quality assurance program. Such a program at the State Agency level needs to focus not only on favorable decisions but also on unfavorable decisions and adequate development of the record. To date, there is no evidence that this has been done.

As just one example, SSA has a treating physician rule set forth at 20 C.F.R 404.1527 and further explained in Process Unification Ruling SSR 96–2p. This rule is applicable at all levels of adjudication. Yet, State agencies repeatedly fail to apply this rule and the perception is that DQB condones and sometimes even encourages this practice. The actions of DQB have a profound impact on the work of the State Agencies, and we suggest that SSA focus on the function and performance of its quality assurance component as a means of strengthening the Federal-State relationship.

2. You state that claimants' subjective complaints are not evaluated at the DDS level, but are when the cases reach OHA. Why is this? What could be done to improve the evaluation of subjective complaints at the DDS?

Evaluation of subjective complaints, i.e., symptoms, such as pain and fatigue is a very difficult task because it requires an assessment of a claimant's credibility. Subjective complaints are not measurable by means of clinical tests or lab findings. Under SSA law, if a person has a medically determinable impairment that could cause subjective complaints of the type alleged, then the extent of those complaints must be evaluated. Reports from both claimant representatives and ALJs indicate that it is fairly standard that State Agency reviewing doctors will inevitably conclude that a person with a bulging lumbar disk that impinges on a nerve is capable of light exertional work. Yet, because this medically determinable impairment has the potential to cause debilitating pain in any given individual, SSA law requires that a number of factors beyond the objective clinical findings be considered in evaluating the person's ability to function. At 20 C.F.R. 404.1529, seven factors are set forth and they include: activities of daily living; location, duration and intensity of pain or other symptoms; precipitating and aggravating factors; type, dosage, effectiveness and side effects of medications; treatment other than medication for alleviation of the pain or other symptoms; measures used to alleviate pain or the other symptoms such as lying flat on one's back, sleeping on a board, changing positions; and other factors concerning one's functional limitations due to pain or other symptoms. These factors are elaborated upon in SSR 96–7p.

Given the time and resources available to State Agency examiners, evaluating subjective complaints is a daunting task. Moreover, consideration of subjective complaints can lead to what appear to be inconsistent results in cases involving identical or similar objective findings. Yet, SSA regulations and rulings require that subjective complaints be assessed at all levels of adjudication.

We submit that examiners who attempt to perform this kind of individual assessment may be taken to task by State Agency medical consultants, as well as SSA's quality component, as they tend to focus almost exclusively on objective clinical findings. It is much easier, more predictable, and less time-consuming to make decisions based solely on objective findings. As prototype States are discovering, if the State Agencies are going to evaluate subjective complaints they need more resources—more time per case, more employees, more training and better retention of trained employees. This means one thing—more money.

3. During the hearing, you seemed to indicate that the DDSs needed to better evaluate claims. What suggestions do you have for improving case evaluation by the DDSs?

The answer to this question is inextricably entwined with the response to the previous question. In addition to my previous response, however, there are steps that can be taken at the DDS level to better evaluate claims. First, there needs to be better development of the record. All sources of relevant medical evidence need to be identified and contacted. Where medical evidence is scant, appropriate consultative examinations must be obtained. Too often, a claimant with an orthopedic problem is sent to an internist or family practitioner rather than to an orthopedist or physiatrist and the examination is not particularly enlightening. Yet, it is relied upon to decide the claimant's eligibility for benefits. In addition, the old saw, "you get what you pay for" certainly applies to CEs, and DDSs do not pay a competitive fee to the doctors performing these examinations.

Obtaining medical evidence is not always easy to do. Sources can be dilatory and uncooperative. If SSA could facilitate cooperation from hospitals and doctors, it would go a long way to improve the process. In addition, involvement early on at the DDS level by claimant representatives could facilitate the gathering of evidence. Unfortunately, such involvement at the State Agency level tends to be viewed as interference rather than assistance and thus may be discouraged.

Claimants need to be provided a rational explanation for why they have been denied benefits. The determinations issued by the DDSs can best be described as uninformative. They are crammed full of standard language but they are very short on explanation as to why the claimant is being denied. A typical explanation reads something like this:

You said that you are disabled because of chronic obstructive pulmonary disease, bursitis and depression. The available medical evidence shows that your condition or combination of conditions is not severe enough to be disabling. The evidence does not show an impairment that would prevent you from performing some work-related activities. It has been decided, therefore, that you are not disabled according to the Social Security Act. We have concluded that you are able to return to your past work as it is usually done in similar jobs.

This sheds little light on how this decision was reached. A real explanation for the denial could result in fewer appeals if claimants understood why they don't meet the standard for disability.

In 1996, SSA embarked upon a process unification initiative to assure that the same standards are used at all levels of adjudication. State Agencies were expected to assess subjective complaints and provide a reasoned rationale in their determinations. At the OHA level, ALJs would then be expected to give deference to those rationales. Other than in prototype states, this has not happened and it appears that SSA has quietly abandoned this initiative.

4. In your testimony, you question the need for an Appeals Council. You give as an example that the substantive legal correctness of the decisions of the Appeals Council has been frequently challenged. Do you suggest an alternative to the Appeals Council? If so, what?

In theory, the role of the Appeals Council is a good one—a final review in the administrative process before a claimant reaches Federal Court. Where an ALJ has erred or failed to provide a full and fair hearing, the Appeals Council can remand the case for a new hearing and decision. In this way, the Appeals Council acts as a filter for the Federal Court system weeding out many cases that might otherwise be filed in court.

Unfortunately, however, of late the theory has been far better than the reality. In recent years, the Appeals Council has been overwhelmed and unable to provide timely, effective review. Yet, to its credit, when faced with the overwhelming workload, the Appeals Council has implemented strategies that have reduced average processing time by over 200 days since early 2000. Moreover, the pending request for review workload has been decreased from nearly 156,000 to below 58,000 as of December 2002.

Nonetheless, as at all levels within the disability process, there is need for improvement within the Appeals Council. I offer a few suggestions. First, there must be a better way to maintain the recording of the hearings. Far too many cases are remanded solely because the hearing tape has been lost at the Appeals Council. Second, SSA should consider the suggestion set forth by the Supreme Court in *Sims v. Apfel*, 530 U.S. 103, 120 S.Ct. 2080 (2000), that SSA impose an exhaustion requirement, i.e., that the Appeals Council will limit review to those exceptions raised in the request for review whenever the claimant is represented. Third, consideration should be given to setting a time limit by which review must be accomplished or the claimant is afforded the right to proceed to Federal Court. Fourth, as noted earlier, SSA needs a quality assurance program at all levels. At the Appeals Council, this should result in a reduction in the large number of cases where the Appeals Council has affirmed an ALJ decision and, after a complaint has been filed in district court, the Appeals Council agrees to seek a voluntary remand finding the same record it had earlier reviewed to be now legally insufficient. It should also result in more meaningful feedback and direction to ALJs in the remand orders.

Sincerely,

Hon. Kathleen McGraw
Chair
Social Security Section

Benjamin N. Cardozo Law School, Yeshiva University
New York, New York 10005

Washington College of Law, American University
Washington, DC 20016
August 15, 2002

Hon. E. Clay Shaw, Jr., Chairman
Chairman
Subcommittee on Social Security
House Committee on Ways and Means
Washington, DC 20515

Dear Chairman Shaw:

This is in response to your follow-up question from the June 20, 2002 hearing. Your question, and our response, follows:

1. You stated that the SSA's ALJ hearings are the only hearings processes that you know of where the agency is not represented. Would you explain what makes the ALJ hearings in SSA unique from other agencies' administrative hearings?

Although we haven't completely researched the issue, we believe that SSA ALJ hearings are the only ones where the agency is, as a rule, unrepresented. This has been the case since the beginning of the disability program, (except for the short-lived government representation experiment in the 1980s). In such cases the Administrative Law Judge (ALJ) has been relied upon to "wear three hats"—(1) neutral adjudicator; (2) protector of the claimants' rights; and (3) trustee of the Social Security Trust Fund.

This makes the SSA adjudication process unique from other adjudications presided over by ALJs. Of course there are many different types of ALJ adjudications—benefit claims denials, benefit revocations, initial license denials, license revocations, civil money penalties, etc. In agency enforcement cases, the agency is, of course, represented since it is, in effect, the "prosecutor" in the case. In initial benefit or initial license denial cases, there might appear to be less reason for an adversary proceeding since nothing is being "taken away" from an applicant. Nevertheless, someone from the agency normally is charged with defending the agency's decision to deny the benefit or license if the case is contested before an ALJ.

SSA disability cases are the exception to this rule. This obviously places a great responsibility on the ALJ. It may have been more understandable for the government to not be represented in the early days of the program when most claimants were also unrepresented. As late as 1977, less than half of all claimants were unrepresented (by either a lawyer or non-lawyer) at the ALJ hearing. Now, however, the figure is about 87% (70% by lawyers and 17% by non-lawyers).

Sincerely,

Paul Verkuil
Professor of Law
Yeshiva University

Jeffrey Lubbers
Fellow
American University

[Questions submitted by Mr. Matsui to Ms. Ford and Ms. Shor, and their responses follow:]

Consortium for Citizens with Disabilities
Washington, DC 20005
July 12, 2002

The Honorable. Robert Matsui, Ranking Member
Subcommittee on Social Security
Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

This is in response to questions in your letter of June 27 requesting additional information following the June 20 hearing in the Subcommittee on Social Security regarding challenges in the Social Security disability programs.

1. How would closing the record force workers at SSA field offices, DDSs, and OHA to do a more complete job of developing all evidence necessary to make a well-considered disability decision, since this does not always happen under current procedures?

I do not believe that closing the record earlier than is required under current law would improve the performance of workers at SSA field offices, DDSs, or OHA in collecting evidence. The penalty, closing the record to evidence that comes in late, falls only on the claimant.

It does seem clear that ensuring better development of evidence earlier in the process would help at all later stages of the process. Collection of better evidence earlier requires that SSA look carefully at all of the factors that currently hinder the effort now. Applicants come to SSA with varied backgrounds. Some will not understand the process or the importance of the evidence; some may not have consistent treating medical sources in their history; and still others may not fully grasp

their own impairments. To fill these gaps will require addressing such things as: whether the claimant needs assistance in understanding the process and the nature and importance of the material to be collected; whether the field offices and DDSs have adequate staffing and resources to thoroughly carry out evidence collection functions, including necessary follow-up with treating sources; whether physicians and others from whom evidence is sought are given enough guidance about what documentation is needed and the importance of a speedy response; whether consultative exams should be purchased earlier in the process for those without adequate medical treatment histories; and whether payment rates for consultative exams are adequate. Improving the whole range of factors that result in slow development of evidence will be necessary to ensure any significant improvement.

2. How would SSA obtain the resources necessary to provide agency representation, given the severe constraints on its budget and the rising backlog of claims awaiting decisions at the DDS, ALJ, and Appeals Council levels? In your opinion, would this be the best use of additional resources, should they be provided to the agency?

Providing agency representation at the ALJ hearings would be very costly. As reported by Nancy Shor of the National Organization of Social Security Claimants' Representatives, the SSA government representation project of the '80s was very costly. I do not believe that the cost can be justified, especially since agency representation has proven to change the nature of the hearings to an adversarial process. In addition, agency representation is likely to add processing time (based on experience with the project in the '80s) and, certainly, does nothing to ensure that overall processing times are reduced or better evidence is developed earlier.

Any additional resources available to SSA should be targeted to the better development of evidence earlier in the process, as discussed above.

Thank you for this opportunity to provide comment on these issues. I would be happy to respond to any further questions.

Sincerely,

Marty Ford
Co-Chair
Social Security Task Force

National Organization of Social Security Claimants' Representatives
Midland Park, New Jersey 07432
July 12, 2002

Honorable Robert T. Matsui, Ranking Member
Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Dear Representative Matsui:

I am responding to the questions in your June 27, 2002, letter to provide additional information for the record of the June 20, 2002, hearing before the House Ways and Means Subcommittee on Social Security.

1. Proponents of having a "government representative" represent the agency claim that this change would result in better development of evidence. Why would a "government representative" do a better job of developing a claimant's case and the evidentiary record than the existing cadre of field office personnel, Disability Determination Service workers, attorneys at the hearing offices and Administrative Law Judges?

SSA's duty to develop the evidence is well established in its own regulations and the case law, a duty that exists even it the claimant is represented at the ALJ hearing level. In the past, OHA staff developed cases at the hearing level. However, in most cases where claimants are represented, the ALJ will rely on the representative to obtain updated evidence, as ALJ Kathleen MCGRAW. testified before the Subcommittee on June 20, 2002. If the claimant is unrepresented, OHA staff develops the evidence. Even if there is a representative, the ALJ may nevertheless decide to obtain evidence, for example, a consultative examination.

Existing DDS and OHA staff can do an adequate job of developing the record, if provided with sufficient resources and staffing. As discussed below in response to question 4, the government representatives did not adequately assist in development of the evidence during SSA's mid-1980's "Government Representation Project (GRP). Based on testimony before this Subcommittee in March 1986, the cost of the GRP was nearly $1 million per year for the 5 OHAs participating in the Project. Given the enormous cost of providing government representation at the more than

100 OHAs that currently exist, we believe that the limited dollars available to the agency could be put to better use by assuring adequate staffing at the DDS and OHAs and developing better procedures to obtain evidence, including reasonable payment for medical records and examinations.

2. If the agency is represented at a hearing only when the claimant has his or her own representative, wouldn't the agency representative unavoidably be placed in the position of opposing the claim and defending the agency's prior decision?

In *Salling v. Bowen*, 641 F. Supp. 1046 (W.D.Va. 1986), the court held that SSA's previous effort to have the agency represented at the ALJ hearing in the 1980's was unconstitutional and permanently enjoined SSA from holding further proceedings under the GRP. The court found that "[t]he mere presence of a government advocate at the hearing renders it adversarial—The government advocate is under no obligation to try to ascertain the truth but, rather, he is there to state the SSA's position in the case." 641 F. Supp. at 1070. The court noted that while the 1982 GRP regulations baldly stated that the project would not be adversarial, all the evidence presented in the case established otherwise.

It is difficult to see how a representative for the agency would be anything other than adversarial. Otherwise, there would not appear to be any reason to have a government representative. As the *Salling* court noted, the "mere presence" of the government representative makes the proceedings adversarial.

Another matter to consider, which could add to the cost of establishing government representatives, is that the agency would be liable to pay attorneys' fees in some cases under the Equal Access to Justice Act (EAJA). EAJA provides that the federal agency must pay fees where its position was not substantially justified in adversarial administrative and judicial proceedings. These fees are paid by the agency, not the claimant. Under current law, EAJA fees are paid in appropriate court cases involving Social Security and SSI claims, but not for ALJ hearings since they are not adversarial.

3. Some have argued that a "government representative" would be able to facilitate the claims process by offering to "settle" a claim. What does "settle" a claim mean in the context of disability decisionmaking, and in what fraction of cases would "settlement" be an option? Do existing staff have any ability to offer to "settle" a claim?

Although it is unclear what the other witnesses mean by "settling" a case, for NOSSCR members, settling a case could include the following:

- Requesting an on-the-record decision without the need for a hearing
- Amending the onset date to a later point in time
- Agreeing to a period of disability, rather than ongoing benefits, if the claimant has returned to work or otherwise is no longer eligible for benefits at the time of the hearing
- Agreeing to accept SSI benefits and withdrawing a Title II disability claim if there is a remote date last insured

I do not have statistics, however, this is a procedure our Members frequently use under the current process by dealing directly with the ALJs, either through pre-or post-hearing letters or at the time of the hearing. SSA has recognized the value of screening cases for on-the-record decisions by recently including it in recently announced OHA initiatives. ALJs also may issue fully favorable on-the-record decisions or offer to settle the case on their own initiative.

We have serious concerns whether a government representative would facilitate settlements beyond the current number. Based on NOSSCR members' experiences, the procedure currently works smoothly in most situations, without the need for a government representative. Based on past experience, the government representative may actually impede the settlement process. This was the case with the GRP, described in more detail in the answer to question 4, where settlements were often impossible. The GRP statistics showed that government representatives did not request on-the-record decisions in appropriate cases and further, challenged eligibility in cases where the evidence was overwhelming.

4. What was SSA's experience with the previous effort at having the agency represented at the ALJ hearing? Did it improve benefit decisions? Did it speed up or slow down processing times? Were cases better prepared? Was the representative perceived as someone who assisted the claimant, or rather as someone who was there to oppose the claim?

Shortly after the 1986 decision in *Salling v. Bowen*, SSA abandoned the GRP. Information obtained by the plaintiffs during the course of that case provides objective evidence that the project did not achieve its stated goals. In addition, testimony at Congressional hearings in March 1985 and March 1986, the latter before this Sub-

committee, corroborated the findings of the court, providing first-hand experiences from claimants' representatives involved with the GRP.

Processing times were lengthened. The *Salling* court found, based on the evidence presented in the case, that: (1) the time for hearing dispositions greatly increased; (2) there was a longer delay between requesting a hearing and holding a hearing; (3) the number of ALJ dispositions decreased; and (4) more cases were referred to the Appeals Council for its own-motion review by the government representatives, "many of which should not have been sent," causing further unwarranted delay in receipt of benefits by duly entitled claimants. 641 F. Supp. at 1060–1062.

One of the attorneys in *Salling*, Martin Wegbreit, Esq., submitted testimony to this Subcommittee for the March 1986 hearing. His written statement (a copy is attached) provided specific statistics, based on SSA's own information, about the lengthened processing times.

A witness at that hearing, Dennis W. Carroll, Esq., offered first-hand testimony about dealing with the government representatives. His testimony and written statement (a copy is attached) describe extensive delays in individual cases.

The quality of decisionmaking did not improve. The *Salling* court found, based on evidence in the case, that "there has been a remarkable decline in decisions." 641 F. Supp. at 1062.

SSA's own statistics indicate that government representatives did not assist in making recommendations to the ALJ that a favorable decision be issued without the need for a hearing. Mr. Wegbreit's March 1986 statement to this Subcommittee states that although 56.7% of all claimants in the project won at the hearing level, the government representatives opposed 92.2% of the claimants. Mr. Carroll's testimony describes individual cases with strong evidence of disability where the government representative argued against an award of benefits.

Cases were not better prepared by the government representatives. Current proponents of having the agency represented maintain that the duty to develop cases would be taken away from the ALJs so that they could devote time toward making decisions. This also was put forward as a reason for the project in the 1980's. However, the *Salling* court concluded that the goal of the program to assist the ALJ in the development of the evidence has not been achieved. When the ALJ was in control of development, "[t]here was better development of the record than has been shown under the current procedures." 641 F. Supp. at 1069.

According to affidavits from the plaintiffs' attorneys in *Salling*, the court noted that the government representatives "had done very little in developing the files. If the [government representatives] found that the claimant's case was weak, they left it alone; but if the claimant's case was strong, consultative examinations were sought." 641 F. Supp. at 1063. Martin Wegbreit's March 1986 written statement for this Subcommittee's hearing noted two key conclusions based on statistics provided by SSA:

- In 45.54% of the cases, government representatives offered no pre-hearing development at all.
- In 59.8% of the cases, government representatives did not contact treating sources.

Government representatives generally acted in adversarial roles. In Salling, the court found that "[t]he mere presence of a government advocate at the hearing renders it adversarial and indeed, he proceeds so to act on through the appellate process . . . [T]he government advocate is under no obligation to try to ascertain the truth, but, rather, he is there to state the SSA's position in the case. . . . [A]ll of the evidence in this case shows that the [Government Representation Project] is an adversarial process." 641 F. Supp. at 1070–71.

Mr. Carroll's March 1986 testimony to this Subcommittee provides examples from actual cases supporting the view that the government representatives were adversarial:

- They sought to have cases dismissed for technical reasons unrelated to the merits, even after the ALJs indicated they would not dismiss and would hear the merits;
- They cross-examined claimants, often attempting to establish they were lying and asking personal information unrelated to their claims;
- They would not agree to settle a case, despite overwhelming evidence of disability. In one case, the government representative refused to settle a case, even though the ALJ stated during the hearing that the case should not have required a hearing. The government representative called witnesses and the hearing lasted 3 hours. The ALJ found the claimant disabled.

5. Why did Congress establish a non-adversarial hearing process? What have courts found on the matter of Congressional intent regarding whether hearings should be adversarial?

Only 1 month ago, SSA published proposed regulations where it reaffirmed the nonadversarial, informal nature of its proceedings:

> Our administrative process was designed to be nonadversarial. See [20 C.F.R.] §§ 404.900(b) and 416.1400(b) of our regulations; *Richardson v. Perales*, 402 U.S.389, 403 (1971); *Sims v. Apfel*, 120 S. Ct. 2080, 2083–85, 2086 (2000).

67 Fed. Reg. 39904, 39905 (June 11, 2002). This interpretation is consistent with Supreme Court decisions over the last thirty years that discuss Congressional intent regarding the SSA hearings process, with the most recent just 2 years ago:

> The differences between courts and agencies are nowhere more pronounced than in Social Security proceedings. Although many agency systems of adjudication are based to a significant extent on the judicial model of decisionmaking, the SSA is perhaps the best example of an agency that is not. . . . Social Security proceedings are inquisitorial rather than adversarial. It is the ALJ's duty to investigate the facts and develop the arguments both for and against granting benefits . . . .

Sims v. Apfel, 530 U.S. 103, 110 (2000) (citations omitted). The Court relied on another decision that was then nearly 30 years old, *Richardson v. Perales*, 402 U.S. 389 (1971). In *Perales*, the Supreme Court rejected a challenge that would have imposed a formal evidentiary rule into Social Security hearings. In *Perales*, SSA argued against adopting such a rule, stressing the need to keep the system informal, rather than becoming a "full blown adversary procedure." Adopting the SSA's arguments and emphasizing Congress' intent to keep the process informal and nonadversarial, the Court stated:

> [I]t is apparent that (a) the Congress granted the Secretary the power by regulation to establish hearing procedures; (b) strict rules of evidence, applicable in the courtroom are not to operate at Social Security hearings so as to bar the admission of evidence otherwise pertinent; and (c) the conduct of the hearing rests generally in the examiner's discretion. There emerges an emphasis upon the informal rather than the formal. This, we think, is as it should be, for this administrative procedure and these hearings, should be understandable to the layman claimant, should not necessarily be stiff and comfortable only for the trained attorney, and should be liberal and not strict in tone and operation. This is the obvious intent of Congress so long as the procedures are fundamentally fair.

Some have argued that it would be appropriate for SSA to adopt an adversarial system because other Federal agencies have one. However, countering such arguments, a number of noted law school professors, who have studied the Social Security process, have concluded that an informal and nonadversarial process is the only effective way that the Social Security hearing system can function, thus agreeing with the position taken by SSA in the *Perales* case:

> While Federal regulatory agencies have largely chosen adversarial adjudicative systems, federal benefactory agencies typically employ inquisitorial models. Professor Jerry Mashaw has observed that "[v]irtually all mass justice systems have decided that they are unable to function effectively without the active-adjudicator investigation, informal rules of evidence and procedure, and presiding officer control of issue definition and development that characterize an inquisitorial or examinational approach." The SSA, the largest "mass justice" Federal benefactory agency, while employing most APA adjudication requirements, fits this pattern.

Jon C. Dubin, *Torquemada Meets Kafka: The Misapplication of the Issue Exhaustion Doctrine to Inquisitorial Administrative Proceedings,* 97 Columbia L. Rev. 1289, 1301–1302 (1997) (footnotes omitted), quoting Jerry L. Mashaw, *Unemployment Compensation: Continuity, Change, and the Prospects for Reform,* 29 U. Mich. J. L. Reform 1, 16 (1996). Professor Dubin's article was cited with approval by the Supreme Court in the *Sims* case.

Finally, the Court's reasoning in *Perales* formed a basis for the court's decision in *Salling v. Bowen*, 641 F. Supp. 1046 (W.D.Va. 1986), that SSA's effort in the 1980's to implement government representation violated due process:

> The greatest lack of fundamental fairness as required in the *Perales* test is that the proceedings which have heretofore been deemed to have been informal and

nonadversarial are now formal, stiff, strict and adversarial. . . . Congress did not intend it to be an adversary proceeding. . . .

641 F. Supp. at 1070.

Thank you for the opportunity to provide this additional information for the hearing record.

Sincerely,

Nancy G. Shor
Executive Director

[The Subcommittee on Social Security Hearing Print # 99–63 is being retained in the Committee files.]

[Whereupon, at 12:03 p.m., the hearing was adjourned.]
[Submissions for the record follow:]

Statement of the Federal Managers Association, Alexandria, Virginia

Mr. Chairman, thank you for the opportunity for the Federal Managers Association—Social Security Conference to submit written testimony on the challenges and opportunities facing the Social Security Disability Program.

The Federal Managers Association (FMA) represents the interests of over 200,000 executives, managers and supervisors in the Federal Government. The FMA–SSA Council represents executives, managers and supervisors in all Social Security Program Service Centers, the Office of Central Operations and the Office of Hearings and Appeals (OHA).

We have read, with significant interest, the testimony of all of the Social Security Disability Program stakeholders who have testified to date. FMA supports a number of positions expressed on June 11th and again on June 20th. Briefly, FMA supports testimony on:

- The Due Process Hearing
- The recommendation to closing the record following the decision by the Administrative Law Judge (ALJ)
- Accelerating the use of electronic disability folder (eDib), video teleconferencing, digitally recorded hearings, and a strong management information system
- The need to aggressively address the staffing issue in the Social Security Administration (SSA)
- Agency efforts to correct problems with the OHA process
- The need for Agency representation at the hearings

FMA does not support:

- Moving the hearing process to Disability Determination Services (DDS)
- Assigning clerical duties to paralegal specialists
- Combining OHA and SSA field offices

Testimony submitted to date has covered issues ranging from providing greater autonomy to the ALJs, to turning the ALJ process over to DDS, having skilled paralegal specialists performing clerical duties, and ALJs performing routine screening. In addition to the many divergent views, testimony further differed on what led to the purported failure of the Hearing Process Improvement (HPI) initiative. The vast majority of views laid the blame on the process rather than the initiative's implementation. With HPI, the devil was truly in the initiative's implementation.

There are several barriers that prevented successful implementation of the HPI initiative. At the top of the list was not giving management the ability to replace the hundreds of clerical workers who were promoted from clerical positions they performed very well, to positions with steep learning curves. Much of the failure in the early stages of HPI can be attributed to our inability to prepare cases for ALJs because of severe staffing imbalances. From implementation until the present, this inability to backfill for lost clerical support has had a far more serious impact on OHA than senior attorneys losing signatory authority. The ability to backfill clerical positions, coupled with a balanced MOU and time to mature could have dramatically changed the results of the Hearing Processing Improvement initiative.

For SSA to meet the challenges and opportunities facing our disability programs, it will require staffing levels that will permit us to handle the anticipated retirement wave. In addition, we will need the technology necessary to accomplish the work in today's digital age, and tools to hold individuals accountable for the work they perform. We would like to focus on these three critical issues that are essential

to meeting the challenges, and comment on three that would help, but to a lesser degree.

Top Three Issues

1. Meaningful Performance Management system
2. E-Dib and other automation enhancements
3. Addressing the staffing imbalances in OHA

Additional Areas Requiring Attention

4. Elevating the Federal manager's ability to hire on equal footing with private sector
5. Short term initiatives
6. Consistency between DDS and OHA

We feel that it is important to note that action on the top three will have short and long term positive impact on the disability process regardless if any other issues are addressed. Action on the additional areas will have marginal impact without action on the top three.

Meaningful Performance Management System

The success or failure of any of these initiatives will be directly related to management's ability to hold all employees accountable for their work. Without meaningful performance measurements, we can realize only limited success at best.

The deterioration of the disability process has run parallel to the deterioration of our performance management system. Our performance management system began to decay in the late 1980s and has steadily gotten worse. Group-based accountability, under HPI, only moved us further from individual accountability. The current Pass/Fail appraisal system does not provide incentives for high performance and we are seeing the consequences of that.

Each year the Social Security Administration presents its Government Performance and Results Act Annual Performance Plan. This plan describes specific levels of performance and outlines the means and strategies for achieving those objectives. The objectives are supported by indicators, which are used to measure the agency's success in achieving the objectives. The performance indicators are translated into goals that are shared with SSA executives. These goals are then clearly presented to managers and supervisors as expectations for performance. At OHA for example, the indicators are expressed in terms of dispositions per day per ALJ, processing time, percent of aged cases, etc. As noted above, SSA holds managers and supervisors responsible for communicating performance goals to agency employees. However, when the goals are communicated to the employees, managers are required to communicate in very generic terms due to the absence of numeric standards.

Our current Performance Management system in SSA addresses these elements, but at an organizational rather than an individual level. We certainly have set performance expectations (**Planning**), but these are agency goals, not individual goals. As directed by the system, progress reviews are held (**Monitoring**), but since there is no individual measurement, the discussions are generic. Ideally, we would spend time training (**Developing**) our employees, but in reality, most of our offices suffer from significant staffing imbalances and struggle just to accomplish our most basic missions. We rate (**Rating**) our employees on a Pass/Fail appraisal system, which fails to distinguish individual performance. And finally our reward (**Rewarding**) system is essentially a "do it yourself" process.

According to a White Paper published by the U.S. Office of Personnel Management in April 2002, "(I)n the current Federal white-collar pay system, performance does not matter very much . . . In any given year, Federal employees receive more pay increases for remaining on the rolls than for meeting or exceeding performance expectations. The dominance of these performance-insensitive pay increases can make performance-oriented tools appear trivial." While this paper, in addressing the issue of pay for performance, goes beyond the scope of our immediate concerns, many of the principles addressed apply readily to performance management at SSA.

Our current performance management system sends the message that performance does not matter. Because the standards are so generic, performance cannot be measured on an individual level. The labor-management contract requires that data focus on the process, not the individual. For all intents and purposes, the system is one of non-accountability. In spite of an employee's best effort, the employee will simply "pass". Award money is distributed on a formula based on the number of employees on the payroll. This distribution is completely devoid of any recognition for performance, even at an office level. Since we have no individually measurable standards (numerics) that can be taken into consideration, overtime/credit hours/flexiplace must be given to anyone interested.

It is our belief that it is imperative that our employees are provided with clear goals. These goals must be measurable, understandable, verifiable, equitable, and achievable. According to an Associated Press article on 5/27/02, The Department of Veteran's Affairs slashed their backlog of pending claims. Secretary Anthony Principi was quoted, "We decided to really declare war on that backlog and took some rather bold steps to address it. We're really getting this backlog under control, and we did it through sheer focus and discipline, performance measurements, and production goals." When employees know what is expected of them, they are better able to focus their efforts.

The National Council of Social Security Management Association (NCSSMA), who previously testified, clearly stated the difficulties in addressing this issue earlier this year. They cite 'a dysfunctional merit promotion process, overly restrictive performance improvement procedures, lack of objective performance criteria, and an impractical awards process . . .' We agree with this assessment and believe in fact that these problems all relate back to the weaknesses of our current performance management system.

There is an old adage that states, "What gets measured, gets done." Implementing an effective performance plan within SSA given the current culture will be difficult. But if the Agency expects to meet its objectives it must be done. OPM has prepared A Handbook for Measuring Employee Performance. This Handbook outlines the guiding principles for performance measurement as follows: 1) performance management must be viewed as a valuable tool, not as an evil; 2) acceptance of the process is essential to its success; 3) we must measure what is important, not what is easy; 4) the plan must be flexible enough to allow for changes in goals to keep the process credible; 5) we must rely on multiple measures; 6) employees must perceive that performance measurement is important; and 7) management must demonstrate that performance is critical to organizational and individual success. These are the principles, which must guide efforts to reform the current system.

A strong performance management system will go a long way in restoring the Social Security Disability Program to the status of a premier program. Our current leadership is committed to reforming our performance management system, but it will take several years to have a system in place. Any initiative implemented prior to having a meaningful performance management system will have minimal impact.

E-DIB and Other Automation Initiatives—

Potentially, this will have the greatest impact on productivity and would significantly alter the way we do business. All necessary resources need to be devoted to E-DIB, as we will virtually eliminate case preparation (not to mention savings on mail and storage).

As we move closer to this reality, we need to look at the entire structure of the field office and the positions within. We cannot start too early on this project considering the impact on the senior case technicians (SCTs) and the potential to easily distribute work to where the resources are.

That said, there are a number of automation initiatives that are currently available, and FMA feels that the Agency should fast-tract rollout for:

Voice Recognition software—When the initial learning curve period is over, this will save time both with writing decisions and eliminate the need to type decisions. Many offices have a limited number of typists and must ship cases to other offices to type. The time involved could be eliminated. The software is very inexpensive ($200.00 per office) and would not tax the budget.

Video Teleconferencing—This technology can also have very positive impact on both production and the budget. The Agency has made a decision to fast track the rollout and this is commendable. However, FMA feels the rollout should be further accelerated.

Reminder Pro Software—This is currently being piloted as a way to reduce "no shows" for our hearings. Offices using it find it very useful. Again, all OHA offices need this technology. Although Reminder Pro comes at a greater cost than Voice Recognition ($2500.00), FMA feels that the overall savings realized from not rescheduling so many "no show" hearings will significantly offset the initial expense.

Local Systems Support

As we move to new technology it will be extremely important to ensure that OHA has qualified, competitively graded employees in systems positions in each field office and in Central and Regional offices. The need for enhanced position descriptions (PD) has been apparent for some time, but any forward momentum to enhance our computer specialists has stalled. The Hearing Office Systems Administrator position description no longer meets our needs, and the Agency needs to address this critical need as soon as possible.

Addressing Staffing Imbalances in OHA

As previously noted, the hundreds of promotions from the clerical ranks during the transition to HPI have left OHA with severe staffing imbalances. OHA does not have the clerical support necessary to adequately support our Administrative Law Judges. The Agency is currently looking at ways to ease the problem without additional staffing, but these types of fixes will not hold up as more and more Baby Boomers begin to retire. We need the ability to replace the personnel that we lost to promotion if we are to be in a position to handle the claims anticipated over the next decade. Social Security has worked hard to try to ease its staffing losses by at least replacing the people who retired in recent years. The problem stems from not replacing highly trained technical staff until after they have left! Many positions within our Agency require three or more years of training/experience before a person reaches journeyman status. We must have the ability to hire additional staff before we are faced with the retirement wave so we do not slip as new, inexperienced employees are trained. As with performance management, we can expect only marginal improvement with any initiative implemented without the staff to perform the tasks.

Elevating the Federal Manager's Ability To Hire on Equal Footing With the Private Sector

The Federal Government still hires following OPM rules established in 1948. We still use the outdated "Rule of Three" which has been in existence much longer. Some Federal Agencies have the ability to hire locally, but at SSA we ask potential applicants to inquire at OPM and we then must go through the labor-intensive process of OPM certificate of listings. Often, it takes months to complete this process and usually means that the most qualified of our potential candidates have usually accepted positions with Federal departments or private companies with greater hiring flexibility.

We stand to lose a considerable degree of our accumulated knowledge over the next 7 years, and we must have the ability to fill this void with the best and brightest if we are to effectively serve the American public and ensure an experienced workforce. As with our earlier discussion on performance management and staffing imbalances, we need to address all of these issues if any new initiative is to be met with success. A change or an initiative implemented without the staff to carry it out and/or a performance management system that does not give managers the tools to effectively lead and manage is doomed from the beginning.

The New OHA Process Initiatives Recently Announced

FMA fully supports the Agency as we work to correct problems discovered following our transition to HPI. Our concern is that the first series of initiatives will have only marginal impact without addressing issues within the Agency and government such as performance management and hiring roadblocks that that would have a far greater long term impact than surface issues such as new process initiatives.

Ending the Certification Process—

Any impact on eliminating certification will, in large part, be determined by the number of offices still actually doing them. It is our understanding that many offices ended certification when the "flexibilities" were introduced last year. Some offices never began certification to begin with. The idea of an initial review by a higher graded employee is still a good idea and is worth considering, in some format, as long as we have sufficient writing resources to absorb the additional duties without appreciable reductions in our writing production. Accelerated distribution of voice recognition software may allow some review with current staffing levels. It was just not viable in the formal way HPI designed it, and certainly not without some additional resources or relief for our writing staff. FMA does not support prior testimony asking that clerical duties be added to a paralegal's position description. This would only serve to further impact productivity and would devalue the position.

Ending Rotational Assignments—

Again, many offices have already eliminated rotations either fully or partially. We asked for the elimination of rotations shortly after Phase II was implemented. However, once rotation officially ends, what will replace it? Many offices have few, if any, case technician's (CT) so the burden of doing the mail and reception duties fall to the SCT's. Logic would suggest the hiring of a mail clerk and receptionist at a lower pay than a GS–8 SCT. FMA previously submitted an enhanced receptionist PD for consideration. We are pleased to learn that our proposal is receiving strong consideration by the Agency. Even with the addition of an enhanced receptionist position, we will still be forced to rotate to some extent unless without an infusion of FTEs and additional positions to handle scheduling.

In the end, this will have a minimal impact on production without an infusion of FTEs. We still need to have someone do the clerical work.

Extend Early Case Screening to ALJ's—

In order for this initiative to succeed we would have to make the following assumptions:

- The ALJ's would have time to conduct this review
- The ALJs would be willing to do it, and
- There are a significant number of On the Record decisions available

Unfortunately we have no empirical data that would support these assumptions. The anecdotal information we have would indicate that:

- The ALJs will not have time to go through significant numbers of unpulled files given the number of cases they must schedule, hear and decide to meet ever increasing budgeted goals.
- Although there are some ALJs willing to review raw files, it has been our experience that most will not, and
- Although there are cases that can be paid prior to a hearing and with minimal development, these are the exceptions. A significant number require extensive development.

Short-Form Favorable Decision Format—

We must have agreement with the Appeals Council and OQA on an acceptable format. Once that is achieved, it could result in significant production increases.

We can reduce the number of cases sent to writers and thus reduce processing time on unfavorable cases. We could potentially free-up writers to perform other tasks.

The ALJs should be encouraged to complete the form. It should be simple enough for them to complete via speech recognition, typing, or by writing. **We must keep the writer out of the workflow.** If the case has to go to a writer, to edit or elaborate on the ALJ decision, then the new format's effectiveness would be greatly diminished. Although the Agency could mandate the use of a short-form, receiving ALJ buy-in would be the most effective method if we want a successful initiative.

Bench Decisions—

The "bench" decision is the same idea as the short-form reversal. It is all part of the idea to have the ALJ make the **complete decision** and by-pass the writer. Whether the ALJ does it by voice recognition at the end of the hearing (a so-called bench decision) or typing later (or even handwriting it so an SCT can type the decision) is not material. Whatever format the ALJ feels most comfortable with should be the one to go with. The buy-in can come by giving them the option as long as it meets ALJ needs and is acceptable to everyone. We can't emphasize enough the fact that if the case goes to a writer, to add to the decision, then we defeat the purpose of the process. Once again, the Agency can mandate its use, but ALJ buy-in is the key.

Folder Assembly Service Contract—

This was an excellent idea to get more cases pulled quickly. The initiative should fit well with the short-form reversal since, in theory, we will have more cases to write.

We need enough ALJ's who are willing to hear the additional pulled cases. There is no point in pulling more cases if the ALJ's are not willing to hear them and we have no other means to dispose of the cases. It was mentioned that a new Code of Conduct for ALJ's would be issued. Perhaps a minimal standard on the number of cases scheduled and heard per month could be part of the code.

Contracts would be best utilized at the local level. Local management should have the authority to find, train and pay the contractor in the same way as we pay the Hearing Reporters. Payment, by case, seems to make the most sense since that will guarantee a level of production. There appears to be a sufficient pool of recent retirees from SSA that might be interested in this. Although FMA is fully aware of the competitive sourcing initiative, and believes there are functions that can be competitively sourced, this is a case where we believe we would be better served with personal service contracts controlled locally.

Another benefit of these contracts is that it will free up our experienced SCTs so they can devote more time to maintaining their analytical skills. E-DIB will virtually eliminate the "shuffling" paper exercise of the work up process and the analytical skills of the SCTs will be used to a higher degree. Maintaining these skills now by not spending time on lower graded work, will pay dividends when OHA transitions to the electronic folder.

Consistency Between DDS and OHA

Process Unification Training was supposed to bring consistency between OHA and DDS decision making in disability cases. Consistency has not happened for several reasons.

1. DDS and OHA speak different languages. DDS speaks in a language focused on diagnosis while OHA is focused on credibility. Thus, DDS decision makers focus on objective medical findings and whether complaints are proportionate to objective medical findings. OHA judges focus on concepts in the 1996 Social Security Rulings (SSR), such as whether a treating source's medical opinion is well supported (96–2p), whether an impairment could reasonably be expected to produce the alleged symptoms (96–3p, 96–7p). Rarely, if ever, do DDS decision-makers address credibility concepts in the 1996 SSRs.
2. DDS decision-makers rarely, if ever, address the concept of sustainability whereas (SSR) 96–8p requires such consideration, and such consideration is important at OHA.
3. DDS decision-makers often do not resolve conflicts between their opinions and opinions of consultative examiners or treating physicians. For instance, a treating physician (physical medicine) will submit specific Sit/Stand/Walk limitations, which preclude performance of sustained work. However, DDS will check a block on form SSA 4734–U8, p. 7 stating that there is no treating source statement regarding the claimant's physical capacities in file, or, if the block is checked yes, will reject the treating sources statement on the basis of lack of objective evidence. Similarly, with regard to mental impairments, frequent are the cases where a consultative examination provides evidence of a severe impairment but DDS reports No Severe Impairment on a Psychiatric Review Technique Form (PRTF). The exigency of time (DDS medical consultants have only 15 minutes to review an unpulled file and make a decision) brings about these failures of DDS to resolve conflicts between their opinions and opinions of consultative examiners or treating sources. OHA must, and attempts to, resolve these conflicts.
4. DDS, unlike OHA, has no person who looks at a case as a whole. DDS bifurcates consideration of an individual's mental and physical impairments, sending the case first to one specialty and then to the other. Once both specialties have reviewed the case and made a decision, there is no decision maker who has authority to look at the decisions of both specialties and act like a judge at OHA, who has the authority to accept, remand, or overrule medical determinations.

The Social Security Administration is an agency that affects the lives of millions of Americans, particularly in its disability services. With increased staffing and funding, the Agency would be able to improve its service to its customers—the American public. The missions performed by SSA could be completed at an even higher level of proficiency if a meaningful performance management system were instituted within the Agency. These changes would allow SSA to provide to the public the level of service that is both expected and needed by taxpayers.

FMA would welcome the opportunity to act as a sounding board for any initiatives that this Subcommittee, as well as SSA would like to create to further enhance the mission of the Social Security Disability Program. We thank you, Mr Chairman and the Subcommittee, for your hard work and interest on this very important topic.

Statement of Larry Jacks, Public Employees Federation, New York, New York

Major changes are required in the national disability program if we plan to meet the needs of the disabled and ensure the solvency of the disability trust funds. I offer the following steps to simplify the program and process.

1. Establish the age 50 medical severity test. Under the current process an applicant may be found disabled at any age due to a less than sedentary Residual Functional Capacity. 70% of all Administrative Law Judge awards are made using this restriction. This finding is HIGHLY subjective and cannot be measured. Under the new process applicants under age 50 MUST meet or equal the level of medical severity as published in the the Listing of Impairments to be found disabled. For applicants age 50 and older, consideration will still be given for diminished RFC as the vocational outlook is reduced by age. This approach is simple to understand and administer. Program and administration costs would be reduced by 35% at all levels.

2. Replace the current determination process and medical improvement standard with Diary Decisions with Recertification. Under the current process, decisions are reached on average in 100 days at the DDS and appealed denials may take as long as 500 days until heard by the ALJ. In addition under the current program FEWER than 5% who are put on the disability rolls are ever removed or leave. This results in a slow and costly program. Under the new process decisions, will be determined much faster because we combine the age 50 severity application and a Diary Decision. Decision-makers will make faster approvals because decisions will be based on projected medical limitations such as cancer with chemo, heart surgery with rehab, severe fractures with physical therapy etc. The diary approval will then allow the applicant to 'recertify' his/her disability 90 days prior to the end diary date if the condition remains severe. The medical improvement standard WILL NOT apply since recertification will be a de novo decision. Decisional timeframes will be reduced for DDS decisions by 20% and future program and administration costs will be significantly reduced while improving customer service and payment of benefits. Citizens will receive much needed benefits quicker and exit the rolls earlier.

3. Intake of disability applications will be done by the DDS and not SSA. This will result in an immediate savings of 7–10 days in process time. State public libraries can be utilized as a gateway for applications.

4. Replace the Reconsideration appeal step with a DDS pre-hearing review. Upon review the DDS will process any case that can be found fully favorable. Cases that cannot will not be redetermined but rather moved forward to the Office of Hearings and Appeals and the ALJ decision.

5. Close the record after step 4.

6. Regulations are needed to standardize the educational requirements, training programs and quality procedures within the DDS system. DDS decision-maker turnover and subsequent erractic decisions are due to woefully inadequate salaries. The disability decision is a complex decision that requires medical, legal and technical expertise. In order to recruit and retain a quality DDS workforce, salaries must be raised by regulation not left to the States and administrators to do it on the cheap. Only the American public is shortchanged.

7. Create a Social Security Court to provide a uniform review of SSA decisions.

8. Revise the Administrative Procedure Act to give requisite authority to manage OHA.

I appreciate the opportunity to discuss these ideas with you and applaud the leadership of the committee in trying to resolve the problems with this critical national program.

Statement of Philip A. Robinson, Framingham, Massachusetts

Chairman Shaw, Ranking Member Matsui, members of the subcommittee, I am an individual non-attorney claimants representative.

I work with a former agency employee with a wealth of experience and we represent disabled persons before SSA who have problems with the admittedly complicated system that is SSDIB and SSIDIB in place today. Our purpose is to ensure that the people we represent have an opportunity to present their claims for disability and other matters before SSA in a cogent manner. It is our goal to ensure that claimants receive fair treatment and due process at all levels of the system.

I applaud the desire of the members of the subcommittee to make the disability process work better and am pleased that Commissioner Barnhart has quickly begun the process of examining the more disastrous experiments that have been in effect for the past years to the detriment of claimants, all of whom are your constituents. I am happy that the Commissioner and the subcommittee have begun the process of listening. I would add to your expert panelists a number of employees of the OHA 's across the country. Not just the ALJ Association President, not just the Union heads or area Union representatives and not just the DDS state Commissioners, but the real people who do the work every day in every DDS and Social Security Field Office across the country. The real workers. You should travel to them, listen to them out of the spot light and seek the larger truths which only they know. Even the upper level managers at OHA and SSA (deputies and associates) only speak of what you wish to hear, not often of what you should hear.

A brief history of the immediate past.

For the purpose of these comments, the recent past is 1996 to now. The agency budget has been reduced substantially as has the number of employees. Many senior and well trained employees throughout the agency have left and many more are ready to retire. Tele-service centers originally designed to handle basic retirement

questions and related matters have been expanded to handle many tasks that well trained CRs in the Field Offices used to handle. Budget cuts and reductions in staff caused the agency to make unrealistic promises, to the Congress and this and prior administrations, about this change to the tele-service mission. The agency has not and cannot now keep those promises.

Training money has been cut to such an extent that videos are used to substitute for what previously were many hours of direct class training and employee monitoring in the field over many months. Field office personnel are expected to handle the rising applications for DIB with fewer employees and no work year credits in the budget for this added work load.

The DDS partnership between the agency and the states does not work because training is inadequate and insufficient budget money for payroll has led to lower standards and higher turnover. Add to that the cultural and regional differences and the disconnects between the agency and the DDS and there is a formula for disaster.

The process unification rulings, which were designed to improve the process of developing claims are not followed by the DDS components in the individual states. The uniformity of decision making expected in this program has never happened. HPI plans implemented at the OHA offices across the country have been a disaster, as you are aware, for claimants and the agency.

Emphasis has been placed on speed rather than quality at all levels. We have been told that the average Disability Examiner in a DDS has about 20 minutes of actual time spread over 2–4 months to make an initial disability determination and that decision is usually problematic. The agency policy to examine approvals only for quality lets horribly unjust decisions pass through to claimants.

The OHA offices have old outdated computers for use in processing their work. A simple examination (without prior announcement) will find DOS based systems running on computers so old that school children would not use them. Employees at OHA are expected to produce outstanding work with outmoded and inadequate computers and programs because there is no money to purchase modern computers with compatible programs and provide the needed training and technical services. I have been in the State offices of a number of Congressional Representatives and found the newest and best PC systems money can buy. That grade of equipment would be perfect for the agency. We do not believe that the Congress has ever appropriated and the agency has not requested the funds for this type of upgrade. The purchasing systems, which are based on distrust, and take years to complete, ensure that outdated equipment is all that is purchased.

A small start has been made.

Fortunately, HPI has been halted but the problems created by this ill-conceived program have had a detrimental effect on the OHA staff, promotions and the career tracks of dedicated employees. This may not be able to be undone.

What proper funding and training can buy.

1. DDS disability examiners should be adequately trained and instructed to follow the law as written. The goal of a uniform interpretation of the laws will not be met unless and until the DDSs in every state use the same interpretations of the law as the agency. Denials of claims should be examined for errors by DQB offices and returned with instructions for corrections. If the error rate for approvals is xx% then it is logical that the error rate for denials would at least be the same or even higher.

2. The reconsideration process at DDS should be more than a pro forma scan of the records and a quick denial. Doing away with reconsideration and extending the time an examiner has to handle an initial claim would almost provide the same result as the 2 step system at DDS does now. SSA considered the experiment in this prototype a failure because more claims were paid and more denials were appealed to OHA. A local elected representative once described the disability process as follows: "You apply, you get denied, and then you go away". The public perception of the process is disastrous. I believe that DDS management is overreaching in attempting to expand the role of DDS in the disability hearing process. However, I also believe that with proper training and funding for employee work years and more competitive pay scales that the DDS work product can be improved to the point where approvals and denials will be more realistically arrived at and the number of appeals to OHA will decline.

3. OHA has substantial numbers of very experienced staff people, ALJs and attorneys. Moral is low because of the HPI problems. A lack of respect between professional staffers and support staff is obvious to all. Productivity has suffered because of management failure at highest levels. Accountability is lacking and numbers are over emphasized. Utilization of staff is poor. Many attorneys function well above

their level of competence while others are not competent in their present positions. All are rewarded for time in grade.

4. An institutional attitude to 'save the money' is fostered by senior management. The term 'not cost effective' and variations of same appear often in reviews of programs tried and dropped. Generally the body of comments describing end results seems to be that too many claims were paid. If this is what the Congress really wants, if this is to be the goal of every administration then the simple solution is to do away with the disability program. Payroll and payout will drop to zero. We do not believe that is the intent of either the administration or the Congress. It is most assuredly not the desire of the public.

Looking to the future.

Please do away with the idea of an SDM at any level. No matter how experienced a claim manager or SSA employee may be or is expected to be the experience of those of us who work representing claimants in states where SDM has been tried have been disastrous. DDS and SS employees fear face to face conferences with angry claimants and telephone interviews have usually been used to convince the claimant not to pursue a claim. The DDS claim managers are not doctors or vocational experts, yet the SDM model places them in that position. I and other claimants representatives have found that communication with our local Field Offices where CRs' are knowledgeable about the program is more productive. That is a place where staffing can and should be increased so that more career track employees can be hired and trained as the agency used to do and individual claimants can be encouraged to use the experienced people there for information instead of the Tele-service centers where lack of knowledge leads to errors and incredibly wrong information being provided to people in distress.

The tele-service centers should be used as originally intended, processing retirement information for citizens and legal residents whose retirement age is rapidly approaching and who will tax the systems across all areas. This may mean reductions in the numbers employed in the centers, but that money can be more productively used in the FOs' to hire career track employees as the agency used to do.

Plans for increased technical and computer use including electronic filing and processing and file maintenance is not in the agencies immediate future and neither are televised hearings. The proper equipment is not on hand at this time. The idea is wonderful and should be implemented, but it cannot be done with yesterday's technology and equipment or can this activity be set up incrementally. To work the system needs to be set up in advance in each region on a rolling basis from DDS to FO to OHA and AC and for every employee expected to use the system. Not one machine, but at every work station and every front desk. The equipment exists in embryonic form in the market now and can be purchased with simple specifications and off the shelf programs. The purchasing process will need to be changed in order to do this. Proper equipment including up to date computers (this is one area where individuals use free standing PC's) and well trained and well paid technical backup for OHA would enable that component to do its intended job.

Changes in the laws and listings and definitions used to define 'disability' to reflect our modern post industrial society and changed work habits should be a priority and can improve the process. Millions of our citizens have jobs and work in industries that did not exist 10 years ago. Skill levels required for even the most mundane jobs are constantly rising

Millions more have illnesses that are controlled or whose effects are reduced to an extent that part time work is a possibility. But millions more never have that relief available to them. High school students working part time after school can, and often do, earn more than the dollar amount specified as the threshhold for 'substantial gainful activity'.

Each ALJ should be responsible for her/his case load and the HOCALJ should not only be the titular head of the office, but should be able to manage the entire office.

Who is in charge at the agency?

The simple answer is every one and no one. No one has any responsibility for what goes wrong and no one has the authority to say stop. The CALJ should be responsible directly to the Commissioner of Social Security. The CALJ should have an ACALJ for DIB who is an administrator and an Senior Executive Service career manager for operations, both responsible for the day to day functions of OHA and answerable to the CALJ.

Myths and excuses to explain shortcomings in the process.

Social Security Advisory Board which you all know is a Congressional created agency to examine the way SS operates and offer suggestions for improvements has recently issued a commentary that suggests that there are lawyers and representa-

tives who cheat by delaying the submission of helpful medical or other evidence to build up the amount of the fees payable. The Board also noted that some physicians fudge or cheat on the medical reports they submit to the agency to help their clients secure benefits. This has become a part of the 'one size fits all' explanation on why the system is dysfunctional.

Like all the stories of welfare cheats there is little beyond anecdotal evidence. Legitimate claims are denied at every DDS office in the country. Medical reports are read by MEs' who never see the claimants or examine them, who miss important points in the records and opine that people with long-term illnesses will recover in the immediate future and become productive members of society. These are errors which are difficult to correct in the process and they represent a healthy majority of claims that are brought before OHA and allowed. However in order to overcome the prior errors more records must be obtained, more statements elicited to rebut the errors made. Claims that end up in the District and Circuit Courts are remanded less than 25% of the time and they are occasionally paid but usually returned for further development because the agency violated its own rules or ignored critical evidence.

We all know that medical records are often delayed. Physicians dealing with lawyers are like oil and water. They fear the lawyers, they fear the representatives and clients who ask for records and written statements to explain the physical and mental problems of their patients. OHA itself and the FO's treat requests to copy the claimant files as impositions on their limited resources. Although regulations exists instructing OHA and FOs to forward files to the OHA or FO office closest to the claimants' representatives because of distance or explain why in writing as part of the record, some OHA offices refuse to do so causing additional expenses in the of 100s of dollars for copy and shipping fees to be taxed to the claimant. The alternative is a lost claim at OHA and a potential remand from the AC because the claimant was deprived of due process all other matters being properly presented.

"Experts" for DDS 'are created' by regulations which describe the expertise in the rules and laws gained by several weeks of training by SSA employees in classroom settings. These experts are not provided with the time to properly examine a medical file or paid any reasonable sum of money. There is a myth that representatives 'purchase' favorable medical reports from physicians and/or others in order to win a claim. The medical and vocational expert 'vetted' by each states DDs and used throughout the process do not meet any legal definition of 'expert'. Most are alive, they breath, they walk, they talk, but they are not what SSA says they are with extremely rare exceptions.

There is no benefit to either the claimant or the representative to withhold records or reports. Fees are limited by law and also are part of the Federal Code.

A final comment.

1SSA's problems can be solved with trained, adequate staff, money and proper equipment.

Mr. Chairman and members, thank you for the opportunity to present this testimony in writing.

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