

**SECOND IN A HEARING SERIES ON SECURING THE
FUTURE OF THE SOCIAL SECURITY DISABILITY
INSURANCE PROGRAM**

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

SECOND SESSION

JANUARY 24, 2012

Serial No. 112-SS12

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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CONTENTS

	Page
Advisory of January 24, 2012, announcing the hearing	2
OPENING STATEMENTS	
The Honorable Sam Johnson	63
The Honorable Xavier Becerra	65
WITNESSES	
Carolyn Colvin, Deputy Commissioner, Social Security Administration, testimony	8
Patrick P. O'Carroll, Jr., Inspector General, Social Security Administration, testimony	24
Thomas Brady, Special Agent, Office of the Inspector General, Social Security Administration, Kansas City Field Division, St. Louis, Missouri	31
Paul Neske, Detective, St. Louis County Police Department, St. Louis, Missouri, shared testimony	31
Steve Clifton, President, National Council of Social Security Management Associations, testimony	36
SUBMISSIONS FOR THE RECORD	
Consortium for Citizens with Disabilities	87
National Council of Disability Determination Directors	91
QUESTIONS FOR THE RECORD	
Ms. Colvin	68
Mr. O'Carroll	73
Mr. Brady	79
Mr. Clifton	82

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THE FUTURE OF THE SOCIAL SECURITY
DISABILITY INSURANCE PROGRAM**

TUESDAY, JANUARY 24, 2012

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

The subcommittee met, pursuant to notice, at 10:47 a.m., in Room B-318, Rayburn House Office Building, the Hon. Sam Johnson [chairman of the subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Johnson Announces the Second in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program

Tuesday, January 24, 2012

U.S. Congressman Sam Johnson (R-TX), Chairman of the House Committee on Ways and Means Subcommittee on Social Security, today announced a hearing on combatting disability waste, fraud and abuse. **The hearing will take place on Tuesday, January 24, 2012, in B-318 Rayburn House Office Building, beginning at 10:30 a.m.**

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 Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

In December 2011, the Subcommittee began a hearing series focusing on the history of the Disability Insurance (DI) program, the income security it provides, and its financing challenges. DI benefits currently average \$1,111 per month for disabled workers. According to the Social Security Administration (SSA), almost half of families receiving DI benefits rely on these benefits for the majority of their family income. On average, each disability benefit award is valued at \$250,000 in DI and Medicare benefits over a beneficiary's lifetime.

Over the past four decades DI program annual costs have climbed from \$18 billion to \$124 billion as the number of those receiving benefits has more than tripled from 2.7 to 9.7 million. Demographic changes also played an important role as during this same period the size of the overall workforce has grown, the large baby-boom generation has aged into its most disability-prone years, women have entered the workforce and become insured for benefits should they become severely disabled, and Congress has periodically reevaluated and revised eligibility guidelines. Wage levels, the basis for both the program's financing and its benefit levels, have also risen. In their 2011 Annual Report, the Social Security Trustees project that the DI Trust Fund will become exhausted in 2018, at which point revenues will cover only 86 percent of benefits.

As DI program enrollment has increased, so too has the potential cost of error, waste, fraud, and abuse. The DI program has an overpayment rate of 1.5 percent, but in fiscal year (FY) 2010, each tenth of a percentage point in payment accuracy represents about \$706 million in retirement and disability program outlays, according to the SSA. DI medical and work-related overpayments detected by the SSA have grown from about \$860 million in FY 2001 to about \$1.4 billion in FY 2010, according to the Government Accountability Office. While the agency collected or recovered \$839 million in overpayments in FY 2010, DI overpayment debt reached \$5.4 billion. The SSA has no agency-wide performance goals for debt collection.

One of the SSA's FY 2012 Agency Performance Plan priority goals is to "ensure the effective stewardship of our programs by increasing our program integrity efforts." In the Plan, the agency pledged to "continue to demonstrate an unyielding commitment to sound program integrity efforts by minimizing improper payments and strengthening efforts to protect program dollars from waste, fraud, and abuse."

FY 2012 goals include completing 592,000 full medical continuing disability reviews (CDRs), an increase of 82 percent over FY 2010. CDRs are a valuable tool in ensuring that disability beneficiaries continue to be eligible for the benefits they receive. Every dollar spent on CDRs results in at least \$10 in lifetime program savings, including savings accruing to Medicare and Medicaid. At the beginning of FY 2011, there was a backlog of 1.4 million medical CDR cases. In the Budget Control Act of 2011, Congress authorized \$13 billion in additional funds above the discretionary budget caps over the next ten years exclusively for program integrity work.

According to the SSA, these funds will enable the agency to complete nearly 8 million full medical CDRs, eliminating the DI CDR backlog by 2016.

Another important tool in combatting fraud is the Cooperative Disability Investigation (CDI) program. The FY 2012 Performance Plan identified a strategic goal to “preserve the public’s trust in our programs” with the objective to “protect our programs from waste, fraud, and abuse,” by expanding the CDI program as resources may permit. The CDI program was created in 1998 as a joint effort between the SSA and OIG, working with the State Disability Determination Services and State or local law enforcement, to pool resources for the purpose of preventing fraud in the SSA’s disability programs. Since the program’s inception, the CDI program efforts nationwide have resulted in savings of \$1.9 billion in Social Security disability benefits and \$1.2 billion in programs such as Medicare and Medicaid, for a total savings of approximately \$3.1 billion.

In announcing the hearing, Social Security Subcommittee Chairman Sam Johnson (R-TX) said, **“Waste, fraud, and abuse in the disability insurance program cheat honest, hardworking American taxpayers. As we work to secure the future of this program, we need to protect the American taxpayer from con artists who are stealing from the system by making sure benefits are paid only to those who deserve them.”**

FOCUS OF THE HEARING:

The hearing will focus on the SSA’s efforts to minimize improper payments and protect taxpayers’ dollars from waste, fraud, and abuse.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, **by the close of business on Thursday, February 7, 2012**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item 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. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies 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. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

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.

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

Chairman JOHNSON. Welcome to our second hearing in our hearing series on Securing the Future of the Social Security Disability Insurance Program. Today our focus is on combating waste, fraud, and abuse.

In our first hearing, we talked about the important milestone set in 1956 by the creation of this cash benefit program for those who could no longer work due to disability. From the beginning, there was a great deal of concern about the high risk for fraud, waste, and abuse because of the changing nature of disability and the inherent subjectivity of determining whether a person was truly disabled.

Today, the disability insurance program pays benefits to individuals with disabilities that meet certain medical criteria, so long as they work long enough and paid Social Security taxes.

Over the past four decades, disability program costs have soared from \$18 billion to \$124 billion as the number of those receiving benefits has more than tripled from 2.7 to 9.7 million people. The size of the overall workforce, more women in the workforce, the aging of the Baby Boomers into their disability-prone years, and relaxed eligibility requirements have all contributed to this growth.

That continued growth is putting a massive strain on the program. According to the 2011 Trustees' Report, without Congressional action, the Disability Insurance program will be unable to pay full benefits beginning in 2018. That's just a few years from now. And as the size, cost, and complexity of the disability insurance program has increased, so has the program's exposure to waste, fraud, and abuse.

In fiscal year 2011, Social Security paid \$130 billion—that's with a "b"—in disability benefits. That's about what it costs to run three federal agencies, believe it or not: the Department of Homeland Security, NASA, and the Department of Housing and Urban Development. In that same year Social Security's disability overpayments were 1.4 percent of total benefits paid. That percentage may sound small, but 1.4 percent of benefits equals \$1.8 billion in overpayments.

In fact, according to Social Security, each tenth of one percent point in payment accuracy represents 706 million in outlays for the retirement and disability program. Said another way, for every 1/10 of 1 percent Social Security improves its payment accuracy, it can pay disability benefits for a full year to close to 5,300 people. That's real money for those who can't work and who count on these benefits to keep a roof over their head and food on the table.

Finally, while Social Security collected \$839 million in overpayments in fiscal year 2010, cumulative overpayment debts still reached \$5.4 billion that same year.

Continuing disability reviews also protect the disability program by making sure those receiving disability benefits are still disabled. Every \$1 spent on the reviews results in \$10 of program savings, including both Medicare and Medicaid. There is a growing backlog of medical continuing disability reviews, and in the Budget Control Act, Congress authorized \$13 billion in additional funding over the next 10 years exclusively for these and other reviews.

The best way to protect the disability program is to prevent fraud before it occurs. The Cooperative Disability Investigation program does just that. This program is a joint effort between Social Security, the Office of Inspector General, working with the state disability determination services and state or local law enforcement. Since 1998, efforts by these units nationwide have resulted in \$3.1 billion in disability savings. As impressive as some of these anti-fraud efforts appear, their very success raises questions about how many other examples of abuse are yet undetected.

The disability program is of vital importance to millions of Americans whose lives are changed forever by the onset of a disability. We need to protect that program for those who truly need its benefits. Waste, fraud, and abuse in the disability insurance program cheat honest, hardworking American taxpayers. As we work to secure the future of this program, we need to protect taxpayers from con artists who are stealing from the system by making sure benefits are paid only to those who deserve them, an undertaking I know all of us on the Subcommittee stand firmly behind. And I thank the IG for working that program.

Everybody says it's just a minor amount. But billions of dollars is not minor, in my view, regardless of how you compare it to other programs.

With that, I yield to Mr. Becerra for his comments.

Mr. BECERRA. Thank you, Mr. Chairman. Nearly 157 million Americans contribute to Social Security with every paycheck. In return, these workers and their families earn guaranteed protection against the devastating consequences of disappearing pensions and retirement savings, premature death, and career-ending disability.

The vast majority of American workers never have to use the disability insurance in Social Security. But for those who become so disabled that they can't work at all, it is a lifeline. We owe it to American workers to safeguard their contributions to the Social Security trust fund, whether against the Wall Street privatizers who would raid the trust fund, or from erroneous payment of disability benefits to those who have not earned them.

That is why it's crucial that the Social Security Administration receive the funding it needs to fight waste, fraud, abuse, and to prevent simple errors. The increased funding for program integrity within the SSA, which was authorized in last fall's bipartisan Budget Control Act, is a very good step in that direction.

The Congressional Budget Office estimates that the increased resources will prevent about \$11 billion in overpayments within the decade, and even more later. That's because the eligibility reviews that SSA is able to conduct as a result of this special funding will generate \$10 to \$12 in savings for every dollar we invest.

It sure would be nice, though, to see more consistency in Congress's commitment to payment accuracy. A little more than a

decade ago, the Clinton Administration, working with Congress, completely eliminated the backlog of benefit payment cases that needed review. Devastating subsequently, we saw that Congress has let the funding drop by almost 75 percent by the year 2007. And the backlog came back with a vengeance.

In 2009 and 2010, working with President Obama, we restored some of SSA's budget, and succeeded in reducing the backlog. But then last year was a disaster. Congress's continuing resolution for 2011 froze the Agency's funding once again, and at a time when over 13,000 Baby Boomers are starting to collect their Social Security benefits every day. This funding roller coaster has real consequences for the Social Security trust fund.

We also need to put the program integrity funding, which is about six percent of Social Security's overall operating budget, in context. One of our witnesses, Mr. Steven Clifton, will let us know a little bit more about that. He will indicate that most of SSA's quality control efforts, including program integrity, are performed on the front lines by regular office staff, not by some special cadre of employees.

Preventing and correcting errors is a day-to-day responsibility. It falls on the same field offices and the same state disability determination workers who process the initial claims, who answer questions for the public, who track down lost checks, who assign Social Security numbers, and who do everything to provide other services Americans need under Social Security. It's up to them to do the program integrity, as well.

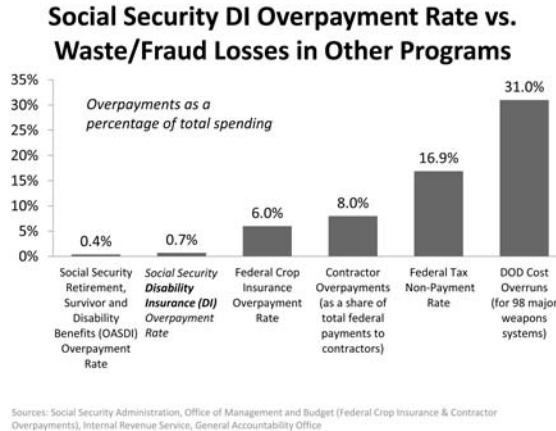
So, when Congress decides to limit SSA to a smaller actual operating budget than what SSA had the year before, that has real consequences for payment accuracy. When you force SSA to operate under a hiring freeze, as it had to last year, and continues to this year, that means SSA can't replace retiring or departing employees who are the experienced and hard-working members of the force. They are the very people who we rely on to prevent mistakes on the front end, so we don't have to correct them on the back end.

One final point. As important as it is to make sure Social Security payments are accurate, and as significant as the savings can be when SSA has the resources to do the job well, I want to make sure we keep SSA's overpayments in perspective. In 2010, Social Security, which had 72 million field office visits and phone calls, processed over 8 million benefit applications, and paid out benefits to over 54 million seniors, survivors, and disabled workers, had a 4/10ths of 1 percent overall overpayment rate.

More specifically, Social Security's disability insurance program, which handles a complicated eligibility process and requires applicants to provide specialized medical and vocational evidence, had an overpayment rate of 7/10ths of 1 percent. Most of this was due to simple error.

I refer you to charts that you see on the screens. For comparison, the cost overrun for 98 of the Department of Defense's major weapons systems was 31 percent. Not 31/100ths of 1 percent, 31 percent. What makes this a glaring statistic and makes it even worse and more staggering is the fact that DoD continues to do business with hundreds of contractors which the Pentagon knows were involved in fraud against the taxpayers.

[The insert of The Honorable Xavier Becerra follows:]



So, Mr. Chairman, I look forward to working together with you and our colleagues to safeguard the investment American workers make in Social Security. And let's keep the big picture in mind. Tens of millions of Americans and their families rely on Social Security to be there when they need it. That means having a Social Security office open and fully staffed to help them. It means getting back every penny in Social Security overpayments. And for the sake of fairness and integrity, it means applying the same rigor and standard of accountability for all programs within the federal budget, from Social Security to national security.

I yield back, Mr. Chairman.

Chairman JOHNSON. Yes. I might remind you this is not the Armed Services Committee.

Mr. BECERRA. But Mr. Chairman, we always are looking for ways to collect any overpayments.

Chairman JOHNSON. I know, I know.

Mr. BECERRA. National security or Social Security.

Chairman JOHNSON. Thank you.

Ms. Colvin, I understand Social Security is going to resume making benefit estimate statements available, but only to certain groups. I look forward to being briefed by your staff and holding a future hearing on this. The statements are an essential tool for helping Americans prepare for their retirement. But you can tell your Chief he should have told us about it before he did that.

As is customary, any Member is welcome to submit a statement for the hearing record. Before we move on to our testimony today I want to remind our witnesses to please limit their oral statement to five minutes. However, without objection, all the written testimony will be made a part of the hearing record.

We have one panel today, and our witnesses who are seated at the table are Carolyn Colvin, Deputy Commissioner of Social Security Administration; Patrick O'Carroll, Jr., who is the Social Security Administration's Inspector General; Thomas Brady, who is

Special Agent, Office of the Inspector General, Social Security Administration, from the Kansas City field division in St. Louis. He is joined by Paul Neske, Detective, St. Louis County Police Department, St. Louis. Steve Clifton is President, National Council of Social Security Management Associations.

I appreciate you all being here. And, Ms. Colvin, you are welcome to proceed for five minutes.

**STATEMENT OF CAROLYN W. COLVIN, DEPUTY
COMMISSIONER, SOCIAL SECURITY ADMINISTRATION**

Ms. COLVIN. Chairman Johnson, Ranking Member Becerra, Members of the Subcommittee, thank you for inviting me to discuss our efforts to preserve the integrity of our disability programs. I am the Social Security Administration's Accountable Official for improper payments.

I want to thank Congress for getting our budget to us early this year. It helps us minimize disruptions in serving the American public. Our dedicated employees continue to improve our efforts to prevent, detect, and recover improper payments, making the Social Security program the most accurate in Federal Government.

Throughout my career I have worked closely with the vulnerable individuals who benefit from Social Security's programs. They look to the disability program for assistance, a program they have contributed to through their payroll taxes.

The payments we make under the SSDI program are exceptionally accurate. In fiscal year 2010, 99.31 percent of all SSDI payments were free of an overpayment, and 98.97 percent were free of an underpayment. While we are proud of these results, we still look for ways to do better, because we realize that even a small error rate represents sizeable incorrect payments.

Funding for our program integrity work is key to ensuring that we continue proper payments to those individuals who are entitled to benefits. Continuing disability reviews play an especially important role. CDRs are re-evaluations of beneficiaries' medical conditions and earnings to determine whether they should continue to receive benefits. Medical CDRs yield \$10 in savings for every \$1 invested.

In 1996 we received a 7-year commitment of special funds to conduct medical CDRs. At the end of the 7 years, we had processed 4.7 million full medical reviews. Over the subsequent five years, inadequate funding meant that we had to reduce the number of medical CDRs we completed. Now we have a backlog of about 1.3 million cases. We are doing 90,000 more medical CDRs this year. But because we did not receive full funding for program integrity, as authorized under the Budget Control Act, we will complete about 130,000 fewer full medical reviews than we could have done. Given the high return on investment of medical CDRs, full funding of this workload is a smart investment.

We are focusing resources on our work CDRs. We are taking actions more timely, and addressing overpayments more quickly. Our workloads are growing at the same time we are losing experienced staff, increasing the strain on our front-line employees, the same employees who conduct CDRs and perform core duties, including getting out that first payment to deserving beneficiaries. We must

balance quality and quantity. Thus, we are forced to do less with less.

The SSDI work activity rules are extremely complex and difficult to implement. The President's fiscal year 2012 budget included a work incentive simplification proposal that we believe could simplify SSDI program rules, and address a significant disincentive to work that occurs under the current rules: the fear of losing benefits due to work activity. We urge Congress to consider the work incentive simplification policy proposal.

We would not be good stewards of our programs if we did not have a comprehensive debt collection program in place to recover program dollars. We do. Across all of our programs we recovered \$3.2 billion in debt in fiscal year 2011, and \$14.7 billion over the previous 5-year period at an administrative cost of \$.08 for every dollar collected.

We make every effort to identify and collect that as soon as possible, so we can arrange a repayment plan with the beneficiary. If the overpaid person no longer receives benefits, we arrange for debt collection through installment payments. If this is unsuccessful, we turn to authorized external debt collection tools.

Our employees are vigilant and, when they suspect someone is receiving benefits through fraudulent means, make referrals to our Office of Inspector General. Last year we made 19,000 referrals. OIG opened 4,600 of these cases for investigation and possible criminal prosecution. We have a low incidence of fraud in our programs.

We are committed to preserving the integrity of our programs. I must emphasize that just because a benefit payment is improper does not mean there was fraud. Our programs are complicated. And we work to ensure that our beneficiaries understand the reporting requirements. We take pride in our ability to protect and manage the resources and programs entrusted to us. We have earned the public's trust, and we intend to keep it.

Congressional support is vital. To complete all of the work for which we are responsible, we need Congress to fully fund our workloads in future appropriation cycles.

Thank you very much. I am happy to answer your questions.
[The prepared statement of Ms. Colvin follows:]



HEARING BEFORE

**THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY**

UNITED STATES HOUSE OF REPRESENTATIVES

JANUARY 24, 2012

STATEMENT

OF

CAROLYN W. COLVIN

DEPUTY COMMISSIONER

SOCIAL SECURITY ADMINISTRATION

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

Thank you for inviting me to discuss our efforts to preserve the integrity of our disability programs. I am the Social Security Administration's Deputy Commissioner, as well as the Accountable Official for improper payments. We make every effort to pay benefits to the right person in the right amount at the right time. Accordingly, one of our strategic goals is to preserve the public's trust in our programs.

Due to tight budgets in fiscal years (FY) 2011 and 2012, we have suspended or postponed lower priority activities so that we can continue to achieve our most important goals—eliminating the hearings backlog and focusing on program integrity work. Our available funding in FY 2012 is almost \$400 million less than what we operated with in FY 2010. At the same time, our fixed costs and our workloads continued to increase. We lost over 4,000 employees in FY 2011, and we expect to lose over 3,000 more employees this year that we cannot replace. We simply do not have enough staff to complete all of the work for which we are responsible, and we made strategic decisions about the areas in which we must do less with less.

Eliminating the hearings backlog remains our top priority. With the resources we received in FY 2012, we can still achieve our commitment to reduce the average hearings processing time to 270 days by the end of FY 2013 provided we are able to hire enough administrative law judges. It will be an extraordinary accomplishment because we have faced a significant increase in hearing requests due to the economic downturn.

While we cannot afford to complete the level of program integrity work authorized under the Budget Control Act of 2011 (BCA) because Congress did not appropriate the full amount, we will increase the number of program integrity reviews that we conduct by 90,000 more full medical continuing disability reviews (CDR) this year.

I am pleased to report that our hard-working, dedicated employees continue to improve our efforts to prevent, detect, and recover improper payments. As a result, the Social Security program is the most accurate in the Federal Government. Our employees also are vigilant about protecting program dollars from waste, fraud, and abuse, and make referrals to our Office of the Inspector General (OIG) as appropriate. Our OIG has the agency lead for investigating cases of possible fraud and referring them for criminal prosecution and other penalties. We believe that our cooperative efforts with the OIG have resulted in an extremely low incidence of fraud in our programs. It is important to remember that not all overpayments are improper and not all improper payments are necessarily fraud. For example, beneficiaries whom we have determined have medically recovered have the right under the statute to request that their benefits continue while they are awaiting the appeal. While such continued benefits are not improper payments as they were correctly paid under the statute, if the appeal upholds our medical recovery determination, they are considered overpayments subject to recovery.

The Disability Programs We Administer and Our Payment Accuracy

Social Security touches the lives of nearly every American, often during times of personal hardship, transition, and uncertainty. Our 80,000 Federal and State employees serve the public through a network of 1,500 offices across the country. Each day, almost 180,000 people visit our field offices and more than 435,000 people call us for a variety of services such as filing claims, asking questions, and reporting changes in circumstances (including a return to work).

The two disability programs we administer are the Social Security Disability Insurance (SSDI) program and the Supplemental Security Income (SSI) program. The SSDI program protects against loss of earnings due to disability. The SSI disability program assists blind and disabled persons with limited income and resources. These two disability programs provided an average of 15 million beneficiaries with a total of approximately \$175 billion in benefit payments in FY 2011.

Overall, our SSDI payments are highly accurate. Our most recent data show that, in FY 2010, 99.3 percent of all SSDI payments were free of an overpayment, and 99.0 percent were free of an underpayment. While we are proud of our high accuracy rate for SSDI payments, we recognize that our SSI overpayment accuracy rate falls short of that high standard. To a large extent, inaccuracy is inherent in the complex program rules and the delays in receiving income data. SSI payments can change each month due to income and resource fluctuations and changes in living arrangements. Our overpayment accuracy rate, though improving, reflects that complexity. In the SSI program, 93.3 percent of all payments were free of an overpayment, and 97.6 percent of all payments were free of an underpayment, a significant improvement from FY 2008.¹

The Complexity of Our Disability Programs and the Causes of Payment Errors

Our disability programs are challenging to administer. Determining that an individual is eligible for SSDI or SSI benefits is a complex and generally time-consuming process. Under the SSDI program, we must evaluate an individual's mental and physical impairments to determine whether the impairments are so severe that they prevent the claimant from engaging in work that exists in the national economy. In the SSI program, we apply the same standard for adults but we must also consider an individual's often rapidly changing income and resources before awarding SSI benefits based on disability. When we consider a person's continued eligibility for SSDI or SSI benefits, the law adds further complexity by requiring us to document medical improvement that relates to a person's ability to work, a higher standard.

¹ These data include all categories of SSI beneficiaries.

The leading cause of overpayments in the SSDI program is error in the application of substantial gainful activity (SGA). SGA refers to the level of a beneficiary's work and earnings that can affect benefit payments.² Beneficiaries are required to tell us if they return to work. However, because the statutory rules for return to work are complicated, beneficiaries are often unsure when they have to report work to us. Congress has created opportunities for beneficiaries to try to return to work. For example, under the SSDI program, beneficiaries can test their ability to work in a trial work period (TWP) without affecting their benefits. The TWP ends when a beneficiary completes 9 months with earnings over a threshold amount (\$720 per month in 2012) within a rolling 5-year period. After the TWP, a beneficiary enters into the extended period of eligibility (EPE). The EPE is a 36-month period during which we pay benefits only in the months a beneficiary earns below SGA. Entitlement to benefits ends with the first month of SGA after the EPE. In many cases, beneficiaries fail to report that they have begun a TWP or have continued to work into the EPE. A beneficiary's failure to report can lead to an overpayment.

Even when a beneficiary reports to us, we cannot always act immediately if the person is still working in a TWP. Determining whether a beneficiary's work and earnings are SGA takes considerable time and requires delays while we get the additional information we need to make the determination. We must get information about the beneficiary's return to work from the beneficiary or the beneficiary's employer. Each year we must address large volumes of work reports, and there are inevitable delays in receiving and processing this supplemental information. Our work-related activities require a lot of starting and stopping work on a case while we develop the case, answer necessary questions, review it, and finally have the right information to take action. This work also requires expertise, and we need to have enough trained employees to complete it timely. The same employees who help the 45 million people who come into our offices each year must also handle this work. The longer it takes us to get to this work, the more likely the overpayment will be higher.

SSI has a different set of work rules. For SSI disability, SGA is a test to determine only initial eligibility rather than continuing eligibility. When an SSI disability beneficiary returns to work, we do not apply the SGA rules. Rather the law requires that SSI benefits be reduced by \$1 for every \$2 in earnings.

Improper payments often occur when beneficiaries fail to timely report changes, such as an increase in the value of resources or an increase or decrease in wages. Failure to report these changes is the primary cause of improper payments in the SSI program.

Given the complexity of the statutes governing our disability programs and the volume of work, some overpayments are unavoidable. The complexity of our return-to-work provisions

² Generally, earnings averaging over \$1,010 a month (in 2012) demonstrate an individual's ability to perform SGA. This amount is subject to modifications and exceptions based on other statutory incentives designed to encourage work, such as impairment-related work expenses, subsidies, and special conditions.

is exacerbated when a beneficiary receives both SSDI and SSI, because the beneficiary is subject to two different sets of rules. For example, almost 30 percent of SSI beneficiaries aged 18-64 also receive SSDI.

The President's FY 2012 budget included two proposals that have the potential to reduce disability program overpayments by testing programmatic simplification and giving us access to important State, local government, and private insurer benefit information.

The first proposal is the Work Incentives Simplification Pilot (WISP). We believe WISP could address a significant disincentive to work under the current SSDI rules: the fear of losing benefits due to work activity. The current set of work incentive policies and post-entitlement procedures have become very difficult for the public to understand and for us to effectively administer. The goal of WISP is to conduct a test of simplified SSDI work rules, subject to rigorous evaluation protocols, that may encourage beneficiaries to work and reduce our administrative costs. WISP would eliminate complex rules on the TWP and EPE. It would also eliminate performing SGA as a reason to terminate benefits. Further, we would count earnings when they are paid, rather than when earned, which would better align the rules of the SSDI and SSI programs. If a beneficiary's earnings fell below a certain threshold, we could reinstate monthly benefit payments as long as the person was still considered to be disabled.

The second proposal would require State and local governments and private insurers that administer worker's compensation (WC) and public disability benefit (PDB) plans to provide us with information on WC and PDB payments. By requiring plan administrators to provide payment information to us promptly, this proposal would improve the integrity of the WC and PDB reporting process, improve the accuracy of SSDI benefits and SSI payments, and lessen our reliance on the beneficiary to report this information in a timely manner.

We urge Congress to consider both of these proposals. They hold significant promise to help us reduce improper payments in our disability programs and save taxpayer dollars.

Our Primary Program Integrity Tools

"Curbing Improper Payments" is the first objective under our 2008-2013 Agency Strategic Plan Goal to "Preserve the Public's Trust in Our Programs." When an individual applies for one of our disability programs, we have a system in place to ensure accurate decisions. Each year, we are statutorily required to review at least 50 percent of all State Disability Determination Services (DDS) initial and reconsideration allowances for SSDI and SSI disability for adults. Based on the results of these reviews in FY 2009—the most recent year for which data are available—the decision to allow or continue disability was correct in 98.9 percent of all favorable SSDI determinations and 99 percent of all favorable SSI disability determinations for adults. These reviews allow us to correct errors we find before we issue a

final decision, resulting in an estimated \$558 million in lifetime program savings, including savings accruing to Medicare and Medicaid. The return on investment has been roughly \$11 for every \$1 of the total cost of the reviews.

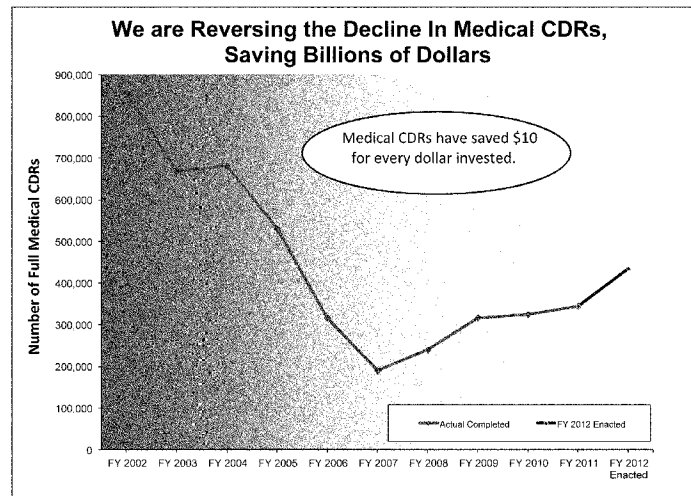
Once an individual is on the disability rolls, our primary program integrity tools are medical and work CDRs and SSI redeterminations. We periodically conduct medical CDRs to evaluate whether SSDI and SSI beneficiaries continue to meet the medical criteria for disability. We also conduct medical CDRs when we receive a report of medical improvement from a beneficiary or third party. We complete medical CDRs in two ways, which together ensure that we are targeting our resources to the most problematic areas in the most cost-effective way. The medical CDR process uses a statistical modeling system that uses data from our records to determine the likelihood that a disabled beneficiary has improved medically. If the statistical modeling system indicates that the beneficiary has a high likelihood of medical improvement, we send the case to the State DDS for a full medical review. The remaining beneficiaries who are due for review but have a lower likelihood of medical improvement receive a questionnaire requesting updates on their impairments, medical treatment, and work activities. If the completed mailer indicates that there has been potential medical improvement, we send the case to the DDS for a full medical review. Otherwise, we reschedule the case for a future review. To date since 1996, we estimate that on average each dollar spent on medical CDRs yields at least \$10 in lifetime program savings, including savings accruing to Medicare and Medicaid.

We have shown that with adequate funding for medical CDRs, we are able to produce results. For example, in 1996 we received a 7-year commitment of special funds to conduct medical CDRs. By the time the funding commitment expired at the end of FY 2002, we had completed 9.4 million CDRs (including 4.7 million full medical reviews) and were current on all CDRs that were due. For all the medical CDRs completed during the period FYs 1996 through 2002, we spent roughly \$3.4 billion, with an estimated associated lifetime savings from this activity of approximately \$36 billion.

Unfortunately, from FY 2003 through FY 2007, inadequate funding forced us to reduce the volume of medical CDRs we completed, and, as a result, we could not keep up with all the CDRs that were due. In recent years, additional funding for program integrity has allowed us to increase the volume of full medical CDRs though not to the level that the President has recommended. Last fiscal year, we completed about 345,000 full medical CDRs, a 66 percent increase over the number we completed in FY 2007. Nevertheless, we still have a backlog of about 1.3 million medical CDRs. With full funding of the additional program integrity levels authorized under the BCA, we project that we could nearly eliminate the medical CDR backlog over the next decade, with the exception of SSI adult medical CDRs, which have the lowest return on investment. However, in FY 2012 Congress did not fully fund the BCA level of program integrity resources. Therefore, we will complete about 435,000 full medical CDRs, a significant increase over FY 2011 but 130,000 fewer than the

number authorized under BCA. Given the historically high return on investment of medical CDRs, we believe that fully funding this workload is a smart investment.

Figure 1



A work CDR is a review of eligibility requirements regarding an SSDI beneficiary’s earnings or ability to work. Work CDRs are triggered by reports of earnings from beneficiaries or third parties, systems alerts, and earnings posted to a beneficiary’s record. For instance, after an SSDI beneficiary completes a TWP and continues to work, we would conduct a work CDR to determine if the beneficiary’s earnings preclude entitlement to payment. We may also receive either a report of earnings or an earnings alert for unreported earnings. Our Continuing Disability Review Enforcement Operation uses Internal Revenue Service earnings data to identify possible work CDRs for SSDI beneficiaries. It generates about 600,000 alerts annually, and we target the alerts with the highest identified earnings and work those cases first. In recent years, we have allocated additional staff resources to analyze the work reports we get from all sources and to conduct more work CDRs. We are also targeting the cases with the oldest work reports—those over 365 days old.

We handle work CDRs in field offices and processing centers. We use a program called eWork to automate work CDR processing. eWork collects necessary data from mainframe databases, prepares forms, notices, and work report receipts, incorporates policy and decision logic, and adjusts benefits.

Despite our budget constraints, we have focused resources on completing more work CDRs to minimize overpayments. In FY 2010, we completed 312,471 work CDRs.³ Of these, 105,279 resulted in a finding of cessation of disability, or a subsequent reinstatement or suspension of benefits in the EPE. In FY 2011, we increased the number of work CDRs we completed to about 324,000.⁴ While we are still finalizing our data regarding the outcome of those work CDRs, we estimate that about 130,000 resulted in a finding of cessation of disability, or a subsequent reinstatement or suspension of benefits in the EPE. This fiscal year we are focusing our limited resources in a few key areas to reduce overpayments. We are dedicating resources to ensure that we handle actions related to work more timely and address overpayments quicker. Nevertheless, we simply do not have the resources to complete all of these cases.

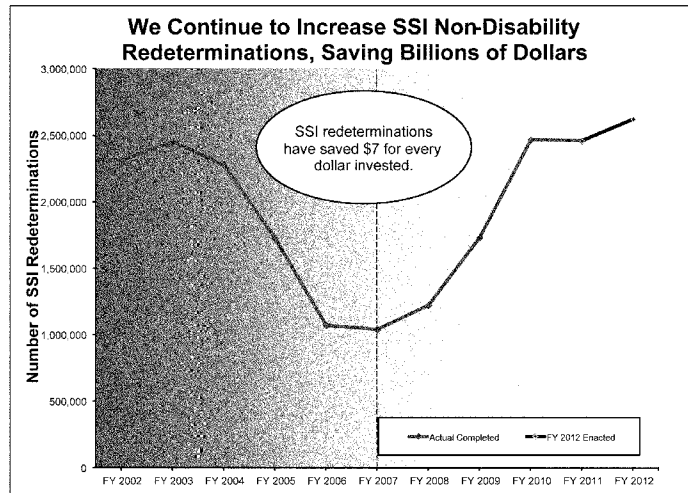
Redeterminations are reviews of all of the nonmedical factors of eligibility to determine whether a beneficiary is still eligible for SSI and still receiving the correct payment amount. We focus on the most error-prone cases each year using a statistical model. In FY 2011, this statistical model allowed us to prevent \$1.4 billion more in overpayments than what a random selection of cases would have prevented. Historically, every dollar spent on SSI redeterminations returns more than \$7 in lifetime program savings, including savings accruing to Medicaid.

Just like the number of medical CDRs from FY 2003 to FY 2007, the number of SSI redeterminations we conducted over the same period dropped precipitously due to inadequate funding. Compared to FY 2007, we are now completing about 1.5 million more SSI redeterminations each year due to increased funding for program integrity. We anticipate completing 2.6 million SSI redeterminations in FY 2012. The additional SSI redeterminations we have completed in recent years are the primary reason why we have been able to increase our SSI overpayment accuracy rate by 3.6 percentage points—a statistically significant amount—over the past 3 years.

³ Because we reviewed some beneficiaries more than once during the fiscal year, the number of completed work CDRs involves about 264,000 SSDI beneficiaries.

⁴ The number of completed work CDRs for FY 2011 likely includes some beneficiaries for whom we completed reviews more than once.

Figure 2



The same employees who complete CDRs and redeterminations also have many other critical responsibilities, such as taking and adjudicating SSDI and SSI applications. While our workloads continue to grow and expand, the number of people to do the work has decreased.

Any workloads that we must defer due to inadequate funding—whether program integrity work or deciding initial claims—become only more complex and costly to complete the longer that the workload ages. For example, with a work CDR, we have to look at virtually every month over a specified period to determine if a person worked, the amount of his or her earnings, and whether the person had impairment-related expenses or special subsidies. If we do not get to the work CDR shortly after the person goes to work, we have more months in the period to analyze, more pay stubs to examine, and, generally, more variables to factor into our determination. As the time it takes to handle this workload increases, the likelihood of large overpayments in those cases also increases.

The President's FY 2012 Budget included a legislative proposal to require employers to report wages quarterly. Increasing the timeliness of wage reporting would provide us more current information on our beneficiaries' work activity, which could help to minimize the

amount of overpayments. Reverting to more frequent wage reporting would enhance program integrity in a variety of programs.

In the past few years, we have developed and rolled out two initiatives further that improve our SSI accuracy rates. Those initiatives are the Access to Financial Institutions (AFI) project and the SSI Telephone Wage Reporting (SSITWR) system.

AFI is an electronic process that allows us to identify financial accounts of SSI applicants and beneficiaries that exceed statutory limits. As of June 2011, all 50 States use AFI, and we achieved this goal 3 months ahead of schedule. We will soon complete systems enhancements that will further automate the AFI process.

The AFI project has proven very useful in identifying undisclosed accounts. For example, just last summer, we had a case in which a claimant stated he had a bank account under the \$2,000 SSI limit. The actual account balance verified through AFI was \$200,000. In another case, a claimant said he had only one bank account under the resource limit. Using AFI to contact multiple banks, we uncovered six bank accounts with balances of nearly \$25,000 in each account. We are looking at the possibility of expanding this successful program to real property.

SSI beneficiaries can report wage data through the SSI Telephone Wage Reporting (SSITWR) system, which automatically processes the wage information into the SSI system. In FY 2011, we processed more than 325,000 monthly wage reports using this system. These reports generally are accurate and require no additional evidence, which saves time in our field offices. SSITWR has allowed us to increase the volume of wage reports we receive, and therefore reduces wage-related errors.

We are also expanding our marketing of this service to the public. This fiscal year, we expect to conduct a targeted outreach to representative payees of working SSI beneficiaries, a population that has successfully adopted SSITWR in prior testing.

Data Exchanges and Other Systems Enhancements

We rely on data exchanges to help us protect the integrity of our programs. Efficient, accurate, and timely exchanges of data promote good stewardship for all parties involved. We have over 1,500 exchanges with a wide-range of Federal, State, and local entities that provide us with information we need to stop benefits completely or to change the amount of benefits we pay. We also have about 2,300 exchanges with prisons that allow us to suspend benefits to prisoners quickly and efficiently.

Data exchanges are also a cost-effective way to prevent and detect improper payments. For example, in FY 2008, for every dollar spent on our pension match with the Department of Veterans Affairs, we saved nearly \$39 in SSI benefits. Similarly, during the same timeframe, every dollar we spent on our match with Office of Personnel Management saved us almost \$20 in Old-Age, Survivors, and Disability Insurance (OASDI) benefits.

We also depend on advanced technology to help balance the need to keep up with growing workloads and to be effective stewards of the Social Security Trust Funds and taxpayer dollars. Technology and automation are keys to providing quality service to the public as our workloads continue to grow. For example, we recently introduced systems enhancements to the Returned Mailer System (RMS), which tracks the status of a medical CDR mailer from release until we receive a response from the beneficiary. The enhancements included implementing text-mining software that scans the mailer responses for keyword matches, thereby eliminating the manual handling of mailers that meet certain criteria. In those cases, the RMS decides the appropriate action to take (full medical CDR, manual review of the mailer response, or no further action), thus expediting decisions.

Tools to Recover Overpayments

In addition to our efforts to prevent improper payments and improve our payment accuracy, we also have a comprehensive debt collection program. We recovered \$3.2 billion in program debt in FY 2011 and \$14.72 billion over the previous 5-year period (FYs 2007-2011) at an administrative cost of \$.08 for every dollar collected.

We recover OASDI and SSI overpayments from overpaid beneficiaries and representative payees who are liable for the overpayment. To recover debt, we withhold current benefit payments from the debtor. It is harder to recoup a debt once benefits end; therefore, we make every effort to identify and collect debt as soon as possible. If the overpaid person no longer receives benefits, we offer the opportunity to repay debt via monthly installment payments.

When we cannot recover a debt on our own, we turn to authorized external debt collection tools. These tools include:

- Tax Refund Offset;
- Administrative Offset (collection of a delinquent debt from a Federal payment other than a tax refund);
- Credit Bureau Reporting;
- Administrative Wage Garnishment;
- Non-Entitled Debtors Program (a system that facilitates recovery of debt owed by non-beneficiaries, such as representative payees); and
- Federal Salary Offset.

We plan to improve our debt collection programs by implementing several enhancements to allow us to take advantage of changes in the law that expand the availability of administrative offset. For example, we will make systems changes to allow us to collect delinquent debt via the Treasury Offset Program beyond the current 10-year statute of limitations. The Department of the Treasury removed the 10-year limitation to collect delinquent debts via the program and we amended our regulations in October 2011 to conform to this change. As resources permit, we will start using other existing debt collection authority such as private collection agencies, charging administrative fees and interest, or indexing a debt to reflect its current value.

In providing us with these debt collection tools, Congress recognized that maximum debt collection is not the only consideration. We must balance our stewardship responsibilities with compassionate recognition of our beneficiaries' individual situations. For example, the law limits us to withholding no more than 10 percent of an SSI beneficiary's monthly income to recover an overpayment. Reducing the already minimal SSI payment too much could leave the beneficiary without enough money to meet basic living expenses. Similarly, the law prohibits recovery of overpayments from any beneficiary who is without fault if the recovery would defeat the purpose of the programs or be against equity and good conscience.

However, we are considering regulatory changes that could potentially allow us to collect more of our programmatic debt. Such regulatory changes could include increasing the minimum monthly repayment amount for certain beneficiaries with overpayments.

Our Cooperative Efforts with OIG

We work with our OIG to operate investigative units—called Cooperative Disability Investigations (CDI) units—across the country. Each unit consists of an OIG special agent, State or local law enforcement investigators, State DDS examiners/analysts, and our management support specialists or similar employees. Our CDI units allow us to more quickly determine whether fraud has potentially taken place and move forward with deciding disability claims if we are satisfied that fraud has not occurred. By fostering an exchange of information between disability decision-makers and the CDI units, the CDI program increases our ability to identify and prevent overpayments, as well as deny potentially fraudulent initial applications. The program also ensures timely investigation and the termination of benefits when we detect fraud during work or medical CDRs.

CDI units also investigate and support criminal prosecution of doctors, lawyers, and other third parties who commit fraud against the SSDI and SSI disability programs. The results of these investigations may also be presented to Federal and State prosecutors for consideration

of criminal or civil prosecution, as well as to the Office of the Counsel to the Inspector General for the possible imposition of civil monetary penalties.

There are currently 25 CDI units operating throughout the United States, with a 26th unit expected to be operational before the end of this fiscal year. According to our OIG, since the program's inception in FY 1998 through September 2011, CDI efforts nationwide have resulted in \$1.8 billion in savings to our disability programs and \$1.1 billion in savings to non-Social Security programs, such as Medicare and Medicaid.

These monetary achievements are the result of CDI units opening more than 34,700 cases and developing evidence to support approximately 26,270 actions, resulting in a denial, suspension, or termination of disability benefits.

In cases where Federal prosecutors would be otherwise unable to take action on fraud cases referred by the OIG due to resource constraints, our agency attorneys may prosecute these cases in Federal court instead. These attorneys serve as a Special Assistant to a United States Attorney's Office in eight of our regional offices. There are a total of nine attorneys who take on these cases. From FYs 2003 through 2010, our attorneys secured over \$36.9 million in restitution orders and 717 convictions or guilty pleas. In FY 2011, we secured nearly \$6.8 million in restitution orders and 97 convictions for identity theft, program fraud, and Social Security number misuse.

The law provides a wide-range of penalties for individuals who make false statements, or who misrepresent or omit material facts used in determining eligibility for, or the amount of, OASDI or SSI benefits. We train our field employees to alert OIG to any cases of suspected fraud. We made nearly 19,000 such fraud referrals related to our disability programs in FY 2011, from which the OIG opened about 4,600 cases.

Conclusion

We take pride in our ability to protect and carefully manage the resources, assets, and programs entrusted to us. We have earned the public's trust, and we intend to do everything we can to keep it. We are firmly committed to sound management practices, including using accurate metrics for evaluating our programs' integrity, and following up with appropriate enforcement and recovery actions. We know the continued success of our programs is inextricably linked to the public's trust in them. Properly managing our resources and program dollars is critical to that success.

We also know that congressional support is vital. In order to complete all of the work for which we are responsible, we need Congress to fully fund those workloads in future appropriations cycles. We are doing what we can to target our program integrity efforts to

areas that provide the best value, but we need adequate and timely resources to balance this work with the increasing demand for our services.

Chairman JOHNSON. Thank you, ma'am.
Mr. O'Carroll, welcome. Please go ahead.

**STATEMENT OF PATRICK P. O'CARROLL, JR., INSPECTOR
GENERAL, SOCIAL SECURITY ADMINISTRATION**

Mr. O'CARROLL. Good morning, Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee. Thank you for the invitation to testify today.

SSA provides about \$10 billion in disability insurance payment to more than 10 million citizens every month. More and more Americans are turning to SSA as Baby Boomers reach their most disability-prone years. The Agency received an all-time high 3.2 million initial applications for disability benefits in fiscal year 2011. Thus, it is a critical time to focus on the future of the disability program.

My office's efforts to secure the disability program focus on investigating individuals suspected of committing Social Security fraud, completing audit reviews, and recommending ways for SSA to improve disability program integrity and efficiency. Last year OIG agents reported more than \$410 million in investigative accomplishments. That includes more than \$80 million in SSA recoveries and restitutions, and about \$330 million in projected savings from programs such as the Cooperative Disability Investigations effort, which we will hear about more shortly.

Last year our office received more than 103,000 fraud allegations and 43 percent of all allegations were disability-related. We have also made many recommendations to SSA in recent years that support OIG's focus on disability program integrity.

SSA projected a backlog of about 1.4 million continuing disability reviews at the end of Fiscal Year 2011. Our audit work has found the Agency would have avoided paying hundreds of millions of dollars to ineligible beneficiaries if CDRs were conducted when they were due. SSA estimates that every dollar spent on CDRs yields at least \$10 in SSA program savings. The Agency has requested additional funds this year for program integrity efforts. SSA has a goal of conducting more than 1.4 million CDRs. However, this amount will not significantly reduce the CDR backlog.

We also believe reducing the complexity of SSA's disability programs would help prevent millions of dollars in overpayments that occur each year.

SSA has had to evaluate earnings and work incentives before stopping benefits. So simplifying these provisions could have a positive effect.

Our support for stewardship activities has never wavered. My written statement for the record includes other recommendations we have made to SSA. We continue to pursue the establishment of self-supporting fund for integrity initiatives, such as CDRs and our CDI program.

The CDI program has received tremendous support from your subcommittee. In late August, Chairman Johnson was kind enough to visit our Dallas CDI unit. And Congressman Brady and I toured the Houston CDI unit, and we greatly appreciate all of your interest.

I am also pleased the subcommittee invited OIG Special Agent Tom Brady and St. Louis County Detective Paul Neske to be here today. They are members of our CDI unit in St. Louis.

To highlight our anti-fraud efforts, I would like to share with you a CDI surveillance video. We currently have 25 CDI units across the country, and this case comes from our Tampa CDI unit.

[Video.]

Mr. O'CARROLL. The unit investigated a 54-year-old man. He said he used a cane for walking for assistance, and he could not perform household chores. The Tampa disability examiners referred the case to the CDI unit, due to medical inconsistencies. And here you see him limping into the local SSA office.

The investigation revealed that the man was hardly incapable of performing household chores. Surveillance showed the man, as you can see here, lifting a large piece of wooden furniture, and sweeping debris from the roof of his home. With this information, the DDS denied the claim, preventing an improper SSA payment.

I have also available additional case example videos from Chairman Johnson's district that we showed during a CDI unit visit last summer. Special Agent Brady and Detective Neske will provide more details on the CDI program in their testimony.

And thank you, again, for this opportunity to testify. And I will be happy to answer any questions.

[The prepared statement of Mr. O'Carroll follows:]

U.S. House of Representatives

**Committee on Ways and Means
Subcommittee on Social Security**



Statement for the Record

Hearing on Combating Disability Waste, Fraud, and Abuse

**The Honorable Patrick P. O'Carroll, Jr.
Inspector General, Social Security Administration**

January 24, 2012

Good morning, Chairman Johnson, Ranking Member Becerra, and members of the Subcommittee. It is a pleasure to appear before you, and I thank you for the invitation to testify today. I have appeared before Congress many times to discuss issues critical to the Social Security Administration (SSA) and the services the Agency provides to American citizens. Today, we are discussing SSA's Disability Insurance (DI) program, focusing on efforts to secure the program's future and safeguard it from fraud, waste, and abuse.

SSA DI is the nation's primary Federal disability program. According to the most recent data from SSA, in November 2011, the Agency provided about \$9.8 billion in DI payments to more than 10.5 million citizens across the country (more than 8.5 million disabled workers, along with 2 million spouses and children). As baby boomers reach their most disability-prone years, more Americans have turned to SSA. Since FY 2007—when the Agency received 2.5 million initial applications for disability and the economy began its downturn—initial applications to SSA for disability have increased each year, with SSA receiving more than 3.2 million initial applications for disability in FY 2011. Thus, it is a critical time for the Agency to focus on the future of the DI program.

Ensuring the stability of the DI program is also an important undertaking for SSA because Agencies across the Federal government are working to reduce improper payments and to develop new solutions to eliminate and prevent wasteful spending, as President Obama signed into law the *Improper Payments Elimination and Recovery Act* in July 2010. SSA has reported about \$1.8 billion in overpayments in its DI program for FY 2011; SSA paid about \$130 billion total in DI in FY 2011. As Federal employees, we must ensure that taxpayer dollars are spent wisely and efficiently, and that government benefits are administered correctly. Improper payments cover a number of financial transactions, but in SSA's case, they are largely benefit payments made to ineligible program participants. They can be the result of documentation and administrative errors or fraudulent activity. OIG's involvement in the effort to reduce overpayments in SSA's DI program focuses on investigating individuals suspected of committing Social Security fraud, completing audit reviews, and recommending ways for SSA to improve DI program integrity and efficiency.

According to SSA, as reported in its March 2011 *Improper Payment Report*, there are three major causes of errors and improper disability payments:

- **Substantial Gainful Activity (SGA):** An adult is considered disabled if he or she is unable to engage in SGA because of a medically determinable physical or mental impairment. The SGA for Calendar Year (CY) 2012 is earnings above \$1,010 per month for non-blind individuals, and earnings above \$1,690 per month for blind individuals. Errors occur when beneficiaries fail to report earnings timely, or SSA does not timely withhold monthly benefit payments from those engaging in SGA.
- **Government Pension Offset:** SSA may offset benefits for a spouse or a surviving spouse if he or she receives a Federal, State, or local government pension based on work on which the spouse did not pay Social Security taxes. Errors occur if receipt of these types of pensions is not reported to SSA.
- **Wages/Self-Employment Income:** When an individual's earnings record does not accurately reflect the worker's actual earnings, there may be errors if the mistake goes undetected when the worker applies for benefits.

From FY 2005 to FY 2009, according to SSA, SGA errors resulted in an average of \$975 million in overpayments per year, government pension offset errors resulted in an average of \$240 million in overpayments per year, and wages/self-employment income errors resulted in an average of \$195 million in overpayments per year.

SGA is strictly an issue with DI cases, according to SSA. From FYs 2005 to 2009, 64 percent of the improper payments associated with SGA errors resulted from the beneficiaries' failure to report their work activity, while the remaining 36 percent of errors were associated with SSA's failure to schedule a work continuing disability review (CDR) after the beneficiary notified SSA that he or she had returned to work.

We know there are individuals who will purposely withhold or fabricate information to collect government benefits that they are not entitled to receive. Our agents investigate those who aim to defraud SSA and the Federal government. In FY 2011, our investigators reported more than \$410 million in investigative accomplishments, including about \$82 million in SSA recoveries and restitutions and about \$329 million in projected savings from programs such as the Cooperative Disability Investigations (CDI) initiative. CDI detects potential fraud and limits improper SSA disability payments. Members of the CDI Unit in St. Louis, Missouri, are with us today to discuss the program in detail.

In addition, OIG agents opened and closed nearly 7,200 cases in FY 2011, leading to 1,374 criminal prosecutions. OIG received more than 103,000 allegations of fraud, waste, or abuse in FY 2011, and while the majority of those allegations are related to SSA's disability programs, 43 percent of all allegations were specifically related to the DI program.

To give you an example of the types of DI fraud cases our agents pursue, an investigation by our Seattle agents recently led to prison sentences for a Washington couple that defrauded SSA and other State and Federal assistance programs out of almost \$300,000.

Anthony George, 37, of Washington, reportedly obtained a second Social Security Number under a fictitious name in 1982, and, in 1993, he used the fake identity to apply for disability benefits, claiming he could not work. During multiple medical interviews over the years, George, using the fake identity, pretended he was profoundly disabled and unable to work. George's wife, Roxanne, 35, accompanied her husband at an interview and pretended to be his neighbor, claiming George never worked and could not work.

However, an OIG investigation revealed Anthony George bought and sold used cars, lived in a \$430,000 house, and had more than \$10,000 in his bank account. Roxanne George reportedly further defrauded State and Federal assistance programs by failing to report that she lived with her husband and claiming to be a single mother with three children. During in-home visits and written statements, Anthony and Roxanne George pretended to be brother and sister, rather than husband and wife.

Both Anthony and Roxanne George pleaded guilty to Social Security fraud in September 2011. Earlier this month, Anthony George was sentenced to 27 months in prison and ordered full restitution of \$198,148 to State and Federal disability programs. Roxanne George was sentenced to six months in prison, six months in a halfway house and has agreed to pay \$91,527 for her fraudulent use of State and

Federal assistance programs. According to reports, when he addressed the court, Anthony George said, "I am a liar. It's all there in black and white."

In addition to our ongoing investigative work, we have made many recommendations to SSA in recent years that support OIG's focus on DI program integrity. Although disabled beneficiaries are required to report their work activity to SSA, they do not always do so. In a September 2010 Congressional Response Report, *SSA's Process for Identifying and Preventing Improper Payments to Individuals Who Return to Work*, we said the Agency should devote additional resources to effectively make improvements to identify and prevent DI overpayments, because reviewing work activity and earnings is a complex process that requires staff to consider all of the return-to-work provisions of the *Social Security Act*.

The OIG's work has shown that SSA identifies beneficiaries who return to work through employer reports, computer matching with other Federal and State agencies, and other Agency projects. However, SSA must balance service initiatives, such as processing new claims, with stewardship responsibilities, such as conducting timely CDRs. Therefore, the Agency has not reviewed work activity for all beneficiaries and recipients who have earnings that may be substantial enough to affect their benefit payments.

For example, in an April 2009 review, *Follow-up on Disabled Title II Beneficiaries with Earnings Reported on the Master Earnings File*, we found that SSA did not evaluate all beneficiary earnings, and overpayments resulted from work activity. We estimated that about \$1.3 billion in improper payments went undetected by the Agency to about 49,000 disabled beneficiaries.

Also, in a March 2010 report, *Full Medical Continuing Disability Reviews*, we determined SSA's number of completed medical CDRs declined by 65 percent from FY 2004 to FY 2008, resulting in a significant CDR backlog. We estimated SSA would have avoided paying at a minimum \$556 million during CY 2011 if the medical CDRs in the backlog had been conducted when they were due.

Medical CDRs are effective in reducing overpayments in the DI program. SSA estimates that every \$1 spent on medical CDRs yields at least \$10 in SSA program savings and Medicare and Medicaid. In FY 2011, SSA conducted more than 345,000 full medical CDRs, up from 325,000 in FY 2010. In FY 2012, it is intended the Agency will receive \$896 million for program integrity efforts like medical CDRs, and SSA has a goal of conducting 1.44 million CDRs total, including a proposed 592,000 full medical CDRs.

SSA estimates that meeting the goals for medical CDRs and other integrity efforts will result in about \$9 billion in savings over 10 years, including Medicare and Medicaid savings. However, SSA's Office of Quality Performance projects that at the end of FY 2012, SSA will still have a backlog of 1.2 million medical CDRs.

Additionally, SSA has said it would make the following improvements to its work CDR efforts:

- Dedicate staff to target the oldest CDR cases—initially, cases over 365 days old, then a gradual reduction of the age threshold;
- Prioritize earnings alerts by amount of earnings and work cases with highest earnings to minimize overpayments;

- Improve communication between operational components;
- Allocate additional staff resources to conduct work CDRs; and
- Provide additional information in disability publications on when, where, and how to submit work reports to SSA.

Also, SSA has developed a legislative proposal—the Work Incentive Simplification Pilot—to simplify work policies in the DI program, which would reduce administrative complexity and workloads, enhance correlation of program rules among SSA’s disability programs, and encourage DI beneficiaries to return to work because they would not face a permanent loss of benefits and Medicare.

We in the OIG believe reducing the complexity of SSA’s disability programs would help reduce millions of dollars in overpayments that occur each year. For example, because SSA has to evaluate earnings and work incentives before stopping benefits—and cannot simply stop paying benefits because wages are reported—simplifying these provisions could have a positive effect. A proposal exists to change the Federal wage-reporting process from annual to quarterly reporting. A change of this nature would increase the frequency that employers report wages to SSA, improving the timeliness of the work CDR process.

We also encourage SSA to support any legislative proposals that would improve the identification and prevention of improper payments in its programs. The OIG community is pursuing an exemption to the *Computer Matching and Privacy Protection Act of 1988* (CMPPA), which would exempt OIGs from certain restrictions of the *Privacy Act* that forbid the use of matching programs to compare Federal records against other Federal and non-Federal records. The CMPPA restrictions weaken OIG efforts to detect improper payments and identify weaknesses that make Federal programs vulnerable to fraud. In 2010, the Department of Health and Human Services (HHS) and HHS OIG obtained an exemption for data matches designed to identify fraud, waste, and abuse. SSA and SSA OIG are not exempt from the CMPPA.

Finally, we continue to pursue the establishment of a self-supporting program fund for activities, such as CDRs, to ensure payment accuracy—that applicants and beneficiaries are eligible at the time they apply and as long as they remain in payment status. The proposal would provide for indefinite appropriations to make available to SSA 25 percent, and to OIG 2.5 percent, of actual overpayments collected based on detection of erroneous overpayments SSA collects. These funds would be available until spent for stewardship activities.

The OIG has conducted, and continues to conduct, significant audit and investigative work to identify areas where SSA’s DI program can be vulnerable to improper payments, and to recommend actions to reduce and eliminate those errors. We will continue to provide information to SSA’s decision-makers and to this Subcommittee, and we look forward to assisting in these and future efforts.

I would like to conclude with a CDI case example, as the CDI program continues to be SSA and OIG’s most successful anti-fraud initiative. The CDI Program has received tremendous support from Congress. In late August 2011, Chairman Johnson was kind enough to visit the Dallas CDI Unit to learn more about the program and tour the Unit’s office, and Congressman Brady and I previously toured the Houston CDI Unit. We greatly appreciate your interest in the program. I’m also very happy the Subcommittee invited OIG Special Agent Tom Brady and St. Louis County Detective Paul Neske, members of the St. Louis CDI Unit, here today to discuss, in detail, the CDI program.

We currently have 25 CDI Units in operation across the country, and this example comes from the Tampa CDI Unit in Florida:

The Unit investigated a 54-year-old man who applied for disability benefits due to intestinal problems and shortness of breath, and the man said he used a walking cane for assistance, he could only walk for about a minute before he needed to rest, and he could not perform household chores. Tampa disability examiners referred the case to the CDI Unit due to inconsistencies in the medical evidence and the man's alleged impairments.

The CDI investigation, which included video surveillance of the man, revealed the man was hardly incapable of walking for longer than a minute and performing household chores. Surveillance showed the man lifting a large piece of wooden furniture and sweeping debris from the roof of his mobile home. Throughout the surveillance, the man did not display any apparent disabilities. With this information, the Tampa DDS denied the man's claim, preventing improper SSA payments.

Special Agent Brady and Detective Neske will provide more details on the CDI program in their testimony. I thank you again for the invitation to be with you here today. I would be happy to answer any questions.

Chairman JOHNSON. Thank you, sir. Keep up the good work. Special Agent Brady and Detective Neske, welcome. Please proceed.

Mr. BRADY. Thank you, sir.

STATEMENT OF THOMAS BRADY, SPECIAL AGENT, OFFICE OF THE INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION, KANSAS CITY FIELD DIVISION, ST. LOUIS, MISSOURI, ACCOMPANIED BY PAUL NESKE, DETECTIVE, ST. LOUIS COUNTY POLICE DEPARTMENT, ST. LOUIS, MISSOURI

Mr. BRADY. Good morning, Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee. My name is Tom Brady, and I'm a special agent with the SSA office of the inspector

general. I serve as the team leader for the cooperative disability investigations unit in St. Louis, Missouri. I am joined today by Detective Paul Neske of the St. Louis County Police Department, one of the St. Louis CDI unit's local law enforcement partners. Thank you for the invitation to testify.

We believe program integrity is a critical element in the Agency's efforts to secure the future of its disability insurance program. For the past 12 years, our unit has been extremely successful in detecting abuse in SSA's disability programs, and preventing payment on disability cases involving potential fraud.

CDI was established in 1998 with 5 units. There are currently 25 units covering 22 states, with the most recent unit opening in Jackson, Mississippi in November. Since the program was established, the program's work nationwide has resulted in approximately \$1.9 in projected SSA savings. Our St. Louis CDI unit includes two detectives and an intelligence analyst from the St. Louis County police department, one detective from the Sikeston, Missouri police department, an SSA operations supervisor, and a DDS hearings officer.

I now introduce Detective Neske, who will provide more information on the CDI process.

Mr. NESKE. Thank you, Tom. The process typically begins with the fraud referral from the state's DDS or SSA to the CDI unit. The referrals are benefit applications or reviews that have been identified as suspicious by DDS.

Types of disability fraud can involve malingering, filing multiple applications, exaggerating or lying about disabilities, and concealing work or other activities. The CDI unit team leader screens the allegations and works with the team members to investigate. Upon completion of the investigation, a report detailing our findings is sent to DDS, which determines whether a person is eligible for benefits. Some of our cases may result in criminal prosecution or civil penalties.

[Video.]

Mr. NESKE. For example, in this video you see a 45-year-old woman who had been collecting Social Security disability benefits since 2009. She alleged chronic back pain, and said she used the cane for assistance. But during our continuing disability review by the Missouri DDS in 2011, the disability examiner noticed that the woman walked without a limp. The case was referred to the St. Louis CDI unit for further investigation.

As you can see at her home, she was able to walk down the front steps and carry her cane under her arm. But on the day—but on that day, outside of the medical office, she struggled to climb the steps to the office door. After her appointment, the woman is seen climbing her front steps without the use of the cane, and she is even carrying a child's playseat.

We forwarded this information to Missouri DDS and they seized the woman's Social Security benefits.

Mr. BRADY. Thank you, Paul. Since 1999, the St. Louis CDI unit has closed more than 1,900 cases, resulting in more than \$84 million in projected SSA program savings. The Government Accountability Office has advocated expansion of the CDI program to all 50 states. We in the OIG share that enthusiasm. We look forward

to continuing to assist SSA in this vitally important and growing initiative, doing our part in maintaining the integrity of Agency programs, and protecting the taxpayers of this great nation.

Thank you again for the invitation to testify. Detective Neske and I would be happy to answer any questions.

[The prepared statements of Mr. Brady and Mr. Neske follow:]

U.S. House of Representatives

**Committee on Ways and Means
Subcommittee on Social Security**



Statement for the Record

Hearing on Combating Disability Waste, Fraud, and Abuse

**Tom Brady
Special Agent and St. Louis CDI Team Leader
Office of the Inspector General, Social Security Administration
Paul Neske
Detective, St. Louis County Police Department**

January 24, 2012

Good morning, Chairman Johnson, Ranking Member Becerra, and members of the Subcommittee. It's a pleasure to appear before you, and I thank you for the invitation to be here today. My name is Tom Brady. I am a Special Agent with the Social Security Administration (SSA) Office of the Inspector General (OIG), and I serve as the Team Leader for the Cooperative Disability Investigations (CDI) Unit in St. Louis, Missouri. I'm joined by Detective Paul Neske of the St. Louis County Police Department, one of our local law enforcement partners in St. Louis, to speak to you about the CDI program, a collaborative anti-fraud effort between SSA and the OIG. Today, we're discussing SSA's Disability Insurance (DI) program and SSA's efforts to secure the program's future. The CDI program has been extremely successful in detecting abuse in SSA's disability programs, specifically in preventing payment on disability cases involving potential fraud. The work of CDI Units across the country is a critical piece of the OIG and SSA's cooperative efforts to limit improper payments in SSA's disability programs.

As Americans continue to adjust their lives as the economy recovers, more and more people are turning to SSA. In Fiscal Year (FY) 2011, SSA received more than 3.2 million initial disability claims. Also, SSA paid about \$130 billion in disability benefits in FY 2011. These numbers challenge SSA's ability to provide world-class service delivery, creating workloads that strain resources, causing delays and backlogs, and leaving the Agency susceptible to fraud and abuse. As more individuals apply for benefits, allegations of unlawful disability claims will also increase across the country, challenging the OIG with regard to stewardship in SSA programs. The CDI Units play a key role in ensuring that SSA and the State Disability Determination Services (DDS) have an avenue to further explore disability claims that appear suspicious. The CDI program helps maintain the level of accuracy and integrity in these programs that the American public deserves.

SSA and OIG jointly established the CDI Program in FY 1998, in conjunction with State DDS and State or local law enforcement agencies, to effectively pool resources and prevent fraud in SSA's disability programs. The Units investigate disability claims under SSA's Title II and Title XVI programs that SSA employees believe are suspicious, and also investigate suspicious claims relating to other Federal and State programs. The CDI program's primary mission is to obtain evidence that can resolve questions of fraud before benefits are ever paid. CDI Units also provide reports to DDS examiners during continuing disability reviews (CDRs) that can be used to cease benefits of in-payment beneficiaries.

In 1998, the CDI program launched with Units in five states. The program currently consists of 25 Units covering 22 states, with the most recent Unit opening in Jackson, Mississippi, in November 2011. In FY 2011, the CDI program reported \$281.2 million in projected savings to SSA's disability programs—the program's greatest single-year savings total—for a return-on-investment of \$14-to-\$1. Since the program was established, through December 2011, the CDI efforts have resulted in \$1.9 billion in projected savings to SSA's disability programs and \$1.2 billion in projected savings to non-SSA programs.

Each CDI Unit comprises an OIG Special Agent who serves as the Team Leader, employees from that State's DDS and an SSA employee who act as programmatic experts, and State or local law enforcement officers. Tapping the skills of each member, the CDI Units receive benefit applications identified as suspicious by the DDS and, where appropriate, investigate these claims. In St. Louis, I have served as the Team Leader since February 2011, and I work side-by-side with Detective Neske, another detective

and an intelligence analyst from the St. Louis County Police Department, a third detective from the Sikeston (Missouri) Police Department, an SSA operations supervisor, and a DDS hearings officer.

The process typically begins with a fraud referral from the DDS or SSA to the CDI Unit. We also receive fraud referrals from SSA's Office of Disability Adjudication and Review, private citizens, anonymous sources, and other law enforcement agencies. Disability fraud can involve malingering, filing multiple applications, concealing work or other activities, and exaggerating or lying about disabilities. The CDI Unit Team Leader screens the referral, and if it's accepted as a case, the Team Leader will work with the State or local law enforcement members of the team to investigate the allegation, either by interviewing the applicant and third parties and/or conducting surveillances of the applicant. Upon completion of the investigation, a report detailing the investigation is sent to the DDS, where DDS staff serves as the ultimate decision-making entity in determining whether a person is eligible to receive a monthly disability benefit payment. If the claimant is already receiving benefits, DDS and/or SSA will determine whether the person's benefits should be continued or terminated. There are also, in some cases, opportunities for criminal prosecution and the imposition of civil monetary penalties or administrative sanctions.

In one recent case, our CDI Unit investigated a 45-year-old woman who had been collecting Social Security disability benefits since December 2009. At the time her disability claim was allowed, the woman alleged chronic back pain, and she said she was using a cane for assistance. During a CDR by the Missouri DDS in 2011, the woman alleged that she was unable to sit, stand, or walk for long periods, that she could not bend or squat, and that she spent "about 75 percent of her day in bed." She said she used a cane to move around, however, the DDS examiner noticed the woman had a normal gait, and her case was referred to the CDI Unit for further investigation.

During a subsequent surveillance, Detective Neske observed the woman exit her house and carry a wooden cane in her left hand. The woman walked down several steps and on a sidewalk with a normal gait toward a parked car. She reached the vehicle, placed the cane in the vehicle's back seat through the open front passenger window, opened the front passenger door, and sat in the front passenger seat.

I later observed the vehicle arrive at a doctor's office, where the woman was scheduled to have a consultative examination. The woman exited the vehicle near the front door to the office, and then walked toward the door, using the cane in her right hand for assistance. She had a limp in her gait and her pace was very slow and lethargic. When she reached the steps leading to the front door, she took each step one by one. She later exited the building in the same slow and lethargic manner, using the cane to walk down the steps, one by one. She entered the same vehicle that brought her to the appointment.

Detective Neske and I followed the vehicle, which stopped at a nearby gas station. The woman exited the vehicle and walked without a cane and with a normal gait to the station's convenience store. She then purchased two drinks, carried them outside, and entered the vehicle. The vehicle traveled to another residence, which the woman entered without the assistance of a cane, and she soon left the residence with a child's play-seat. She entered the vehicle and returned to her residence, exiting the vehicle, walking with a normal gait, and carrying the child's play-seat and her cane into her residence.

After receiving the CDI Unit's report, the Missouri DDS ceased the woman's disability benefits in June 2011. The woman requested reconsideration from the DDS, and in October, the DDS issued a decision that confirmed its original decision to cease her benefits. She then requested an appeals hearing before

an Administrative Law Judge, which was held on Jan. 9, 2012. The judge requested and received a copy of our surveillance video, and we are awaiting a final decision.

The St. Louis CDI Unit, like the other 24 CDI Units across the country, is continually saving money and ensuring the integrity of SSA's disability programs. Since the inception of the St. Louis CDI Unit in September 1999 through December 2011, the Unit has opened 1,926 cases and closed 1,903 cases, resulting in more than 1,200 cases of fraud or similar fault. The Unit's work has resulted in \$84.2 million in projected SSA savings and \$32.6 million in projected non-SSA savings.

Several years ago, the Government Accountability Office recommended expansion of the CDI program to all 50 states, and the OIG and local law enforcement agencies like the St. Louis County Police Department share that enthusiasm. The OIG and SSA are committed to expanding the CDI program and ensuring disability program savings for the Agency. Plans for future expansion are made on a yearly basis and are contingent upon the availability of funds; expansion sites for FY 2012 and FY 2013 have not been decided at this time.

The CDI program helps maintain the level of accuracy and integrity in SSA's disability programs that the American public deserves, and it reduces improper payments, deters fraud, and saves taxpayer dollars. We in the St. Louis CDI Unit are proud to make sure the people in our community who truly need assistance receive their benefit payments in an efficient and proper manner. We look forward to continuing to work with SSA in this vitally important and growing program.

I thank you again for the invitation to speak with you today, and Detective Neske and I would be happy to answer any questions.

Chairman JOHNSON. Thank you so much for your testimony. I appreciate it.

Mr. Clifton, welcome. Please go ahead.

STATEMENT OF STEVE CLIFTON, PRESIDENT, NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS

Mr. CLIFTON. Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, I am Steve Clifton, president of the National Council of Social Security Management Associations, NCSSMA, and the district manager of the Social Security office in Greeley, Colorado. Thank you for the opportunity to speak on behalf of the 3,500 NCSSMA members across the country. We

share your concern about the disability program and combating waste, fraud, and abuse.

First, let me thank you for the fiscal year 2012 appropriation SSA received, which included specific funding for program integrity initiatives such as medical continuing disability reviews. This funding is critical to process core workloads, and to improve payment accuracy. NCSSMA considers it a top priority to deliver quality service to the American public, and to be good stewards of the taxpayers' monies. SSA completed 1.4 million medical CDRs in fiscal year 2011. But a backlog of 1.3 million still exists.

The fiscal year 2012 program integrity funding could allow SSA to complete 592,000 full medical CDRs, an 82 percent increase over fiscal year 2010. This is a program integrity workload that saves at least \$10 in lifetime program savings for every \$1 invested.

In addition to conducting program integrity workloads after benefits have been paid, we believe that it is equally critical to prevent improper payments before claims are processed. While this hearing is taking place, the American public is calling or walking in to Social Security field offices all across the country to discuss retirement, the loss of a loved one, or the onset of their disability, frequently with a sense of urgency or even desperation, as they look to us for assistance.

Last fiscal year, we assisted almost 45 million visitors. We also received 3.2 million initial disability claims and nearly 860,000 hearing requests. Both were the highest volume in our history.

The same employees that process program integrity workloads also answer public telephone calls, take initial applications for disability and retirement benefits, and process claims, core workloads that are not program integrity funded, but do ensure the accuracy of payments. To this end, having adequate staffing levels in SSA field offices to process workloads, sufficient time to address complex issues, answer questions, and educate the public on their reporting responsibilities is essential to saving taxpayer dollars.

SSA employees want to do quality work and prevent overpayments at all points of contact with the public. Adequate resources to conduct training and to perform quality reviews for claims accuracy are also imperative to discharging SSA's stewardship responsibilities. Even with the fiscal year 2012 appropriation enacted, SSA field offices have been operating for over 15 months under a continuing hiring freeze, with very little overtime. Geographic staffing imbalances are occurring, due to uneven attrition across the country. These all detract from the efficiency of operations and serve to compromise efforts to improve payment accuracy.

We also see areas to improve efficiency and to prevent improper payments by expanding electronic services available to the public, simplifying disability rules such as enacting WISP legislation, implementing federal wage reporting, and expanding data exchanges such as workers compensation information. This would allow SSA to address payment accuracy and ensure program integrity, both before and after claims are processed.

We ask that Congress give thoughtful consideration regarding the future of SSA to ensure the preservation of this valued program. We sincerely appreciate the subcommittee's interest in the vital services Social Security provides, and your ongoing support.

A strong Social Security program equates to a strong America. And it must be maintained as such for future generations.

On behalf of NCSSMA members nationwide, thank you for the opportunity to present our testimony.

[The prepared statement of Mr. Clifton follows:]

**United States House of Representatives
Hearing**

**Subcommittee on Social Security
Of the Committee on Ways and Means**

**Testimony of
Steve Clifton
President**

**National Council of Social Security
Management Associations, Inc.**

**Hearing Series on Securing the Future of the Social Security
Disability Insurance Program**

January 24, 2012

Chairman Johnson, Ranking Member Becerra, and members of the Subcommittee, on behalf of the National Council of Social Security Management Associations (NCSSMA), thank you for the opportunity to submit this written testimony regarding the future of the Social Security disability insurance program. We share your concern for combatting disability waste, fraud, and abuse and offer our perspective on the disability insurance program and the important work addressed by the dedicated employees of the Social Security Administration (SSA).

NCSSMA is a membership organization of nearly 3,500 SSA managers and supervisors who provide leadership in nearly 1,300 community-based Field Offices and Teleservice Centers throughout the country. We are the front-line service providers for SSA in communities all over the nation.

In this role, our interactions with the American public often come at a time when they experience life-changing events such as retirement, loss of a loved one, or onset of disability. Oftentimes this translates into a sense of urgency or even desperation as they look to SSA for assistance. We are also the federal employees who work with your staff members to resolve problems and issues for your constituents who receive Social Security retirement, survivors and disability benefits (RSDI), and Supplemental Security Income payments (SSI).

Since the founding of our organization over forty-two years ago, NCSSMA has considered our top priority to be a strong and stable SSA, which delivers quality and timely community-based service to the American public. We also consider it a top priority to be good stewards of the taxpayers' monies and the Social Security programs we administer. Our testimony provides a summary of the current state of SSA operations, a review of SSA's current funding situation, the many challenges confronting our agency, and our recommendations for improving payment accuracy and the disability insurance program.

Despite SSA's enormous workloads and challenges, SSA's FY 2012 appropriation for administrative funding through the Limitation on Administrative Expenses (LAE) account was only slightly above the FY 2011 appropriation. While the dedicated funding to address program integrity workloads included in the FY 2012 appropriation is much needed and appreciated, the overall funding level does not allow SSA to cover inflationary costs for fixed expenses. This has resulted in a hiring freeze and drastic reduction of overtime hours in our Field Offices, as well as the postponement of agency initiatives to improve efficiency—all of which will have major public service repercussions on payment accuracy and overall program integrity.

SSA already has an acute staff-to-workload imbalance and is over-extended in critical program areas as the agency struggles to keep up with rapidly increasing workloads and existing backlogs. Congress must give thoughtful consideration to future appropriations for SSA to ensure the preservation of this valued program.

Preventing improper payments is important before claims are adjudicated as well as protecting tax payer dollars after claims are adjudicated. Properly funding SSA to process core workloads not eligible for specific program integrity monies and investing in program integrity initiatives improve payment accuracy will save taxpayer dollars and is fiscally prudent in reducing the federal budget and deficit.

The Current State of SSA Operations

NCSSMA has critical concerns about the dramatic growth in SSA workloads, and the need to receive necessary resources to maintain service levels vital to the 60 million Social Security beneficiaries and SSI recipients. Despite agency strategic planning, expansion of online services, significant productivity gains, and the best efforts of management and employees, SSA still faces many challenges to providing the service that the American public has earned and deserves.

Over the last several years, SSA has experienced a significant increase in Social Security claims. The additional claims receipts are driven by the initial wave of the nearly 80 million baby boomers who will be filing for Social Security benefits by 2030—an average of 10,000 per day. In addition, since 2008 there has been a surge in new initial claims filed due to poor economic conditions and rising unemployment levels.

In FY 2011, SSA Field Offices assisted 44.9 million visitors, received 4.8 million retirement, survivor and Medicare applications, and 3.2 million initial disability claims—the highest number in SSA history. Also in FY 2011, SSA completed 795,424 hearing requests—the largest annual total to date—and received 859,514 requests for hearings—an all-time high.

During FY 2011, there were 16.4 million new and replacement Social Security cards issued. Over this same time period, benefit verifications, status inquiries and Social Security card applications accounted for nearly 50% of all transactions where the public walked into a Field Office without an appointment.

To address program integrity and reduce improper payments, SSA completed 2.4 million SSI non-disability redeterminations in FY 2011. SSI redeterminations provide a return-on-investment of more than \$7 in program savings over 10 years for every \$1 spent, including savings accrued to Medicaid. SSA also completed over 1.4 million medical continuing disability reviews (CDRs) in FY 2011. Every \$1 spent on medical CDRs produces at least \$10 in lifetime program savings.

It is important to note that program integrity workloads are processed by the same SSA Field Office employees that answer public telephone calls, take initial applications for disability benefits, and develop and adjudicate benefit claims. In addition, it is also important to note, that while program integrity initiatives are vital in protecting taxpayer dollars after claims have been adjudicated, it is equally critical to prevent improper payments before they occur.

To this end, having adequate staffing levels in SSA Field Offices to process workloads, answer questions and educate the public on their reporting responsibilities is essential to save taxpayer dollars. Adequate resources to conduct training and to perform quality reviews to ensure that claims are adjudicated accurately are also imperative to discharging SSA's stewardship responsibilities.

Social Security Administration Funding

SSA appropriations are an excellent investment and return on taxpayer dollars. The additional funding Congress provided SSA in FY 2008-2010 helped significantly to prevent workloads from spiraling out of control, allowed the agency to accomplish its program integrity workloads, and assisted with improving service to the American public.

Despite SSA's enormous workloads and challenges, SSA's FY 2011 appropriation for administrative funding through the Limitation on Administrative Expenses (LAE) account was below the FY 2010 enacted level and \$275 million was rescinded from Carryover Information Technology (IT) funds. While SSA's FY 2012 appropriation was slightly above the FY 2011 amount and the dedicated funds for program integrity workloads is appreciated, this funding level still does not allow SSA to cover inflationary costs for fixed expenses. This has resulted in noticeable public service repercussions in FY 2011 and the first quarter of FY 2012, including a hiring freeze, drastic reduction of overtime hours in our Field Offices, closing all Field Offices to the public one-half hour earlier, and the postponement of agency initiatives to improve efficiency.

From the chart below, you can see the cumulative final appropriation levels SSA received from FY 2008 through FY 2011.

SSA FUNDING REQUESTS AND FINAL APPROPRIATIONS: FY 2008 – FY 2011					
(Figures in SBillions)	Commissioner's Request	President's Request	Final Appropriation	Final vs. President	Final vs. Commissioner
FY 2008	\$10.420	\$9.597	\$9.745	\$0.148	(\$0.675)
FY 2009	\$10.395	\$10.327	\$10.454	\$0.059	\$0.127
FY 2010	\$11.793	\$11.451	\$11.447	(\$0.004)	(\$0.346)
FY 2011	\$13.143	\$12.379	\$11.424	(\$0.955)	(\$1.719)
Total	\$45.751	\$43.754	\$43.070	(\$0.752)	(\$2.613)

Assessment of SSA Challenges

The FY 2011 and FY 2012 funding levels have impacted SSA and its dedicated employees. Field Offices across the country are struggling to address increased workloads without overtime while a hiring freeze remains in place. Employees, faced with these additional job stressors, frequently choose retirement in greater numbers, contributing to the loss of significant institutional knowledge, which exacerbates the problem.

SSA has a highly skilled but aging workforce with about two-thirds of its employees involved in delivering direct service to the public. Of SSA's 68,880 full-time and part-time permanent employees on duty as of October 1, 2010, 22.5% were eligible to retire in FY 2011. By FY 2015, 32.9% of SSA employees will be eligible to retire, and by FY 2020, this number will increase to 44.9%.

In FY 2011, there were approximately 3,600 federal and DDS employee losses in SSA. In FY 2012, it is estimated that another 4,400 federal and DDS employees will leave the agency for a total of nearly 8,000 losses in two years. As the chart below illustrates, through December 2011, there were 3,315 fewer employees in SSA Field Offices and DDS offices than in FY 2010.

SSA FIELD OFFICE AND DDS STAFFING FY 2010 - PRESENT						
	Field Office (FO) Without TSC	FO Staffing Change +/- vs. FY 2010	Disability Determination Service (DDS)	DDS Staffing Change +/- vs. FY 2010	TOTAL FO & DDS Staff	FO & DDS Staffing Change +/- vs. FY 2010
FY 2010 - 9/30	30,623		16,193		46,816	
FY 2011 - 9/30	29,202	-1,421	15,469	-724	44,671	-2,145
FY 2012 - 12/31	28,767	-1,856	14,734	-1,459	43,501	-3,315

This is an incredible loss of institutional knowledge considering that the agency is confronted with exploding workloads resulting from aging baby boomers, very complex programs to administer, and the volume of important program integrity work to be accomplished. With the hiring freeze in SSA Field Offices, there is no relief in sight, and the agency is quickly becoming severely understaffed.

These resource reductions significantly compromise SSA's ability to provide complete attention to claims accuracy and properly discuss beneficiary reporting responsibilities. Managers and supervisors are frequently pressed into direct service duties such as answering public telephone calls, interviewing and adjudicating claims for benefits, and processing program integrity workloads. This prevents them from essential management responsibilities, including the oversight of quality initiatives, addressing critical on-going training, and ensuring efficient field operations.

Geographical staffing disparities have occurred and will only increase as ongoing attrition spreads unevenly across the country. This leaves many offices significantly understaffed. Managers report the following situations in their offices:

- *We are down to 24 (from 30) employees and one of our SRs just suffered a major heart attack. The other offices in the state are at (or will soon be) in identical circumstances. It is a daily challenge to keep morale afloat. We struggle every day to make the hard choices of what we can and cannot get done. The staff is feeling disillusioned, given all of the negative discussions concerning the future of the federal workforce and the uncertainty regarding our future. The other offices in the state have indicated that they have lost staff as a direct result of this uncertainty. From a succession management standpoint, we are disenfranchising those who would carry the agency forward into the future.*
- *The office had 27 employees but currently has 15 on duty. The office is receiving help with processing their Internet claims and answering their phones.*
- *It is getting more serious daily. My office is at a historically low staffing point as no doubt many offices are. Yet we are providing assistance to another office that is down from 21 to 12 employees in the span of about a year.*
- *A manager is expected to lose 60% of her staff early next year and with the hiring freeze, she doesn't expect to get any replacements. Even if she did, it would take at least a year before those employees could really be productive. With the loss of overtime, the ability to process work has also been significantly impacted.*
- *We received about 150% increase in SSI redeterminations this year. Because of this, we have needed to shift all of the initial claims appointment over to our T2 unit. This has caused our appointment calendar to be extended and we are now receiving assistance with our RSI appointments. In trying to keep our office wait time under 30 minutes, we have been unable to maintain adequate phone coverage.*

One of SSA's top priorities, and most significant challenges, is eliminating the disability hearings backlog. SSA has made a major resource investment to improve this situation and the goal is to eliminate the backlog by FY 2013 and to improve processing time to 270 days. The Commissioner has implemented several initiatives to achieve this goal, but this will depend on the available resources provided by SSA funding and the volume of new hearings received.

SSA's efforts have resulted in significant progress in reducing the amount of time a claimant must wait for a hearing decision. In December 2011, the average processing time for a hearing was 343 days, a 171 day improvement over Fiscal Year 2008. Even though this is positive news, Hearing Offices are facing a significant wave of new hearings with approximately 140,000 more

hearings filed in FY 2011 than were filed in FY 2010. This is attributable to the increased number of disability claims filed since the economic downturn that began in 2008.

SSA Payment Accuracy and Program Integrity Investments

SSA issues approximately \$800 billion in benefit payments annually to 60 million people. Balancing service commitments with stewardship responsibilities is difficult given the complexity of the programs SSA administers, but the reduction of improper payments (both overpayments and underpayments) is one of SSA's key strategic objectives.

- In FY 2010, the accuracy rate for Old Age, Survivors, and Disability Insurance (OASDI) payments was 99.6 percent for overpayments. The comparable accuracy rate for FY 2009 was 99.6 percent.
- In FY 2010, the SSI accuracy rate was 93.3 percent for overpayments. This represents an increase of 1.7 percentage points over the FY 2009 overpayment accuracy rate of 91.6 percent.

These figures illustrate that SSA pays a very high percentage of benefits accurately. To adjudicate claims with an accurate payment amount and to ensure that claimants reporting responsibilities have been fully explained, an adequate number of trained SSA employees are of paramount importance to program integrity.

Equally important is sufficient time to address these complex issues. The hiring freeze in SSA Field Offices, the higher attrition rate, and increasing workloads, all serve to compromise efforts to improve payment accuracy. SSA places a high priority on meeting workload goals, but meeting these goals and maintaining payment accuracy requires sufficient resources.

One important initiative to provide relief to SSA Field Offices and to improve efficiency is increasing Internet services. In FY 2011, SSA received 999,203 retirement applications online and 289,418 Medicare-only applications online. The percentage of retirement applications filed online increased to nearly 41 percent, from approximately 37 percent in FY 2010. In FY 2011, almost 33 percent of disability applications were filed online compared to 27 percent in FY 2010.

The expansion of electronic services available to the American public has helped to alleviate the number of visitors and telephone calls to SSA. NCSSMA believes that SSA must be properly funded to continue to invest in improved user-friendly online services. Electronic services that are extended to benefit estimates, benefit verifications, Social Security card replacements, claim status inquiries, and processing routine transactions (such as change of address, change of direct deposit, etc.), in real time, would reduce contacts with Field Offices and allow employees to concentrate on efforts that would promote payment accuracy and program integrity.

In the Budget Control Act of 2011, Congress authorized \$13 billion in additional funds above the discretionary budget caps over the next ten years exclusively for program integrity work. We appreciate this much needed support to ensure the future viability of our disability and SSI programs. Once benefits are paid, two powerful tools for reducing improper payments and maximizing program integrity investments are conducting medical CDRs and SSI

redeterminations.

- Medical CDRs determine whether disability benefits should be ceased because of medical improvement. Every dollar spent on medical CDRs produces at least \$10 in lifetime program savings.
- SSI redeterminations review nonmedical factors of eligibility, such as income and resources to identify payment errors. Every dollar spent on redeterminations produces at least \$7 in lifetime program savings.

SSA budgetary constraints have caused a shortfall between the number of medical CDRs due and the number conducted each year. Although SSA achieved its target for full medical CDRs by completing over 345,000 in FY 2011, a backlog of approximately 1.4 million cases still exists. The SSA Office of Inspector General has identified this as one of SSA’s most serious management challenges. As a result of the additional program integrity funding, SSA’s FY 2012 goals include completing 592,000 full medical continuing disability reviews (CDRs), an increase of 82 percent over FY 2010. It is critical that SSA receives the necessary funds to eliminate this backlog by FY 2016.

The chart below is based on data from the Social Security Administration Office of Quality Performance. It illustrates the cost savings achieved from completing SSI redetermination program integrity workloads.

SSI REDETERMINATIONS CHANGE RATE							
Review Name	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11
Redeterminations/Limited Issue Completions	2,462,086	1,414,503	1,038,943	1,220,664	1,730,575	2,445,550	2,216,145
Overpayment Benefits (Millions)	\$2,211.0	\$1,378.7	\$1,141.4	\$2,139.2	\$2,843.1	\$3,764.7	\$2,974.30
Underpayment Benefits (Millions)	\$1,247.8	\$849.4	\$709.7	\$1,085.5	\$1,034.1	\$1,425.0	\$1,323.30

Two major causes of improper payments for disability beneficiaries relate to return to work activities resulting in performing substantial gainful activity (SGA) and the detection of unreported financial accounts and wages. SGA is determined during work CDRs and financial accounts affect SSI eligibility.

SSA initiates work CDRs when earnings are reported to a disabled individual’s record that could affect their benefit eligibility. Local SSA Field Offices handle self-reported earnings as well as many third party earnings reports. The Office of Disability Operations (ODO) or Program Service Centers (PSCs) conduct reviews based on earnings reports posted on the disabled individual’s earnings record.

Regardless of the source of work reports, contact is required with the disabled beneficiary, employers, and often others providing support to the individual to determine if the earnings reported affect disability. In addition to verifying the work activities, SSA must evaluate whether this work is SGA and consider such things as impairment related work expenses (IRWE), subsidies, extra assistance with duties and other special accommodations to determine

continuing eligibility. This work is funded out of SSA's general operating budget, not the dedicated program integrity funds.

The work activity of disabled beneficiaries is a significant cause of overpayments. SSA identifies the majority of these cases through the current work CDR process, but a percentage are undetected because either the wages were not identified or work CDRs were not completed on identified reports of wages.

Prompt attention to this workload prevents or minimizes the amount of overpayments. The ability of SSA to promptly and efficiently address these workloads is a direct function of having sufficient time and an adequate number of employees. Generally, the same employees who evaluate work CDRs are also the same employees that take and adjudicate initial claims, answer public telephone calls, and process other important agency workloads. NCSSMA believes a continued investment to address work CDRs would enhance SSA's program integrity efforts.

SSA must improve work reporting mechanisms for disability beneficiaries to make this activity more "user friendly" and to ensure payment accuracy. While SSA has made significant strides in improving mechanisms for reporting work activity of disabled beneficiaries, additional investments in technology in this area would result in fewer overpayments. There are impediments to reporting work activity with the SSI wage reporting telephone number. Additionally, there is no SSA online tool for disabled beneficiaries to report work activity. NCSSMA recommends investing in technological improvements to improve wage reporting. Increasing the timeliness of wage reporting would enhance tax administration and improve program integrity for a range of programs, thereby improving payment accuracy.

NCSSMA also supports legislative changes and/or regulatory proposals that improve the effective administration of the Social Security program with minimal effect on program dollars. We believe the following proposals have the potential to increase administrative efficiency, lower operational costs, and save taxpayer dollars. These proposals would increase the accuracy of SSA payments.

- **Enact the Work Incentives Simplification Program (WISP):** This proposal would replace the complex work provisions in the Social Security Disability Program, including the Trial Work Period, SGA Determinations, Extended Period of Eligibility and Expedited Reinstatement, and replace these provisions with an earnings test comparable to that of RSI beneficiaries under full retirement age. This provision would simplify the entire work incentive process for the beneficiary and SSA. Work years saved by SSA currently spent in enforcing the prior provision could be redirected to other priority workloads.
- **Federal Wage Reporting:** This proposal would require employers to report wages quarterly; the proposal would not affect reporting of self-employment. Increasing the timeliness of wage reporting would enhance tax administration and improve program integrity for a range of programs. This program would give SSA more immediate access to earnings information for the SSI program, thereby decreasing underpayments.
- **Require that SSA be provided with Workers Compensation Information:** Providing workers compensation data exchange information, in an electronic fashion, to SSA would

greatly reduce the number of times SSA personnel must contact state governments, local governments, and private insurance providers. Having accurate information at the time of determinations would ensure more accurate decisions, thereby reducing incorrect payments. This proposal would save both administrative and program dollars.

Conclusion

NCSSMA recognizes in the current budget environment it is difficult to provide adequate funding for SSA. However, Social Security is one of the most successful government programs in the world and touches the lives of nearly every American family. We are a very productive agency and a key component of the nation's economic safety net for the aged and disabled.

With sufficient resources, program simplifications, legislative reforms, enhanced data exchanges, and expanded electronic services, SSA can address payment accuracy and ensure program integrity, both before and after claims are adjudicated. A strong Social Security program equates to a strong America and it must be maintained as such for future generations.

We sincerely appreciate the Subcommittee's interest in the vital services Social Security provides, and your ongoing support to ensure SSA has the resources necessary to serve the American public. We also request your continued support for funding dedicated program integrity workloads as well as adequate funding to address core workloads not eligible for specific program integrity monies, which ensure accurate payments, saves taxpayer dollars and is fiscally prudent.

Failure to process program integrity workloads has adverse consequences on the federal budget and the ongoing administration of SSA programs. NCSSMA is confident that this increased investment in SSA will benefit our entire nation.

On behalf of NCSSMA members nationwide, thank you for the opportunity to submit this written testimony. We respectfully ask that you consider our comments, and would appreciate any assistance you can provide in ensuring the American public receives the critical and necessary service they deserve from the Social Security Administration.

—

Chairman JOHNSON. Thank you, sir. I appreciate all your testimony.

Mr. Brady is not here yet. He had an illness in the family so he had to leave town. But we appreciate his support. And he is behind everything that you all are doing. And I thank the IG for getting out there where the action is.

As is customary, for each round of questions I will limit my time to five minutes and ask my colleagues also to limit their time to five minutes.

Mr. O'Carroll, I want the Subcommittee to hear about the cases I saw when I visited your office in Dallas. Would you walk us

through that video, and then I'll ask questions on the other side of it?

Mr. O'CARROLL. Yes, Mr. Chairman. Thank you for your interest in this. If you remember when you were in our Dallas CDI unit, we showed three videos. The first one was a person conducting some business that—we had a video camera with us and were showing that he was actively engaged in business. And then there was another one with a lot of driving and other things which really wouldn't lend themselves too good for this—you know, for showing here today.

This one I did bring with me today, is one of the ones you saw. And it's about a 53-year-old woman who alleges chronic back pain, headaches, loss of vision, and she says she uses a walker for mobility and is incapable of driving. She says she falls down often because her legs give out.

[Video.]

Mr. O'CARROLL. I think this one is going to speak well for itself. You can see her getting into a taxi without the walker. Now she comes back to her car or her truck, and heads to a convenience store. Then, when she goes to the convenience store she purchases three cases of soda, which you can see her carrying here. And as a result of that, obviously, we turned this information over to the DDS and they turned down her application.

Chairman JOHNSON. I wonder how many of those go on that we don't know about?

Mr. O'CARROLL. Yes, these are the ones that we actually see—

Chairman JOHNSON. Yes.

Mr. O'CARROLL.—and can record. There are thousands more out there that we just don't have the opportunity to investigate.

Chairman JOHNSON. Are the states working with you pretty well?

Mr. O'CARROLL. Yes, sir. The states are working with us very well. We have very good cooperation with the states. It's getting a little more difficult with funding in some of the states where they're not as ready to help us as they used to be in the past. And I can give you details on that.

Chairman JOHNSON. Thank you. Ms. Colvin, according to the GAO, in fiscal year 2010 Social Security failed to collect \$5.4 billion in cumulative disability overpayments. GAO also told us Social Security has no performance goal for debt collection. Is collecting the debt not a priority for Social Security?

Ms. COLVIN. I think that we—yes. Collecting the debt is absolutely one of our highest priorities. I believe that we have a very excellent debt collection program. I will say that our cumulative debt is about \$15 billion. Last year we had newly established debt of about \$5.6 billion. But last year we also collected \$3.2 billion in debt.

It is easier for us to collect the debt when the beneficiary is on the rolls. We can simply deduct the monthly payment that's been determined from the monthly benefit. It becomes much more difficult when the individual is no longer on the rolls. However, we have a number of tools that we use to collect the debt. We have the tax offset, we have regular billings where we attempt to collect

and have the ability to report debt to the credit reporting agencies. We have numerous tools and we're always looking at additional tools. So it does remain a high priority.

I do want to point out that many of these individuals who receive an overpayment are most vulnerable. They are probably our most destitute. And therefore, the amount that we are able to collect on a monthly basis is small.

But we are very aggressive. The debt now, with the new rule with IRS, we are no longer limited to 10 years. So we are implementing a system that will allow us to continue to go after that indefinitely. And then, if someone leaves the rolls and come back on the rolls again, we use a process that would allow us to reduce the amount. If they receive another Federal benefit, we can also offset that against the amount.

So, I believe that we have a very strong debt collection process in place. We have to balance what we are able to do with other resources. And so we are always looking at what is the most cost-effective way of doing this.

Chairman JOHNSON. Thank you. Mr. Brady and Detective Neske, what's the most common way people commit disability fraud and what tools do you have to use for your investigations?

Mr. BRADY. Some of the most common areas that we see are individuals that are malingering, exaggerating their symptoms, or just outright, straight-out lying about their disabilities.

We also find that there is information out there in the public about steps to take to get on disability. In fact, recently we became aware of a document that prisoners had created—a prisoner had created called "15 Steps to SSI." And basically, it explains to them the process of trying to get on disability.

Chairman JOHNSON. Well, thank you for the work you all do.

My time is expired. Mr. Becerra, you are recognized for five minutes.

Mr. BECERRA. Thank you, Mr. Chairman. And thank you all for your testimony. And to those of you who do the work out there, thank you so much for the effort. And I suspect you would love to have a few additional folks on your team to be able to do some of this, because we all know that that's not the only person out there that you could videotape.

A few questions. Mr. Brady, let me ask you first. How do you—what's the source of the information that you get that allows you to move on that tip and start the investigation?

Mr. BRADY. The majority of our allegations come in from either DDS or the Social Security Administration. But we also receive tips from the general public, anonymous sources. Also ODAR, part of Social Security. And, based on that information, we will have our—do an extensive background history on that person.

Mr. BECERRA. Okay. So you can actually—we can encourage the public to submit those complaints or that information, those tips, directly to you?

Mr. BRADY. Absolutely.

Ms. COLVIN. Yes.

Mr. BECERRA. I suspect they also can give them directly to the Social Security office, and they would then send that to you.

Mr. BRADY. Yes, they do.

Mr. BECERRA. So the majority of your cases come through your—the Social Security system itself, through the personnel at the Social Security offices.

Mr. BRADY. Correct.

Mr. BECERRA. Okay. And give me a sense. What's the typical case of fraud? A case like this, where it's clear that somebody was abusing the system, what's a typical punishment that someone like that would face?

Mr. BRADY. Well, generally, in most of the CDI cases, since—and in the example we gave today, it was an initial claim. And DDS subsequently denied that person's claim. So—

Mr. BECERRA. Okay. Give me a sense—not someone who hasn't been collecting, because we just deny them and I suspect they go away, unless they're crazy enough to try again. What about someone who has actually been collecting for some time? Give me a sense of the typical penalty that they're going to face?

Mr. BRADY. In those cases that we present to the U.S. Attorney's Office for prosecution, it could range from anywhere to probation to some time in prison, depending on what the loss is to the government.

Mr. BECERRA. Okay. So let me ask you now—and also to Officer Neske, Mr. Neske—that particular question. Are the penalties severe enough for those that we prove defrauded the Social Security system and the taxpayers?

Mr. BRADY. That's—if you're asking my personal opinion—

Mr. BECERRA. I am.

Mr. BRADY [continuing]. I think in some respects they need to be more severe or they need to—there needs to be more of a penalty as far as—what we see, what frustrates us, is that a person will apply for benefits, they will get denied, and then the next day they're applying—

Mr. BECERRA. They're right at it again. Mr. Neske, would you like to comment? Is the penalty severe enough for those who commit that kind of fraud?

Mr. NESKE. Some of it is desperation.

Mr. BECERRA. Your microphone.

Mr. NESKE. Can you hear me now?

Mr. BECERRA. Yes.

Mr. NESKE. A lot of it's desperation. They don't have anywhere to turn to for income.

Mr. BECERRA. Yes.

Mr. NESKE. You can kind of sympathize with them and understand, but it doesn't make it right.

Mr. BECERRA. And I suspect in those cases where there is some desperation involved, the prosecutor or the judge is probably going to have some empathy there, and try to make the punishment fit the crime.

But to my thinking, we should descend on folks who do this. Because if you don't, then it only encourages neighbors and others who see this and say, "Hey, you can do it? I can do it." And I would hope that in the clear cases that we make—these are the poster child cases, where you put them out there and say, "Do this, and you're in trouble. So if you're close to getting a disability benefit,

don't mess around because you may deprive yourself of, in the future, being able to get it."

Now, Mr. O'Carroll, let me ask this. You mentioned that if we reduce the CDR backlog, we reduce overpayments. So let me ask you this. If we had more personnel to conduct these CDRs so they could more quickly reduce the backlog of CDRs, would we reduce the level of overpayment?

Mr. O'CARROLL. The easy answer on that is yes, which—but in a little bit more definition to it is that they are very—

Mr. BECERRA. And give it to me in 20 seconds, because otherwise I won't get to ask other questions.

Mr. O'CARROLL. Okay, okay. Real quick on it is that they're very difficult labor-intensive to do. The more people doing it, the better on it. The more resources that are put towards doing the CDRs, the better for it. And it's decisions that have to be made on prioritizing.

Mr. BECERRA. Okay. So you can't just do a CDR quickly, or with just one or two individuals. That takes time. And I suspect Mr. Clifton would say you—it takes a lot of his personnel moving away from providing someone the assistance they need to apply for a Social Security number or apply for retirement benefits to do these CDRs, which are essential to make sure that we're not giving money to people who don't deserve it.

But that means unless we're going to increase the backlog of people who are applying for their benefits appropriately, we need to have the personnel who can do this very important work, because we know the return, 10 to 1 on the dollar, is excellent.

So, it's all pointing to me that no one is telling me that Social Security personnel are sitting on their duff, doing nothing. It's that we found out that if we pursue some of these—I would call some of these folks crooks—we can get some results. And in many cases, it's not that they're crooks, it's that they're desperate. Or, as we find—and, Ms. Colvin, I know my time is up, but I suspect you would say to me that the majority of cases where there has been an overpayment to an individual aren't the case of fraud, it's a case of mistake, either by the individual, who had a very complicated case, or maybe the Agency missed something. But it was more an error, and then once you correct it you try to see if you could collect the overpayment.

Ms. COLVIN. Absolutely. I couldn't say that better.

Mr. BECERRA. Well, I hope we continue to give you the resources. I'm glad that after—at the beginning of the year the Congress cut, or essentially left flat, the funding for that program integrity work—that we were able to get the money last month to actually beef it up. But the more we can do this—and I think the more we can hang it out there like a poster child, that if you do this stuff, you know, you do the crime, you pay the fine—I think the better off we'll be, and let only those who legitimately deserve the benefits get them.

So, Mr. Chairman, I thank you for this hearing, and thank you for the time.

Chairman JOHNSON. Thank you. Mr. Smith, you're recognized for five minutes.

Mr. SMITH. Thank you, Mr. Chairman. And Mr. O'Carroll, we have heard a little bit about the penalties. Sometimes it is just denial of benefits. Other times it is jail time, perhaps more. Can you elaborate?

Mr. O'CARROLL. Yes, sir. It's pretty much what we're—again, with the CDI units we're talking about here is the deterrent at the beginning of it. We are trying to keep the money from being spent.

Then, the other one there was some discussions on is that we do have a lot of tools out there in terms of jurisdictions that we can use for people defrauding the United States Government. Unfortunately, what we're up against with a lot of these things is that the amount of fraud, in terms of the dollars, when we go to a U.S. Attorney's office for a prosecution on these things, is so much less than, you know, bank robbers or whatever it is. In the priorities of the jurisdiction, it's difficult to get prosecutions for a lot of the disability fraud that we have.

So, for that reason, on it—is that we use—you know, we do try to bundle them, to get U.S. Attorney's offices to prosecute on it. As Mr. Brady said on it, the range of prosecution or penance—penalty of it goes anywhere from probation to prison time. But I got to admit, it's usually going to be the more egregious ones that are going to be getting the prison time on it.

Another tool that we are using is civil monetary penalties, so that if we can't get them prosecuted, at least we're going after any of the resources that they have.

Mr. SMITH. Do you have the authority to do that already?

Mr. O'CARROLL. Yes, we do.

Mr. SMITH. Okay. So, in terms of resource allocation, because I mean, that's kind of what this boils down to, can you share kind of the cost benefit analysis of, I mean, what kind of resources it takes? You know, savings—of course we've got the bigger issue of wanting to send a message that this is not good, and prevent others from even trying. Can you elaborate on that?

Mr. O'CARROLL. Yes, I can. Usually on the cost of doing this thing—for example, CDRs that we were talking about, there is sort of a range on them. To do a medical CDR, where somebody is coming in, where we believe that they are feigning a medical issue or whatever, they cost about \$1,000, and they take a, you know, series of months.

The next one down on it is that when we do the worker—SSA does a work CDR on it type of thing, there is—that's the next one down. That's about \$400 per one that they do, to give you an idea of the cost on it. And then a mailer that goes out is about \$20.

So, those are pretty much the costs going into it. And just to kind of use the flip side of it is that the savings that we have on the back end that we're experiencing on this thing is that we're seeing about a \$90,000 savings for every person that doesn't come—get on to benefits is what we've been figuring out on our adjustment for that.

And then, when we're also figuring is anybody who is in pay, we're going to be taking whatever they would have been getting for that percentage, or a percentage of what they're getting on their pay, and then multiplying that for it by—we're usually throwing

them off the benefits for about five years. So we can include that into it.

And then, the other one that's not seen on this thing is it's sort of a waterfall effect on different ones with state supplements that are put into it. We're taking a look at other benefits that are coming for—you know, that are out there on it. And then all those get thrown in that are savings to the government, too.

Mr. SMITH. How much review is there, in terms of the supporting witnesses? Is there review of that situation or that process, where someone may have erred, or even worse than that, in terms of providing supporting information?

Mr. O'CARROLL. Yes, again, that is significant. I don't really have a good figure on how much time would go into the prepping on something like that. But in terms of, you know, the witness interviews and all the other ones that, you know, pretty much we're talking about today are all very time-consuming and all go into the length of time it takes us to do an investigation.

Mr. SMITH. Thank you. I yield back.

Chairman JOHNSON. Thank you. You care to question Mr. Stark?

Mr. STARK. May I?

Chairman JOHNSON. Yes, sir. Mr. Stark, you are recognized.

Mr. STARK. Well, thank you, Mr. Chairman. And thank you for this exceptional hearing. Let it be known that the scooter store called me this morning and I said no, I wouldn't ride their scooter to the hearing.

[Laughter.]

Mr. STARK. And also, this hearing is a first—

Chairman JOHNSON. You had the IG watching you.

Mr. STARK. The hearing is really a first for me, because it is the first time I have ever been in a room with a detective where I get to ask the questions.

[Laughter.]

Mr. STARK. But I want to congratulate Ms. Colvin on the excellent record that SSA has had under your leadership in these areas. How many claims a day does—do you have any idea—that SSA has to process under this program?

Ms. COLVIN. I don't know that I can give you—

Mr. STARK. Thousands?

Ms. COLVIN. Thousands, yes. The staff do both initial claims, as well as CDRs, et cetera. I can certainly provide you the specifics—

Mr. STARK. No, I just—

Ms. COLVIN. But it is significant.

Mr. STARK. It is many thousands, I would—

Ms. COLVIN. It is many thousands. And—

Mr. STARK. And wouldn't it— isn't it correct that most of the overpayments or incorrect payments, if you will, are not fraud? They are mistakes?

Ms. COLVIN. I am really pleased that you raised that. Most of the improper payments are not fraud. In fact, improper payments are overpayments. The reason for most of the overpayments are directly related to the work activities, like the substantial gainful ac-

tivity. People are confused about when they report and how—and the other pieces of that legislation.

For instance, they have a nine-month trial work period. They have an extended eligibility period. They can earn up to the substantial gainful activity amount, which I believe in 2012 is \$1,010. So, even when we get a work report, we still have to review all of those things to determine whether or not the payment is impacted. And that's why it takes us so long to do a work CDR.

Also, no one has mentioned that improper payments are also underpayments, which means that we have made some errors and people are entitled to a higher benefit. And I think focusing on underpayments is just as important as focusing on overpayments.

Mr. STARK. It is important to get it right. If the system—

Ms. COLVIN. It's important to get the right check to the right person the right time. And we take very seriously fraud. As was mentioned, our team referred over 19,000 suspicious activities last year. They do not want to see the program jeopardized by individuals getting a benefit to which they are not entitled. And this is something we focus on daily, with everything we do.

Mr. STARK. And I thought that guy following me around with a camera was just interviewing me for a political ad.

[Laughter.]

Mr. STARK. I wanted to suggest to my colleagues, if they don't already know—but I will bet that for all of us sitting here on the dais, certainly in my office—next to immigration cases, the most case work, as we call it in our district office, comes in regard to people with questions about Social Security or disability benefits.

And, Mr. Clifton, I just have to congratulate your colleagues, or the people you work with. We—our office goes to the San Jose office. And they have just been—over the years, I am talking 20 years—this office has just been more than helpful. And I hope you will extend to them our gratitude from Fremont, California, for all the help they give us. Because we couldn't handle it all. Many of them take special expertise, which the people that work in your department enjoy. And we really appreciate it.

So I wanted to just, in all seriousness, thank those of you who are working to make this system work. We have to—the public has to make sure that they think it is on the level. And Sam, I just—I think you are heading in the right direction. We have got to see—we want to see the program continue. A few years, you will be old enough to get into it, but don't rush. And I will let you know what it is like.

Then, as I say, it is an important—one of the most important social policies that we have in this country, is taking care of seniors and children. And I just appreciate all of our witnesses' efforts in the direction of making the program secure, fair, accurate. And I know that you need help.

Ms. COLVIN. We do.

Mr. STARK. I think we all know that. And you can't cut—what did you have to lay off, 4,000 employees? Something like that?

Ms. COLVIN. Not layoff, but they retired and—

Mr. STARK. You couldn't rehire.

Ms. COLVIN. We could not rehire them, yes.

Mr. STARK. And you probably need more than that. And I hope that we can find a way to get the necessary resources.

Ms. COLVIN. We need adequate sustained funding.

Mr. STARK. Okay, thank you. We will try and see what we can do to do that.

Ms. COLVIN. Thank you.

Mr. STARK. Thank you again, Mr. Chairman.

Chairman JOHNSON. Thank you, Mr. Stark.

Mr. STARK. I yield back the balance of my time.

Chairman JOHNSON. The time frame on the continuing review is what that CDR is. We use acronyms around here, and a lot of people don't know what we are talking about. Are the time frames that are set for CDRs okay, or do we need to look at them?

Ms. COLVIN. I believe that the reviews that we have done indicate they are adequate. Depending upon the disability, it could be within one to three years, if medical improvement is expected. If medical improvement is not expected rapidly, it could be three to five years. And then, of course, there are some conditions where medical improvement is not expected at all, a terminal illness or something of that nature.

And we have a profiling system that allows us to select the CDRs that would have the highest return on investment, and that's a very elaborate matrix. I am not able to explain that here, but I could provide that to you later. But I think that the time line works. In fact, we have got a backlog because we can't get to them within the time frame that we should be. We have about 100—

Chairman JOHNSON. Yes, more than you can handle.

Ms. COLVIN [continuing]. 1.3 million—

Chairman JOHNSON. Yes, okay.

Ms. COLVIN [continuing]. that we can't handle.

[The insert of Ms. Colvin follows:]

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SSA employs a series of statistical scoring models to predict the likelihood of medical improvement for adult Disability Insurance (DI) beneficiaries and Supplemental Security Income (SSI) beneficiaries who receive benefits due to disability. These statistical scoring models apply mathematical formulas developed through our historical disability data to generate a statistical score that equates to the predicted likelihood of medical improvement at a given point in time. The disability data we use to estimate these scoring models consist of longitudinal data files based on our core transactional, case processing, and management information systems; they include a wide array of medical, demographic, and disability case-related information on our disability beneficiaries. These scoring models allow us to conduct CDRs in a cost-effective and efficient manner that is also less burdensome for disability beneficiaries.

The key predictive variables in the models include the age of the disabled individual, time on the disability rolls, the type of impairment involved, and the number of prior full medical reviews the individual has received. The statistical scoring models are periodically re-estimated and are monitored on an ongoing basis to ensure continued accuracy and reliability.

Based on the CDR statistical scoring model results, a case selected for a CDR will receive one of two possible treatments. The first treatment is the direct release or full medical review CDR process, which applies to beneficiaries with profile scores signifying a relatively higher likelihood of medical improvement. In most of these cases, we will interview the beneficiary and obtain evidence to evaluate the beneficiary's condition. We will then determine whether the beneficiary has medically improved.

The second treatment, which we can process without field office, processing center or disability determination services involvement, is the mailer process. We use this process for beneficiaries with profile scores signifying a relatively lower likelihood of medical improvement. In these cases, we send a mailer questionnaire to the beneficiary for completion. The CDR mailer contains six short questions concerning recent work activity, medical treatment, and medical condition. If the beneficiary's answers indicate a possible recent improvement in his or her medical condition, we select the case for a full medical review.

Prioritizing this workload by expected medical improvement helps ensure that regardless of the resources to perform medical CDRs in a given year, we work the most productive and cost-effective reviews possible each year. Consequently, our CDR scoring models are a highly effective tool for prioritizing cases for medical CDRs. In addition, the CDR mailer process helps us efficiently screen out unproductive cases, significantly minimizing the unnecessary burden of conducting unproductive full medical reviews for disabled beneficiaries.

Chairman JOHNSON. Thank you. Mr. Marchant, you are recognized.

Mr. MARCHANT. Thank you, Mr. Chairman. For clarification, the CDIs and CDRs, they don't involve overpayments, do they?

Mr. O'CARROLL. The CDRs and CDI, what they are involved with is preventing overpayments.

Mr. MARCHANT. So the actual overpayments that Ms. Colvin is talking about are not really in the CDR and CDI backlog. Is that correct?

Ms. COLVIN. Go ahead, you want to answer?

Mr. O'CARROLL. No.

Ms. COLVIN. Some of them could be. The CDI program was really set up as a joint effort between OIG and SSA to prevent people from actually coming on the rolls to begin with, so you wouldn't have an overpayment there.

But if we get information that suggests that someone who is on the rolls is, in fact, not disabled, that would be the type of referral that we would send to OIG. And that could be reviewed by the CDI unit. If, in fact, that person then is found not to be disabled, has been getting a benefit, that's an overpayment. It's a fraudulent payment, though, and that person—

Mr. MARCHANT. Are inadvertent overpayments or mistakes or any of those things ever referred over to the CDI/CDR units?

Ms. COLVIN. Not if there is no instance of or suspicion of fraud.

We have some overpayments inherent in the system. For instance, if someone is on the rolls and they file an appeal, they are entitled to stay on the rolls until such time as that appeal is adjudicated. If we—if the appeal is denied, then all of that money that they have been getting is an overpayment. So then we have to start a collection process to get that money back.

Mr. CLIFTON. And Congressman, if I may add too, there are overpayments—as we are developing work CDRs, we discover that they have worked, perhaps not told us. We determine that they are not due benefits, determine that they are overpaid. Those can be referred not necessarily to the CDI unit, but to OIG for possible prosecution. Because they did something perhaps in our investigation where we felt like they were fraudulent. So it may not go to CDI, but it could go to OIG.

Ms. COLVIN. Yes.

Mr. MARCHANT. I would like to go down a little different line of questioning. In many instances, a claimant will hire an attorney. And in many of those instances, that trial or that process will take months and sometimes it could take as long as a year.

Many times there is a pretty large lump sum payment made at the end of that. And at the end of that period, I have heard of people getting \$20,000, \$30,000, of which, in many instances, a third of that or 40 percent of that is going to the attorney. When it gets to an investigation for fraud later down the road, do you have recourse against anyone that assists the person that might have committed the fraud in the repayment system?

Mr. O'CARROLL. That's the first time that one has come up, where we'd be looking for anybody who helped somebody or facilitated them getting on the rolls when they shouldn't have been on it, and then do we have the recourse to penalize that person—

Mr. MARCHANT. Do you have legal recourse to go and bring them into the suit or into the recovery? Say there was \$20,000 recovered, of which you got \$8,000. The person that you assisted in committing this fraud, as you have determined fraud, are we making a demand on all \$20,000 for them? Does their recourse then go against the person that assisted them in that fraud, or do you have the right to go straight to anyone that assisted? Maybe it would be a doctor, maybe it would be somebody who gave false testimony. Maybe it would be somebody who had a Yellow Pages ad.

Chairman JOHNSON. Good question.

Mr. O'CARROLL. I guess probably the easiest way on that one is—which ties into the CDIs that we're talking about—is that we are looking for third-party facilitators, anybody else that is assisting a person to fraudulently get on benefits. And we do go after them both criminally, when we have that evidence on it.

On your question of if we are assessing an overpayment and trying to recalculate it, we have, to my knowledge, have not gone after a third—

Mr. MARCHANT. I am off of overpayment. I am on to just direct fraud.

Mr. O'CARROLL. Right, fraudulent. Well, fraudulent overpayment.

Mr. MARCHANT. Yes, fraudulent overpayment. And I am really more targeted towards the large, lump sum payments that are made which, in many times, much of that goes to pay for the expense of getting on the roll itself.

Mr. O'CARROLL. I will have to tell you, Mr. Marchant, I am not familiar with us going after anybody, you know, kind of concurrently as we are going after somebody who is defrauding us. But let me check on that and get back to you if we've had any other examples of that.

Mr. MARCHANT. A lot of newspaper articles that have been written in the last few months have been about this kind of fraud. And I think the public is interested in it, and it may be a way that we can make a higher recovery. Thank you.

Chairman JOHNSON. That is an interesting question you guys ought to take a look at. Are there lawyers that help these people when they come to you? Do you know?

Mr. O'CARROLL. I am sure there are. I don't have any specific examples of it.

Chairman JOHNSON. You don't know if they have?

Mr. O'CARROLL. But let me take a look at it and get back to you formally on that one.

Chairman JOHNSON. Thank you. Mr. Tiberi, you are recognized.

Mr. TIBERI. Mr. Chairman, I would just like to provide some information for the record, if I may. Social Security's fiscal year 2012 total operating budget, which was encompassed in 2 pieces of legislation that passed the House, the Senate, and signed by the President, is 22 million more dollars than the fiscal year 2011 appropriation. It was H.R. 2055 and H.R. 3672. They were supported equally by both parties, including the President, the Chairman of the Committee, the Ranking Member of the Committee, the Chairman of the Subcommittee, the Ranking Member of the Subcommittee, as well.

Social Security continues to receive an increase in dollars, despite a 1.5 percent decrease in the discretionary cap. In fact, while Social Security is subject to the same long-term domestic spending caps that were in the Budget Control Act, which was mentioned at the beginning of the hearing, that same bill gives the Social Security Administration an additional \$11 million from fiscal year 2012 to fiscal year 2021 over the budget caps to increase continuing eligibility reviews and its Disability Insurance and Supplemental Security Income programs.

With respect to employees, I think it is important to note that Social Security increased its overall staff by 3,269 employees in fiscal year 2009 and by 2,346 in Fiscal Year 2010. The Social Security Administration continued to hire during fiscal year 2011 at a lower rate. It was mentioned, and it is true, that retirements and resignations reduced Social Security Administration's employee level by 2,791 in fiscal year 2011 to a total staff of 64,176 employees. It is important to note that that exceeds the number of employees by 2,824 that began fiscal year 2009.

And a final note, Mr. Chairman. According to a recent Commissioner's broadcast, funding levels near the House or Senate fiscal year 2012 Labor HHS level will enable Social Security to hire replacements this year. I just want to put that in for the record.

And I do have a question for Mr. O'Carroll or Mr. Clifton. As Mr. Stark said, we have a lot of Social Security activity in our district office as well. I have a constituent who was notified that she was overpaid by \$100,000 between 2003 and 2009. And it was a CDR that caught this. My understanding, however, is by law there needs to be a review every three years. And apparently in her case there was not a review.

My question is, is there a better way to do this? Maybe matching IRS records? Working with the Internal Revenue Service? Are there a number of reviews that aren't done timely, according to the law, as was this case? Or did this happen to be maybe just one that fell through the cracks?

Mr. CLIFTON. If I can, I will start.

Mr. TIBERI. Sure.

Mr. CLIFTON. There is some confusion about continuing disability reviews. There are medical ones and there are work ones. I don't know the particulars of your case, but I would venture to guess it was not a medical CDR. Medical CDRs, when DDS determines that a person is no longer eligible for disability benefits because they have medically improved, those are not retroactive.

Ms. COLVIN. Right.

Mr. CLIFTON. So if I decide today that you have medically improved, typically not retroactive, so it would be extremely unusual we would go back three years and say you were not disabled clear back here.

So I would venture to guess that was probably a work CDR. So it wasn't a diary, like a three-year or a five-year or a seven-year diary. Those are medical CDRs. So I would suspect, without knowing the specifics, but based upon what you said, we probably discovered earnings on her record and said at that point, "In the past, your benefits should have stopped." And so it created a very large overpayment.

But going back to your question—it's a very good one—what kind of tools can we use to catch those quicker? There are a couple of things. Of course it's a resource issue in the sense that if I have a work CDR and she reported her work, I've got to have the time to get to it. Those are time-consuming, because they are complicated. I send out information to an employer, they reply back to me. It takes a while to develop those.

We get information on earnings once a year, based upon W-2s. Things that could help is if we got earnings reported quarterly, much quicker than the earnings that they already get.

Patrick, any further things?

Mr. O'CARROLL. Yes, just to follow up on it, as you were saying, it is a work CDR. And one of our concerns—and we've mentioned it a few times already—is the backlog on it. And that is probably what happened with this one. It was identified, went into the backlog, and it took a while for it to be addressed.

So, the two things. One, if they were getting the wages quicker, the alerts quicker on it, and then getting to the work CDR and addressing it with the claimant quicker, would have avoided all this. And that's where we keep going back to here, is trying to reduce the backlog on CDRs. And this is obviously an example of that.

Mr. TIBERI. Thank you.

Chairman JOHNSON. Thank you. What is the backlog, do you know?

Mr. O'CARROLL. The backlog is about 1.2 million CDRs.

Ms. COLVIN. No, that's not work—

Mr. O'CARROLL. Oh, oh—

Ms. COLVIN. That's not work CDRs.

Mr. O'CARROLL. Oh, that was all CDRs.

Ms. COLVIN. We really don't have what is considered a backlog on work CDRs. We have 1.3 million for medical CDRs. The work CDRs is a rolling workload. Whenever we get a report of work, we try—if it's a self-report, we try to get to that report within 30 days. It generally takes us about 270 days to process that because of the complexity of what we have to go through. We have to look at every month that the individual has had work reported. We have to see if it exceeded the SGA, which is \$1,010. We have to see if they have finished their trial work period. We have to see if they are finished their extended eligibility period. We have to see if they have any impairment-related expenses.

That is why we are hoping that this committee will support the work simplification proposal that we have in the President's budget, WISP, the work incentive simplification proposal, to help simplify this.

Also, there are a number of other proposals, such as the workman's compensation proposal, that would allow us to get this information directly from the administrator of the compensation program, rather than the individual.

So it is the complexity of the program. And the reason it takes so long—right now we—last year we did about 312,000 work CDRs. We are—that was in 2010. And in 2011 we did 324,000. This year so far we have done 80,000. We hope we can do as many. But it really is a resource issue, because the same people who do this work, this program integrity work, are the ones who do the initial work to get these checks out, et cetera.

But we are devoting attention to this. I have set goals, and we are monitoring the progress in that area. We have dedicated more staff to process the work CDRs, so they can get them timely. We triage the work so that we address those that have the highest earnings first. And we have drastically improved our processing time. Less than six percent of the work CDRs are now over 270

days old. And the work CDR is at the end of the process. You have to do all these other things to determine.

The other thing I need to mention is that probably about less than a third of the work issues that we review actually result in work CDRs, because the people are falling within those other categories that I talked about. And so their benefit is not yet impacted.

Chairman JOHNSON. You know what? You guys convinced us that if we upgraded your computer system you could do all of this faster. You got 18,000 computers over there now, and you ought to be able to get it done.

Mr. Berg, you are recognized.

Mr. BERG. I am not sure if I want to go after that.

[Laughter.]

Mr. BERG. We are running late here, but I hopefully will be able to catch a ride back with Mr. Stark, I am sure.

[Laughter.]

Mr. BERG. I do want to thank you for being here. And, Mr. Clifton, thank you for your help and your office's help with all the constituents that we have. It is frustrating for me. It is such a huge, complicated thing. I know there are people that don't understand all the rules and legitimately make mistakes. I am sure there is people on the other spectrum that they know the rules are complicated and they know they always have an out, because they can say, "We didn't understand that."

Ms. Colvin, I think in your testimony you mentioned there were 4,000 new cases a year.

Ms. COLVIN. No, I indicated that we made 19,000 referrals to the OIG for suspected fraud, and—

Mr. BERG. Well, let me back up.

Ms. COLVIN. Oh.

Mr. BERG. My question is, just in the big picture, how many cases do we have per year? And if you can't answer this, maybe you could provide the Committee with that information. But the number of cases that you have, and then ultimately how those things play out. Has 4,000 a year been typical? Are we having 400 people that end up doing jail time? If that is information we get later, I would appreciate it.

Mr. O'CARROLL. Since you're talking cases—I guess that's where we got confused—cases, investigative cases on that—

Mr. BERG. Yes, I am sorry.

Mr. O'CARROLL. What we are doing with our investigative cases every year is we are getting—we get about 150,000 referrals every year, which end up being about 7,000 investigations. And on that, our—I guess their conviction rate on that one is probably about 20 percent of those investigations end up in—with convictions. But I can give you all those specifics on it. They are in our semi-annual report.

Mr. BERG. What I am trying to do is to somehow very quickly drill down to the questions that Mr. Becerra addressed on if the penalties are appropriate. Certainly if someone walked into a store and stole something out of a store, we have pretty clear penalties for that.

The other question—probably even the bigger question this is to you, Mr. O'Carroll—is there a way we can reduce the complexity of this program? You mentioned that in your testimony. What would you do to reduce this complexity?

Mr. O'CARROLL. A lot of the complexity on it that we are concerned with is that—and I guess in general the program is very complex. What I was talking about in my testimony was the complexity of the CDRs, and that it's so hard to do the continuing disability reviews.

As the Deputy Commissioner said, one of the big issues of it is we are trying to figure out when a person is working, get that information right away. But the other part that Mr. Clifton I am sure will go into is that then the claimant's rep has to go in and be taking a look at any bonuses that a person made, any severance pay that they got, any sick pay that they got. There is a lot of calculations that all go into this thing, many of which would probably, if they could simplify whether or not—could simplify the process of it—would make it a bit easier.

But right now, in order to give all the benefits to the beneficiary on it, there is so many different steps, it takes a lot to do it. So that is part of the complexity, is all the calculations that go in it. Mr. Clifton?

Mr. CLIFTON. I would echo that. It's a very complicated workload. And you hit the nail on the head when you say the ability of the public to understand the disability program and what they're allowed to do—they are allowed to work, but there is just certain levels when that work will stop their benefits.

So, one, if you're talking about incentives for people to work, they're scared at times because they're not sure what the outcome will be. As they mentioned, they're afraid if they work, three years later someone will discover that they owe the government \$100,000. Now, that's different than the out and out fraud that they mentioned before in there.

So, program simplicity, simplifying the program, would go a long way towards the public understanding what effect the work would have. It would also go a long way towards processing a very complicated workload. As you mentioned, they could get severance pay, they could get things that are not going to affect their disability, but it will show up as work and earnings that you have to investigate. I hope that helps.

Mr. BERG. Good luck.

[Laughter.]

Mr. BERG. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. I appreciate you all being here. We visited a Wal-Mart down in Texas that had disability workers as part of their program, and they were doing a good job. They really were.

Mr. BECERRA. Mr. Chairman, can I add something?

Chairman JOHNSON. Yes?

Mr. BECERRA. Mr. Chairman, I just wanted to add something. I think Pete did a good job of acknowledging the work that you all do. I hope that in no part of this hearing we leave the impression that we don't believe that each and every one of you, wherever you are, whether you are a detective, with the local police department,

whether you are in the investigative offices, or you're in the shop day to day in Social Security doing the work, I hope we don't leave the impression that we don't think you are working hard.

And I would like to echo what Mr. Stark said, that we want to thank each and every one of your people—I don't care what office it is—for the work that you are doing. Because, at the end of the day, what we are trying to do is make sure that millions of Americans who every day are paying through their paycheck for Social Security to be there, have an opportunity to see it there for them, because they legitimately earned it, not for folks who are trying to abuse it.

So, thank you for the work. Convey that message to all the folks back home. Because we hope we can give you the tools you need to do this better so that everyone agrees that the program works for them the way it should. Thank you.

Chairman JOHNSON. Again I want to thank you all for being here today and for your testimony. And I look forward to working with you and all my colleagues, as we continue to examine ways to secure the future of Social Security and this vital program.

With that, this Subcommittee stands adjourned.

[Whereupon, at 12:05 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

OPENING STATEMENTS

Statement of The Honorable Sam Johnson

**Hearing on Securing the Future of the Social Security Disability Insurance Program
Subcommittee on Social Security
Chairman Sam Johnson
Opening Statement
January 24, 2011**

Good morning and welcome to our second hearing in our hearing series on Securing the Future of the Social Security Disability Insurance Program. Today our focus is on combating waste, fraud and abuse.

In our first hearing we talked about the important milestone set in 1956 by the creation of this cash benefit program for those who could no longer work due to a disability. From the beginning, there was a great deal of concern about the high risk for fraud, waste, and abuse because of the changing nature of disability and the inherent subjectivity of determining whether a person was truly disabled.

Today, the disability insurance program pays benefits to individuals with disabilities that meet certain medical criteria, as long as they worked long enough and paid Social Security taxes.

Over the past four decades, disability program costs have soared from \$18 billion to \$124 billion as the number of those receiving benefits has more than tripled from 2.7 to 9.7 million. The size of the overall workforce, more women in the workforce, the aging of the baby boomers into their disability-prone years, and relaxed eligibility requirements have all contributed to this growth.

That continued growth is putting a massive strain on the program. According to the 2011 Trustees' Report, without Congressional action, the Disability Insurance Trust Fund will be unable to pay full benefits beginning in 2018, only a few years from now.

And as the size, cost and complexity of the disability insurance program have increased, so has the program's exposure to waste, fraud, and abuse.

According to the Government Accountability Office, medical and work-related overpayments grew from about \$860 million in FY 2001 to about \$1.4 billion in FY 2010. Social Security collected \$839 million in overpayments in FY 2010, but cumulative overpayment debt reached \$5.4 billion.

Continuing disability reviews are a valuable tool in making sure that those receiving disability benefits are still eligible. Every \$1 spent on the reviews results in at least \$10 of program savings, including both Medicare and Medicaid. There is a growing backlog of medical continuing disability reviews, and in the Budget Control Act, Congress authorized \$13 billion in additional funding over the next ten years exclusively for these and other reviews.

The Cooperative Disability Investigation program is a joint effort between Social Security and the Office of Inspector General, working with the State Disability Determination

Services and State or local law enforcement to *prevent* fraud before it occurs. Since 1998, efforts by these units nationwide have resulted in \$3.1 billion in disability program savings.

As impressive as some of these anti-fraud efforts appear, their very success raises questions about how many other examples of abuse are yet undetected.

Waste, fraud, and abuse in the disability insurance program cheat honest, hardworking American taxpayers. As we work to secure the future of this program, we need to protect taxpayers from con artists who are stealing from the system by making sure benefits are paid only to those who deserve them.

The disability program is of vital importance to millions of Americans whose lives are changed forever by the onset of a disability. We need to protect that program for those who truly need its benefits.

That means we all have a responsibility to make sure that the integrity of the disability insurance program is not compromised.

The effort to prevent improper payments and protect our taxpayer dollars from waste, fraud, and abuse goes hand-in-hand with securing the future of this vital program -- an undertaking I know all of us on the Subcommittee stand firmly behind.

Statement of Honorable Xavier Becerra

Social Security Subcommittee

Hearing Series on Securing the Future of the

Social Security Disability Insurance

The Hon. Xavier Becerra

(Remarks as Prepared for Delivery)

Mr. Chairman, thank you for calling this hearing.

Nearly 157 million Americans contribute to Social Security with every paycheck. In return, these workers and their families earn guaranteed protection against the devastating consequences of (1) disappearing pension and retirement savings, (2) premature death and (3) career-ending disability.

The vast majority of American workers never have to use the disability insurance in Social Security. But, for those who become so disabled that they can't work at all, it is a lifeline.

We owe it to America's workers to safeguard their contributions to the Social Security Trust Fund, whether against the Wall Street privatizers who would raid the Trust Fund or from erroneous payment of disability benefits to those who have not earned them. That's why it is crucial that the Social Security Administration (SSA) receive the funding it needs to fight waste, fraud, and abuse, and to prevent simple errors.

The increased funding for "program integrity" within SSA which was authorized in last fall's bipartisan Budget Control Act is a very good step in that direction. The Congressional Budget Office (CBO) estimates that the increased resources will prevent about \$11 billion in overpayments within the decade, and even more later. That's because the eligibility reviews that SSA is able to conduct as a result of this special funding will generate \$10-\$12 in savings for every dollar we invest.

It sure would be nice to see more consistency in Congress' commitment to payment accuracy. A little more than a decade ago, the Clinton Administration, working with Congress, completely eliminated the backlog of benefit payment cases that needed review. Devastatingly, subsequent Congresses let the funding drop by almost 75% by 2007, and the backlog came back with a vengeance.

In 2009 and 2010, working with President Obama, we restored some of

SSA's budget and succeeded in reducing the backlog. But then last year was a disaster. Congress' Continuing Resolution for 2011 froze the agency's funding once again -- at a time when over 13,000 baby boomers are starting to collect their Social Security benefits EVERY DAY! This funding roller coaster has real consequences for the Social Security Trust Fund.

We also need to put the program integrity funding -- which is about six percent of Social Security's overall operating budget -- in context. One of our witnesses, Mr. Steve Clifton, runs a Social Security field office in Greeley, Colorado. He also represents the men and women who manage Social Security's offices across the country. As we'll hear from Mr. Clifton, most of SSA's quality control efforts -- including "program integrity" -- are performed on the front lines, by regular office staff, not by a special cadre of employees.

Preventing and correcting errors is a day-to-day responsibility. It falls on the same Social Security field offices and the same State Disability Determination workers who process initial claims, answer questions for the public, track down lost checks, assign Social Security Numbers, and provide every other service Americans need from Social Security.

So when my colleagues across the aisle make the choice, as they did in early 2011 and then again last month, to limit SSA to a smaller ACTUAL operating budget than SSA had the year before, that has REAL consequences for payment accuracy. When you force SSA to operate under a hiring freeze, as it had to last year and continues to this year, that means SSA can't replace retiring or departing employees who are experienced and hard-working. They are the very people we rely on to prevent mistakes on the front end so we don't have to correct them on the back end. Put another way: the boost in "program integrity" funding was a step forward. But the overall cut in SSA's funding which hits the very people expected to perform the "program integrity" work amounts to several steps backwards.

One final point. As important as it is to make sure Social Security payments are accurate, and as significant as the savings can be when SSA has the resources to do the job well, I want to make sure we keep SSA's overpayments in perspective.

In 2010, Social Security -- which had 72 million field office visits and phone calls, processed over 8 million benefit applications, and paid out benefits to over 54 million seniors, survivors and disabled workers -- had a four tenths of one percent overall overpayment rate. More specifically, Social Security's disability insurance program, which handles a complicated eligibility process and requires applicants to provide specialized medical and vocational evidence, had an overpayment rate of seven tenths of one percent. Most of this was due to simple errors.

For comparison, the cost overrun for 98 of the Department of Defense's major weapons systems was 31 PERCENT! What makes this glaring statistic even more staggering is the fact that DoD continues to do business with hundreds of contractors which the Pentagon KNOWS were involved in fraud against the taxpayers.

So, Mr. Chairman, I look forward to working together with you and our colleagues to safeguard the investment American workers make in Social Security. And let's keep the big picture in mind. Tens of millions of Americans and their families rely on Social Security to be there when they need it. That means having a Social Security office open and fully staffed to help them. It means getting back every penny in Social Security overpayments. And, for the sake of fairness and integrity, it means applying the same rigor and standard of accountability for all programs within the federal budget, from Social Security to national security.

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[Questions for the Record follow:]

Questions for the Record Ms. Colvin

Questions for the Record
For the January 24, 2012 Hearing
On Combating Disability Waste, Fraud, and Abuse

1. In August, Congress authorized \$896 million in additional funds for FY 2012 so that the agency could perform Continuing Disability Reviews (CDRs) and redeterminations. In December, Congress appropriated \$758 million for this work. In response to questions for the record on September 16, 2011, you stated that you had a backlog of 1.4 million medical CDRs, but that you anticipated that with the appropriated money “we would be able to catch up on Title II CDRs by 2016.” As you were able to make this projection last September, you must have had projections and plans on the drawing board to get started on the integrity work. Has the money been allocated to the front lines to get this work started? The growing backlogs of CDRs, including full medical CDRs, needs to be reduced as soon as possible. Please submit to this Subcommittee a full detailed plan for how this will be accomplished.

The Administration strongly supports the program integrity cap adjustments authorized by the Budget Control Act, which would put us on a ten-year path to essentially eliminate the backlog in program integrity reviews. In fact, the President’s 2013 Budget urges Congress to appropriate the remaining \$140 million in program integrity funding authorized under the BCA for 2012, which would save taxpayers an additional estimated \$800 million.

We plan to complete 435,000 full medical CDRs with our fiscal year (FY) 2012 appropriated program integrity funding--about 90,000 more than we completed in FY 2011. We began ramping up our program integrity work at the beginning of the fiscal year; we have allocated the necessary resources and are on track to achieve our CDR and Supplemental Security Income (SSI) redetermination targets for the appropriated funding level.

While we will complete significantly more full medical CDRs than we did last year, we will not be able to complete as many as we would have with the level of funding authorized in the *Budget Control Act of 2011* (BCA). If we had received full BCA funding-- \$896 million for FY 2012--we would have been able to complete a projected 568,000 full medical CDRs.

Adequate funding is critical to the reduction of the CDR backlog. The BCA allows increases to the Government’s annual spending caps through FY 2021 for program integrity spending, and these increases would allow us to complete substantially more CDRs at considerable savings to the taxpayers. It is important to understand that the same people who handle CDRs also handle initial disability claims. Therefore, we need an adequate number of trained employees to complete both workloads. If we do not receive increased funding for our program integrity work, it will be virtually impossible to reduce the CDR backlog.

The FY 2013 President’s Budget includes \$1.024 billion for our program integrity work, consistent with the BCA. If we receive this funding on a timely basis, we plan to complete 650,000 full medical CDRs--about 215,000 more than we expect to complete in FY 2012. In

Enclosure – Page 2 – The Honorable Sam Johnson – Questions for the Record

FY 2013, we estimate that every dollar spent on CDRs will yield about \$9 in program savings over 10 years, including Medicare and Medicaid program effects.

Our Office of the Chief Actuary has updated its estimates based on our current CDR review and profile processes. If we received the full amounts authorized under BCA, we could become current on title II medical CDRs in 2014, two years earlier than our prior estimate.

2. How aware are agency personnel of the Cooperative Disability Investigation program and its successes? How does the agency make sure that front line employees know about their responsibilities to find and report fraud?

We promote awareness of the Cooperative Disability Investigations (CDI) program in several different ways. The CDI units conduct regular training with our field offices and the disability determination services (DDS) to make them aware of the CDI program and to instruct them on how to report fraud. To raise awareness of the CDI program and its accomplishments, we distribute to our field offices a monthly fact sheet that the Office of the Inspector General (OIG) publishes. Due to these efforts, the CDI program received 6,208 allegations of potential fraud in FY 2011. Of this number, approximately 64 percent came from the DDSs, 23 percent from our field office employees, and 13 percent from other sources, such as our Office of Disability Adjudication and Review, OIG, and the fraud hotline.

Our frontline employees are often the first to identify potential fraud. Field office employees routinely assess the authenticity of evidentiary documents, scrutinize statements made by applicants, use our databases and Internet tools to find discrepancies, and follow up on complaints or tips from the public.

3. Your own policies require CDRs for 60 percent of beneficiaries within three years. What kinds of disabilities are included in this 3-year category?

We set the three-year review, otherwise known as the Medical Improvement Possible (MIP) diary, for adult beneficiaries whose medical conditions may improve and allow them to be able to work. While the timeframe for a review depends on individual case facts, generally, the majority of beneficiaries receive a MIP diary. Although MIP diaries have historically comprised 60 percent of our diaries, our policy does not require that 60 percent of beneficiaries receive a review in three years. Examples of impairments that can fall within this category include heart failure and severe diabetes with end organ damage. By contrast, we set a seven-year review for impairments where medical improvement is not expected due to the nature of the impairment(s), such as some intellectual disabilities. Regardless of when we schedule the review, we will need the full level of program integrity funding authorized under the BCA to keep up with all of the cases that are due for a medical review.

Enclosure – Page 3 – The Honorable Sam Johnson – Questions for the Record

4. I understand about five percent of beneficiaries are scheduled for a review in a 6 to 18 month time period; this is the medical improvement expected category. What conditions are scheduled for reviews within these timeframes?

We set the Medical Improvement Expected (MIE) diary for adult beneficiaries whose medical conditions will probably improve and allow them to be able to work. Whether we set an MIE diary depends on individual case facts. Examples of impairments that can fall within this category include traumatic injuries and severe bone fracture.

5. In the FY 2012 Annual Performance Plan, your message states, “We will use technology to reduce our back logs, improve service, and target our program integrity efforts. For example, we are capitalizing on advances in video technology and electronic processes.” Can you elaborate on what kinds of “electronic processes” are being utilized, and how they have helped improve program integrity efforts?

We use an array of electronic processes to improve our program integrity efforts. For example, we created the Access to Financial Institutions (AFI) electronic process to automatically verify financial account balances of claimants and recipients during the SSI claims and redeterminations process. We developed AFI to address the leading cause of SSI overpayment errors--excess resources in financial accounts. We also use an electronic process to track all allegations of benefit misuse by representative payees.

We have much more work than we can complete in one year. Technology has allowed us to develop tools to prioritize our program integrity work to focus on the cases that give us the greatest return for our limited administrative dollars. We use these tools to select the most cost-effective medical and work CDRs, as well as the SSI redeterminations we should complete. As a result of these types of tools, we expect that the SSI redeterminations that we conduct in FY 2012 will save about \$3.2 billion in total lifetime SSI overpayments compared to only \$1.8 billion in savings if we had selected the cases randomly.

Moreover, we strive to provide the DDSs with the tools they need to quickly and accurately decide disability cases to help ensure that we pay disability benefits to those applicants who qualify. Our Compassionate Allowances initiative allows us to identify claimants who are clearly disabled because the nature of their disease or condition meets the statutory standard for disability. With the help of sophisticated new information technology, we can quickly identify potential Compassionate Allowances and then swiftly make decisions. Our Quick Disability Determination initiative uses a computer-based predictive model in the earliest stages of the disability process to identify and fast-track claims where a favorable disability determination is highly likely and medical evidence is readily available.

We are developing other new electronic tools. For example, we are developing the Veterans Affairs (VA) Supplemental Security Record Pension Calculation for the *Medicare Modernization Act*, which will help prevent improper payments by ensuring veterans receiving VA pensions who apply for Part D Low Income Subsidy receive the most advantageous subsidy amount possible.

Enclosure – Page 4 – The Honorable Sam Johnson – Questions for the Record

6. Why has the number of CDRs performed by the SSA declined recently? How significant has the decline been? What are the lost savings as a result?

We have steadily increased the number of full medical CDRs we complete every year since FY 2007. In FY 2012, we are completing more than double the number of full medical CDRs we completed in FY 2007. We have saved significantly more program dollars by completing more CDRs. Sustained, adequate funding is critical for us to continue this cost-effective work, because the same employees who do this work also handle initial claims and other program integrity activities.

7. What are the future projected numbers of CDRs the Social Security Administration (SSA) expects to schedule and complete?

In FY 2012, we expect to complete 435,000 full medical CDRs and 850,000 mailer CDRs.

The FY 2013 President's Budget includes \$1.024 billion for program integrity work, consistent with the BCA. With funding at this level, we plan to complete 650,000 full medical CDRs. In FY 2013, we estimate that every dollar spent on CDRs will yield about \$9 in program savings over 10 years, including Medicare and Medicaid program effects.

8. How does the SSA select which medical CDRs are conducted each year and the percentage that are mailers?

The number of periodic CDRs we complete each year depends on the level of funding we receive. Our annual budget request includes the number and type of CDRs we plan to complete. For cases we initiate centrally, we use one of two methods. We send some cases to the DDSs for a full medical review; others we complete using the mailer process.

We decide whether to initiate a full medical review or send a mailer after identifying those cases with a higher likelihood of medical improvement. We send cases with a higher likelihood of medical improvement to the DDS for a full medical review. We send a mailer for those cases with a lower likelihood of medical improvement to obtain more information from beneficiaries; we evaluate the information we receive to determine if there is any indication of medical improvement. If there is, we send the case to the DDS for a full medical review. Otherwise, we do not initiate a full medical review, and we schedule the case for a future CDR.

9. The Disability program provides an essential income safety net for those who cannot work. But we also know there are those receiving disability benefits who want to work and believe they can work. Given the increase in applications for benefits during the recession and with so few coming off the rolls is the disability insurance program becoming a long term unemployment program for these people?

The changing age distribution of the population is the main driver of long-term Disability Insurance (DI) program growth. For example, the aging of the baby boom generation into more disability prone ages accounts for a large portion of the growth in DI awards, and that


growth has been predicted for many years. Increased labor force participation among women over the past decades, which has led to an increase in the proportion of the population who meet the DI program's coverage requirements, is another important factor in the growth of the DI program.

Prior to FY 2009, we received about 1.6 million title II initial disability claims each year. Since 2009, that level has increased dramatically. In FY 2011, we received nearly 2.1 million title II disability claims. The recession played an important role in the increased number of applications; people with disabilities tend to have a higher unemployment rate than others, and long unemployment spells can make it more difficult to re-enter the work force. In a recession, people with disabilities may apply for and receive DI benefits sooner than they would in normal economic times, which could result in receiving DI benefits for a slightly longer period. To the extent that the recession may have motivated people to file DI claims based on less severe impairments that typically would not meet the definition of disability, we would expect that the average probability of an allowance should go down. That trend is exactly what we have seen. During the recession, our allowance rates have dropped at the DDS and appeals levels.

10. The SSA Office of Inspector General was able to identify high dollar overpayments that the SSA missed just by looking at it a different way. What is the SSA going to do differently in the future to make sure high dollar overpayments are identified?

The Office of Management and Budget (OMB) requires us to report on high-dollar overpayments. We base the methodology we use to detect high-dollar overpayments on a statistically valid sample of Old-Age, Survivors, and Disability Insurance payments and SSI payments, from which we conduct our payment accuracy reviews (also known as Stewardship reviews). OMB has agreed that the manner in which we detect and report our high-dollar overpayments meets the requirements, as provided in Executive Order 13520. Every quarter, we review our Stewardship data to determine if we have identified any overpayments that meet the criteria of the Executive Order for high-dollar overpayments. To date, we have not found any high-dollar overpayments.

Not every overpayment is an improper payment. For example, we do not consider overpayments resulting from legal or policy requirements as improper payments. OMB recognizes that the Stewardship data do not account for this difference but agrees that using these data provide the most efficient method to meet the intent of the Executive Order.



Questions for the Record for Mr. O'Carroll



April 5, 2012

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
B-317 Rayburn House Office Building
Washington, D.C. 20515

Attn: Kim Hildred

Dear Chairman Johnson:

This is in response to your letter dated March 22, 2012, in which you requested information related to the Social Security Administration's (SSA) Disability Insurance (DI) program, following your Subcommittee's January 24, 2012 Hearing on Combating Disability Waste, Fraud, and Abuse. I appreciate the opportunity to provide information related to this critical issue. Below are responses to your specific questions.

- 1. How do you calculate projected savings for the disability programs and non-Social Security programs? You said that for every \$1 invested in the Cooperative Disability Investigations (CDI) program, \$14 dollars in disability-program savings results. I can understand how the CDI programs save disability funds, but explain more about other Federal and state savings.**

Please see the following calculations:

In pre-effectuation cases, SSA savings are calculated at a flat rate of \$90,125 for each initial claim denied. This rate is calculated by multiplying the percentage of CDI investigations that result in a denial (83 percent) by the average lifetime disability benefit (\$108,585).

In cases in which benefits are already being paid, SSA savings are calculated by multiplying the percentage of such CDI investigations that lead to Continuing Disability Reviews (CDRs) where the benefits are ceased or terminated (74 percent), by the total of: the monthly disability benefit amount, times 12 months times the average years a recipient or beneficiary remains on the disability rolls (5.06 years).

Page 2 – The Honorable Sam Johnson

Non-SSA programs (Medicare and Medicaid) are also impacted by CDI investigations. Medicare and Medicaid benefits are often granted when a claimant receives disability. Conversely, if an ineligible claimant is denied SSA benefits due to a CDI investigation, Medicare, and/or Medicaid benefits are also denied. Medicare and Medicaid savings are calculated by the following methods:

- Medicare (Title II Initial Claims): The “Average Cost per Disabled Medicare Beneficiary” multiplied by three years.
- Medicaid (Title XVI Initial Claims): The “Charred Threshold Amounts” by state multiplied by five years.
- Medicare and Medicaid (Concurrent Initial Claims): the same calculation as above for Medicare and Medicaid is multiplied by two years, resulting in a total of five years claimed for non-SSA savings, in both disability programs.

2. What are the steps taken to open a new CDI unit? What factors are involved in the decision-making process?

Several factors are taken into account when pursuing CDI program expansion. The first factor is the availability of an approved budget for expansion. Upon confirmation of an available budget, the following criteria/factors are considered when determining whether to open a new CDI Unit:

- Is there a potential workload to support opening a unit (including a review of the number of disability claims filed in the area, the number of CDRs conducted in the area, and major sources of referrals in the area)?
- Does the Office of the Inspector General (OIG) Office of Investigations (OI) have a Special Agent available to serve as a CDI Unit team leader?
- Is there support and are employees available from the SSA, Disability Determination Services (DDS), and a state or local law enforcement agency?
- Is the state DDS meeting performance standards and budgeted workload goals?
- Is existing space available to house the unit or do additional funds exist to build out space (includes determining where the unit will be housed, proximity of the unit to SSA, the State DDS and the Office of Disability Adjudication and Review (ODAR) offices, and geographic areas of coverage for the unit)?

3. How does your office locate and partner with local law enforcement agencies? Is local law enforcement enthusiastic about these partnerships and willing to make resources available?

The Special Agent-in-Charge and/or the OIG/OI CDI Unit team leader canvass their local areas of jurisdiction to speak with state and local law enforcement agency officials regarding the CDI program and its mission and objectives. OIG addresses the importance of potential monetary savings to the state, such as Medicaid savings.

Based on the law enforcement agency's interest and support of the CDI program, as well as the availability of dedicated resources to the unit (2-3 investigators), a suitable law enforcement partner is selected. The partnership is then formalized through a Memorandum of Understanding (MOU), which is signed by all parties. In those situations in which the law enforcement partner is a local law enforcement agency, a contract is signed in lieu of the MOU. This contract is drafted by the SSA Regional Contracting Office and similar to the MOU, details the responsibilities of the law enforcement partner, to include the duties of the assigned investigators.

The availability and enthusiasm of local law enforcement agencies to collaborate with CDI varies by region and jurisdiction. Local priorities and budgets are currently a concern for many law enforcement agencies. Due to budget constraints, many agencies are unable to hire new personnel and need all of their current officers and investigators available to fulfill their primary mission. Having an officer's salary reimbursed by the SSA is not as appealing as it once was, because the local law enforcement agency, in effect, still loses staff.

4. You say in testimony you have units in 22 states. What are the current CDI program expansion plans? Do you have any projections on how much fraud could be prevented in the Disability (DI) program if you had CDI units in every state? How much additional funding would you need?

We are currently working on establishing a CDI Unit in Philadelphia, Pennsylvania, but further expansion sites for this fiscal year (FY 2012) have not been discussed. Historically, expansion is based on the availability of funding from the SSA, the availability of personnel and resources from the SSA, the OIG, and the local DDS, and finding a viable law enforcement partner.

With respect to how much fraud could be prevented if we had a unit in every state, the OIG can only investigate allegations of fraud that we receive and that are reported. In locations where there is no CDI Unit, the local DDSs do not have an avenue to refer cases with possible fraud indicators, as these pre-effectuation cases do not have a monetary loss to the government. In addition, we are limited by our investigative resources as to which allegations we investigate. Each allegation is reviewed and triaged at the local level. In FY 2011, the OIG received 44,440 allegations related to disability fraud. The OIG opened 7,196 cases in FY 2011; of these, 2774 were TII disability fraud cases (38.55 percent). In our CDI program, for FY 2011, we closed 3,885 cases, 3,383 of which (87 percent) saw benefits either terminated or denied.

The average start up cost for a new CDI Unit varies depending on whether current office space exists and how much renovation the space needs. The average cost to run a unit is approximately \$821,000 per year.

5. In your testimony, you recommended that one way to combat waste, fraud, and abuse in the DI program would be to reduce the complexity of the Social Security Administration's (SSA) programs, without sacrificing their intent. Can you give some examples of what could be simplified and how?

Page 4 – The Honorable Sam Johnson

One example includes simplifying the rules for determining if disabled beneficiaries have earnings that affect disability benefits. Even if SSA received earnings data—such as Federal payroll information—more frequently, Agency staff still needs to review the earnings. SSA cannot simply stop benefit payments because it is notified that a beneficiary is working. For instance, because earnings reported to SSA may include amounts that are not related to current work—such as bonuses, termination pay, and sick pay—SSA must evaluate the earnings to determine whether they represent earnings from substantial gainful activity performed after entitlement to disability benefits began, or whether the earnings exceeded the “countable earnings” threshold. SSA must also assess trial work and other work incentive provisions. This review—a work CDR or Supplemental Security Income (SSI) redetermination—is a labor-intensive process, and the staff resources required compete against the Agency’s need to complete other priority workloads.

Another example would be to exempt the SSA OIG from the *Computer Matching and Privacy Protection Act* (CMPPA). The CMPPA contains several useful and practical exceptions, specifically exempting matches performed for routine uses, law enforcement purposes, statistical reviews, and Congressional investigations, among others. However, with regard to any computer matches that are performed that primarily affect benefit determinations, a formal computer matching agreement (CMA) pursuant to the CMPPA is still required. The main objective of many of our audits and investigations is to ensure that only eligible individuals receive payments from SSA; thus, the CMPPA requires a computer matching agreement during many of our work efforts. All computer matching agreements must go through an exacting and lengthy approval process within the Agency before receiving final approval from SSA’s Data Integrity Board. This process typically takes more than a year (and sometimes years) to complete. An amendment to CMPPA will increase the effectiveness of the OIG in detecting fraud, waste, and abuse by authorizing computer matches without the need for a CMA, thereby, facilitating savings of taxpayer resources through the prevention and recovery of improper payments of SSA program benefits.

The Department of Health and Human Services (HHS) and its OIG received an exemption as part of the enacted healthcare reform legislation; *i.e.* the *Patient Protection and Affordable Care Act*, Pub. L. 111-148. Section 6402(b)(2) of the legislation amended the Privacy Act to exempt “matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse, including matches of a system of records of non-Federal records.” See 5 U.S.C. § 552a(a)(8)(B)(ix).

Both SSA OIG and HHS OIG are charged with combating waste, fraud, and abuse in vital and important Federal benefit programs. Just as Congress determined that an exemption to the CMPPA would be invaluable to the HHS and its OIG in its efforts to combat waste, fraud, and abuse in HHS’s programs and operations; so, too, would a similar exemption assist the SSA OIG to combat fraud, waste, and abuse more efficiently and effectively within SSA’s programs and operations.

6. You also recommended establishing an integrity fund. How would an integrity fund operate in order to increase the funds available for integrity efforts?

One proposal is to amend the *Social Security Act* to authorize SSA and its OIG to receive a percentage of the overpayments collected yearly by SSA to fund program integrity related activities. These activities include, but are not limited to, CDRs (both periodic medial reviews and those triggered by

Page 5 – The Honorable Sam Johnson

work activity), full and limited issue SSI redeterminations, CDI Units, and Office of the General Counsel prosecutors. Together, these activities have resulted in preventing improper payments, as well as recovering millions of dollars in Social Security benefits improperly paid.

Under this Program Integrity Fund proposal, SSA would receive up to 25 percent and SSA OIG up to five percent of the overpayments recovered during a fiscal year. (For FY 2010, SSA collected approximately \$3.144 billion in overpayments.) This funding would be used to supplement, not supplant, current funding and would provide additional resources to both SSA and OIG to combat waste, fraud, and abuse within SSA's programs and operations. Amounts provided for these stewardship activities from this fund would be off-budget and not scored.

An alternate method for funding an integrity fund would be to use a percentage of payments prevented (as opposed to overpayments collected). SSA and its OIG could each receive a percentage of prevented payments or savings from a claimant not getting on the rolls during the application process. For example, CDI Units focus on preventing claimants from getting on the disability rolls. In FY 2011, our investigators reported about \$329 million in projected savings from programs such as the CDI program.

Finally, SSA conducts CDRs, which result in savings by taking disability beneficiaries who no longer meet SSA's criteria for benefits off the rolls. In SSA's February 15, 2011 annual CDR report to Congress for FY 2009, the Agency estimated the present value of future benefits thus saved for the Old-Age, Survivors, and Disability Insurance (OASDI), SSI, Medicare, and Medicaid programs to be \$4.6 billion

7. Do you have any suggestions for funding more efforts to prevent fraud, waste, and abuse in the DI program?

We believe the proposed integrity fund would allow for more efforts to prevent fraud, waste, and abuse in SSA's programs. See answer 6 above.

8. What can you tell us about the accuracy of continuing disability reviews?

As of February 2012, SSA had a 97.5 percent accuracy rate according to the quality assurance review of full medical CDRs. However, historically, SSA estimates about 25 percent of initial CDR cessations are overturned on appeal. We have an audit planned that will analyze the reasons beneficiaries are ceased after a CDR but are overturned after appeal or returned to the rolls on a new application for disability. We will share the results of our review with you once it is completed.

9. Your office recently published a report on high-dollar overpayments in calendar year 2010 and discovered seven such overpayments even though the SSA did not report any. Why was your office able to identify high-dollar overpayments when the SSA did not? What changes should the SSA make to ensure that all high-dollar overpayments are identified?

The OIG was able to identify high-dollar overpayments using a different approach from the Agency. SSA relied on the cases selected during its sampling process for its Stewardship reviews. Each month, the Office of Quality Performance (OQP) selects a statistically valid national sample of Title II and Title XVI beneficiaries who received a payment in that month to redevelop the case and ensure the payments

Page 6 – The Honorable Sam Johnson

were accurate. The Agency used that national sample to determine if an overpayment meeting the high-dollar criteria existed. This approach used only a sample of cases and included several limitations, which resulted in no high-dollar overpayments being identified.

The OIG designed a methodology, which used Computer Assisted Auditing Techniques to obtain data for one segment of the Master Beneficiary Record for all instances in which a potential high-dollar overpayment existed. Our process used data from overpayments already identified and posted on an individuals' record by the Agency associated with the reporting quarter. We further analyzed the results to identify individual cases that met the criteria for being reported as a high-dollar overpayment. As a result, the OIG identified seven cases, and the Agency confirmed that six Title II cases might have met the criteria to potentially be reported as high-dollar overpayments.

Thank you for the opportunity to address these issues, and for your continuing support of our vital work. I trust that I have been responsive to your request. If you have further questions, please feel free to contact me, or your staff may contact Misha Kelly, Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,



Patrick P. O'Carroll, Jr.
Inspector General

Questions for the Record for Mr. BRADY



SOCIAL SECURITY
Office of the Inspector General

April 20, 2012

The Honorable Sam Johnson
Chairman, Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
B-317 Rayburn House Office Building
Washington, D.C. 20515

Attn: Kim Hildred

Dear Chairman Johnson:

This is in response to your letter dated March 22, 2012, in which you requested information related to the Social Security Administration's (SSA) Office of the Inspector General's (OIG) Cooperative Disability Investigations (CDI) program, following your Subcommittee's January 24, 2012 Hearing on Combating Disability Waste, Fraud, and Abuse. I appreciate the opportunity to provide information related to this critical issue. Below are responses to your specific questions.

1. Do CDI Units use social media to find out whether people are actually working?

Yes, our CDI Unit investigators use social media and additional third-party databases to obtain as much information on claimant and beneficiaries that have been referred to the CDI Units for investigation.

For example, the Kansas City CDI Unit investigated a man who applied for disability benefits and stated that he could not stand for more than five to 10 minutes. The Disability Determination Service (DDS) in Topeka, Kansas, suspected the man was making exaggerated mental and physical complaints and referred the case to the CDI Unit.

A review of the man's Facebook account included several photos of the man standing with friends at an outdoor music festival site, and the account indicated the man worked for an on-site festival taxi service. CDI investigators turned the photos and other evidence over to the DDS, and the DDS denied the man's claims for disability benefits.

2. Who are the perpetrators of the fraud your unit finds? What is their level of sophistication? Are they organized scams or do they work alone? Are they first-timers or repeat offenders?

Most of the fraud is one individual committing fraud for his or her benefit. Many of these individuals have applied for and been denied disability benefits previously, and, in fact, one of the high-risk factors that can be indicative of fraud is multiple benefit applications from the same individual. Often the subsequent applications that CDI Units see are submitted in quick succession with little or no change in the applicants' medical records. It is not uncommon for an applicant to have one new application pending while they are appealing a previous denial.

CDI Units have investigated organized groups of people committing fraud, as well as third-party facilitators of fraud (doctors, lawyers, interpreters, etc., who are assisting many different individuals), and those cases are a priority; however, individual fraud is much more common.

3. How do defrauders you find receiving benefits get away with their pretense for so long? Is disability that easy to fake?

The challenge for SSA is to balance service initiatives, such as processing new claims, with stewardship responsibilities, such as conducting timely continuing disability reviews (CDRs). We in the OIG issued a report in 2010 that found SSA's number of completed medical CDRs decreased from Fiscal Year (FY) 2004 to FY 2008 because of increasing SSA service workloads.

Medical CDRs are effective in reducing overpayments in SSA's Disability Insurance (DI) program. SSA estimates that every \$1 spent on medical CDRs yields at least \$10 in SSA program savings and Medicare and Medicaid. In FY 2011, SSA conducted more than 345,000 medical CDRs, up from 325,000 in FY 2010. In FY 2012, it is intended the Agency will receive \$896 million for program integrity efforts like medical CDRs, and SSA has a goal of conducting 1.44 million CDRs total, including a proposed 592,000 medical CDRs.

SSA estimates that meeting the goals for medical CDRs and other integrity efforts will result in about \$9 billion in savings over 10 years, including Medicare and Medicaid savings. However, SSA's Office of Quality Performance projects that at the end of FY 2012, SSA will still have a backlog of 1.2 million medical CDRs.

In addition, simplifying the rules for determining if disabled beneficiaries have earnings that affect disability benefits could help combat fraud in the DI program. Even if SSA received earnings data—such as Federal payroll information—more frequently, Agency staff still need to review the earnings. SSA cannot simply stop benefit payments because it is notified that a beneficiary is working. For instance, because earnings reported to SSA may include amounts that are not related to current work—such as bonuses, termination pay, and sick pay—SSA must evaluate the earnings to determine whether they represent earnings from Substantial Gainful Activity performed after entitlement to disability benefits began, or whether the earnings exceeded the “countable earnings” threshold. SSA must also assess trial work and other work incentive provisions. This review (that is, a work CDR or SSI redetermination) is a labor-intensive process, and the staff resources required compete against the Agency's need to complete other priority workloads.

SSA has developed a legislative proposal—the Work Incentive Simplification Pilot—to simplify work policies in the DI program, which would reduce administrative complexity and workloads,

Page 3 – The Honorable Sam Johnson

enhance correlation of program rules among SSA's disability programs, and encourage DI beneficiaries to return to work because they would not face a permanent loss of benefits and Medicare.

4. How aware is the public of your efforts? Do you run TV ads asking the public to report fraud?

We do not use television ads to disseminate information on reporting potential fraud. However, we recently launched an expanded and redesigned OIG website (<http://oig.ssa.gov>), and we are in the process of establishing several social media tools (a blog on the OIG website, and YouTube, Twitter, and Facebook accounts) to improve communication with the public on how to report suspected Social Security fraud and what information to provide to the OIG.

5. How do you train Disability Determination Services (DDS) and field office employees to recognize fraud?

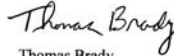
The CDI Units conduct regular training with the DDS and SSA district offices to make employees aware of the CDI program and to instruct employees on how to report fraud. The OIG publishes a monthly fact sheet and distributes the report to local OIG, DDS, and SSA offices to raise awareness of the CDI program and to highlight its accomplishments and successful cases. Additionally, some of the CDI Units publish local, periodic newsletters to highlight some of their more interesting cases and to thank the DDS or SSA staff that referred cases.

6. What changes in the process at the DDS or in field offices might assist in screening out more fraudulent claims?

SSA can do many things to screen claimants or beneficiaries for eligibility before they can commit fraud. SSA could use several third-party databases to look for real property, wages, and employment and marriage information. In addition, SSA could utilize social media tools to see if claimants and beneficiaries are posting updates or photos that are inconsistent with their alleged disabilities.

Thank you for the opportunity to address these issues, and for your continuing support of our vital work. I trust that I have been responsive to your request. If you have further questions, please feel free to contact me, or your staff may contact Misha Kelly, Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,



Thomas Brady
Special Agent

Questions for the Record for Mr. Clifton



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April 4, 2012

The Honorable Sam Johnson
Chairman
United States House of Representatives
Committee on Ways and Means
Subcommittee on Social Security
B-317 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Johnson:

Thank you for providing the National Council of Social Security Management Associations (NCSSMA) with the opportunity to answer written questions resulting from the January 24, 2012 oversight hearing on the Social Security Administration, Combating Disability Waste, Fraud and Abuse. The responses to the two questions you posed are attached below.

Please feel free to contact me if you would like additional information. Thank you again for the opportunity to appear before the Subcommittee, your interest in the vital services Social Security provides, and for your ongoing support of SSA.

Sincerely,

/s/

Stephen Clifton
NCSSMA President

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

**Responses Submitted for the Record
Stephen Clifton, President
National Council of Social Security Management Associations, Inc.**

**Hearing on Combating Disability Waste, Fraud and Abuse
January 24, 2012**

1. In your experience as a local office manager, what are the kinds of behavior you and your employees see in certain applicants that provide clues to possible fraud?

In SSA Field Offices, the possibility of fraud is pursued both at the time a claim for Social Security Disability (SSDI) or Supplemental Security Income (SSI) is filed, and after a claimant is receiving benefits. The following are some specific circumstances that may alert an SSA representative to possible fraud:

- During the initial application for SSDI or SSI benefits, a Claims Representative may record observations that are inconsistent with an alleged disability. For example, a claimant is observed walking without any assistance, has no complaints of pain, sat through a lengthy interview without complaint, and their alleged disability is severe back problems. These observations are recorded for the Disability Determination Services (DDS) to consider while gathering medical evidence to make their medical decision.
- Also during the initial application for disability benefits, the DDS may receive information from a medical source that the claimant is currently working. The DDS would refer this information to the Field Office to investigate and resolve possible work issues.
- For SSI eligibility, in addition to a claimant being found medically disabled, they must also have income and resources below certain statutory limits. The individual's living arrangement (such as where they live, who they live with, and whether they are living with a spouse), non-liquid resources that they own (such as property), and liquid resources (such as bank accounts) all affect eligibility for SSI payments. The complexity of SSI rules and regulations provide many opportunities for potential fraud. Examples of where fraud may appear include: recipients alleging they pay rent when they do not, statements that they are separated from their spouse who works, when they are not, and statements that they do not have property or financial accounts when they do.
- An SSDI beneficiary or SSI recipient may return to work and fail to report their earnings or conceal their earnings from work, which may indicate possible fraud. This work may demonstrate they have medically improved or are engaging in substantial gainful activity

that would cease or reduce the amount of their payments. Their SSI eligibility may also be affected due to receipt of income, acquiring resources, or living arrangement changes.

- To identify and combat potential fraud, SSA employees use the Access to Financial Income (AFI) program to discover resources. The AFI program allows our offices to electronically request and receive financial account information for SSI recipients. By automatically checking an applicant's or recipient's known bank accounts, and by systematically checking for unknown accounts with financial institutions in a given area, the AFI program helps the agency reduce many payment errors that were common in the past.
 - Referrals of potential fraud from the public are received by SSA and OIG and sometimes yield determinations that affect eligibility to SSDI or SSI benefits.
 - One of the most effective means of determining the accuracy of benefit payments and identifying possible fraud is the processing of program integrity workloads. This includes processing medical continuing disability reviews (medical CDRs) and SSI redeterminations (identifying SSI eligibility changes). These program integrity initiatives reduce opportunities for overpayments and fraud.
 - Program simplification such as the Work Incentives Simplification Pilot (WISP) and SSI simplification would significantly improve program administration and allow for greater understanding by SSDI beneficiaries and SSI recipients.
 - Finally, having a sufficient number of Field Office personnel allows sufficient time to explain complex program rules, develop, investigate and accurately process claims, and greatly reduces overpayments and program fraud and abuse.
- 2. The Commissioner has been focused on reducing the hearings backlog and progress has been made. In a 2009 report, the Government Accountability Office found that the Social Security Administration (SSA) did not have a systematic approach to identify and address unintended effects of the hearings backlog reduction plan. One of these effects is that the resources available for front line operations have not kept up with growing workloads. Has some relief been provided to those on the front lines in Social Security offices after receiving the agency's appropriation?**

SSA is challenged by ever-increasing workloads resulting from aging baby boomers, complex programs to administer, and increased program integrity work with diminished staffing and resources. The resources available for front line operations in SSA Field Offices have eroded significantly.

SSA has lost more than 4,000 SSA and State Disability Determination Services employees in FY 2011, expects to lose more than 3,000 employees in FY 2012, and expects to lose more than 2,000 employees in FY 2013—a total loss of more than 9,000 employees in just three years. In FY 2013, the agency will have about the same number of employees as it did in FY 2007, even though workloads have increased dramatically.

By FY 2013, retirement and survivor claims will have increased by 30 percent and disability claims by 25 percent from FY 2007. The number of initial disability claims pending rose from 581,929 in FY 2007 to 759,023 in FY 2011. The number of pending initial disability claims is expected to increase to 861,000 in FY 2012 and to over 1.1 million in FY 2013.

Overall Field Office staffing has gone from about 31,000 employees in June 2010 to around 28,300 employees in February 2012—a nearly 9 percent decrease. Since SSA received its FY 2012 appropriation, some relief has been provided to those on the front lines in SSA Field Offices. This has been largely in the allocation of overtime hours to address critical program integrity workloads. Overtime in FY 2012 is being worked at a reduced level of approximately 2,125 work years.

SSA Field Offices operated under a hiring freeze in FY 2011. In FY 2012 minimal SSA hiring of 175 positions has been authorized for locations outside of ODAR. Of these new hires, 100 positions will be directed to the most stressed SSA Field Offices. This translates to a 1:27 replacement ratio for SSA Field Offices, which is insufficient to maintain adequate service levels to the public. The same employees that process program integrity workloads, also answer public telephone calls, take initial applications for disability and retirement benefits and process claims—core workloads that are not program integrity funded but do ensure the accuracy of payments.

There are a number of public service repercussions that are occurring due to the insufficient staffing levels in SSA Field Offices:

- Service to the public is deteriorating because of inadequate Field Office staffing levels. This manifests itself in increased waiting times in reception areas, higher telephone busy rates or unanswered calls, delays in claims processing, and backlogs in less visible post-entitlement workloads.
- As a result of this erosion of SSA service, public frustration continues to grow. This has translated into increased security incidents, and an increase in their severity, in SSA Field Offices. This includes personal threats against employees, physical violence in reception areas, verbal abuse, and threats against the government.
- Geographical staffing disparities have occurred and will increase as ongoing attrition spreads unevenly across the country. This leaves many offices significantly understaffed and targets for closure or consolidation.
- SSA has a highly skilled but aging workforce with more than 22 percent of its employees eligible for retirement. With offices struggling to address increased workloads with diminished resources, employees are choosing to retire in greater numbers. This loss of experienced personnel with institutional knowledge exacerbates the problem.
- Reduced SSA Field Office resources have a negative effect on program integrity and stewardship responsibilities. Resource constraints compromise SSA's ability to provide

attention to claims accuracy and beneficiary reporting responsibilities. This includes addressing quality initiatives and conducting critical training. In addition, reduced Field Office resources prevent timely processing of payment-changing events, which results in improper payments and insufficient time for quality case reviews and mentoring. SSA Field Office managers across the country indicate they receive complaints regularly from the public about the accuracy or timeliness of the work the offices process. These managers indicated that the number of quality case reviews performed in their local offices is insufficient to ensure an accurate and timely work product.

NCSSMA believes that a comprehensive SSA service delivery plan is necessary to help ensure balanced public service. While an SSA service delivery plan will not solve SSA's problems without the commensurate level of funding needed to implement solutions, it will help to identify the resources required to achieve established agency-wide benchmarks and goals for all workloads.

The prudent use of available resources is critical to the achievement of the best possible success for the agency. A comprehensive service delivery plan will also help to ensure that regardless of the method the public chooses to conduct their business with SSA, or the nature of the business conducted, the level of service provided will be delivered in a balanced and equitable manner.

[Submissions for the Record follow:]

Consortium for Citizens with Disabilities



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

Statement for the Record

**Hearing on Securing the Future of the
Social Security Disability Insurance Program:
Combating Waste, Fraud, and Abuse**

**Subcommittee on Social Security
House Committee on Ways and Means**

January 24, 2012

**Submitted on behalf of the undersigned members of the Consortium for Citizens with
Disabilities Social Security Task Force:**

American Council of the Blind
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Easter Seals
Epilepsy Foundation
Health and Disability Advocates
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Disability Rights Network
National Down Syndrome Congress
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association

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The Consortium for Citizens with Disabilities (CCD) is a working coalition of national organizations working together to advocate for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of the 54 million children and adults with disabilities in all aspects of society. The CCD Social Security Task

Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program.

The undersigned members of the CCD Social Security Task Force submit this Statement for the Record of the January 24, 2012, House Ways and Means Social Security Subcommittee hearing on Securing the Future of the Social Security Disability Insurance (SSDI) Program. The SSDI program¹ provides vital and much-needed economic security and access to health care for individuals whose impairments are so severe that they preclude substantial work. This income support program is an integral component of our nation's safety net, reflecting the core American value of assisting those in need. We appreciate Chairman Johnson's and Ranking Member Becerra's interest and attention to this critical program for people with disabilities and their families. The undersigned organizations recognize the importance of ensuring that Social Security disability payments are only made to people who are entitled to receive them and that the amount of the payments are accurate. The Social Security Administration (SSA) does a good job of ensuring that payments are accurate. As Deputy Commissioner Colvin points out in her testimony, SSA has one of the lowest error rates in the government, with a less than 1% rate of inaccurate payments for the SSDI program. Although this low error rate is good compared to other government agencies and programs, the undersigned organizations of the CCD Social Security Task Force believe that more needs to be done to prevent overpayments and are concerned that recent appropriations decisions will undermine these efforts.

The Social Security Administration Requires Adequate Resources for Program Integrity

Adequate resources and staffing are essential to ensuring that all payments made to SSDI beneficiaries are accurate and that SSA can perform necessary program integrity functions (e.g. medical and work continuing disability reviews (CDRs), redeterminations). Unfortunately, recent appropriations to SSA's limitation on administrative funding (LAE) have not been adequate to allow SSA to complete these vital tasks. In fact, by the end of FY2012, inadequate funding and reductions in staffing through attrition will result in the loss of nearly 8000 SSA staff members (see testimony of Steve Clifton, President, National Council of Social Security Management Associations, Inc). This staffing reduction, prohibition of overtime hours, and hiring freeze threaten SSA's ability to fully perform its program integrity functions.

SSA Deputy Commissioner Colvin specifically addressed the impact of reduced funding over the past several years on program integrity efforts in her testimony. Deputy Commissioner Colvin reported, for example, that SSA currently has a backlog of about 1.3 million medical CDRs due to inadequate funding and the lack of staff available to complete the reviews as a result. Medical CDRs save \$10 for every \$1 spent and are vital to SSA program integrity efforts. Based the overall LAE level, as staffing levels continue to be reduced in field offices, these backlogs will only increase. As Deputy Commissioner Colvin stated "The same employees who complete CDRs and redeterminations also have many other critical responsibilities, such as taking and adjudicating SSDI and SSI applications. While our

¹ This includes all individuals with disabilities receiving benefits through the Old-Age, Survivors, and Disability programs, including disabled workers, surviving disabled spouses, and disabled adult children.

workloads continue to grow and expand, the number of people to do the work has decreased.” (p.8).

Delay in Processing Work CDRs Due to Inadequate Staffing Results in Significant Overpayments and Hurts People with Disabilities

When an SSDI beneficiary goes to work, she is required to report her earnings to SSA so that a work CDR can be performed and benefits can be adjusted when appropriate. If the earnings report is processed in a timely manner, the benefits are adjusted and no overpayment results. However, if SSA lacks the staff to process earnings reports in a timely manner, the beneficiary is likely to receive an overpayment. The longer the delay in processing, the larger the overpayment will be. According to Deputy Commissioner Colvin’s testimony, SSA has allocated additional resources to work CDRs, targeting cases with the oldest earnings reports – those more than a year old (p.6). During the hearing, Deputy Commissioner Colvin stated that it takes more than 270 days on average for SSA to complete a work CDR. Every month that passes from the time that a beneficiary reports earnings before a work CDR is completed increases the likelihood of a large overpayment.

This delay in processing of earnings reports often has a very detrimental impact on people with disabilities. When beneficiaries faithfully notify SSA of earnings or other changes that may reduce their benefit payment amounts, as noted above, it may be months or years before SSA sends an overpayment notice to the beneficiary, demanding repayment of sometimes tens of thousands of dollars of accrued overpayments. It is shocking to beneficiaries to receive these notices, when they reasonably assumed that SSA had processed the information they submitted, and it is challenging, if not impossible, for someone subsisting on benefits alone to repay the overpayments. Many individuals with disabilities are wary of attempting a return to work out of fear that this may give rise to an overpayment, resulting in a loss of economic stability and health care coverage upon which they rely.

SSA needs to develop a better reporting and recording system and promptly adjust benefit payments –thus preventing these overpayments. It is important to note that, in and of themselves, **overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able.** The problems arise when reported earnings are not properly recorded and monthly overpayments are not properly adjusted. SSA must have adequate resources and staffing to allow the agency to reduce both the backlog and processing time of earnings reports.

We look forward to continuing to work with the Members of the Social Security Subcommittee to explore ways to secure the future of the SSDI program for the long-term and to protect the vital income support function the program provides for some of the most vulnerable Americans.

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Submitted on behalf of the undersigned members of the Consortium for Citizens with Disabilities Social Security Task Force:

American Council of the Blind
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Easter Seals
Epilepsy Foundation
Health and Disability Advocates
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Disability Rights Network
National Down Syndrome Congress
National Multiple Sclerosis Society
National Organization of Social Security Claimants' Representatives
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association

National Council of Disability Determination Directors

STATEMENT OF
VICKI L. JOHNSON, PRESIDENT
NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS
to the
SUBCOMMITTEE ON SOCIAL SECURITY
OF THE
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
February 6, 2012

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

Thank you for the opportunity to present a statement on behalf of the National Council of Disability Determination Directors (NCDDD). We appreciate the opportunity to comment on the specific concerns of the Committee, raised at the Second in a Hearing Series on Securing the Future of the Social Security Disability Insurance Program, which took place on January 24, 2012.

The National Council of Disability Determination Directors (NCDDD) is a professional association composed of the Directors and managers of the Disability Determination Services (DDS) agencies located in each state, the District of Columbia, and Puerto Rico. Collectively, members of the NCDDD are responsible for directing the activities of approximately 14,600 employees who processed nearly 4.8 million claims last fiscal year for disability benefits under the Social Security Act. NCDDD goals focus on establishing, maintaining and improving fair, accurate, timely, and cost-efficient decisions to persons applying for disability benefits. The mission of NCDDD is to provide the highest possible level of service to persons with disabilities, to promote the interests of the state operated DDSs and to represent DDS directors, their management teams and staff.

The DDSs work in partnership with the Social Security Administration (SSA) to provide public service to individuals applying for disability benefits and to help ensure the integrity of the disability program. The DDSs make complex medical determinations for the Social Security disability programs pursuant to Federal Regulations. The majority of DDS staffs are state employees subject to the individual state personnel rules, governor initiatives and state mandates, with the remainder of staff under state contract to provide services to the DDS. The DDSs adjudicate various disability claims including initial applications, reconsiderations, continuing disability reviews (CDRs), and disability hearings.

The DDSs' role in helping SSA curb improper payments includes processing CDRs (to ensure that only those individuals who continue to be medically eligible remain on benefits), identifying potential fraud in the disability application process, and contributing staff and expertise to SSA's Cooperative Disability Investigation

(CDI) Units. Other ways that DDSs prevent improper payments include their internal training and mentoring programs, quality assurance, the examiner-doctor adjudicative team, and proper supervisory/managerial oversight.

Impact of Funding/Staffing Shortfalls

SSA determines the DDSs' funding levels and workload targets. Funding the various workloads to provide good program service and stewardship is challenging at best, and even more so now, as we experience difficult economic times, with increasing disability applications and fewer resources. While staffing did increase in FY 2009 and 2010 in response to higher workloads, since early FY 2011, SSA has imposed a hiring freeze on all DDSs due to funding limitations. At the end of the first quarter of FY 2012, DDSs were only 3% above the staffing level at the end of FY 2008 (total full time equivalents including overtime), while total receipts from FY 2008 to 2011 increased by 32.5%.

DDS staffing is critical to the processing of all disability claims and CDRs. DDSs also contribute staff to the CDI units. Inability to replace staff losses over time will erode the DDSs' ability to process applications promptly, to complete sufficient numbers of CDRs in a timely manner, and to contribute to CDI unit fraud investigations.

Nationally, the DDS examiner attrition was 13.5% for FY 2011 (a loss of 1195 examiners) and continues at 13.3% (with an additional 266 in examiner losses) in the first quarter of FY 2012. Currently, the DDS is still managing to maintain high productivity, as the remaining staff does a short-term push to keep up with the workload, and some critical support resources are temporarily shifted to production. However, the DDSs cannot sustain these resource shifts for the long term without serious detriment to important program integrity areas, such as quality assurance, training, supervision, and consultative examination oversight.

Ultimately, the loss of examiner staff equates directly to fewer cases completed. For as long as it can, DDSs will do whatever it takes to keep the cases moving and meet workload targets. DDS staffs are extremely elastic and expand their work ethic to meet the need. However, continued attrition without replacement will eventually reach a tipping point with burgeoning backlogs and case processing delays.

The longer the time before DDSs can resume replacement hiring, the harder and longer the recovery will be. DDS examiners are not quickly replaceable cogs in a wheel. It takes time and resources to hire the right employees for the job and then several years and considerable training/mentoring before those employees have the knowledge and expertise to handle all case types independently at full production levels. DDSs need to keep a steady pipeline of trainees and a strong support infrastructure to keep the workload well managed while training the successors, not only for the examiners that have already left, but also for those that will leave in the next two years.

The DDSs continue to seek SSA support and funding for proactive, strategic replacement hiring as soon as possible, to mitigate the long-term negative effects of attrition. As each DDS gets closer to its tipping point, those negative effects include lessening capacity to process all types of cases including CDRs. As backlogs develop and worsen, the progress made over the past few years to reduce pending workloads, complete more CDRs, and staff up CDI units will be lost.

Since beneficiaries may continue to receive benefits during the appeal process, the full benefit of CDRs in the conservation of program dollars will not be realized as long as there are delays at any of the appeal levels. We appreciate that the Budget Control Act of 2011 directs SSA to increase the number of medical CDRs that the agency completes FY 2012. Although all the funding was not ultimately appropriated, we will still complete more CDRs this year than last. SSA determines the number of CDR cases to be worked by the DDSs each year. In preparation for the higher workload target, SSA began sending higher numbers of CDR cases to the DDSs at the beginning of the fiscal year.

Money alone is not sufficient to ensure that the DDSs can process these cases accurately and timely. CDR case processing requires experienced examiners with the capacity for expert judgment in comparing medical findings and function over different periods of time and determining medical improvement following complex legal guidelines. Appeals of CDR cessations require hearings with disability hearing officers, the highest level of DDS adjudicator, requiring many years experience and specialized training in holding administrative hearings and deciding legal findings of fact and conclusions of law. The DDSs also need to use these experienced examiner resources for other aspects of program stewardship, including ensuring the quality of adjudication and providing casework guidance for less experienced examiners. As veteran DDS staff continues to leave, while the pipeline of new examiners remains dry, we foresee increasing difficulty with processing CDRs and their appeals this year and beyond.

The DDSs also face the challenge of managing the initial (and reconsideration) workloads with insufficient funding. Many states consider the adjudication of initial claims (including the associated eligibility for health care benefits) a top priority, as these claimants have not had the "first bite of the apple." While stewardship through completion of a large number of CDRs is important, it is unlikely that all states will be willing to keep prioritizing them over the initial/reconsideration workloads if those workloads start to develop serious delays. Delays are now even more likely to occur, as SSA has decided to redeploy its federal case processing units, which have been assisting with DDS case backlogs, to assistance work for the Office of Disability Adjudication and Review (ODAR). While we appreciate the additional funding for program integrity work and are eager to eliminate the delays in CDR reviews by 2016, lack of sufficient funding for all workloads results in insufficient replacement hiring, which will have the unintended consequence of impeding DDSs' ability to do the CDR workload, even with the additional funding.

Cooperative Disability Investigation Units

The Cooperative Disability Investigation (CDI) program is a promising initiative for fraud prevention. In the states with CDI units, the DDSs contribute experienced adjudicative staff (usually senior examiners or hearing officers) to help assess fraud referrals and investigations. The DDSs that work with CDI units are pleased with the results and find the investigation reports very helpful.

The CDI unit's very presence, if publicized, can be a deterrent to fraud. We recommend a standard process for communicating to claimants and beneficiaries the potential repercussions of committing fraud. We also recommend additional funding and staffing so that all appropriate referrals can be investigated and the investigations completed in a timely manner.

Expansion of the CDI units must be done strategically. Some large states need more units for adequate state-wide coverage. Some states, on the other hand, are too small to warrant a dedicated CDI unit. Currently, DDSs in states without CDI units make fraud referrals to the Office of Inspector General (OIG) or to CDI units in neighboring states. However, many of the CDI (and OIG) units need to be better staffed and funded to enable them to investigate all appropriate referrals and to provide reports in a timely manner.

With initial claims, a timely investigation that proves fraud prevents incorrect benefit payments. Without such a report, the DDS is left to make a judgment about the claimant's credibility and the appropriate weight to give the available evidence. Even if a denial determination results, this decision is more easily reversed on appeal than is a decision based on a clear report of fraudulent behavior. Even when there is no prosecution, the fraud investigation itself may serve as a deterrent to appeal. In the alternate scenario where an investigation disproves fraud, a timely report enables the DDS and SSA to make an accurate determination and grant benefits to the eligible claimant quickly.

Investigation of fraud referrals on CDR cases is also recommended, with appropriate funding and staffing. Determining medical improvement is a very complex process often involving difficult judgments about the person's ability to function, and taking away a person's benefits must clear a high bar of assurance that the person is no longer disabled. Even when beneficiaries are found no longer disabled, they may continue receiving benefits throughout the appeal process, greatly increasing the overpayment SSA will attempt to collect if the final decision is unchanged. Appropriate fraud referrals accepted and expeditiously investigated would be a significant help in determining continued eligibility and limiting overpayments.

Conclusion

In summary, the stewardship initiatives that the DDS is primarily involved in – CDR case processing and CDI unit referral and staffing – are critical for insuring appropriate payments and eliminating fraud in the disability program. Neither has yet reached its full potential because of underfunding and understaffing. Both are labor-intensive but ultimately cost-effective in achieving their goals, based on SSA's reports of the program savings in relation to administrative costs. To achieve the best cost benefit ratio, the approach to both CDR processing and CDI unit expansion should be strategic. It is shortsighted not to invest the necessary funds and staffing for the expansion of these initiatives. Inadequate funding results, as we have seen, in priorities and resources bouncing back and forth between initial cases and CDRs, between DDSs and ODAR, between service workloads and integrity workloads. Ultimately, for the investment to be successful there must also be commitment to a long range strategic plan that supplies all areas of the disability program with sufficient resources and deploys them in a carefully balanced, steady manner, so that both program integrity and high quality service to people with disabilities can be realized.

Mr. Chairman, on behalf of NCDDD, I thank you again for the opportunity to provide this statement. NCDDD has a long record of accomplishment working with SSA to provide the highest level of service and careful

program stewardship. I hope that this information is helpful to the Subcommittee. NCDDD is willing to provide any additional assistance you may need and answer any questions you may have.

