THIRD 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

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

TUESDAY, MARCH 20, 2012

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

The subcommittee met, pursuant to notice, at 10:31 a.m. in Room B–318 Longworth House Office Building, the Honorable Sam Johnson [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

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

Tuesday, March 20, 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 how disability is decided. **The hearing will take place on Tuesday, March 20, 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:

The disability insurance program pays benefits to those who have worked in the past but are determined unable to work because of a disability that is expected to last more than a year or result in death. The responsibility to make the initial finding on disability was assigned to the State Vocational Rehabilitation Agencies or other appropriate State agencies in the Social Security Act Amendments of 1954. All 50 states, plus the District of Columbia and Puerto Rico, maintain fully federally-funded agencies, collectively referred to as Disability Determination Services (DDSs), which decide initial and continuing eligibility of disability claims. The DDS examiner does not see claimants face-to-face and must rely on relevant medical evidence that is provided by the claimant and/or medical sources in deciding whether the individual is disabled, as defined by Federal regulation and Social Security Administration (SSA) policies.

In FY 2011, the DDSs received over 3.3 million initial disability claims, the highest in the SSA's history. Examiners completed nearly 3.4 million initial claims, reducing the backlog of pending applications to 759,000, nearly 300,000 fewer claims than were pending at the end of FY 2010. The average processing time for initial disability claims was 109 days in FY 2011 and is projected to rise slightly in FY 2012. Over the most recent five-year period for which data is available, the percentage of all applications for disability benefits that were allowed ranged from 36–38 percent.

The Social Security Act considers people eligible for benefits when they are unable "to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." The disability has to be so severe as to prevent them from doing any "substantial gainful work which exists in the national economy," whether a specific job is available or not. The disability must result from a physical or psychological condition that is "demonstrable by medically acceptable clinical and laboratory diagnostic techniques." In 2012, the level of earnings that constitutes performing SGA is $1,010 per month for non-blind individuals and $1,690 for blind individuals.

Most claims are evaluated under a five-step sequential evaluation process. The first two steps screen out individuals who are currently working above the SGA threshold and applicants whose impairments are not severe. The third step compares the individual's condition to the "medical listings"—a regulatory list of conditions that are considered severe enough to prevent a person from doing any gainful activity. If the individual's condition does not meet or equal the severity of a condition in the medical listings, the examiner proceeds to step four, which is assessing the individual's residual functional capacity (what an individual can do despite his or her impairment—including past relevant work). If the individual is found able to perform past relevant work, the claim is denied. If not, the examiner must determine at step five whether the individual can undertake other work. State examiners rely on medical evidence obtained from the claimant's health care providers, and can also consult with medical experts and may purchase one or more consultative examinations.

The SSA also has several fast-track procedures for evaluating claims from individuals with a terminal illness, or who have certain especially severe conditions that are highly likely to be allowed (called Compassionate Allowances and Quick Disability Determinations).

In announcing the hearing, Social Security Subcommittee Chairman Sam Johnson (R–TX) said, "**Americans with disabilities deserve to get the right decision as early as possible, but that's just not how it currently works. States struggle on the front lines to make sense of the program's complex rules to decide who gets benefits. At the same time advances in treatment, rehabilitation, and the workplace have created new opportunities for those with disabilities to return to work. Securing the future of the disability insurance program should address these challenges and opportunities while keeping the process fair for both claimants and taxpayers.**"

FOCUS OF THE HEARING:

The hearing will focus on how disability insurance eligibility decisions are made, including the definition of disability and the Federal-State relationship.

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 Tuesday, April 3, 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/*.

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Chairman JOHNSON. Good morning.

The hearing will come to order. Good morning and welcome to the third hearing in our series on "Securing the Future of Social Security Disability Insurance."

Today, we will focus on how disability is decided. For more than 50 years, the Social Security Disability Insurance Program has provided a vital safety net for workers who have worked long and recently enough and who meet the definition of "disability."

When Congress created the Disability Insurance Program in 1956, it defined "disability" as the "inability of an individual to work due to a physical or mental impairment."

"Qualified impairments" are those that are expected to last for no less than one year or those expected to result in death.

Over the years, the Social Security Administration has created complex criteria, emphasizing "complex," and a time consuming process that is frustrating to claimants, costly to the taxpayer, and frequently raises questions about the consistency, accuracy and fairness of this program.

Our witnesses today will tell us how claimants apply for disability, how the state disability determination agencies, which are fully funded by Social Security, decide eligibility.

As we will hear today, deciding whether someone is eligible for benefits is far from easy.

The examiners supported by medical consultants must analyze medical and other evidence and take a series of complicated steps to make their decisions.

In the 1980s, Congress also created requirements relating to the opinion of treating doctors, and how pain and other symptoms affect the ability of an individual to work.

A morass of policies developed to help ensure consistency and respond to the courts have also added to the complexity of the program.

It is no surprise then that there are wide variations in outcomes, raising questions about whether this program is being administered consistently across the country, and whether claimants are being treated fairly.

Further, Social Security has had an up hill climb for years to provide the kind of policy oversight, quality review, and ongoing training that massive disability workloads require.

It has also struggled to stay current with needed updates to the list of medical conditions considered severe enough to qualify for benefits.

While this program has served as a vital safety net to millions of Americans, the reality is much has changed since 1956.

Thanks to advances in medical care, many people with disabilities experience greater independence, and as a result, can live more productive lives.

Legal and social changes have promoted participation by people with disabilities into mainstream society, and the nature of work has changed significantly, as we have moved from an economy largely defined by manual labor to a service and knowledge based economy.

Yet, the "all or nothing" standard of half a century ago is often criticized as "work disincentive," furthering dependence by those who might otherwise be able to achieve varying levels of self support.

As we consider securing the future of this program, we owe it to the American public to ensure that the program effectively serves the interests of applicants, beneficiaries, and taxpayers.

I now recognize the Ranking Member, Mr. Becerra, for his opening statement.

Mr. BECERRA. Mr. Chairman, thank you very much for calling this, the third hearing in our series examining the Social Security Disability Insurance System.

I want to just begin by mentioning that Social Security disability is an earned benefit. It is not something that you just get. You have to have paid into the system, which means you have to have worked and paid into the system, and you must have suffered a work ending disability to be able to qualify.

Even so, the requirements for receiving benefits are very tough. You mentioned that. Only the very sickest and most disabled Americans qualify.

The majority of Americans with disabilities do not meet Social Security's strict eligibility standard. To qualify, applicants must submit detailed medical and other evidence demonstrating that they are either dying or too sick or disabled to work at all, and that their condition will last more than a year.

Moreover, in deciding whether someone cannot work, SSA considers not just an individuals' previous job or occupation, but whether he or she can assume any job in the nation's economy that that individual could do despite the person's medical condition.

Individuals who do not meet these criteria are not eligible for disability assistance from Social Security.

Evaluating whether an individual is so sick or disabled that he or she cannot work is a difficult task, involving complex evaluations of medical evidence and other factors.

DI benefits are not generous. A typical worker receives about $13,000 a year. Because they are either too sick or too disabled to work at all, those benefits translate into a life line for many of those Americans and their families.

We owe it to these Americans to pay their benefits when they need them. Let's remember one in seven beneficiaries of these disability benefits dies within a year of being awarded benefits.

We owe it to all Americans and workers who pay into the Social Security system to safeguard their contributions and pay only benefits to those who meet the strict standard.

Social Security's operating budget is lower today than it was in 2010, because of decisions made in this Congress in what to appropriate and how much to appropriate to the different agencies.

That, to me, is alarming, at a time when Social Security is increasing its workload because of the economy, because of the number of individuals aging into the system. We are finding that the Department's budget or the Administration's budget is actually shrinking in its ability to meet the needs.

That, I believe, is distressing.

As I have said before, I think we owe it to the hundreds of millions of Americans who pay into the system or who receive benefits to hold hearings specifically on these critical decisions on budgets for the Social Security Administration.

Americans' contributions into the Trust Fund are what pay for Social Security's operating expenses. Budget cuts have real consequences now and in the future for Social Security and its recipients.

Initial disability claims, the topic of this hearing, are a good example. With an aging population and the worst recession since the Great Depression, the Social Security Administration receives over three million applications for disability benefits a year, an average of nearly 13,000 claims a day.

Right now, it takes SSA an average of 111 days to make a decision on a disability application.

Due to budget cuts, SSA has been operating under a hiring freeze, which means there are fewer workers to process claims, assist the public, and safeguard the Trust Fund than there were in 2011.

The state DDS offices which evaluate applications have lost more than ten percent of their staff compared to last year. This is the equivalent of about 2,000 skilled workers, many of whom had years of experience.

As a result, the amount of time it takes to make the decision on an application is rising, as is the backlog of people waiting for a decision, which is currently about 750,000 disabled individuals.

Mr. Chairman, this is an important hearing. I believe that we must continue to take a close look at how the system operates. We have to make sure the benefits are there for those who need them, and I am glad that we are holding this in a series of hearings on the Social Security Administration, and in this case, on the disability program.

With that, I yield back the balance of my time.

Chairman JOHNSON. Thank you, Mr. Becerra.

As is customary, any member is welcome to submit a statement for the hearing record.

Chairman JOHNSON. Before we move onto our testimony today, I want to remind our witnesses, all of them, to please limit your oral statements to five minutes.

However, without objection, all the written testimony will be made part of the hearing record.

We have two panels today. Seated at the table is our first panel witness, the Commissioner of Social Security, Michael Astrue.

Welcome, Commissioner. You may proceed.

STATEMENT OF MICHAEL J. ASTRUE, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

Mr. ASTRUE. Thank you, Mr. Chairman.

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, thank you for this opportunity to talk about our disability programs.

These programs have become more complex and more people depend on them. Over the past five years, we have improved service despite limited resources and the huge influx of new disability claims.

In addition to our core work, we have seen a drastic rise in our non-program work. Increasingly, our waiting rooms are filled not with people looking for help with retirement or disability, but with people needing verifications so they can qualify for Federal, state or local programs, or for employment.

Together, we need to figure out how to keep improving services as the population expands and baby boomers age.

To succeed, we need experienced employees, up to date technology, and streamlined policies. We must make more and smarter investments in technology in order to best use our declining resources.

Toward this goal, we are providing people with convenient online options. We are close to testing an uniform case processing system for DDSs.

We are using electronic tools to help us better decide and document cases to improve quality. We are using technology to identify more and more cases for fast tracking, and we are moving from pilots to permanent process with health IT, which has the potential to make dramatic improvements, both in quality and efficiency.

These IT investments demonstrate that we understand that we can no longer do business as usual.

Nevertheless, technology alone cannot make disability determinations. The complexity of the disability programs requires skilled employees to make those decisions.

Unfortunately, after two straight years of less funding than we had in Fiscal Year 2010, we will have lost 7,000 experienced employees who we cannot afford to replace.

Rather than spend time on initiatives we cannot fund, we have focused on program simplifications. Some of these ideas we have implemented on our own. On others, we need your help. With your support, we can make other smart changes.

The President's Fiscal Year 2013 budget includes a legislative proposal, the Work Incentives Simplification Pilot, or WISP, which has great potential to encourage persons with disabilities to return to work.

For several years prior to 2009, we received about 2.6 million initial disability claims each year. Since 2009, that level has increased dramatically to last year's nearly 3.3 million disability claims.

To deal with this sharp increase, we added capacity to our DDSs and flexible national resources to help us quickly reallocate additional support to the most stressed states.

The dedication of our DDS staff and support from our Federal resources has helped us keep pending disability claims considerably lower than our original projected levels.

Furthermore, our average processing time of 104 days, and that includes both the field office and the state DDS time, is near a record low since we began using that combined measure.

Social Security remains a sound investment. We have drastically reduced the time claimants wait for a hearing decision.

In Fiscal Year 2011, we cut the average wait for a hearing below one year for the first time since 2003. Wait times are also down in field offices and our 800-number.

Through the hard work of our employees and technological advancements, we have kept our administrative costs very low.

Moreover, we have increased employee productivity by about four percent in each of the last five years. Few if any organizations, public or private, have similar accomplishments.

We are proud of these accomplishments, and appreciate your confidence in us.

The scope, sensitivity, and complexity of our programs requires well-trained people on the front lines and in key support roles. We simply cannot continue to lose so many employees and keep up.

That challenge requires a complicated and ongoing conversation with Congress, which is why we are so pleased to participate in today's hearing.

Before I conclude, I want to give you also an update on the Social Security Death Master File, which I testified about last month.

After working closely with OMB and interested Federal agencies, I am pleased to announce that we have provided the Subcommittee with our proposed legislative specifications designed to limit access to the Death Master File in order to reduce identity theft.

The Subcommittee's leadership on this important issue has guided our work and we are grateful for it.

Thank you. I will be happy to answer any questions you may have.

[The prepared statement of The Honorable Michael J. Astrue follows:]

HEARING BEFORE

THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 20, 2012

STATEMENT
OF
MICHAEL J. ASTRUE
COMMISSIONER
SOCIAL SECURITY ADMINISTRATION

Chairman Johnson and Members of the Subcommittee:

Thank you for this opportunity to discuss our disability programs. They are a crucial part of America's safety net. Through these programs, we provide vital support to some of the most vulnerable members of our society. Today, I will discuss how the definition of disability has changed over time, how we evaluate disability claims, the role State agencies play in the disability claims process, and a legislative proposal in the President's current budget request that would restore Social Security Disability Insurance (SSDI) demonstration authority and initiate a pilot project to simplify return to work rules.

Introduction

Under the Social Security Act (Act), we administer two major programs that provide cash benefits to persons with disabling physical and mental disorders: the SSDI program and the Supplemental Security Income (SSI) program. The SSDI program provides benefits to disabled workers and to their dependents and survivors. Workers become insured under the SSDI program based on contributions to the Social Security trust funds through taxes on their wages and self-employment income. Under the Act, most SSDI beneficiaries receive Medicare after being entitled to cash benefits for 24 months. SSI is a Federal means-tested program funded by general tax revenues designed to provide cash assistance to aged, blind, and disabled persons with little or no income or resources to meet their basic needs for food, clothing, and shelter. Last fiscal year, our programs provided an average of about 15 million beneficiaries with a total of approximately $175 billion in benefit payments.

These programs have grown in both complexity and the number of people who depend on them. Over the last five years, we have improved the disability process despite the huge influx of new disability claims that has strained our limited resources. We have met new program and administrative requirements at minimal cost to the taxpayers. Our overhead is approximately 1.5 percent of all the benefit payments that we make. During my time as Commissioner, we have faced several extraordinary service delivery challenges. The aging of the Baby Boomer population affected us in two ways: we saw an increased workload, and we lost our more experienced employees to retirement. We have seen an increase in initial disability claims of about 25 percent during the economic downturn.[1]

For FY 2013, we are requesting $11.760 billion for our administrative expenses, a modest increase from FY 2012. I urge Congress to pass this level of funding because we have proven that we deliver. We have drastically reduced the time claimants wait for a hearing decision. In FY 2011, we cut the average wait below one year for the first time since

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[1] See http://www.socialsecurity.gov/legislation/testimony_120211.html

2003. Wait times were also down in field offices and on our 800-number. Busy signals on our 800-number were the lowest ever. Through the hard work of our employees and technological advancements, we have increased employee productivity by an average of about four percent in each of the last five years. Few, if any, organizations have accomplished similar improvements.

We achieved these improvements even as we have steadily increased our program integrity work as well. Since 2007, we have doubled our Supplemental Security Income (SSI) non-disability redeterminations and increased our medical Continuing Disability Reviews (CDRs) by over 80 percent, and we will conduct even more reviews this fiscal year. The benefits we save through these efforts far outweigh their costs, and we have seen a significant increase in SSI payment accuracy. The Administration strongly supports the program integrity cap adjustments authorized by the Budget Control Act, which would put Social Security on a ten-year path to eliminate the backlog in program integrity reviews. The President's Budget requests $1 billion for SSA program integrity in 2013 and calls on Congress to appropriate the remaining $140 million in program integrity funding authorized under the BCA for 2012.

Despite these remarkable outcomes, in FY 2011 and FY 2012, we received appropriations that were far below what the President requested. Although our annual appropriation increased between FY 2011 and FY 2012, due to rescissions to our information technology account in FY 2012 we are operating with $400 million less than we had in FY 2010. The lower-than-requested appropriation, coupled with the IT account rescissions, forces us to make hard choices so that we can direct our limited resources to our most vital services.

Our FY 2013 budget request is lean. We have already curbed lower priority activities so that we can continue to achieve two of our most important goals – eliminating the hearings backlog and focusing on program integrity work. While we will achieve goals associated with these priorities, we simply cannot do all of the other work we are required to do. We expect to lose over 3,000 employees in FY 2012 and over 2,000 more in FY 2013, on top of the more than 4,000 employees we already lost in FY 2011 – a total loss of more than 9,000 Social Security and State Disability Determination Services employees in just three years. When I leave office in 2013, the agency will have about the same number of employees that we had when I arrived in 2007 even though our work has increased dramatically. Retirement and Survivor claims will have increased by over 30 percent and disability claims will have increased by nearly 25 percent since that time.

In addition to increases in our core program workloads, we offer lesser-known but important services that lead to millions of Americans visiting our field offices or calling us each year. For example, in FY 2011, we issued about 1 million replacement Medicare cards, and handled nearly 1 million transactions in administering the Medicare low-income subsidy program. Other responsibilities include supporting the Department of

Homeland Security's program to verify new employee hires, for which we handle nearly 125,000 inquiries each year. In fact, if you look at our waiting rooms today, you see very few older Americans. You do see younger Americans, often with children, waiting for a document some other Federal, State, or local agency is requiring for authentication purposes. It could be a replacement Social Security card or a benefit verification; we handle about 25 million requests for these documents each year. Together, we need to figure out how to build upon our successes in light of these challenges.

Definition of Disability

For both the SSDI and SSI disability programs, the Act generally defines disability as the inability to engage in any substantial gainful activity (SGA) due to a physical or mental impairment that has lasted or is expected to last at least one year or to result in death.[2] Under this very strict standard, a person is disabled only if he or she cannot work due to a medically determinable impairment. As the Committee on Ways and Means noted in its report that accompanied the *Social Security Amendments of 1956*, even a person with a severe impairment cannot receive disability benefits if he or she can engage in any SGA. Moreover, the Act does not provide short-term or partial disability benefits.

Let me emphasize that the Act uses a specialized definition of disability developed over the years by Congress to address the stated statutory purposes of the SSDI and SSI programs. The Act's definition of disability would not be suitable for other Federal programs with different purposes. Under SSDI, insured workers who become disabled receive monthly benefits based on their past earnings. In contrast, the Department of Veterans Affairs provides disability compensation to veterans based on the severity of disabilities resulting from injuries or diseases incurred while on active military service, or were made worse by active military service; furthermore, veterans may receive benefits for partial disability. This specialized standard for Americans who have sacrificed their health for the good of the entire country is appropriate for the specific circumstances they are intended to address.

To provide a more complete understanding of our definition, I will sketch the history of its development.

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

1950s

Congress first defined disability in the *Social Security Act Amendments of 1952*. This law applied to workers who were either blind or unable to engage in SGA because of any medically determinable impairment, which could be expected to be permanent. The law did not provide cash benefits to disabled workers but instead protected their ability to receive retirement benefits. Retirement benefits are computed based on earnings; therefore, a disabled worker with a "period of disability" could have experienced reduced or no retirement benefits due to his or her lost earnings. The 1952 amendments established the concept of a "disability freeze," under which we could exclude a disabled worker's periods of disability when calculating his or her retirement benefits. However, as enacted, the law expired on July 1, 1953, and did not allow a person to file a claim until after June 30, 1953. It was essentially non-operative.

Two years later, the *Social Security Amendments of 1954* created the first operational Social Security disability program; it instituted the disability freeze for workers who met the law's definition of disability. The 1954 law defined disability as blindness or the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration." Other than a slight change in the durational requirement, this definition did not differ from the 1952 definition.

Congress established the payment of cash benefits in the *Social Security Amendments of 1956*. To be eligible for cash benefits, the legislation defined disability to also require that the claimant had to be between the ages of 50 and 65, complete a 6-month waiting period, and could not qualify on the basis of blindness. The Committee on Ways and Means reported:

> [R]etirement protection for the 70 million workers under old-age and survivors insurance is incomplete because it does not now provide a lower retirement age for those who are demonstrably retired by reasons of a permanent and total disability.[3]

It is important to remember that during the debate on the 1956 amendments, some opponents of this legislation argued that Congress had not properly assessed the future cost of providing disability benefits. In response, the legislation's supporters argued that the very strict definition of disability and other features of the new program would ensure that it would remain financially sound.

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[3] H.R. Rep. No. 1189, 84th Congress, 1st Sess., at 3.

1960s and 1970s

The *Social Security Amendments of 1960* removed the minimum age requirement (50) for receiving disability benefits. Congress then changed the durational requirement from "long-continued and indefinite duration" to "expected to last for a continuous period of not less than 12 months" in the *Social Security Amendments of 1965*.

In the *Social Security Amendments of 1967*, Congress adjusted the definition of disability to clarify when a person is considered unable to work due to impairment.[4] Specifically, Congress supplemented the definition of disability to clarify that:

> [A]n individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.[5]

In passing this law, the legislative history indicates that Congress intended to overturn judicial interpretations that effectively made it easier for persons to be eligible for disability benefits.

Rounding out the legislative activity of this period, Congress reduced the waiting period from six months to five months in the *Social Security Amendments of 1972*. These amendments also created the SSI program, which used the SSDI definition of disability. Congress would not again revise the definition of disability until 1996.

1990s

Between 1989 and 1994, the number of people on disability and program costs increased significantly. In fact, in 1992 the Board of Trustees predicted that the DI Trust Fund would run out in 1997, and urged prompt legislative action.

Congress subsequently held a number of hearings from 1993 to 1995 on the disability program's rising costs. One issue discussed in these hearings was the increasing number of disability allowances based on drug addiction or alcoholism (DA&A). Congress initially passed legislation in 1994 to limit benefits to beneficiaries with DA&A. However, in the *Contract with America Advancement Act of 1996*, Congress narrowed

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[4] The 1967 amendments also changed the definition of blindness from central visual acuity of 5/200 or less to the current standard of 20/200 or less.

[5] Pub. L. No. 90-248, § 158, 81 Stat 821, 868.

the definition of disability to exclude DA&A; a claimant is not considered to be disabled if DA&A is a contributing factor material to the determination of disability.

The Role of Work Incentives

Since creating the disability freeze in 1954, Congress has consistently emphasized the importance of vocational rehabilitation (VR) for disabled persons. Congress has established various work incentives to help disability beneficiaries return to work. These work incentives allow SSDI and SSI beneficiaries to continue to receive benefits while performing some level of work. However, over the years, these work incentives have been difficult to administer and difficult for beneficiaries to understand. They have also complicated the definition of disability.

The *Social Security Amendments of 1956* allowed SSDI beneficiaries who were participating in a state VR program to work at SGA for up to one year. This provision was the forerunner to the trial work period (TWP), which Congress originally enacted in 1960 in order to broaden the work incentives offered to disabled beneficiaries. The TWP now allows SSDI beneficiaries to test their ability to work for 9 months over a rolling 60-month period; during the TWP, disability beneficiaries receive full SSDI benefits regardless of how high their earnings might be.

In the *Social Security Disability Amendments of 1980*, Congress created a 15-month re-entitlement period, known as the extended period of eligibility (EPE), for disability beneficiaries who have completed a TWP. Under the EPE, a beneficiary may receive benefits at any time during the re-entitlement period when work activity falls below the SGA level. In 1987, Congress subsequently expanded the EPE to 36 months.[6]

For the SSI program, Congress took a different approach to removing work disincentives. It created rules for counting income from earnings that were more beneficial to SSI disability beneficiaries. For example, the *Social Security Amendments of 1972* created the Plan to Achieve Self-Support. This provision allows beneficiaries to set aside other income or resources for a specified period to pursue work goals that will reduce their reliance on benefits. The *Social Security Disability Amendments of 1980* eliminated SGA as a reason to terminate an SSI disability beneficiary's benefits. Congress added section 1619 to the Act, which provides special benefits to SSI disability beneficiaries who perform SGA.[7]

I will now discuss the way we apply the definition of disability in order to evaluate disability claims.

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[6] This extension was in the *Omnibus Reconciliation Act of 1987 (OBRA 1987)*.
[7] Initially a temporary provision, Congress made it permanent in *OBRA 1987*.

Evaluating Disability Claims – The Sequential Evaluation Process

For both disability programs, we evaluate adult claimants under a standardized five-step evaluation process (sequential evaluation), which we formally incorporated into our regulations in 1978. At step one, we determine whether the claimant is engaging in SGA. SGA is significant work normally done for pay or profit. The Act establishes the SGA earnings level for blind persons and requires us to establish the SGA level for other disabled persons.[8] If the claimant is engaging in SGA, we deny the claim without considering medical factors.

If a claimant is not engaging in SGA, at step two we assess the existence, severity, and duration of the claimant's impairment (or combination of impairments). The *Social Security Disability Benefits Reform Act of 1984* revised the Act to require us to consider the combined effect of all of a person's impairments, regardless of whether any one impairment is severe.[9] Throughout the sequential evaluation, we consider all of the claimant's physical and mental impairments singly and in combination.[10]

If we determine that the claimant does not have a medically determinable impairment, or the impairment or combined impairments are "not severe" (i.e., they do not significantly limit the claimant's ability to perform basic work activities), we deny the claim at the second step. If the impairment is "severe," we proceed to the third step.

Listing of Impairments

At the third step, we determine whether the impairment "meets" or "equals" the criteria of one of the medical Listing of Impairments (Listings) in our regulations.

The Listings describe for each major body system the impairments considered so debilitating that they would reasonably prevent an adult from working. The Act does not require the Listings, but we have been using them in one form or another since 1955. The listed impairments are permanent, expected to result in death, or last for a specific period greater than 12 months.

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[8] For blind persons, the SGA earnings limit is currently $1,690 a month. Currently, other disabled persons are engaging in SGA if they earn more than $1,010 a month. Both SGA amounts are indexed annually to average wage growth. However, the Act specifies that we cannot necessarily count all the person's earnings. For example, we deduct impairment-related work expenses when we consider whether a person is engaging in SGA

[9] This law also focused on other aspects of the evaluation process. For example, it temporarily codified our existing policy for evaluating pain and other symptoms.

[10] Prior to this law, our regulations required a claimant to have at least one severe impairment. Thus, we would have denied claimants who had two or more non-severe impairments, but no severe ones.

Using the rulemaking process, we revise the Listings' criteria on an ongoing basis.[11] When updating a listing, we consider current medical literature, information from medical experts, disability adjudicator feedback, and research by organizations such as the Institute of Medicine. As we update entire body systems, we also make targeted changes to specific rules as necessary.

If the claimant has an impairment that meets or equals the criteria in the Listings, we allow the disability claim without considering the claimant's age, education, or past work experience.

As part of our process at step three, we have developed an important initiative - our Compassionate Allowance (CAL) initiative – that allows us to identify claimants who are clearly disabled because the nature of their disease or condition clearly 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. We currently recognize 113 CAL conditions, and we expect to expand the list later this year. We continue to review our CAL policy to ensure it is based on the most up-to-date medical science.

Residual Functional Capacity

A claimant who does not meet or equal a listing may still be disabled. The Act requires us to consider how a claimant's condition affects his or her ability to perform previous work or, considering his or her age, education, and work experience, other work that exists in the national economy. Consequently, we assess what the claimant can still do despite physical and mental impairments – i.e., we assess his or her residual functional capacity (RFC). We use that RFC assessment in the last two steps of the sequential evaluation.

We have developed a regulatory framework to assess RFC. An RFC assessment must reflect a claimant's ability to perform work activity on a regular and continuing basis (i.e., eight hours a day for five days a week, or an equivalent work schedule). We assess the claimant's RFC based on all of the evidence in the record, such as treatment history, objective medical evidence, and activities of daily living.

We must also consider the credibility of a claimant's subjective complaints, such as pain. Such decisions are inherently extremely difficult. Under our regulations, disability adjudicators use a two-step process to evaluate credibility. First, the adjudicator must determine whether medical signs and laboratory findings show that the claimant has a medically determinable impairment that could reasonably be expected to produce the

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[11] We have also revised our listings to meet statutory requirements. The *Social Security Disability Benefits Reform Act of 1984* required us to revise the criteria under the *Mental Disorders* category.

pain or other symptoms alleged. If the claimant has such an impairment, the adjudicator must then consider all of the medical and non-medical evidence to determine the credibility of the claimant's statements about the intensity, persistence, and limiting effects of symptoms. The adjudicator cannot disregard the claimant's statements about his or her symptoms simply because the objective medical evidence alone does not fully support them.

The courts have influenced our rules about assessing a claimant's RFC. For example, when we assess the severity of a claimant's medical condition, we historically have given greater weight to the opinion of the physician or psychologist who treats that claimant. We followed this policy because a treating source usually is the most knowledgeable about his or her patient's medical condition and is in the best position to assess its severity. While the courts generally agreed that adjudicators should give special weight to treating source opinions, the courts formulated different rules about how adjudicators should evaluate treating source opinions. In 1991, we issued regulations that articulate how we evaluate treating source opinions.[12] However, the courts have continued to interpret this rule in conflicting ways.

Once we assess the claimant's RFC, we move to the fourth step of the sequential evaluation.

Medical-Vocational Decisions (Steps 4 and 5)

At step four, we consider whether the claimant's RFC prevents the claimant from performing any past relevant work. If the claimant can perform his or her past relevant work, we deny the disability claim.

If the claimant cannot perform past relevant work (or if the claimant did not have any past relevant work), we move to the fifth step of the sequential evaluation. As I will discuss later, we have proposed slight modifications to this rule to streamline the adjudication process. At step five, we determine whether the claimant, given his or her RFC, age, education, and work experience, can do other work that exists in the national economy. If a claimant cannot perform other work, we will find that the claimant is disabled.

We use detailed vocational rules to minimize subjectivity and promote national consistency in determining whether a claimant can perform other work that exists in the national economy. When we issued these rules in 1978, we noted that the Committee on

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[12] Under those regulations, we will give controlling weight to a treating physician's opinion if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record. In that case, a disability adjudicator must adopt a treating source's medical opinion regardless of any finding he or she would have made in the absence of the medical opinion.

Ways and Means, in its report accompanying the *Social Security Amendments of 1967*, said that:

> It is, and has been, the intent of the statute to provide a definition of disability which can be applied with uniformity and consistency throughout the Nation, without regard to where a particular individual may reside, to local hiring practices or employer preferences, or to the state of the local or national economy.[13]

The medical-vocational rules, set out in a series of "grids," relate age, education, and past work experience to the claimant's RFC to perform work-related physical and mental activities. Depending on those factors, the grid may direct us to allow or deny a disability claim. For cases that do not fall squarely within a vocational rule, we use the rules as a framework for decision-making. In addition, an adjudicator may rely on a vocational expert to identify other work that a claimant could perform.

I now will explain the role that State agencies play in administering both of our disability programs.

<u>Disability Determination Services</u>

Our disability process consists of several levels of review. Our partners in the State agencies play a crucial role in our disability claims process. When we receive a disability claim, we generally send the claim to a State disability determination service (DDS).[14]

We rely upon the 54 State DDSs to develop medical evidence and determine whether claimants are disabled or whether beneficiaries continue to be disabled. We fully fund what it costs the DDSs to make these determinations, including the salary and benefits of DDS personnel. DDS employees are State employees, but States are required to follow our program rules in a consistent and uniform manner.[15] There is only one national definition of disability in the SSDI and SSI programs. DDSs generally use a team consisting of a disability examiner and a medical or psychological consultant to adjudicate claims.

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[13] H.R. Rep. No. 544, 90th Congress, 1st Sess., at 30.

[14] A claimant can apply for disability benefits online, by telephone, or in a field office. A claims representative interviews all claimants filing their claims by telephone or in a field office. During this interview, the claims representative explains the definition of disability and our disability claims process and obtains all required applications and forms. When claimants file online, our system provides the definition of disability and an explanation of the claims process, and a field office employee reviews the information the claimant provides.

[15] To help ensure disability adjudicators apply our policy uniformly at all levels, we use the same language in all of our policy instructions when communicating our policy to our adjudicators. We have followed this practice since 1996.

If the claimant is dissatisfied with the initial disability determination, our regulations provide for the following three levels of administrative review: a reconsideration by the DDS;[16] a hearing before an administrative law judge; and a request for review by our Appeals Council. If the Appeals Council denies the request for review (or if the Appeals Council grants the request and issues a decision), the claimant may appeal to Federal district court. Although it is not the focus of this hearing, the appeals process is an important part of the disability determination process and an area that we have devoted a great deal of energy and resources to over the past five years.

History of the Federal-State Relationship

Our relationship with the DDSs dates back to 1954. At the time, the States already had responsibility for administering vocational rehabilitation programs under the *Vocational Rehabilitation Act*. Congress tasked the States with determining whether workers qualified for the disability freeze; it reasoned that the States routinely undertook medical and vocational case development and had well-established relationships with medical professionals through the existing vocational rehabilitation programs. We entered into negotiated agreements with the States to administer the disability freeze under criteria and procedures that we established. When Congress created the SSDI program in 1956 and the SSI disability program in 1972, we extended those negotiated agreements to the new programs.

Following public criticism of the lack of uniformity and quality in State disability decisions, Congress ended our negotiated agreements with the States in the *Social Security Disability Amendments of 1980*. Under that law, Congress instead required the States to make disability determinations in accordance with the standards and criteria contained in the Act and our regulations. The 1980 Amendments also authorized us to issue regulations containing performance standards and other administrative requirements. Congress gave each State the option of turning over the disability determination function to us, and authorized us to assume the disability determination function of any State that we found, after notice and opportunity for a hearing, to be substantially failing to make disability determinations consistent with our regulations and other written guidelines. To date, we have not assumed the disability determination function of any State.

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[16] A different adjudication team that was not involved in the initial decision makes this reconsideration. We are currently conducting a prototype project in ten states that authorizes the disability examiner to make the initial disability determination alone (instead of working with a medical or psychological consultant) in some cases and eliminates the reconsideration step.

Performance Standards and Quality Review Initiatives

We take our responsibility to be good stewards of the trust funds and taxpayers' money very seriously and strive to provide the highest quality service possible. We have performance standards and multiple layers of quality review to ensure that the DDSs uniformly and correctly apply our program rules.

Our rules require the DDSs to have an internal quality assurance (QA) function. In addition, our Office of Quality Performance (OQP) conducts QA reviews of samples of the initial, reconsideration, and continuing disability review (CDR) determinations of the DDSs. Between FY 2007 and FY 2011, OQP reviews showed that the DDSs improved their accuracy across the board. The DDSs increased their initial claims decisional accuracy from 93.8 percent to 95.5 percent. They increased their reconsideration decisional accuracy from 91.9 percent to 95.3 percent. Moreover, they increased their CDR decisional accuracy from 95.6 percent to 97.7 percent.[17]

As required by the Act, we perform a pre-effectuation review of at least 50 percent of all DDS initial and reconsideration allowances for SSDI and SSI disability for adults. We also review a sufficient number of DDS CDR determinations that continue benefits. These pre-effectuation reviews, which are separate from the OQP reviews mentioned above, allow us to correct errors we find before we issue a final decision. These reviews result in an estimated $558 million in lifetime program savings, including savings accruing to Medicare and Medicaid. Based on our most recent data, the return on investment has been roughly $11 for every $1 of the total cost of the reviews. [18]

To improve the consistency and quality of DDS decisions, we established the Request for Program Consultation (RPC) process. The RPC process allows DDSs and our quality reviewers to resolve differences of opinion they have on cases that OQP has cited as deficient. In general, DDSs use the process to resolve the most complex cases. Our policy experts in headquarters thoroughly review these cases. We post all RPC resolutions and related data on our intranet. The process serves several key functions. It provides real life examples of proper policy application, identifies issues and areas for improved disability policy, and provides our regional offices and DDSs information to assess local quality issues. Since 2007, we have reviewed almost 5,000 cases and posted their resolutions online. Further, the RPC team has worked directly with policy components to develop policy clarifications, training, and other resources that can further improve the consistency and quality of disability determinations at all adjudicative levels.

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[17] The percent is based upon a statistically valid sample of cases OQP reviews. It reflects the percent of cases reviewed where OQP agrees with the decision made by the DDS.

[18] Details can be found in Annual Report on Preeffectuation Reviews at http://www.ssa.gov/legislation/PER%20fy09.pdf

The Act and our regulations set out a process to help a DDS that does not meet our expectations. Currently, our threshold level for performance accuracy in the DDSs is 90.6 percent. When a DDS falls below that threshold during a quarter, we notify the DDS in writing and provide performance support. Based on available resources, we may work with the DDS to identify the root cause for the drop in quality and to prevent another quarter below the threshold. Corrective actions may include DDS in-line and end-of-line quality reviews and additional training. We then provide the DDS a three-month adjustment period. We have provided optional support to States that have fallen below the accuracy threshold for two consecutive quarters. With our help, those States improved their accuracy rates to meet our threshold level. All DDSs are currently meeting performance accuracy expectations.

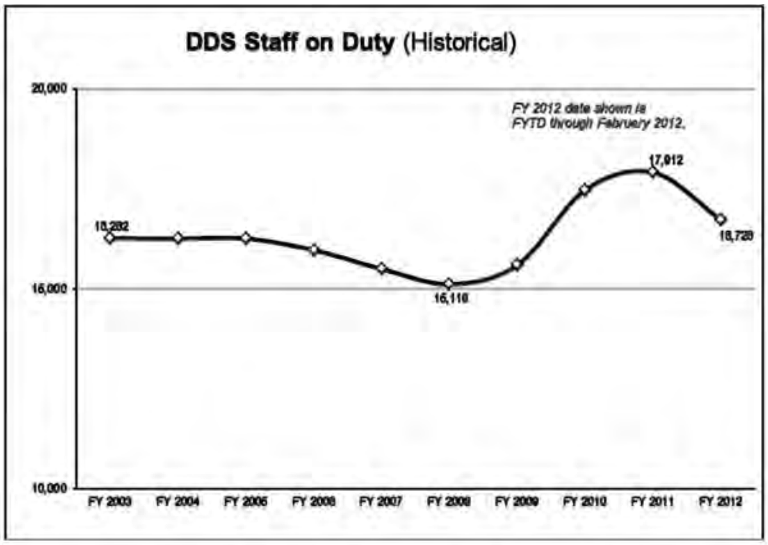
Budget Process

When we develop the DDS budget, we initially estimate how much funding DDSs require to do their three workloads: initial disability claims, reconsiderations, and CDRs. We consider actuarial forecasts for initial disability applications, Administration and congressional priorities (such as program integrity), staffing levels, attrition rates, and productivity. We determine our expected case production and desired workload targets, and we decide the amount of resources that DDSs need to meet those targets. We formulate an Annual Plan in advance of a fiscal year; we ask our regional offices and DDSs to submit their estimated funding and capacity needs based on a national estimate for workload processing.

As the appropriations process unfolds, we constantly communicate with our regional offices and DDSs and adjust the Annual Plan as necessary. Based on the resources that Congress appropriates, we adjust our case production and workload targets as necessary. Once we determine the pool of money available for DDS work, we allocate funding to individual DDSs according to our targets in the Annual Plan. During the second and third quarters of a fiscal year, we also conduct a quarterly spending plan process to allow the regional offices and DDSs to update their plans based on workload targets, any changes in the budget, and actual DDS spending and staffing changes.

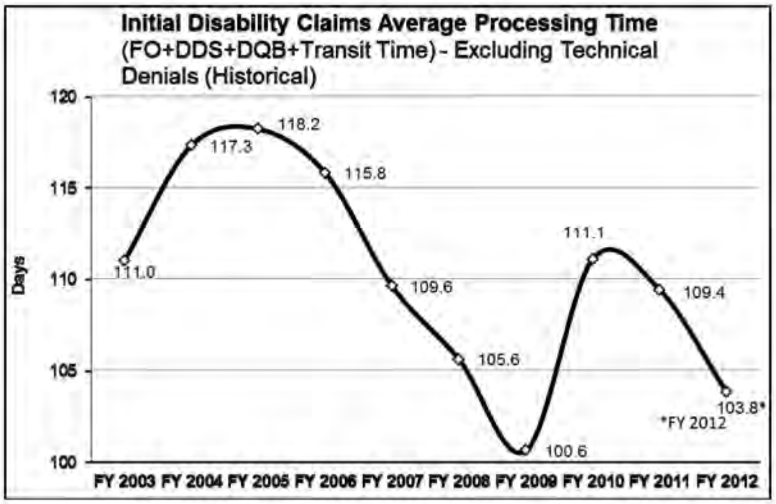
Current Challenges and our Response

Prior to FY 2009, we received about 2.6 million initial disability claims each year. Since 2009, that level has increased dramatically; in FY 2011, we received nearly 3.3 million disability claims. We moved nimbly to shift resources into initial claims in order to help the States avert a potential new backlog. We hired approximately 2,600 DDS employees in FY 2009 and FY 2010; those hires became fully productive in FY 2011.



In addition, we developed flexible national resources to help us quickly direct additional support to the most stressed DDSs. We created Extended Service Teams (ESTs) in four DDSs with a history of high quality and productivity (Arkansas, Mississippi, Oklahoma and Virginia), and we increased the capacity of our Federal disability units across the country. As a result, we completed a record number of initial claims in FY 2011 and reduced our pending claims from our historic high in FY 2010. The dedication of our DDS staff and support from these national resources have helped us keep initial disability claims significantly below projected spending levels. Furthermore, as the chart below shows, our average processing time of 104 days to date this year is near a record low since we began tracking the current measure. Our success during a time of abruptly increasing applications is a tribute to the skill and dedication of the State employees who handle these claims.

Our FY 2012 funding is about $1 billion less than the President's request. Based on this funding level, we expect a net loss of 3,000 State and Federal employees this fiscal year, which is on top of the 4,000 State and Federal employees we lost last fiscal year. With the hiring freeze in FY 2011 and only limited critical hiring in FY 2012, this level of performance will be short-lived. We project the amount of time it takes to decide a disability claim will increase to 111 days by the end of this fiscal year. Similar to our successful strategy for eliminating the hearings backlog, reducing the processing time for initial disability claims will require a multi-year approach.



The *Budget Control Act of 2011* (BCA) outlined a level of program integrity funding that would have required DDSs, with the help of our national disability resources, to complete 569,000 CDRs in FY 2012-- a 65 percent increase over the FY 2011 CDR level in addition to a continued high level of initial disability claims. Unfortunately, our FY 2012 appropriations did not provide the BCA level of funding for program integrity work; therefore, we can only complete 435,000 medical CDRs this year.

In addition, we have evaluated our extremely limited resources, our success in holding down the initial disability claims pending level and average processing time, and a further spike in hearings requests. As a result, we decided to temporarily redirect our Federal disability units, which would have helped handle the BCA level of CDRs, to help screen hearing requests for cases where they can make fully favorable decisions without the need for a hearing before an ALJ.

Further exacerbating the our challenges in handling initial disability claims is the decision of many governors to respond to fiscal crisis by furloughing DDS employees whose salaries and benefits we fully fund. Since December of 2008 through February 2012, DDS furloughs have resulted in $53 million in delayed benefits and about $108 million in lost administrative funding to the States. More information on DDS furloughs is available at www.ssa.gov/furloughs. We encourage you and your constituents to visit the site, and we are happy to work with you on this issue.

Despite the many challenges we face in the DDSs, we are doing what we can to make our disability processes more efficient. We have developed faster and easier online services to meet the Baby Boomers' expectations and keep pace with the high number of disability claims.

Our easy-to-use online application, iClaim, has been a huge success. Disability applicants can now file for benefits online at their own pace and on their own schedule. Meanwhile, the increase in online claims has helped us to deal with the additional economy-driven claims and to reduce our field office waiting times. In FY 2009, we rolled out the first phase of iClaim, and we immediately saw a significant increase in internet claims as a result. Our numbers continue to increase. In FY 2011, more than one million SSDI claimants (33 percent of the total) filed online, almost quadrupling the volume from the year before iClaim. For the first 5 months of FY 2012, 37 percent of SSDI claimants filed online.

We are continually identifying ways to streamline the disability claims process. Over the next several years, we will be making significant improvements. We are modernizing our internet disability appeals by streamlining data collection and improving functionality. To make our electronic folder completely electronic, we will begin capturing electronic signatures for medical authorization and allowing users to upload supporting files directly into our disability systems.

As we expand and improve our online services, we must provide the DDSs with the tools they need to quickly and accurately decide disability cases. In addition to the CAL initiative I discussed earlier, our Quick Disability Determination (QDD) uses a computer-based predictive model in the earliest stages of the disability process to identify and fast-track claims where a favorable disability determination is highly likely and medical evidence is readily available, such as low birth-weight babies, certain cancers, and end-stage renal disease. We expect that our enhancements to QDD and CAL will allow us to fast-track about 165,000 claims for the most obviously disabled Americans while maintaining decisional accuracy. Identifying and paying clearly eligible claimants early in the disability process benefits persons with severe disabilities, and at the same time, it helps our backlog reduction efforts.

The Electronic Claims Analysis Tool (eCAT) is a web-based application designed to assist the examiner throughout the sequential evaluation process. eCAT helps examiners document, analyze, and adjudicate critical aspects of disability claims consistent with our policy. eCAT uses "intelligent" pathing whereby user-selected options determine the subsequent questions and guidance presented. eCAT's features, such as quality checks and quick links to relevant references, aid examiners in producing well-reasoned determinations. This documentation is particularly useful for future case review because it enables an independent reviewer to understand the examiner's actions and conclusions throughout the development and adjudication of the claim.

In addition to enhancing the documentation, quality, and consistency of our disability decisions, eCAT has been an extremely useful training tool for new examiners in the DDSs. Training through eCAT is helping new examiners more quickly gain proficiency in handling complicated cases. We are currently planning for every State to fully implement eCAT by September 30, 2012, which is a testament to our partnership with the DDSs.

We continue to make significant progress in developing the Disability Case Processing System (DCPS). DCPS will replace the 54 different COBOL-based systems that support the DDSs with state-of-the-art web-based technology. This system will integrate case analysis tools and health information technology (health IT). It will allow us to disseminate policy changes faster, and it will improve consistency among the DDSs. It will save money because each time we want or need to modify our system, it will be one set of changes instead of 54 very different sets of changes. We expect the changes to improve processing times and decisional accuracy. We plan to begin testing the initial version of DCPS later this year. We believe full DCPS implementation will make it easier to implement other important technology changes to improve the disability process.

Health IT is one of those important technology changes because it has the potential to revolutionize our disability determination process. We rely upon doctors, hospitals, and others in the healthcare field to timely provide the medical records that we need; we send more than 15 million requests for medical records annually. This largely paper-bound workload is a very time-consuming part of the disability decision process. As the medical community moves toward electronic health records, we are moving towards an electronic system of requesting and receiving medical records. With the consent of our claimants, we will have near instantaneous access to their medical records. Health IT will dramatically improve the speed, accuracy, and efficiency of this process, thus reducing the cost of making a disability decision for the both medical community and the taxpayer. Once health IT becomes standard, our accuracy should improve significantly and we, along with Congress, will want to study changes to the disability process that build on this success.

In addition to paradigm-shifting technology, streamlining and updating our business processes will also help us to decide claims more quickly without disadvantaging the claimant. For example, we allow adjudicators to proceed to step five of the sequential evaluation process when we have insufficient information about a claimant's past relevant work history to make the findings required at step four. In certain cases, if we find that a claimant is able to do other work based solely on his or her age, education, and RFC, we could deny the claim without determining whether the claimant is able to perform past relevant work. This change would promote administrative efficiency and help us make more timely disability determinations.

To make consistent, better-informed decisions on whether disability claimants meet our disability criteria, we are developing a new Occupational Information System to replace the Dictionary of Occupational Titles. In FY 2009, we convened a panel of experts to guide us in the development of the Occupational Information System. In FY 2011, we developed a research and development plan that we will update annually, and we completed critical baseline activities to inform the design of the Occupational Information System. In FY 2012 through FY 2013, we will design and develop prototype components of the Occupational Information System, which will lay the groundwork for pilot testing scheduled to begin in FY 2014.

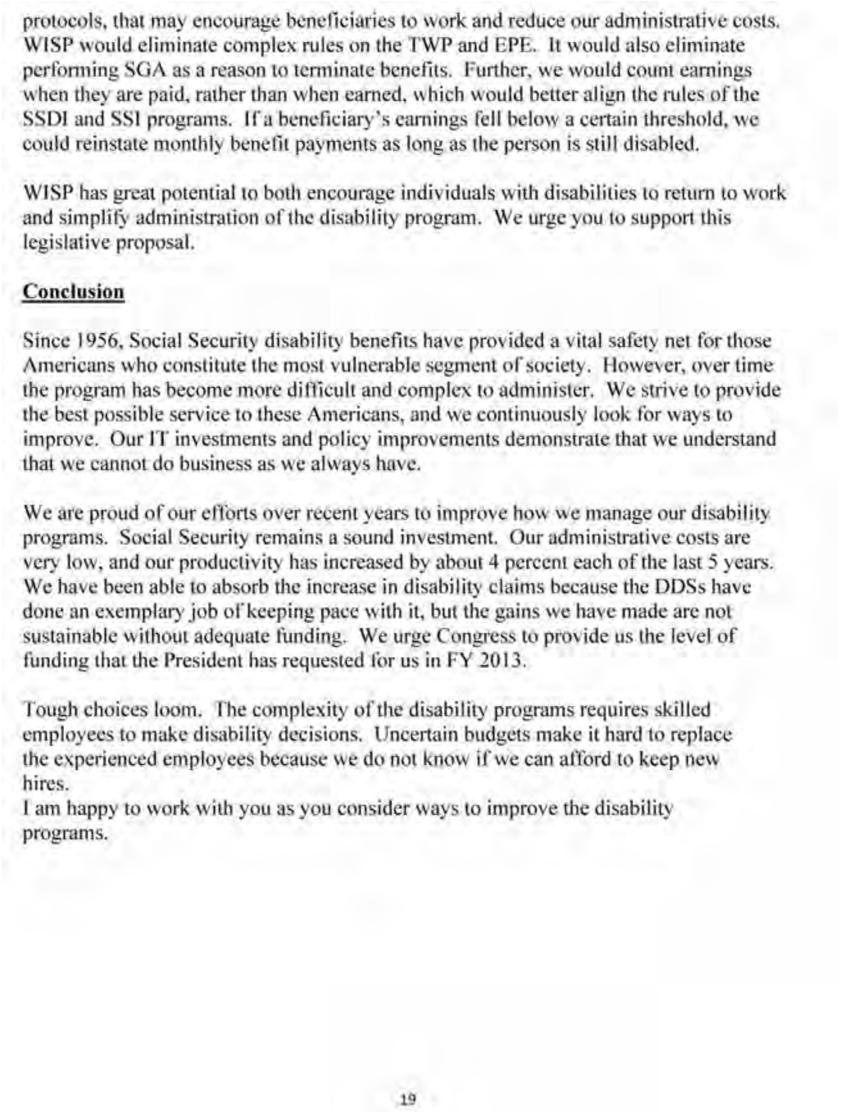
Reducing the Hearings Backlog

Congress has made it clear that addressing our hearings backlog is still our top priority. We have made great strides in cutting the average wait for a hearing decision from a high of nearly 18 months to below one year for the first time since 2003. We have drastically reduced the wait for justice despite receiving a 45 percent increase in hearing requests since FY 2008. In fact, we estimate that we received over one million more hearings requests than we expected when we implemented our 2007 hearings backlog reduction plan. We are so close to achieving our commitment to reduce the average wait for a hearing decision to 270 days by the end of FY 2013, but severe budget cuts for the last two years and associated the inability to hire a sufficient number of ALJs are challenging our progress. Nevertheless, we are doing everything we can to achieve this commitment. We are working with the experts and the Office of Personnel Management to address our needs to identify and hire qualified ALJs in the near-term as well as the long-term to help meet our commitment.

SSDI Demonstration Authority, Work Incentives Simplification Pilot

Our authority to initiate demonstration projects to test changes to the disability program rules expired in December 2005. The President's FY 2013 budget includes a legislative proposal that would give us the authority to initiate new projects for five years, which is important for generating and testing new ideas for how to improve the SSDI program. One of the ways we would use this demonstration authority would be to initiate the Work Incentives Simplification Pilot (WISP).

The current set of work incentive policies and post-entitlement procedures have become very difficult for the public to understand and for us to administer effectively. 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 is still disabled.

WISP has great potential to both encourage individuals with disabilities to return to work and simplify administration of the disability program. We urge you to support this legislative proposal.

Conclusion

Since 1956, Social Security disability benefits have provided a vital safety net for those Americans who constitute the most vulnerable segment of society. However, over time the program has become more difficult and complex to administer. We strive to provide the best possible service to these Americans, and we continuously look for ways to improve. Our IT investments and policy improvements demonstrate that we understand that we cannot do business as we always have.

We are proud of our efforts over recent years to improve how we manage our disability programs. Social Security remains a sound investment. Our administrative costs are very low, and our productivity has increased by about 4 percent each of the last 5 years. We have been able to absorb the increase in disability claims because the DDSs have done an exemplary job of keeping pace with it, but the gains we have made are not sustainable without adequate funding. We urge Congress to provide us the level of funding that the President has requested for us in FY 2013.

Tough choices loom. The complexity of the disability programs requires skilled employees to make disability decisions. Uncertain budgets make it hard to replace the experienced employees because we do not know if we can afford to keep new hires.

I am happy to work with you as you consider ways to improve the disability programs.

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Chairman JOHNSON. Thank you. I appreciate your testimony. As is customary for each round of questions, I will limit my time to five minutes and ask my colleagues to also limit their questioning time to five minutes.

Commissioner, determining whether someone meets or equals the medical listings is a critical step in deciding disability. Advances in medical science and treatment are constant.

I was disappointed to learn from GAO's testimony that some of the listings have been extended repeatedly for the last 19 to 33 years, without updates.

In fact, two of the listings including those for mental impairment, which count for 21 percent of all claims, have not been comprehensively revised for more than 27 years.

How in the world could updating these listings take that long? Nineteen to 33 years?

Mr. ASTRUE. Well, it should not, Mr. Chairman. Very early in my tenure, I made it a priority to change that long-standing practice in the Agency.

On my management initiative, not because Congress said so, not because OMB said so, not because GAO said so, I set the standard for the Agency of trying to be on a five-year cycle going forward, in terms of updating our medical regulations.

I worked in biotech for almost 15 years. I know how important it is to have updated medical information.

I think quite frankly GAO's comments were a bit unfair. We did this on our own initiative. We have updated, if I remember correctly, eight of the 14. We are making very good progress on the others.

We will not in all likelihood quite hit five years, depending on when you decide those five years start. It might be five and a half years.

Considering there was catch up, as you yourself pointed out, the regulations had not been updated in 33 years, it will be easier and faster in the future when you only have to update for three to five years of medical advancement, instead of going over 33 years, which is what we have been doing.

We have been trying to do this the right way. We have been trying to do this with a high degree of consensus, with participation from NIH, with patient advocacy groups. We have had relatively little complaints about this process.

I think we have done this extremely well from a quality point of view. We are doing it extraordinarily quickly by historical standards. I do not really think GAO has anything to complain about at all.

Chairman JOHNSON. Do you have one or two people that look at that all the time?

Mr. ASTRUE. We have a person who does nothing but manage the regulatory process, named Paul Kryglik. He is overseen by our Deputy for Retirement and Disability Policy, David Rust. We have a lot of people working on this.

Could I do it faster if I had more people? Yes. We are doing the best we can with what we have.

Chairman JOHNSON. In their testimony, GAO says "Social Security has made several changes that hold promise for needed updates."

Yet, GAO also raises questions about whether the new process will work. What changes are you making and are you sure they will work?

Mr. ASTRUE. Well, if I understand, they have embraced the five year goal. That came from me. That comes from my management oversight of my people.

I think in general they are doing a terrific job. I am not quite sure. There was a certain vagueness to the GAO criticism there, so I do not really quite frankly understand what it is they are complaining about.

Chairman JOHNSON. Well, they have to complain.

[Laughter.]

Mr. ASTRUE. It is Washington. Silly me. I forgot.

Chairman JOHNSON. To assess the functional demands of specific jobs, Social Security has long relied on the Dictionary of Occupational Titles maintained by the Department of Labor.

Labor decided to replace this with a new system to track occupations, the Occupational Information Network, known as "O*NET."

According to GAO's testimony, Social Security decided O*NET was not detailed enough and would not be able to withstand legal challenges. As a result, Social Security, according to what we know, is now developing its own informational system for a cost of $108 million by 2016.

Worse, the estimate does not include the cost of implementing or maintaining a system, which according to Mr. Bertoni's testimony, could be significant, based on other agencies' experiences.

Tell me why Social Security cannot use Labor's system instead of asking taxpayers to pay again to develop a separate system?

Mr. ASTRUE. Well, quite frankly, the statute does not allow us to do it. O*NET does not have the specificity that the statute requires in order to make the individualized determinations that we need.

The Dictionary of Occupational Titles, which was developed in 1938, was always at best an imperfect fit. It was not designed for us. It just happened to be convenient and there was some overlap.

O*NET is by comparison to the DOT very superficial and designed for—it is further away from our purposes than the DOT is.

We have brought in outside experts to advise us on this. Except for a few consultants who thought they could make money off this, no one has looked me in the eye and said Commissioner, you can just substitute O*NET for DOT.

That is simplistic and a simply wrong approach to something that is very complicated and important.

I think this Agency and a lot of Washington has had their heads in the sand about our vocational guidelines for a long time.

The last update on this was 1991, and that was a superficial update. This has been a tool that needed work for a long time, no one was doing it.

I am not going to benefit from this. We have diverted a lot of resources into this, despite all the pressures to deliver in other areas, because it is critically important for the long term future of the disability program, just as important as it is to be up to date on medical, it is important to be up to date for vocational, and there is no other way to do it than grind it out and do the hard work to do it right.

Chairman JOHNSON. Well, ask Labor to give you some money for it then.

Mr. ASTRUE. Mr. Chairman, I have had this conversation with some committee staff, not on this committee. There is a perception that is wrong, that there is this huge pool of untapped resources over at Labor.

Labor decided basically to get out of this business a long time ago, even O*NET is done largely by contractors.

We have tried to work with Labor as best we can. We have invited them into the process. There is this misconception that there is this huge untapped pool of expertise at Labor that we are not trying to take advantage of. That is simply not true.

Chairman JOHNSON. I am just worried about the cost. Mr. Becerra, would you care to question?

Mr. BECERRA. Thank you, Mr. Chairman.

Commissioner, thank you for being here. Thank you, by the way, for the work on the DMF, on that file. All those records of deceased individuals that have been used by people to invade people's privacy and steal their identity, the work you are doing, I think, will benefit many, many people, and we thank you for that.

The faster we can get to that, the better. If we can help you as you go around to the other departments and agencies to try to make sure everyone works under the same standards, so we do not have people's death records being revealed and used by others for the wrong reasons, the better off, I think, all of us will be.

Mr. ASTRUE. It took a little while, but I think the agencies are aligned now. We support this proposal. What we need now is the Congress to move.

I would turn it around on you a little bit. We want to help you. I think there is bipartisan support, which is a little rare in this city right now, for doing something in this area.

I think it would be a great thing if we could find a way to all work together to try to make sure this bill still passes this year.

Mr. BECERRA. It may surprise you, Commissioner, but I think the Chairman would agree with that statement and I would, too, that there can be bipartisan support on that particular issue. I hope we are able to work with you to make something happen soon to protect people's identity.

You mentioned earlier that your caseload has increased on the disability side. What were the numbers?

Mr. ASTRUE. It is up to about 3.3 million.

Mr. BECERRA. As opposed to what?

Mr. ASTRUE. To 2.6, 2.65 before the recession hit.

Mr. BECERRA. In the last two or three years, you have increased by almost a third, 25 percent?

Mr. ASTRUE. We are taking in roughly 600,000 to 650,000 more cases than what the actuaries were projecting we would have in this time period before the recession hit.

Mr. BECERRA. You were already going to increase because of the size of the baby boom population that was going to start working its way into the Social Security system, whether through disability or retirement, but on top of that, with the recession, double whammy.

Now, more people than you expected are coming into the system.

Mr. ASTRUE. Triple whammy. We have a lot more retirement applications because desperate older Americans are applying for retirement in higher numbers than we projected.

Because we are doing so much verification for other Federal, state and local programs, which people are using more because of the recession, those workloads have gone up as well.

Mr. BECERRA. I am looking at your written statement on page two where you talked about the budget. You said toward the bottom there of page two, "Our Fiscal Year 2013 budget request is lean."

You go on to say "While we will achieve goals associated with these priorities, we simply cannot do all of the work we are required to do. We expect to lose over 3,000 employees in Fiscal Year 2012, the current year, and over 2,000 more in Fiscal Year 2013, on top of more than 4,000 employees we already lost in Fiscal Year 2011, a total loss of more than 9,000 Social Security and state disability determination services employees in just three years."

While your caseload is rising, you are losing valuable and experienced personnel, and your budgets are shrinking.

Your current budget from Congress is about $1 billion lower than what you requested, and it is lower than what it was in 2010.

By the way, working men and women are contributing to the Social Security system every day through their paycheck contributions, so it is not that there is not the money there for Social Security to do its work because everyone who sees that paycheck deduction, that FICA tax deduction, knows they are paying for Social Security.

If Congress is short changing your budget, are you able to keep up with these caseloads?

Mr. ASTRUE. The answer is we have done a remarkable job up to this point in keeping up, and it is because of simplification, great work by the employees, a lot of things.

We cannot keep this up indefinitely. I want to make sure that all of you understand that we are probably four to six months away from moving significantly backwards in most of our major service metrics.

Even if we keep up the four percent increase in productivity, which is an extraordinary achievement, and I am not sure we can do that, but even if we do, it is not going to be enough to compensate for all the people that we are losing so quickly.

Mr. BECERRA. Longer waits to get your determination on your disability, longer waits to be able to apply for retirement benefits, longer waits to receive your surviving spouse benefits.

Probably more mistakes, because we know the longer a case sits, the more likely errors will be made in the determinations, so it seems like some folks in D.C. are being penny wise but very pound foolish when it comes to services that most Americans have paid for.

I hope you will continue to sound the alarm and get us the information that will help us make the right decisions so that we do not short change our seniors and all those Americans who paid into the system for Social Security, whether disability, retirement, or surviving benefits.

I thank you, Commissioner, for being here.

Mr. ASTRUE. Thank you, Mr. Becerra.

Chairman JOHNSON. Commissioner, I want to just set the record straight. This year, Social Security received an increase in its budget despite a 1.5 percent decrease in an overall discretionary cap.

In fact, while Social Security is subject to the same long term domestic spending caps enacted in the Budget Control Act, that same bill gave Social Security an additional $11 billion, from 2012 to 2021, over the budget caps, to increase continuing eligibility reviews in its DI and SSI programs.

This year's appropriation bills were supported equally by both parties, including the President, the Democrat led Senate, Ranking Member Levin and Ranking Member Becerra.

Even the President's Fiscal Year 2013 budget requested $753 million below your request of $12.5 billion.

The fact is our nation faces a sea of red ink that will break the back of our great nation unless we act now to get our fiscal house in order.

The Federal Government has to live within its means, just like families do. That means doing more with less.

Mr. ASTRUE. Mr. Chairman, I understand the fiscal needs, and certainly we live with whatever judgments Congress makes.

Let me be clear, because I am not sure it was clear from your statement, our appropriation is smaller two years in a row. We had less in 2011 than we did in 2010 and we have less in 2012 than we did in 2011.

Chairman JOHNSON. You reduced your force, too, have you not?

Mr. ASTRUE. Substantially.

Mr. BECERRA. Mr. Chairman, since we are out of order, if I could just comment as well.

Chairman JOHNSON. Go ahead.

Mr. BECERRA. Thank you. I think we also have to remember that Congress forced the Social Security Administration to use its reserves to try to continue to perform at a higher level.

Those reserves were meant to help deal with any number of important activities that the Social Security Administration must perform. Those reserves are now gone, so while——

Mr. ASTRUE. Most of those were rescinded. We used some, but the majority of them were rescinded.

Mr. BECERRA. Congress stripped them away from you. Not only are you receiving less money in your budget, but money was taken away from you that you would have otherwise have used for good purposes.

Mr. Chairman, let's be clear. We can try to paint this however we wish, and we should do hearings on this particular issue on the budget, because Americans have paid for the administration of the Social Security programs.

This is not one of those areas where because we are in fiscal red ink that the Social Security Administration should suffer the consequences, because to this point today, Americans through their taxes have contributed more to Social Security than they have spent.

Therefore, we should not find that this agency, which does tremendous work for tens of millions of people, should all of a sudden have to make cuts to its services because it is getting short changed by a Congress for deficit spending unrelated to Social Security.

I think it is important, Mr. Chairman, that we continue to do these hearings, but as the Commissioner just said, there are consequences.

Chairman JOHNSON. I believe it is your Administration that cut back two percent.

Mr. BECERRA. We can have those conversations later. Let's just agree on a bipartisan basis that we will not make cuts to Social Security that have no place when Americans have contributed to the system to pay for the services and the administration.

Chairman JOHNSON. Thank you, Mr. Becerra. Mr. Berg, you are recognized.

Mr. BERG. Thank you, Mr. Chairman.

Moving on to a different area, Commissioner Astrue, I understand the statutory definition of "disability," Social Security has a regulatory framework and listing of impairments considered severe enough to prevent an individual from working.

I have a few questions relating to the medical listings of impairments. First, would you say that these listings rely on objective medical findings and are less subjective to the judgment of the DDS examiner?

Mr. ASTRUE. Yes. I think that is generally the notion. If we think something is clear enough we can do a listing for it, in other words, create a presumption. Invariably, there are at least substantially objective criteria that go into that. I would not want to say there is no subjective element, but it is substantially objective.

Mr. BERG. A higher standard from your point?

Mr. ASTRUE. Yes, I think that is generally right.

Mr. BERG. I know you have invested personally a lot of time and effort into the development of compassionate allowances.

Mr. ASTRUE. Yes.

Mr. BERG. How do compassionate allowances differ from conditions in listings set forth by the regulations?

Mr. ASTRUE. It is basically an expansion of the concept. What we do is we have gone—the listings historically would only apply to fairly common diseases and conditions, and what we found is we were making a lot of mistakes in the aggregate, in sort of rare diseases and conditions.

The notion was on a one time effort, we went through to try to identify those diseases and conditions that pretty much by definition make you disabled.

Now because we are electronic, we have the ability to pull those out at the front end and just allow them, which is what we do. I think it is about ten days now.

They are basically an extension of the philosophy of the listings. I think the differences are we have moved to much smaller diseases and conditions than what we would historically recognize.

We have pulled them out electronically in the system, and we have set up procedures in the DDS so they are triaged at the front end, so it is a very short amount of time for a decision.

Mr. BERG. You have a more streamlined processing procedure?

Mr. ASTRUE. Right.

Mr. BERG. Last, I have heard from constituents in North Dakota. They are asking about the disability listing for Huntington's Disease.

How do you decide to add a new listing?

Mr. ASTRUE. Well, what we try to do is we look not only at the medical literature in detail, but we try to speak to the patient groups. Increasingly, we have a very broad and very productive partnership with NIH.

With Huntington's, I guess I will jump on one of our announcements, so on April 11, we are going to be announcing that we are adding juvenile Huntington's to the compassionate allowance list. That is a first step.

I have met with a Huntington's group. I think the dilemma there is trying to figure out where to draw the lines. I think we think we can do it, but actually, it is one of those rare cases where it is harder because of technology.

Now with genetic tests, where a lot of people are getting diagnosed at a very young age, you cannot give benefits consistent with the statute, just with the genetic test that says you have Huntington's.

Historically, it took so long to diagnose Woody Guthrie. By the time they knew Woody Guthrie had Huntington's, he was long gone, and obviously disabled.

Now with the new technology, we have to figure out exactly what symptoms of people with Huntington's make them unable to work. We have not finished that process, but we are fairly optimistic that we are going to be able to do that.

We have been in contact with both NIH and with the patient groups. That is in the neurological listings. My guess is we will have an NPRM out on that probably early next year, would be the likely schedule.

Mr. BERG. Thank you, Mr. Chairman. I yield back.

Chairman JOHNSON. Mr. Marchant, you are recognized.

Mr. MARCHANT. Thank you, Mr. Chairman.

Commissioner, last week in our district work period, I spent most of my time visiting with senior groups. In the conversation, usually in the question and answer section afterwards, in every instance, I had a senior that raised their hand that said they knew someone or some family that they were confident was receiving disability benefits that they felt like that person was defrauding the Social Security System.

In response to that question, I would use your statistic, that there are 600,000 to 700,000 new claimants more than, was it ten years ago?

Mr. ASTRUE. Three years ago.

Mr. MARCHANT. Three years ago. That response brought on the question is the Social Security Trust Fund solvency threatened by the 600,000 to 700,000 more claimants.

The general attitude is there is a fear among people who have worked their entire life and that this program, the disability program itself is threatening the entire integrity of the Trust Funds.

Can you address that for me?

Mr. ASTRUE. Sure. There is a mythology in a lot of quarters, and the media feeds this from time to time, that the system is ripe with fraud. That is simply not true.

Is there fraud? Well, sure. With a system this big and with standards this complicated, is there some small level of fraud? Yes.

I think the level of fraud is much smaller than in most government programs. I think it is some fraction of one percent.

We do everything that we can to try to root those out, but I think what you have to be aware of is that increasingly, particularly as our society's and Congress' definition of "disability" has expanded, there are people who are legitimately disabled who do not look that way to their neighbors, and their neighbors make unfair conclusions. You see this with people with a variety of mental conditions. You see this fairly typically, for instance, with people with early Alzheimer's.

We even had a case with one of our own medical examiners who saw someone with early Alzheimer's and just ridiculed the person. I apologized in a public hearing for the way one of our own people reacted.

I think people are sometimes very quick to assume fraud when in fact what they are seeing is a non-apparent disability.

Mr. MARCHANT. What about the issue of these claims threatening the solvency of the Trust Fund?

Mr. ASTRUE. My view is the level of fraud is so low that it is a rounding error in terms of the solvency of the system.

Mr. MARCHANT. Setting fraud aside, what about the increased number of cases, with the 1.8% total payroll deduction. Are there statistics out there that say the 1.8% raises this much money, and this much money is coming out of the system?

Mr. ASTRUE. That is a good question. Something that should give you confidence in the integrity of the system, with the recession related claims, which economists and others would say typically would not meet our standards, if the system has integrity, then the allowance rates should drop.

Our allowance rates have dropped during the recession, both at the DDSs and even more dramatically at the hearings and appeals level, because we are seeing more claims that are not meritorious.

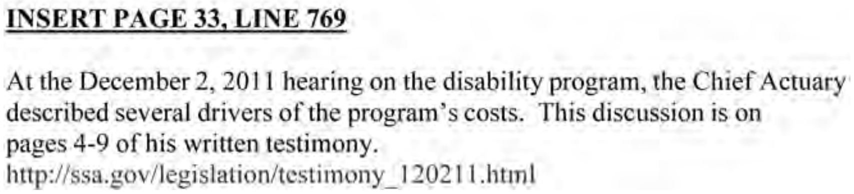
The increase in claims is not a result of any significant change that we have made or that you have made.

Eighty to 90 percent of the change probably, and we will supply more information to you about the record, is entirely predictable, has been predictable for decades.

It is what the Office of the Actuary has been telling the Congress would happen because people basically, with my profile, aging baby boomers, are in their disability prone years.

The amount of disability allowances we are seeing are relatively close to what the Agency, CBO and other experts have been predicting for a long time.

[The insert follows,The Honorable Michael J. Astrue follows:]



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At the December 2, 2011 hearing on the disability program, the Chief Actuary described several drivers of the program's costs. This discussion is on pages 4-9 of his written testimony.
http://ssa.gov/legislation/testimony_120211.html

Mr. MARCHANT. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, Mr. Marchant. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman. Thank you, Commissioner Astrue, for coming here today and certainly for your service.

Mr. ASTRUE. Thank you.

Mr. SMITH. I appreciate the Social Security Administration's efforts obviously to expedite cases through the quick disability determination process. Obviously, I believe it is important we find ways to move the easily decided cases through the system more quickly.

Can you speak to the safeguards that you might have in place to ensure that the system still cannot be gamed perhaps amidst the fast track that we know probably needs to exist?

Mr. ASTRUE. That is a very fine question. None of this happens on automatic pilot. As fast as this is, there is still a full medical review. Not necessarily a full vocational review, if it is not necessary, for instance, for a compassionate allowance.

For QDD cases, there is still a medical/vocational analysis. It is just put up at the top of the queue.

We confirm all these medical analyses. We do not take the representation of the claimant as definitive.

I think it is a system with a lot of integrity.

The other aspect to integrity that I think is important, it is not statutory, not regulatory, but something that I think you should know about and be concerned about for the future, is again, at a management level, we have set the threshold for the QDT cases, 95 percent probability or more of allowance.

There has been occasional internal and external pressure to lower that. What I would tell you is if you lower that, you start damaging the integrity of the system.

It might look good in the short run, but I think you start damaging something that works really well, and I think the discipline of making sure that only the most likely cases are compassionate allowances or QDTs is an important one, but by doing it the right way, we are up to almost six percent, I think, of the cases decided in that way. I think by the end of next year, we will probably be at seven percent.

It will start flattening. There is a natural end to it. I think if you water down the system, you start damaging something that is really important for disabled people.

I hope in the future you will protect the integrity of the system and ask the Agency in the future to maintain that 95 percent threshold.

Mr. SMITH. Thank you. Shifting gears a little bit, in terms of the hearings' backlog, you committed to eliminate the backlog and reduce the average time it takes, and there has been some progress made obviously.

The productivity by ALJs has increased, the backlogs have been reduced, and waiting times for the hearing decision are down from over 500 days in 2008 to 345 days in 2011. Some progress.

Conditions sometimes change perhaps, but in the 2013 budget request, I know hearings pending and hearing wait times will continue to decline, looking at that request, and yet the workloads pending and wait times will increase.

Social Security has always worked to make the right decisions as soon in the process as possible. Can you speak to that and how the budget request reflects the numbers?

Mr. ASTRUE. Sure. You know, at some point as much as we have tried to lay out a plan for what we can do, it is contingent on a couple of things.

It is contingent on adequate funding from the Congress. It is contingent on an adequate supply of judges supplied by the Office of Personnel Management. Those are the two key variables.

At some point, as the budget gets tighter, we are going to have to make hard choices about whether we back off from the goal that we set for ourselves, and I think that is on the table for next year. I hope not.

My view is we have done, I think, a much better job than I think most Members of Congress expected five years ago when we started this process.

If you had said to me at the time, Commissioner, can you do this, oh, and by the way, you are going to have the worst recession since the Great Depression, and you are going to have budget cuts for two straight years, are you still going to be able to do this, my answer would have been no, Congressman, I cannot do it.

We are here. We have made great progress.

The question of whether we can get from approximately 345 days to 270 days in the next year and a half will turn a lot on the funding situation.

When I was General Counsel of HHS, I had in my closet a cartoon wall. My favorite was a lawyer looking at a client. He looked at the client and said, "Well, how much justice can you afford?"

That is basically where you are. If you want justice, if you want 270 days, then you can get that, but you have to support the budget to get there.

Mr. SMITH. Okay. Thank you, Mr. Chairman.

Chairman JOHNSON. The time of the gentleman has expired. Mr. Tiberi is recognized.

Mr. TIBERI. Thank you, Chairman. Thank you, Commissioner, for your service. Thank you for being here.

I want to make just a couple of points and then ask a question. One of the best things that Social Security has ever done is provide those of us who pay into Social Security, and yes, congressmen pay into Social Security, even though there is a long-standing myth that we do not, when I get my statement, and I got my statement last summer, the notice that says I am going to get this much money based upon quarters that I have put in, and what I have paid in, but then a little asterisk that says "If nothing is done by the time you are scheduled to turn 67," it does not say 67, but by the time you are ready to retire at full retirement age, "you will only get 77 percent of your benefit."

I think that is great. I think that illustrates that there is a problem with the future of funding Social Security, not just for me, but for my four daughters, if we do nothing.

I think that is a great service, and I would hope you would highlight that better, and obviously we are here talking about the disability fund, which according to the Congressional Budget Office, is in worse shape than the retirement fund.

In my office, I had a case worker who has been doing Social Security long before I got elected to Congress, who was working for my predecessor.

He says anecdotally that he can count on three out of every four constituents who come in to our office to seek help will ultimately get denied initially, and then will go to an appeal. A majority of those anecdotally in our office who go through the appeal process will ultimately get awarded.

In relation to that context that I just gave you, when you have numbers that have been provided to us that it takes about $1,050 to process a DDS claim on average initially up front, so it is a little over $1,000, that claim is processed in a little over 100 days, through our office at least, most of those are denied initially.

Then they go to an appeal. That appeal through a judge costs about three times as much, three times as long.

In view of those numbers, and those are national numbers, in addition to what we see in our office in terms of the time frame, is there an inconsistency in this process?

Do we need to look at what the DDSs are doing versus the appellate process to make that system maybe more efficient? Are they not trained the same?

Is there some sort of breakdown between the initial process and the appeal process? Can we streamline this process to make it more cost effective, more timely?

Mr. ASTRUE. I am tempted to answer yes to most of those questions, but let me say this.

Different iterations of that question we have been dealing with for a long time. I do think we have made some significant progress.

Compared to five years ago, quality in the DDSs is up substantially. We have additional quality initiatives or quality related initiatives in the pipeline.

The most important one is that we are moving from a fragmented, antiquated 54 siloed IT system to a state-of-the-art unified system that builds in the best practices that we know work.

The most important one is something called eCAT, which uses basic artificial intelligence techniques to prompt examiners with everything they need to know when something comes up relevant, if multiple sclerosis comes up or rheumatoid arthritis comes up, whatever, it tells them everything they need to know.

In fact, it requires for quality reasons documentation of certain things if our rules require it, in essence, to prevent examiners from taking shortcuts.

The quality is getting better in the DDSs, and I think they have done a great job.

It is also helping the fast track that Mr. Berg and others have mentioned, it has been a big help in terms of quality.

When I came in and there was some resistance to doing the compassionate allowances, we did a retrospective study, and we found that on the things that were on my list, our error rate, which at that point was about six percent in the DDSs, it is probably about 20 to 40 percent, and most of them were closer to 40 percent.

Picking out those rare things and giving precise guidance, those things help.

By definition, you are going to see the close cases. Ohio may be a little worse than some other states. Ohio is one of the states that did a lot of furloughs. That damaged morale, increased turnover, aggravated backlogs, meant more acrobatics in terms of staffing and higher costs to get things done.

It may be a little worse in Ohio at the DDS because of that. I think it is moving in the right direction now.

One of the things you should be real happy about, one of the real success stories, is five years ago, Columbus was probably one of the sixth worse hearing offices in terms of backlog in the country, made enormous progress, about 500 days off the wait time.

You should particularly go and thank the new Chief Judge over there, Judge Allen. This is one of those cases where one person with backbone and management talent has made an enormous difference.

Mr. TIBERI. Great point. I appreciate that. You are right about that.

The only thing that is depressing for me is when my case worker has to tell people up front that you know what, you are probably going to get denied when you initially apply because that is what usually happens. That is kind of unfortunate.

Mr. ASTRUE. Statistically, it is about one in three. I know it feels differently, I think because you do not get a representative sample——

Mr. TIBERI. That is probably true.

Mr. ASTRUE. In hearing offices. It is about one in three at the DDSs, and right now, the allowance rate is about 50/50, it is about 51 percent are allowed on appeal.

Again, some of that is rational. People who are severely ill, that is not a static situation, particularly if the time lines stretch out, their situation changes.

The obligation of our people on the way is not to decide whether the previous decision was right, but to look at it fresh and new.

It is not necessarily inconsistent. Sometimes it is.

Mr. TIBERI. Thank you.

Mr. ASTRUE. It is not necessarily inconsistent when an ALJ comes to a different decision from an examiner.

Chairman JOHNSON. The gentleman's time has expired. Mr. Becerra, you are recognized for 30 seconds.

Mr. BECERRA. Thank you, Mr. Chairman. By the way, Commissioner, thank you very much for your visit to Los Angeles and the offices that we have there in Los Angeles, and the work you are doing with them.

Just a quick point, maybe we can follow up because we need to move on. I know you have instituted a new policy that will withhold the names of the administrative law judge to Americans who are filing their claims or to their representatives, as they try to move through the appeal process. I know there is some concern as to whether or not some folks are trying to judge shop who will conduct the hearing for that appeal.

I think it may have been overly broad in its approach in targeting both in-person and video hearings. It sounds to me like the concern with judge shopping may be more related to video hearings than the in-person hearings.

I am hoping that maybe we can talk further. I do not think that what we want to do is end up with more errors in the decision making, and a more arduous process for folks who do not have a lot of money.

I know what we want to do is make sure the appeals process works in the most efficient and adequate way forward, and perhaps we can talk about that.

Mr. ASTRUE. Always happy. You have my number, call any time.

Mr. BECERRA. Thank you so much. Thank you, Mr. Chairman.

Chairman JOHNSON. Commissioner, thank you for being here. You are doing a great job.

Mr. ASTRUE. Thank you. I appreciate all the support from members of this committee. It does make a huge difference for us in a lot of big and small ways. Thank you for what you do as well.

Chairman JOHNSON. Thank you. We will now proceed to our second panel. You will be excused. Thank you, sir.

Our witnesses that are taking their seats at the table are Trudy Lyon-Hart, Director, Office of Disability Determination Services, Vermont Agency of Human Services, on behalf of the National Council of Disability Determination Directors.

Lisa Ekman, Senior Policy Advisor, Health & Disability Advocates, on behalf of the Consortium for Citizens with Disabilities Social Security Task Force.

Dan Bertoni, Director, Education, Workforce and Income Security Issues, U.S. Government Accountability Office.

Dr. Leighton Chan, Chief, Rehabilitation Medicine Department at the National Institutes of Health.

Dr. Nicole Maestas, Senior Economist, RAND Corporation, all the way from Santa Monica, California.

Ms. Lyon-Hart, welcome. Please go ahead. You are recognized.

STATEMENT OF TRUDY LYON-HART, DIRECTOR, OFFICE OF DISABILITY DETERMINATION SERVICES, VERMONT AGENCY OF HUMAN SERVICES, ON BEHALF OF THE NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

Ms. LYON-HART. Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, I am Trudy Lyon-Hart, President-Elect of the National Council of Disability Determination Directors, NCDDD, and Director of the Vermont Disability Determination Services.

Thank you for this opportunity to testify on behalf of the administrators of the Disability Determination Services, the DDSs, of the states and the District of Columbia.

Collectively, we direct the work of over 14,000 employees, processing nearly 4.8 million disability cases a year, including initial claims, reconsiderations, and continuing disability reviews, CDRs.

DDSs make determinations with high accuracy, ensuring that over a million deserving disability applicants get benefits quickly each year.

In any given year, over 70 percent of the allowance determinations in the disability program are made at the DDS level, with no need for an administrative law judge hearing.

DDS accuracy, speed and volume are notable considering the program's complexity. Adjudicators must obtain health care records and detailed descriptions of daily activities and work history, arrange for consultative exams if needed, analyze reams of electronic evidence, in the process evaluating symptoms, weighing different medical opinions, assessing medical severity, and determining individuals' remaining work capacity.

Social Security and the DDSs have historically worked together to provide the American public with prompt, accurate and cost effective service.

However, our ability to continue to do so is now increasingly threatened. Funding in the Fiscal Year 2012 budget will not cover all the cases the DDSs will receive.

The deeper cuts scheduled to occur in 2013, as part of the Budget Control Act, will dramatically worsen the situation.

In early Fiscal Year 2011, SSA imposed a hiring freeze extending even to replacement hiring. Since then, the DDSs have lost over 2,000 employees. Three-quarters were examiner losses, a lost capacity of over 900,000 case determinations a year.

Already many thousands of cases are delayed in growing DDS backlogs.

Recently, with release of the Fiscal Year 2012 budget, SSA authorized 200 DDS hire's nationally. These hire's, while appreciated, are a drop in the bucket.

With the DDS situation so fragile, further increase in our medical CDR workload is a concern. We would need both additional funding and advance hiring.

Our pipeline of disability examiner trainees has been empty for a year and a half, and examiners are not quickly replaceable. It takes a minimum of several years of training and mentoring before they have the knowledge and skills to handle all cases, especially CDRs.

For as long as they can, the DDSs will continue to keep cases moving and meet workload targets. DDS staff are highly skilled and extremely elastic.

In the short term, we have shifted some support resources to case processing, but this is not sustainable.

With insufficient funding for the incoming cases, continued attrition, and only minimal replacement hiring, the DDSs will reach a tipping point with backlogs and case delays.

Policy changes would make the process more efficient. NCDDD continues to recommend consistent application of policy across the nation and across all appeal levels.

Our written testimony includes recommendations in such areas as policy simplification, enhancement of technology tools, expansion of the medical listings, expansion of single decision maker authority, and reinstatement of the reconsideration in the ten prototype states.

Last year alone, the DDSs allowed over 92,000 claimants at the reconsideration step, an invaluable service.

SSA and the DDSs have a long history of accomplishment working together to provide high quality service and careful program stewardship.

This relationship has never been more important. Collaborative strategy is crucial if we are to find ways to continue the service on which the American public relies.

Policy changes and technology tools can further improve program efficiency and consistency, but the foundation must be adequate in funding and highly trained staff.

On behalf of NCDDD, thank you again for the opportunity to provide this testimony, and I would be happy to answer any questions you have.

[The prepared statement of Ms. Lyon-Hart follows:]

TESTIMONY OF

TRUDY LYON-HART, PRESIDENT ELECT

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

to the

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

March 20, 2012

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

I am honored to have this opportunity to appear on behalf of the National Council of Disability Determination Directors (NCDDD) to comment on issues of concern regarding the Social Security Disability Program. My name is Trudy Lyon-Hart. I am President-Elect of NCDDD and the Director of the Vermont Disability Determination Services (DDS).

NCDDD is a professional association composed of the Directors and managers of the DDS agencies located in each state, the District of Columbia, and Puerto Rico. Collectively, members of NCDDD are responsible for directing the activities of approximately 14,800 employees who process nearly 4.8 million cases per year for disability benefits under the Social Security Act. NCDDD's goals focus on establishing, maintaining and improving fair, accurate, timely, and cost-efficient decisions to 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 law and 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 cases including initial claims, reconsiderations, continuing disability reviews (CDRs), and disability hearings.

The Disability Determination Process

The DDSs provide high quality service at the front end of the process. In fact, for many applicants the front end is the entire process. The vast majority of allowance determinations are made at the DDS at the initial and reconsideration steps. For example, in 2010, DDS determinations at the initial and reconsideration steps accounted for 77% of all allowance decisions made that year (Title II, Title XVI and concurrent claims), while only 23% were made at the Administration Law Judge and Appeals Council steps. DDS allowance accuracy as measured by Social Security's review is very high at over 97% for all programs. In FY 2011, DDS processing time was 90 days for initial cases, and 73 days for reconsideration cases.

There is also a small subset (about 5.5% of the initial workload) of "Quick Disability Determination" and "Compassionate Allowance" (QDD/CAL) cases, for which DDS processing time is 9.7 days currently. These cases are identified by Social Security's predictive modeling software (software that scores each initial case on factors related to probable allowance with quick case processing and flags those with the highest scores for expedited processing).

DDS case processing time overall is quite fast considering that processing cases involves obtaining healthcare records, sending claimants as needed to consultative examinations, analyzing a large volume of medical, functional, and vocational evidence, evaluating individuals' symptoms, weighing different medical opinions, and determining individuals' remaining function and ability to perform work in the national economy. Determinations require applying complex law, regulations and policy in each case and making correct denials as well as allowances. Outcome measures show that the DDSs have historically given the American public prompt, accurate, and cost effective service, providing over one million disability applicants with accurate allowance determinations each year.

The DDSs also provide stewardship oversight by determining continuing medical eligibility and by holding disability hearings for the appeals of those whose benefits are ceased. As initial claims increased substantially from FY 2008 through FY 2011 (due to demographic and economic factors), balancing both workloads with limited resources has become much more challenging.

Fragility of the Front End

The DDSs have historically provided the American public with timely, high quality service, even during hard economic times when resources are fewer and public need greater. However, our ability to continue to do so right now is increasingly threatened. Funding in the FY 2012 budget will not cover all the cases that the DDSs will receive, and cuts now scheduled by law to occur in FY 2013 will dramatically worsen the situation.

In early FY 2011, SSA imposed a hiring freeze on all DDSs due to funding limitations. This freeze extends even to replacement hiring. Nationally, the DDSs lost 2194 employees from October 2011 through February 2012. Even more critical to the ability to process cases, 1591 of these losses were examiners, which equates to a lost capacity of over 900,000 case determinations a year. With the recent release of the FY 2012 budget, SSA gave the DDSs authority for 200 hires, but without replacement hiring for nearly a year and a half, these hires – while appreciated – are but a drop in the bucket to prepare the DDSs for the future.

For as long as they can, DDSs will continue to do whatever it takes to keep the cases moving and meet workload targets. DDS staffs are highly skilled and extremely elastic. In the short term, many DDSs are handling the challenge by shifting resources (such as training, mentoring, quality assurance, professional medical relations, consultative examination oversight, supervision, and management) to case processing. However, the DDSs cannot sustain these resource shifts for the long term without serious detriment to important staff development and program integrity outcomes. With insufficient funding for the incoming cases, along with continued attrition and only minimal replacement hiring, the DDSs will reach a tipping point with burgeoning backlogs and case processing delays.

On top of staffing losses, SSA recently shifted most federal resources from DDS assistance to ODAR. Now these resources are no longer available to help some DDSs. DDS cases that were pending at the federal sites were returned to the DDSs with minimal notice or planning, adding to the many thousands of cases already in growing DDS backlogs and further lengthening the wait time of those claimants.

With the DDS situation so fragile, the prospect of further increases in the CDR workload is of concern. Any increase must come with additional funding, but funding alone will not be sufficient to enable the DDSs to process the additional workload unless it includes advance-hiring authority. The fact that the DDSs have not been able to hire for the past year and a half is a critical factor in our ability to process CDRs. 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 a minimum of several years and considerable training/mentoring before those employees have the knowledge and expertise to handle all case types independently at full production levels. CDRs in particular require 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 must be handled by state Disability Hearing Officers, the highest level of DDS adjudicator, with many years experience and specialized training in holding administrative hearings and deciding legal findings of fact and conclusions of law. As veteran staff continues to leave, the 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 and hearing officers that have already left, but also for those that will leave in the next two years.

Recommendations to Address Immediate Issues

1. Sufficient resource allocation at the front end. Resources must support the front end of the disability claims process that serves all applicants and is for many all the service they require. While a small percentage

continues to be well served through the Quick Disability Determination (QDD) and Compassionate Allowance (CAL) process, most of the allowances are less obvious and take longer to determine. DDSs need sufficient resources to process cases timely; otherwise, the claims of many disabled applicants will wait in backlogs too big to manage, while DDSs may be unaware of their dire need, worsening impairments, and even death. Applicants who do not meet the criteria also deserve to receive accurate denial determinations without a long wait, so that they can take appropriate next steps in managing their medical and financial situation. The longer a case sits in a backlog, the more expensive it becomes to process, as medical records age and updated records much be purchased. In addition, the DDSs need sufficient resources to handle medical CDRs, so that they can keep all workloads in balance.

2. Increased SSA/DDS collaboration. We recognize that in the current economic situation, resources are scarce and cannot always cover all the service needs of all our applicants. We also recognize the challenge of balancing scarce resources across the entire system from the Field Offices to the DDSs to ODAR. SSA and the DDSs have a long history of working together to serve the American people to the best of our ability. This collaboration is very important and would be further improved in the current situation with joint operational strategizing. DDSs can provide the best service when the workflow and hiring flow are steady and balanced, with SSA and the DDSs in partnership proactively and strategically planning for workload and resource changes. This process should include deliberative risk assessment with mitigation and transition planning. Turning the "faucet" on and off, as has been done with hiring, changing workload priorities, the medical CDR workload, and federal assistance resources for the DDS, causes bulges in the workflow – these bulges will inevitably work their way through the system causing backlogs and delaying claims at each future step. It also causes critical gaps in the expertise of the DDS staff, which compromise our current and future capacity to adjudicate all cases accurately and promptly.

3. Further expansion of SSA's use of predictive modeling software. The QDD software now serves a small percentage of applicants very well, with the system working behind the scenes automatically flagging claimants with extremely severe impairments for expedited case processing. The scoring threshold for QDD

flagging might be expanded to include more claimants. This must be done carefully so as not to dilute the subset with cases that cannot be allowed quickly. The scoring of claims that do not reach the threshold for QDD flagging could provide useful information to assist the DDSs in further triaging their front-end backlogs for other claims that are likely to meet the disability criteria.

We understand that SSA is also developing similar predictive modeling software to help identify ODAR cases that would most likely be allowed through the informal remand process. Perhaps predictive modeling software along these lines might be adapted or developed for use with reconsideration cases, to help DDSs better identify those reconsiderations that might be allowed, and therefore, avoid a lengthy appeal to ODAR. Two examples are cases that were originally denied because the impairment was not expected to last a full year and cases where the claimant's age is approaching the borderline for a medical/vocational allowance.

4. Simplification of disability program policy. Another recommendation is to make disability program policy simpler, easier and quicker to apply in real cases. SSA is to be commended for recently extending to all DDSs a vocational analysis expedient used in Prototype DDSs for many years. This saves a great deal of time that was previously spent obtaining and evaluating past work information that would not make a difference to the final determination.

   The DDSs have provided SSA with ideas for other expedients, and we recommend that they be fast-tracked to implementation. One example is extending SSA's regulatory definition of an "acceptable medical source" to include more of the professionals most commonly seen by claimants, such as nurse practitioners, physician assistants, licensed social workers, licensed mental health clinicians, and physical therapists. We believe that this could save considerable time and money that is currently spent on sending claimants to consultative examinations with acceptable medical sources merely to replicate the findings of their regular treating (but not SSA-acceptable) sources.

5. Changes to the criteria for relevancy of past work. Currently, substantial work that claimants have performed up to fifteen years ago is considered relevant when adjudicators are determining whether

claimants can do any of their past jobs. We recommend shortening this period to ten years. Given the rapid changes in technology, the relevance of work last performed more than ten years ago or the continued existence of the work in the national economy is very questionable. Obtaining and evaluating such old information is problematic, as claimants and even employers have difficulty remembering exactly how the work was done that long ago. Different ways of obtaining and evaluating this past work information may be one of the differences in decision making at the DDS and ODAR appeal steps, since DDSs do not have the same access as ODAR to vocational experts with knowledge of the current local and national economy.

6. Continued enhancement of the Electronic Case Analysis Tool. SSA has developed an electronic case analysis tool (eCAT) for DDS examiners, which has recently been made mandatory by SSA. This software tool assists examiners in writing an explanation of their determination, prompting them to address each step of sequential analysis and critical issues such as credibility and medical opinions. It provides quick links to related policy. It still requires the examiner to use critical thinking and judgment. In other words, the tool does not "make the decision". Many DDSs have found it to be a useful training tool, especially for newer examiners, and SSA reports the resulting explanation of the determination is helpful to quality reviewers and administrative law judges. Concerns remain about the significant learning curve that may affect staff productivity and morale. The tool should continue to be further enhanced to be more intuitive, to streamline the formulation of the examiners' analysis, and to provide a better presentation of the analysis in the written explanation document.

Longer-term Recommendations

1. Single Disability Case Processing System (DCPS). We recommend continued funding and development of the DCPS to replace the individual DDSs' various case-processing computer systems. DCPS is needed to support nationally consistent, efficient, cost-effective disability case processing, since multiple different systems do not talk to one another very well. The single system should include improved tools to support

accurate case analysis. SSA and the DDS community are working together on the management of this project.

2. Further expansion of disability examiner authority. Currently examiners have the authority to decide fast-tracked cases independently, in consultation with medical and psychological doctors only as needed but not required. In addition, experienced Single Decision Maker (SDM) examiners in nineteen DDSs for nearly fifteen years have decided initial cases independently, incorporating medical consultation as needed. These SDM examiners have the authority to make independent decisions on initial claims, not just QDD/CAL cases, within certain legal parameters. Ongoing quality data has not been made available to the DDS community but we hope to see it in the coming months. Based on experience, the DDSs believe that independent examiner determinations have maintained high accuracy standards with a streamlined case process and cost-effective use of medical consultant time and expertise. Expanding this examiner authority to all DDSs and to additional types of cases (such as reconsideration allowances and CDR continuances) would be appropriate and would enable better service overall to the American public.

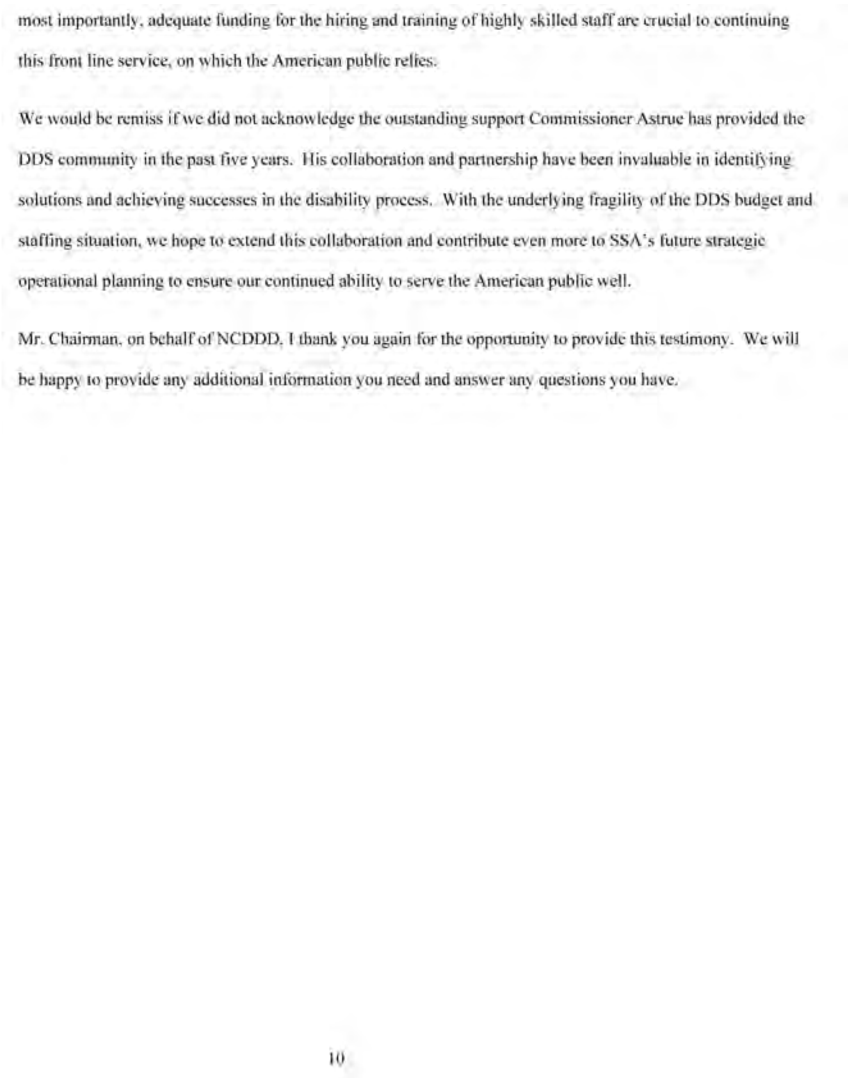
3. Expansion of the Medical Listings. The percentage of allowances based on claimants' condition(s) meeting or equaling a Medical Listing has been steadily decreasing for many years, even as SSA has instituted more Listing updates. These Listing updates appropriately incorporate advances in medical diagnosis and treatment outcomes. The Listings also need to be expanded to include the medical findings typical of claimants who through our current medical-vocational analysis are found unable to sustain basic work activities. Medical-vocational analysis is complex and often subject to considerable variation in individual adjudicators' evaluation and at different appeal steps. The Listings are paramount for providing parity and consistency in the evaluation of impairment severity nationwide. Making the criteria as objective as possible will promote greater accuracy and consistency. The Listings must include some functional requirements, since two people with the same diagnosis and exam/test findings may have very different functional effects, but these requirements should be described as objectively and clearly as possible, so that they can be applied consistently and fairly.

4. New Occupational Information System. We also recommend continued funding and faster development of a new Occupational Information System, to replace the outdated Dictionary of Occupational Titles with one that meets the specific needs of Social Security disability determination, and that provides current information about occupations in the national economy. SSA is pursuing research and development of this new system; however, the completion of a useable, updated occupational informational system is still many years away. The length of the timeline is discouraging to DDS adjudicators, and lack of updated occupational information continues to contribute to the differences in DDS and ODAR decision outcomes.

5. Reinstatement of reconsideration in all states. While budget constraints continue to dictate the status quo, we continue to recommend consistent policy application across the nation. We ask that Congress give further consideration to providing sufficient funding and staffing to reinstate and strengthen the reconsideration step in the ten Prototype states. The cost would be an investment that would be paid for in part by having fewer appeals that must be processed at ODAR. For example, in FY 2011 alone, over 92,000 claimants were allowed at the reconsideration step, an invaluable service to these claimants. Reinstating the reconsideration step in the Prototype states would give those states' citizens the same opportunity to get benefits sooner at less cost to the system, while allowing the administrative law judges to focus on a smaller subset of cases that truly needs their attention. For those cases that are not allowed at reconsideration, the additional DDS case development provides greater longitudinal evidence to support better decision-making at the ODAR appeal.

Conclusion

The DDSs have a long record of collaboration and accomplishment working with SSA to provide high quality service and careful program stewardship. Insufficient funding and the resulting freeze on replacement hiring are jeopardizing front-end public service for this important program in both the short and long term. Policy changes and technology tools can further improve program efficiency and consistency of public service, but



most importantly, adequate funding for the hiring and training of highly skilled staff are crucial to continuing this front line service, on which the American public relies.

We would be remiss if we did not acknowledge the outstanding support Commissioner Astrue has provided the DDS community in the past five years. His collaboration and partnership have been invaluable in identifying solutions and achieving successes in the disability process. With the underlying fragility of the DDS budget and staffing situation, we hope to extend this collaboration and contribute even more to SSA's future strategic operational planning to ensure our continued ability to serve the American public well.

Mr. Chairman, on behalf of NCDDD, I thank you again for the opportunity to provide this testimony. We will be happy to provide any additional information you need and answer any questions you have.

Chairman JOHNSON. Thank you, ma'am.

Ms. Ekman, welcome. Please proceed.

STATEMENT OF LISA D. EKMAN, SENIOR POLICY ADVISOR, HEALTH & DISABILITY ADVOCATES, CHICAGO, ILLINOIS, ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES SOCIAL SECURITY TASK FORCE

Ms. EKMAN. Thank you. Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, thank you for this opportunity to testify at this very important hearing.

My name is Lisa Ekman. I am a Senior Policy Advisor for Health & Disability Advocates. I testify today on behalf of the Consortium for Citizens With Disabilities Social Security Task Force.

The Social Security Disability Insurance or SSDI Program, provides vital economic security and access to health care for individuals whose impairments are so severe that they preclude work.

The importance of SSDI to people with disabilities cannot be overstated. I would like to begin by sharing the stories of two SSDI beneficiaries with you, and tell you a little about the difference of SSDI being in their lives.

First, there is the story of Angelice P. Angelice was diagnosed with Type I Diabetes as a teenager. She went to college and she worked for many years.

Two years ago, when she was 36, she had to be hospitalized for diabetes related complications. Angelice spent a long time in the hospital, due in part to the fact that she continued to work when she should have stopped because it was aggravating her diabetes.

As a last resort, Angelice applied for benefits while she was in the hospital. Due to the severity of Angelice's diabetes, she was approved for SSDI benefits.

Angelice came very close to becoming homeless when she could not work due to her diabetes. Fortunately, she was able to keep her apartment but only because a charity helped support her and pay her rent.

She received a quick decision regarding her eligibility and because of SSDI, she was able to keep her home.

Angelice receives just around the average SSDI benefit of just over $1,000 per month. Her rent is $550. Her SSDI allows her to live in her home, but she squeaks by. Without SSDI, she would be homeless.

It is with sadness that I tell you that last night, Angelice passed away due to diabetes complications, but in the two years that she received SSDI, it made a tremendous difference in her life.

There is also the story of Henry H. Henry is in his 60s and has severe cardiac problems. He was working in the insurance industry for a long time, but was not able to keep his job due to his heart condition.

Henry spent all of his savings and cashed out his 401(k) before he applied for SSDI benefits.

When he filed his application as a last resort, he was homeless and living in his car. He lived there for about a year.

Once his SSDI benefits were approved, Henry was able to secure housing again and has not been homeless since.

Given the importance of SSDI to people with disabilities, like Angelice and Henry, I want to highlight three key points.

First, providing the Social Security Administration or SSA with an adequate administrative budget is essential to accurate and timely initial processing of SSDI claims.

Second, the current definition of "disability" and structure of the SSDI program are appropriate and should not be changed.

Third, SSA does a good job of administering the program, but improvements could be made.

First, as has been discussed quite a bit during the Commissioner's testimony, SSA requires an adequate administrative budget to effectively administer the SSDI program and complete initial disability determinations in an accurate and timely manner.

We were pleased to see the progress SSA was able to make during Fiscal Years 2008 and 2010 in reducing the time for people with disabilities to receive their disability determinations.

Unfortunately, as discussed, SSA has received no increase, although debate whether there was a decrease, no increase in their funding since 2010, and we are likely to see an increase in the processing time for initial disability applications because the funding, as discussed, is completely inadequate to keep up with SSA's workload.

Second, because the intent of the SSDI program is wage replacement and to provide income support for individuals who do not have the capacity to engage in substantial gainful work, the current definition of "disability" is appropriate.

The definition is strict, providing benefits only to individuals with the most significant impairments.

However, keep in mind that just because an individual has an impairment, it does not mean they will be eligible for benefits. Neither Angelice nor Henry would have been eligible for benefits if their impairments were less severe and did not prevent them from working.

Third and finally, both SSA and the state disability determination services do a good job of administering the SSDI program, especially given the resources they have available.

However, we encourage SSA to make some modest changes to ensure that medical evidence is fully developed early in the process so that unnecessary delay and unnecessary and costly appeals can be avoided.

Such modest changes include providing more assistance to claimants earlier in the process, providing better guidance to doctors and other professionals regarding what evidence SSA is looking for, and by providing additional and improved training to disability evaluators.

Our written testimony contains additional recommendations.

Thank you for the opportunity to testify, and I look forward to answering any questions you might have.

[The prepared statement of Ms. Ekman follows:]

CCD

CONSORTIUM FOR CITIZENS
WITH DISABILITIES

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

How Disability Insurance Eligibility Decisions Are Made

March 20, 2012

Testimony of
Lisa D. Ekman, JD, MSW
On Behalf of the Social Security Task Force
Consortium for Citizens with Disabilities

ON BEHALF OF:
Association of University Centers on Disability
Bazelon Center for Mental Health Law
Community Legal Services
Corporation for Supportive Housing
Easter Seals
Health & Disability Advocates
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Disability Rights Network
National Organization of Social Security Claimants' Representatives
National Multiple Sclerosis Society
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association

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

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, thank you for the opportunity to provide testimony for this hearing on how Social Security Disability Insurance (SSDI) eligibility decisions are made.

I am a senior policy advisor for Health & Disability Advocates (HDA). HDA is a national policy and advocacy group headquartered in Chicago, Illinois. I also am a member of the Consortium for Citizens with Disabilities (CCD) Social Security Task Force. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force focuses on disability policy issues in the Title II disability programs and the Title XVI Supplemental Security Income (SSI) program. I present this testimony on behalf of the undersigned members of the CCD Social Security Task Force.

The SSDI program provides vital and much-needed economic security and access to health care for individuals whose impairments are so severe that they preclude substantial, gainful 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 your interest in and attention to this critical program.

The Social Security Administration (SSA) requires adequate administrative resources to effectively administer the SSDI program and complete initial disability determinations in an accurate and timely manner. SSA's administrative budget (Limitation on Administrative Expenses or LAE) has been inadequate in recent years. We urge Congress to provide SSA with adequate resources to carry out all necessary program functions, especially to process initial claims, including hiring sufficient staff at the state Disability Determination Services (DDS) offices and in SSA's field offices.

We believe that the basic structure of the SSDI program is effective and should be preserved. Because the intent of the SSDI program is to replace wages and provide income support for individuals who do not have the capacity to engage in substantial gainful work, the current definition of disability is appropriate. The definition is strict, providing benefits only to individuals with the most significant impairments. And although more needs to be done to support SSDI beneficiaries to return to work to the extent that they are able, the vast majority of SSDI beneficiaries are not able to work beyond the substantial gainful activity level given the severity of their impairments and the likely course of their disabilities. Yet, the current definition provides sufficient flexibility to allow, encourage, and expand policies that can promote employment within the existing structure. While we support a number of Social Security and SSI program improvements, they do not depend on revising the definition of disability or changing the basic structure of the SSDI program.

In general, SSA does a good job of making disability determinations, given the complexity inherent in evaluating whether an individual with disabilities is entitled to SSDI benefits. There are areas, however, in which SSA can improve. We will outline some recommendations for improvement later in our testimony.

I. SSA Requires Adequate Resources to Effectively Administer the SSDI Program

Processing initial disability applications and completing initial disability determinations are resource intensive activities. Both require a significant amount of staff time to collect relevant information and fully develop the evidence required to make the correct determination. Unfortunately, SSA's LAE has not kept up with its increasing workload. This threatens SSA's ability to process disability applications in a timely manner.

As you know, for many years, SSA did not receive adequate funds to provide its mandated services, a key reason for the hearings backlog. Between FY 2000 and FY 2007, the resulting administrative funding shortfall was more than $4 billion. The dramatic increase in the hearing level disability claims backlog coincided with this period of significant under-funding.

Congressional efforts to provide SSA with adequate funding for its administrative budget between 2008 and 2010 were encouraging. In FY 2008, the tide finally changed for the first time in a decade, when Congress appropriated $148 million over the President's budget request. The FY 2009 appropriation provided SSA with more than $700 million over the FY 2008 appropriation.

We were extremely grateful to Congress for recognizing SSA's need for adequate resources and including additional funds for SSA in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provided SSA with $500 million to handle the unexpected surge in both retirement and disability applications due to the economic downturn. SSA also received badly needed funds to replace its aged National Computer Center. With the FY 2009 appropriation and the ARRA funding, SSA was able to hire thousands of new employees, including additional ALJs and hearing level support staff. This additional staff undoubtedly led to SSA's ability to make progress on the disability backlog at the hearing level.

The FY 2010 appropriation of $11.45 billion for SSA's Limitation on Administrative Expenses (LAE), a 10 percent increase over the FY 2009 appropriation, continued to provide SSA with the resources it needed to meet its service delivery needs. Unfortunately, that trend did not continue and the current trend in funding threatens to undo all of the progress SSA made between 2008 and 2011. SSA has received virtually no increase in LAE since 2010. In FY 2011, SSA's appropriation was $11.42 billion, a small decrease from the FY 2010 level. The FY 2012 appropriation has returned SSA's LAE to just slightly above the FY 2010 level at $11.46 billion. This level of funding, however, is completely inadequate to keep up with SSA's workload.

As SSA's Deputy Commissioner Carolyn W. Colvin stated in her testimony for the previous hearing in this series on January 24, 2012:

> 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....

The failure to provide SSA with adequate resources has had an impact on the ability of SSA to process disability applications and complete determinations in a timely manner, in both SSA field offices and state DDS offices. According to the SSA's Fiscal Year 2013 Budget Request, SSA had funding for 16,739 DDS employees in FY 2011.[1] That number fell to 14,825 in FY 2012 and, even under the President's FY 2013 budget request, it is expected to fall farther to 14,391in FY 2013. That represents a 14% reduction in the number of DDS staff available to process disability applications in just the last two years.

At the same time, there has been a significant increase in the number of initial applications both for retirement and disability benefits. According to Steven Goss, Social Security's Chief Actuary, in his December testimony before this Subcommittee, this increase is driven by baby boomers entering their high disability years and the first wave becoming eligible to retire, the historic entry of women into the workforce in the 1960s and 1970s enabling them to qualify for Social Security disability benefits in larger numbers, and the recession. In FY 2011, SSA received 4.8 million retirement, survivor, and Medicare applications, and approximately 3.2 million initial disability claims—the highest number in SSA history. This trend of increased retirement applications is not likely to reverse itself anytime soon based on demographics and the aging of the baby boomers. Although the recent growth in initial disability applications is expected to level off, the number of initial disability claims is expected to remain high.

Assuming that the number of initial disability claims levels off but remains high, SSA predicts that both the number of pending disability claims and the processing time to complete them will increase.[2] The President requested an increase in funding for SSA's LAE to $11.76 billion for FY 2013, a very slight increase of the FY 2012 LAE. Even if SSA receives the increase it has requested, SSA predicts that pending disability claims will increase to 861,000 in FY 2012 and to over 1.1 million in FY 2013. In addition, SSA predicts that the average number of days it will take to process initial disability claims will increase from 111 in FY 2012 to 137 in FY 2013, more than a 23% increase in one year. If SSA receives less than its FY 2013 budget request for LAE, it is likely that the pending claims and the disability processing time will only increase beyond the prediction.

Making disability determinations is a complex process and requires time to properly obtain and evaluate the evidence to make the correct decision regarding an applicant's claim. SSA field office and DDS personnel, who face increasing workloads due to both internal and external factors, might be unable to devote the resources and time needed to adequately process and evaluate disability applications. The failure to adequately develop the evidence can result in an incorrect initial decision, denying the claim for an eligible individual, thus increasing the likelihood of an appeal. For example, it might be determined that the applicant actually meets a medical listing when all of the evidence has been collected during an appeal. If the DDS personnel had been able to complete the development of the case record during the initial determination, the individual would have received benefits sooner and the cost and delay of an appeal might have been avoided.

Additional funding is required for SSA's LAE in order to reduce and eliminate the backlog at the DDS and hearing levels and to provide essential services to the public. While the current situation is dire, without adequate, ongoing appropriations to fund SSA, the forward progress recently made by the agency will deteriorate, leaving people with severe disabilities to wait years to receive the benefits to which they are entitled.

We strongly urge Congress to provide SSA with sufficient administrative funding so that there are enough personnel in both the SSA field offices and the DDSs to adequately process, develop, and determine disability claims in a timely manner. Additional funding is also needed to ensure that SSA is able to provide other critical services to the people with disabilities and to conduct program integrity activities.

II. The Current Definition of Disability Is Appropriate and Should Not Be Changed

The current definition of disability is appropriate and ensures that only those individuals with the most severe disabilities are eligible to receive benefits. The current definition is strict, requiring an individual to prove that he or she cannot maintain substantial gainful employment in the national economy. The end result is that the SSDI program provides benefits only to individuals with the most significant impairments. Many individuals receiving SSDI have made repeated attempts to work, often exacerbating their impairments, before finally turning to the program as a last resort for critical income support for themselves and their families.

The intent of the SSDI program is to provide wage replacement for workers who can no longer work at a substantial gainful level due to a physical or mental impairment. The statutory definition contained in 42 U.S.C. § 423 is:

> (d)(1) The term "disability" means—
>
> (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months;

In 2012, SSA defines substantial gainful activity (SGA) as earning more than $1010 per month for individuals with disabilities other than blindness and $1,690 for individuals who are blind. Individuals who earn more than SGA (after the application of the SSDI work incentives) or who have disabilities likely to last less than 12 months are not entitled to receive SSDI benefits. Moreover, in evaluating whether an applicant is able to perform SGA, SSA considers not only the individual's current job or occupation, it must by law examine all jobs in the national economy which that individual might be capable of performing, regardless of whether the individual would be hired or whether there is an actual job opening. This standard is very strict and most people who apply for benefits are denied because they cannot establish that they meet the statutory requirements. In 2010, for example, only 36% of those who applied were awarded benefits during the initial application process.[5]

Examining the characteristics of the people who receive benefits can assist in illustrating the appropriateness of the current definition of disability and attest to SSA's effective application of that definition.

Beneficiaries Are Diverse and Significantly Impaired

The people who are approved for benefits have diverse disabilities. Beneficiaries include people with: late stage cancer, advanced heart disease, end-stage renal failure, intellectual disabilities, physical disabilities, endocrine disorders, pulmonary disorders, mental illness, individuals with visual impairments, and individuals who are deaf, just to give a few examples. However, just because an individual is diagnosed with any of these impairments does not mean that he or she will be eligible for benefits. The one thing all SSDI beneficiaries have in common is that their impairments are severe enough to prevent them from performing substantial gainful activity.

Many beneficiaries are terminally ill when they apply. In fact, about one in five male SSDI beneficiaries and one in seven female SSDI beneficiaries die within the first five years of receiving benefits.[4] Nearly 70% of SSDI beneficiaries in 2010 were age 50 or older and nearly 1 in 3 was age 60 or older.[5] Forty-five out of one-hundred disabled workers receiving benefits qualified for benefits based on an age-related impairment, impairments which are likely to worsen rather than improve over time.

SSDI Benefits Are Modest and Many Beneficiaries Are Poor

It is also important to note that SSDI benefits only replace a percentage of the workers' previous earnings and, especially for low and moderate earners, are quite modest. The average monthly benefit in January 2012 for a SSDI program beneficiary was only $1,110 per month, an annual income of just $13,320.[6] It is important to keep in mind, for comparison purposes, that a person working full-time, 40 hours per week, and earning at the federal minimum wage of $7.25/hour, earns $15,080 annually.[7]

SSDI benefits are so modest that they actually do not provide enough income to lift all beneficiaries out of poverty. In fact, nearly one-third of the people receiving SSDI live in households with total household income below 100% of the federal poverty level.[8] People with work-limiting disabilities, despite the availability of SSDI, are 4.5 times more likely to live in chronic poverty than people without disabilities.[9] Forty-seven percent of those living in poverty overall are people with disabilities and 65% of people living in long-term poverty are people with disabilities.[10]

III. The Disability Determination Process

Establishing eligibility for disability benefits is not a rubber-stamp process. Applicants must have a physical or mental impairment established by medical evidence provided by a physician.[11] Statements of symptoms alone are not sufficient.[12] Thus, the key to appropriate disability determinations is full and adequate development of the relevant evidence.

Individuals can file SSDI applications in person at a Social Security office, by telephone, or online. SSA obtains information about the individual's impairment(s) through the "Disability Report," Form SSA-3368. On the form, the individual lists impairments, treating sources and other sources of medical evidence. SSA also obtains signed consent forms, which include permission to contact any treating sources to obtain medical evidence, and any medical evidence that the individual has obtained. The package is then sent to the DDS to develop the disability claim. All requests for medical evidence necessary to evaluate the impairment are sent out by the DDS.

CCD supports initiatives to improve the process at the initial determination level so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Inadequate case development at the DDS level means that ALJs will need to spend more time reviewing cases prior to the hearing. This leads to longer processing times at the hearing level. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process.

A. New Screening Initiatives. We support SSA's efforts to accelerate decisions and develop new mechanisms for expedited eligibility throughout the application and review process for people whose conditions are the most severe and/or terminal. We encourage the use of ongoing screening as claimants obtain more documentation to support their applications. However, SSA must work to ensure that there is no negative inference drawn when a claim is not selected by the screening tool or allowed at that initial evaluation. There are two initiatives that appear to be working well, with SSA increasing the number of claims considered in these categories each fiscal year:

- **Quick Disability Determinations.** We have supported the Quick Disability Determination (QDD) process since it first began in SSA Region I states in August 2006 and was expanded nationwide by Commissioner Astrue in September 2007.[13] The QDD process has the potential of providing a prompt disability decision to those claimants who have extremely severe impairments and readily available medical evidence. Since its inception, the vast majority of QDD cases have been decided favorably in less than 20 days, and sometimes in just a few days.

- **Compassionate Allowances.** This initiative allows SSA to create "an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both…." There are now 113 conditions on this list, published on SSA's website.[14] These are conditions that clearly qualify under the disability standard based on objective medical information that can be obtained quickly. Unlike the QDD screening, which occurs only when an application is filed, screening for compassionate allowances can occur at any level of the administrative appeals process.

B. Improve development of evidence earlier in the process. We have a number of recommendations to ensure that disability claims are properly developed at the beginning of the process. Why are we so concerned about denials at the initial levels based on incomplete records? For a variety of reasons, many claimants denied at the initial level do not appeal to the reconsideration level, even though they may be as likely to be entitled to benefits as those who do appeal. We have long been concerned about claimants being discouraged from appealing denials and dropping out of the process.

While an imperfect measure of the appeal rate because the data is not longitudinal, an SSA chart for fiscal year 2011, "Fiscal Year 2011 Workload Data: Disability Decisions," does provide a very general idea about the difference in appeal rates after initial claim denials and after reconsideration denials. Far less than half of claimants whose initial claims are denied go on to request reconsideration (about 39%). In contrast, far more than 50% of claimants who receive reconsideration denials, if they proceed to that step, appeal to the ALJ hearing level.

Our specific recommendations for better development of evidence earlier in the process include the following:

- **SSA should provide more assistance to claimants at the application level.**

At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing the application, particularly in light of electronic filings, so that all impairments and sources of information are identified, including non-physician and other professional sources.

- **SSA should ensure that DDSs obtain necessary and relevant evidence.**

Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. However, DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating and examining doctors. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to DDS adjudicators. SSA has created some national forms to collect evidence, but they vary in quality. The situation is further complicated because some DDSs use their own forms, which also vary in quality. SSA should review its own national forms and DDS forms that are used to collect evidence, and set standards for state-specific forms to ensure higher quality.

- **SSA should increase reimbursement rates for providers.**

To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts. Increasing the reimbursement rate will undoubtedly improve provider response rates. It also will help to improve the medical expertise available to adjudicators for consultative examinations and for medical experts.

- **SSA should provide better explanations to medical providers.**

SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and they should ask providers for evidence relevant to the standard.

- **SSA should provide more training and guidance to adjudicators.**

Many reversals at the appeals levels are due to earlier erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as: weighing medical evidence, including treating source opinions; the role of non-physician evidence; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings. In 2006, SSA piloted using Pediatric Medical Units (PMUs) to provide specialized expertise for adjudicators who determine eligibility for disability benefits. Teams of interdisciplinary clinicians with specialized developmental and assessment expertise provided important support for state disability adjudicators. We support these types of efforts to help make disability decisions as efficiently and as early as possible in the process.

- **SSA should improve the quality of consultative examinations.**

Steps should be taken to improve the quality of the consultative examination (CE) process. The current low reimbursement rate is not sufficient to ensure the quality of consultative examinations (CEs) and undoubtedly is a factor regarding which doctors and psychologists are willing to conduct CEs for SSA. But this does not explain why claimants are referred to the wrong physician, given the disabling impairments. We hear far too many stories about inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's. This is wasted money for SSA and unhelpful to individuals, especially those with low incomes who do not have complete medical records documenting their conditions and who need a high quality CE report to help establish their eligibility.

It is important to note that the regulations allow SSA to pay treating physicians to provide CEs, but they are rarely used in that capacity. It is likely that the low reimbursement rate contributes to non-use of treating physicians for CEs. SSA should explore ways to expand use of treating physicians to provide this information.

Also, to ensure that its funds are being used as effectively and appropriately as possible, SSA should provide more oversight of the CE process, which is conducted by the state agencies.

It appears that some DDSs refer cases for CEs rather than wait for medical documentation from the claimant's treating sources, both physicians and non-physician (if requested). A significant factor is likely the fact that DDSs operate under processing time standards against which SSA measures their performance. Claimants' representatives frequently report on the problems with obtaining medical evidence – requests are often given low priority given the busy nature of many medical offices; reimbursement rates are inadequate; and many offices lack medical records staff. The DDSs face these same challenges and when coupled with the regulatory time constraints, we believe that the DDSs are under pressure to cut short efforts to obtain medical information from treating sources.

What Statistical Analysis Can and Cannot Tell Us about the Disability Determination Process

The process of evaluating whether a person has a disability that is severe enough to qualify for DI is complex. No two people with a disability are truly alike, no matter how similar they might look on paper based on simple factors such as age, prior earnings level, primary diagnosis code, or geography. That is why disability evaluators use in-depth reviews of evidence from professionals who have actually treated and interacted, in person, with the applicant in order to make a disability determination. They must evaluate the severity of the disabling condition or conditions on a unique individual and compare this severity to the standard in the law, regulations, and SSA policy.

Statistical analysis that examines characteristics like the ones mentioned in the previous paragraph can be very useful in evaluating aspects of the overall SSDI program, like trends in the impairments for which people receive disability benefits, geographic disparities in disability prevalence, or the age or earnings profiles of new beneficiaries, for example. We do not believe, however, that even the most sophisticated statistical analysis can predict with any degree of accuracy whether an individual disability determination was correct or incorrect or whether a particular individual's impairment prevents the individual from working. Key factors in making the disability determination, such as the medical evidence presented, simply cannot be captured in statistics.

A recent working paper by the RAND Corporation entitled "Does Disability Insurance Receipt Discourage Work?"[15] illustrates the danger in attempting to apply statistical analysis to evaluate the accuracy of the disability determination process. The statistical observations made by this working paper, which did not include a review of a single individual disability case or the medical evidence in any case, have been repeatedly misrepresented in making unfounded claims about SSDI adjudication and beneficiaries – such as the notion that one-quarter of current beneficiaries had their cases wrongly decided and are not eligible for benefits, and would be working if they did not receive SSDI. Such inferences are false and misinterpret what can be concluded from the working paper findings.[16] The most the RAND authors' statistical analysis seems to be able to show is that 23 percent of applications (not those whose applications are allowed benefits, or all those receiving SSDI benefits) have at least a chance, however small, of having a different outcome if another examiner had evaluated the claim. The RAND authors do not appear to estimate the actual probability or likelihood of having a different outcome. We believe it is quite low for a number of reasons, primarily because the large majority of examiners have fairly similar allowance and denial rates and it is likely a different evaluator would come to the same decision as the first.

That same RAND study finds very low levels of earnings (even among those denied benefits), which would suggest that many people with very serious barriers to work are denied benefits because they do not meet the strict legal standard. The working paper does not document poor decision making by DDS examiners, nor does it show that disabled individuals who do receive benefits could work instead and do not need them. Finally, the working paper could not attempt to determine whether any actual disability determinations were correct or not, because the researchers didn't have access to the kinds of detailed information used by an adjudicator to determine whether an individual applicant's condition met the severity standard in the law. Instead, it looked for statistical trends based on general indicators.

We caution against drawing any conclusions regarding the accuracy of the disability determination process or on the effect of SSDI benefit receipt on the work behavior of applicants based on a statistical analysis of administrative data. Although the current system could be improved in the ways we have previously outlined, it is fundamentally sound and the state DDSs are to be commended for the careful, thoughtful evaluation of evidence and application of the law which they use to award benefits.

Conclusion

The President's Budget Proposal for FY 2013 is the minimum needed to continue driving down disability backlogs, improve services to people with disabilities, increase efficiency, and keep pace with the rising demands of the American public. The speed and quality of SSA's disability process must continue to improve and should not be allowed to regress into the longer waiting periods of the recent past. These challenges can only be addressed if Congress and the Administration work together to ensure that Social Security continues to be the safety net it was designed to provide for people with disabilities and their families, as well as retirees and survivors of workers and retirees.

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

Submitted on behalf of:
Association of University Centers on Disability
Bazelon Center for Mental Health Law
Community Legal Services
Corporation for Supportive Housing
Easter Seals
Health & Disability Advocates
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Disability Rights Network

National Organization of Social Security Claimants' Representatives
National Multiple Sclerosis Society
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association

Endnotes

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[1] http://www.socialsecurity.gov/budget/2013BudgetOverview.pdf

[2] http://www.socialsecurity.gov/budget/2013BudgetOverview.pdf

[3] http://www.socialsecurity.gov/policy/docs/statcomps/supplement/2011/6c.html#table6.c7

[4] Gina Livermore, David Stapleton, and Henry Claypool, *Health Insurance and Health Care Access Before and After SSDI Entry*, page X, The Commonwealth Fund, May 2009.

[5] Social Security Administration, *2010 Annual Statistical Supplement to the Social Security Bulletin*, February 2011, Table 5.D4, http://www.socialsecurity.gov/policy/docs/statcomps/supplement/

[6] http://www.socialsecurity.gov/policy/docs/quickfacts/stat_snapshot/index.html?qs

[7] See http://www.dol.gov/dol/topic/wages/minimumwage.htm,

[8] Gina Livermore, *et al.*, *Work Activity and Use of Employment Supports Under the Original Ticket to Work Regulations: Characteristics, Employment, and Sources of Support Among Working-Age SSI and DI Beneficiaries*, Final Report, April 2009, p. 8, http://www.ssa.gov/disabilityresearch/documents/TTW5_2_BeneChar.pdf

[9] Gina A. Livermore and Peiyun She, *Long-term Poverty and Disability Among Working Age Adults*, Research Brief, August 2006, http://digitalcommons.ilr.cornell.edu/edicollect/1226/

[10] Livermore and She, August 2006, http://digitalcommons.ilr.cornell.edu/edicollect/1226/

[11] 20 C.F.R. §§ 404.1508, 404.1513(a), 416.908, and 416.913(a). As specified in the regulations, certain other licensed professionals can establish the existence of specific impairments, e.g., licensed optometrists can establish visual disorders.

[12] 20 C.F.R. §§ 404.1508 and 416.908.

[13] 20 C.F.R. §§ 404.1619 and 416.1019.

[14] http://www.ssa.gov/compassionateallowances/conditions.htm

[15] Maestas, Nicole , Kathleen J. Mullen and Alexander Strand. Does Disability Insurance Receipt Discourage Work? Using Examiner Assignment to Estimate Causal Effects of SSDI Receipt. Santa Monica, CA: RAND Corporation, 2011. http://www.rand.org/pubs/working_papers/WR853-2.

[16] *See e.g.* http://www.washingtonpost.com/opinions/the-dwindling-state-of-social-security/2011/10/31/gIQAt8rzjM_story.html; Burkhauser and Daley: Journal of Public Policy Analysis and Management, 2012

Chairman JOHNSON. Thank you, ma'am.

Dan Bertoni, welcome back.

Mr. BERTONI. Thank you.

Chairman JOHNSON. You are recognized.

STATEMENT OF DAN BERTONI, DIRECTOR, EDUCATION, WORKFORCE AND INCOME SECURITY ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. BERTONI. Mr. Chairman, Ranking Member Becerra, Members of the Subcommittee, good morning.

I am pleased to discuss our preliminary findings on the Social Security Administration's efforts to modernize its disability criteria.

Last year, SSA paid nearly $170 billion to about 12 million beneficiaries and independents, and given the size and cost of its programs, the Agency needs current criteria to assess whether an applicant's medical condition affects his or her ability to work.

In 2003, we designated SSA's disability programs high risk, in part, because its criteria for determining medical eligibility did not reflect advances in medicine and technology, and its occupational information did not reflect changes in the labor market.

My statement today addresses SSA's most recent efforts to update its medical listings and develop its own occupational information system, to better reflect the existence of jobs in the national economy.

In summary, the Agency has made several changes to improve the timeliness and effectiveness of its medical listings updates, such as adopting a two tier system that first includes a comprehensive review of all disorders in a body system and making appropriate revisions; then, on an ongoing basis, conducting subsequent targeted reviews of that body system, focusing only on a limited number of conditions.

To date, the Agency has completed comprehensive reviews for eight of 14 body systems, and has moved to the targeted phase.

In 2010, they also established a five year cycle time for updating its listings to ensure more systematic consideration of advances in the treatment and evaluation of conditions.

The Agency also contracted with the Institute of Medicine, and has acted on several of their recommendations, such as creating a standing committee to review and provide advice on the listings.

However, SSA still faces challenges keeping its listings up to date, and has yet to complete comprehensive revisions for six body systems, which in many cases, have been ongoing for decades.

Moreover, despite multiple extensions, four body systems will expire in 2012, and it is uncertain whether SSA will complete the required reviews.

The Agency has also experienced delays with its targeted reviews, and slippage in its plans to conduct post-implementation evaluations of previously revised listings.

SSA has noted that challenges in this area are mainly due to limitations in the number and expertise of staff needed to update the listings, and complexity of the regulatory process.

As you know, the Agency has begun an ambitious project to develop its own occupational inventory database by 2016, which will replace an outdated system it currently uses.

In 2008, SSA took steps to guide the development of this occupational information system or OIS, to capture both the physical and mental demands of work to better support its disability decisions.

Accordingly, SSA established an advisory panel of external experts tasked with making recommendations on developing a system, and held initial meetings with outside experts and other agencies that collect occupational information to gain insight into sampling methods and other challenges.

Last year, the Agency issued a research and development plan detailing activities necessary to complete this phase by 2016, at a cost of $108 million.

To date, they have made progress on several fronts, including using its own administrative data to identify the most frequently cited occupations and functional and vocational characteristics of its applicants.

However, due to staffing constraints, several planned initiatives have slipped, and officials know that further time line adjustments are likely.

To offset this challenge, SSA has used consultants with specialized expertise and is working with OPM to obtain additional staff skilled in industrial organizational psychology on a part time basis.

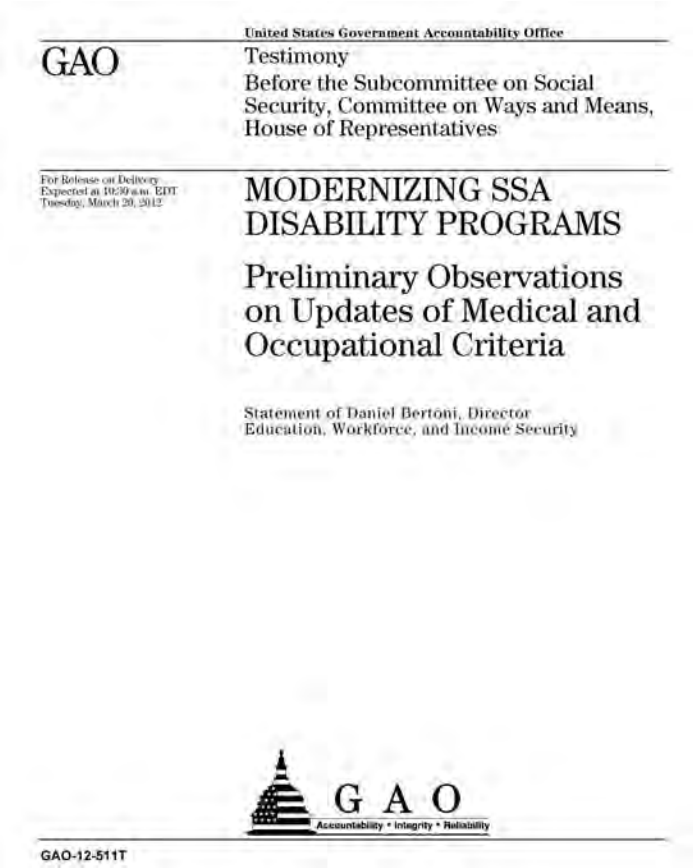
Finally, in the course of our work, we have identified some gaps in SSA's approach, such as insufficient documentation supporting SSA's research and development cost estimate, and the absence of any information on total cost of the project over time.

We will continue to pursue these and other issues as our work progresses, including how SSA is managing the OIS against best practices, and ensuring that the project schedule reliably estimates key activities and length of time they will take.

Finally, we plan to review any risk analyses conducted by the Agency, as well as mitigation plans to address identified risks, including how this complex project will proceed should funding be reduced.

Mr. Chairman, this concludes my statement. I am happy to answer any questions you or other Members of the Subcommittee may have. Thank you.

[The prepared statement of Mr. Bertoni follows:]



United States Government Accountability Office

GAO

Testimony
Before the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives

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MODERNIZING SSA DISABILITY PROGRAMS

Preliminary Observations on Updates of Medical and Occupational Criteria

Statement of Daniel Bertoni, Director
Education, Workforce, and Income Security

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GAO-12-511T

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Highlights

Highlights of GAO-12-511T, a testimony to the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives

Why GAO Prepared This Testimony

SSA administers two of the largest disability programs, with annual benefit payments that have grown fivefold over the last 20 years—from $35 billion in 1990 to over $164 billion in 2010—and the agency receives millions of new applications annually. GAO has designated federal disability programs as a high-risk area, in part because eligibility criteria have not been updated to reflect medical and technological advances and labor market changes. Given the size and cost of its disability programs, SSA needs updated criteria to appropriately determine who qualifies for benefits.

In this statement, GAO discusses initial observations from its ongoing review and assessment of SSA's efforts to (1) update its medical criteria and (2) develop a new occupational information system. To do this, GAO reviewed prior GAO and SSA Inspector General reports; relevant federal laws and regulations; program documentation including policies, procedures, strategic goals, and supporting project plans; and cost estimates. GAO also interviewed SSA officials, project stakeholders, experts, and representatives from other agencies that administer disability programs. This work is ongoing and GAO has no recommendations at this time. GAO plans to issue its final report later in 2012.

View GAO-12-511T. For more information, contact Daniel Bertoni at (202) 512-7215 or bertonid@gao.gov.

March 20, 2012

MODERNIZING SSA DISABILITY PROGRAMS

Preliminary Observations on Updates to Medical and Occupational Criteria

What GAO Found

The Social Security Administration (SSA) has made several changes to improve the process it uses for updating its medical criteria, but continues to face challenges ensuring timely updates. SSA's medical criteria for adults are in the form of listings of medical conditions and impairments organized under 14 body systems, which SSA periodically updates. To help ensure timely, periodic updates of a body system's listings, SSA is moving away from comprehensively revising a body system's listings toward a more targeted approach, wherein SSA selects for revision those impairment listings most in need of change. To date, SSA has completed comprehensive revisions of listings for 8 of the 14 body systems and now is in the process of reviewing them to determine whether and which targeted revisions are appropriate. In 2010, the SSA Commissioner set a 5-year cycle time for updating listings for each body system, replacing the agency's prior practice of setting expiration dates for listings that ranged from 3 to 8 years and then frequently extending them. To further increase the timeliness and accuracy of decisions, SSA has sought recommendations from the Institute of Medicine and has acted on some of them, such as creating a standing committee to provide advice on updating the listings. However, SSA continues to face challenges keeping its listings up to date. For example, SSA is still working on completing comprehensive revisions of listings for six body systems that have been ongoing for 19 to 33 years. SSA staff told us that a lack of staff and expertise, along with the complexity and unpredictability of the regulatory process, have made it challenging to maintain its schedule of periodic updates for all listings.

SSA has embarked on an ambitious plan to produce by 2016 an occupational inventory database to support its disability benefit decisions, but it is too soon to determine if SSA will meet key time frames. SSA currently relies on an occupational information source developed by the Department of Labor that was updated for the last time in 1991 and is viewed by many as outdated. In 2008, SSA initiated a project to develop its own occupational information system (OIS), which SSA expects will provide up-to-date information on the physical and mental demands of work, and in sufficient detail to support its disability benefit decisions. To guide the creation of its OIS, SSA established an advisory panel, collaborated with outside experts and other agencies, and in July 2011 issued a research and development plan detailing all relevant activities and goals between 2010 and 2016. As of February 2012, SSA had completed many initial research efforts, including investigating other types of occupational information systems and identifying job analysis methods. Despite preliminary progress, it is too early to determine if SSA will meet its target implementation date. SSA officials told us that due to staffing shortages it did not meet all initial goals on time and may need to adjust its time frames for future activities. While GAO is still evaluating SSA's schedule and cost estimates against best practices, we have preliminarily identified some potential gaps in SSA's approach, such as not reflecting the costs to both implement and maintain a new OIS.

United States Government Accountability Office

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

I am pleased to be here today to discuss our preliminary observations on efforts by the Social Security Administration (SSA) to modernize its disability criteria. In the last 20 years, SSA disability benefit payments to beneficiaries and their dependents have increased almost fivefold, from $35 billion in 1990 to over $164 billion in 2010. The number of working-age beneficiaries also grew from about 9 million in 2000 to almost 12 million in 2010, and, as more baby boomers enter their disability-prone years, SSA expects the number of claims to grow.[1] Given the extensive size and cost of its disability programs, SSA must have current and appropriate criteria by which to assess whether an applicant's medical conditions affect his or her ability to perform work in the national economy. GAO has designated SSA's federal disability program as a high-risk area; in 2008, we reported that the agency's medical criteria did not fully reflect medical and technological advances, and the occupational criteria it used from the Department of Labor (Labor) had not been updated since 1991, despite the trend away from manual labor jobs and towards service- and knowledge-based jobs.

My statement today focuses on initial observations from our ongoing review for this subcommittee and examines the status and management of SSA's efforts to (1) update its medical listings to reflect current medical knowledge and (2) develop its own occupational information system (OIS) to reflect labor market changes. To examine these issues we reviewed prior GAO and SSA Office of Inspector General reports; relevant federal laws and regulations; program documentation including policies, procedures, strategic goals, and supporting project plans and cost estimates; and position papers and testimonies from disability groups and commissions. We interviewed SSA officials, key project contractors and stakeholders, disability experts, and representatives of other agencies that administer disability programs. In our ongoing work, we will further evaluate SSA's plan to develop its own OIS against best practices for cost estimating and scheduling. We will also review more broadly other steps SSA is taking to incorporate modern concepts of disability into its programs. We plan to issue our final report later in 2012 in accordance

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[1] In fiscal year 2010, SSA received 6.3 million benefit claims from either workers with disabilities or their dependents, up from 3.1 million in 2000.

with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

SSA administers two of the largest disability programs: the Disability Insurance (DI) program, enacted in 1956, and the Supplemental Security Income (SSI) program, enacted in 1972.[2] In order to be eligible for DI or SSI benefits based on a disability, an individual must meet the definition of disability for these programs—that is, they must have a medically determinable physical or mental impairment that (1) prevents the individual from engaging in any substantial gainful activity, and (2) has lasted or is expected to last at least one year or result in death.[3]

To determine eligibility, SSA uses a five-step sequential process that is intended, in part, to expedite disability decisions when possible and limit administrative costs by conducting less intensive assessments at earlier steps (see fig. 1).[4] At steps 1 and 2 of the process, SSA determines whether an applicant is working and meets income thresholds as well as the medical severity of impairments. If so, the applicant moves to step 3 of the process. At this step, SSA examiners assess the applicant's medical impairment(s) against the Listings of Impairments, also known as the medical listings, which are organized into 14 major body systems for adults and reflect medical conditions that have been determined by the agency to be severe enough to qualify an applicant for benefits.[5] If the individual's impairment meets or is equal in severity to one or more of

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[2] The DI program provides monthly cash benefits to eligible applicants who have a sufficient work record. The SSI program provides monthly benefits to eligible applicants with limited income and resources who are disabled, blind, or age 65 or older.

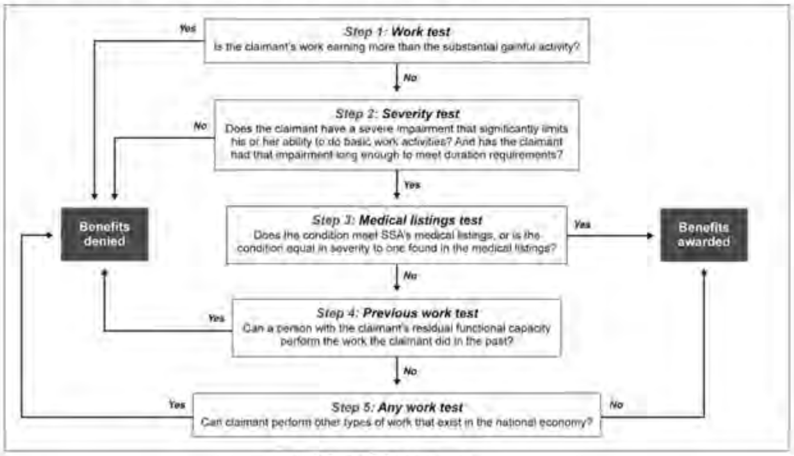
[3] 42 U.S.C. §§ 423(d)(1)(A) and 1382c(a)(3)(A). Substantial gainful activity is generally work activity involving significant physical or mental activities that are done for pay or profit, whether or not a profit is realized. 20 C.F.R. §§ 404.1572 and 416.972. In 2012, the substantial gainful activity threshold is $1,690 per month for blind recipients and $1,010 per month for individuals with other disabilities.

[4] See 20 C.F.R. §§ 404.1520 and 416.920.

[5] According to agency officials, there are almost 300 medical impairments organized in 119 listings under the 14 major body systems for adults.

those in the listings, the individual is determined to have a disability. If not, SSA performs an assessment of the individual's physical and mental residual functional capacity.[6] Based on this assessment, SSA determines whether the individual is able to perform past relevant work (step 4) or any work that is performed in the national economy (step 5). To inform determinations at steps 4 and 5, SSA uses a Department of Labor database—known as the Dictionary of Occupational Titles (DOT)—for an inventory of occupations performed in the national economy.

Figure 1: SSA's Five-Step Sequential Evaluation Process for Determining Disability



Source: GAO analysis of SSA's evaluation process.

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[6] SSA's physical and mental residual functional capacity assessments establish the extent to which an individual's medically determinable impairment(s), including any related symptoms, such as pain, may cause physical or mental limitations or restrictions that may affect his or her capacity to do work-related physical and mental activities.

Since 2003, SSA's and other federal disability programs have remained on our high-risk list, in part, because their programs emphasize medical conditions in assessing work capacity without adequate consideration of work opportunities afforded by advances in medicine, technology, and job demands. Since the 1990s, we, along with SSA's Office of Inspector General and the Social Security Advisory Board, have expressed concerns that the medical listings being used no longer provide sufficient criteria to evaluate disability applicants' inability to work and that SSA was simply extending the listings instead of periodically updating them. In 2008, we reported that SSA had established a new process for revising the listings—referred to by SSA as the "business process"—to better incorporate feedback into its continuous updates.[7] This process, which has been in effect since 2003, includes incorporating feedback from multiple parties, including medical experts and claims examiners, to update their medical criteria. SSA should also gather external feedback through comments associated with regulatory actions, such as the publication of advanced notices of proposed rulemaking (advanced notices) and notices of proposed rulemaking (notices) in the Federal Register.[8] In addition, one year after a revision is made, SSA should conduct a study reviewing the changes. According to SSA documentation, this internal case study, now referred to as the postimplementation study, should involve surveying the field regarding the results of the regulation and areas to improve, as well as reviewing the data to determine whether expectations from the revision have been proven.

With respect to information on jobs in the national economy that supports SSA's occupational criteria, we and others have reported that the DOT, which SSA still relies on to assess eligibility at steps 4 and 5 of the process, is outdated. The DOT has not been updated since 1991, and Labor has since replaced the DOT with a new database called the

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[7] GAO, *Federal Disability Programs: More Strategic Coordination Could Help Overcome Challenges to Needed Transformation*, GAO-08-635 (Washington, D.C.: May 20, 2008).

[8] Any changes to the medical listings have to proceed according to an established process for rulemaking outlined in federal law. As such, when changes are made to the listings, a notice of proposed rulemaking must generally be published in the Federal Register with a public comment period before the final rule is issued. 5 U.S.C. § 553.

Occupational Information Network (O*NET).[9] However, SSA has determined that O*NET is not sufficiently detailed for evaluating DI and SSI disability claims and therefore has begun developing its own OIS in order to better reflect the physical and mental demands of work in the national economy.

SSA Has Improved Its Process for Updating Medical Listings, but Faces Challenges Completing Updates

SSA Has Improved Its Strategy to Update Medical Listings

Since our last review in 2008, SSA has made several changes that hold promise for improving medical listings updates. First, the agency is using a two-tiered system for ongoing revisions to the listings. Under this system, SSA first completes a comprehensive listings update for a body system that reviews all the diseases and disorders listed within that system and makes revisions it determines are needed. For subsequent updates of listings for a body system that underwent a comprehensive revision, SSA will pursue a more targeted approach—that is, SSA will conduct ongoing reviews with the expectation of making targeted revisions for a small number of medical diseases or disorders that need to be updated. Agency officials told us that targeted updates should be completed more quickly than comprehensive updates, allowing them to focus on the most critical changes needed. However, officials also noted that these ongoing reviews could result in major or even no changes, as appropriate. As of early March 2012, SSA had begun the ongoing review process to consider opportunities for targeted revisions for 8 out of 14 adult body systems that were recently comprehensively revised. Also as of early March 2012, the agency had not yet completed comprehensive revisions for the six remaining systems, which the agency expects to do before they conduct subsequent reviews under the targeted approach.

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[9] Labor launched O*NET, a general purpose occupational information database used for workforce development, economic development, career exploration, academic and policy research, in 1998.

Another change, according to agency officials, is that in 2010 the SSA Commissioner set a 5-year cycle time for updating listings for each body system.[10] Previously, SSA set expiration dates for periodically updating listings according to each body system, ranging from 3 to 8 years, but frequently extended them. SSA officials believe that conducting targeted reviews will generally allow the agency to conclude any necessary revisions prior to the 5-year expiration period. Additionally, they expect that using the "business process," which requires early public notification of changes and obtaining necessary data and feedback from internal and external parties, should help keep continuous reviews on track. See figure 2 for the status and expiration dates of listings for the 14 adult body systems, undergoing review for either comprehensive or possible targeted revisions, as of early March 2012.

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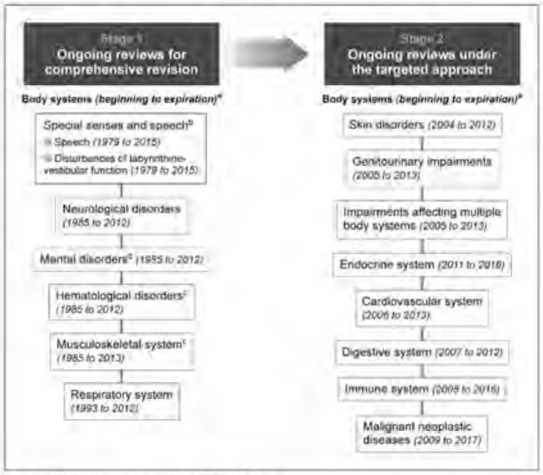
[10] The 5-year expiration period will be applied to listings under a body system upon completion of their current revision. SSA began applying the 5-year expiration period in 2011 when it comprehensively updated the endocrine body system listings. For other body systems listings updated prior to 2011, SSA generally assigned expiration periods extending beyond 5 years.

Figure 2: Status of Revisions for SSA's Adult Body System Listings



Source: GAO analysis based on information provided by SSA officials.

[a] For the two-tiered revision process, the beginning point is the date of the last comprehensive or targeted revision.

[b] SSA officials told us they have grouped the disorders in the special senses and speech listings into two broad sections—vision and hearing—and two standalone medical conditions. SSA has not yet comprehensively revised the two standalone medical conditions that cover speech and disturbances of labyrinthine-vestibular function. The two sections have undergone comprehensive revisions and are undergoing reviews that began in 2007 for the vision section and in 2010 for the hearing section. Special senses and speech listings are set to expire in 2015.

[c] SSA published limited revisions for the hematological disorders listings in 1986, the mental disorders listings in 2000, and the musculoskeletal system listings in 2002.

SSA has made another change by more extensively engaging the medical community to identify ways to improve the medical listings. For example, SSA contracted with the Institute of Medicine to study its medical criteria for determining disability and to make recommendations for improving the timeliness and accuracy of its disability decisions, resulting in a 2007 report with recommendations[11] and a symposium of experts in 2010. SSA has addressed some of the institute's recommendations, such as making better use of its administrative data to update criteria and creating a standing committee through the institute to provide recommendations for listings revisions.

SSA Has Experienced Delays with Its Revision Process

SSA continues to face delays in completing both comprehensive and other ongoing updates. For example, as of early March 2012, SSA officials told us they still needed to complete comprehensive revisions for listings of six body systems that have been ongoing for the last 19 to 33 years, after numerous extensions beyond the original expiration periods (see table 1). Two of the remaining six body system listings—mental and neurological disorders, which are among those SSA uses most frequently in its eligibility determination process—have not been comprehensively revised for 27 years.[12] Four of the remaining body system listings are set to expire in 2012. Of these four, SSA is developing a notice of proposed rulemaking for three of them and has issued a notice on the fourth. However, it is unclear whether SSA will complete the revisions before they are set to expire.

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[11] Institute of Medicine, *Improving the Social Security Disability Decision Process* (Washington, D.C.: 2007).

[12] According to SSA officials, the agency made limited, but not comprehensive, revisions to the mental disorders listings in 2000.

Table 1: Key Dates for Comprehensive Revisions to Body System Listings

Body system and section	Year comprehensive revision last published	Years since comprehensive revision last published[a]	Current expiration date[b]
Special senses and speech[c] - Speech - Disturbances of labyrinthine-vestibular function	1979	33	2015
Neurological disorders	1985	27	2012
Mental disorders	1985	27	2012
Hematological disorders	1985	27	2012
Musculoskeletal system	1985	27	2013
Respiratory system	1993	19	2012

Source: GAO analysis based on information provided by SSA officials.

[a] SSA published limited revisions to listings for the hematological disorders in 1988, the mental disorders in 2000, and the musculoskeletal system in 2002.

[b] SSA has continually extended the expiration dates of the listings.

[c] The special senses and speech listings have two sections—vision and hearing—which have been comprehensively revised.

While ongoing reviews involving SSA's targeted approach seem to be moving at a faster pace than the comprehensive revisions, SSA has already extended the expiration date for its review of the cardiovascular system. SSA may also need to extend expiration dates for listings under two other body systems set to expire in 2012, according to agency officials. Extensions may be needed because SSA has not yet published the notice of proposed rulemaking for those two body system listings and may not have time to publish these notifications, respond to comments, and complete the final updates of the listings by their current expiration date.

At the same time that SSA has been experiencing delays completing timely revisions, agency officials reported challenges with other steps in the business process. Whereas they always intended to review data at the one year mark to determine whether expectations from a revision were met, SSA officials told us they only began conducting these reviews in 2010. Specifically, they completed one postimplementation study in 2011 that involved a targeted sample of 175 cases, and they are conducting and planning to conduct two more studies at the one year mark. While disability experts we interviewed spoke highly of SSA's business and targeted review processes to obtain feedback early on and update the listings more promptly, recent delays raise questions regarding the agency's ability to follow its current business process while completing continuous and timely revisions for all 14 body systems.

SSA officials offered two key reasons for the delays in updating the listings: limitations in the number and expertise of staff and the complexity and unpredictability of the regulatory process. According to SSA officials, revising the medical listings requires research, deliberation, testing, regulatory review, and consensus with many stakeholders, and consequently is difficult and time-consuming to achieve. In addition, according to an SSA official in the Office of Medical Listings Improvement, the office is short-staffed and some staff lack the expertise necessary to perform this work. To address these constraints, SSA has contracted with the Institute of Medicine to review and develop recommendations for revising two of the body system listings.[13] However, SSA officials told us that the agency does not currently have a plan to renew this contract after it expires in 2012, nor use any other contractor to address staffing shortfalls due to budget constraints. Also contributing to delays is the time required for internal review and public comment under the regulatory process that depends largely on the number and the substance of comments received, according to an SSA official. For example, SSA officials told us that the advanced notice of proposed rulemaking to the listings of mental disorders in 2003 resulted in 500 comments, which took SSA 5 years to incorporate into a draft notice of proposed changes for regulatory review.

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[13] The institute provided recommendations for changes to the cardiovascular and the Human Immunodeficiency Virus listings in two reports. For the reports see, Institute of Medicine, *Cardiovascular Disability: Updating the Social Security Listings* (Washington, D.C.: 2010) and *HIV and Disability: Updating the Social Security Listings* (Washington, D.C.: 2010).

SSA Has Begun an Ambitious Project to Develop Its Own Source of Occupational Information

SSA is in the Preliminary Stage of Developing a New Up-to-Date Source of Occupational Information

In 2008, SSA began a multiyear project to develop a new source of occupational information that will replace the outdated information currently being used to determine if claimants are able to do their past work or any other work in the national economy. Since the 1960s, SSA has been using the DOT, which contains a list of job titles found in the national economy and was last updated in 1991.[14] The DOT provides SSA with descriptions of the physical demands of work—such as climbing, balancing, and environmental requirements—for each of the more than 12,000 occupations listed. According to SSA, these descriptions have been essential to its evaluations of how much a claimant can do despite his or her impairment and whether this level of functioning enables the claimant to do his or her past work or any other work. After its last limited update, Labor decided to replace the DOT with O*NET, which has far fewer job titles compared with the DOT, but has served Labor's purposes more efficiently. According to an SSA report, after investigating potential alternatives, SSA decided that O*NET and other existing databases with occupational information were not sufficiently detailed and able to withstand legal challenges for use in its decision-making process. SSA further decided to develop its own occupational information system, which would contain detailed information as in the DOT, but would also include additional information, such as the mental demands of work. In addition, the OIS should (1) meet SSA's legal, program, and data requirements; (2) be flexible enough to incorporate changes in SSA's policies and processes; and (3) be able to be updated to reflect the evolving workplace environment.

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[14] The DOT provides a wide range of occupational information that could be used for job placement, occupational research, career guidance, labor-market information, curriculum development, and long-range job planning.

In 2008, SSA began taking several steps to guide the development of its OIS. SSA created an internal office and working group, as well as an Occupational Information Development Advisory Panel, comprised of external experts in areas related to the development of occupational information systems.[15] The advisory panel holds quarterly public meetings and has several subcommittees that review material and make recommendations to SSA on developing various components of the OIS. For example, in a 2009 report, the advisory panel supported the need for SSA to develop a new source of occupational information, rather than adapt O*NET, and recommended the type of data SSA should collect, as well as suggested ways to classify occupations.

To further inform its efforts, SSA has sought input from agencies or organizations that either collect occupational information or also use the DOT. For example, SSA officials held initial meetings with Labor and U.S. Census Bureau officials to gain information on sampling methods used for the O*NET, the Occupational Employment Statistics program, and Census Bureau's household surveys.[16] Additionally, SSA and Labor are in the process of completing a Memorandum of Understanding that will formalize their collaboration efforts on the new OIS. According to an SSA official, as the OIS project progresses, SSA plans to convene ad hoc roundtables with experts and other agency officials to explore specific subject areas, such as sampling issues. Besides working with Labor and Census Bureau officials, SSA officials and panel members have sought input from other experts and current users of the DOT, such as SSA disability adjudicators and external rehabilitation professionals, by conducting a user needs analysis in 2009 and presenting the OIS project at events and conferences.

In July 2011, SSA published a detailed research and development plan outlining all activities related to researching, developing, and testing the

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[15] The Occupational Information Development Advisory Panel was formed in December 2008 under the Federal Advisory Committee Act.

[16] The Occupational Employment Statistics program produces employment and wage estimates for approximately 800 occupations. The Census Bureau's household surveys include (1) the American Community Survey, which is an ongoing survey that provides annual data on demographics such as age, education, and disabilities, and (2) the Current Population Survey , which is primarily a labor force survey, conducted every month by the Census Bureau for the Bureau of Labor Statistics and provides data such as the national unemployment rate.

key components of the OIS in order to implement the OIS by 2016 at an estimated cost of $108 million. For example, the plan includes several baseline activities to identify and study other occupational information systems and various approaches for analyzing occupations that may inform or could be leveraged in SSA's OIS data collection. The plan also includes activities to identify the primary occupational, functional, and vocational characteristics of current beneficiaries. Other key components of the plan include developing descriptions of work requirements, such as the physical and mental demands for jobs, and data collection and analysis strategies. SSA also plans to develop a strategy for piloting data collection nationwide within this time frame.

SSA Has Made Progress on Its OIS, but It Is Too Soon to Know if Project Timelines Will be Met

As of February 2012, SSA had made progress on many of the baseline activities outlined in its research and development plan for the OIS.[17] For example, according to an SSA official, its investigation of existing occupational information systems, now complete, has resulted in useful information about design issues other organizations have confronted and mitigated when creating their own system. Additionally, SSA's preliminary analysis of its own administrative data identified the most frequently cited occupations and functional and vocational characteristics of disability applicants. SSA officials told us the agency will target the occupations identified in this analysis for its pilot studies of the OIS. Also in 2011, SSA completed a comprehensive framework for assessing an individual's capacity to work—key to informing the OIS content, according to SSA officials—which was based on recommendations of outside experts as well as SSA's policy and program requirements.

While SSA has made progress on several key activities, agency officials delayed 2011 completion dates for certain activities and anticipate making additional changes to its timeline as a result of not meeting its staffing goals for fiscal year 2011. For example, the activities that were delayed by several months included finalizing reports for the baseline studies and conducting a literature review that would inform how occupations might be analyzed for the OIS. SSA officials told us that they would have needed to have the full complement of projected 2012 staff by September 2011 to complete all of the 2012 planned activities within the estimated

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[17] Some of the activities that were part of the research and development plan were completed in years prior to the plan's issuance.

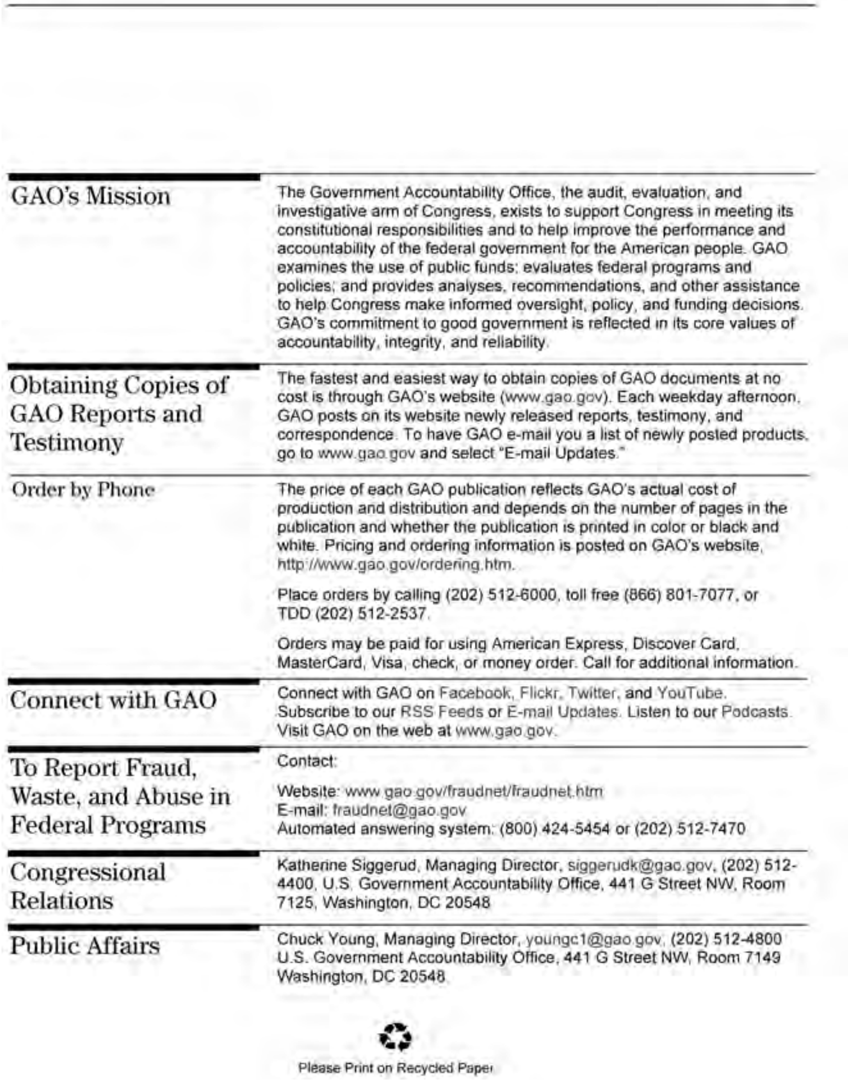
schedule. However, SSA officials said they did not have the budget to hire new staff in September 2011. To address this challenge, SSA officials hired consultants to meet some of their needs. SSA officials also met with the Office of Personnel Management to explore the possibility of an interagency agreement that would allow SSA to use one or two of the Office of Personnel Management's industrial organizational psychologists to help on a part-time basis.

As part of our ongoing work, we are assessing SSA's current OIS project schedule and cost estimates against best practices, and have preliminarily identified some gaps in SSA's approach. For example, best practices require cost estimates to be comprehensive and include information about life cycle costs—that is, how much the project is expected to cost over time. However, while SSA has estimated the cost to research and develop the OIS, the estimate does not project the future costs to implement or maintain the system. The cost of sustaining an OIS could be significant, based on other agencies' experiences maintaining their systems for collecting national occupational information. We preliminarily identified other gaps, such as lack of documentation describing step by step how the cost estimate was developed so that those unfamiliar with the program could understand how it was created. For our final report due later in 2012, we plan to deliver more comprehensive findings on how well SSA is managing the development of its OIS against best practices, such as estimating costs of the OIS and ensuring that the project schedule reliably estimates related activities, the length of time they will take, and how they are interrelated. We will also identify any mitigation strategies the agency may have to address project risks, such as the risk of the agency not receiving full funding.

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, this concludes my prepared statement. I will be happy to respond to any questions.

Contact and Acknowledgments

For further information regarding this testimony, please contact me at 202-512-7215 or bertonid@gao.gov. In addition, contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony are Michele Grgich, Assistant Director, James Bennett, Kate Blumenreich, Julie DeVault, Alex Galuten, Sheila McCoy, Patricia M. Owens, Anjali Tekchandani, Kathleen Van Gelder, and Walter Vance.



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Chairman JOHNSON. Thank you, sir.

Dr. Chan, you are recognized, sir.

STATEMENT OF LEIGHTON CHAN, CHIEF, REHABILITATION MEDICINE DEPARTMENT, NATIONAL INSTITUTES OF HEALTH

Dr. CHAN. Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, I am honored to have the opportunity to appear before you today to testify about NIH's collaboration with the SSA.

The SSA approached NIH in late 2007 for advice on new assessment methods that might inform their disability evaluation process. The NIH Clinical Center's Rehab Medicine Department agreed to help, and based our work on widely adopted contemporary disability concepts.

Our collaboration has been facilitated by an interagency agreement that was initiated in February 2008. I want to note this area we are talking about today is just one of many factors that SSA takes into account in their statutory role to ensure that the Agency's disability evaluation standards reflect appropriate medical and vocational information.

Currently, the SSA disability determination process is linked to a claimant's diagnosis or their impairment. However, a diagnosis or impairment may no longer be so closely connected to an individual's ability to work, as it has been in past years.

The concept of disability has evolved over the last few decades, and this evolution has now culminated in an international agreement.

In 2001, the World Health Organization adopted a landmark standard called the "International Classification of Functioning Disability and Health," or the ICF.

The ICF has been endorsed by all 191 WHO members, including the United States.

The ICF considers disability to be the result of not only a person's diagnosis but also two other very important factors, the impact that diagnosis has on their ability to function and the environmental demands placed on them in their workplace.

It is this ICF theoretical construct that really informs our collaboration with SSA.

Our work with the SSA has several components. One of the most important projects is the direct attempt to create a rapid, reliable, and objective functional assessment tool that SSA could use one day in real time.

To do this, we have engaged colleagues at Boston University to help us develop a series of computerized functional assessments that utilize something called "Item Response Theory and Computer Adaptive Testing" or IRT/CAT.

The scientific evidence validating IRT/CAT instruments has been available for decades. If you have recently taken the SAT or GRE or LSAT, you have taken an IRT/CAT test.

The theory is really quite simple. If you want to assess an individual's capabilities regarding a single characteristic, let's say their ability to lift 300 pounds, and you need to know that in one pound increments, well, you could ask 300 separate questions. That would give you a very precise estimate, but it would take some time.

Item response theory utilizes information gathered in prior questions to determine what questions should come next.

For instance, you might ask that same individual can you lift 50 pounds. If the answer to that question is yes, the next question might be can you lift 100 pounds. If the answer to that is no, the next question might be can you lift 75 pounds, and so on.

By asking five or six questions rather than 300, you can determine how much that person thinks they can lift.

IRT/CAT tests have a significant advantage to the SSA, in addition to administering them to claimants, the SSA might also apply these same tests to clinicians to obtain their functional assessment of the claimant. This information could add an important perspective to a person's disability claim.

Our team is currently in the process of creating two initial IRT/CAT instruments. They will assess a claimant's interpersonal interaction skills and their mobility.

These two topics were selected because of the high relevance they have to SSA's current applicant pool.

For these topics, assessment questions have been developed and the calibration tests are being completed. We will calibrate the tests not only to SSA claimants but also to the population as a whole, after which we will put together the IRT/CAT instruments themselves.

An RFP or Request for Proposal is currently posted for the development of four additional IRT/CAT instruments that will cover all the remaining topics in the ICF related to work disability. These topics will likely include self care, communication, learning and applying knowledge, and general tasks and demands.

We hope to have much of the initial work for all six IRT/CAT instruments completed by 2016.

Mr. Chairman, this completes my prepared remarks. Once again, thank you for the opportunity to testify today and provide an overview of our work with the SSA. I will be happy to answer any questions.

[The prepared statement of Dr. Chan follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

TESTIMONY OF DR. LEIGHTON CHAN

CHIEF, REHABILITATION MEDICINE DEPARTMENT

NATIONAL INSTITUTES OF HEALTH,

CLINICAL CENTER

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES

WAYS AND MEANS COMMITTEE

SOCIAL SECURITY SUBCOMMITTEE

MARCH 20TH, 2012

Chairman Johnson, Ranking Member Becerra, and Members of the Subcommittee, I am honored to have the opportunity to appear before you today to testify about the National Institutes of Health's collaboration with the Social Security Administration in studying approaches for analyzing function as it relates to disability assessment.

My name is Leighton Chan. I am the chief of the Rehabilitation Medicine Department at the NIH Clinical Center. I am a physician who specializes in the diagnosis and treatment of individuals with disabilities. I am also a researcher in the NIH intramural research program and have spent my career trying to identify and remove barriers to care for this vulnerable population.

Background on NIH-SSA collaboration

The SSA approached the NIH in August of 2007 for advice on new technologies, diagnostic tools, and novel assessment methods that might inform their disability evaluation process. The NIH Clinical Center's Rehabilitation Medicine Department agreed to help the SSA examine the disability determination process. Our collaboration has been facilitated by an initial Inter-Agency Agreement (IAA) that was executed in February, 2008. We anticipate that our work together will extend at least through 2016.

I want to note that our research at NIH in this area is one of many factors that the SSA takes into account in their statutory role to ensure the agency's disability evaluation standards reflect appropriate medical and vocational information.

Shifting paradigms of disablement

The way in which disability is conceptualized and measured has changed dramatically in the past 50 years, starting with the work of a distinguished medical sociologist, Saad Nagi in 1965. Over time, many others have built on Nagi's original framework. Prominent conceptual models of disability (Altman 2001) include those proposed by Nagi (1965, 1991), Verbrugge and Jette (1994), the Institute of Medicine (Brandt Jr. and Pope 1997; Pope and Tarlov 1991; Pope 1992), Abberley (1987), Oliver (1996, 1990, 1993) and the World Health Organization (1980, 2001). Although aspects of these models differ, they all agree that disability cannot be viewed as an individual attribute (Zola 1993). Disability may be thought of as the difference between individual capabilities and their environmental demands (Verbrugge and Jette 1994). The Institute of Medicine (IOM) (1991) noted that disability is not a stable attribute across situations, since physical and mental functioning is influenced by environments. Disability is a complex process, which is multidimensional, dynamic, and interactive in nature.

The World Health Organization (WHO) International Classification of Functioning, Disability and Health (ICF)

Debate about the concepts of disability culminated in 2001 when the WHO adopted a landmark standard called the International Classification of Functioning, Disability and Health (ICF) (World Health Organization 2001). The ICF has been officially endorsed by all 191 WHO members, including the United States. The ICF is a framework that provides a common language to describe functioning as well as a comprehensive accounting of sub-domains of functioning, a feature that other contemporary models lack (see Figure 1).

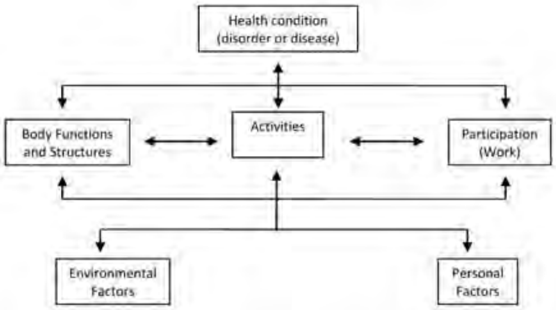

Figure 1: World Health Organization's International Classification of Functioning

The ICF is being integrated into important institutional frameworks in this country and abroad. In 2007, the Institute of Medicine (IOM) recommended that government agencies adopt ICF as a conceptual framework and language (Field and Jette 2007). This approach breaks through institutional and disciplinary boundaries that have long plagued disability research and inhibited cohesive efforts on behalf of persons with disability. The ICF now serves as the conceptual framework and terminology for the most recent edition of the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment* (AMA Guides) (Rondinelli 2009).

The ICF is being taught in academic institutions to future generations of health care professionals and integrated into professional standards of practice by numerous professional organizations including the American Psychological Association, the American Occupational Therapy Association, the American Speech-Language-Hearing Association, the American Physical Therapy Association, the American Therapeutic Recreation Association and the National Association of Social Workers. It is the ICF theoretical construct that informs the NIH collaboration with the SSA.

Research objectives

This collaboration has several components. One of the most important projects is to create a real time functional assessment that is rapid, reliable and objective. This project assesses the feasibility of developing Computer Adaptive Test (CAT) instruments that could be considered for integration into the SSA's disability evaluation processes. CAT methodology, coupled with Item Response Theory (IRT), is used to measure outcomes precisely across the full continuum of human functioning. IRT/CAT represents a simple form of artificial intelligence software requiring a computer for administration. We are working with researchers from Boston University (BU) on IRT/CAT development.

To illustrate: If you want to assess an individual's capabilities regarding a single characteristic, their ability to lift up 300 pounds in 1 pound increments, you could ask them up to 300 separate questions. This would provide a very precise assessment of how much that individual could actually lift but would take quite some time to figure out. Item response theory utilizes information gathered in prior questions to determine what question should come next, thereby eliminating many questions and saving time needed to assess an individual disability claim. For instance, you might ask that same individual, can you lift 50 pounds? If the answer to that question is yes, the next question may be, can you lift 100 pounds? If the answer to this question is no, your next question might be can you lift 75 pounds? Within a short period of time you can determine how strong that person is.

An IRT/CAT is programmed first to present a question from the mid-range of a defined list of hierarchically ordered questions. The program then selects subsequent questions at an appropriate level based on the respondent's previous answers. Comprehensive calibrated question banks reflect a broad range of ability across each functional domain of interest. IRT/CAT administration permits the use of far fewer test questions (in total) because the questions are selected based on the individual's level of function. In the future, the utilization of IRT-IRT/CAT technology could potentially allow the SSA to collect more relevant, comprehensive, and precise data about human functioning in a faster, more efficient fashion.

The development of IRT/CAT tools is a sequentially dependent process that takes about two years. Each step of IRT/CAT tool development proceeds in an ordered fashion; one step must be completed before advancing to the next step. The first step of the process is the development of assessment questions. This step encompasses working with content experts, examining literature and reviewing other models/taxonomies to develop question content and structure. The next step is to calibrate the questions; order them from easiest to hardest and remove redundant or non-informative questions. Statistical analyses are conducted on data collected from samples of persons similar to the intended audience for the instrument. The objective is to assess the psychometric properties of the questions. The final step of developing IRT/CAT tools is to validate the instrument. In our collaboration we plan to develop multiple IRT/CAT tool instruments. The content of each instrument is unique and development of each instrument must follow the sequential process. Examples of questions from the physical mobility IRT/CAT instrument we are developing include:

- Are you able to lift a full small (carry-on size) suitcase from the floor to table height?
- Are you able to stand up from a low, soft couch?
- Are you able to go up one flight of stairs with a handrail?

IRT/CAT instruments may be quite useful to the SSA. In addition to administering these tests to claimants, the SSA could also apply them to a clinician about a patient to obtain his or her functional assessment of the claimant. This could add an important perspective to a person's disability claim.

The SSA/NIH/BU collaboration is developing IRT/CATs tailored specifically for SSA's purposes -the assessment of work disability. This effort likely will yield a series of six IRT/CAT instruments to assess function. These assessment instruments will cover all the major ICF areas that are highly related to work, such as basic mobility, cognition, interpersonal interaction, communication, self care, and general tasks and demands.

The SSA/NIH/BU team is currently in the process of creating the first two IRT/CAT instruments. They will assess claimant's physical mobility and interpersonal interactions skills. These two were selected because of their high relevance to SSA's current applicant pool. For these domains, questions have been developed and preliminary testing is complete. Normative data are currently being collected using these question banks, after which, final IRT/CATs will be developed. Data were collected from claimants as well as their health care providers. A request for proposal is currently posted for completion of the remaining IRT/CAT development activities. We hope to have much of our initial work for all six IRT/CAT instruments completed by 2016.

Mr. Chairman, this completes my prepared remarks. Once again, thank you for the opportunity to testify today and provide an overview of NIH's collaborative work with the Social Security Administration on the IRT/CAT program. I would be happy to answer any questions that you might have related to my work.

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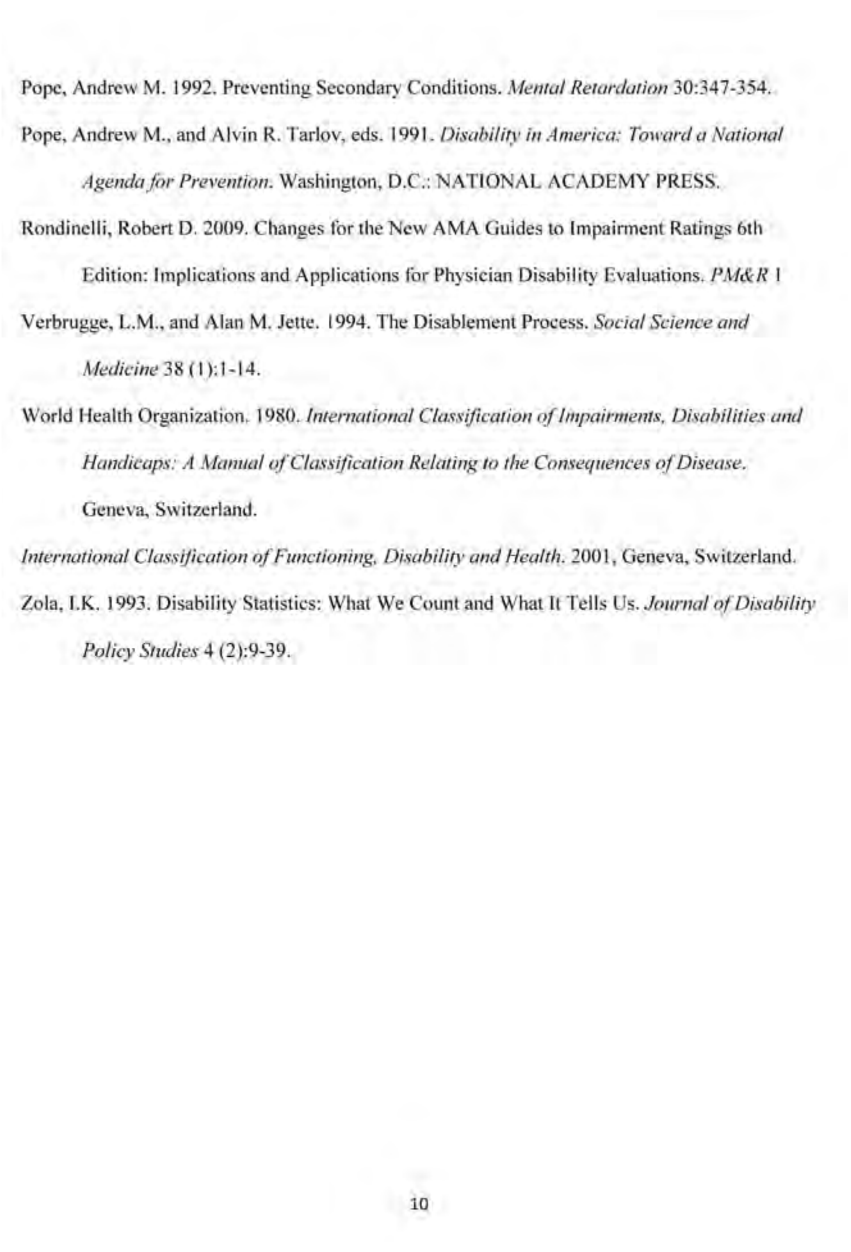

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Chairman JOHNSON. Thank you, sir.

Dr. Maestas, welcome. Please go ahead.

STATEMENT OF NICOLE MAESTAS, SENIOR ECONOMIST, RAND CORPORATION

Dr. MAESTAS. Thank you, Chairman Johnson and Ranking Member Becerra, for this opportunity to testify.

I will address my comments to the question of consistency in the initial disability determination process drawing on recent RAND research.

DDS case examiners are called on to evaluate and weigh many aspects of complex cases against extensive medical and vocational criteria in a dynamic medical environment.

They have heavy caseloads, and although they may consult with physicians, they are not themselves trained physicians. Moreover, as the SSDI caseload has grown, the composition of applications has shifted toward impairments with greater diagnostic uncertainty.

Chief among these are musculoskeletal and mental impairments, which now comprise 59 percent of all applications.

Given these factors, some variation in decision outcomes across DDS examiners is expected. Nonetheless, it is worth trying to minimize the extent of variation as much as possible.

In our analysis of initial disability determinations recorded in SSA's disability operational data store in 2005 and 2006, we find a notable degree of variation in initial outcomes across DDS examiners within the same office.

This variation cannot be explained by differences in the mix of cases they evaluate. We find that after adjustments for case mix, one-third of examiners have allowance rates more than six percentage points above or below the average allowance rate in their DDS, and as many as five percent of examiners have allowance rates more than 12 percentage points above or below the average.

As a result, for many applicants, whether they are allowed or denied benefits depends upon the examiner to which their case is assigned.

While most examiners have initial allowance rates near the average for their DDS office, some do not. This means that most applicants would receive the same initial determination if their application had been assigned to a different examiner in the DDS office, but even so, due to the examiners who are not near the average, we estimate that as many as 60 percent of applicants could have received a different initial determination from at least one other examiner in the DDS office, had they been assigned to that examiner instead.

The magnitude of this measure is driven by the examiners who have the lowest and highest allowance rates in a DDS office.

For example, if we remove from our calculations the top and bottom one percent of DDS examiners, those with the highest and lowest allowance rates, then the percent of applicants whose initial decision depends on the examiner they are assigned to would fall by half, from 60 percent to 28 percent.

As you would expect, the appeals process significantly dampens the effect of examiner variation. In our administrative data, nearly two-thirds of all initial denials are appealed and 75 percent of these are eventually overturned.

Once we account for appeals, we estimate that only 23 percent of applications could have received a different ultimate outcome, that is accounting for appeals, had they been assigned to a different examiner, and if we again remove the highest and lowest examiners in an office, this number falls to 11 percent.

These figures illustrate two points. First, although most examiners have allowance rates that are near the average for their DDS office, many have allowance rates that are notably below or above their office average even after adjusting for differences in case mix.

Because an applicant could potentially be assigned to one of these examiners, applicants face significant uncertainty as to whether their application will be initially allowed or denied.

Improving consistency across examiners would significantly reduce this uncertainty about initial outcomes.

Second, it bears emphasizing that these statistics are not estimates of the fraction of applicants who should have been denied. Rather, they identify the size and characteristics of the group that would be most affected by changes in the policies and procedures used in initial disability determinations.

This group disproportionately includes younger claimants, claimants with very low earnings histories, and claimants with mental impairments.

At present, the variation in examiner allowance rates and the high probability of having an initial denial overturned on appeal means it is usually worthwhile for denied applicants and their attorneys to pursue appeals.

The appeals process, as you know, is costly. From the time the initial DDS application is filed to the time a final determination is made, an applicant may not earn more than $1,000 a month in paid employment since this would exceed the SGA threshold and result in denial of benefits.

In our administrative sample of SSDI applicants who received decisions, initial decisions, in 2005, the average time from SSDI application to final determination exceeded one year.

While those who did not appeal waited an average of only four months, those who did appeal waited an average of two years before receiving a final determination. That is after exhausting all appeals.

Time spent out of the labor force while seeking benefits may have detrimental effects on employability. Indeed, we find that longer application processing times reduce the employment of SSDI applicants in the years after their initial decision.

Our calculations suggest that the SSDI determination process itself reduces the post-application employment of denied applicants by an average of 3.6 percentage points in years two and three after the initial determination, and similarly, reduces the average employment of allowed applicants by five percentage points.

In sum, by reducing the variation in initial determinations, we would improve the targeting of the SSDI program. That is we would increase the chances that people who truly qualify receive benefits and reduce the chances that those who do not truly qualify receive benefits.

To the extent the decision thresholds could be better aligned between the initial and appellate phases, the share of those initially denied applicants who decide to appeal would likely decline, and the detrimental effects on future employment potential would be reduced.

Thank you.

[The prepared statement of Dr. Maestas follows:]

TESTIMONY

Securing the Future of the Social Security Disability Insurance Program

NICOLE MAESTAS

CT-373
March 2012
Testimony presented before the House Committee on Ways and Means, Subcommittee on Social Security on March 20, 2012

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Nicole Maestas[1]
The RAND Corporation

Securing the Future of the Social Security Disability Insurance Program[2]

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

March 20, 2012

Although consistent treatment of similarly situated individuals is an important principle in any evaluative system like the Social Security Disability Insurance (SSDI) program, some degree of variation in decision outcomes across evaluators is inevitable. In other settings, variation in decision outcomes has been associated with case complexity, dynamism of the subject matter, size of caseload, the resources available to assist decision-making, attributes of the evaluators such as their prior experiences, and the training and guidance provided to evaluators (Ramji-Nogales, Schoenholtz and Schrag, 2007; Legomsky, 2007).

Indeed, Disability Determination Service (DDS) case examiners are called on to evaluate and weigh many aspects of complex cases against extensive medical and vocational criteria in a dynamic medical environment. They have heavy caseloads and although they may consult with physicians, they are not themselves trained physicians. These factors point to the importance of examiner judgment in initial disability determinations. The Social Security Administration (SSA) has undertaken studies examining variation in allowance rates across DDS examiners, states and adjudicative levels. In a seminal study, Nagi (1969), SSA commissioned an expert panel to perform external audits on a sample of SSDI applications and found that the panel agreed with the original award decision in just under 70 percent of cases. In a similar study, Gallicchio and Bye (1981) replicated a sample of claims decisions both within and between states, and found that within-state disagreements were in many cases as large or larger than disagreements across states. It is unlikely that matters have improved since the time of these early studies. As the SSDI caseload has grown, the composition of applications has shifted toward impairments with greater diagnostic uncertainty; chief among these are musculoskeletal and mental impairments, which now comprise 59 percent of all applications. These points suggest that even though consistency in applying the disability assessment criteria is intended, it may not be easily achieved in practice.

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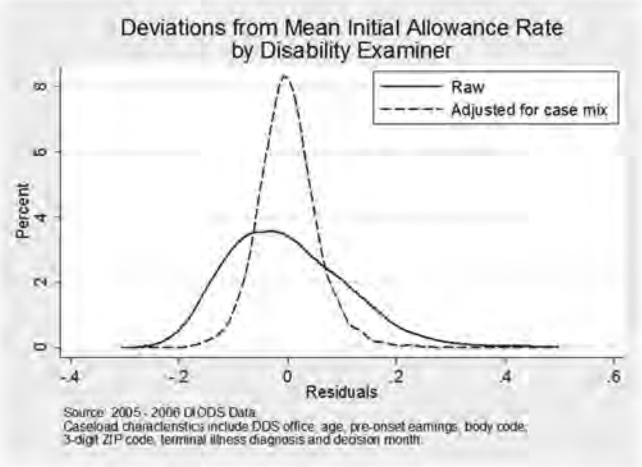
While we can be certain that variation in examiner decisions is expected, it is much more difficult to determine *how much* variation is expected and how much variation is too much. While we may not be able to say how much is too much, we should nonetheless try to minimize the extent of variation as much as possible.

In our analysis of initial disability determinations recorded in SSA's Disability Operational Data Store in 2005 and 2006 we find a notable degree of variation in initial outcomes across DDS examiners within the same DDS office that cannot be explained by factors such as differences in the mix of cases they evaluate (Maestas, Mullen and Strand 2010). Figure 1 presents a histogram of examiners' deviation from the overall allowance rate within their DDS office, both unadjusted and adjusted for differences in case mix. Case mix controls include the fraction of cases in a given age group, body system code category, terminal illness category, the fraction decided in a particular month, as well as the average prior earnings of applicants assigned to a given examiner, and indicators for DDS office and 3-digit zip code.

Figure 1



Source: 2005 - 2006 DIODS Data
Caseload characteristics include DDS office, age, pre-onset earnings, body code, 3-digit ZIP code, terminal illness diagnosis and decision month.

As expected, adjusting for case mix reduces the standard deviation of examiner initial allowance rates from 10 percent to 6 percent. This means that after adjustment for case mix, one-third of examiners have allowance rates more than 6 percentage points above or below the average allowance rate in their DDS, and 5 percent of examiners have allowance rates more than 12 percentage points above or below the average.

A consequence of the variation in decision outcomes across examiners—variation that cannot be readily explained by differences in the characteristics of their caseloads—is that for many applicants, whether they are allowed or denied benefits depends upon the examiner to which their application is assigned. Since, as Figure 1 shows, most examiners have initial allowance rates near the average for their DDS office, most applicants would have received the same initial determination if their application had been assigned to a different examiner. But even so, due to the examiners who are not near the average, we estimate that as many as 60 percent of applicants *could have* received a different initial determination from at least one other examiner in the DDS office, had they been assigned to that examiner instead. The magnitude of this measure is driven by the examiners who have the lowest and highest allowance rates in a given DDS office. For example, if we remove from our calculations the top and bottom one percent of DDS examiners in an office (those with the highest and lowest allowance rates), then the percent of applicants whose initial decision depends on the examiner they are assigned to would fall by half—from 60 percent to 28 percent.

The appeals process significantly dampens the effect of examiner variation. In our administrative data, nearly half of all initial denials are appealed, and 75 percent of these are overturned. Once we account for appeals, we estimate that 23 percent of applications could have received a different *ultimate* outcome had they been assigned to a different examiner. If we again remove from our calculations the top and bottom one percent of examiners in a DDS office (again, those with the highest and lowest allowance rates) this number would fall to 11 percent.

These numbers illustrate two points. First, although most examiners have allowance rates that are near the average for their DDS office, many have allowance rates that are notably below or above their office average even after adjusting for differences in case-mix. Because applicants could potentially be assigned to any of these examiners, applicants face a significant degree of uncertainty as to whether their application will be initially allowed or denied. Improving consistency across examiners would significantly reduce this uncertainty about initial outcomes. Second, these statistics are not estimates of the fraction of applicants who should have been denied. Rather, they identify the size and characteristics of the group that would be most affected by changes in the policies and procedures used in disability determinations. This group disproportionally includes younger claimants, claimants with low earnings histories and claimants with mental impairments (Maestas, Mullen and Strand 2010).

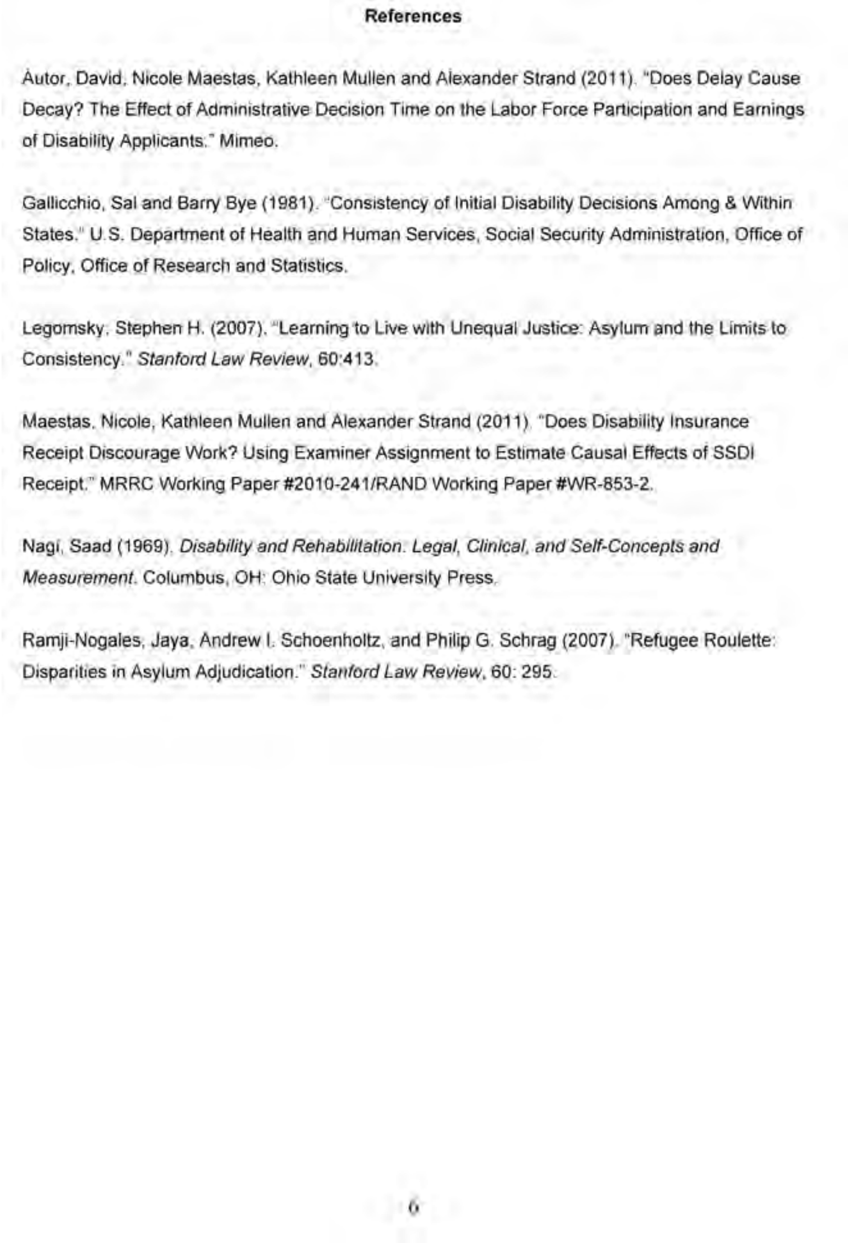
At present, the variation in examiner allowance rates and the high probability of having an initial denial overturned on appeal means that it is usually worthwhile for denied applicants and their attorneys to pursue appeals. But the appeals process is costly—not just for the federal government but also for the individual applicants themselves. From the time that an SSDI application is filed to the time a final determination is made, an applicant may not earn more than $1,000 per month in paid employment, since this would exceed the Substantial Gainful Activity (SGA) threshold and result in a denial of benefits. In our administrative sample of SSDI applicants who received initial decisions in 2005, the average time from SSDI application to final determination exceeded one year. But this average masks a dramatic difference in average waiting time between those who did not appeal their initial decision and those who did. Those who did not appeal waited an average of 4 months while those who did appeal waited an average of 2 years before receiving a final determination.

This substantial time spent out of the labor force while seeking benefits may potentially have detrimental effects on skills, job readiness, and employability. Indeed, we find that longer application processing times significantly reduce the employment and earnings of SSDI applicants in the years after their initial decision. A one standard deviation (2.4 months) increase in initial processing time reduces annual employment rates by about 1 percentage point (3.2%) in years two and three following the initial determination, and persists into the fourth post-determination year (Autor, Maestas, Mullen and Strand 2011).

To contextualize these numbers, we use them to estimate the impact of average applicant processing times on labor force participation of SSDI applicants. This calculation suggests that the SSDI determination process reduces the post-application employment of denied applicants by an average of approximately 3.6 percentage points (6.8%) in years two and three following the initial determination and, similarly, reduces the average employment of allowed applicants by 5.2 percentage points (33%).

Our results suggest that the post-determination employment potential of applicants could be improved if the system could achieve greater consistency not only within the initial determination process itself, but also greater consistency between initial determinations and outcomes on appeal. Improvement along these dimensions would also help reduce the notable disparities between the system's treatment of different impairment types, some of which exhibit a much greater likelihood that benefits would be awarded on appeal versus in the initial determination. For example, among new SSDI beneficiaries, we find that 63 percent of those with musculoskeletal impairments were awarded benefits at the appellate levels, compared to 39 percent of new beneficiaries with mental impairments—consequently, beneficiaries with musculoskeletal impairments spend significantly more time pursuing benefits than those with mental impairments.

By reducing the variation in initial determinations, we would improve the targeting of the SSDI program—that is, we would increase the chances that people who truly qualify receive benefits and reduce the chances that people who do not qualify receive benefits. To the extent that decision thresholds could be better aligned between the initial and appellate phases, the share of those initially denied applicants who decide to appeal would likely decline, and the detrimental effects on future employment potential would be reduced.



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Chairman JOHNSON. Thank you, ma'am. Did you listen to Dr. Chan? Did you agree?

Dr. MAESTAS. I did. I was actually quite excited by what I was hearing.

Chairman JOHNSON. Dr. Chan, you testified about the collaboration between Social Security and the National Institute of Health and Boston University to develop your computer tests.

Are you saying by taking a test, Social Security can credibly assess a claimant's ability to function in a matter of minutes?

Dr. CHAN. I think the techniques and the procedures behind IRT/CAT instruments are well validated. They have been utilized in educational arenas for quite some time. We have been using them in health care for quite some time.

They are remarkably powerful and insightful tools that can be done very, very quickly, particularly in the area of functional assessment.

Chairman JOHNSON. Can people fake them?

Dr. CHAN. Well, you know, our job really was to look at functional assessment, to determine a technique for functional assessment. Clearly, there is no functional assessment tool that would be completely immune to gaming.

On the other hand, there are, I think, several aspects to IRT/CAT that are really beneficial in this area.

The first would be that the IRT/CAT instruments themselves are comprised of dozens if not hundreds of questions that would be very difficult to memorize, and indeed, very difficult to figure out the order those questions might come in.

Second, we could also give the same assessment tools to the claimant's clinicians, and that would provide very interesting information, and I think useful for SSA in validating certain things.

In addition, we would be applying these tests to millions of individuals, so we would probably have some really wonderful baseline data looking at what a normal response pattern would be, so individuals who have aberrant response patterns potentially could be identified.

Chairman JOHNSON. It just takes one person to do the test?

Dr. CHAN. Yes. Mostly, it would be claimants who would be doing the tests, but for those individuals——

Chairman JOHNSON. I understand that. The person administering the test.

Dr. CHAN. Oh, on the testing side. In general, these are computer administered tests.

Chairman JOHNSON. One person can do them?

Dr. CHAN. Yes, a person could do it by himself, if that is what you are asking.

Chairman JOHNSON. Do they have to be trained?

Dr. CHAN. We sort of tailor these tests so they are at a relatively low and easy level. Obviously, we need to do that so that a broad range of individuals——

Chairman JOHNSON. That is the kind of test we need up here. [Laughter.]

Chairman JOHNSON. Do you agree with that, Doctor?

Dr. MAESTAS. I think this sounds quite promising.

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

Mr. BECERRA. Thank you, Mr. Chairman. I cannot get quite as excited on the numbers, but it sounds like the two of you put a great deal of numbers in, and I am glad it raises your blood pressure a bit to see we might have some opportunities.

I do think as you say, quite promising, Dr. Maestas, that we might have other ways to try to validate the process.

What I take from what every one of you have said is this ain't easy to do. In many cases, you are making judgments because you are looking at folks who are maybe right on the edge, could they work, and not just in their current occupation, but in some capacity whatsoever, and it is sometimes not an easy call to make.

What we are trying to do is make the system as efficient and standardized as possible, so that way when folks have to make the decision, they are not guessing. They should be collecting the information as early as possible to try to help these determiners, those who make the determinations, to have all the information and evidence they need.

Certainly, we have to make sure that we continue to push the SSA to have the tools in place that let them effectively make those judgments. We are talking life and death, as I think Ms. Ekman made clear, in most cases.

I am troubled that what we are hearing is SSA is having to try to do all of this with less and less money.

Ms. Lyon-Hart, you mentioned SSA is already struggling. You have already seen a number of these folks who make determinations gone.

Have you been losing folks with little experience or lots of experience?

Ms. LYON-HART. It is a mix. Just as the baby boomers are getting more disabled, they are also leaving our offices. I would say it is probably heavy on the—I do not know the exact numbers, I can get them for you probably with some polling of my members, but what I hear is they are losing experienced examiners.

Mr. BECERRA. It is not as if when you do a hire, you automatically compensate for the loss of that seasoned examiner.

Ms. LYON-HART. Correct.

Mr. BECERRA. This worries me because we were making progress. We were getting the wait time down, the backlog down.

I believe, Ms. Lyon-Hart, you also mentioned that the longer a case sits, the greater the chance we are going to make some mistakes with it, or it is going to become more difficult to adjudicate.

Ms. LYON-HART. It was not me that testified we would make more mistakes, but it definitely takes longer. You end up refreshing the medical evidence and getting more information. It becomes more complicated the longer it sits.

Mr. BECERRA. What I take from everything you are saying is that we have to continue to find the tools to let us make these assessments, to try to avoid the outlier decisions, whether in denial or granting the benefits, so that we have more consistency, but at the same time, do not tie the Social Security Administration's hands behind its back as it is trying to move forward with an increasing caseload of individuals who are filing for claims.

We want to make sure that those who deserve it get it, and at the same time, we want to make sure that those who do not deserve it do not clog the system for those who are waiting to get the benefits they have earned.

Ms. Ekman, you brought up some real cases. I think it is important to know that we are talking about real people who are affected, who paid into the system, who are now applying for those benefits that they worked to have.

What is your sense out there in the community of folks who are on the verge of securing these disability benefits or believing they may be on the verge of having to apply for these disability benefits?

Is there some concern about where we may head in the future?

Ms. EKMAN. Thank you for the question, Congressman Becerra. I am not sure for the people who are going to be applying for benefits, that is a concern. They are concerned about how do I pay my rent, how do I get my medication.

Mr. BECERRA. Good point.

Ms. EKMAN. I think for advocates, there is a huge concern that the longer the Social Security Administration and the state DDSs remain under funded, the worse the conditions will get. The longer people will have to wait.

It is not an overstatement to say that people die while they are waiting for a disability determination.

There is definitely a sense that we need to provide adequate resources to SSA and the DDSs to ensure that they can make accurate and timely decisions so that people who desperately need the benefits can get them.

Mr. BECERRA. One final question. I know the Social Security Administration in an effort to try to concentrate the resources it has on those services that are most important had to make other decisions which are tough.

They are closing offices at earlier hours. They are less able to respond to people who are applying for retirement benefits so they can deal with those seeking disability benefits.

Ms. Lyon-Hart, do you think at some point it is going to become very obvious to the average American who is getting ready to apply for his or her Social Security benefits that there is a problem with Social Security because its budget is being so short changed?

Ms. LYON-HART. I do think it will be obvious if it is not already.

Mr. BECERRA. Thank you. I thank you all for your testimony. I hope that research can produce some real results sooner than later so we can apply those.

Mr. Chairman, I thank you for bringing these witnesses.

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

Mr. BERG. Thank you, Mr. Chairman.

I just have one question. Dr. Maestas, when someone is seeking disability insurance, it takes a long period of time. There is a detrimental effect on their skills during this period, and their ability to be employed.

My question is if you could tell us a little bit more about these findings in your research that looks at that, and also what is it we can do about that.

Dr. MAESTAS. It has been known for some time that many SSDI recipients have some employment potential. We are not talking about full time employment potential at the level of their predisability earnings necessarily, but those effects are rather large.

For example, we estimate that had many beneficiaries, and these are the relatively healthy of the disabled beneficiaries, had they not received benefits, their employment rate could increase by as much as 28 percentage points.

Again, not the full time employment capacity. If you look at annual earnings, it is an increase in annual earnings of about $3,700.

For many people, this will not rise above the SGA threshold, although for many people, it would.

What this new research is saying is in addition to these effects of benefit receipt on employment potential and employment capacity, there are additional effects coming from the process itself that keeps people waiting.

We have been able to disentangle these two components to get an estimate of the decay in employability that arises with every month that somebody waits for a final decision.

The problem is not the initial decisions, per se. Those occur relatively quickly. The problem is when someone gets a denial, and of course, most people do get a denial from the initial determination process, they go on to appeal.

The appeals process takes them into this waiting game that goes on a very long time. If they are denied at the ALJ level, many of them go on to pursue appeals at higher levels.

It is well known in economics that as people stay out of the labor force, and of course, these people have to stay out of the labor force while they are pursuing an appeal because otherwise, they would be denied, employability declines. Skills depreciate. Employment networks erode. Investments in the latest information and technologies are not made.

Mr. BERG. What do we do about it? What is the solution?

Dr. MAESTAS. It is a hard problem, admittedly. We have to shorten processing times. We have to shorten waiting times.

It is not only about—the Administration has made good attempts in this area to actually shorten times by reducing backlogs and the like.

Part of the problem, what I would like to draw attention to here, is that too many people perceive that an appeal is worthwhile.

If we could better align the decision thresholds that are used in the initial phase and the appellate phase, then we would not have a system where everybody believes they need to appeal to get the right decision outcome.

Mr. BERG. We tend to have an automatic appeal when there is a denial.

Dr. MAESTAS. Exactly.

Mr. BERG. Which extends that period, extends that cost. Obviously, when someone is out of the workforce, it is hard for them to get back in, regardless of what the outcome is at the end of the appeal process.

Dr. MAESTAS. The rules, of course, do require a five month waiting period.

Mr. BERG. Thank you. Thank you, Mr. Chairman. I will yield back.

Chairman JOHNSON. Thank you. Mr. Marchant?

Mr. MARCHANT. Thank you, Mr. Chairman.

I have a couple of process questions. We talked a lot today about baby boomers and they are entering the system as disabled beneficiaries.

Once a person reaches the threshold of age 62 and they have the ability to go on early retirement, what is the process a person would go through once they have reached that threshold but they do not want to take early retirement, but then they apply for Social Security disability?

Then they are denied initially, and then they are given a waiting period that might take them past the time whereby they would enter the system at age 65 in full retirement.

How are you handling people that are entering with those kinds of problems? I am not sure who to direct that question to, but perhaps somebody that has some every day experience.

Ms. LYON-HART. Actually, I am just going to speak up to say that I am probably not the person. We really need to know from Social Security, because that kind of decision happens in the field office.

I do know that you can have sort of a simultaneous early retirement and disability applications going at the same time, but I cannot tell you exactly how that works.

Obviously, you would not double dip, but that kind of thing simultaneous applications does occur. I would hesitate to answer the question.

Mr. MARCHANT. If the person was 62 years old and they applied for total disability and the total disability benefit was $1,100 a month, and they were able to receive early Social Security benefits, they cannot receive Social Security retirement benefits and receive Social Security disability benefits as well.

This whole perception of the system being weighted down and broken because of all the baby boomers that are entering the system because they are retiring and more and more of them are becoming disabled, there seems to be a point at which that would flatten out because they would either go into early retirement or into permanent retirement. You would not be receiving both at the same time, would you?

Ms. LYON-HART. No, you would not receive both at the same time. I misspoke.

Mr. MARCHANT. Dr. Maestas.

Dr. MAESTAS. I can speak to that a little bit. They would not receive both at the same time, but of course, the early retirement benefit is an actuarially reduced benefit, and the disability benefit is not.

They would receive a higher benefit if they are awarded disability benefits, and then at their full retirement age, they just convert into the regular retirement program, but maintaining that higher benefit level.

Mr. MARCHANT. Are any of these things taken into consideration when the initial claim is made? It would be a very small cost for a person to have a combination of partial disability benefit and an early retirement benefit, and why would someone wait one, two or three years and appeal their claim if they are going to reach the threshold of retirement anyway?

Yes, ma'am?

Ms. EKMAN. Thank you, Congressman. A person—as Dr. Maestas said, if I am 62 and I go and apply for retirement benefits, I am going to receive a reduced benefit. That will happen for as long as I receive benefits.

As an individual, I am entitled to get disability benefits until I reach my full retirement age, which I would point out is now 66 for people who are retiring now, and will go up to 67.

It is a big disadvantage to me in terms of my income if I applied for retirement at that point.

In the SSA evaluation for disability, there is a piece that takes age into account, in the vocational guidelines.

That is considered from that perspective when someone comes in and applies, but it is up to the individual to decide whether they want to apply for early retirement or disability, and if it is an individual who has a disability, it is in their best interest to apply for disability because their benefit will be at the higher level, as opposed to reduced for the remainder of their life.

Mr. MARCHANT. Okay. Thank you. Thank you, Mr. Chairman.

Chairman JOHNSON. You bet. Mr. Becerra, do you have a clarification question?

Mr. BECERRA. Yes. I just wanted to be sure. Dr. Maestas, I think during some questioning by Mr. Berg, when you were talking about the appeals process, I think you may have mentioned there is an automatic appeal.

There are not any automatic appeals, although a lot of claimants ultimately do file for appeal, but there is no automatic right to appeal a case to a higher level.

I just wanted to clarify that. That is the case; correct?

Dr. MAESTAS. The appeals channel is open to everybody, but there is no automatic appeal. They decide themselves whether or not to pursue an appeal.

Mr. BECERRA. Right. In other words, it does not go to appeal immediately if the decision is against you. You have to actually——

Dr. MAESTAS. You have to initiate the appeal.

Mr. BECERRA. Correct.

Chairman JOHNSON. Their lawyer decides.

Mr. BECERRA. Ms. Ekman.

Ms. EKMAN. If I could also just clarify, I do not have the exact number in front of me, but will be happy to get that to you, but a significant portion of people who are denied at the initial level choose not to continue on appeal.

I think that is an important point, that we are not getting 100 percent appeals of denials.

Mr. BECERRA. That is my understanding as well. If you could provide those numbers to the Committee, I think that would be helpful.

Dr. MAESTAS. I have those numbers from our data. It is two-thirds, almost two-thirds, 65 percent that do pursue an appeal of the initial denial, as of 2005/2006.

Chairman JOHNSON. They do appeal?

Dr. MAESTAS. One-third do not.

Mr. BECERRA. If you could provide those numbers, that would be great.

Dr. MAESTAS. Those are in my testimony, in the written remarks.

Mr. BECERRA. Thank you. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. Again, I want to thank you all for being here and your testimony.

I look forward to continuing this discussion on ways to secure the future of this vital program at our next hearing, which will focus on what happens when someone appeals a denied claim.

I want to thank you all again for being here. We appreciate it. Great time to see the trees outside. You have perfect timing.

With that, the Subcommittee stands adjourned.

[Whereupon, at 12:14 p.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]

Questions for the Record
For the March 20, 2012 Hearing
On Disability Decisions

Questions from Chairman Johnson

1. **The State responsibility for initial disability decisions was established by the Social Security Act Amendments of 1954. Given the challenging fiscal times at the State level do you worry that States have an incentive to award federal benefits to protect their own benefit programs? If not, how can you be sure that these initial decisions are being made objectively and accurately?**

   The State disability determination services (DDS) must evaluate disability claims based on our disability program policies and regulations. We have no evidence that State fiscal issues affect these determinations. In fact, during the recent economic downturn, our allowance rates for initial claims and reconsiderations have decreased.

   We use the statutorily required pre-effectuation review process to conduct a State-level quality review of 50 percent of DDS allowances. Moreover, we routinely conduct performance accuracy reviews on a sample of cases adjudicated by the States to ensure that DDS decisions are objective and accurate.

2. **I understand there are DDS performance standards in regulations. The only stated performance measures are accuracy and processing time. The current minimal acceptable level for processing of disability insurance claims is 49.5 days. Given the average DDS processing time is over 100 days, are you planning on updating these regulations and will you include other standards to ensure a uniform national program?**

   We are currently reviewing these regulations to determine whether there are changes that would help us ensure a uniform national program.

3. **Dr. Maestas discussed variations among DDS examiners that lead to inconsistent outcomes for beneficiaries. She finds that 5 percent of examiners have award rates of more than 12 percent higher or lower than the average. Have you reviewed outlier examiners across the State DDSs? If not, do you have plans to do so?**

   We do not review outlier examiners across State DDSs, and we do not have plans to do so. While we do not focus on decisions from specific examiners, we do conduct regular accuracy reviews on a sample of cases from each State to monitor and ensure the accuracy of DDS disability determinations.

   Every fiscal year (FY) we set a goal for the accuracy rate of initial disability determinations, track that accuracy rate, and publish our performance in our annual Performance and Accountability Report. Each year since FY 2007, the DDSs have met our annual accuracy goals.

4. **If a claimant's condition does not meet or equal the listings, the next step is an assessment of the claimant's remaining ability to function. How does an examiner or medical consultant assess someone's function? How subjective is that assessment?**

   If a claimant's condition does not meet or equal the listings, we assess his or her residual functional capacity (RFC). An RFC assessment is a function-by-function assessment based upon all the relevant evidence of an individual's ability to do work-related activities. We arrive at an RFC by reviewing the claimant's medical record, his or her allegations of symptoms, opinion evidence from medical and nonmedical sources, and reports of the day-to-day function obtained from the claimant or other individuals who are familiar with the claimant.

   In assessing RFC, we consider limitations and restrictions that result from medically determinable impairments (MDI). We also consider any available information about symptoms because subjective descriptions may indicate more severe limitations or restrictions than can be shown by objective medical evidence alone. However, we do not consider limitations or restrictions resulting from age, gender, body habitus (e.g., body type and stature), conditioning, or inherent strengths or predispositions not attributable to the claimant's MDI. While the RFC assessment is "subjective" in the sense that we base it on the individual facts of each claimant's case, we minimize this inherent subjectivity by applying consistent policy standards. Our electronic case analysis tool (e-CAT) helps ensure policy consistency. We currently use e-CAT in 72 percent of our initial claims. We recently mandated that all DDSs use e-CAT by October 2012.

5. **At the hearing, Dr. Chan discussed the work you are doing with the National Institutes of Health to build a computer adaptive test that can help assess function. What can you tell us about this research, its impact on deciding disability in the future, and the timing of when such an assessment tool might be ready for implementation?**

   In 2008, we implemented an interagency agreement with the Rehabilitation Medicine Department at the National Institutes of Health's Clinical Research Center to analyze existing agency data and assess the feasibility of developing Computer Adaptive Testing (CAT) instruments.

   CAT is a form of computer-based testing that tailors question selection based upon the claimant's ability level. It is similar in approach to standardized tests such as the Graduate Record Examination and Graduate Management Admission Test. Unlike a fixed-form test that asks the same questions of everyone, CAT instruments ask claimants and their providers only the most informative questions based on a person's response to previous questions. Using this approach allows the instrument to ask fewer questions (in total) because the selected questions are based on the individual's level of function. Using research and technology that is methodologically rigorous and defensible, we are developing the CAT instrument to obtain information on claimants' functional abilities in a manner that is systematic, comprehensive, and efficient.

To date, Boston University, which is a subcontractor, has developed questions for two of six categories of functioning to be included in the CAT instrument; these categories are mobility and interpersonal interactions. Additional domains include learning and applying knowledge, communication, self-care, and general tasks and demands. This scientific process will take four more years as each domain must be developed, calibrated, and validated to be scientifically defensible before we are able to integrate the CATs into our current disability process. Therefore, we expect to complete this instrument in 2016 and subsequently test it with claimants and providers.

6. **Consistent training can go a long way to creating consistent outcomes. In an Inspector General report on training in the DDS released on March 14, 2012, the IG found that State offices were supplementing the Social Security Administration's (SSA) training resources, and in some cases creating their own training materials for the same topics. That means Social Security is paying twice for some training. How does Social Security plan to address these findings and ensure a single presentation point for the SSA policy and practice in making disability decisions?**

We are taking several steps to improve DDS access to up-to-date and accurate training materials on disability policy and procedures. For example, we are enhancing our on-line tools to provide national access to all training materials, expanding the use of podcasts and video-on-demand to ensure accessibility to training, using trend analysis to identify specific training needs, and sharing best practices with disability-training officers at the regional and State levels.

We believe these steps will help us ensure consistency in our training and eliminate any redundancy.

7. **It seems like your efforts implementing health IT will significantly reduce wait times for initial decisions. How much have wait times been reduced in the pilot sites? What challenges are you facing?**

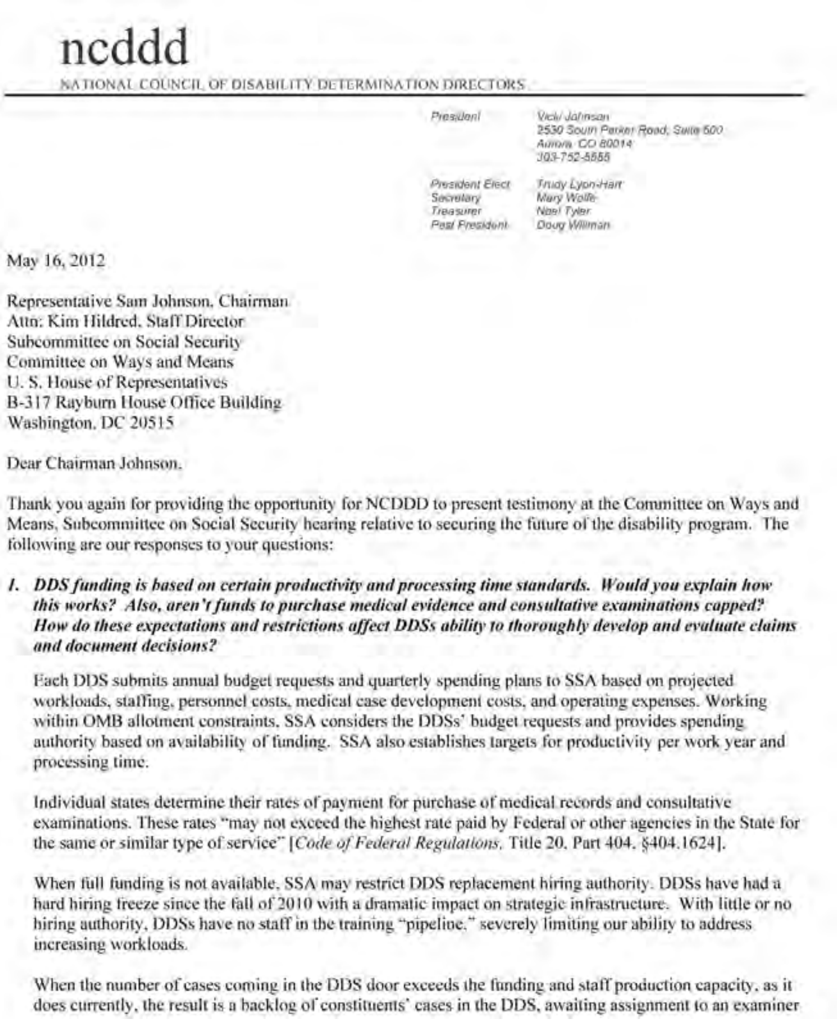
Health IT has the potential to transform our disability determination process. Developing the medical record via our current process is costly and time-consuming. Health IT automates this process and potentially provides a more complete medical record, thus improving the speed, accuracy, and efficiency of our decision-making.

While the actual volume of cases involving health IT data is still extremely small, we have seen a decrease in the time needed to adjudicate those cases. For the approximately 10,500 cases containing electronic data that we reviewed from October 2011 through April 2012, we experienced an approximately 20 percent reduction in total case processing time, which is the time from when a DDS receives an initial disability claim to when it decides that claim. The component time required to gather medical evidence dropped dramatically for these claims; a matter of seconds for electronic medical evidence compared to weeks or months for a typical paper-based medical evidence request. We look forward to the next stages of implementation of health IT standards that will advance our ability to have a uniform process and system to interact with the medical community.

8. How many continuing disability reviews have been performed so far this fiscal year? How many of those reviews are full medical reviews?

Through April 2012, we have completed 865,287 continuing disability reviews. Of these reviews, 338,655 are full medical reviews. We plan to complete 435,000 full medical CDRs with our fiscal year (FY) 2012 appropriated program integrity funding.

While we will complete significantly more full medical CDRs than we did last year, we will be unable 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.



ncddd
NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

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President Elect	*Trudy Lyon-Hart*
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May 16, 2012

Representative Sam Johnson, Chairman
Attn: Kim Hildred, Staff Director
Subcommittee on Social Security
Committee on Ways and Means
U. S. House of Representatives
B-317 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Johnson,

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

1. ***DDS funding is based on certain productivity and processing time standards. Would you explain how this works? Also, aren't funds to purchase medical evidence and consultative examinations capped? How do these expectations and restrictions affect DDSs ability to thoroughly develop and evaluate claims and document decisions?***

   Each DDS submits annual budget requests and quarterly spending plans to SSA based on projected workloads, staffing, personnel costs, medical case development costs, and operating expenses. Working within OMB allotment constraints, SSA considers the DDSs' budget requests and provides spending authority based on availability of funding. SSA also establishes targets for productivity per work year and processing time.

   Individual states determine their rates of payment for purchase of medical records and consultative examinations. These rates "may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar type of service" [*Code of Federal Regulations*, Title 20, Part 404, §404.1624].

   When full funding is not available, SSA may restrict DDS replacement hiring authority. DDSs have had a hard hiring freeze since the fall of 2010 with a dramatic impact on strategic infrastructure. With little or no hiring authority, DDSs have no staff in the training "pipeline," severely limiting our ability to address increasing workloads.

   When the number of cases coming in the DDS door exceeds the funding and staff production capacity, as it does currently, the result is a backlog of constituents' cases in the DDS, awaiting assignment to an examiner for processing, or awaiting other case actions such as medical assessment. Currently, despite record high DDS productivity per work year, front-end staging of initial and reconsideration cases awaiting assignment to an examiner is at 119,352 cases nationally [SSA Staged Case Report, for week ending 5/11/12]. These delays will not be captured in official SSA/DDS processing time data until the cases are finally completed. However, constituents are already experiencing case delays, lengthening of overall processing times and deterioration of service.

If the severe budget cuts resulting from the Budget Control Act take effect in FY 2013, it is likely that these backlogs will increase exponentially, both in the number of cases affected and in the length of the delays. Many of the DDS operating costs are fixed, such as rent, utilities, state personnel and administrative costs. Any reduction in force of trained DDS staff needed to process cases would obviously be extremely counterproductive and harmful to public service. Reduction in spending for medical evidence and consultative exams would further delay case determinations since we are required to request evidence from every relevant medical source and to purchase required examinations/tests not in the healthcare record. Paying less for medical records would result in fewer timely reports and more need for consultative examinations resulting in longer processing times and higher cost per case. Many states already have difficulty finding sufficient consultative examination providers due to low rates of reimbursement under the Medicare ceiling.

2. ***What quality controls do Disability Determination Services (DDSs) have in place to monitor DDS examiners' and medical consultants' accuracy and ensure consistency?***

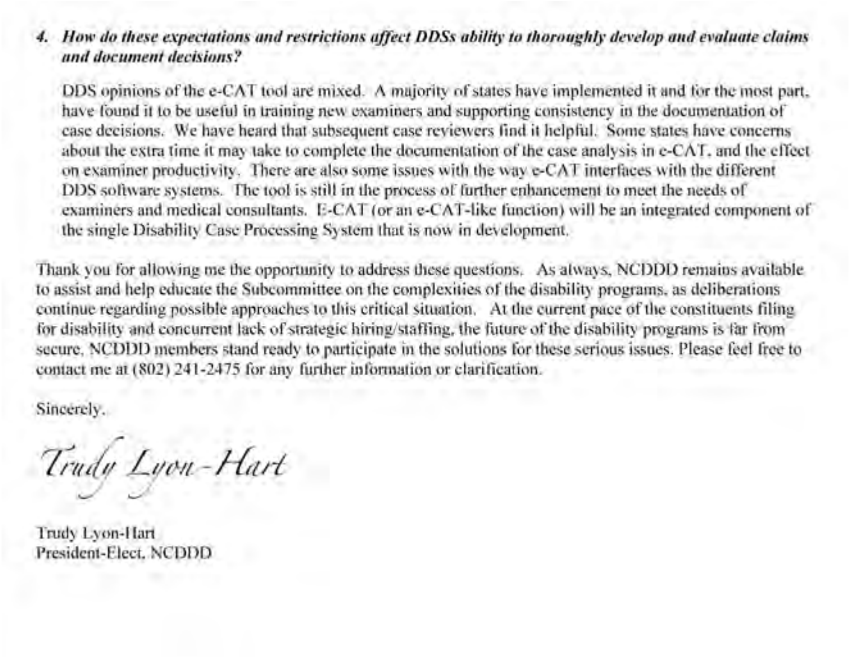
DDSs are required to have an internal "quality assurance function sufficient to ensure that disability determinations are made accurately and promptly" [*Code of Federal Regulations*, Title 20, Part 404, §404.1620]. The organizational structure may look different in different DDSs, but all DDSs have a function that involves review of cases for accuracy and policy compliance at various decision points during the life of the case.

Another aspect of quality assurance is training. DDSs provide training for new examiners and ongoing mentoring and updated training as needed. SSA provides online training manuals, handbooks, banks of case examples, and other materials such as interactive video training, both live and recorded/available on demand. DDS trainers and management monitor quality review data for trends and request program consultation with SSA on policy questions in the interests of ensuring consistency of policy application.

DDSs generally have rigorous internal performance standards, which include accuracy as well as timeliness, cost effectiveness and productivity. Federal regulations hold DDSs to a high accuracy standard. To meet the standard, the DDSs must ensure that their staff is producing accurate, well-documented determinations.

3. ***Social Security recently mandated the use of an electronic claims analysis tool (e-CAT) for all DDS examiners. Would you provide more details as to how e-CAT works and its benefits?***

The claims analysis tool (e-CAT) leads the examiners through the steps of sequential evaluation of disability, asking the examiner to answer the pertinent questions at each step. It incorporates some basic case information from the claimants' application, such as allegations, age, education, and alleged onset date,. It provides links to online policy, but the DDS examiners must decide how the policy applies in the individual case, appropriately weighing all the evidence. E-CAT provides a uniform place for examiners and medical consultants to record the findings, their analysis of the evidence, and their decisions at each step of sequential evaluation. When complete, e-CAT generates a document for the electronic case folder detailing the analysis done on the case, so that other components reviewing the case can see how the DDS arrived at its determination.



4. How do these expectations and restrictions affect DDSs ability to thoroughly develop and evaluate claims and document decisions?

DDS opinions of the e-CAT tool are mixed. A majority of states have implemented it and for the most part, have found it to be useful in training new examiners and supporting consistency in the documentation of case decisions. We have heard that subsequent case reviewers find it helpful. Some states have concerns about the extra time it may take to complete the documentation of the case analysis in e-CAT, and the effect on examiner productivity. There are also some issues with the way e-CAT interfaces with the different DDS software systems. The tool is still in the process of further enhancement to meet the needs of examiners and medical consultants. E-CAT (or an e-CAT-like function) will be an integrated component of the single Disability Case Processing System that is now in development.

Thank you for allowing me the opportunity to address these questions. As always, NCDDD remains available to assist and help educate the Subcommittee on the complexities of the disability programs, as deliberations continue regarding possible approaches to this critical situation. At the current pace of the constituents filing for disability and concurrent lack of strategic hiring/staffing, the future of the disability programs is far from secure. NCDDD members stand ready to participate in the solutions for these serious issues. Please feel free to contact me at (802) 241-2475 for any further information or clarification.

Sincerely,

Trudy Lyon-Hart

Trudy Lyon-Hart
President-Elect, NCDDD

GAO
Accountability * Integrity * Reliability
United States Government Accountability Office
Washington, DC 20548

May 17, 2012

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

Thank you for the opportunity to testify before the Committee on Ways and Means, Subcommittee on Social Security on March 20, 2012 during the hearing on Securing the Future of the Social Security Disability Insurance Program. The attached enclosure is GAO's response to the subcommittee's questions for the record. If you have any questions, please contact Daniel Bertoni at (202) 512-7215.

Sincerely yours,

Daniel Bertoni

Daniel Bertoni, Director
Education, Workforce,
and Income Security Issues

Enclosure

1. In Mr. Bertoni's testimony, he said that Social Security's disability program has remained on the Government Accountability Office's high-risk list "in part, because their programs emphasize medical conditions in assessing work capacity without adequate consideration of work opportunities afforded by advances in medicine, technology, and job demands."

Would you explain what this means?

Modern concepts of disability focus on an individual's functional abilities in the workplace environment, including consideration of the presence or lack of assistance. In our 2011 high risk update, we noted that efforts to update and revise eligibility criteria did not incorporate a modern understanding of how technology and labor market changes could affect eligibility for disability benefits.[1] These modern views are reflected in the International Classification of Functioning, Disability, and Health (ICF), which is the World Health Organization's framework for assessing health and disability. This framework takes into account the interaction of health conditions and contextual factors, such as products, technology, attitudes, and services, on an individual's functioning, rather than viewing disability solely as a medical or biological issue. In other words, under this concept, two people with the same impairment might have different degrees of work disability for a variety of reasons.

SSA's disability programs have fallen short of modern concepts, in part, by relying primarily on medical conditions to determine disability. At step 3 of SSA's disability determination process, SSA examiners assess the applicant's medical impairment(s) against the Listings of Impairments, also known as the medical listings. If the individual's impairment meets or is equal in severity to one or more of those in the listings, the individual is determined to have a disability at step 3. At this step, SSA generally relies on information on the applicant's diagnoses, including laboratory findings, diagnostic tests, and symptoms, as well as some limited consideration of the applicant's functional limitations to determine the severity of an impairment. SSA created the listings to have a clear set of medical conditions that, if present, preclude the individual from working, and to limit the number of cases requiring a more involved and individualized assessment of individual function and capacity for work. At the same time, this step 3 approach tends to equate medical severity of a medical condition with an inability to work, which is not consistent with modern concepts. Rather than eliminate this expedient step, experts have recommended that SSA incorporate more consideration of individual functioning in its medical listings where appropriate.

SSA's disability programs also fall short of modern concepts at other steps of its disability determination process, by relying on outdated occupational information to determine capacity to perform past relevant work (step 4) or any work that is performed in the national economy (step 5). To inform determinations at steps 4 and 5, SSA uses a Department of Labor database—known as the Dictionary of Occupational Titles (DOT)—which is an inventory of occupations performed in the national economy. GAO and others have reported that the DOT—which has not been updated since 1991—is outdated. In our testimony, we reported on SSA's progress in creating a new occupational information system (OIS) to replace the outdated DOT.

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[1] GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February, 2011)

Finally, researchers and disability experts have commented on the limitations of SSA's current disability program eligibility criteria to fully consider whether an individual can function in the workplace due to limited consideration of assistive devices, including those in the workplace—limitations that GAO has also noted.[2] Several groups, such as the Social Security Advisory Board and the Urban Institute—have reported that SSA's disability programs should focus more on whether an individual can work given appropriate environmental or other supports, and that SSA—through its demonstration authority or other means—has played or could play a role in testing options.

Our forthcoming report will describe how well SSA is managing the development of its OIS against best practices and will identify mitigation strategies to address project risks. Our report will also describe SSA's progress and challenges related to incorporating modern concepts into its disability criteria, such as additional consideration of individual function, assistive devices, and/or workplace accommodations in SSA's disability determination process.

2. What should Social Security be doing differently to get off the high-risk list?

GAO removes a high-risk designation when legislative, administration, and agency actions—including those in response to our recommendations—result in significant progress toward resolving a high-risk problem. Specifically, the five criteria for determining if the high-risk designation can be removed are (1) a demonstrated strong commitment to, and top leadership support for, addressing problems; (2) the capacity to address problems; (3) a corrective action plan; (4) a program to monitor corrective measures; and (5) demonstrated progress in implementing corrective measures.

SSA's high-risk designation is based, in part, on not fully incorporating a modern understanding of how technology and labor market changes could affect eligibility for disability benefits, but also for continuing struggles with growing workloads and long waits for decisions. In our last high risk update, we found that SSA has taken steps in both areas, but further action is needed. With respect to incorporating a modern understanding of disability, our forthcoming report will detail progress SSA has made and recommend areas for further action. In turn, GAO will assess SSA's response to these recommendations against our criteria for removing SSA's high risk designation.

3. The Dictionary of Occupational Titles, which was the go-to resource for jobs in the national economy, is no longer being kept up to date by the Department of Labor. As a result, Social Security has decided to develop its own resource, called the Occupational Information System (OIS). Is this decision in the best interest of taxpayers? How much is the statutory definition of disability driving such a costly and time-consuminig effort?

While GAO and others have reported that SSA needs to base its disability decisions on more updated occupational information, whether SSA's decision to develop a new occupational information system (OIS) is in the best interest of taxpayers will depend on the final shape, scope and cost, which have not yet been determined. In our testimony, we

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[2] GAO, *SSA Disability Programs: Fully Updating Disability Criteria Has Implications for Program Design*, GAO-02-919T (Washington, D.C.: July 11, 2002).

reported that SSA has already determined that the Department of Labor's own replacement for the DOT—the Occupational Information Network (O*NET)—is not sufficiently detailed for evaluating disability claims, so the agency began developing its own occupational information system to better reflect the physical and mental demands of work in the national economy. We also reported that SSA has made progress on baseline activities and experienced delays in completing others. Our forthcoming report will assess SSA's management of the OIS project against sound practices for estimating costs, scheduling, and assessing risk. In particular, our report will discuss challenges associated with developing a new OIS, including the cost of maintaining a new OIS, that could affect the overall success of the project.

Because SSA has not yet determined the scope of the OIS, it is still unclear the extent to which the statuatory definition of disability is driving or will drive the cost of the OIS. SSA has determined that the new OIS must enable the agency to adjudicate claims based on the requirements of the Social Security Act, including the statutory definition for disability—notably, that the severity of the impairment prevents the individual from doing not only his or her prior work, but any work which exists in the national economy. This in turn means that the OIS must reflect the national existence and incidence of work, must reflect work requirements, and must be legally defensible. Our forthcoming report will take note of SSA's progress in determining the number of occupations and other types of information needed to meet these requirements. It will also note SSA efforts to determine the number and type of jobs that are applicable to SSA claims.

4. In Mr. Bertoni's testimony, he noted that Social Security has developed cost estimates for the research and development of OIS but not for the implementation or maintenance of the new system. Why is it important for Social Security to have life cycle costs for the entire OIS project at this point in time, considering they are still in the research and design phase? Is this feasible at this juncture?

According to industry best practices, cost estimates should be comprehensive and include all costs necessary to achieve agency objectives and these costs should be updated as the agency proceeds with the project and gains more information. In our testimony, we noted that the cost of sustaining an OIS could be significant, based on other agencies' experiences maintaining their systems for collecting national occupational information. Our forthcoming report will discuss the importance of estimating production and maintenance costs to ensure the system being designed is viable and affordable to both produce and maintain. It will also discuss how other federal information systems—such as O*NET—can provide some basis for estimating the cost of producing or maintaining an OIS.

5. Is the cost and structure of the current disability process sustainable?

We have not conducted the work necessary to answer this question. The sustainability of the current disability process both in relationship to costs and structure is dependent on many variables and would require complex analysis of alternatives.

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Questions for the Record for Dr. Leighton Chan
March 20th Hearing on Disability Determinations
Social Security Subcommittee of the House Ways and Means Committee

1. In your testimony, he stated "the way in which disability is conceptualized and measured has changed dramatically in the past 50 years." Please explain what this means and how it impacts who should and shouldn't receive benefits.

As I mentioned in my testimony, the way in which disability is conceptualized and measured has changed dramatically in the past 50 years, starting with the work of a distinguished medical sociologist, Saad Nagi in 1965. Over time, many others have built on Nagi's original framework including Verbrugge and Jette (1994), the Institute of Medicine (Brandt Jr. and Pope 1997; Pope and Tarlov 1991; Pope 1992), Abberley (1987), Oliver (1996, 1990, 1993) and the World Health Organization (WHO) (1980, 2001). Although aspects of these models differ, they all agree that disability cannot be viewed as an individual attribute. Instead, disability should be thought of as the difference between individual capabilities and their environmental demands. The Institute of Medicine (IOM) has noted that disability is not a stable attribute across situations, since physical and mental functioning is influenced by environments. Disability is a complex process, which is multidimensional, dynamic, and interactive in nature.

The question of who should and should not receive disability benefits falls outside of my area of expertise. The National Institutes of Health (NIH) was asked to work on this project, in part, because of our expertise in measuring *function*. The Social Security Administration (SSA) is charged with determining how those functional assessments relate to the definition of disability in the Social Security Act and the payment of benefits. Thus, the SSA would be in the best position to provide a response to this question.

2. Based on your experience, how would you define disability today?

We have chosen to use the WHO's taxonomy called the International Classification of Functioning, Disability and Health (ICF) as the conceptual framework for our collaboration with the SSA. The ICF is one of the most widely used models of disability. It has been endorsed by all 191 WHO Member States and is the international standard used to describe and measure health and disability. In the United States, the ICF is being integrated into important institutional frameworks. In 2007, the Institute of Medicine recommended that government agencies adopt ICF as a conceptual framework and language.

ICF uses a bio-psychosocial model of disability, in which disability is a multi-dimensional phenomena experienced at the level of the body, the person, and society. The ICF describes disability using impairment information to capture changes in an individual's body structure and body function while acknowledging the influence of environmental factors, such as workplace demands and accommodations.

Questions for the Record for Dr. Leighton Chan
March 20th Hearing on Disability Determinations
Social Security Subcommittee of the House Ways and Means Committee

3. If a claimant's condition does not meet or equal the listings, the next step is an assessment of the claimant's remaining ability to function. How does an examiner or medical consultant assess someone's function? How subjective is that assessment?

Our understanding is that the residual functional capacity (RFC) forms are filled out by adjudicators in the Disability Determination Service (DDS) offices. However, in our current research, we have not examined SSA's operations related to the residual functional capacity assessment. The SSA may be in a better position to respond to this question.

4. Should the electronic claims analysis tool ultimately be implemented by the Social Security Administration? Will these tools alone be sufficient to determine the ability to work? Will medical listings still be needed to determine eligibility?

The Electronic Claims Analysis Tool (eCAT) is a web-based application designed to assist the adjudicator throughout the sequential evaluation process. eCAT aids in documenting, analyzing, and adjudicating the disability claim in accordance with SSA regulations. This system is not part of our work with SSA, and we are not in a position to judge whether it should be implemented.

NIH's collaboration with the SSA is based on item response theory and computer assisted technology (IRT-CAT). Unfortunately, the names are similar but the systems are distinct. The goal of the NIH project is to create a real time functional assessment process that is rapid, reliable, objective and could be considered for integration into the SSA's disability evaluation processes. We are coupling Computer Adaptive Testing (CAT) methodology with Item Response Theory (IRT) to measure outcomes precisely across the full continuum of human functioning. IRT-CAT represents a simple form of artificial intelligence software requiring a computer for administration.

While we are very happy with the progress we are making to create new IRT-CAT tools, the ultimate decision on how they might be implemented or whether these tools could be used instead of the Medical Listing process will be up to the SSA.

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May 17, 2012

Dear Chairman Johnson:

Attached please find my written responses to the questions posed by Committee Members for the record. Please let me know if you have further questions.

Sincerely,

Nicole Maestas
Senior Economist
Director, RAND Center for Disability Research

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United States House of Representatives Committee on Ways and Means
Subcommittee on Social Security
Hearing on Securing the Future of the SSDI Program
March 20, 2012

Questions Submitted for the Record

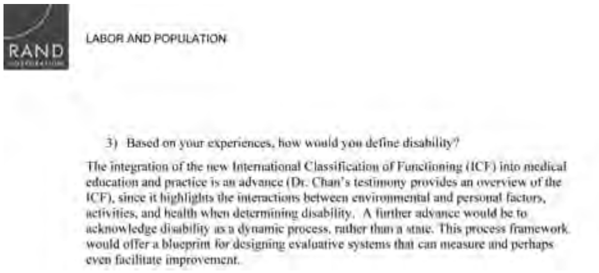
Questions from Chairman Johnson Followed by Response from Dr. Nicole Maestas, Senior Economist, RAND Corporation

1) In Ms. Ekman's testimony, she provides a critique of your research. Would you like to respond? How can statistical research be used to inform disability policy?

Statistical research is one of our most powerful tools for informing disability policy. Statistical research has the great advantage of enabling us to draw objective, evidence-based conclusions about policy matters. Perhaps more importantly, statistical research embodies rigorous protocols for determining whether a particular conclusion can be generalized to the larger population. Statistical research helps avoid the pitfalls of the anecdotal approach, where the experience of a single case or small group of cases is used to draw (often incorrect) inferences about an entire program or population. Our approach is rooted in the long-established statistical principle of random assignment, which provides a simple method for drawing sound inferences about the program, without the need to review individual disability cases. This same statistical principle underlies randomized controlled trials, which form the gold standard for scientific inference in medical science. Ms. Eckman expresses uncertainty about the proper interpretation of our findings. My written testimony provides the proper interpretation in careful detail.

2) In his testimony, Dr. Chan spoke about the shifting paradigms of disability, saying "the way disability is conceptualized and measured has changed dramatically in the past 50 years." Do you have anything to add to Dr. Chan's assessment? What ideas do you have for how to improve the program?

I would only highlight Dr. Chan's citation of the IOM statement that "disability is not a stable attribute across situations, since physical and mental functioning is influenced by environments." Environmental factors include advances in medical and surgical treatments that increase the likelihood of some degree of recovery. Our current disability evaluation system, however, is based on the notion of a disability being "permanent" if it is expected to last longer than 12 months. This is an area where much more research is needed to understand the dynamics of and interaction between particular health impairments and different work environments.



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3) Based on your experiences, how would you define disability?

The integration of the new International Classification of Functioning (ICF) into medical education and practice is an advance (Dr. Chan's testimony provides an overview of the ICF), since it highlights the interactions between environmental and personal factors, activities, and health when determining disability. A further advance would be to acknowledge disability as a dynamic process, rather than a state. This process framework would offer a blueprint for designing evaluative systems that can measure and perhaps even facilitate improvement.

[Submissions for the Record follows:]

AFGE, Statement

STATEMENT BY

Witold Skwierczynski

President

American Federation of Government Employees
National Council of SSA Field Operations Locals, AFL-CIO

BEFORE THE

HOUSE WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

ON

SECURING THE FUTURE OF
THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

Hearing on March 20, 2012

TESTIMONY

Statement of Witold Skwierczynski, President
AFGE National Council of SSA Field Operation Locals, AFL-CIO
Baltimore, MD

Chairman Johnson, Ranking Member Becerra, and members of the Social Security Subcommittee, I respectfully submit this statement on *Securing the Future of the Social Security Disability Insurance Program*. As President of the National Council of SSA Field Operations Locals, I speak on behalf of approximately 31,000 Social Security Administration (SSA) employees in over 1300 facilities. These employees work in Field Offices, Teleservice Centers, and Social Security Card Centers throughout the country where retirement, survivor and disability benefit applications, Supplemental Security Income (SSI) applications and appeal requests, and Social Security card applications are received, processed, and reviewed.

SSA employees are dedicated to providing the highest quality of service to the public in a compassionate manner. AFGE represents employees who are committed to serving communities in the face of a significant increase of work and insufficient field staff to process such work.

The primary message AFGE wants to convey to you today is that without sufficient funding to carry out Social Security programs, backlogs will grow, public service will deteriorate and mismanagement of the programs will inevitably occur, as Administrators look for ways to satisfy Congressional and public criticism.

For example-

> In the FY13 budget, the Commissioner emphasizes the resources that he has shifted to the hearing process, which he believes will reduce the backlogs and processing time for the hearing cases. However, if you look closer[1], you will see that reductions in processing time for hearings decisions is at the expense of the initial claims and reconsideration process, resulting in an increase in the overall time to process disability claims from the first application to the final hearing decision. Currently, hearings backlogs continue to grow and now exceed 820,000, while other disability workloads, such as initial disability claims, reconsiderations and CDRs, exceed 1 million cases.
>
> In the Budget Control Act of 2011, Congress established budgetary mandates for SSA regarding its integrity workloads (i.e. Supplemental Security Income (SSI) redeterminations and Continuing Disability Reviews (CDRs). However, after close attention and interpretation of the legislation, it was determined SSA will not receive additional funding to address these workloads, but is required to spend the amount specified for each year performing these workloads. This will result in great attention given to SSI Redeterminations and CRDS, but at the expense of all other workloads of the Social Security Administration. This will be a managing nightmare for any agency administrator!

At some point in time, Congress lost its way with regards to the funding of the Social Security programs. The Social Security Act of 1935 authorized, for each of its programs, "a sum sufficient to carry out the purposes of this title." This language insured that there would always be sufficient funding to operate the Social Security programs and that all moneys spent to administer the programs would be from the Social Security Trust Fund. However, over the years, the funding to administer Social Security's programs became tangled in the appropriation process and forced Social Security to compete with the many important and valuable programs under the Appropriation Subcommittee of Labor, HHS, Education and related Agencies.

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[1] Social Security Administration, Justification of Estimates For Appropriation Committees, Fiscal Year 2013, Table 11-Selected Performance Measures.

SSA faces unprecedented service demands based on the aging of the workforce and the impact of the recession. Too many applicants lose their life savings, their health insurance, their homes, and even their families and their lives, while they wait years for a final administrative decision. Disabled individuals who paid for disability insurance protection throughout their working lives deserve much better service than they are now receiving. The loss of more than 7000 Full Time Equivalent (FTE) positions in FY 11 and FY 12, and the threat of sequestration in FY13, will place many families in greater jeopardy

SSA must be authorized enough funding to make disability decisions in a timely manner and to carry out other critical workloads. AFGE strongly urges the Leadership of this Subcommittee to introduce the necessary legislation to all of Congress, to separate SSA's LAE budget authority from the Section 302(a) and (b) allocations for discretionary spending, while maintaining necessary Congressional oversight. The size of the SSA's LAE is driven by the number of administrative functions it conducts to serve beneficiaries and applicants. Congress should remove SSA's administrative functions from the discretionary budget, which supports other important and vital programs.

Disability

AFGE Continues to support the Federalization of the Disability Determination Services (DDS).

DDSs are in each of the 50 States plus the District of Columbia and Puerto Rico.

SSA reimburses the DDS for 100 percent of allowable expenditures up to approved funding authorizations. In FY 2012, SSA will spend about $2.216 billion to fund the State DDS operations - $149,477 per DDS employee. About 14,800 DDS employees are expected to process 3.1 million disability medical decisions nationwide.

However, in 2011, a majority of States instituted furloughs for State employees due to State budget deficits. Many of the State furloughs included DDS staff. Additionally, some States have implemented changes in hiring practices which may also affect the disability claims processing in the DDSs. AFGE strongly believes that these furloughs are a sign of the failure of the current bifurcated federal-state system to provide a quality disability decision product.

The Social Security Act and Federal regulations give SSA limited control over the State DDSs, although the Agency fully funds them. However, federal law allows the Social Security Administration to federalize DDS employees if a state "substantially fails" to live up to its responsibilities to process claims.

For more than 10 years, AFGE has continued to raise concerns about the inconsistency in medical decisions by the State DDSs, and has also called for the federalization of the system. SSA's approach to disability fails to address the problems and inadequacies of the State Disability Determination Services (DDS). AFGE strongly believes that if problems with inconsistent decisions at the initial claims level are addressed, appeals will diminish. Disability claimants deserve consistent initial claim and reconsideration decisions, and payments as soon as possible in the claims process.

Unfortunately, the chances for a claimant to be approved at the initial level have a lot to do with where they live and their income, rather than the nature of their disability. That's inherent in the system. Each state has different criteria for hiring Disability Examiners. Each state provides them with different pay and benefit packages. Some are unionized, while others are unorganized. Each state provides different training to their employees. Employee retention rates vary dramatically from state to state. In effect, there are 50 different disability programs when there should be one.

For example, State Agency Operation's records indicate that those who can obtain medical treatment early and often have a better chance of being approved for benefits than those who have limited income or resources and poor access to treatment. Nationwide, those applying for Social Security disability have a much greater chance of being approved than those who only apply for the Supplement Security Income (SSI) program that serves the low income population.

Current reports reflect that 60 percent of Social Security disability claims for benefits were being approved in the Washington DDSs, while just 32.8 percent of those who filed for benefits were being approved in the Tennessee DDS. New Hampshire approves the most initial SSI only disability cases – 51.7 percent. However, residents of Mississippi are approved just 22.4 percent of the time by the DDS in their state. The concurrent (Social Security/SSI) claim disability process also shows inexplicable variable allowance rates depending on the state of residence. Allowance rates are low in every state. In the states of Vermont, Washington, and Wyoming, the allowance rates were 41 percent. Only 17 percent of those filing concurrent disability claims were approved in the state of Tennessee and North Carolina. There is no evidence to show that residents of some states are twice as susceptible to becoming disabled as residents in other states. Obviously, different state initial claims approval rates have more to do with the bifurcated system than the health of residents of these states. Claimants are entitled to consistent decisions regardless of their state of residence or whether they are filing for Social Security or SSI disability benefits in our federal programs.

Updated February , 2012

State DDS	**T2 Initial**		**T16 Initial**		**Concurrent Initial**	
DDS – State Disability Determination Service	**Allow %**	**Deny %**	**Allow %**	**Deny %**	**Allow %**	**Deny %**
National Average	**43.2**	**56.8**	**32.7**	**67.3**	**33.3**	**66.7**
Boston Region	**48.4**	**51.6**	**38.5**	**61.5**	**26.1**	**73.9**
Connecticut	42.0	58.0	30.4	69.6	18.5	81.5
Maine	42.8	57.2	34.1	65.9	32.7	67.3
Massachusetts	51.8	48.2	42.8	57.2	29.5	70.5
New Hampshire	57.5	42.5	51.7	48.3	37.8	62.2
Rhode Island	45.2	54.8	30.4	69.6	22.2	77.8
Vermont	52.4	47.6	45.1	54.9	41.5	58.5
New York Region	**56.4**	**43.6**	**38.5**	**61.5**	**29.2**	**70.8**
New Jersey	57.8	42.2	40.3	59.7	32.7	67.3
New York	51.6	48.4	37.9	62.1	27.9	72.1
Puerto Rico	66.1	33.9	N/A	N/A	N/A	N/A
Philadelphia Region	**44.0**	**56.0**	**32.7**	**67.3**	**22.5**	**77.5**
Delaware	43.6	56.4	31.1	69.9	24.5	75.5
Maryland	47.2	52.8	30.5	69.5	23.1	76.9
Pennsylvania	45.3	54.7	34.1	65.9	21.3	78.7
Virginia	43.3	56.7	34.2	65.8	25.9	74.1
Washington DC	45.3	54.7	43.6	56.4	33.6	66.4
West Virginia	37.5	62.5	24.8	75.2	26.9	73.1
Atlanta Region	**35.8**	**64.2**	**27.3**	**72.7**	**19.9**	**80.1**
Alabama	41.4	58.6	26.7	73.3	21.3	78.7
Florida	36.6	63.4	34.4	68.6	22.1	77.9
Georgia	34.5	65.5	26.4	73.6	20.6	79.4
Kentucky	35.8	64.2	27.3	72.7	17.4	82.6
Mississippi	35.3	64.7	22.4	77.6	19.8	80.2

North Carolina	34.1	65.9	26.3	73.7	17.3	82.7
South Carolina	36.3	63.7	25.8	74.2	21.5	78.5
Tennessee	32.8	67.2	24.3	75.7	17.3	82.7
Chicago Region	**43.3**	**56.7**	**29.1**	**70.9**	**22.4**	**77.6**
Illinois	41.4	58.6	28.3	71.7	23.2	76.8
Indiana	41.5	58.5	27.5	72.5	22.5	77.5
Michigan	44.0	56.0	59.9	70.1	22.3	77.7
Minnesota	44.3	55.7	33.8	66.2	21.1	78.9
Ohio	44.2	55.8	27.2	72.8	21.9	78.1
Wisconsin	45.7	54.3	33.7	66.3	23.6	76.4
Dallas Region	**42.5**	**57.5**	**35.9**	**64.1**	**26.9**	**73.1**
Arkansas	42.8	57.2	33.4	66.6	23.9	76.1
Louisiana	46.7	53.3	31.6	68.4	27.3	72.7
New Mexico	37.0	63.0	64.7	65.3	21.7	78.3
Oklahoma	36.9	63.1	31.5	68.5	20.9	79.1
Texas	44.3	55.7	39.2	60.8	29.6	70.4
Kansas City Region	**47.1**	**52.9**	**32.3**	**67.7**	**22.9**	**77.1**
Iowa	42.7	57.3	31.7	68.3	20.7	79.3
Kansas	48.3	51.7	39.5	60.5	24.1	75.9
Missouri	48.3	51.7	29.9	70.1	23.2	76.8
Nebraska	47.9	52.1	38.1	61.9	23.6	76.4
Denver Region	**46.5**	**53.5**	**51.3**	**58.7**	**26.3**	**73.7**
Colorado	43.2	56.8	38.1	61.9	24.6	75.4
Montana	49.1	50.9	40.2	59.8	27.1	72.9
North Dakota	52.3	47.7	44.4	55.6	29.3	70.7
South Dakota	54.1	45.9	40.6	59.4	26.9	73.1
Utah	45.7	54.3	48.6	51.4	24.3	74.7
Wyoming	60.2	39.8	49.7	50.3	41.1	58.9
San Francisco Region	**40.6**	**59.4**	**36.9**	**63.1**	**24.3**	**75.7**
Arizona	33.1	66.9	32.3	67.7	20.7	79.3
California	41.7	58.3	37.3	62.7	24.3	75.7
Hawaii	45.1	54.9	45.0	55.0	30.2	69.8
Nevada	42.6	57.4	38.5	61.5	28.6	71.4
Seattle Region	**45.6**	**54.4**	**39.9**	**60.1**	**25.1**	**74.9**
Alaska	43.8	46.2	54.5	45.5	36.3	63.7
Idaho	39.8	60.2	37.3	62.7	21.1	78.9
Oregon	43.4	56.6	39.7	60.3	22.5	77.5
Washington	60.2	39.8	49.7	50.3	41.1	58.9

According to the Government Accountability Office (GAO), a majority of DDS's do not conduct long-term, comprehensive workforce planning, which would incorporate key strategies for recruiting, retaining, training and otherwise developing a workforce capable of meeting long-term goals. The State DDS's lack uniform minimum qualifications for Disability Examiners (DE's), have high turnover rates for employees, and do not provide ongoing training for DE's.

AFGE is convinced that SSA is not willing or able to correct these problems. AFGE has expressed these concerns to the Subcommittee for several years, and has seen little or no improvement with the State DDS situation. The State DDSs use different disability decision-making procedures than decision-makers at the hearing levels. This has not been addressed by this Administration. It is a key problem that must be reconciled in order to reform the disability system. AFGE strongly believes that the only way to resolve the problems that plague the State DDS' is to federalize them. ***This will bring consistency to the initial claims decisions in the same way that the Supplemental Security Income program that was established in 1974 created a uniform system of benefits for the low income blind, disabled and aged population.***

As AFGE has emphasized in previous testimony before the House Ways and Means Social Security Subcommittee, the Disability Claims Manager (DCM) pilot (another SSA initiative) proved to be highly successful in addressing many problems in the disability program. DCMs were responsible for making decisions about the non-medical factors of entitlement, as well as the medical decisions for initial disability benefit claims. The Lewin and PEM Associates performed an evaluation of the DCM, which was performed between November 1999 and November 2000. Lewin issued its findings in June 2001. According to Lewin, processing time was significantly better than the bifurcated process. In fact, the DCM processing time of 62 days was just over half of SSA's initial disability claim processing time goal of 120 days. Lewin also found that customer service improved dramatically. Claimants expressed record high satisfaction rates with the DCM process, even when claims were disallowed. The public preferred a process which allowed them to interact with the decision maker. Currently, the only interaction with the disability decision maker occurs at the hearing level, when the Administrative Law Judge (ALJ) conducts the hearing. Observation of the impact of the alleged disabling condition and evaluation of the credibility of the claimant is a prime reason for the high percentage of reversals at the hearing level. If the system was reformed so that claimants could interact with decision makers at all levels, it would result in improvements in the initial claims process, and reduce the number of hearings that are filed.

The DCM was a positive step in ensuring the public that consistent and equitable disability decisions were made by the Agency. Unfortunately, despite the positive DCM experience, SSA terminated the pilot. Although SSA contended that the DCM would cost more than the current process, the pilot was terminated before valid statistical data could be compiled regarding full program costs. Cost no longer appears to be a barrier to improving the disability process as evidenced by the extraordinary expenditure of administrative expenses to reduce the processing time of disability hearings.

It appears that the primary reason SSA terminated the DCM pilot was due to resistance from the States. Such resistance certainly was not based on a poor pilot result. Instead, the decision appears to have been based on political considerations and the fear of losing work. The concerns of the states are understandable in view of their unacceptably poor performance regarding decision consistency from state to state, and their poor processing time in comparison to the DCM. However, the only real criteria should be the level of service that is provided to the claimant. Using customer service as a measure, the DCM exceeded State DDS performance in virtually every category.

AFGE recommended to Commissioner Astrue that he reconsider the Agency's decision to terminate the DCM pilot, and implement the position of the DCM at SSA as soon as possible. The Commissioner has not acted on AFGE's recommendation. The Union is willing to work with the Commissioner in an incremental approach to improving the disability process. We understand there will need to be changes in policy, procedures, and institutional arrangements, as well as funding to implement the DCM. However, we feel that federalizing the entire disability process is key to improving disability claims processing and correcting the current appellate nightmare.

Legislative amendments to the Social Security Act would be necessary to allow SSA workers to make disability decisions. However, the crisis in the disability program requires immediate and long-term changes. When trained to make medical decisions, SSA employees can provide immediate relief to backlogged state Disability Determination agencies, and provide faster and better service to the public by serving as a single point of contact. The pilot demonstrated that the public likes the DCM, employees enthusiastically support it, employees are capable of mastering all aspects of the claims process, and that it provides substantially better service than the current bifurcated disability process.

Ticket to Work

AFGE has been and continues to be a proponent of the "Ticket to Work and Work Incentive Improvement Act of 1999." AFGE has worked with dedicated SSA employees, who were charged with implementing the legislation. It became apparent from the very beginning that the Agency was not prepared to take on this massive program. Decisions were made to contract out the most vital element of the program - the Program Manager. Some said the decision was financial, some said this was an interpretation of the intent of the law. Nonetheless, it appeared to be the beginning of a new bureaucracy. Rather than have an agency accountable for its failures, we now have a "program" entirely administered by unaccountable 3rd party contractors.

Congress looked at Ticket to Work legislation to resolve many problems, but primarily to correct

- the failure of SSA to accurately and consistently explain work incentives to the disabled community;
- the failure of State Rehabilitation programs; and
- the resistance of disabled recipients to attempt rehabilitation and/or return to work.

It has now been more than 10 years and it appears that we are no closer to resolving the issues that plagued the agency and now plague the Ticket to Work program. The findings of the GAO[2] report indicate that the initial concerns still remain, but there is less accountability than ever.

There appears to be an inability to provide consistent and correct information about work incentives whether you work for SSA or its Program Manager. This is most likely caused by the complexity of the work incentives. If it's difficult to explain, it's more difficult for the disabled recipient to understand. If the recipient becomes confused and calls back and receives different information, the resistance to attempt work should be understandable.

Through regulations, SSA has grown the bureaucracy by unnecessarily bifurcating the responsibilities of the Program Manager. In spite of the lack of accountability and oversight provided to the Employment Networks, the original contractor, Maximus was granted another new contract as one of the Program Managers. The Agency is rewarding Maximus for failure to achieve their goal.

Additionally, SSA's Office of the Inspector General (OIG) reported its concerns in August 2011[3] that SSA awarded approximately $93 million in grant funds to 103 work incentive and assistance (WIPA) grantees, yet the Agency was unable to determine how many beneficiaries actually received WIPA services during the period of review.

AFGE ***strongly*** recommends that the Subcommittee hold hearings on the challenges of successfully rehabilitating and encouraging the disabled to attempt work. AFGE would hope that such hearings will allow for discussion of simplifying the work incentives and returning major aspects of the Ticket to Work program back to SSA.

iClaims

AFGE has conducted its third annual survey of SSA employees regarding their experiences with the iClaims system. The survey results reveal continuing flaws in the program. Consistent with previous surveys, employees confirm that unsuspecting applicants are at great risk of disadvantaging themselves. Applicants can easily lose thousands of dollars in benefits! Those surveyed were SSA employees who assist people who

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[2] GAO-11-828T Social Security Disability, Participation in the Ticket to Work Program has Increased, but More Oversight Needed.

[3] OIG/ SSA, *Work Incentive Planning and Assistance Project*, August 12, 2011

are elderly, disabled, uneducated, poor and homeless. SSA has invested millions of dollars to train each employee to obtain information that will meet all requirements of the law. However, the agency continues to give Congress the impression that someone without training can be equally effective in determining what benefits to apply for, and when to file for them, without the assistance of trained SSA employees.

This is simply **not** the case.

- More than half of the employees surveyed reported backlogs of iClaims.
- 71% reported that they are not given adequate time to re-contact iClaim applicants when necessary.

Regarding retirement claims:

- Only **4%** reported retirement iClaims do not require re-contacts to correct problems with the application and/or incomplete ***or*** incorrect wage information.
- Only **6%** reported retirement iClaims do not require re-contacts due to a Month of Election response that would be disadvantageous, or because of incomplete marriage information.
- Only **8%** reported retirement iClaims do not require re-contacts due to incomplete information regarding children or military service.
- 89% reported that the public does not have the knowledge to ask about break-even calculations to determine the best Month of Election without prompting from a trained CR.

Regarding disability claims:

- Only **7%** reported disability iClaim applicants do not require re-contacts to correct alleged dates of disability onset.
- Only **5%** reported disability iClaim applicants do not require re-contacts due to incomplete medical information.
- **82%** reported that a minimum of 2 follow-ups are required to re-contact the applicant because of incomplete or incorrect information.
- **71%** reported that re-contacts require a minimum of 30 minutes.

Other Issues:

- **88%** reported ongoing problems with 3rd Party applications.
- Only **3 %** reported that 3rd Party claims are submitted timely.
- **54%** reported a loss of benefits caused by 3rd Party applications.
- **64%** reported post-claim contacts are required regarding Medicare Part B entitlement, after applicants erroneously refuse to apply for it on the initial application.

Since the implementation of iClaims, iClaims applications have been reviewed and corrected by trained SSA employees before payments were authorized. Unfortunately, SSA continues to make changes in historic policy regarding critical factors such as Month of Election and Questionable Retirement, while expecting employees to ignore problems with these issues. Many employees feel obligated to fully assist applicants in spite of changed policies, in order to protect applicants and ensure that they receive the benefits they are due.

SSA refuses to perform audits on the internet claims at the point the applicant submits them, prior to any employee involvement. AFGE is convinced that such an audit is necessary. Last year, SSA lost more than 4000 employees due to budget cuts. The vast majority of staffing losses were Field Office employees. This year, SSA may be facing another hiring freeze, which would result in another 4100 jobs lost. With fewer and fewer employees to meet the public's demands, AFGE is concerned that Commissioner Astrue will implement his final phase of the iClaims process, which would automate adjudication of applications, and eliminate all SSA employee involvement.

AFGE strongly urges Congress to require SSA to conduct a thorough audit on a statistically valid sample of submitted iClaims, ***prior to*** any handoff to a trained SSA employee for correction and adjudication.

AFGE strongly urges Congress to direct SSA to cease implementation of any and all policy changes or application "simplification" that will result in, cause, or allow incorrect benefit payments.

AFGE strongly urges Congress to request authorizing committees to hold hearings on the effects of the Internet Claims process on SSA workloads and beneficiaries, and invite the employees' AFGE representatives to testify.

In Conclusion

The threat of sequestration would be detrimental to the Agency, its employees and the public that relies on its services. SSA officials have informed AFGE that they have not submitted a sequestration budget to OMB in the event sequestration is necessary. However, SSA officials explained that funding below the current year's funding could result in one (1) furlough day for every $25 million cut. The result could be as severe as 41 furlough days per employee.

Unfortunately, there will always be conflicting budget priorities within SSA and throughout the Federal government. However, both workers and employers contribute to the Social Security system and are entitled to receive high quality service. It is entirely appropriate that spending for the administration of SSA programs be set at a level that fits the needs of Social Security's contributors and beneficiaries, rather than an arbitrary level that fits within the current political process.

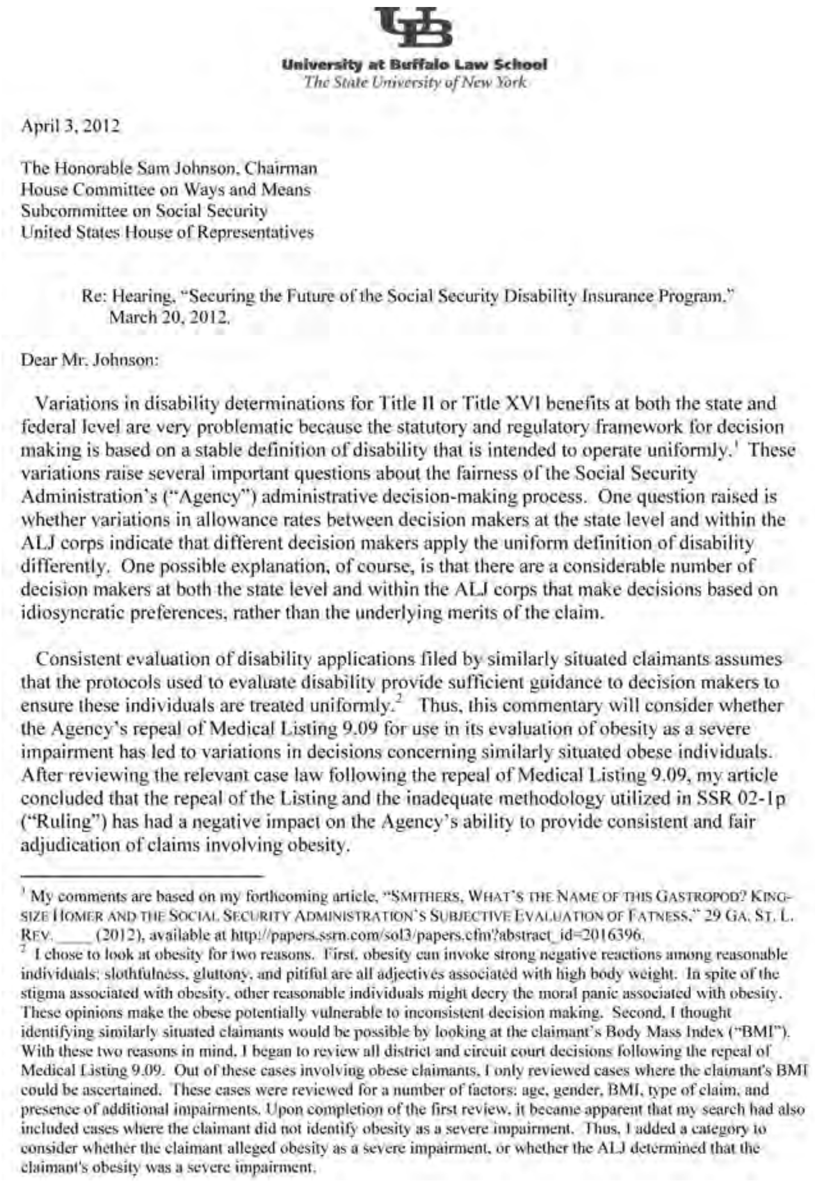
In 2000, then Chairman Shaw and Rep. Benjamin Cardin reintroduced the Social Security Preparedness Act of 2000 (formerly H.R.5447), a bipartisan bill to prepare Social Security for the retiring baby boomers. AFGE strongly encourages this Subcommittee to reconsider introducing legislation that will provide SSA with the appropriate funding level to process all claims and all post-entitlement workloads timely.

Taking SSA's administrative expenses "off-budget" has vast support, not only from AFGE and SSA workers, but from senior and disability advocacy organizations. This would include AARP, the National Committee to Preserve Social Security and Medicare, the Alliance for Retired Americans, the Consortium for Citizens with Disabilities, and the Social Security Disability Coalition.

AFGE believes that by taking the administrative costs OFF-BUDGET with the rest of the Social Security program, Congress will still be able to provide strict oversight to ensure the administrative resources are being spent efficiently.

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

University at Buffalo Law School, Statement



University at Buffalo Law School
The State University of New York

April 3, 2012

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

Re: Hearing, "Securing the Future of the Social Security Disability Insurance Program," March 20, 2012.

Dear Mr. Johnson:

Variations in disability determinations for Title II or Title XVI benefits at both the state and federal level are very problematic because the statutory and regulatory framework for decision making is based on a stable definition of disability that is intended to operate uniformly.[1] These variations raise several important questions about the fairness of the Social Security Administration's ("Agency") administrative decision-making process. One question raised is whether variations in allowance rates between decision makers at the state level and within the ALJ corps indicate that different decision makers apply the uniform definition of disability differently. One possible explanation, of course, is that there are a considerable number of decision makers at both the state level and within the ALJ corps that make decisions based on idiosyncratic preferences, rather than the underlying merits of the claim.

Consistent evaluation of disability applications filed by similarly situated claimants assumes that the protocols used to evaluate disability provide sufficient guidance to decision makers to ensure these individuals are treated uniformly.[2] Thus, this commentary will consider whether the Agency's repeal of Medical Listing 9.09 for use in its evaluation of obesity as a severe impairment has led to variations in decisions concerning similarly situated obese individuals. After reviewing the relevant case law following the repeal of Medical Listing 9.09, my article concluded that the repeal of the Listing and the inadequate methodology utilized in SSR 02-1p ("Ruling") has had a negative impact on the Agency's ability to provide consistent and fair adjudication of claims involving obesity.

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[1] My comments are based on my forthcoming article, "SMITHERS, WHAT'S THE NAME OF THIS GASTROPOD? KING-SIZE HOMER AND THE SOCIAL SECURITY ADMINISTRATION'S SUBJECTIVE EVALUATION OF FATNESS," 29 GA. ST. L. REV. ____ (2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2016396.

[2] I chose to look at obesity for two reasons. First, obesity can invoke strong negative reactions among reasonable individuals; slothfulness, gluttony, and pitiful are all adjectives associated with high body weight. In spite of the stigma associated with obesity, other reasonable individuals might decry the moral panic associated with obesity. These opinions make the obese potentially vulnerable to inconsistent decision making. Second, I thought identifying similarly situated claimants would be possible by looking at the claimant's Body Mass Index ("BMI"). With these two reasons in mind, I began to review all district and circuit court decisions following the repeal of Medical Listing 9.09. Out of these cases involving obese claimants, I only reviewed cases where the claimant's BMI could be ascertained. These cases were reviewed for a number of factors: age, gender, BMI, type of claim, and presence of additional impairments. Upon completion of the first review, it became apparent that my search had also included cases where the claimant did not identify obesity as a severe impairment. Thus, I added a category to consider whether the claimant alleged obesity as a severe impairment, or whether the ALJ determined that the claimant's obesity was a severe impairment.

Several key themes emerged from my review. First, the lack of consistent results for seemingly similarly situated individuals, particularly for individuals with a higher BMI became apparent. This finding was surprising because of the assumption that the claimant's size would be sufficient to put the ALJ on notice that obesity could be a potentially limiting factor.[3] Second, a seemingly low BMI might place a claimant at risk for an adverse decision when in fact the low BMI masks significant (and disabling) health problems.[4] This is problematic given the debate concerning the accuracy with which BMI can be used to evaluate the epidemiological link between fatness and health. For example, for women the waist-to-hip circumference provides a more accurate way to consider how a patient's obesity impacts other bodily systems. A third, and potentially more significant problem, is that the Agency's evaluation of obesity might be under-inclusive. Again, the Ruling provides little guidance. Terms in the claimant's medical records (e.g, "severe," "extreme," or "morbid") cannot be used to establish BMI as a severe impairment. Accordingly, establishing obesity as a severe impairment through the use of objective medical records and specific evidence of functional impairments should be an area of significant concern in a practitioner's case preparation.[5]

PART I: THE AGENCY'S CURRENT RULING FOR THE EVALUATION OF OBESITY

After the Agency repealed Medical Listing 9.09, the Agency enacted SSR Ruling 02-01p to provide guidance as to the evaluation of obesity. A background on the Ruling is necessary because the Ruling itself may be a source of potential points of vulnerability for obese claimants. At least one district court has complained about the Ruling's lack of guidance.[6] The Ruling correctly acknowledges that obesity is a "complex, chronic disease characterized by excessive accumulation of body fat," and concludes that obesity is generally the result of a combination of factors (e.g., genetic, environmental, and behavioral). Like other Agency protocols, the Ruling seemingly puts great emphasis on objective evidence of disability. Here, the Ruling utilizes BMI as a means for the ALJ to determine the presence of obesity. However, the utility of using BMI as an accurate predictor of the impact of weight on health is somewhat questionable for certain

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[3] For instance, in *Rockwood v. Astrue*, a female claimant had a BMI of 38.8, yet the ALJ did not mention the claimant's obesity anywhere in his decision. On appeal, the Agency, despite the fact the claimant's treating physician had diagnosed her as being obese, argued the claimant's weight was "in the range of her normal weight." *Barr v. Astrue* provides another example of why practitioners need to aggressively be prepared to develop the record concerning the claimant's obesity. In *Barr*, while the claimant did have a BMI of 40.6, the ALJ only mentioned in passing that the claimant's obesity "probably exacerbat[ed]" the claimant's sleep apnea and back pain. In remanding the case the district court, however, perhaps offered a slight criticism of the claimant's representative. Specifically, the court noted the claimant had only submitted records to the Appeals Council concerning the claimant's obesity from a nurse practitioner and physical therapist, which raised questions of whether the record had been sufficiently developed at the ALJ hearing level. *Rockwood* and *Barr* illustrate the need the need for a claimant's representative to prepare to address the impact of the claimant's weight on the claim, even where such impact may seem obvious because of the claimant's size.

[4] Some courts have noted that an ALJ should take note where a claimant a BMI that would place her at either Level II or Level III obesity. *Compare Skarbek v. Barnhart*, 390 F. 3d 500 (7th Cir. 2004)(claimant's BMI was 32.3) *with Norris v. Astrue*, 776 F. Supp. 2d 616 (N.D. Ill. 2011)(claimant's BMI was 46.1 and the court noted this difference to distinguish *Skarbek*).

[5] See e.g., *Rockwood*, 614 F. Supp. at 278 (acknowledging Agency's contention that medical evidence of claimant's obesity was "scant").

[6] *Norman v. Astrue*, 694 F. Supp. 2d 738, 748 (N.D. Ohio 2010)("This Court concedes that SSR 02-01p does not identify a specific level of analysis.").

groups (e.g., women and African-Americans). Even the Agency acknowledges that using BMI to determine whether an individual is obese can result in both false positives and false negatives.[7] Despite this concession that measurements of obesity other than BMI exist, such as hip-to-waist ratio, the Ruling states the Agency will not purchase these additional tests on behalf of the claimant because the Agency believes the medical or other evidence in the case file will be sufficient to establish whether the claimant is obese. However, my review of case law suggested that the Agency (and reviewing) courts struggled with the question of how much evidence would be sufficient to establish the presence of obesity and whether obesity was in fact a severe impairment.

The guidelines for Step 3 are troublesome because the Ruling does not make it readily apparent how the adjudicator should consider the accumulation of related impairments. While the Ruling does acknowledge that obesity can impact both physical and mental health, the Ruling's inability to articulate how obesity impacts related impairments reflects the Agency's difficulty in evaluating how the combination of impairments associated with obesity impact different bodily systems. When the Agency rescinded Medical Listing 9.09, the Agency noted it would take steps to provide adequate guidance as to the impact of obesity on health. To this end, the Ruling added prefaces to three Listings - musculoskeletal, respiratory, and cardiovascular - to provide guidance about the potential effects of obesity. For example, Medical Listing 1.00 Q (musculoskeletal) provides:

> Effects of obesity. Obesity is a medically determinable impairment that is often associated with disturbance of the musculoskeletal system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with musculoskeletal impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity.

However, the Medical Listing does not provide further guidance as to how obesity can impact musculoskeletal impairments. Additionally, the prefaces to Medical Listings 3.00I and 4.00F are almost identical and also do not provide any instruction to evaluate the impact of obesity on each respective bodily system.

In my review of the case law only a small number of cases were decided at Step 3. In part, equivalence is a difficult concept because there are a number of plausible explanations as to what equivalence means.[8]

Like the criteria outlined for the evaluation of obesity at Step 3, the criteria utilized for

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[7] A true positive would refer to an individual who does meet the statutory definition of disability. A false negative would refer to an individual who does meet the statutory definition of disability but whose claim was erroneously denied by an ALJ.

[8] See e.g., *Diaz v. Comm. of Soc. Sec.*, 57 F. 3d 500, 504 (3d Cir. 2009)(ALJ erred in failing to discuss the interaction between the claimant's obesity and other severe impairments).

determining the functional impact of obesity at later steps in the evaluation process is sufficiently vague enough to pose a considerable challenge for claimants. The Ruling notes that obesity can cause limitation of function and limitations in exertional ability, postural requirements, gross and fine motor skills, and the ability to be exposed to certain elements, such as heat or humidity. Additionally, the Ruling notes the combined effects of obesity with other impairments may be greater than might be expected without obesity.

The challenge for claimants, however, is how much evidence is needed to prove that the claimant's obesity has impacted the claimant's ability to perform the functional requirements of work. Two cases illustrate this point: *Rutherford v. Barnhart* and *Skarbek*.[9] The claimant in *Rutherford* indicated her obesity made it more difficult to manipulate objects with her fingers, in addition to her ability to walk and stand. In *Skarbek*, the claimant alleged his obesity limited his ability to walk and stand. Both courts, however, rejected these allegations as being too generalized.

Another problem with the Ruling's guidance is its lack of predictive power. For example, the Ruling suggested that someone with obesity and arthritis affecting a weight-bearing joint might have more pain and limitation than might be expected from the arthritis alone. Despite the Ruling's attempt to point out how obesity can impact other impairments such as arthritis, there are numerous examples of where seemingly similarly situated claimants experience different results.[10] For example, in *Barrett*, the claimant was 5'1" tall, 301 pounds, and the alleged disability was a result of her arthritis and obesity. In *Heino*, the claimant was 5'1" tall, with a weight range of 230 to 325 pounds, and alleged disability as a result of her osteoarthritis and obesity. In *Barrett*, the court rejected the ALJ's conclusion that the claimant could stand for two hours a day because, in the opinion of the reviewing court, the ALJ did not adequately consider the impact of the claimant's obesity on her arthritis. In contrast, the court in *Heino* accepted the ALJ's conclusion that despite the claimant's obesity and arthritis, she retained the functional ability to stand for six hours (with breaks) in an eight-hour workday.

The results in *Barrett* and *Heino* provide a cautionary tale for claimants because it may be impossible to predict how decision makers will apply SSR-02-1p. The result in *Barrett* seems to logically follow SSR-02-1p's guidance on the functional limitations of obesity,[11] whereas the ALJ in *Heino* did not address how the claimant's obesity impacted her arthritis.[12] These cases suggest claimants need to specifically address how the claimant's obesity exacerbates existing impairments.

PART II: THE LIMITS OF THE COMMON SENSE APPROACH

It is a matter of common sense that obesity can exacerbate other impairments, right? Consider *Diaz*, where the Third Circuit observed the claimant's morbid obesity would seem to have

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[9] *Rutherford v. Barnhart*, 399 F. 3d at 553.

[10] *See e.g.*, *Heino v. Astrue*, 578 F. 3d 873 (8th Cir. 2009) and *Barrett v. Barnhart*, 355 F. 3d 1065 (7th Cir. 2004).

[11] *Barrett*, 355 F. 3d at 1068 ("A great many people who are not grossly obese and do not have arthritic knees find it distinctly uncomfortable to stand for two hours at a time. To suppose that Barrett could do so day after day on a factory floor borders on the fantastic, but in any event has no evidentiary basis that we can find.").

[12] *Heino*, 578 F. 3d at 881 (in his hypothetical to the Vocation Expert, the ALJ referenced the claimant's history of obesity).

exacerbated her joint dysfunction as a matter of "common sense, if not medical diagnosis."[13] The problem with this common sense approach, however, is that this standard is sufficiently vague that opposite conclusions could be drawn by decision makers who may be disinclined to grant benefits. For instance, in *Santini v. Commissioner of Social Security*, the court noted there was no "common sense expectation that the obesity would exacerbate the impairing effects of either the seizure disorder or diabetes."[14] This conclusion is, in fact, contrary to medical literature on the subject.

My review of the case law highlights the degree of randomness that exists in the disability certification process. An understanding of case law involving obesity is important for claimants because despite the clear articulation by the Seventh and Third Circuits in *Skarbek* and *Rutherford* of how obesity is to be addressed by the ALJ, there appears to be some variation at the district court level in what will be expected from the ALJ.[15] Yet, despite the uncertainties about positive outcomes, there are lessons from past cases that can help practitioners prepare to represent obese claimants and avoid points of vulnerability.

A. DO NOT ASSUME ABNORMAL BODY MASS WILL PROVIDE SUFFICIENT NOTICE FOR THE DECISION MAKER TO CONSIDER OBESITY

The Ninth Circuit's decision in *Celaya v. Hunter* illustrates how an ALJ may choose to ignore a claimant's obvious high BMI, especially when the claimant does not allege obesity as a severe impairment.[16] The record did contain some inconsistencies as to Celaya's height, ranging from 4'9" to 5'7".[17] Additionally, during the period Celaya asserted she was eligible for benefits, Celaya's weight fluctuated between 205 and 213 pounds.[18] Depending on the estimate of height and weight used, Celaya's BMI would have ranged from either the lowest classification of BMI, Level 1, to the highest classification, Level III.[19] However, despite this obvious level of disability, the dissent expressed concern that the ALJ, despite visually observing an obese claimant, did not have to explore the claimant's obesity in a multiple impairment analysis:

> This approach would transform Social Security administrative hearings into seance-like

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[13] Diaz, 57 F. 3d at 504.

[14] *Santini v. Comm. of Soc. Sec.* 2009 WL 3390319 No. 08-5348 at *5 (Oct. 15, 2009) *aff'd* 413 Fed. Appx. 517 (3d Cir. 2011).

[15] *Rockwood*, 614 F. Supp 2d at 278 (reviewing various district court decisions that follow and decline to follow the approach utilized in *Skarbek*); *see also*, *Sotack v. Astrue*, No. 07-CV-0382, 2009 WL 3734869 (Nov. 4, 2009)(observing district courts vary in their interpretation of the extent and explicitness of the ALJ's explanation of how the ALJ considered the claimant's obesity at Steps 4 and 5) *cf. Cruz v. Barnhart*, No. 04 CV-9011, 2006 WL 1228581 (S.D.N.Y 2006)(claimant did not claim obesity as a severe impairment, but remand was not needed as ALJ's acknowledgment of the claimant's obesity in the statement of facts was sufficient consideration of the impairment).

[16] *Celaya v. Hunter*, 332 F. 3d 1177 (9th Cir. 2003). Celaya applied for benefits when Medical Listing 9.09 was still in effect. While the case was analyzed under this Listing, this decision is a good example of the difficulties claimants will have in establishing the impact of obesity on functional limitation.

[17] *Id.* at 1179, 1183 n. 3.

[18] *Id.*

[19] BMI describes the relationship between height and weight and is significantly correlated with total body fat content. Obese individuals are placed into one of three classes depending on their BMI. Class I includes individuals with a BMI between 30.0-34.9; Class II includes individuals between 35.0-39.9; and Class III includes those whose BMI is greater than 40.

> proceedings where the ALJ must divine implicit impairments, diagnose disabilities lying close to the listing criterion and detect any aura compelling further development of the record. Nothing in our precedent condones such wholesale disregard of the ALJ's adjudicatory role.[20]

The majority disagreed and argued the ALJ had an obligation where viewing the claimant in-person should have alerted the ALJ that he needed to facilitate a multi-impairment analysis, even though the non-asserted condition (obesity) was not noted in the record.[21]

Two problems emerge from *Celaya*. First, my review of cases indicates that even in instances of claims filed by individuals with a BMI greater than 40, there are multiple decisions where the ALJ did not list obesity as a severe impairment.[22] These cases illustrate that practitioners need to be aware that further development of the record concerning the impact of weight on health or functional limitation may be necessary, even for individuals whose weight would constitute Level III, or morbid obesity.[23] This potential pitfall leads to a second problem with *Celaya*, which concerns the level of detail about the impact of obesity on health and functional limitation the medical records will need to establish.

Another area of concern regarding the Agency's use of BMI to evaluate obesity concerns claimants with lower BMIs. These relatively lower levels of obesity may mask the fact that the claimant's obesity has in fact greatly exacerbated other health concerns.[24] As previously discussed, the Agency's current protocols for the evaluation of obesity place heavy emphasis on

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[20] *Id.* at 1186 (J. Rawlinson, dissenting).

[21] *Id.*, at 1183 n. 3.

[22] See e.g., *Warner v. Astrue*, 2011 WL 1135810 No. 1:09–cv–01112 (Mar. 25, 2011)(claimant's BMI was greater than 40, but the ALJ declined to find obesity was a severe impairment because medical records did not indicate claimant's obesity caused functional limitations); *Norton v. Astrue*, 2010 WL 4273108 No. 4:09CV3100 (Oct. 21, 2010)(despite BMI of 43.3, the claimant's obesity was not determined to be a severe impairment); *Deaver v. Astrue*, 2008 WL 4619823 No. 7:07-CV-158 (Oct. 20, 2008)(ALJ did not find that obesity was a severe impairment despite multiple references in the medical records to the claimant's morbid obesity and her BMI of 51.6); *Adkins v. Astrue*, 2010 WL 5825428 No. 3:10CV60 (Sept. 28, 2010)(despite claimant's BMI of 50, condition non-severe where the claimant did not allege obesity as a severe impairment, nor did he testify as to any physical limitations caused by obesity); *Bassett v. Astrue*, 2010 WL 2891149 No. 4:09-CV-142-A (June 25, 2010)(ALJ did not mention claimant's obesity despite BMI of 40.6); *Radford v. Astrue*, 2010 WL 2891149 No. 5:10-CV-00022-J (May 28, 2010)(claimant's BMI was 40 but ALJ did not determine that obesity was a severe impairment because the claimant did not testify as to the limiting aspects of her obesity at the hearing); *Bogans v. Astrue*, 2010 WL 2927486 No. 8:09-CV-0682-T-27 (June 22, 2010)(claimant's BMI was as low as 32 when he left employment but had ballooned to 40); *Callicoatt v. Astrue*, 296 Fed. Appx.. 700 (10th Cir. 2008)(harmless error where ALJ did not consider claimant's obesity (BMI 40.7)); *cf. Early v. Astrue*, 481 F. Supp. 2d 1233 (N.D. Ala. 2007)(claimant had a BMI greater than 40 and ALJ erred when he did not consider claimant's obesity to be a severe impairment).

[23] *See also Zonak v. Comm. of Soc. Sec.*, 290 Fed. Appx. 493 (3rd Cir. 2008)(suggesting claimant could not rely on high BMI as "obvious" indicator of limitations).

[24] See e.g., *Hefliek v. Astrue*, 2009 WL 1417913 No. 08-C-996 (May 20, 2009)(claimant's BMI was only 31.5 but ALJ failed to consider whether the claimant's obesity, in combination with her knee problem, limited her ability to walk); *Parks v. Astrue*, 2008 WL 4147559 No. CIV-07-1229-D (Sept. 2, 2008)(ALJ erred by failing to consider how claimant's obesity (BMI 33) affected his chronic obstructive pulmonary disorder); *Eskridge v. Astrue*, 569 F.Supp.2d 424 (D. Del. 2008)(BMI 33.9 and the ALJ failed to identify obesity as severe impairment); *Thomason v. Barnhart*, 344 F. Supp. 1326 (N.D. Ala. 2004)(ALJ did not consider the claimant's obesity (BMI 33.7) in addition to her other impairments, including arthritis); *Segal v. Barnhart*, 342 F. Supp. 2d 338 (E.D. Penn. 2004)(claimant's BMI was 32 and the ALJ determined her severe impairments included chronic ulcerative colitis, spastic colon and migraines, but failed to consider whether obesity impacted exertional and non-exertional functioning).

use of an applicant's BMI. While the Agency does acknowledge in the Ruling that there are alternative means of establishing that a claimant is obese, the Ruling's suggestion that BMI can be an appropriate tool used to establish that the claimant is obese causes two problems during the disability certification process. First, while BMI measures the presence of fat, it might not be the best measurement to identify true positives. To this end, some researchers have stated BMI is a "noisy" measurement of obesity because it does not distinguish fat from muscle, bone, or other lean body mass. Richard Burkhauser of Cornell University compared two definitions of obesity, BMI and percent of body fat. His research suggests that BMI might be a more useful predictor of the impact of obesity on health and functional limitation for men but not women. Professor Burkhauser concluded that among men, BMI produced 14.20% false positives and 33.50% false negatives. Among women, Professor Burkhauser concluded that BMI did not produce any false positives, but 61.25% classified as non-obese were false negatives. Second, the high number of women erroneously classified as non-obese is particularly disturbing because of the fact that of the district and appellate court decisions surveyed, over 70 percent of the claimants were women, and BMI is not the best measurement of the impact of fatness on health for women.

B. A MOST DANGEROUS STEP: IS OBESITY A SEVERE IMPAIRMENT?

The decisions in *Rutherford v. Barnhart* and *Diaz* illustrate the importance of the claimant's allegation that obesity is a severe impairment on the initial application for benefits or at the hearing.[25] Both *Rutherford* and *Diaz* involved two morbidly obese claimants: the claimant in Rutherford had a BMI of 44.8 whereas the claimant in Diaz had a BMI of 50.9. In *Rutherford*, the claimant did not allege that her obesity was a severe impairment; but rather, argued that references to her obesity in the medical record were sufficient to put the ALJ on notice that the claimant's weight could be a factor in the decision. Despite these obvious signals of the claimant's obesity, the *Rutherford* court reasoned the ALJ did not specifically have to address the claimant's obesity in his decision because the claimant's doctors were likely aware of her "obvious" disability, so it was appropriate for the ALJ to consider and adopt their opinions concerning her functional limitations and impairments.

In *Diaz*, which followed Rutherford, the court reached a different result. While Diaz did not allege obesity as a severe impairment, the difference is attributable to the ALJ's acknowledgment at Step 2 that the claimant's obesity was a severe impairment. This determination triggered the ALJ's obligation to consider her obesity at the other steps as required by SSR 02-01p.

These cases illustrate points of vulnerability in the process for a claimant. For example, *Diaz* and *Rutherford* show that it is important for claimants to establish obesity as a severe impairment. If the claimant alleges obesity as a disabling condition or the ALJ determines that obesity is a severe impairment, reviewing courts potentially expect the ALJ to provide a more substantive discussion of how a claimant's obesity may impact other impairments or functional

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[25] *See also*, *Halsell v. Astrue*, 357 Fed. Appx. 717, 723 (7th Cir. 2009)(court rejected claimant's argument that ALJ erred by failing to consider her obesity based on inferences from the reports of the state-agency physician where claimant did not allege obesity as severe impairment); *Briggs v. Astrue*, 221 Fed. Appx 767, 771 (10th Cir. 2007)(ALJ correctly determined obesity was not a severe impairment where the claimant did not allege it); *Wind v. Barnhart*, 133 Fed. Appx. 684, 690-91 (11th Cir. 2005)(claimant did not allege obesity as a severe impairment, so ALJ did not have to list obesity as a severe impairment where there was no medical evidence the claimant's obesity impacted her ability to perform medium level work).

limitations.

For example, in *Ellis v. Astrue*, the claimant applied for SSI alleging disability on the basis of arthritis in the knees, hands, and wrists, diabetes, and high cholesterol; obesity was not identified.[26] At the hearing, the claimant testified that her current weight was 268 pounds but fluctuated to as high as 298 pounds.[27] At Step 2 of the decision, the ALJ found that the claimant's obesity was a severe impairment.[28] The only other reference to the claimant's obesity came during the discussion of Step 3, where the ALJ acknowledged his legal obligation to discuss the impact of the claimant's obesity on other impairments.[29] The court, however, found this discussion inadequate and remanded the case for further development of how the claimant's obesity impacted her bilateral knee disorder and her ability to walk and/or stand.[30] Where obesity has been determined to be a severe impairment, the ALJ will have to explain in her decision how obesity figured into her determination at any point in the five step sequential evaluation process, or adopt the recommendations of doctors who were aware of plaintiff's obesity.[31]

A review of case law suggests reviewing courts vary widely in their expectations of how ALJs evaluate obesity during the five-step sequential evaluation process. In part, the differing results are a product of tension between the Act, regulations, and SSR 02-1p.[32] However, the idea that an ALJ has virtually no obligation to further develop generalized points of evidence or testimony is somewhat at odds with other regulations and SSR 02-1p. Specifically, 20 C.F.R. § 404.1545(a)(3) provides that before making a determination the claimant is not disabled, the ALJ has an obligation to assist the claimant in developing the record. Additionally, SSR 02-1p at ¶ 5 suggests the ALJ has the power to seek additional guidance from a medical source to clarify whether the individual has obesity in situations where the clinical records only contain references to the claimant's high body weight.[33]

Notwithstanding the ALJ's obligations, the review of case law indicates claimants should take steps to develop the record with respect to the limitations caused by obesity on the claimant's functional capacity and the effect of the claimant's obesity in combination with other medical impairments.[34] This can be a difficult hurdle for two reasons. First, it is not necessarily clear to

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[26] *See e.g.*, Ellis v. Astrue, 2010 WL 1817246 * 1 (E.D. Penn. 2010).

[27] *Id.* at *2.

[28] *Id.*

[29] *Id.*

[30] *Id.* at *5.

[31] *Eskridge v. Astrue*, 569 F. Supp. 2d 424, 439 (D. Del. 2008).

[32] See C.F.R. § 404.1521(b). Basic work activities include physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; capacities for seeing, hearing, and speaking; understanding, carrying out, and remembering simple instructions; use of judgment; responding appropriately to supervision, co-workers and usual work situations; and dealing with changes in a routine work setting.

[33] The Ruling, however, contains conflicting guidance because the next sentence in Paragraph 4 states, "[h]owever, in most such cases we will use our judgment to establish the presence of obesity based on the medical findings and other evidence in the case record, even if a treating or examining source has not indicated a diagnosis." This is perhaps an example of a communications problem that can impede the furtherance of Agency goals.

[34] *See e.g, Castel v. Astrue*, 355 Fed. Appx. 260, 264 (11th Cir. 2009)(record did not establish claimant's obesity resulted in any functional limitations). My review did find several instances of poor development of the medical record. For example, in Rutherford, the ALJ held the record open for thirty days after the hearing to receive additional records regarding a pulmonary function test, but the claimant never provided further documentation that

what extent the medical records have to discuss the claimant's obesity. For instance, single references in the claimant's file to his or her obesity may be insufficient to establish obesity as a severe impairment.[35] Additionally, in *Guadalupe v. Barnhart*, the ALJ did not have to consider the claimant's obesity where the claimant's medical records described her as obese, but she was not diagnosed as obese nor did the claimant's doctors suggest her obesity contributed to her other impairments.[36] The second problem is that the ALJ may also expect the medical records to not only diagnose the claimant with obesity, but also to discuss the impact of the claimant's obesity on health or functional limitation.[37] More specifically, the claimant may have to produce medical records that explicitly discuss how the claimant's obesity affects her ability to work.[38]

CONCLUSION

Two reforms are necessary. First, the Agency should revise its protocols for the evaluation of obesity so that greater accuracy and consistency in decision making can be achieved. My second conclusion is that the Agency should develop other criteria in addition to BMI that can be used to evaluate the epidemiological link between fatness and health.

Please let me know if I may provide you with any further information regarding my research.

Regards,

Chris Pashler

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could have established the connection between her obesity and her work-related limitations. *Rutherford*, 399 F. 3d at 554. See also *Rickabaugh v. Astrue*, 2010 WL 1142041 (2010)(physician concluded severe reduction in maximal ventilatory volume on pulmonary function test but the claimant dialed to submit additional evidence).

[35] *See e.g., Bowser v. Commissioner of Social Security*, 121 Fed. Appx. 231, 236 (9th Cir. 2005)(medical record contained one reference from the treating physician that the claimant was obese); *Prochaska v. Barnhart*, 454 F.3d 731, 737 (7th Cir. 2006)(one treating physician diagnosed claimant as obese, and other medical reports relied upon by ALJ noted claimant's height and weight).

[36] *Guadalupe v. Barnhart*, 2005 WL 203380 No. 04-CV-7644 (S.D.N.Y. Aug. 24, 2005).

[37] *See Wiese v. Astrue,* 552 F. 3d 728, 732-33 (8th Cir. 2009)(claimant's medical records indicated she had been diagnosed with obesity, but records did not suggest what the impact was on other impairments or what the limiting effect of her obesity was).

[38] *Cranfield v. Comm. of Soc. Sec*., 57 F. 3d 500, 504 (3d Cir. 2009).

NHCHC, Statement

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

WRITTEN TESTIMONY
OF SARAH ANDERSON, J.D., CHAIR, SSI TASK FORCE, NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
to the
SUBCOMMITTEE ON SOCIAL SECURITY OF THE COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

April 2, 2012

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

Thank you for the opportunity to submit written testimony for the Hearing before the House Ways and Means Committee Subcommittee on Social Security on How Disability Insurance Eligibility Decisions Are Made. The National Health Care for the Homeless Council is a membership organization comprised of over 100 organizational members and over 1,000 individual members who work to improve the health of people experiencing homelessness. NHCHC organizational members include grantees and subcontractors of the federal Health Care for the Homeless funding stream, other health care providers, and advocacy organizations. In 2010, our members served nearly one million homeless patients, many of whom have disabilities. The SSI Task Force of the National Health Care for the Homeless Council (NHCHC) attempts to eliminate systemic barriers to accessing benefits for people who have a disability and are concurrently experiencing homelessness.

The Link Between Homelessness and Disability

Disability causes and prolongs homelessness. About 15% of the non-institutionalized U.S. population is disabled, yet people with disabilities constitute 37% of people who are homeless in America.[1,2] Diminishing affordable housing, depressed wages, higher unemployment, and decreased access to health insurance coverage over the past two decades has placed an increasing number of individuals and families with disabilities at risk of homelessness, and makes leaving homelessness more difficult as well.

Disability assistance can mitigate the health risks associated with homelessness. Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) constitute a safety net for persons with disabilities, providing cash assistance and, usually, eligibility for publicly supported health insurance (Medicaid/Medicare). Those who receive SSI/SSDI are also more likely to be eligible for low-cost housing, including supportive housing. Housing alleviates the extraordinary health risks associated with homelessness, expedites recovery, improves quality of life, and helps beneficiaries achieve stability and resume productivity.

Demonstrating disability is more difficult for individuals experiencing homelessness. Medical records and other historical documents needed to demonstrate functionality and the duration of disabling conditions are often dispersed among many emergency rooms and hospitals where those without insurance have sought care in the past. These records are often incomplete and not thorough enough in themselves to establish documentation over time, given that visits tend to be episodic. In addition, individuals with serious mental illness, developmental delay, or other cognitive impairments may not be able to remember where more permanent records may be located (e.g., the name and location of their elementary school, their primary care provider as an adolescent, etc.). Living in emergency shelters and on the street also makes retaining documentation and identification more difficult—papers are often ruined by weather, stolen or lost, or discarded by corrections officials upon arrest. All of these factors make documenting disability much more difficult.

Homeless SSI/SSDI claimants often are denied benefits for failure to meet the requirements of an arduous application process, rather than for lack of serious medical impairments that meet SSA disability criteria. Systemic barriers include poor access to health care, insufficient documentation of diagnosis and functional impairments by an approved medical source, remote application offices, complex application processes, disability evaluators unfamiliar with the realities of homelessness, and inconsistent implementation of SSA disability determination policy across jurisdictions. Barriers can be exacerbated by an applicant's mental illness or by the lack of stability necessary to maintain contact, keep paperwork organized, and meet deadlines throughout the application review.[3] In short, homeless claimants do not often get the right decision as early as possible. There is more work to be done to make that promise into a reality.

RECOMMENDATIONS

Include questions in the SSI application package to ensure personnel correctly identify homeless claims: Many offices that expedite processing of homeless claims have difficulty identifying claims from homeless people. Being able to provide an address does not guarantee that the claimant is not homeless. We recommend adding questions to the Disability Report that would reflect a claimant's possible homeless status, including questions about the person's living arrangements, about the length of time at the current address, and past episodes of homelessness. Such questions on the Disability Report would not only indicate a claimant's homeless status, but could add information regarding a claimant's functional limitations.

Flag and expedite homeless claims: Claims filed by homeless persons should be flagged at all levels of consideration to trigger expedited disability determination due to urgency of need. This same process worked well when applied to the disability claims filed by Katrina survivors and demonstrates that the proposed process is both feasible and effective in connecting disabled individuals with life-saving benefits. The Social Security Administration, in special circumstances, has had policies in place for some time that allow for flagging cases. In some offices, the e-file recognizes "homelessness" and in others, DDS offices use paper flags to identify homeless claimants and direct their claims to certain units or workers.[4] The problem with this *ad hoc* process is that there is no uniform system that could identify the claims. A directive from headquarters that mandates such flagging and more complete inquiries about homelessness at district offices would be extremely useful and can be accomplished administratively. Although SSA did issue an administrative message encouraging offices to do this, we believe such flagging needs to be required and this policy set at the HQ level. A new system should include mechanisms for electronically notifying SSA and DDS personnel of an expedited claim.

Ensure that all DDSs and District Offices have personnel who are trained to handle homeless claims: This can be accomplished through a dedicated Homelessness Unit (as in the Boston DDS and other urban DDS offices that have large homeless populations). In other areas, it might be more feasible to have designated DDS staff to work on applications from people who are homeless. In both instances, designated staff would develop expertise on homelessness and would understand how such a living situation affects people's lives. This would also be consistent with flagging homeless claims so that such applications would go to designated staff. The National HCH Council and our community partners who serve people who are homeless would be more than happy to offer training to DDS (and SSA) staff on issues related to homelessness as well as on mental illness, should that be of interest.

Expand the list of Acceptable Medical Sources: We appreciate the Social Security Administration's recognition of evidence from non-physician professional sources such as therapists and social workers. However, we believe that these non-physician professional sources should be considered "acceptable medical sources." Although most medical doctors and psychiatrists have the training necessary to determine disability, they are not often found in high concentration in the programs that serve extremely low-income and homeless populations. HRSA consequently recognizes Health Professional Shortage Areas and Medically Underserved Populations in awarding Health Center grants. [5] Low-income and homeless patients receive much of their care from Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Physician Assistants, and Licensed Clinical Social Workers. These professions follow national standards of care and have the skills necessary to determine the source of functional impairment in their patients. We urge SSA to expand the list of acceptable medical sources to include Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Physician Assistants, and Licensed Clinical Social Workers in order to expedite and improve access to SSI/SSDI entitlements.

Revise the SSA Homelessness Plan to incorporate lessons learned from HOPE,[6] the SSI/SSDI Outreach, Access & Recovery (SOAR) Project,[7] and the Baltimore SSI Outreach Project and increase support for these initiatives:[8] Demonstration projects have confirmed policies and procedures that can improve allowance rates at initial consideration, and expedite access to SSI/SSDI for applicants who are homeless. Successful strategies include: (1) educating SSA and DDS staff about issues related to homelessness; (2) designating SSA and DDS staff to assist homeless claimants; (3) ensuring that all such applications are flagged for expedited processing; (4) tracking outcomes of applications from homeless applicants separately from those of other applicants; and (5) developing processes to ensure that eligibility determinations are made as soon as possible. Such strategies should be incorporated into a revised SSA Homelessness Plan that includes timelines for implementation. By implementing these strategies, SSA could improve approval rates while reducing waiting periods for homeless claimants. Indeed, the SOAR program has resulted in a 71% approval rate at initial application with an average processing time of 101 days. [9]

Repeal the Drug Abuse and Alcoholism (DAA) policy: The 1996 termination of SSI and SSDI eligibility for individuals whose drug addiction or alcoholism is material to their disability was not intended to disqualify persons disabled by co-occurring impairments that include substance use disorders. Such denials have nevertheless been widely reported to occur at the initial stage of disability determination, many of which are reversed to allowances at the appeals level. Inconsistent interpretation and application of the DAA policy combined with the complexities of determining whether DAA is material to disability have prevented many people with severe disabilities from accessing assistance. One study found that over half of the people who lost their benefits due to the DAA policy had severe physical health disabilities that required hospitalization the year before termination. Another 15% of the population had been hospitalized for schizophrenia and psychosis unrelated to substance abuse.[10]

Extend Compassionate Allowances for people who are diagnosed with schizophrenia. Whereas the national incidence of homelessness is less than one percent, twenty percent of people with schizophrenia are homeless.[11] Homelessness is an indicator of the extent of functional impairment among people with schizophrenia. Commissioner Astrue held a Compassionate Allowances Outreach Hearing in San Francisco, California on November 18, 2009. As SSA has noted , "[s]ome of the nation's leading experts on schizophrenia provided testimony about possible methods of identifying and implementing Compassionate Allowances for young adults with schizophrenia. Many of the experts including clinicians and advocated provided information on the effects of homelessness on individuals with schizophrenia."[12] While SSA and its state and local partners are to be commended for implementing a demonstration project in San Francisco and Santa Cruz CA Counties offering Presumptive Disability to individuals experiencing homelessness with schizophrenia [13], we look forward to the day when this population will be offered something more than a demonstration project. Expedited receipt of SSI will reduce homelessness among people with schizophrenia.

Thank you again for the opportunity to submit these comments.

Respectfully Submitted,

Sarah Anderson, esq.
Chair, on behalf of the SSI Task Force
National Health Care for the Homeless Council

Notes

[1] The federal HUD definition of chronically homeless is an unaccompanied disabled individual who has been continuously homeless for over one year. http://www.hud.gov/offices/cpd/homeless/chronic.cfm.

[2] HUD. 2010 Annual Homeless Assessment Report. http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf

[3] O'Connell et al. (2007). *Documenting Disability: Simple Strategies for Medical Providers*. Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council, Inc. http://www.nhchc.org/DocumentingDisability2007.pdf

[4] See, e.g., POMS DI 81020.085[Certified Electronic Folder Flags]

[5] http://bhpr.hrsa.gov/shortage/

[6] The Homeless Outreach Projects and Evaluation (HOPE) program, established by the Social Security Administration, provided grant funding to 41 agencies in 2004 to assist chronically homeless individuals in applying for SSI and SSDI benefits. http://www.ssa.gov/homelessness/outreach.htm

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[7] Policy Research Associates. (2012). 2011 SOAR outcomes. Retrieved from http://www.prainc.com/cms-assets/documents/51178-875138.2011-outcomes-summary-021612.pdf. For more information about SOAR see: www.prainc.com/soar

[8] The University of Maryland Medical System Baltimore SSI Outreach Project began in 1993 as SSA funded outreach demonstration project, designed to assist homeless adults with severe and persistent mental illness in obtaining SSI benefits. Over 10 years, the project achieved a 96% success rate on application for those whom project staff believed to be eligible for benefits.

[9] Ibid 5.

[10] Hanrahan, P., Luchins, D., Swartz, J., et al. (Jan 2004). Medicaid eligibility of former Supplemental Security Income recipients with drug abuse or alcoholism disability. Am J. Public Health, 94(1): 46-47.

[11] Folsom, D.P, Hawthorne, W., et. al. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System." *Am J. Psychiatry*. 2005.

[12] USICH Agency Annual Reports:2011, pp.72-73; available at: http://www.usich.gov/resources/uploads/asset_library/Annual%20Update%202011%20Appendix_Jan12.pdf

[13] Id.

Ruth Kolb, Statement

I am writing regarding the upcoming hearing on the process for deciding social security decisions. I practice law in this area and continue to be concerned at the number of claimants age 50-64 with long, productive work histories who are routinely denied for benefits at the initial stage. They then must wait over a year to get a hearing before an administrative law judge. In the meantime, the dire financial impacts of losing employment (and often medical insurance) often leave these workers near foreclosure, bankruptcy etc. Often, the agency's own consultative examiner has found medically documented limitations which would require an award of benefits under the correct application of Medical-Vocational guidelines. This opinion is routinely over-ruled by an agency reviewer who never even examines the claimant. These situations are not limited to older claimants, however, I think the injustice to these claimants is the most troubling and should be a focus of immediate review. Once a claim gets to an administrative law judge, the troubles can continue. I recently had a gentleman denied for the second time, and after the Appeals Council directed a review of his case. He was over 60 during the relevant time period, suffered from residual knee problems due to a gunshot wound in Viet Nam, cardiac myopathy, diabetes, and hypertension. Despite these medical conditions and his testimony regarding his inability to be on his feet all day, the judge said he was capable of medium work (walking, standing, lifting significant weight all day) and denied benefits *without even discussing the impact of these medical conditions on his ability to do physically challenging work*. Another gentleman after working his entire life as a commercial painter suffered a broken ankle in a non-work related accident. The ankle healed poorly required multiple surgeries and he walks with a severe limp and is limited to walking/standing only 2-3 hours per day. Again, this 56 year old man, with a 9th grade education, who had worked steadily since he was a teenager was denied benefits and had to wait 15 months for a hearing. Fortunately, he was awarded benefits at this stage.

In conclusion, there is much focus on the people who "don't deserve it" and a cry to make it tougher to get benefits. I would argue that a careful and reasoned approach should first focus on protecting those who qualify under the SSDI program and who are over 50. After assuring that these claimants have a fair and speedy resolution of their claims, consideration of other issues (based on facts and not a few isolated incidents) can be made.

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