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MANAGING THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

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[1] January 4, 1995, through July 10, 1995.
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MANAGING THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

TUESDAY, MAY 23, 1995

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

The subcommittee met, pursuant to notice, at 10:04 a.m., in room B–318, Rayburn House Office Building, Hon. Jim Bunning (chairman of the subcommittee) presiding.

[The advisories announcing the hearings follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
May 3, 1995
No. SS-2

CONTACT: (202) 225-9263

BUNNING ANNOUNCES SOCIAL SECURITY DISABILITY HEARINGS

Congressman Jim Bunning, (R-KY), Chairman of the Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings on the Social Security disability insurance program. **The first hearing will take place on Tuesday, May 23, 1995, beginning at 10:00 a.m. in room B-318 Rayburn House Office Building.** On that day, the Subcommittee will examine broadly how effectively the disability insurance program is being administered by the newly-independent Social Security Administration (SSA). The Subcommittee will hear testimony focusing on the causes and extent of the disability claims backlogs, what short- and long-term initiatives have been developed to address these backlogs and to conduct disability reviews, and various concerns surrounding the agency's implementation of these initiatives.

The second hearing will be held on Wednesday, May 24, 1995, beginning at 10:00 a.m. in room B-318 of the Rayburn House Office Building. At that time, the Subcommittee will hear from any Member of Congress wishing to testify regarding his or her views on ways to improve any aspect of the Social Security disability insurance program.

Oral testimony at the May 23 hearing will be heard from invited witnesses only. Witnesses will include representatives from SSA, the U.S. General Accounting Office, and employee and professional organizations. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing. Members of Congress wishing to testify at the May 24 hearing are asked to contact the Subcommittee staff at 225-9263 no later than close of business May 17.

BACKGROUND AND FOCUS:

From 1984 to 1994, the U.S. population grew by 11 percent. In the same 10 years, the number of individuals receiving Social Security benefits on account of disability went up 40 percent, from 4.8 million to 6.7 million. This surge in disability applicants and awards has created unprecedented increases in SSA disability workloads, particularly over the past four years. As a result, backlogs have occurred, causing unacceptable service delays to those suffering from severe disabilities. In particular, applicants who appeal their disability claims as far as a hearing before an Administrative Law Judge often wait over a year after first applying to receive a final decision.

A severe backlog also exists in the number of active disability cases requiring review to determine whether a legitimate disability continues. Experts estimate that for every $1 spent on reviewing disability cases, about $6 in benefits can be saved. Congress passed legislation in 1980 requiring SSA to periodically review at least 500,000 disability cases annually, and terminate benefits to those who have recovered. For the last five years, however, SSA has reviewed fewer than 100,000 disability cases, and in three of those years it reviewed under 50,000. As a consequence, GAO estimates that hundreds of thousands of individuals who have recovered continue to receive hundreds of millions of dollars of disability benefits to which they are not entitled, draining the disability trust fund, and eroding public confidence in the integrity of the disability program.

The solvency of the disability trust fund is of particular concern to Subcommittee Members. In response to imminent insolvency, Congress passed legislation in 1994 shifting a percentage of the payroll tax from the retirement and survivors' trust fund to the disability trust fund. Although the tax reallocation was projected to keep the disability trust fund solvent until 2015, the retirement and survivors' trust fund is projected to lose $275 billion by 2008 as a result.

(MORE)

WAYS AND MEANS SUBCOMMITTEE ON SOCIAL SECURITY

The Subcommittee is interested in ensuring that short- or long-term agency initiatives to streamline or alter various aspects of the disability claims process do not negatively impact public service, the integrity of the process, or the solvency of the trust funds. It is also interested in SSA's efforts to identify the causes for the explosion in disability.

DETAILS FOR SUBMISSION AND PRESENTATION OF TESTIMONY:

Witnesses scheduled to present oral testimony are required to summarize briefly their written statements in no more than five minutes. **THE FIVE MINUTE RULE WILL BE STRICTLY ENFORCED. The full written statement of each witness will be included in the printed record of the hearing.**

In order to assure the most productive use of the limited amount of time available to question witnesses, all witnesses scheduled to appear before the Subcommittee are required to submit 200 copies of their prepared statements for review by Members prior to the hearing. **Testimony for the May 23 hearing should arrive at the Subcommittee on Social Security office, room B-316 Rayburn House Office Building, no later than noon, Friday, May 19, 1995.** Failure to do so may result in the witness being denied the opportunity to testify in person. Members scheduled to testify at the May 24 hearing are asked to submit copies of their testimony by May 19 if they would like Subcommittee Members to review it prior to the hearing.

Any questions concerning a scheduled appearance should be directed to the Subcommittee staff at (202) 225-9263.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, including their address and date of hearing, by Wednesday, June 7, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed at the hearing, they may deliver 200 additional copies to the Subcommittee on Social Security, room B-316 Rayburn House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

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. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV under 'HOUSE COMMITTEE INFORMATION.'

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ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
July 18, 1995
No. SS-3

CONTACT: (202) 225-9263

Bunning Announces Social Security Disability Hearing

Congressman Jim Bunning, (R-KY), Chairman of the Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee's hearing on the Social Security disability insurance (DI) program will be continued on **Thursday, August 3, 1995. The hearing will begin at 9:00 a.m. in room B-318 Rayburn House Office Building.** On that day, the Subcommittee will continue its examination of malfunctions in the disability program. The hearing will focus on management of the program, vocational rehabilitation, and the appeals process.

Oral testimony at the hearing will be heard from invited witnesses only. Witnesses will include representatives from the U.S. General Accounting Office and experts in vocational rehabilitation, program administration, and due process. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Witnesses who appeared at the hearing held in May testified that the Social Security Administration's disability process redesign plan will not correct two of the program's most serious problems -- the discrepancies caused by differing standards in the disability decision-making process, and the variations in disability standards across the country caused by the impact of the Federal courts.

In addition, only 6,154 of the 9.2 million disabled individuals receiving Social Security disability insurance (SSDI) and Supplemental Security Income (SSI) were successfully rehabilitated in 1993 -- and only 21 percent of those awarded were even referred for rehabilitation services.

FOCUS:

Chairman Bunning is committed to restoring fairness to the disability program by enabling those who are truly disabled to receive benefits quickly, and by stopping payments to those who have recovered. The Subcommittee will hear expert views on what action is needed to remedy the abysmal record of vocation rehabilitation of SSDI and SSI recipients, as well ways to improve malfunctions in the disability process.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement (legal size), including their address and date of hearing, by Thursday, August 17, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed at the hearing, they may deliver 200 additional copies (any size) to the Subcommittee on Social Security, room B-316 Rayburn House Office Building, **at least one hour before the hearing begins.**

(MORE)

WAYS AND MEANS SUBCOMMITTEE ON SOCIAL SECURITY

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages (only 2 legal-sized copies need be submitted for printing purposes).

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. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms as desired.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV under 'HOUSE COMMITTEE INFORMATION.'

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Chairman BUNNING. Since we have so many panels, I would like to get the hearing underway.

Let me first welcome our witnesses and guests, especially the agency employees who have traveled so far to be here today.

As is the custom of the subcommittee, without objection, we will dispense with opening statements except for the chairman and for my ranking member, Mr. Jacobs. Any member is welcome to submit his opening remarks for the record.

Today marks Social Security's first appearance before this subcommittee since it became an independent agency on March 31. Social Security is the most important social program ever created and it needed to be rescued from the basement of HHS. Congress did that last year, and I am extremely proud of the role that Andy and I both had in the legislation that passed.

Protecting Social Security is extremely important to the American people. One way to do that is to ensure that the Social Security disability program is accurately administered. The numbers show that the disability program is in trouble. For example, over half a million denied claims are awaiting a hearing before an ALJ, administrative law judge.

Part of the problem is Social Security's management of the program. Today's hearing will focus on what action SSA, the Social Security Administration, is taking and whether its efforts will increase allowances of borderline cases, placing further stress on the program and undermining public confidence even more.

SSA employees, as well as those at the DDS, Disability Determination Services, and OHA, Office of Hearings and Appeals, are to be commended for the work they have done to raise productivity, cut processing time, and reduce backlogs. But SSA administrators must be cautioned that those of us who have been in Congress for a little while know that numbers do not necessarily tell the whole story. The key issue is not whether SSA is getting the numbers down but how SSA is getting the numbers down.

Taken to extremes, one way to eliminate backlogs is just to pay more cases from the beginning, and there is no question that the numbers show that SSA is doing a terrible job getting people off the rolls.

Of the 4 million disabled workers currently getting benefits, roughly half, almost 2 million are long overdue for a continuing disability review or a CDR. The CDR backlog grows by 500,000 each year. Just doing the required CDRs would go a long way toward restoring public confidence in Social Security.

[The prepared statement follows:]

STATEMENT
of
CHAIRMAN JIM BUNNING
Social Security Subcommittee
May 23, 1995

TODAY MARKS THE FIRST APPEARANCE BEFORE THE SOCIAL SECURITY SUBCOMMITTEE OF THE SOCIAL SECURITY ADMINISTRATION -- SSA -- SINCE IT BECAME AN INDEPENDENT AGENCY ON MARCH 31. SOCIAL SECURITY IS THE MOST IMPORTANT SOCIAL PROGRAM EVER CREATED. WITH OVER 42 MILLION AMERICANS RELYING ON IT EVERY MONTH, SSA NEEDED TO BE RESCUED FROM THE BASEMENT OF HHS. CONGRESS DID THAT LAST YEAR, AND I AM EXTREMELY PROUD OF THE ROLE THAT I HAD IN THE LEGISLATION.

WHAT HAPPENED AT THE RECENT CONFERENCE ON AGING -- ATTENDED BY SEVERAL THOUSAND SENIOR DELEGATES FROM ALL OVER THE COUNTRY -- DEMONSTRATES HOW IMPORTANT SOCIAL SECURITY IS TO THE AMERICAN PEOPLE. WHEN THE DELEGATES VOTED, THEIR NUMBER ONE CONCERN WAS PROTECTING SOCIAL SECURITY -- NOT MEDICARE, IN SPITE OF ALL THE ATTENTION IT HAS RECEIVED.

THE AMERICAN PUBLIC CLEARLY WANTS CONGRESS TO PROTECT AND STRENGTHEN THE SOCIAL SECURITY SYSTEM. ONE WAY IS TO ENSURE THAT THE SOCIAL SECURITY DISABILITY PROGRAM IS ACCURATELY ADMINISTERED.

FROM 1984 TO 1994, THE U.S. POPULATION GREW BY 11 PERCENT. IN THE SAME TEN YEARS, THE NUMBER OF INDIVIDUALS ON SOCIAL SECURITY DISABILITY WENT UP 40 PERCENT, TO OVER 5.5 MILLION. OVER $42 BILLION IN DISABILITY BENEFITS WILL BE PAID THIS YEAR. AS A RESULT, CONGRESS HAD TO REDIRECT FUNDS LAST YEAR FROM THE RETIREMENT AND SURVIVOR INSURANCE TRUST FUND TO THE DISABILITY INSURANCE TRUST FUND TO PREVENT THE PROGRAM FROM GOING BROKE THIS YEAR. THIS ACTION GOT LITTLE ATTENTION, BUT IN THE NEXT FIFTEEN YEARS, AS MUCH AS $275 BILLION COULD BE REDIRECTED FROM THE RETIREMENT FUND TO THE DISABILITY FUND.

INDIVIDUALS WHO WORK AND PAY INTO SOCIAL SECURITY MUST BE ABLE TO COUNT ON DISABILITY BENEFITS TO SUPPORT THEIR FAMILIES IF SEVERE DISABILITY STRIKES. BUT BENEFITS SHOULD ONLY GO TO THOSE WHO ARE TRULY DISABLED.

THE NUMBERS SHOW THAT THE DISABILITY PROGRAM IS IN TROUBLE. PART OF THE PROGRAM'S PROBLEMS CAN BE ATTRIBUTED TO SSA'S MANAGEMENT OF THE PROGRAM. OVER A HALF MILLION DENIED CLAIMS ARE AWAITING A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. TODAY'S HEARING WILL FOCUS ON THE PROGRAM'S PROBLEMS, AND WHAT SSA IS DOING TO FIX THEM. WILL THE REMEDIES THAT SSA IS PROPOSING CURE THE PROBLEMS -- OR ULTIMATELY CAUSE THE DEMISE OF THE PROGRAM BY ALLOWING MORE CLAIMS, PLACING FURTHER STRESS ON THE SOLVENCY OF THE PROGRAM, AND UNDERMINING PUBLIC CONFIDENCE EVEN MORE. I WILL BE ASKING GAO TO MONITOR THIS CLOSELY.

SSA'S MANAGEMENT OF THE DISABILITY PROGRAM AFFECTS PROGRAM GROWTH IN MANY CRITICAL WAYS. BY AWARDING BENEFITS TO BORDERLINE CASES THAT SHOULD NOT BE ALLOWED, SSA ENCOURAGES OTHERS WHO ARE NOT TRULY DISABLED TO APPLY IN THE HOPE THAT THEY, TOO, WILL BE AWARDED BENEFITS.

SSA EMPLOYEES, AS WELL AS THOSE IN THE STATE DISABILITY DETERMINATION SERVICES, AND OFFICE OF HEARINGS AND APPEALS, ARE TO BE RECOGNIZED FOR RAISING PRODUCTIVITY, CUTTING PROCESSING TIMES, AND REDUCING BACKLOGS. BUT SSA ADMINISTRATORS MUST BE CAUTIONED THAT THOSE OF US WHO HAVE BEEN IN CONGRESS FOR A WHILE KNOW THAT NUMBERS DON'T TELL THE WHOLE STORY. TAKEN TO EXTREME, ONE WAY TO ELIMINATE BACKLOGS WOULD BE TO SIMPLY PAY MORE CASES FROM THE BEGINNING.

THERE IS NO QUESTION THAT THE NUMBERS SHOW THAT SSA IS DOING A TERRIBLE JOB GETTING PEOPLE OFF THE ROLLS. SSA MUST DO A BETTER JOB REVIEWING CLAIMS TO DETERMINE WHICH BENEFICIARIES REMAIN LEGITIMATELY DISABLED, AND WHICH ARE RECOVERED AND SHOULD HAVE BENEFITS STOPPED.

OF THE FOUR MILLION DISABLED WORKERS CURRENTLY GETTING BENEFITS, ROUGHLY HALF -- ALMOST 2 MILLION -- ARE LONG OVERDUE FOR A CONTINUING DISABILITY REVIEW, OR CDR. THE CDR BACKLOG GROWS BY 500,000 A YEAR.

WHEN SSA TALKS ABOUT CUSTOMER SERVICE, IT SEEMS TO FORGET THAT IT SERVES TWO GROUPS OF CUSTOMERS -- THE APPLICANTS AND CURRENT RECIPIENTS, AND THE TAXPAYERS AND FUTURE RECIPIENTS.

BOTH GROUPS DESERVE TOP-NOTCH SERVICE THAT PROTECTS THEIR INTERESTS.

DOING THE REQUIRED CDRs WOULD GO A LONG WAY TOWARD RESTORING PUBLIC CONFIDENCE IN SOCIAL SECURITY. WHEN PEOPLE BELIEVE THAT A PROGRAM DOESN'T WORK, THEY STOP SUPPORTING IT. THIS WEAKENS THE PROGRAM, AND DOES A DISSERVICE TO TRULY DISABLED PEOPLE WHO ARE LEGITIMATELY ENTITLED TO BENEFITS.

THERE ARE SERIOUS CONCERNS ABOUT SSA INITIATIVES TO STREAMLINE THE PROCESS. THE NUMBER OF EMPLOYEES TESTIFYING TODAY IS EVIDENCE OF THAT. THESE EMPLOYEES ARE TO BE COMMENDED FOR COMING FORWARD WITH THEIR CONCERNS. AS YOU LISTEN TO THEM, IT WILL BECOME OBVIOUS THAT THEY CARE DEEPLY ABOUT PROTECTING THE PROGRAM, RESTORING ITS INTEGRITY, AND ENSURING THAT IT FUNCTIONS AS IT IS INTENDED, PAYING ONLY THE TRULY DISABLED.

BECAUSE THEY ARE THE CLOSEST TO THE PROCESS, THEY CAN BEST IDENTIFY WHAT DOESN'T WORK. WE SHOULD PAY CAREFUL ATTENTION TO THEM, AND I CERTAINLY HOPE THAT COMMISSIONER CHATER STAYS TO HEAR FROM HER EMPLOYEES AFTER SHE TESTIFIES.

FINALLY, SSA IS NOW AN INDEPENDENT AGENCY, EMPOWERED BY CONGRESS TO MANAGE ITS OWN PROGRAMS, FORMULATE ITS OWN POLICY, AND ARGUE FOR ITS OWN RESOURCES WITHOUT UNDUE BUREAUCRATIC INTERFERENCE. CONGRESS WORKED HARD TO BRING ABOUT THIS CHANGE. I SINCERELY HOPE THAT SSA USES ITS NEW STATUS TO MAKE A DIFFERENCE IN THE LIVES OF THE PUBLIC IT SERVES.

Chairman BUNNING. Before I yield to the ranking member, Mr. Jacobs, I would like to remind all the witnesses, with the exception of SSA and GAO, that they will be strictly limited to 5 minutes for their oral testimony. All witnesses are welcome to submit full written statements for the record.

I would like to recognize the ranking minority member, Andy Jacobs, for any comments that he might have.

Mr. JACOBS. Thank you, Mr. Chairman.

My contribution to the quietude and happiness of this gathering is that I pass.

Chairman BUNNING. Thank you.

Now we go to the introduction of our first witness. The first witness will be the Commissioner of Social Security, Shirley Chater. She is accompanied by Susan Daniels, Rita Geier, and Charles Jones. I would like to welcome you all.

Commissioner Chater, if you would proceed.

STATEMENT OF HON. SHIRLEY S. CHATER, PH.D., COMMISSIONER OF SOCIAL SECURITY; ACCOMPANIED BY SUSAN M. DANIELS, PH.D., ASSOCIATE COMMISSIONER FOR DISABILITY; RITA GEIER, DEPUTY ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS; AND CHARLES A. JONES, DIRECTOR, DISABILITY PROCESS REDESIGN TEAM

Ms. CHATER. Good morning and thank you very much for this opportunity to discuss disability program issues with you.

Whenever we talk about the disability program, our starting point has to be the dramatic growth in benefit applications that has taken place in recent years. For example, Social Security received more than 2.6 million initial disability claims in fiscal year 1994. That compares to about 1.7 million in fiscal year 1990, representing a 60-percent increase in applications in just 5 years.

We have done some analysis on the reasons for this growth, and there are a number of key factors that have driven these steady increases in disability applications. These factors include poor economic conditions in the early part of this decade, the growing number of baby boomers who are reaching ages at which they are increasingly disability prone, a rise in the number of women insured for disability benefits, and the disability program changes resulting from legislation, regulations, and various court decisions.

The Social Security Administration cannot control disability application increases that stem primarily from economic and demographic developments, but there are actions that we can take and are in the process of taking to both improve the disability claims process and to control program growth.

These actions include, No. 1, developing a more effective, efficient disability claims process that produces decisions both accurately and promptly. No. 2, ensuring that people who are no longer entitled to disability benefits are not continuing to receive benefits. No. 3, helping more of our beneficiaries, those able to do so, to leave the benefit rolls and return to the work force.

As disability applications have increased in recent years, people who come to Social Security for assistance have felt the impact. While we cannot control the number of applications we receive, we

can and we must develop a more efficient means of processing those claims.

Last October we implemented short-term initiatives aimed at increasing productivity and reducing pending disability claim workloads. Productivity, I am pleased to say, has increased in our Office of Hearings and Appeals and we have seen very positive results in the State Disability Determination Services. Pending workloads in the States have dropped by about 45,000 or 6 percent, and processing times have decreased slightly since the short-term plan was implemented last October.

While we are pleased with this success, we also realize that more dramatic change must take place in order to make the disability claims process more efficient for the long run. The process that we have today cannot adequately handle the workloads we are facing now or will face in the future. It is too slow, it is too expensive, it is too inefficient. It is a process that cannot be fixed by marginal incremental change. It is in need of a total redesign.

Today, for example, as many as 26 different employees are involved in processing an initial disability claim. If the claimant appeals an unfavorable decision and requests a hearing, about 45 people are involved in handling that single case.

So our plan to redesign the disability program is the result of input from SSA employees, from State employees, and the public, as well as expert advice from companies, academic institutions, or advocacy groups and consulting firms with redesign experience.

This redesign plan, which will be fully implemented by the year 2000, is discussed in detail in my written testimony, but let me just say that it will result in a process that is customer friendly and produces decisions more quickly and accurately. A critical part of the plan is extensive use of information technology to provide world-class service to those who come to us for assistance.

This, I should add, will depend on full funding of SSA's automation investment fund, the $88 million in the fiscal year 1995 appropriation, and the $357 million requested for fiscal year 1996.

In the end, we will have a disability claims process that will have only 7 or 8 employees involved, not 26, and our goal is to process claims in about 60 days. On an appealed claim requiring a hearing, we will have 14 employees, not 45, involved, and that case, we hope, will be processed in approximately 165 days.

I would like to say something about CDRs, if I may. To help control program growth, we are committed to increasing the number of continuing disability reviews that the Social Security Administration performs each year. In fiscal year 1995, we expect to process about 271,000 reviews, the largest total in 6 years. We have proposed a budget for fiscal year 1996 that will enable us to process 431,000 reviews. That is a threefold increase in just 2 years.

We have also developed a more efficient review process that will save the Social Security Trust Fund $6 for every $1 spent conducting continuing disability reviews.

We will also be addressing program growth by developing and implementing new employment strategies designed to help individuals with disabilities return to the work force. We have found that most individuals with disabilities have a strong desire to work, and we are intent on helping them do so. I am optimistic that we can

help many of our beneficiaries achieve a more rewarding life while, at the same time, reducing disability program costs.

We are committed to improving the Social Security disability program, and as we make these improvements, Mr. Chairman and members of the subcommittee, we look forward to working closely with Congress, to work together to ensure that we have a program that serves the American people in an efficient and responsive manner.

I would like to answer any questions that you have, but I would also like to tell you who is with me today so that you know their expertise and the positions they hold. To my far right is Rita Geier, who is our Deputy Associate Commissioner for Hearings and Appeals. Dr. Susan Daniels, to my left, is the Associate Commissioner for Disability.

Chuck Jones, to my right, is the director of our Disability Process Redesign Program. He was previously the president of the National Council of Disability Determination Directors. He held that title when he was the Disability Determination Services director for the State of Michigan.

Mr. Jones is coordinating our disability redesign implementation. Dr. Daniels is spearheading the return-to-work initiative that I discussed in my testimony. The disability program at OHA falls under the jurisdiction of Rita Geier.

We will all be pleased to answer your questions.

[The prepared statement, attachments, and supplemental information follow:]

TESTIMONY OF SHIRLEY S. CHATER
COMMISSIONER OF SOCIAL SECURITY

Thank you for inviting me here today to discuss the administration of the disability insurance (DI) program. As you know, this is my first time before this Subcommittee since SSA became an independent agency on March 31, 1995. We are truly entering a new chapter in our history. I would, therefore, like to emphasize today that I am strongly committed to working with the Congress on all issues affecting programs administered by SSA. Working together, I believe we will be successful in providing the public with the quality, integrity, and efficiency of service that they expect and deserve.

You asked me to focus my testimony on the causes and extent of the disability workloads we are facing, the initiatives we have developed to address them, and disability program growth. I am pleased to report that we have made measurable progress in managing our initial disability claims and hearing-level workloads and have substantially increased the number of continuing disability reviews (CDRs) that we conduct. I will be providing more detail about these improvements later in my testimony. I would also like to tell you about one of our initiatives which will assist beneficiaries in re-entering the workforce--our return- to-work strategy. But before I discuss these issues, let me briefly describe the disability program and the people it serves.

OVERVIEW OF THE DISABILITY PROGRAM

The purpose of the DI program, as reflected in Congressional Committee reports in the Social Security amendments of 1956, is to extend Social Security protection for workers and their families due to the loss of earned income when the family provider becomes disabled. To qualify for disability benefits, a worker must meet two basic requirements. That is, a person must have worked a prescribed period of time in employment that is covered under the Social Security program and must be unable to engage in any substantial gainful activity because of a medically-determinable physical or mental impairment. Further, that impairment must be expected to last for at least 12 months, or to result in death.

In fiscal year (FY) 1994, the DI program provided benefits totalling about $37 billion to 5.5 million disabled individuals and their families. These individuals are among our most vulnerable citizens, who, in many cases, depend upon Social Security benefits for their very existence. These facts are important to keep in mind as we examine the DI program.

OVERALL DI PROGRAM GROWTH

Despite the fact that disability requirements are very difficult to meet, the DI program has experienced increased growth in recent years. Growth like this is not a new phenomenon. Historically, the DI program has experienced other surges in growth. During the early and mid-1970s, the number of beneficiaries in the DI program increased dramatically before leveling off in the late 1970s and then declining. Program growth continued to decline until FY 1984 when a steady progression of growth began and continued throughout the remainder of the 1980s. In the early 1990s, the program experienced a sharp increase, and then returned to a steady progression of growth.

Reasons

It is crucial to analyze the reasons for growth in the disability program in order to successfully plan for: (1) our resource needs to deal with future workloads; and (2) policy changes to meet the needs of a potentially changing society. To determine

the causes for the recent growth, SSA, in conjunction with the Department of Health and Human Services, conducted an analysis in 1992 of the DI program and prepared a report which presented some preliminary findings for the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Trust Funds. We were unable to quantify the impact of our preliminary findings, such as unemployment and demographics, on program growth. Therefore, the Board of Trustees recommended that we initiate a research effort to establish whether the growth represents a temporary phenomenon or a longer-term trend.

In response to this recommendation, in 1993 we began major short- and long-term research efforts, including contracting with Lewin-VHI, a highly respected social research analysis firm, to produce an independent assessment which would quantify the reasons for disability program growth.

We know that program growth is driven by both an increase in the number of applications and a decrease in benefit terminations. For example, SSA received more than 2.6 million initial disability applications in FY 1994, compared to about 1.7 million in FY 1990--an increase of more than 60 percent in just 5 years.

Lewin's findings to date confirm the relationship between the increase of applications and program growth. Lewin found that about half of the 40 percent increase in the number of applications between 1988 and 1992 relates to the early 1990s recession, population growth and aging, and increases in the number of women insured for disability benefits. Specifically:

- The number of applications increased in the early 1990s when poor economic conditions prevailed. Lewin found that about 20 percent of total DI application growth related to increases in the unemployment rate between 1988 and 1992. Moreover, Lewin estimated that had the unemployment rate remained the same in 1992 as in 1988, 62,000 fewer applications would have been filed just in 1992.

- Also, Lewin estimated that 15 percent of application growth relates to demographic factors such as the baby boomers entering disability-prone years, and 10 percent relates to the increasing proportion of women who have worked long enough to be insured for DI benefits. We expect these trends to continue.

- Lewin's findings showed that the remaining half of the application growth was related to other factors, such as AIDs, State program cuts and DI program changes resulting from legislation, regulations, and court decisions.

As I already indicated, the other factor affecting DI program growth is disability benefit terminations, or the number of people leaving the disability rolls. Disability benefits are terminated when a beneficiary medically improves, returns to work, dies, or reaches age 65 and transfers to the retirement rolls. The annual percentage of beneficiaries whose disability benefits are terminated has steadily declined. In FY 1990, benefits for about 11 percent of DI workers were terminated. In FY 1994, the figure dropped to about 9.5 percent. This decline is due to:

- increased life expectancy,

- more awards to people with disabling mental impairments who tend to be younger and physically healthier, and

- a lower average age of disability beneficiaries due to the baby boom cohort.

Continuing Disability Reviews (CDRs)

While SSA has little or no control over certain factors affecting the increase in the number of applications, we have a process that can affect the number of beneficiaries who remain on the DI rolls--continuing disability reviews (CDRs). Also, we have a strategy to assist beneficiaries to re-enter the workforce. Let me first briefly provide you with some background on CDRs and bring you up to date with our current actions in this area. Following that, I will explain what we are doing to encourage beneficiaries to seek employment.

The Social Security Act requires SSA to review the continuing eligibility of individuals with non-permanent disabilities at least once every 3 years. This was intended to ensure that individuals remain on the disability rolls only if they continue to be disabled according to the statutory definition.

In the past, as initial claims workloads escalated, difficult decisions had to be made about the prudent use of limited administrative resources. Thus, decisions were made in previous years to give highest priority to processing initial claims and less emphasis was placed on CDRs. Recognizing that we needed to strike a better balance between addressing the growing workloads in initial disability claims and conducting CDRs, we implemented a more efficient CDR process in 1993.

The new CDR process includes a profiling method that helps identify those disability beneficiaries scheduled for CDRs who are most likely to have medically improved as well as those with little likelihood of improvement. Once profiled, those cases identified as likely improvements are sent for a full medical review. Those identified as having little likelihood of improvement are sent a questionnaire asking for updated information about their medical condition, and their responses are reviewed against information in our files. This process allows SSA to identify certain cases for a full medical review based on the beneficiary's response which indicated a greater likelihood of medical improvement than predicted earlier.

The new process which is almost twice as cost effective immediately began to pay dividends. For every dollar invested in administrative expenses (calculated on a lifetime present-value basis), we realize about $6 in program cost savings.

In addition to implementing a new CDR process, we are determined to increase the number of CDRs we conduct. In FY 1995, we expect to process about 271,000 CDRs, the most processed since FY 1989. And, we proposed an FY 1996 budget which would establish, for the first time ever, an earmarked amount for processing CDRs. The $215 million requested will allow us to process 431,100 CDRs--a nearly three-fold increase over the 152,000 reviews processed in FY 1994.

I want to assure you that we are committed to intensifying efforts to ensure that only those people who are eligible for disability benefits receive them. Therefore, as we refine our CDR process, we will continue to employ quality assurance measures to ensure the integrity of the process.

Return-to-Work Strategy

Another key initiative related to program growth that we have undertaken on a priority basis is our return-to-work strategy. The employment strategy is designed to help individuals with disabilities re-enter the workforce. This is a crucial effort since, historically, very few individuals who receive DI benefits ever leave the rolls to return to work.

I have established a proactive strategy team, headed by Dr. Susan Daniels, to develop approaches to increase the employment of current and potential disability beneficiaries. In the near future, we will make decisions about how best to design employment strategies. I am optimistic that we can help many of our beneficiaries achieve a more rewarding life, while at the same time reducing disability program costs.

DISABILITY CLAIMS PROCESS

Let me now turn to another issue you asked me to address, our disability claims workload. To give the discussion of workloads context, I want to briefly describe how disability claims are handled today.

Initial disability claims are taken in Social Security offices located throughout the country. Local field office staff request and evaluate information about the non-medical aspects of each person's claim, such as whether or not the individual has worked enough to qualify for benefits. Field office staff also obtain information about claimants' impairments, including treating medical sources. Claims are then forwarded to the federally-funded, but State-administered, disability determination services (DDSs), in the State where the person lives. State DDS staff obtain and review necessary medical evidence and make the disability determinations based on Social Security regulations and guidelines. This process has been in effect since the beginning of the disability program and was designed to take advantage of the States' established links with the medical community and experience in dealing with the needs of the disabled in State programs.

Individuals dissatisfied with their disability decision may request a reconsideration which is reviewed at the State DDS. If the reconsideration is denied, individuals may request a hearing before an administrative law judge. And, if still dissatisfied, individuals may request an Appeals Council review. Each level of review involves multi-step procedures for evidence collection, review, and decisionmaking.

The current disability process is very lengthy and time consuming. One of the main reasons why it takes so long is that many employees handle each claim. As many as 26 employees are now involved in processing an initial disability claim, and about 45 employees are involved in processing an appeal in which the claimant has requested a hearing before an administrative law judge (ALJ). This process, combined with the increase in initial disability applications in recent years, has had a tremendous effect on our initial disability workloads.

We have also experienced particularly high increases in the number of requests for hearings filed over the last several years. This increase is not surprising, however, considering that in FY 1994 we processed one million more initial disability claims than in FY 1990. Let me explain. Accelerating the number of initial disability claims processed has a direct impact on workloads at the hearing level. That is because many beneficiaries who receive an adverse determination appeal their decision. Thus, the more initial claims processed, the more denied and the more appealed.

I am pleased to report that in FY 1994 we were able to process 40 percent more hearing cases compared to FY 1990. This improvement was accomplished with a 44 percent increase in the use of overtime and the hiring of about 200 additional ALJs in FY 1994. Even so, we have not been able to keep up with the increase in requests for hearings. Workloads increased 34 percent in FY 1994 and processing time averaged 337 days compared to 263 days in FY 1993.

SOLVING THE WORKLOAD PROBLEM

The enormous challenges facing the disability program in the form of unprecedented workloads combined with staffing reductions required that we take immediate action. We responded to the upward trends in disability workloads with two important initiatives--a Short-Term Disability Project and a redesign of the disability process (which should be fully implemented by the year 2000).

While the primary objective in the disability redesign effort is to improve the entire disability process, the goal of the Short-Term plan is to significantly reduce the number of pending claims by December 1996 in a way that will support the long-term redesigned disability process. In addition, quality assurance principles are built into these initiatives.

Short-Term Disability Project

The Short-Term initiatives will reduce the number of claims pending in the State disability determination services (DDSs). As part of the initiative, we are providing additional funds to DDSs to increase their case processing capacity, and we are redirecting headquarters staff to assist in processing workloads.

We have already seen positive results in the State DDSs' pending workloads from our Short-Term initiatives. Pending workloads have dropped by about 45,000, or 6 percent, and processing time has decreased slightly since the Short-Term plan was implemented last October. These results are encouraging.

With regard to pending hearing-level workloads, while the numbers have increased, we have not fully implemented the most significant actions. We believe we will begin to see a decline in pending cases before the end of the year. These actions include:

- expanding the prehearing conference procedures to ensure claimants' files are complete; and

- granting temporary authority to experienced staff attorneys and paralegal specialists to make allowances in certain prehearing cases.

It is important to understand that these initiatives preserve the key principles and parameters of our adjudicative process--the decisional independence of ALJs and the rights of claimants to a hearing. They also preserve the exclusive role of ALJs to hear and decide cases rather than burdening them with matters that do not require their expertise.

Redesign of the Disability Claims Process

This brings me to a discussion of our long-term effort to improve the disability claims process--the disability redesign. Many of SSA's procedures for processing disability claims are based, in large part, on procedures begun 40 years ago. Our customers view the disability process as bureaucratic and unresponsive to their needs. And, our escalating workloads have made it difficult for SSA to provide a satisfactory level of service to claimants who file for disability benefits. As you know, one of our goals is for Social Security to become a world-class service provider, and considering the many challenges facing the DI program, we determined that our first efforts to achieve this goal would address the disability determination process.

Moreover, it was clear even before I arrived at SSA that the current system was not working and that incremental change would not fix it. I doubt that anyone involved with the current process, and who has observed the avalanche of work flooding into field offices, the State DDS, and the Office of Hearings and Appeals believe that tinkering at the edges will permit us to give the American public the service they deserve.

The primary objectives of this new redesign effort include making:

- the process "user friendly." Claimants will be able to choose their mode of access to SSA--in person, mail, phone, computer, through third parties, etc.;

- the right decision the first time. Two examples of changes that support more accurate decisions are enhanced quality assurance and simplified decision methodology;

- a decision as quickly as possible. The redesign creates additional opportunities for face-to-face interviews with the claimant. In addition, disability claims' documentation will be greatly improved; and

- work satisfying for employees. Teamwork and workforce empowerment are fundamental ingredients in the new redesign process.

The success of the redesigned process will be measured against these overall objectives and, of course, emphasis will be continually placed on overall measurement from the customer's perspective.

Our redesign plan is the result of a rigorous, high-level investigation of the reengineering efforts of companies, public organizations, academic institutions, and consulting firms with the most hands-on experience in reengineering. We also facilitated open communications with various unions representing both SSA employees and State DDS employees and various management associations recognized as having an interest in disability issues.

The redesign of SSA's disability process is a long-term initiative with a project life expected to run beyond the turn of the century. Nevertheless, we are moving quickly to implement those aspects of the new process that can be implemented in the near-term, including major changes in the way claimants access our process and the way we process initial claims and requests for a hearing. More specifically we are:

- Enhancing public information. Comprehensive disability information will be available to claimants, medical providers, and appropriate organizations, with particular emphasis on claimant participation in securing medical evidence;

- Training disability adjudicators on critical areas. We are preparing training materials for adjudicators on: the evaluation of pain, residual functional assessment, and weight given to treating source evidence; and

- Developing an adjudication officer position. The adjudication officer would conduct pre-hearing conferences to narrow the issues of a case and, if the evidence warrants, issue favorable decisions based on the record.

I would like to emphasize that any regulation-based change in the process will be tested and reevaluated before fully implemented.

In addition, information technology will be a vital element in the new disability claim process. The new process relies heavily on fully funding of SSA's automation investiment fund--the $88 million enacted in the FY 1995 appropriation and the $357 million requested for FY 1996. Automation is necessary so that electronic files that can be accessed from any SSA office. Accordingly, SSA will take advantage of the "Information Highway" and those technological advances that can improve the disability process and help provide world-class service. When fully implemented, we expect that the number of employees handling an initial disability claim will be reduced from as many as 26 to 8 employees and from as many as 45 to up to 14 employees at the hearing-level. Also, initial disability claims processing time will be reduced to about 60 days for initial decisions and to 225 days for decisions at the hearings level.

The new disability process represents a change in the lives of most of our employees. This has created a great deal of anxiety. Our employees are concerned because there will be major changes in the way in which they will work, and there is potential for relocations. While maintaining a focus on improving customer service, we will also be attentive to the concerns of our employees.

CONCLUSION

Although our progress to date is encouraging, we are by no means satisfied. The effort to make the disability program work better for Americans will require our dedicated effort and long-term commitment.

Therefore, in closing, let me summarize our approach to dealing with our disability workloads.

- First, we are totally redesigning a process that is not working well--our new process will be completed by the year 2000;

- Second, we are taking steps in the short-term to significantly reduce pending levels and processing times;

- Third, next year we are almost tripling the number of continuing disability reviews we will conduct; and

- Finally, we will continue to find ways to improve the process by focusing on our customers' needs. The public deserves a thorough, timely, responsive process, and we will deliver it.

We look forward to working closely with Congress as we move forward in implementing the disability redesign that will bring us much closer to providing world-class service to disability claimants.

SOCIAL SECURITY

Office of the Commissioner

JUL 18 1995

The Honorable Jim Bunning
Chair, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Bunning:

As requested in your letter dated June 27, 1995, we are providing answers to questions for the record that relate to the hearing before your Subcommittee on May 23-24, 1995.

In response to your concerns about the ongoing relationship between the Social Security Administration (SSA) and the General Accounting Office (GAO), as has always been the case, SSA will continue to cooperate with GAO and will provide statistics and other information requested in connection with their audit of SSA management of the disability program. We have a good working relationship with GAO which we intend to maintain.

You asked about SSA's response to proposals to involve third parties in the disability insurance (DI) claim process. SSA's Plan for a New Disability Claim Process stresses the importance of involving third-party organizations in that process. The Allsup proposal you referred to represents one potential way of achieving the goal of increased third-party involvement. However, SSA cannot simply implement the proposal. All federal agencies must follow the procedures of the Federal Acquisition Regulation for awarding contracts by other than full and open competition. We are still evaluating the substantive aspects of the proposal and, once we have completed this evaluation, we will notify Allsup. We have some concerns about entering into agreements with any entity where the proposal has not been subjected to the competitive bidding process.

In your letter, you also inquired about the status of proposals to consolidate our Regional Office operations. As you know, Regional Office consolidation--from ten to five offices--was approved under Phase II of the Administration's Reinventing Government (REGO II) initiative. We commissioned a small workgroup of senior career managers, representing all regional components of the independent SSA, to examine this proposal and to develop options that would provide optimal service to our customers, while carefully considering the impact on our employees.

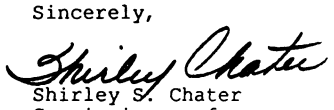
In developing their options, we asked the workgroup to consider:

- Cost savings,
- Geographical balance,
- Workloads,
- Demographic patterns and projections,
- Transportation access,
- Impact on employees,
- Facility of communications,
- Interaction with other Federal agencies and the Federal Court system,
- Impact on Customers, and
- Consideration of State relation issues.

The workgroup is currently finalizing its report, and will be presenting recommendations to me in the near future. After careful consideration of the factors, I will make my decision and inform you expeditiously.

Our responses to your nine questions are enclosed.

Sincerely,



Shirley S. Chater
Commissioner of
Social Security

Enclosures

QUESTION 1

Please provide annual estimates of the amounts that will be reallocated to the disability insurance (DI) trust fund from 1994 through expected exhaustion of the fund in 2016 as the result of enactment of H.R. 4278, the Social Security Domestic Employment Reform Act (P.L. 103-387). In addition, please provide this information in chart form, expanding on table II.F10 (Operations of the DI Trust Funds) and table II.F12 (Operations of the Old Age and Survivors Insurance (OASI) and DI Trust Funds) of the 1995 Trustees' Report.

Response

According to SSA's Chief Actuary, about $499 billion will be reallocated from the OASI to the DI trust fund from 1994 through 2016 as a result of the tax reallocation enacted in P.L. 103-387.

Historically, reallocation of rates has been used on occasion to alleviate temporary funding problems encountered by the trust funds. The 1977 Amendments reallocated money from OASI to DI to help resolve temporary financing problems encountered by DI in the late 1970s. Conversely, funds were reallocated from DI to OASI in 1980 and 1983 to help avoid depletion of the OASI trust fund. Had the funding for the DI program in the 1977 amendments been retained, the DI trust fund today would actually have an actuarial surplus over the next 75 years.

Additional information is provided in the attached tables.

(Note: Because of slightly different interest payments that result from reallocating funds from one trust fund to another, the combined OASDI assets are slightly different from those shown in the 1995 Trustees Report.)

Attachments

Estimated Social Security Taxes
Reallocated from the OASI Trust Fund to the DI Trust Fund
As a Result of the Enactment of P.L. 103-387
(In Billions)

Calendar Year	Reallocated Taxes
1994	$18.0
1995	20.1
1996	21.0
1997	16.5
1998	17.0
1999	17.8
2000	14.5
2001	15.0
2002	15.8
2003	16.7
2004	17.6
2005	18.7
2006	19.8
2007	20.9
2008	22.1
2009	23.4
2010	24.7
2011	26.1
2012	27.5
2013	29.0
2014	30.6
2015	32.2
2016	34.0
Total 1994-2016	$499

Social Security Administration
Office of the Actuary
July 17, 1995

OASI AND DI TRUST FUNDS COMBINED

Date: 07-12-95 || OASDI || Undoing the DI Tax Reallocation
Catalog #95-143T || TRUST FUND ||
Table 8.1 || OPERATIONS ||
1995TR ALT 2 || (Millions) ||

Year	Advance Transfr	Assets (BOY)	TFR	Payroll Taxes	Tax Ben (.0490)	INCOME Excludng Interest	Interest	TOTAL INCOME	Benefit Payments	Admin Expense	RRB Intrchg	TOTAL OUTGO	Assets (EOY)
1994	0	378285	117	344695	5306	350008	31047	381055	316812	2674	3526	323011	436329
1995	0	436329	128	364160	5260	369425	35990	405415	333262	3080	3716	340057	501687
1996	0	501687	140	384838	6823	391664	40957	432621	350337	3436	3745	357518	576790
1997	0	576790	153	403404	7288	410694	46596	457291	368761	3467	3757	375985	658095
1998	0	658095	166	422550	7816	430368	52571	482939	388383	3421	3841	395645	745390
1999	0	745390	179	442339	8386	450726	58625	509351	409638	3509	3913	417059	837682
2000	0	837682	190	464686	9027	473713	64947	538660	432817	3636	4004	440458	935884
2001	0	935884	201	489411	9711	499123	71585	570708	457613	3782	4079	465474	1041119
2002	0	1041119	211	516025	10460	526485	78530	605015	484661	3940	4208	492809	1153325
2003	0	1153325	221	544828	11273	556101	85701	641802	513830	4110	4326	522266	1272861
2004	0	1272861	230	575559	12151	587709	92994	680703	545039	4291	4444	553774	1399791
2005	0	1399791	238	609241	13240	622480	99807	722287	578097	4544	4609	587250	1534828
2006	0	1534828	247	645116	14383	659498	106750	766249	612758	4805	4774	622337	1678740
2007	0	1678740	254	682600	15596	698196	113769	811965	650051	5075	4930	660065	1830640
2008	0	1830640	261	721500	16924	738424	120687	859111	691727	5369	5103	702200	1987551
2009	0	1987551	265	762785	18402	781187	127276	908462	738697	5686	5268	749651	2146362
2010	0	2146362	268	806049	19991	826040	137158	963198	789525	6003	5322	800850	2308710
2011	0	2308710	270	851519	21702	873220	147187	1020408	844838	6344	5381	856564	2472554
2012	0	2472554	269	898277	23581	921858	157155	1079013	906061	6708	5446	918216	2633351
2013	0	2633351	267	946990	25627	972617	166799	1139417	973054	7080	5519	985654	2787113
2014	0	2787113	263	998017	27846	1025863	175867	1201729	1046109	7465	5599	1059174	2929669
2015	0	2929669	257	1051719	31180	1082899	184110	1267009	1125835	7881	5686	1139403	3057276
2016	0	3057276	249	1108111	34835	1142946	191258	1334204	1212528	8321	5770	1226619	3164860

BOY - Beginning of Year
TFR - Trust Fund Ratio (In Percent)
Tax Ben - Taxation of Benefits
Admin Expense - Administrative Expenses
RRB Interchg - Railroad Retirement Board Interchange
EOY - End of Year

DI TRUST FUNDS

Date: 07-12-95 || DI || Undoing the DI Tax Reallocation
Catalog #95-143T || TRUST FUND ||
Table 8.5 || OPERATIONS ||
1995TR ALT 2 || (Millions) ||

Year	Advance Transfr	Assets (BOY)	TFR	Payroll Taxes	Tax Ben (.0193)	INCOME Excludng Interest	Interest	TOTAL INCOME	Benefit Payments	Admin Expense	RRB Intrchg	TOTAL OUTGO	Assets (EOY)
1994	0	8963	23	33351	311	33663	533	34196	37744	1029	106	38879	4280
1995	0	4280	10	35200	297	35497	58	35555	41557	1109	47	42713	-2878
1996	0	-2878	-6	37300	370	37670	-581	37089	45114	1223	113	46450	-12239
1997	0	-12239	-24	39063	408	39471	-1382	38089	48806	1249	127	50182	-24333
1998	0	-24333	-45	40912	449	41361	-2375	38986	52693	1268	136	54098	-39445
1999	0	-39445	-67	42822	496	43318	-3583	39735	57088	1329	147	58563	-58273
2000	0	-58273	-92	52757	547	53304	-4755	48549	61745	1403	157	63306	-73030
2001	0	-73030	-107	56062	604	56666	-5849	50816	66725	1486	146	68358	-90571
2002	0	-90571	-123	59110	666	59776	-7151	52625	72123	1577	155	73855	-111801
2003	0	-111801	-140	62398	736	63134	-8676	54458	78136	1674	170	79981	-137325
2004	0	-137325	-158	65924	814	66738	-10437	56300	84790	1779	186	86756	-167780
2005	0	-167780	-179	69768	897	70664	-12474	58191	91801	1911	153	93864	-203454
2006	0	-203454	-201	73876	986	74862	-14793	60069	99293	2045	119	101458	-244842
2007	0	-244842	-224	78169	1081	79249	-17411	61838	107256	2182	86	109523	-292527
2008	0	-292527	-248	82623	1180	83803	-20346	63457	115683	2321	52	118056	-347126
2009	0	-347126	-273	87351	1283	88635	-23606	65029	124500	2460	19	126978	-409076
2010	0	-409076	-301	92306	1384	93690	-27702	65987	133228	2589	14	135831	-478919
2011	0	-478919	-330	97513	1486	98998	-32303	66695	142174	2727	9	144910	-557133
2012	0	-557133	-360	102867	1594	104461	-37456	67005	151782	2871	3	154656	-644785
2013	0	-644785	-392	108446	1699	110145	-43205	66940	161388	3002	-4	164387	-742231
2014	0	-742231	-427	114289	1797	116087	-49555	66532	170539	3125	-10	173653	-849352
2015	0	-849352	-462	120439	1978	122417	-56539	65878	180500	3260	-18	183743	-967217
2016	0	-967217	-497	126897	2175	129071	-64226	64845	191253	3399	-25	194628	-1097000

BOY - Beginning of Year
TFR - Trust Fund Ratio (In Percent)
Tax Ben - Taxation of Benefits
Admin Expense - Administrative Expenses
RRB Interchg - Railroad Retirement Board Interchange
EOY - End of Year

OASI TRUST FUNDS

Date: 07-12-95 || OASI
Catalog #95-143T || TRUST FUND
Table 8.3 || OPERATIONS
1995TR ALT 2 || (Millions)

|| Undoing the DI Tax Reallocation

Year	Advance Transfr	Assets (BOY)	TFR	Payroll Taxes	Tax Ben (.0533)	INCOME Excludng Interest	Interest	TOTAL INCOME	Benefit Payments	Admin Expense	RRB Intrchg	TOTAL OUTGO	Assets (EOY)
1994	0	369322	130	311344	4995	316345	30514	346859	279068	1645	3420	284133	432049
1995	0	432049	145	328960	4963	333928	35932	369860	291705	1971	3669	297344	504565
1996	0	504565	162	347538	6453	353994	41538	395533	305223	2213	3632	311068	589029
1997	0	589029	181	364341	6800	371224	47979	419202	319955	2218	3630	325803	682428
1998	0	682428	200	381638	7367	389007	54947	443954	335690	2152	3704	341547	784835
1999	0	784835	219	399517	7890	407408	62208	469616	352550	2180	3766	358496	895955
2000	0	895955	238	411929	8479	420409	69702	490111	371072	2233	3847	377152	1008914
2001	0	1008914	254	433349	9108	442457	77435	519892	390888	2296	3932	397116	1131690
2002	0	1131690	270	456915	9794	466709	85680	552390	412538	2364	4052	418954	1265126
2003	0	1265126	286	482430	10537	492967	94377	587344	435693	2436	4156	442285	1410186
2004	0	1410186	302	509635	11337	520972	103431	624403	460248	2512	4258	467018	1567571
2005	0	1567571	318	539473	12343	551816	112280	664096	486296	2634	4456	493386	1738281
2006	0	1738281	334	571239	13397	584637	121543	706180	513465	2760	4655	520879	1923582
2007	0	1923582	349	604431	14515	618946	131180	750127	542796	2893	4853	550541	2123167
2008	0	2123167	363	638877	15744	654621	141033	795654	576045	3048	5051	584144	2334677
2009	0	2334677	375	675434	17118	692552	150881	843434	614197	3227	5249	622673	2555438
2010	0	2555438	384	713744	18607	732350	164860	897210	656298	3415	5307	665019	2787629
2011	0	2787629	392	754006	20216	774222	179490	953712	702664	3618	5372	711654	3029687
2012	0	3029687	397	795409	21988	817397	194611	1012008	754279	3837	5444	763560	3278135
2013	0	3278135	399	838544	23928	862472	210004	1072476	811666	4078	5523	821267	3529344
2014	0	3529344	399	883728	26048	909776	225421	1135197	875571	4340	5610	885521	3779021
2015	0	3779021	395	931280	29201	960482	240649	1201131	945335	4621	5704	955659	4024493
2016	0	4024493	390	981215	32660	1013875	255484	1269359	1021275	4922	5795	1031992	4261860

BOY - Beginning of Year
TFR - Trust Fund Ratio (In Percent)
Tax Ben - Taxation of Benefits
Admin Expense - Administrative Expenses
RRB Interchg - Railroad Retirement Board Interchange
EOY - End of Year

QUESTION 2

SSA faces huge backlogs in processing both new disability claims and cases awaiting continuing disability reviews. What are your views regarding competitively contracting out, as a temporary or demonstration measure, some parts of the backlog -- either to top-performing States, or to private firms? In your opinion, do certain workloads more easily lend themselves to "contracting out?" In your opinion, are certain approaches preferable to others? In your opinion, what specific safeguards are important if "contracting out" were tried?

Response

As part of its Reinventing Government Phase II (REGO II) package, SSA would give the States, working in cooperation with their unions, the opportunity to develop and implement plans to raise the performance levels, within a relatively short period of time, of the lower performing DDSs, and to narrow the gap between the highest and lowest performing States. If this does not produce the desired results, SSA will explore a contracting out option either to higher performing States or private firms.

Factors that must be considered when contracting out to private firms include:

- private contractor access to disability rolls information;
- time needed to get contracts planned, awarded, operational, and periodically recompeted; and
- disruption of claims processing during the changeover periods.

Conversion to competitive contracts for any or all of the disability adjudication process could be beneficial by:

- introducing competitive bidding into the initial disability process which would allow SSA to choose the best performers to meet workload demands and possibly cost less; and
- offering monetary resources of scale and eliminating State level administrative issues such as hiring freezes.

It should be noted that parts of the disability workload, short of the disability determination can be and are being contracted out. For example, many States contract out for some services, such as medical consultants, clerical support, and transcription services, when contracting is cost-effective within the State's administrative structure. SSA encourages States to employ the most effective and efficient methods available in performing the disability determination function, including contracting out parts of the process when it makes sense to do so.

QUESTION 3

In your view, is the disability program more appropriately based on objective medical findings -- the basis for the decisions the DDSs currently make -- or more subjective legal findings -- the basis for the decisions the ALJs make?

Witnesses testified that the accuracy rate of DDS decisions is 97 percent. Yet about 70 percent of these denials are reversed by the ALJs. What is your interpretation of this?

Don't you think that this discrepancy undermines the public's confidence in the integrity of the program to pay only the truly disabled?

In your view, how should this difference in methods be resolved? Does SSA have the authority to resolve this difference, or does it require legislation?

Response

The disability program is based on a balance of both medical and legal findings. Disability decisions at all levels of adjudication require the presence of a medically determinable impairment and must adhere to the definition of disability in the law.

Many factors influence the fact that administrative law judges (ALJs) allow a substantial percentage of claims for disability benefits at the hearing level, including the following:

- ALJ allowances are often made based on additional evidence and new information that was not available to the DDSs.
- At the hearing level, a large percentage of claimants are represented by an attorney or other individual.
- Some cases were denied by the DDSs based on expected improvement in the claimant's condition, but improvement did not occur.
- A change in the claimant's functional capacity or vocational skills may justify changing a denial to an allowance at the ALJ level.
- The ALJ hearing is generally the first step in the adjudication process in which claimants may appear in person before the decisionmaker to explain their impairments and present witnesses who can attest to the effects of their impairments.

SSA's initiative to redesign the disability process will focus on these and other influences in an attempt to unify the process. We will evaluate various remedies including legislative and regulatory remedies.

QUESTION 4

SSA now has 10 years experience with the medical improvement standard. Is it working? Do we need to revisit this standard in the law?

Response

The medical improvement review standard in the 1984 Disability Amendments provided, for the first time in statute, a specific standard that must be met before a disability beneficiary can be found no longer disabled. The standard represented a response to broad-based concerns that the continuing disability review requirements of the 1980 Amendments resulted in hardships to beneficiaries whose benefits were terminated even though their conditions may have been unchanged from the time they were awarded benefits. The standard was also intended to avoid unnecessary program expenditures by assuring that benefits could be terminated when such action is warranted.

We believe that SSA has implemented this provision of law in accord with congressional intent.

QUESTION 5

According to testimony, in a substantial number of CDR cases originally awarded by ALJs, it is difficult to determine that medical improvement has occurred because medical evidence in the original file is insufficient to establish a "baseline" of disability. In what percentage of CDR cases is medical improvement not found simply because of insufficient medical documentation in the original decision?

Response

In fiscal years 1994 and 1995 to date, SSA's quality assurance samples included 8,727 continuing disability review (CDR) continuances. Only 44 (0.5 percent) of those cases were found deficient for the reason that the most recent prior favorable determination was insufficient to determine medical improvement.

QUESTION 6

Do you favor legislation to close the disability claim record, and if so, at what point in the process?

Response

SSA is examining the issue of closing the record in the context of redesigning the disability claim process.

QUESTION 7

Your long-term disability redesign doesn't seem to take human nature into consideration. SSA employees are very service-oriented and try to help people. It's only human to feel sorry for people who are out of work and in need. Why do you think that the disability claims manager will be able to avoid the natural bias in favor of applicants, especially when the disability claims manager will have to personally deal with irate applicants whose claims he or she has denied? Won't there ultimately be a tendency on the part of claims managers to allow borderline cases to avoid the draining and unpleasant task of giving bad news to people? Won't allowance rates inevitably go up as a result?

Response

SSA has a long history of dealing with claimants who are in need of immediate, compassionate, and equitable assistance. While it is true that our employees are service-oriented, they are also professionals who recognize that they are charged with implementing the Social Security law. SSA staff are trained to secure and evaluate necessary evidence and have perfected these skills with years of adjudicative experience. In addition, they have long experience making determinations on the nondisability aspects of disability claims including denials for excess income and resources in SSI claims and denials for lack of insured status in Social Security disability insurance claims.

We will be taking measures to address employee and claimant security as we increase our use of face-to-face contact in the disability process. In addition, our plan to conduct systematic quality reviews of disability decisions as part of ongoing stewardship of the program will continue to ensure accuracy and consistency.

QUESTION 8

Please explain in detail why you believe that allowing non-physicians to allow some cases without physician review will not increase the allowance rate? Have you sought the views of the AMA, APA, or any professional medical association regarding this proposal? What have they advised?

Response

SSA's Plan for a New Disability Process calls for a modified use of medical consultants, in that disability claims managers would be authorized to adjudicate cases as a "single decisionmaker" without the traditional decisionmaking team that requires physician review. Medical consultants would provide expert advice and opinion on questions and issues in difficult cases, allowing for a more focused use of SSA's resources.

Permitting non-physicians to make disability decisions should not in itself directly affect the allowance rate, since each decision must comply with the statutory definition of disability.

In general, professional, medical, and psychological groups have expressed some concern about the changing role of medical consultants in disability determinations. We believe that many of their concerns will be addressed by a full understanding of our redesign plan, a plan that does not eliminate medical consultants' input, but rather more effectively utilizes their expertise at all levels of adjudication.

QUESTION 9

There have been a number of studies of levels of disability within the general population. What is your best estimate of the number of individuals who meet SSA's medical definition of disability, but do not receive disability benefits because they are working at substantial gainful levels in spite of severe impairments?

Response

Because of the imprecision of available data, we are unable to provide an exact answer to this question. Most currently available information on disability in the general population is based on unverified self-reporting, or reports by family members. These reports indicate levels of disability that vary considerably and appear to be substantially affected by questionnaire content and survey procedures.

Estimates of the proportion of the general working-age population that have a work-limiting disability vary roughly in the range of 8 to 16 percent. Reported numbers with "severe" disabilities that are more likely to conform to SSA's medical criteria display similar variation. Therefore, available data can produce conflicting estimates of the size of the disabled population that differ by several million.

Other factors also need to be considered, such as the fact that even though people may be severely disabled, they may not meet the insured status requirement for disability insurance benefits and/or the income and resources tests for supplemental security income benefits.

A final methodological problem is that persons who work in spite of severe impairments are likely to downplay the severity of their disabilities, while those who are not working may exaggerate their limitations.

In order to obtain reliable data, SSA is designing a Disability Evaluation Study that will combine self-reported health and impairment data with objective medical, vocational, and functional measures. The results of the study should provide reliable answers to this and other important policy-relevant questions about the disabled population and how they are served by SSA's programs.

Mr. Chairman and Members of the Subcommittee:

I am submitting this statement for the record as a supplement to my testimony of May 23, 1995, to further address your concerns about the Social Security disability insurance (DI) program. You stated in the press release announcing this hearing that you are committed to fairness in the disability program, enabling those who are truly disabled to receive benefits quickly, and stopping payments to those who have recovered (i.e., are no longer disabled). Let me state at the outset that we absolutely share your commitment. In addition, we are committed to seeing that Social Security DI and Supplemental Security Income (SSI) disability beneficiaries have full access to a positive, quality vocational rehabilitation program to assist them to enter productive employment.

The issues associated with the disability programs we administer are very difficult and complex and have been ongoing for many years. There are no easy fixes. Nevertheless, we agree that we can do a better job in these areas. Let me assure you that solving any problems associated with the disability programs is a top priority. At SSA, we are dedicated to making essential improvements in the disability programs so that they work better for all Americans.

As I indicated in my testimony earlier this year, we have been focusing our improvements in three specific areas that we believe will help us achieve major improvements in the disability programs. First, we are redesigning the disability claims process from start to finish. The current lengthy and complicated decision-making process is broken and needs fixing. Second, we are continuing to seek improvement in the way we conduct continuing disability reviews (CDRs) and greater funding to finance CDRs. And third, we are developing approaches to increase the employment opportunities of current and potential disability beneficiaries. Let me begin with the disability redesign.

SSA's Disability Process Redesign

When I spoke before you in May, I explained that our redesign plan included both short-and long-term initiatives. I mentioned that although our short-term initiatives were designed to reduce the number of claims pending in the State Disability Determination Services (DDSs) and the Office of Hearings and Appeals (OHA), we had not fully implemented the most significant actions in OHA. Consequently, pending hearing-level workloads in OHA had increased. On the other hand, DDSs' pending workloads had dropped by about 45,000 claims (6 percent) as a direct result of our short-term initiatives. Since then, DDSs have continued to reduce the number of pending claims by about 53,000, for an overall decrease of 13 percent. This is a very significant improvement. We are well on our way to our FY 1996 goal of 304,000 pending claims, down from 552,000 at the end of FY 1994.

Since May, we have focused our efforts on OHA and the most significant actions in our short-term initiative plan are now underway. On June 30, 1995, we published a final regulation which granted temporary authority to attorney advisors at OHA to conduct pre-hearing proceedings and, where the evidence warrants, to issue wholly favorable decisions. When this initiative is fully implemented, it will assist us in further substantially reducing the number of requests for hearings that are pending. In addition to ensuring more effective use of automation at OHA, we have increased our pre-hearing screening of cases and temporarily redirected resources from other agency components to draft disability decisions at OHA.

Despite the fact that the number of pending hearings is significantly higher now than at the beginning of the fiscal year, we have begun to reduce the numbers of cases pending at OHA. For the two week period ending August 3, 1995, pendings were

decreased by 4,057 cases. While these results are somewhat small, this is a very significant step in the right direction.

With respect to our long-term initiatives, I stated that we were moving quickly to implement those aspects of the new disability process that could be achieved in the near-term. I specifically mentioned that we would be increasing public awareness of the requirements for disability benefits by providing comprehensive public information, training our disability adjudicators on critical areas, and developing an Adjudication Officer position to conduct pre-hearing conferences. We are currently reviewing comments on the notice of proposed rulemaking we published in the Federal Register on June 9, 1995, to authorize testing of the Adjudication Officer position, and we expect to publish a final regulation authorizing this testing in the near future.

Further, on June 29, 1995, I approved a series of disability process improvements that will begin to move SSA closer to its five-year plan to fully implement the redesigned disability process. These improvements will begin this fall and should significantly enhance the overall disability process. They include:

- More uniform policy guidance and training for all disability adjudicators and reviewers;
- Intercomponent claims representative/disability examiner baseline teaming;
- Enhanced consumer-oriented public information;
- Increased third-party monitoring and assistance; and
- The adoption of quality assurance guiding principles tailored to our new processes.

Once complete, we believe that our disability process redesign initiatives will assure swift, efficient decisionmaking and processing on a continuing basis.

Continuing Disability Reviews

Let me now address the status of our efforts to improve the CDR process. During my last appearance before this subcommittee, I explained that the CDR process directly affects the number of beneficiaries who remain on the DI rolls because this process allows us to terminate disability benefits to those who are no longer disabled. I also explained how unprecedented increases in initial disability claims workloads required previous Commissioners to make difficult decisions on the prudent use of limited resources, one of which was to place less emphasis on CDRs.

However, recognizing the need to strike a better balance between addressing the growing workloads in initial disability claims and conducting CDRs, we implemented a more efficient CDR process in 1993. I elaborated on this new CDR process and our expectations of increasing the number of CDRs we process.

We are continuing to evaluate and improve our CDR process, including the development of a machine-readable CDR mailer questionnaire which will enable us to electronically screen CDRs and store the data for analysis. In addition, we are also responding to a General Accounting Office audit to determine:

- The characteristics of beneficiaries in the pending caseloads in order to more accurately profile these beneficiaries and predict medical improvement;

- What SSA and DDS resources would be necessary to eliminate the current CDR workload over the next few years; and

- What effect this might have on our initial and appeals workloads.

We are determined that disability program dollars should be going only to those who are truly entitled.

SSA's Vocational Rehabilitation Program

I would now like to discuss the issue of vocational rehabilitation (VR). At the May 23, 1995 hearing, I very briefly explained SSA's return-to-work strategy to assist individuals with disabilities re-enter the work force. We are very concerned that, despite the fact that numerous studies show that people with disabilities want to work, SSA's current VR process is not as effective as it could be. Very few disabled beneficiaries have returned to work at the substantial gainful activity level and left the beneficiary rolls as a direct result of our VR program. Because this is a complex issue, let me now provide you with an overview of the history of the VR program, describe our current VR process, and also tell you about some steps we are taking to improve the VR program and increase the number of beneficiaries who leave the rolls and return to work.

History of the VR Program

As you know, the primary public VR program was established in 1920 and is now authorized by the Rehabilitation Act of 1973, as amended. The Rehabilitation Services Administration, which is part of the Department of Education, administers the program as a partnership between the Federal Government and the States--80 percent of the funds come from Federal appropriations and 20 percent from State appropriations. When Congress established the Social Security disability program in 1956, it expressed great confidence in the value of VR for people with disabilities by including a provision that provided for the referral of disability applicants to State VR Agencies.

Current VR Process

People who apply for disability benefits are provided information about the availability of services from their State VR agency. When their claim goes to the State DDS for adjudication, a DDS examiner (or a State VR agency counselor) screens the cases to identify persons who may benefit from VR and then refers these individuals to State VR agencies. (I should point out that SSA's referral process is but one route to receiving VR services. Many disability applicants and beneficiaries, on their own initiative or at the advice of their doctors, employers, or other interested third-parties, seek out services from State VR agencies.)

Once the referral is made, neither SSA staff nor State DDS examiners are involved in deciding who receives services or what services are provided. These decisions are made in light of regulations and policies set forth by the Department of Education's Rehabilitation Services Administration and the State VR agency's own guidelines. If the individual is eligible for services, which could include diagnostic services, counseling, medical services or training, the VR agency counselor and client jointly work out a plan or program of rehabilitation. According to the Rehabilitation Services Administration, many State VR agencies are unable to meet the current demand for services.

Under current law, SSA pays for VR services only when these services result in a successful outcome, i.e., when the beneficiary performs substantial gainful activity for a continuous period of nine months and SSA determines that the VR services contributed to the return of the individual to such activity. In FY 1994, SSA reimbursed State VR agencies $63.4 million for successfully rehabilitating about 5,600 beneficiaries. Since 1983, when the current VR payment program began, just over 55,000 beneficiaries have been rehabilitated and employed through this program.

Steps Taken to Improve the Current VR process

We are concerned about the effectiveness of the current VR process and have taken several steps to increase the number of beneficiaries who are served by State VR agencies and to increase the participation of private sector rehabilitation providers in the process. For example, SSA has been implementing the recommendations of a Federal-State task force to improve the VR referral process; simplifying Federal guidelines for VR referral; sponsoring greater collaboration among SSA, State DDS and State VR agencies; and tracking persons who request referral for VR services in the course of a CDR. SSA is also streamlining the VR payment process, which will expedite claims, and improving its management information about the persons who receive VR services and the services they receive.

In June 1989, SSA submitted a legislative proposal to authorize us to contract directly with private VR providers to serve our beneficiaries. The private sector has grown significantly in numbers in recent years, and there are many small businesses, community-based facilities and national firms with the experience and specialized knowledge to serve people with severe disabilities. In fact, State VR agencies often contract with the private sector for services. In FY 1991, the latest data we have available, 64 percent of beneficiaries who were accepted by State VR agencies received some type of service from the private sector. When SSA's proposal was not enacted, we sought to modify the process through regulations which permit us to use private or other public agencies as alternate sources when a State VR agency declines to serve an individual whom SSA has referred to it.

These new regulations, published March 15, 1994, brought the first substantive changes to the SSA VR program in over a decade. In addition to expanding the pool of potential service providers, thereby expanding opportunities for our beneficiaries to receive rehabilitation services and return to work, the regulations protect consumers by assuring that alternate providers are qualified through licensing or certification to serve them.

Since the publication of these regulations, we have been working hard to put the new process in place. Briefly:

- We have modified the claims system to record when a beneficiary is referred to a State VR agency and are developing a system to track these referrals.
- We are informing public and private sector rehabilitation providers about our VR program.
- We are developing criteria for certifying alternate providers as qualified to serve our beneficiaries under the VR payment program.
- We are working with our attorneys and Federal procurement professionals to draft model agreements and contracts with alternate providers who agree to serve our beneficiaries.

We expect to have the framework in place to begin enrolling alternate providers in the next few months.

Let me briefly describe two other initiatives to expand VR services and job opportunities for disabled beneficiaries. The first, Project NetWork, was initiated in 1991 to test 4 service delivery models that offer alternatives to the current VR program.

Project Network is the SSA's first large-scale demonstration of VR assistance to persons with severe disabilities. This project is also the first major attempt by SSA to take direct responsibility for helping people with disabilities enter or reenter the workforce. Project NetWork used a randomized field experiment design to test 4 models of providing employment and rehabilitation services to DI beneficiaries and SSI applicants and recipients. All of the models were completed in March, 1995. Preliminary results will be available in FY 1996 and a final evaluation report is due December 1997.

We have contracted with a major social science research firm to perform a comprehensive evaluation of Project NetWork. The evaluation will address two key policy questions:

- Is it feasible to increase participation in VR services among DI and/or SSI beneficiaries through a combination of intensive outreach, case management, and enhanced work incentives? and

- Do the interventions tested produce net benefits from the perspective of participants, society, the DI trust fund, general revenues, and the Federal government in general?

The second initiative, Project ABLE--launched in 1993--is a joint Federal-State initiative to link disabled job-ready beneficiaries with public agencies and private sector employers that need their skills and abilities.

Project ABLE began as a pilot program in 1993 for disability beneficiaries residing in Maryland, Virginia and the District of Columbia. Project ABLE is a joint effort of the Office of Personnel Management (OPM) in conjunction with SSA, the Rehabilitation Services Administration and participating State VR agencies. Through this program, State VR agencies enroll job-ready beneficiaries into a database which is used by Federal agencies to find qualified candidates.

I am pleased to report that, based on favorable input from VR counselors and personnel offices, the Project ABLE system has been improved and is being expanded to California, Illinois, Pennsylvania and Texas. In addition, we have enhanced the Project ABLE database to include resume imaging that will allow prospective employers to receive a client resume by fax directly from the Project ABLE database. Another enhancement will automatically give Federal agencies listings of eligible employees from Project ABLE for all posted job vacancies.

While only a very small number of beneficiaries have been hired to date, we believe Project ABLE's success has been limited by restricted hiring and downsizing of government agencies throughout this period. We are beginning to work with the Department of Labor (DOL) to list Project ABLE clients in various databases funded by DOL that are principally used by private sector employers and to work with States that are experimenting with "one-stop shopping" employment centers.

Project ABLE has been recognized as a National Performance Review "Reinvention Lab" and I am pleased that Project ABLE has proven to be a fine example of Federal and State agencies collaborating to give state-of-the-art service to their respective customers.

Employment Strategy for People with Disabilities

In addition to the initiatives I just mentioned, as I indicated at the May hearing, we are examining other approaches to increase the employment of current and potential disabled beneficiaries. I have established a team headed by Dr. Susan Daniels, Associate Commissioner for Disability, to examine approaches to increase the employment of disability beneficiaries. I am very interested in approaches for bringing together the interests of employers, private insurers, and rehabilitation services to achieve more efficient handling of claims and to return to the workplace as many people as are able to work. Over the coming months, we will continue to work with our State partners, other public agencies, and private organizations that serve people with disabilities in an effort to improve these services and to create greater employment opportunities for our beneficiaries as we move forward.

Conclusion

In summary, Mr. Chairman, I thank you for the opportunity to submit my statement for the record. Even though it has only been two months since I last testified before you and your subcommittee, we have made measurable progress and we can assure you that our progress will continue. We are working to maintain fairness in the disability program, improve the integrity of our disability rolls, and increase employment opportunities for current and potential disability beneficiaries. The initiatives I have described will help us accomplish these goals.

Chairman BUNNING. Thank you, Dr. Chater.

I will try to be brief and I hope everybody else is brief because we have a lot of panels here today. Since SSA is an independent agency now, and those of us that were on the subcommittee last year had a lot to do with the changes that were made, I think we can talk with some kind of an authority that one of the reasons that Congress made SSA an independent agency was that it did Social Security and the American public no good to have it buried over in HHS, Health and Human Services.

Congress has had a tough time getting expert advice about Social Security issues and problems when SSA was part of HHS because no one paid any attention to it. But all that has changed now and Congress will be looking to you or whoever heads SSA for advice on SSA policy. If you cannot tell us the best way to approach a Social Security issue, who can?

So I am interested in taking a step back and looking at our national disability policy. I would like your opinion on a few questions.

In your opinion, and I am just asking it, is the definition of "disability" as it is currently in the law still appropriate for the program? Should it be tightened, loosened, or changed?

Ms. CHATER. In my opinion, and my opinion only, I believe the definition of disability, as it is now stated, is still appropriate for our goals at this time.

Chairman BUNNING. In your view, is the disability program more appropriately based on objective medical findings, the basis for the decisions the DDSs currently make, or more subjective legal findings, the basis for the decisions that the ALJs make?

Ms. CHATER. I believe the decisions are based on both.

Chairman BUNNING. Which is more appropriate, since we have an awful lot of reexaminations on the initial disability determinations? We have a 90-percent accuracy rate of the initial disability determinations made. Of these about 40 percent are appealed; 80 percent of these are allowed by the ALJs. How can this be?

Ms. CHATER. First of all, let me say something about the difference that could be explained in terms of the process, Mr. Bunning. It is true that the DDSs make the decision based on a folder, a folder of evidence, including medical evidence and some assessments that substantiate medical evidence or medical diagnoses, such as tests, x rays, and so on.

At the other extreme, when a person requests a hearing, the decision is made not only on a folder, it is made with an individual interview between the ALJ and the client. So there is that variable that differs.

Another differing variable is the fact that the folder, between the time it starts and the time it ends up at the ALJ, is quite different from point A to point B. In other words, all along the line, additional information is added, and, indeed, if 1 year goes by, as in the case of many, the amount of material that is added to the file is substantial, and it is quite possible that the person has become more severely disabled than in the beginning.

So I would say to you that the decisions that are made at the two points in time are quite different, based on the amount and kind of information in the folder.

Second, there is generally an interview, a personal one, at the hearing level. In addition to that, judges make decisions based on their legal expertise and the DDSs do not.

Chairman BUNNING. Madam Commissioner, the DDSs get a decisional accuracy rating of 97 percent when they make the decision the first time around. Eighty percent of the appeals from the DDS level are overturned by the ALJs. There has got to be a better way, and there has got to be a better way before the year 2000 to do this or we are going to have a backlog that will never disappear.

You cannot tell me in 1995 that you are going to solve the problem in the year 2000 when each year we have a bigger backlog. We have to do it now. It is not something that we can put off. All the studies and all the things that you are doing may be wonderful, but they are not getting the job done.

Ms. CHATER. I agree with you that we need to do something now. That is part of the reason that we instituted short-term disability initiatives, so that we could begin to make some changes right now that are temporary in nature. The changes that we are making now in our short-term disability program include committing more resources by redeploying people from one part of the agency to another, and taking people from some of our other programs and moving them over to work on disability workloads.

One of those changes that we are making in the Office of Hearings and Appeals, for example, is to put into place an arrangement whereby senior attorneys could look at the files and get other medical material that is needed to make a decision, if needed. Or, if the case may be that the decision looks as if it is going to be allowed, those senior attorneys could make that decision then and there instead of having the ALJs do everything which they are now accustomed to doing.

Chairman BUNNING. One last question from me, and then I am going to give the other members an opportunity. Do you not think that the current schizophrenic approach to disability decisions, one standard for the DDSs, another standard for the ALJs, is demoralizing to the DDS examiners who see almost 80 percent of their appealed decisions reversed? Does it not also undermine the integrity of the program by awarding benefits to more borderline cases and raising public skepticism and even hostility toward all disability recipients, even those who are legitimately receiving benefits?

Ms. CHATER. I think it is about 66 percent of the cases that are overturned, according to our data, Mr. Bunning.

I understand what you are saying——

Chairman BUNNING. We have the same data that you have, so there should not be a dispute on the percentiles.

Ms. GEIER. May I, Commissioner, Mr. Bunning, the difference is whether or not dismissals are counted. With dismissals, the rate is 66 percent.

Chairman BUNNING. It is still too high.

Ms. GEIER. Yes, I cannot argue with you.

Ms. CHATER. I would like to say something about the people who work in the State DDS offices, because I care very much about them. I understand that they may feel that the overturning of DDS decisions is a reflection on their work. I will tell you, it is not a reflection on their work. They are very good and very accurate.

Their workload has increased but their productivity has increased. They are a very, very committed group of employees, and I have met many of them and I have talked at their annual meetings.

I think they ought not to look at what they do vis-a-vis what the Office of Hearings and Appeals does for the very reasons that I have said to you. They are operating in a different moment in time with a different file and not with the advantage of a face-to-face interview.

Chairman BUNNING. We will hear from some of them later on, so we will make sure that we ask them the proper questions.

Mr. Jacobs will inquire.

Mr. JACOBS. Thank you, Mr. Chairman.

First, I commend you, Dr. Chater, for your concern and involvement in comforting and counseling the bereaved out in Oklahoma City. What you did there did not make headlines, but I am aware of it and I commend you for the devotion you showed.

On the CDRs, Mr. Bunning and I, I believe, last year supported legislation to allow your agency to plow back some of the recovered benefits where people were found no longer to be disabled, and we ran into a buzz saw, as I recall, with the Appropriations Committee.

Chairman BUNNING. Yes, we did.

Mr. JACOBS. Do you think that is a practical thing to do, to get cracking on this? That is to say, the investment of a little bit of what is recovered recovers that much more, and so on. Is that sensible to you?

Ms. CHATER. Obviously, it would be wonderful if we had a revolving fund where we could put some of the money that was recovered from CDRs into that fund that would enable us to do even more. We are well aware that we have many, many more CDRs to do, and for this agency, in past years, we have had to decide between using limited resources on processing initial claims or doing many CDRs. So, obviously, that is a good idea.

But I am aware of the Appropriations Committee's feeling about this. I think part of their reason, as I understand it, is they think it would be precedent setting for other agencies.

Mr. JACOBS. If you do not want to answer this, do not answer it. It would be OK by me. But have you an opinion about the proposal for a Social Security appeals court, a subject matter appeals court to avoid the variations in the various circuits on outcomes, rules, and definitions? If you live in one State, you can have a hangnail and do all right, and if you live in another one, they can be dragging you with a rope and you still do not qualify. Do you have any opinion on that?

Ms. CHATER. There are certainly advantages to having a Social Security court because the judges making decisions would become expert. There would be one set of decisions coming to us, and now there are so many decisions. We have one region implementing certain laws and regulations and another region using slightly different standards. So, certainly, consistency would be an advantage.

On the other side, there are some people who think that more objective decisions would result from not having a Social Security court.

Mr. JACOBS. Some of my friends are for it and some of my friends are against it.

I will not ask the patience of the subcommittee any further. Thank you.

Chairman BUNNING. Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman.

Dr. Chater, welcome. SSA now has 10 years' experience with the medical improvement standard. In your view, is it working and do we need to revisit the standard in the law?

Ms. CHATER. Could I defer to my colleague, Dr. Daniels, and have her respond to that, please?

Mr. ENGLISH. Certainly.

Ms. DANIELS. I think we have to look at the medical improvement standard, Mr. English, in terms of the context in which it came up. It was a time when many individuals were receiving CDRs whose conditions had not changed over time. The Congress thought it was important to be sure that individuals had a fair hearing if their case came up for a CDR. The medical improvement standard was instituted in order to be sure that each beneficiary had a fair evaluation at the time of the CDR.

Now, the medical improvement standard is very important in ensuring the rights of the individual beneficiaries, and so I want to say that first.

Mr. ENGLISH. I understand.

Ms. DANIELS. It is very important for us to recognize that. But I do not think that the medical improvement standard really ties our hands in terms of doing CDRs. We can do effective and efficient targeted continuing disability reviews with the current medical improvement standard that we have, and we have done a lot to improve and target the ones that we are doing.

Mr. ENGLISH. Almost 2 million disability cases out of a total of 4 million cases, as I understand it, are awaiting continuing disability reviews. Half of these are cases where medical improvement is expected or possible. Given the fact that fiscal restraints are worsening, there may never be enough resources for SSA to do CDRs.

In your view, is it time for SSA to consider recommending options such as time-limited benefits, at least when medical improvement is expected, Dr. Chater and Dr. Daniels?

Ms. DANIELS. I would like to make a distinction here, Mr. English, between "medical improvement expected" and profiling CDRs. When the case is originally adjudicated and the DDS medical staff look at the case, they assign it to either a medical improvement expected, medical improvement not expected, or medical improvement possible review category. This is a paper review. This is an individual physician or DDS examiner looking at the case and making that decision from the file that they have.

In the last 2 or 3 years, we have been testing out that concept more from an empirical standpoint. That is, we have been statistically analyzing the data that we have for those people who actually leave the rolls as a result of a CDR. This is called profiling. That is, we looked at certain characteristics to see which particular confluence of characteristics most likely predicts individuals who would leave the rolls through a CDR. So we have focused our

efforts on profiling, as well as those designations that were used originally by the DDS examiner and the physician.

So I want to make that distinction, because sometimes I do not think it is necessarily helpful to use those older distinctions when I think we have modernized our approach, using the empirical data now by looking at the actual variables that lead individuals to have a CDR.

Mr. ENGLISH. I appreciate that, Dr. Daniels, but I guess I am getting back to the question, do you think it is time for SSA to look at other options that might include time-limited benefits?

Ms. DANIELS. I think it is time for us to continue our efforts in improving our CDR process and making it more efficient and effective. I do not think I have an opinion on time-limited benefits at this point.

Mr. ENGLISH. Do you have any view, Dr. Chater?

Ms. CHATER. I think it might be worth looking at the issue of time-limited benefits, Mr. English. If people knew that they were going to be on the rolls for a 3-year time period, for example, it might serve as a motivating factor for them to go back to work.

It would also mean, for the Social Security Administration, we would have to put into place a process by which we would do those reviews in a very prompt way so that people did not get stuck between the fourth and fifth year, for example, of having no benefits. We would have to develop ways of deciding which of our beneficiaries to review.

Mr. ENGLISH. Sure. My final question, because I am running out of time, how many people who are no longer disabled did SSA remove from the rolls last year, just for context?

Ms. DANIELS. Last year, we did 118,000 CDRs and removed about 12 percent.

Mr. ENGLISH. So 12 percent would be about 15,000 people out of roughly 4 million?

Ms. DANIELS. [Nodded head yes.]

Mr. ENGLISH. Thank you very much for your testimony.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Payne.

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

Welcome, Dr. Chater, and thank you for your testimony. I want to return to the chairman's question to see if I can understand exactly where this currently stands and where we are headed in terms of the determination of an individual recipient. The chairman mentioned, and my office has experienced as we deal with those who have been turned down in terms of their disability insurance and then go to the ALJ and through that system, we are seeing that of the people we see, and I must say, about 30 percent of all the casework we do deals with this area, but we see about 80 percent of those people ultimately receiving benefits.

Many of these people we see, as we talk to them, they are obviously people who, at some point in time, are going to receive this. It is apparent from the records that they have, from the conversations we have with them, from what we know their disabilities are, and yet, many, many months go by and often these people become homeless and lose all their assets as these determinations are being made.

I heard you testify that we need to have a major redesign and portions of it need to be customer friendly, which I certainly agree with. We need to find a way to make the decisions more quickly. You mentioned a goal of 60 days. The information technology needs to be improved, and you talked about that and the funds needed for that.

But then, as I heard you talk to the chairman, it seemed to me you were defending the system as it exists and saying that it is OK, the status quo is OK as it relates to what is going on now relative to the decisions being made by SSA and then the process moving on to the ALJs.

Could you clarify that for me? It seems to me that is the crux of the problem, and yet, if we want to leave that in place and do our repairs in other places, we are really not solving the main problem that needs to be addressed.

Ms. CHATER. Yes, I will certainly clarify. First, we have in place a short-term initiative that moves around some resources so that we can be more productive and make decisions quickly, efficiently, and accurately in a shorter time period.

But our major project is the reengineering proposal that will redesign the way we process claims from the beginning to the end, including the Office of Hearings and Appeals. For example, part of our reengineering proposal will help get rid of the problem that Mr. Bunning mentioned about the DDSs and how they feel about ALJs overturning their decisions. We are going to move those two processes closer together by having one book, one set of procedures and policies to look at.

We are also, in our redesign proposal, making changes in the way the Office of Hearings and Appeals is structured, differences in who does the work. Perhaps Mr. Jones, who is the director of this implementation project, could expand on that for you.

Mr. PAYNE. So you are not disagreeing with the concerns that the chairman has expressed? You are in agreement with his concerns? I share his concerns, given what I am seeing just from the folks who I serve here in Congress.

Ms. CHATER. We do share his concerns. We are very concerned that the claims process takes so long. It is simply unacceptable that the American people have to wait so long for a disability decision. We want to do everything we can to shorten the time and be sure that the integrity of the program remains just as high as it has always been.

Mr. PAYNE. In order to make this change that you were just referring to, how long will it be before people will see any significant result from those changes?

Ms. CHATER. Mr. Jones.

Mr. JONES. Mr. Payne, maybe it would be helpful if I could take 1 minute to describe some of the major components that we are going to be dealing with.

First of all, one of the things that brought me to Social Security was the Commissioner's commitment to improve this process. I think everybody agrees the process was broken. One of the things that we are focusing on is what is called process unification, and process unification involves a variety of things. First of all, it involves having one policy manual that will be used at both the ini-

tial level and at the hearings level. Currently, there are separate manuals that are being used.

The other thing that is involved is coming up with a quality assurance system that will provide consistent feedback to both the initial level and the hearings level. Right now, we do not get that consistent feedback.

In fact, as we speak, we have a group that is developing a training packet that focuses on some policy areas that we have identified as needing clarification at both levels. What we are going to be doing is bringing people from OHA and from the DDSs and getting them in the same room at the same time and giving them the same message regarding policy, and that is something new under the redesign that has not been done before.

We are also changing part of the process so that the two processes will be more alike. One of the things that we are going to be doing is to introduce a face-to-face component at the initial level that currently does not exist. You do have face-to-face contact at the hearings level.

So there are a number of things that we are trying to do and will be doing immediately, such as training, to bring these two processes closer together.

Mr. PAYNE. When will we be able to see some results or should we expect to see some results as a result of these changes?

Mr. JONES. The training effort is scheduled to begin in October, and we want to wait until October. We should begin to see training results as soon as the training is completed. Again, the objective of the training is to focus in on these key policy areas so that both the DDSs and the administrative law judges will be adjudicating cases the same way.

Mr. PAYNE. I see my time has expired.

Chairman BUNNING. We will have another round.

Mr. PAYNE. I will yield back to the chairman.

Chairman BUNNING. Mr. Collins will inquire.

Mr. COLLINS. Thank you, Mr. Chairman, and thank you, Ms. Chater, for being with us today.

I was going to ask the question about why there was such a discrepancy in the 97-percent accuracy rate of the first denial versus the—we will go with the 66- or 67-percent reversal, but with the clarification from Mr. Jones of all the different policies and different policy books and manuals, I can see why there would possibly be such a discrepancy.

Reading in yesterday's Post, there is a Social Security Advisory Council that has been appointed by the President, as all Presidents have the opportunity to do so. When do you think we will hear from them on some recommendations dealing with the disability insurance and the problems that you face, or do you think they may do like the trustees of Medicare and the administration and sit back and wait for Congress to make some changes or proposed changes first?

Ms. CHATER. The Advisory Council is expected to have their report completed by the end of summer.

Mr. COLLINS. Do you expect positive results from this, something along the lines of what Mr. Jones was talking about in dealing with

the various policy aspects that you have to look at for different regions, or what do you actually expect to get from them?

Ms. CHATER. I do not think we should expect from them implementation recommendations, such as what Mr. Jones is working on. I think what we will have from them are broader policy recommendations related to the solvency of the trust funds and initiatives that we might take to make sure that the trust funds remain solvent into the future.

Mr. COLLINS. I notice, too, in the article that there seemed to be a split on ideas. It kind of reminds me of the old saying, "One faction is for raising taxes. Another faction is for lowering benefits." I am sure the President has friends on both sides of the issue there. Do you think he will come down on the side of his friends or will actually make some recommendations?

Ms. CHATER. I am hoping very much that the Commission, between now and the end of summer, will have enough time and opportunity to come closer together so that we may not necessarily have two points of view. I think they are working very hard toward that end.

I want to say to you that whatever the recommendations are from that Advisory Council, it is my expectation that we will be able to utilize that very informed group's report and recommendations to work together with Congress in a very bipartisan way to solve these long-term solvency issues, Mr. Collins.

Mr. COLLINS. I hope so. I know last year there were some changes in legislation that actually allow you to use Social Security funds for the disability fund. That is only a temporary fix. By increasing taxes or even by lowering benefits, it is only a temporary fix.

Ms. CHATER. Oh, absolutely.

Mr. COLLINS. You have to get into the meat of the problem, and that is the actual operation and the procedures by which you determine disability, in order to be able to correct the situation. So I am hoping that we will see some very strong recommendations and some very good recommendations. Thank you again for being here.

Chairman BUNNING. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Chater, you told Mr. Bunning that you thought the definition was OK. Why?

Ms. CHATER. Why? Because the disability program, it seems to me, is one that assesses one's inability to work because of a medical condition. The definition at the moment has both of those components contained within it.

Mr. JOHNSON. Determined and expected to last for not less than 12 months or result in death.

Ms. CHATER. Yes.

Mr. JOHNSON. How is that determined by the two people in the appeals process?

Ms. CHATER. There are very specific ways to determine that. Some of it is based on the medical evidence. Some of it is based on the so-called listings that we have that indicate in great detail what our employees look for when they make this assessment.

Mr. JOHNSON. So you think the definition is OK and your people are adhering to it?

Ms. CHATER. My people are——

Mr. JOHNSON. Adhering to it?

Ms. CHATER. Yes.

Mr. JOHNSON. That is a Texas word. You are from Texas; you ought to know it. [Laughter.]

Tell me how many foreign people are on our disability rolls.

Ms. CHATER. I cannot tell you how many "foreign" people are on disability. We have——

Mr. JOHNSON. Let us say noncitizens, then. Do you keep track of those statistics?

Ms. CHATER. Yes, we do.

Mr. JOHNSON. What kind of program have you instituted to take a look at them and purge those who are not really deserving and are not eligible under the law?

Ms. CHATER. First of all, I want to make the point that illegal immigrants are not in any way on the rolls. They are not qualified to be. They are not eligible to be on the rolls.

Mr. JOHNSON. So you are saying there are none on the rolls at this time?

Ms. CHATER. There should be no illegal immigrants on the rolls at this time. If there are, they have gotten on the rolls illegally.

Mr. JOHNSON. No kidding? How do you figure that out? How do you absolve that?

Ms. CHATER. All right. When someone suggests to us or it comes to our attention that, for example, someone may have been coached to act in ways that would make us decide that the person was, indeed, disabled, or if we have any question whatsoever about that, we go back and review the case again. We bring in our own interpreter if it is a case of non-English——

Mr. JOHNSON. But if a guy walks into El Paso, Tex., and he says, I am disabled, do you check his citizenship and his ability to be in this country?

Ms. CHATER. Absolutely.

Mr. JOHNSON. You do? That is the first thing you do? Is that true or false?

Ms. CHATER. I am sure that is true.

Mr. JOHNSON. You are sure it is? You are positive?

Ms. CHATER. Yes.

Mr. JOHNSON. They ask if they are a citizen of the United States?

Ms. CHATER. They do not only ask, they ask for documentation to prove that they are citizens of the United States for SSI claims.

Mr. JOHNSON. OK. The termination numbers that you cited, Dr. Daniels, were 15,000, roughly. You gave a percentage, but that is about what you agreed to.

Ms. DANIELS. After I put my glasses back on after I answered that question, it was 14 percent, so I need to——

Mr. JOHNSON. I want to hear some numbers. What is the real number.

Ms. DANIELS. Hold on for 1 second and I will look it up for you.

Mr. JOHNSON. Fourteen percent of 4 million or what?

Ms. DANIELS. Actually, in 1994, there were about 17,000 initial cessations.

[The following was subsequently received:]

Of the 118,000 CDRs conducted in fiscal year 1994, 17,000 cases or 16 percent resulted in cessations.

Mr. JOHNSON. How do we review the files and make sure that we get that done in an expeditious manner? How long does it take from the time you determine somebody is not eligible until you get him off the rolls?

Ms. DANIELS. The process that we are using right now to conduct continuing disability reviews is a two-stage process. The first is identifying those individuals, using a profile, who are the most likely candidates for cessation. We send those candidates' files to the Disability Determination Services for them to conduct a full medical review of that file. So each year, we send the number that we can do to the DDSs to ask them to conduct the full medical review. How long each——

Mr. JOHNSON. When you say "the number you can," what do you mean by that? You are not getting to all of them each year?

Ms. DANIELS. No, we are not getting to all of them each year.

Mr. JOHNSON. Why?

Ms. DANIELS. It is a workload issue. We are actually trying now to make the process more streamlined and efficient. Last year, we did 118,000 CDRs. The year before that, it had only been 64,000. So we nearly doubled the number. This year we will be doing 184,000 CDRs. Next year, we requested a budget sufficient to do 431,000. So we are increasing the numbers that we are doing as we are increasing the efficiency with which we are doing them by using the profile and the mailer.

Mr. JOHNSON. You did not finish telling me how long it takes from start to finish.

Ms. DANIELS. I cannot because each case is different. Depending upon the age of the case, the kind of medical evidence that is required, whether or not there is a treating physician source that can be used, or whether or not an individual has to go out for a consultative exam. Each——

Mr. JOHNSON. Suppose I write you a letter and say, I am no longer on disability and I want to get off. How long would it take me?

Ms. DANIELS. I think we could do that pretty fast. [Laughter.]

Mr. JOHNSON. That happened to me. It took 2 years. I think that—I hope that you have streamlined the system.

Ms. DANIELS. I'm really glad that you are off, Mr. Johnson.

Mr. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Hancock will inquire.

Mr. HANCOCK. Thank you, Mr. Chairman.

I was late getting here, so this may have been covered. When you go back to when the Social Security law was written, I do not think it had any type of disability protection in it. Maybe it did, but I do not think so.

Ms. CHATER. No.

Mr. HANCOCK. At that time, the definition of disability was extremely limited. I mean, it was strictly medical conditions interpreted as total and permanent disability. We have gotten to the point now where we include disabilities as things that were not even considered disabilities, like alcoholism. That was not a medi-

cal disability, that was something you bought and paid for and people were not that sympathetic with alcoholics. Drug addiction has been added now as a disability. In fact, just about anybody in this room could probably come up with something that would qualify under the Americans With Disabilities Act that would make them eligible for disability.

Has all of this just been done by edict by the Social Security Administration? Was it intended, when Congress passed the act, to provide disability? They did not consider that it would get to the point where people would not want to work because they may have an ache in their back.

Is there any way that we could go back and maybe review what we have gotten into?

Ms. CHATER. First, I want to be sure you understand that it was not just the Social Security Administration that decided to change or revise the definition. The way we implement the particular definition over time comes because of congressional changes. It comes because of court cases. Many of the listings, many of the disease entities that we have on our books now come because new and different medical reforms have identified new and different medical conditions.

While I understand you to say that probably all of us in this room could say that we have some sort of a disability, the truth of the matter is, when it is looked at and examined according to our policies and procedures, it really has to be a condition that lasts for a long time or that ends in death. I mean, there are lots of factors that go into it. It is not just a simple diagnosis.

Mr. HANCOCK. But some of the horror stories are coming out now where work makes me anxious; therefore, I am disabled. If you make enough appeals, maybe some judge will just sign off on it just to get rid of you, just to close the case.

Let me ask you another question, and this, I think, gets to the heart of it. Should disability income be means tested?

Ms. CHATER. The disability income from the Social Security program as we know it in title II is not a means tested program. Everybody——

Mr. HANCOCK. I understand that, and I am asking the question.

Ms. CHATER. That is because they pay into it.

Mr. HANCOCK. In your judgment, should it be means tested?

Ms. CHATER. No, in my judgment, it ought not to be means tested.

Mr. HANCOCK. Let me ask you this question, then. I am not saying it ought to be either, but we have situations where family income is $100,000, $200,000, $300,000 a year and there is a member of the family drawing disability income. That other income is not even considered at all under our present law, is it?

Ms. CHATER. No.

Mr. HANCOCK. Should it be considered?

Ms. CHATER. No, it is not considered, because the assumption is that if you work and you pay into the program, you are entitled to benefits for disability.

Mr. HANCOCK. I understand that. Should it be considered?

Ms. CHATER. In my opinion, it ought not to be considered.

Mr. HANCOCK. Let me ask another question, then. If, in fact, an individual does not want disability coverage, should that individual be entitled to a tax credit?

Ms. CHATER. I cannot answer that question.

Mr. HANCOCK. Think about it.

Ms. CHATER. But I would like to answer a question that you asked earlier. You are worried about the people with disabilities just saying they are disabled or people with minor disabilities coming onto the rolls. Seventy percent of all of the people who apply for disability are denied, and so that suggests to me that we have a very good high-quality set of decisionmakers within the Social Security Administration who can determine whether or not someone meets the criteria.

Mr. HANCOCK. Evidently, we are not doing a very good job of publicizing that you are turning down 70 percent of the people that apply. I would think that the word would get out. Instead of the media talking about how easy it is to get on SSI, it looks to me like they ought to be talking about how difficult it is.

Ms. CHATER. I agree with you. We need to do a lot more publication of the rules, the regulations, the program, and, more importantly, we need to publicize what is happening to the people who are utilizing fraudulent mechanisms for getting benefits. We need to publicize what we do about those.

Mr. HANCOCK. Thank you, Mr. Chairman.

Chairman BUNNING. Thank you.

I would like to continue, Dr. Chater. Is it true that an applicant cannot get paid benefits after being allowed by an ALJ hearing until someone actually writes the official decision and sends it out?

Ms. CHATER. I would like to defer to Ms. Geier.

Ms. GEIER. Thank you. Congressman Bunning, the decision of the ALJ is effectuated through a written decision and that is the final disposition of the case at the hearing office.

Chairman BUNNING. Let me give you some instances, factual cases out of my district offices. I believe they are similar to the kind that Mr. Payne brought up.

A hearing was held February 23, 1994; decision released March 9, 1995, 13 months. A hearing was held June 14, 1994; decision released March 27, 1995, 9 months. A hearing was held January 31, 1994; decision released March 21, 1995, 13 months. A hearing was held June 27, 1994; decision released March 31, 1995, 9 months. A hearing was held September 7, 1994; decision started April 20, 1995, 7 months and counting. A hearing was held October 12, 1994; decision not yet written, 7 months and counting.

Is it not humane to make people who have already had hearings wait this long for a decision and a check? What is the size of your hearing decision backlog now?

Ms. CHATER. The specific answer to the last question is that we have 45,000 cases waiting for a decision to be written, and you are absolutely right, Mr. Bunning. It is a deplorable situation for people to have to wait that long, which is exactly and precisely why we need to reengineer the entire process.

Chairman BUNNING. Not by the year 2000, Madam Commissioner.

Ms. CHATER. I agree, and, therefore, we have implemented the short-term initiative which has some pieces in it that will help this process.

Chairman BUNNING. What will it do for my people and all the other people that are under this kind of a gun right here?

Ms. CHATER. It is going to ensure that they get a decision closer to the time that the hearing officer made it.

Chairman BUNNING. What is closer, 2 months, 5 months? What is it? What is closer? We are 7 months and counting. We are 9 months and counting. What is closer?

Ms. CHATER. Right now, it takes over 1 year to do the whole hearing, including the decision. We are working very hard to get that down to about 9 months.

Chairman BUNNING. Will not shifting the decisionwriters to the temporary adjudication officers position cause this backlog to grow?

Ms. CHATER. No.

Chairman BUNNING. Why not?

Ms. CHATER. Because we have several things that we are doing. For example, there is now a so-called short form that many of the ALJs are using. It is a shorter form that helps through automation. We are giving them personal computers so that instead of writing the decision out in longhand, as many of them do, they can utilize a program that helps them write the decision in a shorter form in a shorter period of time.

As I talk with ALJs, many of them tell me that they have begun to write their own decisions instead of turning it over to a decisionwriter. They have elected to sit down after they make the decision and literally write their own decision so that it is done immediately.

Chairman BUNNING. Madam Commissioner, how fast are you going to do these things so that the people aren't waiting for 1 year? You are giving me all the reasons that they should be sped up, but what is being sped up, the fact that you are spinning the paper faster or the fact that we are going to get a decision to the people faster?

Ms. CHATER. Our aim is to get a decision to the people faster and——

Chairman BUNNING. When? Since you have been an independent agency and since you knew you were going to be an independent agency when the bill passed last year, and there was a lot of planning time for you to get these things going, when?

Ms. CHATER. In 1994 it took 337 days for a hearing from start to decision. In 1996 we are going to have that down to about 260 days, and we are going to continue working on this in a systematic way to get it down to——

Chairman BUNNING. Two-hundred-and-sixty days is not acceptable. It is not acceptable, so you are going to have to do better than that.

Ms. CHATER. We will try.

Chairman BUNNING. Is there anybody else that would like to ask a question? Mr. Christensen.

Mr. CHRISTENSEN. Yes, I do.

Chairman BUNNING. You may inquire.

Mr. CHRISTENSEN. Madam Commissioner, how much or what percentage of its administrative budget does the Social Security Administration spend to manage its disability programs? Then I have some followup questions on that, as well.

Ms. CHATER. I know that we spend less than 1 percent. The administrative budget is less than 1 percent of our total outlays. I do not have today the exact amount that we spend just on disability.

[The following was subsequently received:]

SSA will spend about $1.2 billion in fiscal year 1996 to administer the DI program alone.

Mr. CHRISTENSEN. So your reflection of that would be less than 1 percent? Do you know in actual dollars how much?

Ms. CHATER. Our administrative budget request for 1996 is about $6.1 billion.

Mr. CHRISTENSEN. How much in disability benefits in 1994 was the Social Security Administration responsible for?

Ms. CHATER. I am sorry, I did not hear you.

Mr. CHRISTENSEN. How much in disability benefits did you pay out in 1994?

Ms. CHATER. Thirty-five billion, I am sorry.

Mr. CHRISTENSEN. Thank you. The lifetime costs and benefits of the average disability claim would be what?

Ms. CHATER. The average disability claim is about—you mean over a lifetime?

Mr. CHRISTENSEN. Yes, the lifetime costs and benefits of the average disability claim.

Ms. CHATER. About $66,000.

Mr. CHRISTENSEN. The GAO estimates it is $90,000, including both cash and Medicare benefits. Would that be closer to an accurate figure?

Ms. CHATER. Yes, I think that is about right, if Medicare is included.

Mr. CHRISTENSEN. As far as the administration goes, the GAO estimates that it is $2.7 billion in 1994 for the management administrative budget, as well as one-half of the Social Security Administration's total 1994 administrative budget, I am told, was $5.4 billion, according to the GAO. Would that be an accurate figure, in your opinion?

Ms. CHATER. For that year and including both the SSI disability and DI programs, yes.

Mr. CHRISTENSEN. If the Social Security Administration allowed just 1 percent more claims, that would be 37,000 claims, based on 1994 numbers. It would cost the system roughly $3.5 billion, almost 10 percent of the total amount of the program paid in 1994. Would you not agree this is a serious situation, given the fact that the disability program is only solvent until the year 2016, according to the figures that we have been given from your office?

Ms. CHATER. That is about right, including Medicare benefits.

Mr. CHRISTENSEN. In light of the fact that the disability payment schedule, as you have just stated, is at 200-and-how-many days?

Ms. CHATER. Our goal for 1996 is 262.

Mr. CHRISTENSEN. Two-sixty-two? I would think that we would want to do everything we can to make it more of a consumer

friendly program, and 262 days is not, in my opinion, consumer friendly.

Ms. CHATER. I just want to clarify, Mr. Christensen, the 262 days that I mentioned before, it means that the person has been denied and has gone to hearing. In 1996 we, through our short-term initiative, expect to get it down to 62 days, which we think is a reasonable amount of time to make an initial decision, assuming no hearing.

Mr. CHRISTENSEN. Let me ask you another question. Your long-term disability redesign does not seem to take human nature into consideration. Social Security Administration employees are very service oriented. They try to help people. They feel sorry for people who are out of work and in need.

How do you think that the disability claims manager and adjudication officer will be able to avoid the natural bias in favor of applicants, especially when the disability claims manager will have to personally deal with irate applicants whose claims he or she has denied? Would it not be easier to just allow borderline cases to avoid this? I guess in the case of an adjudication officer, to avoid having to send the case to an ALJ, will not allowance rates inevitably go up under your scenario?

Ms. CHATER. No, I do not think so, and Mr. Jones will tell you why.

Mr. JONES. I think you underestimate the professionalism of our employees. They have and will have specific criteria by which to make disability decisions. As they do today, they will be following those criteria. So I guess I disagree with your basic assumption that simply adding the face-to-face component is going to increase allowances.

Mr. CHRISTENSEN. I guess I am just going on track history and what the past has been. If the past is any indication of what the future may be, I guess that is what I am basing my assumptions on. Your desire is well intended, but looking at past performance, the future does not look like a good situation.

Mr. JONES. Our redesigned system is a comprehensive program that is going to change our quality assurance system. It is going to change the way we currently adjudicate and document cases today. It will have a major training component to make sure that our employees are even better trained than they are today to adjudicate disability claims.

So I think if you take the entire redesign into consideration and how all the different parts and pieces integrate and fit together, I think we will have a system that will make accurate disability decisions.

Mr. CHRISTENSEN. Mr. Jones, what type of timeframe do you think that redesign will take place in?

Mr. JONES. The entire redesign is going to take place over the next 4 to 5 years. Actually, beginning this summer, we are moving to put critical pieces of that redesign into place to begin with what we are calling DDS examiner/claims representative teaming to provide more focused service to our customers.

Mr. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Hancock.

Mr. HANCOCK. Thank you, Mr. Chairman.

I would like to revisit a statement that was made earlier in the testimony that 70 percent of the initial claims are denied. Did I understand you correctly?

Ms. CHATER. Yes, sir.

Mr. HANCOCK. I have a study here that says 57 percent in the initial claims are denied, and then after appeal, the percentage, and that rises to 57.8 percent, or 578 people out of 1,000 applicants. This is your stuff.

Mr. JONES. I do not know what charts you are referring to, but the figures that you are referring to—I believe the 57 percent relates to the percent of those that are denied. So you take the 70 percent that are denied and 57 percent of those apply for a reconsideration. Again, I do not have the specific chart in front of me that you are referring to.

Mr. HANCOCK. It is data based on appeals in the year, not longitudinal tracking of cases, and excludes cases remaining at lower levels. It is your document dated November 12, 1994, and it says initial determinations out of 1,000, 570 denied, 430 approved, and then on down the list, and the total denied is 57.8 percent. Do you want to take a look at it?

Ms. CHATER. Perhaps we should take a look at it and get back to you and give you the correct information, Mr. Hancock.

[The following was subsequently received:]

The chart referred to on the following page presents data for fiscal year 1992, and indicates a disability initial claims allowance rate of 43 percent, i.e., 430 allowances out of every 1,000 initial determinations. The 57.8-percent figure includes allowances at all levels of appeal during that fiscal year; it is not a longitudinal tracking of individual cases.

The disability claims allowance rate at the initial level (before appeals) reached its peak at 43 percent in fiscal year 1992, and has been coming down since. To bring our performance up to date, during the first 6 months of the current fiscal year, we made 1,264,664 disability determinations, of which 874,929 were denials (for a 69-percent denial rate), resulting in a current allowance rate of about 31 percent.

Similarly, the allowance rate through all appeals levels has dropped from a high of almost 58 percent in fiscal year 1992 to about 47 percent for the first 6 months in fiscal year 1995.

* Data based on appeals in the year, not a longitudinal tracking of cases. Excludes cases remanded to lower levels.

Mr. HANCOCK. Thank you.

Chairman BUNNING. I would just like to insert in the record the cost of the Social Security Disability Insurance Trust Fund. It will cost the Retirement and Survivors Trust Fund $275 billion by the year 2008; $106 billion between the year 1995 and 1999, $169 billion by the year 2003, and $275 billion by the year 2008 will come from the Retirement and Survivors Trust Fund.

So I hope that the advisors or the special commission that the President has appointed will address this continuing drain on the Retirement and Survivors Trust Fund by the Disability Trust Fund.

Dr. Chater, I would like to advise you that I intend to submit questions to you for the record after I have heard all the witnesses today and tomorrow. I also hope that you have a little time to stick around and listen to your employees who are here, because I think they have traveled an awful long way to share with us their expertise and their front-line experience in dealing with these problems on a daily basis.

Thank you all for being here.

Ms. CHATER. Thank you.

Mr. COLLINS. Mr. Chairman.

Chairman BUNNING. Yes.

Mr. COLLINS. May I inquire?

Chairman BUNNING. Excuse me. Go right ahead.

Mr. COLLINS. My first inquiry is with you, Mr. Chairman. As I understand those numbers there, are you saying we are robbing from Peter to pay Paul?

Chairman BUNNING. We are taking $275 billion out of the retirement benefits of the Social Security recipients.

Mr. COLLINS. To pay the disability insurance?

Chairman BUNNING. Correct.

Mr. COLLINS. That is basically robbing Peter to pay Paul.

Ms. Chater, the Disability Insurance Program provision was put in place in the midfifties, I believe.

Ms. CHATER. Yes.

Mr. COLLINS. The trust fund, was it established at that same time, differentiating between the Social Security and the trust fund?

Ms. CHATER. I believe so.

Mr. COLLINS. Do you recall the rate at such time that it was implemented?

Ms. CHATER. The rate of tax that goes into the trust fund?

Mr. COLLINS. Or the disability insurance portion.

Ms. CHATER. Yes. It is about 0.9 percent.

Mr. COLLINS. At the time it was first——

Ms. CHATER. Oh, at the time, I do not know that but I will go back and look and find that out for you.

[The following was subsequently received:]

In 1957, the first year the DI payroll tax was imposed, the combined OASDI payroll tax rate was 2.25 percent for employers and employees, each. The 2 percent was allocated to the OASI Trust Fund and 0.25 percent was allocated to the DI Trust Fund. The self-employed rate was 3.375 percent, with 3 percent allocated to the OASI Trust Fund and 0.375 percent allocated to the DI Trust Fund.

Mr. COLLINS. I was just looking at the report here from last year. From 1994 to 1996, the DI tax rate will be 0.94. From 1997 to 1999, it drops to 0.85, and then from 2000 on, back up to 0.90. Based on the fact that we are taking funds from the pension and survivors' benefits to help pay the disability insurance—this is mandated, this is a tax that comes out of everyone's payroll check. It is no voluntary measure at all, is that not true?

Ms. CHATER. That is correct.

Mr. COLLINS. Which is kind of different from the private sector, in the fact that most people who desire to have disability insurance would not pay premiums to an insurance company that was going broke, and, basically, that is what is happening with the Disability Insurance Program when we have to go back and borrow from the survivors' and the pension benefit program in order to sustain its being, is that not true?

Ms. CHATER. That is true.

[The following was subsequently received:]

Historically, reallocation of rates has been used on occasion to alleviate temporary funding problems encountered by the trust funds. The 1977 amendments reallocated money from OASI to DI to help resolve temporary financing problems encountered by DI in the late seventies. Conversely, funds were reallocated from DI to OASI in 1980 and 1983 to avoid depletion of the OASI Trust Fund. Had the funding for the DI program in the 1977 amendments been retained, the DI Trust Fund today would actually have an actuarial surplus over the next 75 years.

Mr. COLLINS. Thank you, Mr. Chairman.

Chairman BUNNING. Is there anyone else that wishes to inquire?

[No response.]

Chairman BUNNING. We thank you all for being here.

Ms. CHATER. Thank you.

Chairman BUNNING. The next panel we would like to come forward is from GAO—Jane Ross, Cynthia Bascetta, and Christopher Crissman.

For the benefit of our guests, GAO is an arm of Congress which we rely on to do audits and investigative work. I will be asking GAO to monitor closely both SSA's short-term disability initiatives and long-term redesign. GAO has already done considerable work on the Social Security disability problem, which we appreciate, and they are presenting their preliminary findings today.

Ms. Ross, if you would get us started.

STATEMENT OF JANE L. ROSS, DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY CYNTHIA BASCETTA, ASSISTANT DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES; AND CHRISTOPHER CRISSMAN, ASSISTANT DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES

Ms. ROSS. Yes, sir, Mr. Chairman.

You have already heard a lot about the growth in the Disability Insurance Program and the growth in the number of beneficiaries, so what I would like to do is concentrate on three issues, all of which were raised by Commissioner Chater.

The first is the growth in the DI caseload and some of the causes for that growth. Second is SSA's efforts to reduce the backlog in

applications and decisions and to streamline the process of determining eligibility. Third is the importance of assuring that only those who are disabled remain on the rolls and improving methods of helping beneficiaries return to work.

As we have already heard, the number of disabled beneficiaries has grown dramatically in the last 10 years. While the pace of growth has tapered off a little recently, the total number of recipients continues to climb. SSA needs to be doing analysis to help all of us understand why the growth occurred in the last decade and whether it is likely to speed up in the future or slow down. We are very anxious to see the results of ongoing analysis conducted under contract for SSA.

Obviously, the huge increase in applications has created workload pressures at all levels of the disability determination process. You already talked about that. Right now, there are over 1 million people who have applied and are waiting for a decision.

At the appeals level, especially, both case backlogs and processing times are still growing and many people wait for over 1 year for their appeals to be heard. The long waits that result from the backlogs can cause substantial hardships, especially for applicants with limited income and no medical insurance.

Last month, in the Philadelphia region, SSA identified about 500 cases in the ALJ backlog where the persons were in dire circumstances, either because they were terminally ill, homeless, or were about to lose their homes due to foreclosure. They were waiting for administrative law judges to make their decisions.

As Dr. Chater said, SSA has underway a short-term effort to reduce the backlogs, but we have some concern that this effort could result in more cases being allowed, perhaps inappropriately. It will be especially important for SSA to guard against sacrificing the quality of decisions for greater speed.

SSA also has underway a more far-reaching initiative to fundamentally rethink and redesign the disability claims process so that it becomes many times more efficient and significantly improves service to the disabled claimants. The success of this reengineering effort is critical if public service is to be improved and also because of the extraordinarily high dollar costs of administering these programs, now $2.7 billion annually. While that is a very small proportion of the program dollars, $2.7 billion is a lot of administrative cost.

GAO will be monitoring the implementation of reengineering, at your request, and will be mindful of several concerns, including that accuracy is not sacrificed for speed and that as cases are developed, there is an adequate baseline of information for conducting future continuing disability reviews.

While SSA has devoted management attention and resources to improving the disability determination process or trying to get people onto the rolls more speedily, it has focused too little attention on the people already on the rolls in determining whether they are still entitled to benefits because they are still disabled. It has also focused too little attention on whether there are people who could be encouraged to leave the rolls and return to work.

SSA has not done nearly enough reviews to assure that persons currently receiving benefits are still disabled. Next year, they plan

to do many more CDRs than they have in the past, but it is still only one-half of the number that the law requires.

Conducting CDRs has profound implications for program expenditures. For example, based on the CDRs they conducted in 1994, SSA estimated that about 11,000 beneficiaries would no longer be eligible for benefits. The total savings from terminating the benefits to these 11,000 persons could amount to about $1 billion over the lifetimes of those people.

Even when people do not recover, they can also be encouraged to go back to work through rehabilitation and work incentives. That is something we should not miss. Currently, SSA puts very little emphasis on rehabilitation. For every $100 that they spend on DI cash benefits, they spend less than 10 cents on vocational rehabilitation for these beneficiaries.

Beneficiaries may also be reluctant to try working because they lose all their cash benefits and medical coverage very quickly. If beneficiaries return to work, cash benefits are cut off entirely after 9 months and Medicare benefits are cut off sometime thereafter. Last year, less than 2 percent of disabled workers left the rolls to return to work.

The Commissioner has recently formed a team to strengthen SSA's efforts in this regard, and Dr. Daniels is leading that team. But what may be required is a shift in program orientation away from long-term benefit receipt and toward helping people move back into the work force and reengineering the whole rehabilitation and incentive structure.

Let me just summarize. SSA has focused most of its effort on getting eligible people enrolled. In light of this, we share congressional concerns that SSA's emphasis on reengineering should be closely watched to ensure that it does not result in increased allowances and less accurate decisions. If the public perceives that the program is loosely run, more people with perhaps only mild disabilities may be encouraged to apply for benefits and clog the application process.

The high and growing cost of the DI program makes it urgent for SSA to expand its focus on continuing disability reviews and return-to-work efforts. Moreover, technological and social changes that have occurred since the fifties make it more likely that beneficiaries can return to work and reduce their dependence on disability benefits.

Mr. Chairman, that concludes my statement. I would be glad to answer any questions you have.

[The prepared statement and attachments follow:]

TESTIMONY OF JANE L. ROSS, DIRECTOR
U.S. GENERAL ACCOUNTING OFFICE

Thank you for inviting me to testify on the growth in the Social Security Disability Insurance (DI) program and the Social Security Administration's (SSA) initiatives to manage this growth. Over the last 10 years, the number of beneficiaries grew 43 percent and benefit costs doubled, raising congressional and public concern. Today 5.6 million disabled workers and their dependents receive $38 billion in DI benefits per year.

My testimony today is based on our reports and ongoing studies of SSA's disability programs. (See app. I for a list of related GAO products.) Our work has shown that increases in applications for disability benefits have led to increased work loads and growing backlogs of claims. As a result, applicants are waiting longer to find out if they have been awarded benefits. Applicants wait almost 90 days to find out if they have been awarded benefits, while persons who appeal their claims to SSA's administrative law judges (ALJs) wait more than a year. These long waits can cause substantial hardship for applicants, particularly those with limited income and no medical insurance.

SSA has undertaken a number of short-term initiatives to address the immediate backlog problem. It also has begun a longer-term effort to redesign its disability determination process. We share congressional concerns that these changes may sacrifice decisional accuracy for faster processing, and we will be working closely with the subcommittee to monitor the situation. SSA is addressing its work load increases while facing substantial resource constraints. Nonetheless, SSA must broaden its management focus beyond expediting and streamlining the eligibility process. It needs to focus more attention on terminating benefits for those who are no longer eligible and encouraging beneficiaries to return to work.

SSA, now an independent agency, also needs to provide more data and advice to the Congress on matters affecting DI policy. We hope its forthcoming research efforts on disability will assist the Congress in overseeing the program and considering improvements.

In my testimony today, I will provide an overview of the growth in disability applications and appeals. Then I will discuss SSA's efforts to reduce its backlogs and redesign its disability determination process. Finally, I will describe SSA's current efforts and future plans for conducting continuing disability reviews (CDRs) and improving its performance in returning beneficiaries to work.

BACKGROUND

Before presenting our findings, let me provide some background on two disability programs administered by SSA: the DI program and the Supplemental Security Income (SSI) program. We realize this subcommittee does not have jurisdiction over the SSI program, but to fully understand what is happening in the DI program, it is necessary to understand the SSI program as well. An increasing number and percentage of DI beneficiaries also receive SSI benefits, and both programs are growing rapidly.

The DI program was enacted in 1956 and provides monthly cash benefits and Medicare eligibility to severely disabled workers. The program defines disability as an inability to engage in substantial gainful activity by reason of a severe physical or mental impairment. The impairment must be medically determinable and expected to last at least 12 months or result in death.

The program is funded through Federal Insurance Contributions Act (FICA) taxes paid into the DI Trust Fund by employers and

employees.[1] Applicants for DI must have worked long enough and recently enough to be insured for disability benefits. Cash benefits received by disabled workers average $660 a month and continue until a beneficiary returns to work, reaches full retirement age (when disability benefits convert to retirement benefits), dies, or is found to have medically improved and regained his or her ability to work.

DI was originally established to extend Social Security old age and survivors assistance to workers who became too disabled to work. Although in effect the program served as an early retirement plan, original legislation also promoted the rehabilitation of disabled beneficiaries. At the time DI legislation was being considered, the House Committee on Ways and Means reported that it

> "...recognizes the great advances in rehabilitation techniques made in recent years and appreciates the importance of rehabilitation efforts on behalf of disabled persons. It is a well-recognized truth that prompt referral of disabled persons for vocational rehabilitation services increases the effectiveness of such services and enhances the probability of success."

DI legislation required that persons applying for disability benefits be promptly referred to vocational rehabilitation agencies for services to maximize the number of such individuals who could return to productive activity.

Turning briefly to SSI, it was enacted in 1972 as a means-tested income assistance program for persons who are aged, blind, or disabled. SSI benefits are based on income rather than work history, and program costs are funded from general revenues. SSI disabled beneficiaries receive an average monthly federal benefit of $380 and immediate Medicaid eligibility in most states.[2] The SSI program uses the same criteria and procedures as the DI program for deciding who is disabled and, like DI, SSI terminates benefits to persons who medically improve and are able to return to work. Moreover, the SSI law also requires applicants to be referred for vocational rehabilitation.

Persons can receive both DI and SSI benefits. If a beneficiary's DI benefit--based on work history--is less than the maximum SSI benefit, the DI benefit is supplemented with SSI. These persons are known as concurrent beneficiaries.

Both DI and SSI are administered by SSA and state disability determination services (DDS). SSA field offices determine whether applicants meet the nonmedical criteria for eligibility and DDSs make the initial determination of whether applicants meet the programs' definition of disability. In 1994, it cost SSA $2.7 billion to manage the disability claims process for these programs.

SSA has a multilayered administrative structure to handle appeals of denied disability applications. When an application is denied by a DDS, the person may request that the DDS reconsider the application. The reconsideration is conducted by different personnel from those who made the initial determination; the criteria and process for determining disability, however, are the same.

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[1]FICA payroll taxes are divided into the Disability Insurance Trust Fund, the Old Age and Survivors Insurance Trust Fund, and the Medicare Hospital Insurance Trust Fund.

[2]Forty-three states provide a supplemental benefit. In 1993, SSI recipients in these states received an average state supplemental benefit of $110.

If the application is denied at the reconsideration level, the person may request a hearing before one of SSA's 1,011 ALJs. At these hearings, applicants and medical or vocational experts may submit additional evidence. Attorneys usually represent applicants at these hearings.

When an application is denied by an ALJ, the applicant may then request a review by SSA's Appeals Council. The Appeals Council may affirm, modify, or reverse the decision of the ALJ, or it may remand the case to the ALJ for further consideration or development. Either the applicant or the agency may appeal the Council's decision in federal court.

Once DI beneficiaries are on the rolls, SSA is required to perform periodic reviews to determine their continued eligibility. The law requires SSA to perform continuing disability reviews (CDRs) at least every 3 years on DI beneficiaries for whom medical improvement is expected or possible, in order to determine whether their condition has improved to the point that they are no longer disabled. SSA is also required by regulation to perform CDRs at least once every 7 years on persons for whom medical improvement is not expected.

Let me now turn to our findings.

GROWTH IN THE NUMBER OF DISABLED BENEFICIARIES

The number of disabled beneficiaries has been growing steadily in the last 10 years. At the end of 1994, almost 5.6 million disabled workers and their dependents were receiving DI benefits, up from 3.9 million at the end of 1985--a 43-percent increase. Most of this growth--an addition of 1.1 million beneficiaries--occurred in the last 3 years.

The caseload has grown primarily because applications and awards have increased. From 1985 to 1994, DI applications grew from 1.1 to 1.4 million, and the percentage of applicants receiving awards increased from 35 percent to 44 percent. Most award decisions are made by DDSs. In fiscal year 1994, DDSs awarded benefits to 437,000 initial applicants, about 33 percent, and 60,000 awards to persons whose initial denials they reconsidered. ALJs awarded DI benefits to 193,000 persons, or 79 percent of those who appealed.

Many factors have contributed to the growth in DI over the last decade. Expansions in eligibility criteria, especially for persons with mental impairments, have played a role. Other factors are program outreach and poor economic conditions in the early 1990s.

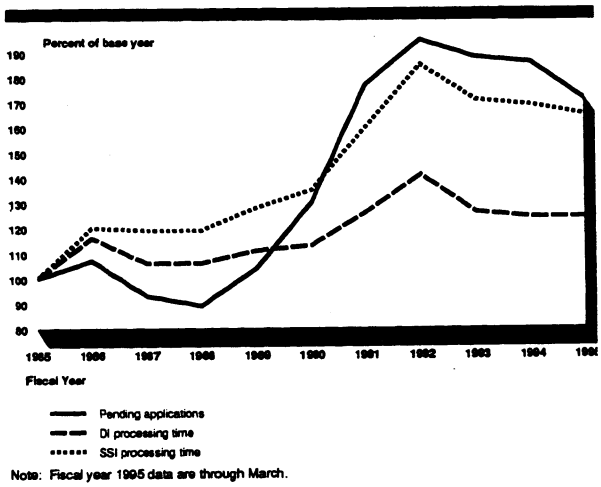
Increases in the number of DI beneficiaries tell only part of the story of the rapidly rising disability rolls. Much of the growth in DI worker beneficiaries is coming from persons who also receive SSI benefits. These concurrent beneficiaries increased 107 percent since 1985.

INCREASED APPLICATIONS AND APPEALS RESULT IN HUGE BACKLOGS

The huge increase in initial applications and appeals have created work load pressures for DDSs and ALJs. Since 1985, initial DI and SSI applications received by DDSs increased 65 percent to 2.6 million, and appeals to ALJs more than doubled to 549,000 in 1994. Backlogs have grown substantially and applicants are waiting longer to find out whether they have been awarded benefits. For those applicants who are awarded benefits on appeal to ALJs after twice being denied by DDSs, the wait is especially long--often much more than a year after they first applied.

In March 1995, DDS backlogs of initial applications were 71 percent higher than in 1985. However, recent DDS backlogs have decreased from their peak in 1992. At the end of March, 505,000 initial applications were pending in DDSs. Their processing times are 87 days for a DI application and 107 days for an SSI application, compared with 70 days and 65 days, respectively, in fiscal year 1985.[3] (See fig. 1.) Since fiscal year 1992, DDSs have added more staff years and productivity has improved.

Figure 1: Huge DDS Backlogs and Processing Times Starting to Improve (Fiscal Year 1985-95)



Note: Fiscal year 1995 data are through March.

For the ALJ caseload, backlogs are larger and processing times are longer. From September 1985 to March 1995, backlogs of pending appeals for all ALJ work loads have increased almost fivefold to 521,000, while average processing times have more than doubled from 167 days to 342 days.[4] (See fig. 2.) At the end of September 1993, 16 percent of all ALJ appeals had been pending for 270 days or more. By March 1995, 37 percent had been pending that long.

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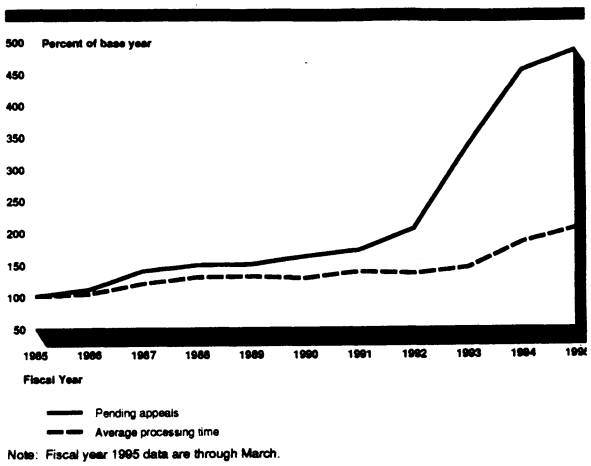
[3]These processing times are measured from the date of application to DDS clearance. Most of this time involves DDS processing.

[4]ALJ processing time is measured from the date SSA receives the appeal to the date that it notifies the applicant of the decision.

Figure 2: Huge Increase in ALJ Backlogs and Processing Times Continue (Fiscal Year 1985-95)



Note: Fiscal year 1995 data are through March.

These long waits can cause substantial hardships for applicants, many of whom have limited income and little or no medical insurance. In March 1995, SSA identified 488 pending ALJ cases in its Philadelphia region in which the applicant was in dire need because they were either terminally ill, homeless or about to lose their homes due to foreclosure, or were without money to buy medicine or food for their children.

Short-Term Initiatives

Over the past few years SSA has relied on short-term efforts to address its increasing work load. Its latest short-term effort began in November 1994, and consists of 19 initiatives[5] to help reduce claims processing time and cut into the DDS and ALJ backlogs at the hearings level in SSA's Office of Hearings and Appeals (OHA). At the DDSs, SSA expects that additional funding and procedural changes will reduce the backlog, while at OHA, it expects reductions from an initiative intended to develop and process cases without a hearing.

SSA's 19 initiatives are in various stages of implementation and not as far along as SSA had originally planned. Part of the delay is attributed to the time associated with asking staff involved in the claims process to do things differently than they have in the past. As a result, there have been considerably more negotiations with employees than anticipated, especially on the initiative that involves using OHA attorneys and paralegals to review appealed claims for possible allowances. In addition, SSA will need regulatory changes in order to permit OHA senior attorneys to make an allowance without ALJ review.

In its efforts to improve its processes, it will be especially important for SSA to guard against sacrificing the quality of decisions for greater speed. We share concerns that these process

[5]Appendix II lists the 19 short-term initiatives.

The ALJs are part of SSA's Office of Hearings and Appeals.

changes could result in more allowances, and that the number of incorrect allowances could rise.

Long-Term Disability Reengineering Efforts

In October 1993, a disability reengineering project team consisting of federal and state officials began to take a hard look at SSA's disability claims process. The objective of this review was to fundamentally rethink and redesign the process so that it becomes many times more efficient and, as a result, significantly improves service to disabled claimants.

The success of this reengineering effort is critical because the administrative cost of these programs is so significant--$2.7 billion annually. Couple this spending with a system that is viewed as slow, labor-intensive, and paper reliant and the need for a new process is obvious. A reengineered process could make better use of technology and assist SSA in more effectively managing its shrinking resources. SSA estimates that it will cost $148 million to administer this reengineering effort, but that the net savings will be $704 million through fiscal year 2001. SSA has also estimated annual savings of $305 million once reengineering is fully implemented. However, SSA has not tested all the assumptions it used for estimating these savings, and they are, therefore, subject to change.

Key features of the reengineering plan that was issued in September 1994 include (1) creation of a disability claims manager position to give claimants access to the decisionmaker, (2) development of a simplified disability decision methodology, (3) emphasis on an SSA and claimant partnership for developing necessary medical evidence, and (4) the use of a predecision interview to provide the claimant with an opportunity to meet with the decisionmaker to discuss the claim before a medical decision is disallowed.

Another key feature is the creation of an adjudication officer who would participate in the process as the initial step in the first appeal level. The adjudication officer would have responsibility for explaining the hearing process, obtaining new evidence, narrowing issues for appeal, developing the case record, and issuing a favorable decision if the evidence warrants.

SSA expects that implementation of the reengineered process will be accomplished over a 6-year period beginning in fiscal year 1995 and concluding in 2000. Full implementation is targeted for fiscal year 2001. We are in the process of evaluating SSA's reengineering effort, and we will expand our work to include validating SSA's model, and assessing its plan and subsequent implementation.

We will also address congressional concerns that this new process will result in pressure to allow more cases, sometimes inappropriately, which would further deplete the trust fund and erode public confidence. To protect against this, long-term reengineering, like the short-term initiatives, should include safeguards to ensure that more cases are not allowed at the expense of correct decisions. Some believe that pressure to allow could come from creating the adjudication officer position, which makes permanent the positions held by attorneys in the short-term initiatives. Others are concerned that the disability claims managers will be more likely to allow borderline cases rather than put themselves in the position of informing applicants face-to-face that they have been denied benefits. Still others worry that speeding up the process could cause inappropriate short-cuts in documentation. If so, this could jeopardize SSA's ability to conduct CDRs in the future. Finally, as SSA attempts to move to a single standard for making disability decisions, we urge paramount attention to program integrity by keeping the process as objective as possible. As we agreed, GAO will monitor the impacts of SSA's

reengineering efforts as well as short-term changes in allowance rates and measures of quality assurance.

A SMALLER PROPORTION OF BENEFICIARIES LEAVE THE ROLLS

While SSA has devoted its management attention and resources to improving the disability determination process, it has focused too little attention and resources on determining whether beneficiaries already on the rolls should still be there and whether more beneficiaries could be encouraged to return to work. For every new beneficiary entering the DI program in 1985, one left. In 1994, one beneficiary left for every two new DI beneficiaries.

Why is a smaller proportion of beneficiaries leaving the rolls? Part of the reason is the trend toward younger adults entering the program. Another reason is that people who medically improve and no longer qualify for DI benefits are not being identified because SSA is not performing enough CDRs.

Finally, SSA has done little to facilitate the movement of persons with disabilities from the DI rolls to payrolls. This is especially evident when we look at the limited role of vocational rehabilitation (VR) and work-incentive provisions used to motivate beneficiaries to return to work.

Changing Beneficiary Characteristics

Before 1985, the typical new beneficiary was a male over 50 years old with either a cardiovascular or musculoskeletal impairment. Newly awarded beneficiaries today are more likely to be younger and mentally impaired.

Changes in eligibility standards prompted by legislative, regulatory, and judicial action have contributed significantly to the increase in awards to people with mental impairments (which include mental retardation and mental illness). The percentage of all persons accepted into DI with mental impairments in 1985 was 18 percent; whereas in 1994, one-fourth of all new beneficiaries were accepted based on a mental impairment.

A beneficiary with a mental impairment is generally younger and likely to receive benefits for a longer period of time than the physically impaired individual. In 1994, three-fourths of new beneficiaries with mental impairments were under 50, compared with one-third of new awardees with physical impairments.

Fewer CDRs

In the early 1990s--because of SSA resource constraints and increasing initial claims work loads--the number of CDRs declined dramatically. For example, SSA performed a total of 367,000 SSI and medical DI CDRs in 1989 and only 73,000 in 1992. Currently, the backlog of DI CDRs is about 1.7 million cases with about 500,000 additional cases coming due each year.

To help reduce the backlog of DI CDRs, SSA now uses computer profiling and beneficiary mail questionnaires, commonly referred to as a mailer, to more efficiently target limited CDR resources. The mailers cost SSA about $50 each, while a medical review costs about $1,000. SSA plans to conduct 234,000 DI CDRs in fiscal year 1996, which includes 119,000 medical reviews. Depending on how beneficiaries answer certain mailer questions and their profiles (e.g., age, impairment type, date of last CDR), those cases with the highest probability of benefit termination are then scheduled for a medical review. SSA estimates that its new CDR process has doubled its cost-benefit ratio from 3:1 to 6:1. The new CDR

process is both more efficient and has resulted in more terminations.

Although it has increased its cost effectiveness and better targeted limited resources, SSA needs to do more CDRs and, therefore, should explore ways to allocate more resources to this activity. Combined with the surge in applications and the growing tendency to remain on the programs longer, conducting CDRs has profound implications for expenditures. For example, in 1994, SSA determined that 17,000 DI beneficiaries were no longer eligible for benefits after conducting a CDR. These results are subject to appeal. SSA estimates that 65 percent will be upheld and that these terminations will save an average of $90,000 in lifetime DI and Medicare benefit costs. As a result, total savings from these CDRs could be almost $1 billion.

Few Rehabilitated Through VR

The Social Security Act requires that persons applying for disability benefits be promptly referred to state vocational rehabilitation agencies for services to maximize the number of individuals who could return to productive activity. Yet SSA has not made this a priority of the DI program. Over the last 5 years, SSA has referred only about 7 percent of initial applicants awarded benefits. Moreover, for every $100 SSA spends on DI cash benefits, it spends a little more than a dime on VR for DI beneficiaries. While we do not know what the appropriate level should be or what other employment assistance might be required, we believe that we need to determine how much this underrepresents the potential for returning beneficiaries to work.

As we reported recently, state VR agencies accept only a small percentage of all persons referred by SSA, and those that are accepted generally receive only modest services with disappointing long-term outcomes.[7] Only about 1 of every 1,000 DI beneficiaries is successfully rehabilitated, which means that they are gainfully employed for 9 months. One reason for VR's limited effectiveness is that a little more than one-third of DI applicants have been out of the work force for more than 12 months before they even apply for DI benefits. Experts generally agree that rehabilitation offered sooner--closer to the onset of the disability--would be more successful.

Another factor contributing to VR's limited effectiveness is that applicants are referred for VR services when their applications for benefits are being processed--a time when applicants are focused on trying to prove their inability to work. The program expectation that one will go back to work after receiving VR services is an expectation that is difficult to reconcile in a program that has historically been for workers who have left the work force because of their inability to work.

We are looking at other ways to offer rehabilitative services and hope to identify more effective approaches to provide vocational rehabilitation. We will share our findings with you when our work is completed.

Despite Work Incentives, Beneficiaries Unwilling to Risk Losing Benefits

Another factor contributing to the low numbers of beneficiaries leaving the rolls is the perceived high risk of losing cash and medical benefits by going back to work. Program provisions--called work incentives--are intended to allow

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[7]Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

beneficiaries to try to return to work without jeopardizing their benefits.

DI work incentives allow beneficiaries to continue to get full benefits during a 9-month trial work period regardless of their earnings. But, after the trial work period, benefits stop if they earn at least $500 a month, which is below the federal poverty level.[8] This total loss of cash assistance may discourage beneficiaries from attempting work. Beneficiaries with low earnings potential especially may be making a rational financial choice to limit work in order to continue receiving cash benefits. SSA officials estimate that in December 1994, approximately 16,000 DI beneficiaries were not receiving cash benefit payments because they had successfully completed this 9-month trial work period. This represents a small fraction of the 4 million disabled workers on the rolls at that time.

DI beneficiaries who work also risk losing medical coverage, not because they have medically improved, but because of earnings. Beneficiary fear of this loss is viewed by advocates and VR counselors as one of the most significant barriers to beneficiaries participating in a VR program and returning to work. DI work incentives provide for 39 months of premium-free Medicare coverage after the trial work period. When this coverage ends, beneficiaries may purchase Medicare coverage. However, the cost of this coverage, currently about $300 a month, may be especially unattractive to low-wage earners.

Few DI Beneficiaries Use SSI Work Incentives

DI beneficiaries who are concurrently receiving DI and SSI benefits may take advantage of the SSI work-incentive provisions as well. In fact, about one-half of the beneficiaries using the SSI work incentives are concurrent beneficiaries. Nevertheless, the number of DI beneficiaries using the SSI work-incentive provisions remains small. Approximately 34,000, or less than 1 percent of all DI beneficiaries, use the SSI work incentives.

SSI work-incentive provisions differ significantly from the DI provisions. Cash benefits do not abruptly stop once a beneficiary begins earning $500 a month or more but are gradually reduced by less than $1 for every $2 earned. SSI work incentives also allow recipients to continue receiving Medicaid coverage until earnings reach an amount considered high enough to replace one's cash and Medicaid benefits.[9]

SSA Developing New Strategies to Employ People With Disabilities

Recognizing that SSA does not have an effective structure in place to steer beneficiaries toward employment, in late 1994 the Commissioner formed a team under the leadership of the Associate Commissioner for Disability to develop a strategy to promote the rehabilitation and employment of current and potential beneficiaries. SSA acknowledges that if it maintains its present structure

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[8]After the trial work period, cash benefits continue for a 3-month grace period then stop if the beneficiary is earning $500 per month or more. The 9 months of the trial work period do not have to be consecutive.

[9]SSA uses a threshold amount to measure whether a person's earnings are high enough to replace SSI and Medicaid benefits. The threshold amount is based on (1) the amount of earnings that would cause cash payments to stop plus (2) the annual per capita Medicaid expenditure for the state in which the beneficiary lives.

-- program expenditures would continue to steadily escalate,

-- people who can work would continue to be trapped on the benefit rolls rather than gaining employment and achieving economic independence,

-- SSA's disability programs would continue to be viewed as being at odds with the Americans with Disabilities Act and other disability legislation, and

-- DI would continue to be viewed as "retirement."

We agree that SSA needs to focus more attention and resources on rehabilitating beneficiaries and returning them to productive employment. We also agree that SSA's current structure and administration of the DI program does not lend itself to doing this. SSA has just begun these efforts and it is too early to assess their effectiveness.

In addition to the work of this group, SSA will soon have the results of Project Network, which is a demonstration initiative for testing alternative ways to provide rehabilitation and employment services to SSA's disability beneficiaries. Project Network, with a budget of approximately $25 million, will test the use of case management to encourage and facilitate movement into the labor force as a possible alternative to long-term benefit receipt.

Although SSA seems to be moving in the right direction, we are not convinced that its current level of effort will be sufficient. A shift in orientation toward helping more people move back into the work force and reengineering the rehabilitation and incentive structure may be required.

CONCLUDING OBSERVATIONS

At nearly $40 billion annually in cash payments to disabled workers, plus $16 billion more for medical coverage, the DI program represents a significant investment of public resources. A program of this magnitude and importance needs proper management and controls to ensure that funds are being spent as the Congress intended.

Our work to date shows that SSA has not paid enough attention to controlling the program and managing caseload growth. Especially in light of this, we share congressional concerns that SSA's emphasis on reengineering should be closely watched to ensure that it does not result in increased allowances and less accurate decisions. If the public perceives that the program is loosely run, more people with only mild disabilities may be encouraged to apply for benefits. Finally, keeping the disability determination process as objective as possible will be paramount in managing caseload growth and improving program integrity, especially as SSA moves to a single standard for decisionmaking.

The high and growing costs of the DI program make it more urgent than ever for SSA to conduct more continuing disability reviews. As such, it is critical that reengineering efforts do not adversely affect the documentation in case files necessary to conduct future CDRs. In addition to CDRs, SSA should expand its focus to include more return-to-work efforts. Technological and social changes that have occurred since the 1950s make it more likely that beneficiaries can return to work and reduce their dependence on disability benefits. Even persons with severe disabilities are now able to work with the help of assistive devices. And the Americans with Disabilities Act sets high expectations for involving persons with disabilities in the work force.

SSA is beginning to look at the return-to-work aspects of the DI program. We believe that it can and should do more to improve the productive capacity of disabled beneficiaries and, in the process, better manage the DI rolls. Our ongoing work focuses on identifying alternative ways in which federal disability programs can better assist beneficiaries to return to work. To this end, we are ready to help the Congress in its deliberations on program improvements.

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

RELATED GAO PRODUCTS

Supplemental Security Income: Recipient Population Has Changed as Caseloads Have Burgeoned (GAO/T-HEHS-95-120, March 27, 1995).

Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Disability Benefits for Addicts (GAO/HEHS-94-178R, June 8, 1994).

Social Security: Most of Gender Difference Explained (GAO/HEHS-94-94, May 27, 1994).

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).

Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993).

Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992).

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (GAO/HRD-92-56, Apr. 21, 1992).

Vocational Rehabilitation Program: Client Characteristics, Services Received, and Employment Outcomes (GAO/T-PEMD-92-3, Nov. 12, 1991).

Social Security Disability: Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991).

Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

Impact of Vocational Rehabilitation Services on the Social Security Disability Insurance Program (GAO/T-HRD-88-16, May 26, 1988).

INITIATIVES IN SSA's
SHORT-TERM DISABILITY PROJECT

1. Publication of work load reduction targets.
2. Informal denials for nonimpairment cases.
3. Reduction of pre-effectuation review reconsideration sample.
4. Increase DDS review of reconsideration claims.
5. Rescind DDS adoption of initial level residual functional capacity or psychiatric review technique form for reconsideration decision.
6. Increase effectiveness of screening units.
7. Expand the prehearing conference initiative.
8. Assure effective utilization of necessary automation in OHA.
9. Increase OHA case preparation capacity.
10. Increase OHA decision drafting capacity.
11. Implement standardized folder assembly format.
12. Increase DDS systems purchases flexibility.
13. Enlist field office cooperation in medical evidence collection when hearing is filed.
14. Implement field office medical evidence of record process.
15. Make Office of Disability and International Operations examiners available to assist OHA.
16. Identify fiscal year 1995 DDS costs that can be forward funded.
17. Front-load fiscal year 1995 DDS budget.
18. Redirect central office staff to process disability work loads.
19. Continue Office of Disability evaluation of process improvement suggestions.

(106500)

Chairman BUNNING. Thank you, Ms. Ross.

What can GAO do to monitor SSA's short-term initiative and disability redesign plan to assure that allowance rates do not go up as a result?

Ms. ROSS. We would like to work with you and SSA to find a way that we can look at the allowance rates at several important parts of the process, especially at the places where they are doing something new, like introducing a new type of process, such as the senior attorneys reviewing cases, or, in the longer term, in reengineering a new disability claims manager position. We would like to be able to see these data monthly, do some analysis on places where there might be some increases in the allowance rate, and then look at the process overall to examine the net effect on the allowance rate.

So we would like to do a design plan and talk with you and then get Social Security's agreement to get those data.

Chairman BUNNING. Given what you currently know about SSA's short-term disability initiatives, which were devised to clear up the backlogs, and the long-term disability redesign, would you say that the number of claims allowed at all levels will go up, down, or stay about the same?

Ms. ROSS. I think we have some concern that just the time pressure, people trying their hardest to reduce the backlog, will encourage allowances. It is very important, therefore, that quality assurance measures be in effect at all levels of the process and include these new pieces of the process.

Chairman BUNNING. That is kind of what Mr. Christensen was asking earlier on. I am fearful that that might be a result of trying to reduce the backlog and speed up the process. It is a lot easier saying yes than it is no, as everybody in this town knows from some of the legislation that we pass and some of the tax laws that we now have.

What are your preliminary concerns about SSA's short-term initiatives and disability redesign plan? Do you think they will result in more allowances?

Ms. ROSS. I talked a little bit about the short term. When you get to the long-term reengineering, the same kind of concerns are there, but let me detail them a little more. We are, again, worried. We believe that these measures ought to be tested and monitored. For example, there are no reconsiderations in the new process, which might mean that more cases will go to the hearings level.

Also, this disability claims manager, a person who would consolidate a couple different claims processing functions, will have face-to-face involvement with each of the claimants, and there may be some tendency to allow cases which are less clear in the judgment area. While I understand what Mr. Jones said about having highly professional people, and I would agree with that, I still think this is a concern and it ought to be monitored.

Chairman BUNNING. We intend to do that.

You mentioned that SSA spends about $2.7 billion of its 1994 administrative budget on managing disability.

Ms. ROSS. Yes, sir.

Chairman BUNNING. This is about one-half of SSA's entire budget. Granted, disability cases are more labor intensive. What percentage of SSA's beneficiaries are on disability?

Ms. ROSS. If you combine the DI and the SSI caseloads, I believe it is about 20 percent of the total caseload.

Chairman BUNNING. Let us keep SSI out of this, because that is another subcommittee and another program. I want to do just SSDI.

Ms. ROSS. A little bit less than 20 percent. It is about 15 percent of all the cases they have to work.

Chairman BUNNING. SSA has approximately 42 million people on retirement?

Ms. ROSS. Yes, and they have 5.6 million on disability.

Chairman BUNNING. Thank you.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

You stated in 1985, there was an equal number of people going on the disability rolls as coming off and now it is about one for two. Can you tell me why?

Ms. ROSS. What you are asking is why there are so few people leaving relative to the number coming on?

Mr. JOHNSON. That is right.

Ms. ROSS. One major reason is that a lot of the people coming on the disability rolls now are much younger. Many of them have mental impairments. About one-quarter of the caseload has mental impairments and those are people who are considered disabled but they are not people who have a life-threatening illness that will cause them to die soon. So you have a set of people who come on earlier and stay longer.

In addition SSA has not been doing continuing disability reviews as fast or as frequently as we think they ought to be doing them. So those factors have meant that the number of people coming off the rolls each year has almost stayed the same while the number coming on has doubled.

Mr. JOHNSON. There are concerns that Social Security may be paying down rather than working down the hearing backlog, by having attorneys and paralegals make allowances and by allowing claimant representatives to submit draft decisions. Do you think these concerns are justified?

Ms. ROSS. As I said before, we are concerned in general in these short-term initiatives that people in an attempt to be speedier, will make more allowances. The issue of whether representatives can submit information to the ALJ or submit something that might be a finding, is an area that we have not actually dealt with at all in our work thus far. I believe the process is something that SSA can do now, but I will be glad to find out and be sure.

Chairman BUNNING. If you will please submit that, as you are going through your process of examination, and return it to the subcommittee.

[The following was subsequently received:]

Under STDP, SSA senior attorneys are authorized to make award decisions, without ALJ concurrence. Paralegal specialists may recommend an award, while the decision is left to the senior attorney or ALJ. Under a separate OHA policy initiative begun in April 1994, claimant representatives may submit draft decisions, but the

actual decision remains with the ALJ and use of any submitted language by an ALJ is purely voluntary.

STDP has experienced implementation delays and the case backlog has grown significantly since STDP was first announced in November 1994. SSA did not revise STDP's original backlog reduction goals, and attempting to meet them could create additional pressure to allow cases incorrectly. The first 4 months of data do not allow us to draw any conclusions yet about whether SSA is "paying down" its backlog. We will continue to closely monitor STDP's impact on award rates by examining, among other things, quality assurance data and the number of on-the-record ALJ awards.

Mr. JOHNSON. You mentioned that SSA saves an average of $90,000 for every CDR that results in termination. Does that not also mean that it improperly spends $90,000 in benefits for every questionable case it allows?

Ms. ROSS. Actually, I think you could calculate that it costs more for every questionable case that it allows.

Mr. JOHNSON. Really?

Ms. ROSS. It is a better answer than you might have thought. [Laughter.]

Ms. ROSS. If you look at the average age of people coming onto the DI rolls, it is somewhat under 50. If you assume many of them will stay on the rolls until they get to retirement age, they are going to be on the rolls 15 years. If you look at their average DI benefit and assume that they have the average expenses for Medicare for that period of about 15 years, total benefits would be about $225,000, without discounting or adjusting for inflation. It is a very crude number.

But the difference in the two numbers is that $225,000 reflects savings you could get from the time beneficiaries first enter the rolls. When we calculated the $90,000 figure, we were talking about a beneficiary that has already been on the rolls for some period of time and how much you would save in the future benefits from the point of cessation. I hope that is helpful.

Mr. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Ms. Ross, the public believes, perhaps justifiably, that many individuals who get benefits are no longer truly disabled and should be removed from the rolls. What are some of the problems in taking such individuals off the rolls?

I would also like to follow up on that. Why not repeal the medical improvement standards that were enacted in 1984?

Ms. ROSS. One problem with the CDR process may be inadequate information in the file in order to determine whether the person has experienced some improvement. Obviously, over the past several years, a greater issue for SSA is that they simply have not been doing enough of the continuing disability reviews.

I certainly want to agree with Dr. Daniels, who talked about the fact that they have improved and made their process much more efficient over the past couple of years.

Moving from there to talking about whether it is time to relook at the medical improvement standard, it did come about at a time when it appeared to the Congress and, I think, to the American public that this set of people really needed protection. I believe before you raise the issue about time-limited benefits for certain

parts of the caseload, a broad study examining those kinds of issues ought to be conducted which might focus on the profiling that SSA is doing.

Mr. CHRISTENSEN. How would you set up a program on a time-limited benefit scenario? How would you set that up? If you were crafting the program to save the Social Security DI system, how would you set up a time-limited benefit program? Would it be based on the type of injury? Would it be based on the track history? How would you set that up?

Ms. ROSS. I have not given it very much thought, but I will give you my first couple of reactions. It certainly would relate to a person's impairment. Did you really expect them to be able to recover, because those are the people you are trying to focus on, I believe. Beyond their impairment types, you might also want to take some account of their ages or their work histories that might make it more likely that they would be able to go back to work.

The combination would probably take a lot of time to work out, but the amount of profiling SSA is now doing is making it easier for them to target the people that look like they can recover.

Mr. CHRISTENSEN. What role has the change in the standards used to determine that mental impairments have affected the growth rate of the DI program?

Ms. ROSS. The 1984 Social Security amendment changed the way mental impairments were considered and broadened their treatment. At a point just after the law was passed, about 18 percent of the people allowed on the program had mental impairments, and now about 25 percent of the new people on the program each year are mentally impaired, so that it is now the largest single category of impairment.

Mr. CHRISTENSEN. I am sure this was discussed during the first panel. Was anything mentioned concerning the mental impairments for the DI recipients who are young such as some of the ADD, attention deficiency disorder, type of impairments that we are seeing an increase in?

Chairman BUNNING. No, that was not mentioned, because that is not jurisdictionally in this subcommittee.

Mr. CHRISTENSEN. All right.

Chairman BUNNING. But you are on the other subcommittee.

Mr. CHRISTENSEN. Yes, I am on the other subcommittee. Sorry about that.

Chairman BUNNING. That is true. [Laughter.]

Ms. ROSS. You can ask me there and I will answer it there.

Mr. CHRISTENSEN. I guess I am out of time. I will reload and come back.

Chairman BUNNING. Let me go back to some things. Would you roughly state the law that requires CDRs, how many years for a normal CDR, and for a CDR that there is very little possibility of ever getting off disability?

Ms. ROSS. The 1980 amendments, which I believe implemented this, said that for cases with medical improvement expected and medical improvement possible, the law requires review every 3 years. Some of them, you were supposed to review more frequently than that. For people where medical improvement was not expected, regulations require review at least every 7 years.

Chairman BUNNING. I have an interesting chart that shows the CDRs and how the backlog has grown and what the law requires that we have on the books. It shows that we are about less than 25 percent in compliance with the law. As you can see, the chart I have in front of me shows what we are doing. This is what the law requires. We are doing a little less than 20 percent of the required CDRs we should actually be doing.

If we do not do good study case history, if we do not get the information that we need to start with, then how can we review properly? Would that not be a major cause in this discrepancy? What I am saying is, if I do not have the proper information from the beginning and do not get the information and we make a decision based on improper or lack of proper information, then does that not create the problem that we are looking at, as far as the reviews?

Ms. ROSS. I think inadequate information can be a part of the problem. I cannot tell you now what part, but I would be glad to find out. What has been much more of a problem is that SSA has not scheduled or has not had the resources to pay for the medical exams for more than the number that you see there. They were trying to balance off increasing numbers of people who were applying for benefits and trying, at the same time, to figure out how many continuing disability reviews they could do. SSA's decision was to work on the front end of the process. As a result, you have very few CDRs.

Chairman BUNNING. SSA proposes to create a new case managers position, authorized to make disability decisions, some without physician reviews. The case manager would inform applicants directly if their claims were allowed or denied. Do you think that this approach will result in a higher allowance or a lower allowance?

Ms. ROSS. We have heard the concern, and we share it. This is something that really needs to be carefully tested because of the concern that people may tend to approve a claim, if they have to deal face to face with the beneficiary. That is a concern. I do not know if it will turn out to be true. I do think that is something that ought to be tested before it is implemented.

Chairman BUNNING. In other words, the situation as far as creating the new position, we ought to test the results before we implement the policy?

Ms. ROSS. I believe we should.

Chairman BUNNING. Or at least put a pilot program out in certain areas of the country?

Ms. ROSS. I think most parts of the reengineering process ought to be tested, and I believe there are plans to test most of them. We will, as I said, be glad to monitor that for you, as you had requested.

Chairman BUNNING. Does anyone have any other questions?

[No response.]

Chairman BUNNING. Thank you all for coming. We appreciate your testimony.

Next is Mary Chatel, president of the National Council of Social Security Management Associations. Ms. Chatel represents SSA field managers who are on the front lines dealing with the public every day. She speaks from personal experience.

On behalf of the subcommittee, I would like to recognize the 15 dedicated SSA field employees who lost their lives in the Oklahoma City bombing. We are deeply saddened by these tragic deaths.

The pressures on you, your fellow managers, and all SSA field employees across the country are great. I want you to know how much we all appreciate the outstanding job that each of you are doing. We welcome you, and you can begin your testimony.

STATEMENT OF MARY CHATEL, PRESIDENT, NATIONAL COUNCIL OF SOCIAL SECURITY MANAGEMENT ASSOCIATIONS, INC., WARWICK, R.I.

Ms. CHATEL. Thank you, Mr. Chairman and members of the subcommittee.

As president of the National Council of Social Security Management Associations, I represent more than 3,500 members, Social Security field office and teleservice managers and supervisors who deal with the disability crisis on a daily basis. We see the impact on people's lives of the disability backlogs and the excessive processing times.

Let me tell you about Albertina. She filed for disability in my office in Rhode Island in October 1992. Her case was denied 6 months later. She filed for reconsideration. This was denied 5 months later. She filed for a hearing in September 1993. The hearing was held an entire year later. It took 3 months for the hearing decision to get to her. She received the approval letter, and 2 days later, she died, 45 years old, 2 years after filing, never having received 1 cent in disability benefits. This is not an isolated case.

The causes that have led to this situation have been well described by SSA and GAO. I want to emphasize two additional factors which we actually have touched on here, the lack of consistency in the Office of Hearings and Appeals and the DDS decision adjudication processes. Unless or until initial and appeals decisionmaking is made consistent regarding interpretation of disability factors, this crisis will continue. Both OHA and DDS must work from one book, applying the guidelines in a uniform manner or OHA will continue to be flooded with appeals.

A fragmented organizational structure—customers have to navigate through a disability maze of disjointed components. We applaud Commissioner Chater for her leadership in recognizing and addressing the disability crisis. We endorse SSA's engineering concept, but implementation is key.

We support specific redesign initiatives to: No. 1, create early decision lists to get checks out to our most severely disabled claimants quickly; No. 2, establish teams in which claims representatives in field offices and disability examiners work together to expedite the disability process. This has been working for 2 years in my office in Warwick with an outstationed DDS examiner. We pay the severely disabled 1 month faster and save administrative costs in the process.

No. 3, create an adjudication officer position which would work with a denied claimant to prepare their case for hearing. These ideas are good ones that can be implemented in field offices today.

Our sense of urgency continues to increase as we see the backlogs at OHA continue to grow. We do not see the solution in con-

tinuing to pour more resources into OHA, particularly in adding even more ALJs or granting them Federal judge status. What we see as crucial is consistency in decisionmaking between appeals levels, changing the quality assurance reviews which concentrate on allowances earlier in the process and denials at the hearings level, and streamlining the appeals process and redefining roles in OHA.

A recent SSA proposal would narrow the function of the ALJ to hearing and adjudicating cases based upon the evidence presented and leave the case development to the adjudication officer. It would make better use of the ALJ's expertise and allow them to make more and quicker and more accurate decisions, thus moving to reduce the hearings backlog and shorten processing times. We endorse this concept, including the proposal that the adjudication officer be community based.

Our association has developed a plan which we urge you to consider. We propose ways to improve the disability process for initial claims, work down disability backlogs, and conduct more continuing disability reviews. These solutions can be found in shifting resources to the field and building community-based teams composed of field offices, DDSs, and OHAs, working cooperatively to maximize the number of cases we do right away in the field office.

The local field office is the one and only place where we can provide any semblance of personal, accessible, one-stop customer service. The future we envision involves a true seamless process which minimizes bureaucracy and enhances clarity and service to the customer. We also need the IWS/LAN computer system so that more of the disability process can be automated and we can link up to the different components to create a much less costly process. Doing all this may not be easy but we need to begin now.

Finally, we must devote more resources to processing continuing disability reviews if we are to protect the disability trust funds and the integrity of the program. If we can save $4–$6 for every $1 we spend to conduct these reviews, does it not make sense to invest this money?

Success depends on two things, commitment and followthrough. We say, let us get going. Thank you.

[The prepared statement follows:]

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STATEMENT OF
MARY CHATEL, PRESIDENT
NATIONAL COUNCIL
SOCIAL SECURITY MANAGEMENT ASSOCIATIONS

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

REGARDING THE
SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

MAY 23, 1995

The National Council of Social Security Management Associations (NCSSMA) represents more than 3500 SSA field office and teleservice managers and supervisors across the country. We are responsible for administering all SSA and SSI programs in person and by telephone to each individual who contacts Social Security each day. We deal personally and professionally with the disability crisis on a daily basis. We see the impact on people's lives of the disability backlogs and the excessive processing times. In our attempts to help these individuals, we are frustrated by the current fragmented disability process.

NCSSMA members are therefore acutely aware of the need to improve SSA's performance in handling the disability program. We have specific recommendations to make regarding how the agency can integrate it's disability re-engineering project into a reorganized SSA to improve all our services, more effectively utilize available resources, and ensure accountability both to our customers and the taxpaying public at large.

CAUSES OF DISABILITY PROGRAM PROBLEMS

The causes and extent of the Social Security disability backlogs have been well described both by SSA and by the General Accounting Office. In March of this year, in testimony before the Senate Special Committee on Aging, GAO identified the following factors contributing to the growth in DI benefits paid (from $19 billion in 1985 to $38 billion in 1994) as well as the growth in SSI benefits paid.

Eligibility expansion and program outreach bringing more persons into the program.

Performing fewer Continuing Disability Reviews (CDRs) than required by law, resulting in fewer persons no longer eligible for benefits leaving the program.

Possible increase in fraud and abuse, particularly among children, immigrants and drug addicted and alcoholic applicants.

Economic factors including the recession.

Disabled individuals with certain medical conditions living longer through advanced medical technology.

Individuals applying for disability benefits in order to obtain affordable health insurance.

Lack of facilitation of the movement of persons from the disability rolls to payrolls, despite a national survey indicating that four of every five persons with disabilities who are not working want to work.

Some of the forgoing -- the economic recession, advances in medical technology -- are beyond the control of SSA. We must simply find ways to accommodate the increased workloads they precipitate. Other factors, such as conducting CDRs, call for immediate intervention not only to help ensure that individuals no longer eligible for benefits do not continue to receive them, but also to help overcome real and perceived fraud and abuse in the system. Still other factors, such as providing improved assistance and incentives for returning the disabled to work, need careful evaluation to identify effective ways for SSA and others to meet the challenge presented.

NCSSMA adds the following to the above list of causes of the disability caseload processing problems:

Inconsistencies in the Office of Hearings and Appeals (OHA) and the Disability Determination Services (DDS) adjudication processes. Unless and until OHA/DDS decision making is synchronized and consistent regarding interpretation of disability factors, this crisis will continue. Both OHA and DDS must work from "one book," applying the guidelines in a uniform manner, or OHA will continue to be flooded with appeals.

Backlogs at the Office of Hearings and Appeals caused by an almost unmanaged process.

Lack of state of the art interactive computer network.

Since the downsizing of the 1980s, lack of adequate staffing to both process initial disability claims AND conduct Continuing Disability Reviews.

Fragmented organizational structure. Customers have to navigate through a disability maze of different components, none of which have responsibility for the whole piece.

SSA'S DISABILITY REENGINEERING PROJECT:

NCSSMA applauds Commissioner Chater for her leadership in recognizing the disability crisis and initiating and giving her full support to a disability reengineering project. SSA's disability reengineering proposal to handle new disability claims in the future was well-researched and evaluated. SSA asked the public what they wanted. SSA spoke with all stakeholders, both internal and external, and listened carefully to what was said. SSA considered the many innovative things managers were doing in field offices nationwide to try to ease the disability crisis. In fact, SSA's reengineering team's extensive research led to a proposal which closely followed changes NCSSMA had long advocated.

Particularly noteworthy was the proposal's responsiveness to what the public has said they want and need:

- The public says it takes too long for a decision. The proposal points to the fragmentation of the disability process as one factor creating inefficiencies and delays. It would streamline the process by eliminating the Reconsideration and Appeals Council steps, without putting the claimants at a disadvantage.

- The public has said that they are confused by a complex disability process and resent having to pay an attorney to guide them through it. The plan proposes to simplify evaluation criteria to a lay level of understanding.

- The public says that they want to be more involved in the disability process. They want to deal with one individual rather than numerous people. They want their claims handled locally all the way through the process. The proposal would give claimants a single contact point for questions, assistance and meaningful dialogue throughout the process, encouraging and inviting their participation and providing clear and understandable explanations of the decision on their case, both verbally and in writing.

- The public wants service that is tailored to their individual needs. The proposal recognizes the value of community based service by calling for greater flexibility in providing service to claimants. Local managers could modify the intake process as necessary to best meet the needs of their claimants. It calls for the COMPLETION of most aspects of the disability process in the local office without the handoffs that create a bureaucratic nightmare for claimants and employees alike. Likewise, local managers could work with qualified third parties in determining how best to meet the needs of the claimants with whom they interact.

If the proposal were properly implemented, with the required commitment of human, financial, training and technological resources, positive results would include:

- Dramatic reductions in the length of time that applicants must wait for eligibility decisions. By reducing the number of handoffs, streamlining the decisional methodology, simplifying the development of medical evidence, and reducing the levels of appeal, applicants should receive more timely decisions.

- The pre-denial interview and the discussions with the Adjudication Officer should give claimants a better understanding of exactly what is going on in their case, what evidence is required, and what they can do to speed up the process.

- Ability to develop complete medical evidence prior to the hearing and clearly identify issues in dispute should lead to a streamlined hearing process.

- Due process protections and appeal rights remain in full force for applicants and should be better understood by them due to their greater involvement in the process. They would have the opportunity for discussions, in person if they so desire, with the decision maker at each step.

- Quality assurance aspects of the proposal should provide for an accurate decision as early as possible in the process. Here, successful implementation of the proposal is directly and strongly tied to initial and on-going training. We applaud the investment in employees and in training efforts which the proposal describes.

- **Using a single mechanism for communicating all policy to all decision makers in the process should also counter the perception that different levels of adjudication use different standards in determining eligibility. It should also help that denials and allowances will be reviewed for all levels of decision-making, rather than the current system which favors a review of allowances at the early levels and of denials at the later levels.**

NCSSMA CONCERNS ABOUT DISABILITY REENGINEERING

There are several causative factors in the disability crisis that are not addressed or are inadequately addressed by SSA's reengineering project. Specifically, the plan:

Does not address the current backlogs or the need to conduct Continuing Disability Reviews. While we understand the need to focus on initial disability determinations, the fact that SSA is unable to conduct the minimum required number of CDRs serves to erode both the disability trust fund and public confidence.

Does not address the organizational structure of the of the agency except to say that organizational change will come about after the process is reengineered. NCSSMA believes, however, that SSA cannot "reengineer" in an organization of 65,000 people without first making decisions about extensive organizational change.

Fails to adequately address the appeals process. This is where the major backlogs have been and continue to occur. Continuing to pour more resources into OHA is not the answer. NCSSMA believes that streamlining the appeals process and redefining roles in OHA is the direction SSA must take.

Therefore, NCSSMA was pleased to read a current proposal from SSA's implementation team on the "Organization and Character of the Administrative Hearing Function". This proposal would narrow the function of the Administrative Law Judge (ALJ) to hearing and adjudicating cases based upon evidence presented and leave the case development to the Adjudication Officer. It would make better use of the ALJs' expertise and allow them to make more and quicker decisions thus moving to reduce hearings backlogs and shorten processing times. NCSSMA endorses this concept as well as the proposal's statement that the Adjudication Officer be community-based. Placing the management of the process, as well as the scheduling of the hearings, under a FO/DDS/OHA team director would further expedite these cases.

Another concern is that the disability process re-design legitimizes the third party role in the disability application process. Further, this proposal may allow direct input of information by third parties to SSA databases. While we recognize the need for and value of, third parties like hospitals, large employers, non-profit organizations, etc. assisting their "clients," we have a different point of view about the growing <u>for-profit</u> sector.

We believe that the ultimate definition of success of a disability re-design would be the demise of these types of <u>for-profit</u> disability representation businesses. The <u>for-profit</u> sector was born and has expanded because the disability process was broken. It should shrink as the process is fixed--as we simplify it, make it more understandable, get the right decision made earlier in the process, create a customer-friendly intake and decision making system, etc. SSA's customers should not have to, or be encouraged to, pay significant sums of money to a representative when SSA could and should be able to provide the

same service at no additional cost. SSA customers have already paid for this service with their FICA taxes. We therefore urge clearer distinctions between the not-for-profit and for-profit third party sector.

People in the field are focused on implementation and accomplishment -- on doing what it takes to get the job done. We anxiously await implementation in the field of the various facets of the redesigned process. Currently, redesign task teams have completed work in several main areas. These include:

- an "early decision" list of disabilities that can be awarded in field offices with appropriate supporting evidence -- thus saving up to several months of processing time in the DDS and getting checks out to our most severely disabled claimants in a more expeditious manner

- several teamwork scenarios in which claims representatives in field offices and disability examiners in DDSs will work together to process and pay claims for disability -- thus reducing handoffs and improving the quality and speed of a final decision

- advocating claimant participation in the development of their claim -- obtaining medical evidence faster and enabling the claimant to be involved in the process

- an Adjudication Officer position which would work with a denied claimant and their representative to ensure that they understand the basis for their denial and to assist them in preparing their case for a hearing if they choose to file.

All of these ideas are good ones that can be implemented in field offices today. They would begin to move us in the direction of improved public service to the disabled population in the form of more expeditious decisions on their disability claims. With backlogs growing at the Office of Hearings and Appeals on a daily basis, our sense of urgency in moving forward with implementation of the redesign also grows.

Finally, we encourage SSA to be open to consider additional ideas for change. Examples of such ideas were contained in the SSA Disability Process Redesign report dated March, 1994.

Appendix VII of that report discussed "Process Change Recommendations That Were Outside the Parameters" of the disability redesign team's mission. Ideas like time-limited benefits, an expanded emphasis on vocational rehabilitation, creation of an SSA Court, and using Hearings Officer positions rather than an Administrative Law Judge are worthy of additional study, debate, and consideration.

A particularly critical item is that of the very definition of disability. In order to define the term, we all (SSA, Congress, the academic, medical and legal community, etc.) must come to grips with a basic question--"What should our disability program be trying to accomplish?" In other words, we ideally should establish a clear disability vision and have our policies and procedures flow from and compliment that vision.

DISABILITY REENGINEERING SHOULD BE INTEGRATED INTO A COMPREHENSIVE, COMMUNITY-BASED SERVICE DELIVERY PLAN

As a result of the ongoing crisis in the disability program, SSA has approached identification of solutions in isolation from other service delivery issues. The long-term disability proposal does not address critical questions of how resources within the agency should be allocated to best manage all of the agency's responsibilities to claimants, beneficiaries, and the taxpaying

public at large who support both SSA benefits and operations with their contributions to the trust funds.

NCSSMA has developed a proposal to restructure the agency and reallocate resources within it to improve efficiency, effectiveness and accountability and offer all who contact us choices in service tailored to their specific needs. (A brief summary of our proposal is attached to this statement.)

Under our proposal to restore SSA to the model agency status it commanded throughout most of its history, we suggest that solutions to the problems of improving the disability process for initial claims, working down disability backlogs, and better conducting Continuing Disability Reviews (CDRs) can be found in shifting resources to the field and building community-based teams. These teams would be composed of SSA field offices, state DDS offices and OHA working cooperatively to maximize the number of disability claims which can be completed in local field offices.

The current confusing, inefficient, and fragmented disability process would be replaced by precisely the kind of process advocated by SSA in their reengineering proposal. The customer's desires for more personal contact, more personal involvement, and intervention and assistance with the decisionmaker would all be addressed by the "case manager" approach. While SSA's disability re-design package avoids specifying implementation strategies, the narrative includes references to "accessible, personal service," "local managers," and "the community."

A local office approach provides the means to reach the goals sought by the re-design:

- more accessible, personal service
- expanded client interaction and dialogue with the decisionmaker
- expanded involvement with non-profit third parties who act on behalf of claimants
- expanded educational efforts with the general public and local agencies and groups who assist them
- maximizing local flexibility to tailor service options and the intake process to local conditions
- in-person pre-denial interview (if the client chooses face to face vs. telephone or video conferencing)
- expanding interaction with local medical providers to secure more prompt and more meaningful medical evidence

HOW TO STRUCTURE DISABILITY TEAMS TO GET THE JOB DONE

The emphasis on greater teamwork in disability redesign is clear in SSA's proposal: "The teamwork concept is a fundamental ingredient in the new process." Our current process is full of hand-offs, disconnects, lack of accountability, lack of understanding, and lack of cooperation.

The teamwork concept is critical but it must become more than a concept to be effective. We will not achieve the teamwork desired if we leave the intake process in the Field Office, the decision-making process in the DDS (or other centralized unit), and the appeals decision in OHA. To achieve it, we have to do radical surgery on our organizational structure.

Teamwork goals, tied with NCSSMA overall re-design goals, again lead to one conclusion -- the local field office must be the focal point. The local field office is the one, and only, place where we can provide any semblance of personal, accessible one-stop shopping. Here's our picture of what the re-designed organizational structure would look like in a typical Field Office:

- The customer will be served by a position called a Disability Claims Manager (DCM). The DCM will be responsible for assisting the customer in filing the application, obtaining medical evidence and fully developing the claim. This same position will decide whether the claim will be allowed or denied.

- The DCM and local management will serve as the focal point for the general public, advocates, and the medical and legal community on issues related to both policy and process.

- A claimant who wishes to appeal an unfavorable decision will be served by a position called the Adjudication Officer (AO). The AO will receive requests for a hearing, explain the hearings process to the claimant and develop and prepare the claim for the hearing. In addition, if the evidence clearly supports a favorable decision, AOs should be allowed to process the appeal to completion.

- The work of the DCM and AO would be supported by field office clerical and technical staff. Workloads would be assigned, controlled and processed under the oversight of local field office management.

- Field Office clerical, technical, and management staff would also provide support to Administrative Law Judges. By performing scheduling, typing, and other miscellaneous support functions in the field office, a separate organizational structure called the Office of Hearings and Appeals would not be necessary. Administrative Law Judges would focus on hearing and deciding cases rather than the management function of assigning, monitoring, and processing work and evaluating its timeliness and quality.

This picture envisions a true "seamless" process which minimizes bureaucracy, maximizes teamwork, and enhances clarity and service to the customer.

The disability reengineering proposal's focus on customer service and teamwork has led us to conclude that SSA must take a local, personalized, readily accessible and highly accountable approach to service delivery. We are aware, however, that there are advocates within SSA for alternatives, such as:

- The "Let's Change Part of It" Alternative, that seeks to simplify the evaluation and decision-making process, get DDS's and OHA on the same wavelength, eliminate steps in the appeals process, but leaves the FO/DDS/ ODIO/OHA service delivery structure essentially as is.

- The "Centralized Service Delivery Mode" Alternative, that seeks to centralize the intake, development, and adjudication functions into remote, largely inaccessible processing centers.

What's wrong with these alternatives? Neither achieves what the reengineering proposals seek. The "Let's Change Part of It" scenario fails to localize, personalize, or integrate the existing service delivery system and leaves a fractured, bureaucratic, and non-customer-friendly system in place. The "Centralized Service Delivery Mode" scenario simply disregards the entire discussion of localized, personalized, accessible, and accountable customer service and chooses instead to place it's sole priority on organizational integration. Both alternatives leave us where we are in terms of disconnects, inefficiencies, redundancies, problems with understanding and communication, and long delays.

We recognize that there are pressures which push SSA to give these deficient alternatives serious consideration:

Pressure to reduce the number of federal employees and concern about the 13,000 employees in the DDS's, currently on "state payrolls."

Pressure from the DDS and OHA communities to minimize change and maximize the status quo.

Pressure from the centralized processing advocates to create new workloads and new responsibilities for organizational components struggling to find a larger niche in the electronic, distributed technology and customer-driven future.

The very premise of the disability reengineering effort was, however, to "start over." That doesn't mean tinkering with what already exists or making incremental changes that leave basic structures intact. Disability reengineering decisions have become SSA service delivery decisions, and will serve as a "litmus test" for the resolution of the community based, personalized, accessible, and accountable approach vs. the centralized, remote, de-personalized, and less accountable approach.

TECHNOLOGICAL ADVANCEMENT CRITICAL TO HANDLING DISABILITY

Ninety percent of SSA field offices are currently run on "dumb" computer equipment long abandoned by other agencies. In many offices, the equipment is so old that it is near the end of its systems life, and SSA offices risk collapse of even this inadequate computer equipment if new technology is not implemented in their facilities soon. In many offices, employees must wait in line to share computers.

In those ten percent of offices where the Intelligent Work Station/Local Area Network (IWS/LAN) computer project is up and running, every process is faster. SSA has a schedule for installing IWS/LAN throughout the field, but every year funding for the program is endangered during the congressional appropriations process.

Funding and installation of this interactive computer equipment is absolutely necessary if SSA is to be able to run the Reengineered Disability System now being developed -- new technology which can speed the disability process by linking field offices to state disability offices and automating disability paperwork.

TRANSITION TO FULL IMPLEMENTATION AND SHORT TERM INITIATIVES

Transitioning to the new process and new organizational structures may not be easy, but we need to begin expeditiously.

NCSSMA proposes the creation of multiple implementation sites around the country where the new process and the new structure is brought under one roof. These would test the new technology, the new medical evaluation process, the new intake and decision making steps, and create the teamwork concept among DCM's, AO's, and support/management staff.

Above and beyond the formal implementation sites, we suggest that SSA aggressively pursue placing state DDS examiners in field offices. Where possible commutes exist, that outstationing should occur quickly. Additionally, we should work with the States to explore personnel re-locations and target future DDS hiring for the out-stationed mode of operation.

Expanded out-stationing will better prepare field offices to transition to the inclusion of DCM's, AO's, and Hearing support staff into their position mix. In essence, out-stationing would give us a "head start" that would provide valuable expert resources

in the near-term, provide for the beginnings of the massive training effort needed to successfully utilize the DCM and AO positions, and provide mini-laboratories that would identify issues/alternatives for the implementation sites and the larger organization to deal with.

This same out-stationing concept could be used for Office of Hearings and Appeals personnel in much the way that the April 28th "Proposal Regarding the Organization and Character of the Administrative Hearing Function" suggests. Again, the purpose would be to get us on the road to creating a "we" mentality, operation, and service delivery system.

CONCLUSION: WHAT IT WILL TAKE FOR SUCCESS

Success depends on two things - commitment and follow through. A seamless, efficient disability process will not occur unless the organization is both willing and able to commit its energies and its resources to it. Movement of staffing resources to the front lines and changing the organizational structure and processes to ensure that the correct disability decision is made as early in the process as possible is essential to success. Other necessities include technological support in the form of a modernized disability system and Intelligent Work Station/Local Area Network computer equipment; training (up-front and on-going) support to allow the new positions, new processes, and new technology to be effective; and financial support for the new equipment, space renovations that address staffing and employee safety issues, employee detailing and redeployment, etc.

SSA can successfully manage all of its workloads, including the increase in disability cases, the effective conduct of Continuing Disability Reviews, and working down backlogs in both new cases and reviews, if and only if all available resources are more closely aligned with agency mission. A truly reorganized and streamlined agency would develop, implement and operate under a comprehensive service delivery plan focused on the customer which places responsibility, authority, and accountability in field offices located where our customers live and work and staffed with competent, trained employees using state of the art information technology. Such a plan would ensure the most efficient possible use of trust fund dollars for Social Security operational expenditures.

Without such a plan, and the commitment to act on it, unsatisfactory and ultimately unsuccessful piecemeal approaches will continue, leading to more and more initiatives which identify others outside the agency to take over our responsibilities. These "solutions" are the result of inability or unwillingness to do the hard work of reorganizing within existing funding constraints. We believe, for example, that the reallocation of one additional employee to each of our 1300 field offices to conduct Continuing Disability Reviews would result in elimination of the CDR backlog within one year, saving four to six dollars for the trust funds for every one dollar spent in this way.

If the promise of true restructuring were realized -- to better serve the public and better spend taxpayer's dollars -- SSA could not only handle the growth in disability cases but could return to the model agency status of which we were once so justifiably proud.

SUMMARY
SSA: MODEL AGENCY IN CRISIS
February, 1995

National Council Social Security Management Associations's members are responsible for field office and teleservice operations -- facilities which are Social Security to the American public. If there are "experts" in customer service and customer preferences in SSA, they are to be found among the 31,000 field employees working in daily contact with this country's citizens in our offices.

SSA has gone from being the most widely respected federal agency over its first forty years to being a struggling agency, overwhelmed with work, with significant gaps in service, falling behind the technology curve, maintaining an obsolete organizational structure. The agency's decline is due to many factors, including: lack of planning time, inadequate preparation, and resource shortages when the SSI program was implemented in the 1970's; a 25 percent reduction in staff in the 1980's; tremendous growth in disability and telephone workloads; legislative initiatives which mandated action without providing adequate resources; and a failure to implement strategic or business plans.

Public confidence in Social Security will not be restored unless SSA organizes itself to serve two complementary goals: 1) its mission to provide tailored service to the many types of customers we serve and will serve in the future, and 2) its accountability to the taxpaying Americans who fund the program with their payroll deductions and have a right to the best stewardship SSA can provide over expenditures from the trust funds.

NCSSMA has a plan -- a bottom-up reorganization which puts into action the driving principles of the Government Performance and Results Act and the National Performance Review -- **a reorganization built around mission and putting the customer first. We propose:**

* **One Stop Shopping:**
  Consolidate services to provide timely, accurate SSA actions in full-service field offices located in communities across the U.S. where every type of caller, claimant and beneficiary is served by accountable, competent employees.
* **State of the art information technology:**
  Put high technology and sufficient numbers of trained staff in community based offices and co-located tele-service centers across the country. Use this technology to handle nearly every SSA action to completion, protect confidential information, and ensure system security.
* **Decentralization:**
  Accelerate downsizing of centralized processing facilities, re-deploy resources to the field, and delegate authority to the front lines.
* **Reorganization:**
  Establish a Chief Operations Officer in charge of day-to-day functioning of the agency.

  Create a streamlined, customer-focused and mission-driven SSA structure with only two layers between the field office and Chief Operations Officer, keeping decisionmaking as close as possible to the customer.

  Shift from a complex top-down hierarchical structure to a simple chain of command beginning with the front line employees who work directly with the public.

  Place authority and accountability at the lowest level on the line.

  Move from functional components which compete for resources to creation of administrative functions existing solely to support the operational mission.

For the full proposal, please contact:
NCSSMA President Mary Chatel, 30 Quaker Lane, Warwick, RI 02886; phone (401) 822-1409 or NCSSMA Washington Representative Janet Garry, P.O. Box 749, Rockville, Md. 20848; phone (301) 770-1850.

Chairman BUNNING. I would like to ask you some questions of what you think of the new disability claim position. Do you think it would actually work on the front lines of SSA? It is part of the redesign.

Ms. CHATEL. I actually see this working in some ways in my office. As I said, we have the claims representative taking the claim and we have a Disability Determination Services person, an examiner, in my office. For 2 years now, we have been working this way. They work together. The claims representative takes the claim. If they have questions right there, the examiner comes out and also talks to the claimant.

We have gotten the people involved in helping us obtain their medical evidence. We are getting better medical evidence. We are getting medical evidence from doctors that usually do not respond to DDS's request, so we have saved money in having less consultative exams.

We have situations where we are able to make a decision within 1 week or so of the person filing. What I am talking about are the most severely disabled, mostly the terminal cases, the people who we should be paying really quickly. I think it can work.

Maybe this teamwork works better than having one person be the disability claims manager. Maybe it is better to have a teamwork approach. I believe, as was discussed here earlier, that if we had one person as a disability claims manager, it could result in more allowances.

Our claims representatives every day deny people to their face for SSI benefits, for retirement benefits. They tell people they are overpaid. If we give them good criteria to go by, they will do the job and they will do the job right. The high allowance rate is not at the initial or the reconsideration level. The high allowance rate right now is at the OHA, at 80 percent.

Chairman BUNNING. Let me ask you, in Rhode Island, who is in charge of appointing the doctors that do the examining?

Ms. CHATEL. The DDS hires—for the consultative exams?

Chairman BUNNING. For the initial exams. In other words, who makes the determination which medical doctor will be an SSA examination doctor?

Ms. CHATEL. I think you are talking about consultative exams and that would be with the Disability Determination Services, the State.

Chairman BUNNING. The State?

Ms. CHATEL. Yes. What doctors we ask for depends on the person applying. We ask, if you are applying for disability, how many doctors do you have, what hospitals have you gone to within the last year, and we ask for medical evidence from all of those doctors. If there is not enough information or a person does not have a doctor or there is some discrepancy in the case, then the DDS can order a consultative exam and that is with doctors that they have contracted out with.

Chairman BUNNING. Who makes that determination?

Ms. CHATEL. The DDS examiner, usually.

Chairman BUNNING. In other words, I am trying to get to the politics of this.

Ms. CHATEL. Whether a consultative exam is necessary, you mean, or——

Chairman BUNNING. No, whether the doctor is a political appointee or whether he is not.

Ms. CHATEL. A political appointee? I am not sure I follow you. I am sorry.

Chairman BUNNING. In other words, if I have a friend of the Governor who happens to be someone that I would like to do the consultative exams, could he be appointed to SSA to do the exams for the local office?

Ms. CHATEL. I have to say that the DDS, at least in Rhode Island, because this is what I know about, has a very difficult time getting doctors to do the consultative exams because they do not pay them that much. I am not sure. I am sure that could happen.

Chairman BUNNING. My staff just said the next panel might be able to help me out on that, so we will go on with some other questions.

The way I understand it, the public does not currently deal directly with the DDS examiners who actually deny their disability applications, but the new disability claims manager would. Is that a correct assumption?

Ms. CHATEL. It is a correct assumption right now. In my office, for 2 years now, we have had a little bit of a different situation and they do talk directly to the DDS person. But throughout the country, that is correct.

Chairman BUNNING. The new disability claims manager is not universally out in the field right now?

Ms. CHATEL. No.

Chairman BUNNING. No, I did not think so. So what you have is different than what I have in Kentucky?

Ms. CHATEL. Absolutely. There are a lot of different pilots going on around the country, though.

Chairman BUNNING. According to the SSA data, roughly 6 out of 10 people are denied the first time they apply for disability. Is that pretty accurate?

Ms. CHATEL. I think so.

Chairman BUNNING. It is? Is Rhode Island the same way as everywhere else?

Ms. CHATEL. Yes, a 40-percent allowance rate.

Chairman BUNNING. Can you tell us something about the typical disability applicant? GAO has said more are younger and more have mental disabilities. Is that your experience?

Ms. CHATEL. I think we have seen a definite increase, and as the Commissioner had said, people are getting—all of us are over 40 now—we are approaching that disability-prone time. There are many more mental impairments, more drug and alcohol claimants.

Chairman BUNNING. So, if a disability claims manager is faced with making a decision on a borderline case, do you not think that he or she may, out of sympathy for the applicant or maybe to avoid having to deal with an angry applicant, allow the claim?

Ms. CHATEL. I do not actually believe—as I said, our claims representatives every day make decisions to deny people. Safety is absolutely a concern, but it is a concern right now, here and now, before they even get into doing that.

I think this whole decision about whether we are going to end up allowing more cases or denying more cases really hinges on this disability methodology, the simplification of it that is part of this disability reengineering thing that has not happened yet. We do not know how they are going to simplify the disability methodology.

Right now, when a person is denied, they receive the letter in the mail and they come in mad, usually, to see the claims representatives in my office, who usually does not have a folder, does not have any information about what this person's disability is or why it has been denied, and then we can say, well, someone else did that. That is not really the best way to deal with it. It is better to say, this is——

Chairman BUNNING. It just makes them madder.

Ms. CHATEL. Yes, it just makes them madder. So in this situation, you have to weigh it. Is it better to have more information and know that a real crazy person is going to come in to see you or not?

I do not think we know the answers to those questions yet. I think we have to try it out. But I do believe that, something we have been saying for years, we need more safety for our employees, whether in the DDS or in our field offices. I think it can work.

Chairman BUNNING. In questioning the Commissioner, she said that the definition of disability was all right. According to your testimony, you think we should take another look at it. Why is there a difference of opinion, or why do you think that we should take a look at the definition?

Ms. CHATEL. I think we probably should take another look at it. I think the definition in itself is probably fine. The way it has evolved over the years, how people have interpreted the definition of disability with the court cases and what is going on, what legislation has been passed, has created this big discrepancy, I think, between how the DDS makes the decision and how the Office of Hearings and Appeals makes the decision, and we have to get that straightened out.

In straightening that out, if it means changing the disability definition or it means just applying the disability definition much more strictly——

Chairman BUNNING. How do we do that, unless there is a policy from SSA to do it?

Ms. CHATEL. I think that is what they are looking at with the process unification, the one book.

Chairman BUNNING. It does not make any difference what is in the book if it is an interpretation of the definition. In Rhode Island, we are going to interpret the definition one way. In Kentucky or in Ohio, we will interpret the definition another way.

Ms. CHATEL. It has to be overall, right.

Chairman BUNNING. There has to be some kind of very consistent interpretation or we are going to have wide discrepancies in what is allowed or what is disallowed in Rhode Island and what is allowed and disallowed in Kentucky, is that correct?

Ms. CHATEL. Yes.

Chairman BUNNING. Do you have some suggestions?

Ms. CHATEL. Of how to change the definition?

Chairman BUNNING. Yes. We are looking for reasons and other alternatives than just continuing the same definition and having one book to work out of, because one book is not going to solve the definition problem if it is interpreted differently on the west coast than it is on the east coast.

Ms. CHATEL. I do not have a solution, but I am sure you will come up with one for us.

Chairman BUNNING. If you were free to make any improvements in the program, what would they be?

Ms. CHATEL. Right now, I would start the action right now. I would redeploy more of SSA's staff to the front lines to make decisions, accurate decisions, faster. I would work in teams with the DDSs. We are so fragmented. We have not been working together. We need to get working together to make the decisions quicker.

I absolutely would put people—I think what I would do is put one person in every one of the 1,300 field offices in the country and say, just do continuing disability reviews. I think in doing that, they could probably do 15 in 1 week, which would work down the 1 million backlog in 1 year. I think that is what I would like to do.

Chairman BUNNING. Thank you very much for your testimony.

Ms. CHATEL. Thank you. Can I also say, I was slipped a note that the Commissioner asked me to state her regrets because she is leaving to catch a plane and she will read everyone's statements. Thank you.

Chairman BUNNING. That is very nice. Thank you.

Mr. Christensen, go right ahead.

Mr. CHRISTENSEN. In your opinion, what does the public least understand about the disability program? As a field manager, what is it that you see that the public least understands about the disability program?

Ms. CHATEL. I think the totally fragmented system. I file in your office today and then I get a letter and I come in and ask you about it and you say, well, someone over there made that decision. The word is out there, if you get denied at the initial level, you had better file for a reconsideration. Then you had better file for a hearing because that is your best chance of getting allowed. They think that this is just a way of delaying paying them the benefits that they are due by paying in their FICA taxes all those years. They think we are doing this on purpose.

Mr. CHRISTENSEN. Would you also consider that your biggest public relations problem?

Ms. CHATEL. Yes, yes, including once the hearing is held, that taking so long to get the disability decision out to them, particularly if it is an allowance. It makes very little sense to take 9 months, I think, to write up an allowance decision that who is going to complain about it, the person who is getting their check? I think that could be cut down quite a bit.

Mr. CHRISTENSEN. I would guess the problem you just enumerated would also be what you consider the biggest problem facing the field?

Ms. CHATEL. In disability?

Mr. CHRISTENSEN. In disability.

Ms. CHATEL. Yes.

Mr. CHRISTENSEN. I am told your organization has assembled a reorganization plan built around a mission and the organization in terms of putting people first. What is this reorganization plan all about? Maybe you talked about it earlier.

Ms. CHATEL. No.

Mr. CHRISTENSEN. Can you just share a little bit about it?

Ms. CHATEL. What it is asking is to put more people on the front lines, more people out in all of the field offices, in the DDSs in the country, of Social Security; cut down the bureaucracy, cutting down headquarters staff; giving more authority to the front-line managers to deal with and utilize community resources. What we have been able to do in my office cuts out 1 month of disability time to process a case and an awful lot of it has come from working with the medical community right there.

Mr. CHRISTENSEN. Did this plan originate out of your office? Is this your plan or not?

Ms. CHATEL. The restructuring plan?

Mr. CHRISTENSEN. Yes.

Ms. CHATEL. This is a plan that I gave five of my best people 3 days to write and then we have debated this for—this has been going on for about 6 months, but it was debated at a conference with delegates from all over the country. No, this is something that has taken us a long time to do.

The other plan, what is happening in my office is something that we got together with the DDS and the regional office and said, let us do something now.

Mr. CHRISTENSEN. What feedback have you received from Commissioner Chater's office on this?

Ms. CHATEL. On what is happening in my office?

Mr. CHRISTENSEN. Yes.

Ms. CHATEL. I think that we are going to be doing something nationally very soon, like what is happening in my office and the other offices.

Mr. CHRISTENSEN. So you have been in touch with the Commissioner's office, they know exactly what you are doing, they are tracking with you, they agree with what you are doing, and they are signed off on it?

Ms. CHATEL. Signed off? Well—we are working on it.

Mr. CHRISTENSEN. You are working on it?

Ms. CHATEL. I tend to be a little bit more anxious.

Mr. CHRISTENSEN. Most of us tend to be a little bit more anxious than what has been, in the past, going on. I think that what you are doing might be a step in the right direction. I do not want to speak for the chairman, but I think that anything to speed up the process and more entrepreneurial activities by the field office to speed up this process, I think, would be encouraged. I think if what you are doing is a microcosm of what we could be doing nationwide, then we are headed in the right direction. I encourage you to keep up and do even a better job.

Ms. CHATEL. Thank you.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman BUNNING. Thank you.

Ms. CHATEL. Is anyone else sneaking in?

Chairman BUNNING. No one else has snuck in.

I would like to ask the next panel to step forward. They are all representatives of the State Disability Determination Services, which makes the medical decisions for disability claims under SSA supervision.

Christopher McCaslin, disability examiner with the Office of Disability Determinations in Queens, N.Y., will testify on behalf of the Public Employees Federation.

Margaret Barnard from Indianapolis, Ind., will speak on behalf of the American Federation of State, County, and Municipal Employees.

Dr. Lyle Yates, a medical consultant in Oakland, Calif., with the Disability Evaluation Division, will testify on behalf of the Union of American Physicians and Dentists.

Linda Langele, a supervisor with the Disability Determination Services in Jackson, Miss., will testify on behalf of the National Association of Disability Examiners.

Jerry Thomas, director of the Disability Adjudication Section in Decatur, Ga., will speak on behalf of the National Council of Disability Determination Directors.

As the front-line employees of the Disability Insurance Program, you have a very important first-hand experience in deciding whether a person is disabled enough to qualify for disability benefits. You have done a tremendous job dealing with the backlogs this past year and deserve recognition. We understand that you did not write the rules; you simply carry them out. However, you, better than anyone, know the weaknesses and flaws in the system.

I am particularly interested in what each of you has to say about the SSA redesign plan. I am confident that your expertise will be very helpful to this subcommittee.

We welcome each of you. Mr. McCaslin, you may start us out.

STATEMENT OF CHRISTOPHER McCASLIN, DISABILITY EXAMINER, OFFICE OF DISABILITY DETERMINATIONS, PUBLIC EMPLOYEES FEDERATION OF NEW YORK, QUEENS, N.Y.

Mr. MCCASLIN. Thank you, Mr. Chairman. I am a disability examiner and a member of the Public Employees Federation of New York. Today, I am speaking on behalf of my coworkers throughout New York State. Last year, I, like my colleagues, completed over 800 individual determinations for applicants under the Social Security and SSDI programs.

I began this challenging job in 1981. At that time, the very first subject I received training on was Congress' statutory definition of disability, that is, the inability to engage in any SGA, substantial gainful activity, due to a medically determinable mental or physical impairment which can be expected to last 12 months or result in death. I quickly learned that this standard was not designed to make everyone happy but rather to provide vital benefits for our truly disabled citizens.

We believe that the American people have a sense of concern and desire to help those who are truly disabled, while at the same time expecting government to administer the program fairly, to protect it against fraud and abuse, and to maintain its fiscal integrity.

Something has gone very wrong. While the Social Security Administration continues to tell the State Disability Determination Services that they have over 97 percent decisional accuracy, administrative law judges are reversing over 70 percent of DDS decisions which are appealed. If Congress wants a continuing explosion in disability entitlements, then let us operate with the same apparent latitude that the hearings level has. This enormous discrepancy in decisional outcomes must be addressed now.

Fourteen months ago, the Social Security Administration announced an elaborate redesign of the disability program. It completely failed to address one of the most critical current problems in the disability program, the lack of a credible continuing disability review process. Congress needs to direct targeted funding to complete CDRs, especially where medical improvement is expected.

Recently, I approved a fracture case in which full healing did not occur within 12 months. The claimant needed crutches and met the disability requirements. Based on the realities of the past few years, it is unlikely that this case will ever be reviewed, despite a high likelihood of the individual's eventual recovery.

Having a fair CDR process makes fiscal sense and will help to restore the public's faith in the program's integrity. We believe that SSA's disability redesign contains provisions that run a high risk of increasing fraud and abuse. Specifically, it eliminates the current statutory requirement for an M.D. or psychologist cosignature and review of the case. It also proposes to have a single decisionmaker responsible for both medical assessment and direct payment authorization.

The disability redesign proposes to drastically increase the reliance on third party representatives as a vehicle to gather medical and psychiatric information, yet SSA has acknowledged that it has no real authority nor the ability to ensure our citizens' privacy rights.

The disability redesign also dilutes the medical basis of the program. The disability redesign proposes to eliminate the equals allowance. Without the equals criteria, which allows adjudication of new and poorly understood medical claims, we would have had no mechanism to allow claims for conditions such as AIDS and chronic fatigue syndrome when they first emerged.

No matter how many task teams, core teams, blue ribbon panels are convened, the job of determining who is truly disabled under a program with standards will never be an easy one. We at the front lines know that decisionmaking requires careful analysis of medical and vocational issues in conjunction with statutory guidelines.

SSA's disability redesign talks about customer service. The reality is that when we deny a claim, that customer is unhappy. But we serve two customers, the applicants and the taxpayers. Every bureaucracy can be improved, and we are no exception.

One area we would like to change is the difficulty we face in evaluating treatable cancer cases. Our experience has been that individuals undergoing long-term chemotherapy and its disabling side effects are often durationally denied. We should consider granting time-limited benefits in this and other appropriate cases.

The DDS Federal-State partnership must and can be strengthened. Despite burgeoning caseloads, the DDSs have continued to be productive.

I am pleased to submit today our specific written proposals, which address in detail the issues I have only touched on today. After 14 months of a continuing struggle to have front-line disability examiners' voices heard by the Social Security Administration, I thank you, Mr. Chairman, for giving us this opportunity to speak about these critical issues in such an important forum.

[The prepared statement and attachments follow:]

Testimony of:
Christopher McCaslin
Disability Examiner
Public Employees Federation of New York

Thank you, Mr. Chairman.

I am a Disability Examiner and a member of the Public Employees Federation of New York. Today, I am speaking on behalf of my coworkers throughout New York State.

Last year, I, like my colleagues, completed over 800 individual determinations for applicants under the Social Security and SSDI programs.

I began this challenging job in 1981. At that time the very first subject I received training on was Congress' statutory definition of Disability:

"The inability to engage in any substantial, gainful activity due to a medically determinable mental or physical impairment which can be expected to last 12 months or result in death."

I quickly learned that this standard was not designed to make everyone happy, but rather to provide vital benefits for our truly disabled citizens. We believe that the American people have a sense of concern and desire to help those who are truly disabled, while at the same time expecting government to administer the program fairly, to protect it against fraud and abuse, and to maintain its fiscal integrity.

Something has gone very wrong! While the Social Security Administration continues to tell the State Disability Determinations Services that they have 97% decisional accuracy, Administrative Law Judges are reversing over 70% of DDS decisions which are appealed.

If Congress wants a continuing **explosion** in Disability entitlements, then let us operate with the same apparent latitude that the hearings level has. This enormous discrepancy in decisional outcomes must be addressed.

Fourteen months ago, the Social Security Administration announced an elaborate redesign of the Disability program. It completely failed to address one of the most critical current problems in the Disability Program--the lack of a credible Continuing Disability Review process. Congress needs to direct targeted funding to complete CDR's, especially where medical improvement is expected. Recently I approved a leg fracture claim in which full healing did not occur within 12 months. The claimant needed crutches and met the

disability requirements. Based on the realities of the past few years, it is unlikely that this case will ever be reviewed, despite a high likelihood of the individual's eventual recovery. Having a fair CDR process makes fiscal sense and will help to restore the public's faith in the program's integrity.

We believe that SSA's Disability Redesign contains some provisions that run a high risk of increasing fraud and abuse. Specifically, it eliminates the current statutory requirement for an MD or Psychologist's cosignature and review of the case. It also proposes to have a single decision maker responsible for both medical assessment and direct payment authorization.

The Disability Redesign drastically increases the reliance on Third Party Representatives as a vehicle to gather medical and psychiatric information. Yet SSA has acknowledged that it has no real authority nor the ability to insure our citizens' privacy rights. The Disability Redesign also dilutes the medical basis of the program.

The Disability redesign eliminates the "Equals" allowance. Without the "equals" criteria, which allows adjudication of new and poorly understood medical conditions, we would have had no mechanism to allow claims for conditions such as AIDS and Chronic Fatigue Syndrome when they first emerged.

No matter how many task teams, core teams, or blue-ribbon panels are convened, the job of determining who is truly disabled under a program with standards will never be an easy one. We at the frontlines know that decision making requires careful analysis of medical and vocational issues in conjunction with statutory guidelines. SSA's Disability redesign talks about "Customer Service." The reality is that when we deny a claim, that customer is unhappy. But we serve two "customers"--the applicants and the taxpayers.

Every bureaucracy can be improved and we are no exception. One area we would like to change is the difficulty we face in evaluating treatable cancer cases. Our experience has been that individuals undergoing chemotherapy and its disabling side-effects are often durationally denied. We should consider granting time limited benefits in such cases.

I am pleased to submit today our specific written proposals which address in detail the issues I have only touched on today.

After 14 months of a continuing struggle to have front-line Disability Examiners' voices heard by the Social Security Administration, I thank you, Mr. Chairman, for giving us this opportunity to speak about these critical issues in such an important forum.

ISSUE: GROWTH IN THE ROLLS

The Disability Programs, both Title II and Title XVI, are experiencing unprecedented growth, placing a severe strain on available resources, while significantly increasing entitlement costs. For Title II, there has been a 40% increase in entitlements from 1984 to 1994, while the population increased only 11%. Nearly 90% of the SSI growth comes from three groups: children, immigrants and adults with mental impairments. The trend is toward younger beneficiaries.

ISSUE	PRESENT SITUATION	RECOMMENDATION
There have been changes in the adjudicative climate, as the courts have redefined the working definition of disability, increasing the influence of subjective elements rather than objective findings. Courts currently have unlimited authority to require SSA to redevelop class action caseloads, sometimes going back 20 years and requiring reviews of the same claim under multiple court decisions.	SSA does not make timely, necessary changes in its program to avoid litigation, nor does it successfully defend itself in court. SSA's "Disability Redesign" Plan fails to address this issue.	We recommend that Congress: 1. Reemphasize that disability be based on objective medical findings, and that important elements such as pain, fatigue and treating source opinion must be consistent with this documentation. 2. Limit Court ordered retroactive remedies to three years prior to the filing of the class action. 3. Establish a Social Security Court that will have authority for issues relating to Social Security claims.
Lack of Process Unification: There is a growing tendency for claimants to exhaust all appeal rights, knowing that there is a "de facto" different standard applied by ALJs compared to that of the DDSs, resulting in an ALJ reversal rate of approximately 75%. ALJs frequently overturn decisions approved by the Federal Quality Reviewers responsible for assessing DDS accuracy.	SSA has been unable to enforce the Administrative Procedures Act's mandate that the ALJs apply SSA policy. SSA's "Disability Redesign" would have SSA continue to relinquish it's authority.	Congress can achieve process unification by: 1. Requiring that all levels apply the same standard, be reviewed by the same central Quality Assurance component and face sanctions if they fail to apply SSA policy. 2. Insisting that the highest rate of allowances should be made at the lowest level of adjudication. If this is not so, the Commissioner should submit a corrective action plan to Congress within 90 days.

ISSUE: GROWTH IN THE ROLLS (CONTINUED)

SSA has invested much of its available talent and resources in a "Disability Redesign." While advocating expensive radical change, the "Redesign" offers little by way of sensible improvements.	There are advantages for both claimants and social agencies when an individual is deemed disabled. For example, there is no family cap for SSI; Medicare or Medicaid benefits are provided to most recipients; and there are auxiliary beneficiaries. Instead of developing a fiscally responsible plan, SSA's Redesign relinquishes its responsibility and encourages more aggressive involvement by advocacy and other third party groups.	Rather than shifting the responsibility for claims development to others, SSA must refocus its effort on developing a program that enables it to manage its caseload.
SSA has been unable to accurately incorporate demographic and technological changes (e.g., the increasing number of older immigrants and citizens, downsizing and the obsolescence of workers' skills) into its planning and policy recommendations.	Backlogs result when SSA underestimates the impact demographic and technological changes will have on filing rates and program costs.	SSA must improve it's research and analysis of national trends to make realistic projections and necessary changes to the program.

ISSUE: EXIT FROM THE ROLLS

There is a backlog of over one million Continuing Disability Review (CDR) Cases. Failure to review claims at the appropriate time creates a basic unfairness in the system and depletes the Trust Fund of needed resources.

ISSUE	PRESENT SITUATION	RECOMMENDATION
CDRs are largely a discretionary caseload.	CDRs are neglected as SSA concentrates on new claims. The failure to adequately review CDRs has eroded the public confidence in the integrity of the program.	SSA should reestablish a credible Continuing Disability Review process. DDSs must be funded to resume CDRs as a non-discretionary caseload.
Medical re-exams are scheduled for all allowances.	Due to backlogs, even cases likely to improve do not receive reviews.	SSA should be required to identify those impairments that are most likely to improve and implement time limited benefits. Instead of posting a diary date, the decision-maker would set an expected end date of disability. Further benefits would require a new application. This would also create a more favorable adjudicative climate for cases which might otherwise be unfair durational denials (e.g., cancer cases with chemotherapy).
The Medical Improvement Review Standard (MIRS)	MIRS, in effect, creates an individual CDR disability standard for every allowance. This causes enormous inequities in decision-making. The different approaches taken by ALJs vs DDSs becomes highly problematic for CDRs under the MIRS. It is one of the ironies of the MIRS that the less severe the original impairment, the harder it is to show medical improvement.	While well- intentioned, MIRS prevents uniform decision-making. The Commissioner of SSA should research and pilot a more equitable alternative. Until an alternative to MIRS is devised, process unification would alleviate many of the present problems with CDRs.

ISSUE: CLAIM BACKLOGS

The burgeoning application rate has exposed deficiencies in the Disability Program, resulting in backlogs at all adjudicative levels. Modifications are necessary to substantially reduce processing delays and improve customer service. SSA announced a "Disability Redesign" plan in April 1994, ostensibly to alleviate backlogs. It promises to be a cost neutral process. If implemented, it would radically dilute the quality of the product and raise entitlement costs. The disability claimants and the American public would be better served by constructive changes to the current process and organization, as described below.

COMPONENT LEVEL	PRESENT SITUATION	RECOMMENDATION
A. SSA FIELD OFFICE	SSA has a teleservice (a toll free 1-800 telephone number) which it concedes is ineffective. Rather than expedite claims intake, it causes additional delays.	The medical disability application could be filed directly with the DDS. This will eliminate the weeks of delay claimants now experience from initial SSA contact through receipt of the file at the DDS. The DDS would not have to clarify the field office intake interview.
	SSI income and resource development is now done end of line, after a medical allowance is proposed. This delays payment effectuation for legitimate allowances, and causes DDSs to do full medical development for cases that will be ineligible for nonmedical reasons.	SSA should return to its original practice of developing income and resource issues simultaneous with DDS medical development.
	SSA has expanded its working definition of "good cause" for late filing of appeals. This increases the likelihood that the claim must be redeveloped, rather than reviewed.	SSA should enforce time limits and criteria for appeals.

ISSUE: CLAIM BACKLOGS

COMPONENT LEVEL	PRESENT SITUATION	RECOMMENDATION
B. STATE DISABILITY DETERMINATION SERVICES (DDS)	DDSs receive program instructions via numerous vehicles (regulations, the POMS, State Agency memoranda, disability digest, program circulars, court rulings, central office responses, case returns). This makes adjudication more difficult and often adds to required development.	The number of policy releases should be radically reduced and strong consideration given to having truly one book (e.g., the regulations) and one document for clarifying policy (i.e., an expanded HALLEX). This would replace the proliferation of program releases. All formal SSA guideline to the DDS or OHA should be incorporated into the regulations following a public comment period.
		SSA should release program changes in an orderly manner. All components should receive these instructions simultaneously. Whenever possible new information should be sent at designated times, e.g., the first week of the quarter.
	SSA uses indeterminate adjectives (e.g., marked, significant, frequent, uncontrollable) in its regulations and other releases. For example, "marked" is an element in some listings, and in residual functional capacity assessments. SSA has defined "marked" as more than moderate, and "moderate" as less than marked. This type of pseudo definition helps no one, and contributes to different decisions at different levels.	SSA should provide clear, consistent definitions for terms and criteria that are subject to different interpretations. This clarification should be appended to the Regulations and be binding on both DDSs and ALJs.
	SSA (central office and regional office) has increasingly refused to provide useful advice or needed definitions for medicalpolicy questions raised by DDSs. They have adopted an "individual case by case" mantra to avoid giving clarification or illustrative examples on a wide range of their policies.	Congress should require SSA to provide adequate policy guidance, available to DDS and all other interested parties. SSA's current abdication of its responsibility in this area threatens uniformity within the program and should be stopped.

ISSUE: CLAIM BACKLOGS

COMPONENT LEVEL	PRESENT SITUATION	RECOMMENDATION
C. ADMINISTRATIVE LAW JUDGE (ALJ)	ALJs are responsible for deciding impairment severity and RFC, medical assessments that precede their final legal determination. While they have access to medical consultants, they are not required to obtain or follow medical advice. There is a high ALJ reversal rate (c. 75%). This results in backlogs as more claimants file appeals.	ALJs have primarily legal, not medical expertise. At the DDS level, SSA currently gives the medical consultant the final authority for establishing RFC. This approach should also apply at the ALJ level.
	DDSs generally concentrate on the objective medical findings. ALJs place great weight on allegations when assessing impairment severity and residual functional capacity. This shift in emphasis often changes the decision.	Request that Congress clarify the adjudicative weight to be given objective medical documentation vs. subjective elements (e.g., allegations, treating source opinions, vagaries of case law). Presently, there is very little direct interaction between ALJs and State Agency regarding policy and operating instructions. Representatives of both levels, along with SSA, should resolve differing approaches before they become fixed.
	There is a lack of real accountability at the ALJ level, with minimal quality assurance review, and no consequence if ALJs fail to follow SSA policy.	Request that Congress consider requiring SSA to develop an effective quality assurance system for the ALJs.
	ALJs increasingly take their direction from court decisions, not agency policy.	The role of the ALJs as independent finders of fact in individual cases must be balanced by the Administrative Procedures Act requirement that they also apply SSA policy.
	With the "de novo" hearing, relevant medical evidence can be withheld until the ALJ level	Consideration should be given to the closing of the case file after all DDS actions are completed, unless there is clearly good cause for late submission of these reports.

Chairman BUNNING. Thank you very much.
Ms. Barnard.

STATEMENT OF MARGARET BARNARD, ADJUDICATOR III, DISABILITY DETERMINATION OFFICE, INDIANAPOLIS, IND., ON BEHALF OF THE AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AFL–CIO, LOCAL 3728

Ms. BARNARD. Mr. Chairman, members of the subcommittee, good morning. My name is Margaret Barnard. I am a member of AFSCME, the American Federation of State, County, and Municipal Employees. I am a disability claims adjudicator in the Indiana Disability Determination Services, and I am the AFSCME representative to the Social Security Administration's internal advisory committee for the process redesign.

I appreciate the opportunity to be here today to share with you some of my concerns and the concerns of other AFSCME members regarding the processing of Social Security disability insurance claims and supplemental security income claims as it relates to process redesign.

There are, indeed, a large number of claims currently being adjudicated in the State agencies. However, it is not the backlog that should be the primary focus because the problem of backlog will not be resolved until other issues are addressed. The primary focus should be on the quality of the determination, no matter at what level, as well as the preservation of program integrity.

The final determination of decision at the initial or reconsideration levels is a result of a team effort. The adjudicator or claims examiner has the primary responsibility for the claim. However, it is only with the combined effort of the adjudicator, support staff, vocational specialist, as well as in-house medical and psychological staffs that the program integrity can be maintained.

This program is very intricate and complex. It can take up to 2 years for the adjudicators to be proficient in all aspects of the program. That proficiency is enhanced by the resources provided by these coworkers. It is with their input and cooperation that complex issues are resolved.

One of the proposals under consideration by the Social Security Administration would limit or curtail input from medical or psychological staff. I would emphasize that adjudicators are not physicians or psychologists. The medical and psychological staff currently provide input and review throughout the initial and reconsideration case processing, as well as reviewing and signing off on completed claims. Their input is very critical to ensure a final product which is the claim which is programmatically correct.

Another proposal in redesign of the disability process would create a position that would combine the roles of the disability adjudicator, a State position, and the claims representative of the Social Security Administration. Currently, the Social Security field office staff take the initial and reconsideration applications and clarify the technical issues, such as quarters of coverage, earnings records, and income and resources. The adjudicators in the State agency are responsible for the medical portion of the claim.

The Social Security Administration is proposing to combine these two functions into one. As a 12-year veteran on this job, it is hard

to envision that this model will work. With current caseloads at all-time highs and expected to rise, it is impossible to envision that both functions could be performed by one person with accuracy and speed. This proposal also envisions reduced levels of staffing across the board.

While there are also other proposals that would streamline the process along the way, the processing and completion of a claim can be difficult to assess and regulate and rarely falls into a set model. The redesign proposals which I have read are anticipating significantly improved cooperation from the claimants or their representatives, the physicians, the medical community, community resources, educators, and mental health service providers, as well as an array of Social Security components. Improved technology and staff training are also planned.

While this all reads very well on paper, it is hard to believe that everyone will be fully funded, everyone will be reeducated, and that all the players will be in their places to pull it off.

The concept of process redesign was presented to the staff at the State agencies in April 1994. From that time, many of the line staff in the State agencies have expressed concern for the lack of our participation in the creation of this redesign process, let alone in the potential implementation.

AFSCME and other State union representatives have tried for months to get represented in this process. I cannot imagine any State employee, adjudicator, staff, or physician/psychologist who would deny that this program needs some work. But to fail to include a proportional representation of front-line workers from the State agency early on is beyond comprehension.

We are told that our comments are valued and solicited, but without spokespersons to reinforce and represent them, few adjudicators take the time to read the massive volumes that come across our desk. This has been especially true in light of the constant push to increase production and reduce current levels of pending claims.

I again want to thank you for the invitation to present this testimony to the subcommittee. I realize the program is complex and costly, but it is because it is so complex and costly that revision should include front-line workers.

[The prepared statement follows:]

Statement of Margaret Barnard
Member of AFSCME Local 3728, Council 62
Indianapolis, Indiana
before the
Ways and Means Subcommittee on Social Security
U.S. House of Representatives
on the
Social Security Disability Insurance Program
May 23, 1995

Mr. Chairman and members of the Subcommittee, I am Margaret Barnard, a member of the American Federation of State, County and Municipal Employees (AFSCME). AFSCME represents more than 1.3 million members nationwide. I work in the Indiana Disability Determination Service (DDS) and I serve as a member of the Social Security Administration's (SSA) Internal Advisory Committee for the Social Security Disability Process Redesign as the AFSCME representative. I also participated in the SSA Task Team to study the Continuing Role of the Appeals Council.

For the past twelve years I have worked as a Disability Claims Adjudicator in the Indiana DDS. My current caseload includes initial, reconsideration, childhood and continuing disability review claims.

The issue of backlog of cases is one that is of great concern to all of us who process claims. There has been a lot of publicity regarding the apparent slow processing of claims. At the same time there has been a significant increase in the number of claims filed. Both situations have caused great concern among those of us who attempt to keep up with our workloads. It is apparent that the blame for the delays in processing has been put on the adjudicators and other state agency front-line staff.

The disability claims adjudicators are the front line workers who have the contact with the largest number of stakeholders: claimants and services providers including hospitals, physicians and educational facilities. We have the contact with the claimant for clarification of such issues as treatment, dates of treatment, medication, sources of treatment and the specific nature of the impairment. We explain to the family and other concerned parties such issues as why additional exams may be needed, why information is needed regarding functioning in relation to substance abuse, and depression or residuals from a stroke.

While we are responsible for keeping the claimant as informed as possible, problems arise when the claimant sometimes does not accept responsibility for keeping adjudicators informed of their location. This adds to claim processing time because the claimant must be tracked down. The following is an example which demonstrates many of the frustrations we must deal with and which also demonstrates reasons for delayed processing time resulting in backlogs. A claimant was denied at the initial level, 45 days after application. The decision was sent to the original filing address by the SSA Field Office that releases decisions. The claimant had moved but did not inform SSA. Several months later the claimant went to the local SSA office in a new city and state to inquire about his claim. He was informed of the denial and he filed for reconsideration. This request was sent to the state agency in the state to which he had moved. By the time the adjudicator in the new state received the claim, the claimant had returned to the city where he had filed the initial claim. The claim was transferred back to the original state agency. The adjudicator in the original state agency tried to reach the claimant by phone. Three to four weeks and five addresses later, contact was made with the claimant. By this time the claimant was complaining that the reconsideration process was taking too long. He was told that several consultative exams would be needed and that it was critical that he inform the adjudicator of any address change. The claimant indicated that he would cooperate. Subsequently, the claimant added two new impairments to support his claim for disability. The adjudication of the second claim took five and one-half months from the time it was sent to the adjudicator until the claim was completed. The total time the reconsideration was pending was more than a year. While this situation may seem exaggerated, such cases occur with some regularity and are very costly in terms of time and resources.

I would like to emphasize that we do not process the medical eligibility determination by ourselves. We also rely upon other state DDS staff who assist us in the decision-making process. We rely upon support staff to assist us with our adjudicatory functions, and the medical and psychological consultants to provide the medical expertise necessary to process a claim.

We are the ones who perform the function of explaining to attending physicians why it is truly cost effective to send records covering the potential condition rather than to contract for an exam when the information is already available. We also explain why 20-year-old medical records are important in the claim of a 42-year-old person with developmental disabilities who is filing on the Social Security number of a retired or deceased parent. We are the ones who must convince the treating source that records covering substance abuse can be helpful in denial as well as allowance of the patient's claim.

We commend the Social Security Administration for attempting to address the problems in the current system through the Disability Process Redesign. However, there are some changes proposed in the Disability Process Redesign which address the issue of backlog that cause us great concern. While the concept of a single decision-maker may sound appealing, it will destroy the integrity of the program. The concept is based on the premise that adjudicators can be trained to make the same decisions as a medical or psychological consultant. One proposal for testing this concept requires three hours of training for adjudicators to perform the function of a psychological consultant, who has a Ph.D. or is a practicing psychiatrist. It is obvious why such a proposal would eliminate the medical basis for disability determination. Such a foolhardy proposal does not even warrant testing as part of the redesign implementation. We support the current requirement that a medical or psychological consultant sign-off on claims.

In addition to the issues of backlog and delays, there is also the issue of the right decision being made the first time. In early SSA communications as well as several Task Team reports, the clear inference has been that the decisions from the state agencies are suspect because many of these decisions are overturned by Administrative Law Judges. I would like to highlight the cause of this problem for the Committee because the perception that the state agencies are not making the right decision at the early adjudicatory level is ubiquitous. The reason for the high reversal rate is due to different methodologies applied at the state level and at the appeal level. Application of different methodologies accounts for the large number of reversals at the appeal level.

The court decision in the Bryan Zebley claim has seriously affected caseloads in state agencies, and subsequently resulted in backlog. Zebley broadened the parameters of eligibility for childhood disability claims. The readjudication of hundreds of thousands of claims that fall within the class as well as adjudication under new program rules have had enormous impact not only on the Social Security Disability Programs but also on several other systems. Educators who spend years working with children trying to surmount learning disabilities feel undermined by further labeling of the students as disabled. We spend a lot of time dealing with the irate families and administrators who feel that such labels will inhibit the student from attaining their full potential and interfere with their success in the workforce as an adult. The same is true for many educators and physicians who are dealing with issues of Attention Deficit-Hyperactivity Disorder. Many teachers are convinced that the child and their family can learn to deal with the problems and gain control of the behavioral problems. Both teachers and administrators express concern over the time and resources required to complete repeated requests for reports regarding classroom functioning or current records. This is especially true when the child is not receiving any special educational services.

Obtaining records from hospitals, physicians, schools, employers and mental health facilities takes up a good portion of the workday. Hospitals are overwhelmed by the volume and extent of requests, especially in large cities which have significant client populations. We find it very frustrating that each entity has different rules and expectations. The sources within the area/state are usually most easily accessed. Out-of-state contacts, which are critical to a claim, cause delays in adjudication. The mobility of the claimant has also added to the processing time. An adjudicator might be requesting records from more than ten to fifteen sources in multiple states over a period of years. We are very aware that this is a critical portion of the job and with the help of support staff we ultimately complete the task. The demands of documentation frustrate the vendors as well. We recommend the use of a uniform release form and questionnaires to physicians and other vendors to improve the processing time.

Another cause of backlog is the increase in processing times for consultative exams. In many instances the consultant does not submit the report in the proscribed time period. In some states, it takes five to six weeks to process the paperwork. Frequently, the consultative exam must be rescheduled because the claimant is unable to make the scheduled appointment. The re-scheduling adds to processing time and

results in frustration on the part of the consultant for the cancellation, often at the last minute. The process of rescheduling can add another month to the claim processing. This problem could be addressed through public education efforts to inform both the medical community and the potential recipients of the program requirements. Additionally, simpler medical forms and higher reimbursements for consultants would alleviate the backlog in the paperwork.

Newer testing procedures used by attending physicians add to backlog of pending cases. Often these newer tests and procedures are not accepted as documentation for the claim because they do not meet program specifications. For example, a computer printout of an electrocardiogram is not sufficient evidence for a claim. When a physician submits a computer printout, the physician must be contacted and required to submit the results of the test in a different format. Current practitioners become frustrated with these requirements. This problem could be resolved by making changes in documentation needed to process a claim.

The current influx of Continuing Disability Reviews has added to the increase of backlog. The effect of these claims on the state agencies has yet to be addressed.

While caseloads have been increasing over the last five years, staff turnover has increased in many states. The high turnover rate prevents some state agencies from tackling the number of pending cases since it can take up to two years for an adjudicator to become proficient in the complexities of the job. It is demoralizing for remaining staff to see large numbers of newly trained personnel leave after eight or nine months. Frequently the high caseload sizes cause the persons to move on to other jobs.

Some have suggested that an approach to attack the problem could be the long-term use of overtime. The disadvantage of this approach is that this may result in burnout of those employees who must do this work on a regular basis. There can be a point of diminishing return in terms of energy available and effects on the personal lives of staff members.

The Disability Process Redesign is of major concern to state employees who process the medical portion of the disability claim for the Social Security Administration. AFSCME members and other unions sought involvement with the Disability Redesign Process as early as the summer of 1994. However, we were not permitted to be part of the process in a formal way until February, 1995.

Those of us who work on disability claims are concerned about the program costs. We are also taxpayers. We have many of the same concerns as those expressed in the media, in public opinion polls and by Members of Congress. The program has gotten out of hand with the level of documentation required for certain claims such as substance abuse.

A major concern of those of us who work in state agencies on disability claims is that we still are underrepresented in the whole redesign process. It is hard to understand how the people who are responsible for a significant part of the program have had such a limited role in examining ways to create a more efficient, streamlined, and cost conscious process. We care deeply about the work we do and about the claimants we serve. We want to make the system more responsive to those in need of services. However, without addressing all of the issues referred to above, the backlog problems will not be solved and the Disability Process Redesign will not achieve the desired results.

Thank you.

Chairman BUNNING. Thank you very much.
Dr. Yates.

STATEMENT OF LYLE N. YATES, M.D., ON BEHALF OF THE UNION OF AMERICAN PHYSICIANS AND DENTISTS

Dr. YATES. Good afternoon, Mr. Chairman and subcommittee members. I am Dr. Lyle Yates. I am here representing the California Union of Physicians and Dentists. I have been a full-time employee as a medical consultant at our local branch for the past 5 years.

As a veteran of World War II, I had the G.I. Bill of Rights. That was the only reason I got to go through medical school, so I am very grateful to be here. I am a member of the American Medical Association, the California Medical Association, my local county medical association. I have been on the Physicians Advisory Committee of Blue Cross for the past 9 years. I was terminated from that job because of term limits, and I think most of you know what term limits are, referring to last month.

I am president of a 2,700-member Foundation for Health Care and president-elect of our county medical association. I have been serving on the Social Security Task Force for Reengineering in the role of the medical consultant.

There are many points that I would like to stress as to the importance of maintaining the medical consultant as a mandatory part of the initial medical determinations of a claimant applying for Social Security benefits. This process consists of reviewing the records, determining if there is sufficient evidence on which to make a determination, making a diagnosis, and then determining the functional capacity of a claimant.

The new redesign process would allow a nonphysician called a disability claims manager to make this determination and use a physician as a consultant only when they deem necessary. The Social Security Act, which we have heard several times and I will not repeat, does require, however, that the impairment must result from an anatomical, physiological, or psychological abnormality which is demonstrated by medically acceptable clinic and laboratory techniques. Medical consultants are uniquely qualified by their background, their medical training, and their knowledge of the Social Security program to ensure that this medical evidential requirements by the law is met.

I would like to restrict my comments to three main points. First, the current system. I have touched on the importance of the medical consultant. Currently, the medical consultant and the disability analyst work as a team. There is a great variation from State to State as to the input of the disability analyst on that team. However, in all cases, the medical consultant must do some review and sign a form if the disability analyst has made some medical conclusion that he or she agrees with it.

This dual approach is a set of checks and balances that ensures accuracy and uniformity of the decision. To allow a disability analyst or the new disability claims managers to make these medical judgments is an attempt to emulate medical judgment which has basically come from our right to practice medicine.

One of the goals of the new process set by the Commissioner is to have the right decision the first time. This cannot be accomplished, in my opinion, by taking the medical consultant out of the initial claim process. The actual time that it takes the medical consultant to review that chart varies from minutes to hours. Other duties of the medical consultants include collection of medical information, calling treating physicians, ordering diagnostic tests in which the claimant may have some chance of a risk, such as a treadmill test, teaching on a daily basis, and doing some community outreach.

The second point I would like to make is that of the claimant. The claimant is the one that really benefits from this dual approach of the analyst and the medical consultant by a more uniform decision. In all jobs, there are those that do not know what they do not know. This includes both the disability analyst and the medical consultant. This set of checks and balances allows the medical expertise of the physician and the program knowledge of the disability analyst to be used concurrently, and yet, they then lap over to a second input by each at the other field.

Currently, every claimant receives this benefit in the participation of a medical consultant. It would be detrimental to the integrity of the process if it was to be handled any differently. It would be very difficult to explain to a claimant that some claims are reviewed by a doctor for a determination of medical disability and others are not. You would only have to explain to those denied.

My third point, and this has been covered quite well, are the cost factors. As I mentioned, the definition of disability will not be changed and it is desired to keep the benefit payment ratio, that is, the allowance denial ratio, equal. Medical consultants, with their background, medical knowledge, knowing the natural course of diseases, how injuries heal, are much more apt at denying claims than someone without this medical expertise. With the new process, the disability claims manager will be meeting face to face with the claimant, and in so doing, human nature will make it less subjective. If a medical consultant denied three additional cases every 2 years, it would more than pay for their salary.

I hope I have demonstrated to you from the standpoint of the integrity of the Social Security disability program, from the standpoint of the claimant, and from the standpoint of cost, keeping a physician in the medical decision is both cost effective and appropriate. I feel strongly that the review of a medical record, making a diagnosis, determining a functional capacity of an individual is within the scope of practice of medicine.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF

LYLE N. YATES, M.D.

UNION OF AMERICAN PHYSICIANS AND DENTISTS

Good morning Mr. Chairman and subcommittee members. I am Dr. Lyle Yates and I am here representing California state employed doctors for the Union of American Physicians and Dentists. It is a privilege to be here and be involved in this democratic process. I am grateful to be an American. As a veteran of World War II, the GI Bill of Rights made it possible for me to go to medical school. I am a member of the American Medical Association, the California Medical Association, and my local county medical society. I am board certified in general surgery and a fellow of the American College of Surgeons. I have been on the Physician's Advisory Board of California Blue Cross for the past nine years, but term limits ended my participation last month. I assume most of you are familiar with term limits. I am currently president of a 2300 physician foundation for health care and on the State Board for the Statewide Foundation. I am president-elect of our 2700 member county medical society. I am serving on the Social Security Re-Engineering National Task Force on determining the role of the medical consultant.

There are many points that I would like to stress as to the importance of maintaining the medical consultant as a **mandatory** part of the initial medical determination of a claimant applying for social security disability benefits. This process consists of reviewing the records, determining if there is sufficient evidence upon which to make a determination, making a diagnosis, and then determining the functional capacity of the claimant. The new re-designing process would allow a non-physician called a disability claims manager to make this determination and use a physician **only** when they deemed it necessary. The social security act requires that those entitled to disability benefits must have an impairment that results from anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical and laboratory techniques. Medical consultants are uniquely qualified by their background, medical training, and knowledge of the social security program to ensure that these medical evidential requirements of the law are met. In the re-design process it is stated that this definition of disability will **not** be changed.

I would like to restrict my comments to three main points. First, the current system. I have touched on the importance of the medical consultant in the medical determination. Currently the medical consultant and a disability analyst work as a team. There is great variation from state to state as to the extent of input by the disability analyst in the medical evaluation. In all cases, however, the medical consultant must do some review of the medical evidence and sign a form that if the disability analyst has done some of the medical evaluation that they agree with it. This duo approach is a set of checks and balances that ensures accuracy and uniformity of the decision. To allow a disability analyst or new disability claims manager to make these medical judgments is an attempt to emulate the medical consultant's expertise and experience and literally takes medical judgment from those licensed to practice medicine. One of the goals of the new process, set by the commissioner, is to have the "right" decision the first time. This cannot be accomplished by taking the medical consultant out of the initial medical evaluation. The actual time that it takes the medical consultant to do this work is minutes, ranging from perhaps five minutes to an hour. Other duties of the medical consultant include the collection of medical information; calls to the treating physician; ordering diagnostic tests which may have a chance of risk to the claimant, such as a treadmill test; teaching on a daily basis to the non-medical personnel and some community outreach. These are important but not as important as the medical review and adjudication of residual capacity.

This leads to my second point, the claimant. The claimant is really the one that benefits from this duo disability analyst/medical consultant approach by a more uniform decision. In all jobs there are those who "don't know what they don't know." This includes both disability analysts and medical consultants. This approach is a set of checks and balances that allows for both the medical expertise of the medical consultant and the program knowledge of the disability analyst to be used concurrently and yet overlaps for a second input by each. Currently every claimant receives the benefit of the participation of a medical consultant in their disability determination. The proposed re-design would substitute an unproven process in an attempt to emulate the medical consultant's expertise. This will be detrimental to the integrity of the process and the claimant will not get a uniform decision. It would be difficult to defend or explain to the claimant that some claims are reviewed by a doctor for a determination of a medical disability and others are not. Of course, you would only have to do it to those denied!

My third point concerns cost factors. As I have mentioned the definition of disability will not be changed and it is the desire to keep the benefits payments neutral. That is, to keep the allowance/denial ratio the same. According to SSA's figures and using the fiscal year 1990 the average lifetime benefit of a claimant allowed was $79,000. Medical consultants with their background, medical knowledge of the natural course of diseases, and healing of injuries are more apt to deny claims than someone without that medical expertise. In the new process the disability claims manger will be meeting face to face with the claimant and in so doing, by human nature will be less objective. Disability claims managers will also tend toward allowances because the next step in the process is directly to the administrative law judge and they will not like to see many of their decisions reviewed and overruled. The administrative law judge decisional process is also very expensive. If a medical consultant denies three cases every two years it will more than pay for their salary.

I hope I have demonstrated to you that from the standpoint of the integrity of the social security disability program, from the standpoint of the claimant, and from the standpoint of cost keeping a physician in the medical decision is both cost effective and appropriate. I feel strongly that the review of a medical record, making a diagnosis from that review and determining the functional capacity of an individual is within the scope of the practice of medicine. Medicine can only be practiced by an M.D. Incidentally, the American Medical Association and the Union of American Physicians and Dentists, and all other medical organizations agree with this position. Medical consultant participation in the claim will lead to the right decision the first time. It will ensure a quick and streamlined process. Medical consultant involvement is cost effective and will keep the program benefit neutral and reduce the risk of fraud.

Thank you for your time and attention. I would be glad to try to answer any questions if you don't make them too tough.

Chairman BUNNING. Thank you, Dr. Yates.
Ms. Langele.

STATEMENT OF LINDA H. LANGELE, SUPERVISOR, DISABILITY DETERMINATION SERVICES, JACKSON, MISS., AND PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Ms. LANGELE. Thank you for inviting NADE, the National Association of Disability Examiners, to testify today. My name is Linda Langele and I am president of NADE. I believe most of the subcommittee members are familiar with NADE and the many times we have previously testified before this subcommittee. Today, we offer our perspective and knowledge for why there are backlogs in the DIB and SSI disability programs and wish to comment on how the proposed short-term and long-term initiatives might alleviate the problem.

Some DDSs are current in their caseloads, but nationally, there are significant backlogs. There are several reasons for these backlogs.

First, there have been a huge number of filings in recent years.

Second, there has been a massive increase in the disabled childhood claims due to the *Zebley* court decision in 1990.

Also, reviews of large numbers of adjudicated claims as a result of court decisions in the various districts have caused backlogs.

The ALJ decisions reversing DDS decisions have impacted. It is obvious to all that the ALJs follow legal methodology, whereas DDSs follow medical methodology to assess claimants' medical status.

NADE has been citing these differences in adjudication standards for years, but without success in getting changes in the program. Unless and until all components, including OHA, use the same medical standards, there can never be consistency in the adjudicative levels.

The fifth thing that has impacted on our backlogs is the SSI outreach programs which were initiated in the late eighties.

In addition to the backlogs in the initial and reconsideration cases, there also exists a backlog of CDR cases. If Congress is serious about conducting CDRs, then SSA should revisit the whole CDR procedure and revise the medical improvement review standard to a baseline medical and/or mental performance level rather than the demonstrated medical improvement requirement. Then the medical improvement expected and medical improvement possible cases should be pulled expeditiously and reviewed. This will require a commitment and adequate funding in order to accomplish this.

For more than 1 year, we have been hearing about the disability program redesign. Many of the DDSs have been on task teams and we have been working on the different aspects of this redesign plan. The following are some concerns we have about the proposal today.

Redesign does not substantially address the discrepancies between DDS and ALJ decisions or the influence of the courts.

The adjudication office process appears to be extremely cumbersome and inefficient.

The disability claims manager concept of a single individual handling both medical and nonmedical aspects of a disability claim, even with technical support, seriously underestimates the complexity of both of these jobs.

The predecision interview increases process inefficiency and prior experience with this concept has not been demonstrated as effective.

There are a number of problems inherent in having claimants secure their own medical evidence which have been only minimally addressed.

Also included in this written testimony are some proposals that NADE has in order to decrease these backlogs.

I appreciate the opportunity to be able to testify before you today.

[The prepared statement follows:]

TESTIMONY OF LINDA H. LANGELE
NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Chairman Bunning and Members of the Subcommittee:

Thank you for inviting the National Association of Disability Examiners (NADE) to testify today. My name is Linda Langele, President of NADE. I am a unit supervisor in the Mississippi DDS. I believe most of the subcommittee members are familiar with NADE and the many times we have testified before this subcommittee previously.

We offer our perspective and knowledge for why there are backlogs in the DIB and SSI disability programs, and wish to comment on how the proposed short and long term initiatives might alleviate the problem.

Some DDS's are current in their caseloads, but nationally there are significant backlogs adversely impacting program performance. There are several reasons for these backlogs.

1. There have been huge numbers of fillings in recent years. This has occurred due to adverse economic conditions, reductions in work force, jobs going off shore, etc. Workers file for assistance with several programs including SSA disability. Increased claims also have come from an aging population who believe they are "disabled" due to vague physical or emotional problems. Further claims have come due to expanded program criteria such as childhood claims and Drug Addiction and Alcoholism claims.

2. There has been a massive increase in disabled child (DC) claims due to the Zebley Supreme Court decision in 1990. This workload has created monumental problems for the DDSs due to more labor intensive case development required from school officials and teachers, day care workers, and others to complete ADL's, collect school records and purchase more medical and/or psychological examinations.

3. The results of court decisions in various districts have produced conflicting interpretations of disability standards. Frequently these decisions do not reflect medical understanding but rather legal technicalities or social issues. These decisions frequently require reviews of large numbers of adjudicated claims thus producing unplanned and unfunded work loads. This problem will persist unless and until the Congress passes legislation to create a Social Security Court of Appeals which can produce rulings with consistent, national interpretation of the legal and medical issues raised in the appeals.

4. OHA/ALJ decisions reversing DDS decisions have also impacted the work loads. It is obvious to all that ALJs follow legal methodology whereas DDS's follow medical methodology to assess a claimant's medical status. ALJ's do not apply the same interpretation and application of the regulations and medical listings. They follow the conflicting district court rulings, as well as placing weight on the

claimant's appearance, and statements and arguments of counsel, while either not understanding the medical information or ignoring medical facts in preference to personal opinions. This more favorable adjudicative climate at the ALJ level has exponentially increased their case loads because claimants and attorneys do not cooperate fully with the DDS--choosing to wait until the case moves through the process to the hearing level. In certain instances the passage of time produces a worsening of claimant's condition from what it was at the time of the DDS decision.

NADE has been citing these differences in adjudication standards for years, but without success in getting changes in the program. Unless and until all components, including OHA, use the same medical standards there can never be consistency in the adjudicative levels. The false perception will remain that any denial by the DDS examiner which is subsequently allowed by the ALJ was not the "right decision the first time." As a result of what is happening in the OHA program, the number of ALJ decisions has increased from 72,200 in FY 73 to 516,863 in FY 94, and currently there are more than 800,00 claims awaiting a decision in OHA. The existing ALJ backlogs and excessive processing time are the direct result of liberal ALJ allowances.

ALJ's are reported to reverse about 75% of the DDS decisions. However, a recent OPIR study showed that 59% of the ALJ decisions are not supported by the objective medical evidence. This is further reason for all levels of adjudication to use the "one book" approach. The Congress must decide what kind of decision it wants. If you want DDS's to adjudicate like ALJ's then we can do that--if SSA permits DDS's a more liberal application of interpertation and examiner discretion.

SSA's efforts to reduce ALJ backlogs by utilizing the short term initiative of screening units to locate and allow cases that ALJ's would be expected to allow has caused confusion and public relations problems for the DDS. Cases that are reversed from the DDS denial to an allowance by the screening units undermine the credibility and consistency of the disability program.

5. SSI outreach programs, initiated in the late 1980's have contributed to the increased backlogs. This outreach effort began mostly with the homeless but has grown through the efforts of attorneys, social workers, and others to the point of "over-reach". Now we have drug addicts, alcoholics, immigrants and charged or convicted felons whose claims are being fed into the system and straining already over-worked examiners. Hopefully recently passed H.R. 1214 may restrict some of these claims--assuming that the Senate will pass similar legislation.

CONTINUING DISABILITY REVIEWS

In addition to the backlogs in initial and reconsideration cases discussed above, there also exist a backlog of Continuing Disability Review (CDR) cases that are awaiting review. The Congress passed legislation in 1980 mandating that SSA do 500,000 CDRs annually. However, adequate funding was not provided. Instead only about 100,000 cases have been reviewed annually. The DDSs are further hampered in reviewing CDR's due to the Medical Improvement Review Standard (MIRS) which requires that there be demonstrable improvement in the claimant's condition. Where the claim was originally allowed by an ALJ, many times it is impossible to show that the condition has improved--thus only a limited number of case reviews result in cessation. If the Congress is serious about conducting CDR's then SSA should revisit the whole CDR procedure and revise the Medical Improvement Review Standard to a baseline physical and/or mental performance level rather than the demonstrated medical improvement requirement. Then, the Medical Improvement Expected (MIE) and Medical Improvement Possible (MIP) cases should be pulled expeditiously and reviewed. This will require commitment and adequate funding to accomplish

SSA DISABILITY PROGRAM REDESIGN

For more than a year we have been hearing about the Disability Program Redesign or so-called Reengineering. Many in the DDS's have been on task-groups working on specific problems or tasks in the redesign plan. The more we see, the less we expect it to make the process more efficient. In fact, we expect the allowance rate to skyrocket and uniformity and quality to decline. The redesign allowance rate may be the final act that bankrupts the system. The Congress must be apprised of this.

The following are some concerns we have with the proposals to date.

1. Re-design doesn't substantially address the discrepancies between DDS and ALJ decisions or the influence of the courts.
2. The AO process appears to be extremely cumbersome and inefficient.
3. The DCM concept of a single individual handing both medical and non-medical aspects of a disability claim--even with "technical support"--seriously underestimates the complexity of both jobs.
4. The pre-decision interview increases process inefficiency and prior experience with this concept has not demonstrated it's effectiveness.
5. There are a number of problems inherent in having claimants secure their own medical evidence which have only been minimally addressed.

In summary, we propose

1. Congressional actions to restrict the volume of claims, as has been proposed by H.R. 1214.

2. SSA must address the difference in the adjudication standards used by OHA vs. the DDS. Put all adjudicative levels on the "one book" concept of disability evaluation.

3. Congressional action should be taken to establish a Social Security Court of Appeals which could bring significant uniformity to the decision-making process

4. Provide sufficient funding to process the backlog of cases awaiting CDR review.

5. Revisit and revise the Medical Improvement Review Standard, to permit cessation of benefits when appropriate.

6. Proceed cautiously with the redesign process, especially relating to the Disability Claim Manager (DCM) and Administrative Officer (AO) positions and responsibilities.

Mr. Chairman, we appreciate the opportunity to state our concerns on this important subject. Thank you.

Chairman BUNNING. Thank you very much.
Mr. Thomas.

STATEMENT OF JERRY A. THOMAS, PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

Mr. THOMAS. I appreciate the opportunity to submit testimony on behalf of the National Council of Disability Determination Directors.

We share the concern of the subcommittee members about the backlogs which persist at the State DDS level and which are at a crisis level at the Office of Hearings and Appeals. Because of the hard work and dedication of the DDS staffs, most of the DDSs have made significant progress in reducing, and in some instances, even eliminating these backlogs.

In a recent survey of DDS directors, the vast majority reported that the short-term initiatives initiated by SSA to reduce the backlogs had no impact or only a marginal impact on the backlog reduction.

Most of the short-term initiatives proposed by SSA are designed to reduce the backlog of claims pending at OHA. However, based on what we have seen and heard, very few of us think these initiatives will significantly decrease these pending backlogs. In our opinion, the initiative identified as the cornerstone of the entire effort will not produce the dramatic reduction in pendings as hoped for by the agency.

As we understand the initiative, SSA will authorize staff attorneys to review pending claims at OHA which have been identified as those most likely to be reversed on the record by the administrative law judges. After the review and a conference with the claimant's representative, if necessary, these staff attorneys, as well as paralegal staff, will be empowered to issue fully favorable decisions and only fully favorable decisions.

It is further our understanding that these decisions will not be subject to any substantive quality review prior to effectuation and that SSA projects these staff attorneys will approve for payment 80 percent of all the cases they review. We feel that any such attempt to allow our way out of the workload problem will fail, but only after incurring staggering ongoing costs to the trust fund.

Since the bulk of the decisionmakers that SSA has at its disposal are in the DDSs and all DDSs want to assist in reducing the backlog at OHA, we suggest to SSA that as an alternative to this initiative, OHA remand back to the States those pending cases which have been identified as most likely to be approved. The DDSs could review those claims and approve for payment those claims that are appropriate under guidelines issued by SSA.

For the claims that could not be approved under existing guidelines, if resources permitted, the DDSs could also obtain outstanding medical reports and provide a rationale for the file to explain why an approval was not possible. The unapproved claims could then go back to OHA for their action.

This alternative proposal would make the claims easier to decide at OHA and would enable the staff attorneys to carry out their normal and very important duties, one of which is decisionwriting.

One long-range initiative that impacts on the DDSs most is the reengineering effort known as the disability process redesign. Our organization has been very supportive of the redesign efforts. Although we remain cautiously optimistic that the redesign effort will meet most of its objectives, we feel the part of the process which is almost universally recognized as the part most broken will remain broken after all the redesign activities are completed.

Those of us inside the system view with amazement and those outside the system view with sheer disbelief the phenomena of a 75-percent reversal rate that disability applicants enjoy when they appeal to OHA after their denials at the DDS. Such a high reversal rate just does not exist in a rational system. Nothing we have seen or heard makes us believe the redesign process will adequately address this dysfunctional part of the process.

We are very concerned that the redesign process will not change the situation we are in now, with the DDSs following the stricter interpretation of the law and the regulations as promulgated by the agency and OHA following the more liberal interpretation of the law and the regulations as enunciated by the courts.

Our membership feels this body, Congress, should tell the agency how it wants the decisions made, should give the agency the tools it needs to make the decisions that way, and to insist the agency make them the way Congress wants them made. Specifically, Congress should insist that SSA remedy the conditions that permit a reversal rate at OHA of 75 percent of appealed cases.

With regard to the backlog of cases requiring review to determine whether disability benefits should continue, our association has little to say other than the fact that we should do whatever is required to get current with this caseload and keep it current. To do so will require additional funding. The administration should request the funds necessary to do this and Congress should appropriate the necessary funds. To do less is a clear disservice to the American public. Also, for the agency to be so knowingly in clear violation of the law is embarrassing.

Although it would offer no help in dealing with the current backlog, most of our membership favors, in concept, the notion of time-limited benefits which, if enacted, could eliminate the problem for the future.

I appreciate the opportunity to testify and would be glad to answer any questions you may have. Thank you.

[The prepared statement follows:]

TESTIMONY OF

JERRY A. THOMAS, PRESIDENT
NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

BEFORE THE
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES

REGARDING SOCIAL SECURITY DISABILITY CLAIMS BACKLOGS

MAY 23, 1995

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to submit testimony on behalf of the National Council of Disability Determination Directors (NCDDD), a voluntary managerial association of the directors and other managers of the state Disability Determination Service (DDS) agencies.

The DDS' share the concern of the subcommittee members about the backlogs which persist at the state DDS level, and which are at a crisis level at the Office of Hearings and Appeals. At no time during this decade have all the DDS' been funded or staffed to process all the applications we were projected to receive. Because of the hard work and dedication of the DDS staffs, most of the DDS' have made significant progress in reducing or eliminating their backlogs. In a recent survey, only six (6) of the forty-three (43) DDS' responding reported that their pending workloads will still be much too high by the end of the current fiscal year, although another fourteen (14) reported their pending workloads would be somewhat too high. Most often cited reasons for the high pending workloads were the requirement to comply with mandated cumbersome procedures that do not contribute to the quality of the decisions, and the lack of sufficient numbers of trained staff. The vast majority reported the short term initiatives implemented by the Social Security Administration (SSA) had no impact, or only a marginal impact on the backlog reduction. We will be working with SSA to determine if we might assist in helping those DDS' with chronic workload problems.

Most of the short term initiatives proposed by SSA are designed to reduce the backlog of claims pending in OHA. However, based on what we have seen and heard, very few of us think these initiatives will significantly decrease those pending backlogs. Some of the initiatives, such as the realignment of the materials in case folders by the DDS', and the increased use of technology, should have some long term positive impact on the pending workloads, and perhaps even some marginal impact in the short term. However, in our opinion, the initiative identified as the cornerstone of the entire effort will not produce the dramatic reduction in pendings as hoped for by the Agency. As we understand the initiative, SSA will promote staff attorneys at OHA and authorize them to review approximately thirty percent (30%) of the claims pending at OHA, which have been identified as those most likely to be reversed "on the record" by the Administrative Law Judge (ALJ). After the review and a conference with the claimant's representative, if necessary, these staff attorneys, as well as paralegal staff, will be empowered to issue fully favorable decisions. It is further our understanding that these decisions will not be subject to any substantive quality review prior to effectuation, and that SSA projects the staff attorneys will approve for payment eighty percent (80%) of all the cases they process. This initiative and others have led many in the DDS community to believe that the Agency has decided that the only way to get out of this backlog crisis at OHA is to "pay their way out." Any such attempt to "allow our way out" of the workload problem will fail but only after incurring staggering ongoing cost to the trust fund.

Although I certainly do not purport to speak for the ALJs, those that I have discussed this initiative with feel this initiative may well slow down their output, since these staff attorneys, who will be reviewing and paying claims, will be doing so at the expense of their normal duties which includes writing decisions for the ALJs. Also, the ALJs will be left with the more difficult claims to hear and decide, to which they have no objection, but which will be more time consuming and which will necessarily slow down their productivity. Also, once knowledge of this procedure is "on the streets", we feel it will produce a higher appeal rate by claimants denied by the DDS, and consequently may well increase rather than reduce the backlog at OHA.

The bulk of the decision makers that SSA has at its disposal are in the DDS', and all DDS' want to assist in reducing the backlog at OHA. We are suggesting to SSA that as an alternative to this initiative, OHA remand back to the states these pending cases that have been identified as most likely to be approved. The DDS' could review these claims and where appropriate under the guidelines issued by SSA, approve for payment those claims where additional medical evidence was submitted, or when there had been a worsening of the condition, or the claimants vocational profile had changed since the previous denial. Other circumstances could also dictate a favorable decision. For the claims that could not be approved under existing guidelines, where resources permitted, the DDS' could also obtain outstanding medical reports and provide a rationale for the file that explained why an approval was not possible.
The unapproved claims would then go back to OHA for their action. This alternative proposal should make the claims easier to decide at OHA and would enable the staff attorneys to carry out their normal and very important duties. Only one (1) of the DDS' responding to our survey said they would not be able to assist in this effort, and nine (9) said they were not sure. Some of the states that could assist would need additional resources.

The two long range initiatives that impact on the DDS' most are the reengineering effort known as Disability Process Redesign (DPR), and the plan to install a new computer system (RDS) in the DDS'. Our organization has been very supportive of the redesign efforts. We have furnished members of our staffs to work on the redesign plan and on the implementation teams, and have offered our DDS' as pilot sites to test out parts of the redesigned process. Although we remain cautiously optimistic that the redesign effort will meet most of its objectives, we feel the part of the process which is almost universally recognized as the part most "broken" will remain "broken" after all the redesign activities are completed.

Those of us inside the system view with amazement and those outside the system view with sheer disbelief, the phenomena of a seventy-five percent (75%) reversal rate that disability applicants enjoy when they appeal to OHA after their denials at the DDS. Such a high reversal rate just does not exist in a rational system. Nothing we have seen or heard makes us believe the redesigned process will adequately address this dysfunctional part of the system. In fact, what we have seen and heard leads us to believe the attempts to fix this anomaly will, only at best, partially do so, and will actually put the trust fund at greater risk than it is now. One of the principles of the redesign is that the right decision will be made the first time in the redesigned process. We interpret this to mean that some of the claims currently approved by OHA will be approved earlier in the application process by the DDS'. This will be accomplished by unifying the presentation of SSA policy, and by implementing a comprehensive quality assurance system which will supply the DDS' with sufficient feedback on how well the policy is being followed. However, since the DDS' will be following the law, the regulations, and the rulings as interpreted by the Agency, and OHA will continue to follow the law, the regulations, and the rulings as interpreted by the federal Circuit Courts of Appeal, and in many instances the federal District Courts, the discrepancy in decision making between the DDS' and OHA will continue to exist, since SSA does not have the authority or the will to enforce its policy interpretations at the OHA level.

We are very concerned that the redesigned process will not change the situation we are in now with the DDS' following the stricter interpretation of the law and the regulations as promulgated by the Agency, and OHA following the more liberal interpretation of the law and the regulations as enunciated by the courts. Our association membership feels this body, Congress, should tell the Agency how it wants the decisions made, should give the Agency the tools it needs to make the decisions the way Congress wants them made, and to insist the Agency make them that way. Specifically, Congress should insist that SSA remedy the conditions that permit a reversal rate at OHA of 75% of appealed cases.

The NCDDD is quite concerned that the success of the redesign rests on a number of necessary enablers, one of which is the development and implementation of a new and highly sophisticated hardware and software system in all the DDS' and the SSA field offices. Although this new system could eventually yield significant savings in staff resources, it will be exceedingly difficult and exceedingly expensive to develop and implement. Any loss of commitment by the Agency or reduction in funding by this body could well ensure the failure of the redesign efforts.

With regard to the backlog of cases requiring review to determine whether disability benefits should continue (CDRs), our association has very little to say other than the fact that we should do whatever is required to get current with this caseload and to keep it current. To do so will require additional funding. The Administration should request the funds necessary to do this, and Congress should appropriate the necessary funds. To do less is a clear disservice to the American Public. Also, for the Agency to be so knowingly in clear violation of the law is embarrassing. Although it would offer no help in dealing with the current backlog, most of our membership favors in concept the notion of time limited benefits, which if enacted, could eliminate the problem for the future.

I appreciate the opportunity to testify on behalf of the National Council of Disability Determination Directors, and will be glad to attempt to answer any questions you might have. Thank you.

Chairman BUNNING. Thank you for your testimony.

There are five of you on this panel and, according to what I have heard from your testimony, maybe you are an exception, Mr. Thomas, but you think the short- and long-term redesign program that SSA is talking about will not, in your opinion, do anything to solve these problems, or if it will, it will just temporarily? That is the testimony I get from you. Is that pretty correct?

Mr. THOMAS. The problem of the higher reversal rate at OHA, that is correct, it will not address that.

Chairman BUNNING. You are on the front line making the initial determination. As the process continues, even in the redesigned process, you are still not going to have the ability to make the initial decision without it being overturned later on.

Mr. MCCASLIN. That is correct.

Chairman BUNNING. Is that what I am hearing from all of you, generally?

Mr. MCCASLIN. The most serious problem that I think has been brought up repeatedly today is this differential between the ALJ decision and the initial decision. That is not effectively addressed in the redesign. We are talking the year 2000.

Chairman BUNNING. That is what I thought.

Let me ask you, Doctor, and you do not have to answer this, but I am interested to know how you became a medical examiner and who appointed you and how you got your job.

Dr. YATES. I applied for the job. About the time that I thought I had done all the surgery that I needed to do, why, I applied for the job and made——

Chairman BUNNING. With SSA?

Dr. YATES. Yes.

Chairman BUNNING. With the Social Security Administration?

Dr. YATES. I work for the State disability organization, DDS.

Chairman BUNNING. The State, then, is the one who hired you?

Dr. YATES. Yes, sir.

Chairman BUNNING. Then that confirms my deepest suspicion that it could be a position that is a patronage position. I am not saying yours is.

Dr. YATES. I think I need to clarify, Chairman Bunning. I just review charts. I do not examine patients.

Chairman BUNNING. You review charts?

Dr. YATES. Yes. I am a medical consultant——

Chairman BUNNING. Let me ask you the question, then, in California, who does the medical exams?

Dr. YATES. A chart is developed, much as has been explained, a chart is developed. If there is sufficient medical evidence in that chart, it immediately goes through the process. The disability analyst looks at it, myself, a consultant, looks at it, and a decision is made. If that chart does not have sufficient information, there are several ways that we get that information. Sometimes I call the treating physician and ask for information that is not reflected in the record. Sometimes, if that information is not available or you need a specialist, we hire a consultative examiner. I think this is the doctor——

Chairman BUNNING. That is the one I am interested in.

Dr. YATES. That is the one you are interested in.

Chairman BUNNING. That is the one I am finding in Kentucky goes to various very good friends of the Governor and other people.

Dr. YATES. I come from California. The consultants that we get for that information can be the consulting physician, can be a specialist in that field that may be there, but most of it is done by panels of doctors who have agreed to work for these miserable wages, namely about $95 for a complete history, physical examination, and will send us a report. These are panels of doctors that will do that for us.

Chairman BUNNING. GAO testified that allowances have gone up because of the changes in the law regarding mental impairments and pain. Can you explain this a little more, any of you? Can you explain it a little more and tell us how you believe the adjudication of these claims based on mental impairments or pain has changed?

Mr. MCCASLIN. The basic change has been a greater influence on subjective findings versus objective findings.

Chairman BUNNING. That would come at the latter stage?

Mr. MCCASLIN. It could manifest itself at any point in the process, but it appears that it takes much greater weight at the ALJ level.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. Ms. Barnard, I acknowledge that we are either blessed or cursed by residence in the same city, like most cities, a little of both, I guess.

Chairman BUNNING. The same district.

Mr. JACOBS. The same district. When did the backlog begin to evolve?

Ms. BARNARD. I think we were aware of it in Indiana with the *Zebley* cases, the readjudication of the *Zebley* cases and the adjudication of childhood claims based on the parameters that we were given at that time. We had to change our whole mindset and how we dealt with childhood cases.

Mr. JACOBS. Do you find it a coincidence that the backlog began to build up about the time they let 17,000 employees go in the eighties?

Ms. BARNARD. No.

Mr. JACOBS. That is not just a coincidence?

Ms. BARNARD. I do not see any relationship. In our situation, we see it as related to that claim.

Mr. JACOBS. My recollection was that the theory was quite valid, that automation would allow diminution in the human staff, but the problem, as I recall, was that every time there was a new Commissioner, and they more or less chain-smoked them at that time, they would go another place in the river and start to, build the automated bridge, so they were always backing up to get a new start. Whereas the RIF-ing went off on schedule, the automation fell badly behind and that is where the crunch came.

Ms. BARNARD. That may be true at the Federal level, but at the State level——

Mr. JACOBS. Does anyone else have an opinion about that?

Mr. THOMAS. I do not see it contributing at the DDS level.

Mr. JACOBS. It is all history, I guess, but the past is prolog, too, is it not, and produces backlog.

Somebody testified this morning that one of the reasons for the reversal rate is that the files themselves gather information along the way. I do not quite understand that. Let us say a log falls on me—I am out here cutting trees or something—and breaks me in half and I am a paraplegic. What evolves from that that you do not know at the initial consideration?

Ms. BARNARD. If you were a paraplegic, you would be allowed.

Mr. THOMAS. Mr. Jacobs, I do think that contributes in some small way to the reversal rate. However, I think there have been very good studies done that have shown that the preponderance of the reversals occur because of a different interpretation of the same facts.

Mr. JACOBS. That is what I suspect. For instance, let us say I am a little bit luckier and I just pull my back or something like this. Is there anybody in the room who has not done that? Is there anything to be said for preparing your case a little better before you apply in the first place, getting your information together?

Mr. MCCASLIN. That would be something that would help both the claimants and the process entirely.

Mr. JACOBS. How would you go about that? Those with insufficient files need not apply until it becomes sufficient.

Mr. MCCASLIN. It is my understanding that under the Social Security Act, the claimant has an underlying responsibility to help provide evidence, and I think that is something that we can improve on, especially if we can convince the public that by doing that, their outcome might be enhanced.

Mr. JACOBS. What if we convinced the public that they have to do that. Is there a statutory step that might be taken?

Ms. BARNARD. The advocate groups would say that this particular claimant may not have the capability to go to——

Mr. JACOBS. How does that person get the capability over time?

Ms. BARNARD. That is where the advocate might come into play.

Mr. JACOBS. Is there any resonance in what I am saying here? Is that a possibility, that you could make a big difference if you just said, do not come down to the office, do not make your claim until you round up your doctors and round up your photographs and x rays and so on. Why do it halfway at the beginning?

Mr. THOMAS. I think that would be in enforcement.

Mr. JACOBS. Out in Indianapolis they say, a hint to the wisecracker is sufficient, and we might give that some exercise.

Ms. BARNARD. When I get a claim, I have direct contact, at least by the phone, with, I would say, 99 percent of my claimants. They quickly, because I send them letters for various things, learn my number and often keep it for use afterward. So when I am doing a predevelopment call, I go through and clarify and say, you need to do these things.

Mr. JACOBS. Good.

Ms. BARNARD. It does not always work, though.

Mr. JACOBS. I think that maybe there is just a possibility that we can write that down. You cannot get into the movie until you get a ticket.

Ms. LANGELE. Right now, though, Mr. Jacobs, it is important to understand that anyone going into the Social Security office can

apply for disability for any impairment. For anything they believe is disabling, an application must be taken.

Mr. JACOBS. I am just saying, why allow the filing of an application until there is sufficient accumulation of the evidence required to make a determination?

Ms. LANGELE. We agree.

Mr. MCCASLIN. That would enhance the process dramatically.

Mr. JACOBS. Why do we not think about that a little bit? Thank you.

Chairman BUNNING. Mr. Christensen.

Mr. CHRISTENSEN. Thank you.

Dr. Yates, I want to question you in light of the fact that I would not expect you as a medical doctor to come here and to for one moment say that the consultants would do a better job or could do the job, but there has to be some reasoning on why the redesign process has proposed going to the consultant.

Is there anybody on this panel that would suggest that there is any reason why we should go to this other method? It is kind of biased coming from the medical doctor, that we need to protect the medical doctor and we need to continue with this diagnosis before we go on. Is there anybody who would have any other opinion on this or not?

Mr. THOMAS. I may have a contrary opinion. I think there are significant numbers of cases that can be adjudicated without medical involvement. The key is, as the Doctor said, in knowing where the line is and being able to recognize those which are beyond your expertise. But I do not think the redesign process has any intention of eliminating the physician from participation in the case when it is necessary.

Mr. CHRISTENSEN. Mr. McCaslin, in your testimony, you said that you approved a leg fracture disability claim in which full healing did not occur within 12 months. You and I both know that a leg fracture will probably heal and will probably be 100 percent, maybe not within that 12-month time, but then you go on to say that that person will probably never have a CDR, will never have a review process, maybe never, or highly unlikely, anyway, and that person, if he is gaming the system, could stay on disability payments for a long time if not indefinitely.

As the disability specialist, should we give you more autonomy to make the decision? I know you were following the law. They were not healed within that 12-month period, so fully, under the law, they were eligible for disability payments. Should we change the law to give you, who is out there in the field, right there on the fighting line, more discretion to make that decision, because you know in this case of this leg fracture that that person is not going to be disabled for life?

Mr. MCCASLIN. I think, to answer that, a step in the right direction would be for Congress to consider time-limited benefits in selected impairment areas. This would be a classic example, where the person would be granted benefits with a closeout date. You will stop getting the benefits on this date, based on the expectation of recovery.

Right now, the onus is on the administration of the Social Security program to prove that you have gotten better, that you have

recovered. That is something that, I think, in my visits here, is under consideration. I think it has merit, it would be something new, and it would respond to this scenario.

Mr. CHRISTENSEN. Mr. Chairman, I think that this is something we ought to look at and go after, because I think there is a lot of value to this idea that Mr. McCaslin has brought. I know it is not something new that you just discovered but it is something that we ought to look into.

That is all I have, Mr. Chairman.

Chairman BUNNING. Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman.

I was pleased earlier to hear that Dr. Chater and her staff are looking into a way to make this process work better. I think this has been going on for quite a long time, and I applaud the fact that things are happening and about to be done. I think you all are, as has already been said, on the front line, and maybe understand this as well as anyone in terms of the process and how it might be fixed.

I will just ask this question generally. Do you generally know, when you deny someone, that they are very likely, when they go to the next process and when they go to the administrative law judge, to be found favorably upon? Is that something you are aware of?

Mr. MCCASLIN. The statistics would bear that out, and so we have learned over time that the probability of those that appeal——

Mr. PAYNE. It is not only the probability, but do you know that this person likely is going to be successful and this person is not? Is it apparent as you go through this process what the likely outcome will be 10 months from now or however long it is?

Mr. MCCASLIN. There are instances where we feel if we had some greater latitude that that is an appropriate allowance and it really should not be going on to the next level.

Mr. PAYNE. What is the latitude that you would need? What is it specifically that you could be given that would address that need at your level?

Mr. MCCASLIN. I think that clearer standards within the regulations regarding establishment of functional capacity, those would go to help us in that area. It is not an easy or simple question to answer.

Mr. PAYNE. Would you say that again? Clearer standards regarding——

Mr. MCCASLIN. Specific regulations on how we view a person's functional capacity, despite having a disability.

Mr. PAYNE. Does anyone else have an opinion about that same question?

Mr. THOMAS. I would just like to second what he said. When the case is at our level, in very few instances do we find that a person's impairments preclude the full range of sedentary work, if they do not meet or equal the medical listings. We find a very small percentage of them preclude a full range of sedentary work. However, at the OHA level, they will look at the same case and say that a complete and full range of sedentary work is precluded in almost 60 percent of the cases.

Mr. PAYNE. So how do you fix that problem? You are both looking at the same criteria and making different judgments, is that correct?

Mr. THOMAS. It depends on whether you want to follow the opinion and advice you get from the medical consultant or whether you want to follow the advice from the courts.

Mr. PAYNE. It was said earlier today that one of the problems, and I think you all have said this, too, is that you really have two different standards. You say you are working on medical information and at the next level they work on legal information. But to bring this together, to have the single manual that was talked about that everybody is singing from the same, not only the same hymnal but hopefully the same page, then that is a very positive step in the right direction?

Mr. THOMAS. Yes, I think it is a step in the right direction, but I would hasten to say that it is not enough. It will not correct the problem. I do not see any mechanism in the redesign process that will limit the administrative law judges' discretion in following the dictates of the court.

The SSA is faced with a true quandary here. If they allow the DDSs to operate under those same guidelines, then they are going to increase the number of people that are approved for benefits. We are going to allow more, and I do not think the administrative law judges are going to allow less, so I think we are going to significantly increase the number of people on the rolls if that occurs.

Mr. PAYNE. Are there any other comments about that?

Ms. LANGELE. I have adjudicated claims for 15 years and there have been instances where my hands are tied and I knew beyond a shadow of a doubt that if this claimant could get to the administrative law judge level, they would be allowed, and I have gone so far as to make sure that they understood the appeals process so that they would go on and be justifiably put on the rolls.

Mr. PAYNE. But in that instance, many months then transpire and much happens in that individual's life until they can finally get that approval.

Ms. LANGELE. It takes a long time and I told them to be very stoic with the situation and get on to the ALJ level.

Mr. PAYNE. Thank you very much.

Thank you, Mr. Chairman.

Chairman BUNNING. I have a question of Ms. Langele. You brought up the fact that you think the disability backlog started with the SSI outreach in, what, 1989?

Ms. LANGELE. That was in the nineties. It certainly contributed to it. I believe during the SSI outreach program, SSA was going out and securing applications from many people that we had not targeted before, the homeless, the drug addicts. We were basically——

Chairman BUNNING. Then you would basically say that that is the reason that that program has kind of exploded, since the outreach program?

Ms. LANGELE. That is part of it.

Chairman BUNNING. I want to thank you all for coming today. We appreciate your front-line testimony about what is really happening. Thank you.

We have one more panel for today, if they would step forward, Judge Ronald Bernoski, Demos Kuchulis, and James Hill.

Ronald, if you would begin, I would appreciate it.

STATEMENT OF RONALD G. BERNOSKI, ADMINISTRATIVE LAW JUDGE, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, MILWAUKEE, WIS., AND VICE PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, INC.

Judge BERNOSKI. Mr. Chairman, thank you for the opportunity of testifying here today. My name is Ron Bernoski. I am an administrative law judge with the Social Security Administration, and I appear here in my capacity as the vice president of the Association of Administrative Law Judges. We represent the judges in the Social Security Administration.

We share the concern of both the Congress and the agency with the Social Security case backlog. In fact, in August 1993 we presented a position paper to the National Performance Review which included suggestions for reform, and many of these are stated in our paper.

We are concerned with the current crash program to address this backlog because the agency has the means to know, and has known, of this backlog for some time.

I will comment upon the initiatives of the agency to address the backlog. We have concern with the short-term disability project, particularly action seven. We believe that this is an attempt to "pay down" the backlog. This plan will have an adverse effect on both the claimant and the trust fund, which we have described more specifically in our paper.

I would like to focus on the lack of legal sufficiency of action seven. It gives the staff attorney a role which infringes upon the APA, or Administrative Procedure Act, jurisdiction of the administrative law judge. It is clear that once Administrative Procedure Act jurisdiction attaches to a claim, that the Commissioner can only take one of three actions. At that time, the Commissioner must either decide the claim herself, assign it to a commission that is within the agency, or assign the case to an administrative law judge.

It is also clear that Administrative Procedure Act jurisdiction attaches in Social Security cases with the filing of the request for hearing. The regulations further provide that no part of an administrative law judge's duty can be assigned to a nonadministrative law judge.

The proposed regulation in action seven clearly violates this regulatory standard when it states as follows: "The staff attorney shall exercise these functions performed by an administrative law judge under section 404.1520 and 1546." This provision clearly violates the existing regulations.

Since the SSA regulations do not provide any interim jurisdiction after the DDS adjudication, this is an improper infringement on both the law and the regulations.

I will also briefly comment on other legal problems with action seven. It violates the rotational rule with relationship to assignment of judges to cases which is required under the Administrative

Procedure Act. It violates the ex parte communications rule under the Administrative Procedure Act. It was implemented without promulgating regulations, and it creates an inconsistency in the handling of drug and alcohol cases.

Action seven, Mr. Chairman, is just the opposite of the initiatives of the eighties. There, the goal was to deny cases. Here, it is to pay claims. This shows the value of the administrative law judge who stands as a buffer between the pendulum of political tides.

I will next comment upon the proposed reorganization of the Office of Hearings and Appeals and I will focus on two of our concerns.

First, the plan states that it will discourage or preclude case development by the administrative law judge. This creates several problems. First, it is contrary to the requirements of a de novo hearing. It will also lead to poor hearing records, which will have a direct adverse effect upon the trust fund, and the case law clearly mandates that the judge complete the record.

Second, the plan calls for a clarifying and redefining of the Administrative Procedure Act. We suggest that the Administrative Procedure Act provides the type of legal process that the American people expect from the government. The rule of law has served well in protecting both the claimants and the trust fund. In the eighties, our judges stepped forward to protect the claimants, for which they were recognized by the American Bar Association. Now, we are stepping forward to protect the trust fund.

The independent decisionmaker, Mr. Chairman, is the cornerstone of administrative law. It provides fairness and dignity to the process. As this system now begins to change and private sector techniques are considered, such as vocational training and conditional awards, it is even more important to have skilled administrative law judges with judicial discretion. The basic integrity of the system will rely on the credibility of the judges.

In closing, I will say there is no substitute for the protections provided to the American people by the Administrative Procedure Act. This concludes my statement.

I would also like to, if I may, just offer into the record a letter that was prepared by our president, Mel Cleveland.

Chairman BUNNING. Without objection.

[The prepared statement and attachment follow:]

TESTIMONY OF RONALD G. BERNOSKI
ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, INC.

My name is Ronald G. Bernoski. I am an administrative law judge who for the last fifteen years has been assigned to the Office of Hearing and Appeals of the Social Security Administration in Milwaukee, Wisconsin.

I appear before you in my capacity as the Vice President of the Association of Administrative Law Judges, Inc., (Association) which is a professional organization having the stated purpose of promoting full due process hearings to those individuals seeking adjudication of controversies within the Social Security Administration (SSA) and the Department of Health and Human Services.

I. SSA DISABILITY BACKLOG

The Association has a long history of promoting administrative due process for both the claimant and the government. The Administrative Law Judge (ALJ) has the legal responsibility of "wearing three hats" at each hearing. The Judge must protect the legal interests of both the claimant and the government while also providing a full and fair hearing for each party. A decision is then issued by the judge which is required to be based upon the evidence of record (Sec. 405 of title 42 USC).

The Association has long shared the concern of Congress and the Agency with the SSA disability claims backlog. In August 1993 we prepared a paper for the National Performance Review of Vice President Gore which addressed the issues of proposed reform of the SSA disability adjudicative system. We recommended that the existing problems in the claims system could not be remedied until two events occurred: First, that the agency be required to follow a single disability standard at each level of claims adjudication; and Second, that control of the hearing process be restored to the judges. We then made fifteen recommendations, some of which have been or will be implemented. Those recommendations not implemented are as follows:

1. Passage of the " Reorganization of the Federal Administrative Judiciary Act" (S.486) to accomplish economies of scale, eliminate layers of management, ensure the independence of adjudicators from improper agency influence, and streamline the personnel structure by replacing it with an efficient system with a lower supervisor-to-staff ratio.

2. Require the agency to adhere to all provisions of the 1984 Social Security Disability Reform Act, in particular those requiring uniform standards of adjudication at all determination levels.

3. Require the agency to discontinue inconsistent policies which impact adversely on the hearing process.

4. Improve the quality of appellate review of ALJ decisions, to provide for decisions of precedential value and thus a uniform system of disability law.

5. Fund and require the agency to perform continuing disability reviews to assure that only those who remain eligible continue to receive benefits.

6. Require vocational rehabilitation in cases where such rehabilitation is likely to result in a productive work life for the claimant (e.g., those whose condition is expected to improve, or who are disabled by vocational factors rather than at "listing" level severity).

7. Reconcile the provisions of the Americans With Disabilities Act with those of the Social Security Disability Act.

8. Close the evidentiary record after the ALJ hearing.

9. Streamline the decision writing process by, for example, providing for oral decisions from the bench; entry of minute orders; or authorizing judges to order claimant's counsel to prepare a proposed decision in cases where the claim is approved.

We suggest that consideration can also be given to reviewing subjects such as the SSA treating physician rule, the SSA pain standard, prospective closed periods of disability and burden of proof rules. The current backlog in SSA disability claims has been caused by many factors which has led to the large increase of disability claims that has overwhelmed the processing capacity of the system. The agency has also not permitted the disability claims system to develop and evolve into an administrative adjudication system which is based upon the full flow of the legal process. The agency has not been willing to accept the concept of judicial review and has been extremely reluctant to follow the precedent of federal circuit court decisions. The agency has not been active in pressing for required changes in the law and has not pursued required reforms through either case law or statutory changes. The agency has instead attempted to achieve substantive legal change by procedural methods. These procedural methods have been attempts to direct the claims process by asserting more control over the decision making process. The methods have taken the form of adopting medical vocational rules (grids), implementing "negative listings", implementing hearing office staff reconfiguration, adopting the Bellmon review and implementing quality assurance programs. The agency has failed to recognize that substantive reform can not be accomplished by procedural means and each time the agency has attempted to assert more control over the decision making process it has lost control by reason of subsequent court challenges by claimants. We believe that the SSA disability claims process should be modeled after state workers compensation programs where the systems are permitted to grow and mature with case law and statutory changes.

This suggestion is supported by the recent Proposed Long Range Federal Court Plan (March 1995) which included a recommendation that "Congress and the agencies concerned should take measures to broaden and strengthen the administrative hearing and review process for disputes assigned to agency jurisdiction, and to facilitate mediation and resolution of disputes at the agency level" (Recommendation 9 at page 32). We are concerned that some elements of the Resigned Plan are again directed at "controlling" the decision making process instead of at substantive reform. .

II. SHORT TERM AND LONG TERM INITIATIVES

A. SHORT TERM INITIATIVES:

The Association has concern with the recent implementation of the Short Term Disability Project (STDP) by the Office of Hearings and Appeals (OHA) of the Social Security Administration. We have particular concern with Action #7 of this initiative. The project is scheduled to last until December 1996. Action #7 removes about 560 trained staff attorneys and paralegals from their support function as decision writers for administrative law judges and places them in a role of claims adjudicators to pay claims. They will assume this responsibility after the claimant has filed the request for hearing and will perform this function without administrative law judge supervision. Only after the claim has been paid will the file will be sent to the respective Hearing Office Chief Judge for dismissal of the request for hearing. This initiative is being developed simultaneously with the SSA Redesign Plan which contains the position of an Adjudication Officer (AO) which has functions similar to those performed by the staff attorneys and paralegals under the STDP. In addition, both of these projects are assumed to be implemented without hiring new personnel and may be resourced from existing OHA staff.

We are of the opinion that the STDP (particularly Action #7) will have an immediate and direct adverse effect on both the claimant and the trust fund, which is more particularly described as follows:

a. Adverse impact on the trust fund.

1. The initiative only allows for the payment of claims. The project can only be a success if a large number of claims are paid. It is an attempt to "pay down" the case backlog. We believe the result will be an increase in favorable claims with more cases being paid, as compared to the payment rate under the present administrative law judge system. This in turn will have an adverse effect on the Medicare fund, on general funds from which SSI claims are paid and on Medicaid funds because SSI recipients are entitled to Medicaid (the Association has addressed these issues in a letter to the

Commissioner). It should be further noted that the staff attorneys and paralegals will not receive any additional training before they start to perform this adjudication function. The goal of the agency is to pay 200,000 cases by this "fast track method" by December 1996. We have been advised that each claim has a value of about $80,000 which may result in a long term payout of about 16 billion dollars.

b. Adverse impact on claimants.

1. The initiative will take about 560 trained decision writers from the administrative law judges and replace them with about 170 writers, many of whom are untrained. This transfer of personnel will result in a reduction of support staff for the judges and will cause a backlog in the issuance of final written decisions after the hearing. Many of these writers are from the Appeals Council, and we believe that the Appeals Council will experience a case backlog from this transfer of personnel functions. The end result will be delay for the claimants.

2. The Reconsideration Denial does not include a notice which advises the claimant of the third level of review, in select profile 3 cases, prior to the ALJ hearing. We believe that this lack of notice may be construed as a denial of due process of law and may become the basis for class action litigation. We are concerned with the impact that successful class action litigation may have upon an already overloaded disability claims system.

3. We understand that disability claims based upon drug and alcohol addiction are included in the select class of cases and are thereby considered to be a potential basis for "fully favorable" decisions. We further note that drug and alcohol cases have been determined to be less than "fully favorable" as a matter of law under the recently promulgated regulations which implement the drug and alcohol legislation adopted by the 103rd Congress. We are concerned with this "fast track" payment of drug and alcohol claims and with the inconsistent classification of this impairment.

c. Legal sufficiency of the Plan.

We have considerable concern with the legality of the plan and we are of the opinion that the STDP initiatives do not meet the requirements of legal sufficiency for the following reasons:

1. The initiative requires that all requests for hearing will be dismissed by the respective Hearing Office Chief Judge after the claim has been paid by the adjudicator. The cases will not be rotated among all judges in each office. This requirement infringes upon the Administrative Procedure Act (APA) which mandates that "administrative law judges shall be assigned to cases in rotation so far as practicable" (Sec. 3105 of title 5 USC).

2. The initiative contemplates that, in a case which has not been paid, the staff attorney will stay with the case and will write the decision for the administrative law judge after the evidentiary hearing. This requirement infringes upon the APA which prohibits an ex parte communication with the judge by any person who has performed an investigative function in the case (Sec. 554 of title 5 USC). In this situation, the staff attorney will have investigated the evidence of record in the claim and is thereby precluded from having any further communication with the judge in the case.

3. The draft Hallex for the initiative refers to certain public laws, statutes and regulations as the legal basis for its authority. However, these references primarily relate to quality control functions and not to adjudication responsibilities which are the foundation of this program. This lack of basic legal authority may render the entire project ultra vires.

4. The STDP initiative effects a substantive right or interest of the claimant. Because of this fact, a regulation setting forth the elements of the program must be promulgated according to the requirements of the APA. This has not been done, and this omission may be a fatal defect under the holding of W.C. vs. Heckler, 629 F. Supp. 791 (W.D. Wash. 1985) which held the Bellmon review process to be unconstitutional

because it affected a substantive right of the claimant and it had not been promulgated pursuant to regulations adopted under the APA.

5. The APA (Sec. 556 (b) of title 5 USC) requires that once jurisdiction attaches to a Federal Agency and adjudication of the claim is required, only the head of the Agency, one or more members of the body which comprise the Agency or an ALJ may preside at the hearing. The agency has no authority to appoint a non-ALJ to preside at the taking of evidence after jurisdiction attaches under the APA. SSA regulations (20 CFR Sec. 404.933 and Sec. 416.1433) clearly set forth the requirements for requesting a hearing before an ALJ. This point is also illustrated in 5 CFR Sec. 930.202, wherein it is stated that an ALJ position means a position in which any portion of the duties include those which require the appointment of an ALJ pursuant to Sec. 3105 of title 5 USC, and in 5 CFR Sec. 930.209, wherein it is stated that an agency may not detail an employee who is not an ALJ to an ALJ position. There is no SSA regulatory procedure for any interim jurisdiction between the DDS Reconsideration review and filing the request for hearing. Jurisdiction of the ALJ is thereby clearly triggered by the request for hearing.

d. Recommendations.

Based upon the above stated reasons, we recommend that the STDP initiatives be immediately terminated and that the Commissioner adopt a case backlog reduction program which implements one of the following procedures:

1. That OHA staff attorneys and paralegals be assigned to work under the direct supervision of an administrative law judge. One of the responsibilities of the staff attorney or paralegal would be to review the evidence in the case file and make a recommendation for a fully favorable "on the record" decision to the judge for the judge's signature. This procedure is within the scope of the current regulations and does not infringe upon the APA; or,

2. If the Agency does not believe that the proper adjudication standards can be applied at the DDS level, then assign the OHA staff attorneys and paralegals to the DDS for their claims adjudication function. This procedure eliminates the infringement upon the APA. It places the adjudication prior to the request for hearing and creates a system similar to the current Reconsideration process; or,

3. Provide the current DDS Reconsideration examiners with the authority to adjudicate claims with the administrative law judge standard . This system can be quickly implemented within the existing law and regulations.

B. Long Term Initiatives

1. Redesign Plan.

The Redesign Plan has been proposed by the Agency as a comprehensive reform of the entire SSA disability system. The Association has concern with several aspects of this plan.

Under the Redesign Plan the Adjudication Officer (AO) is the focal point for all prehearing activities and is responsible for most of the prehearing record development. The Association recommends that a clear line of authority be created between the responsibility of the AO and the APA decision making authority of the ALJ. This can best be accomplished by not locating the AO within the Office of Hearings and Appeals and by having its authority terminate upon the filing of the request for hearing. A request for hearing triggers jurisdiction under the APA and thereafter only the Commissioner, one or more members of the body which comprise the agency, or one or more ALJs can render a decision on the claim (Sec. 556 of title 5 USC).

The basic Redesign Plan calls for the AO to schedule cases for the ALJ. This provision is inconsistent with realities of hearings offices, especially for judges who hear cases not only at their hearing offices but also at remote hearing sites. In these offices considerable

care must be devoted to creating a travel docket to make the best use of the judge's time and travel budget. It is also inconsistent with the judges' responsibility to hold a quality hearing. A judge must review the case prior to the hearing to assure that it is fully ready to be heard and that all appropriate expert witnesses have been obtained to ensure that a complete hearing record will be made. The AO Task Team recommended that the AO not have any ALJ hearing scheduling responsibility. We agree with that recommendation.

The ALJ should also have the authority to return cases to the AO for additional prehearing development. It is intended that this authority would be sparingly used but that it is necessary to permit the AO to perform its prehearing development responsibility. The AO Task Team has recommended that the ALJ have this return authority. We agree with that recommendation.

The Redesign Plan vests the Appeals Council with a new quality assurance responsibility. The new "own motion" preeffectuation authority by the Appeals Council raises the specter of improper interference with the decisional authority of the ALJ. We do not want to return to the days of the Bellmon review which resulted in a court finding in the case of Association of Administrative Law Judges, Inc. vs. Heckler, 594 F.Supp. 1132 9d.D.D.C.1984), as follows:

> The evidence, as a whole persuasively demonstrates that the defendants retained an unjustifiable preoccupation with allowance rates, to the extent that the ALJs could reasonably feel pressure to issue fewer allowance decisions in the name of accuracy.

We recommend that this problem be avoided by reviewing only closed files and that records not be retained for individual judges but instead be retained only for certain classes of cases or for geographical regions to be used only for budget and training purposes.

The Redesign Plan provides for a system of process unification under a single adjudication standard. We reference the language of the Redesign Plan which states that "under the Administrative Procedure Act, the ALJ is an independent decisionmaker who must apply an agency's governing statute, regulations and policies, but who is not subject to advance direction and control by the agency with respect to the decisional outcome in any individual claim" (Plan For A New Disability Claim Process, page 37). We encourage the agency to be mindful of the function the Federal courts have in our legal system and to remain cognizant of the fact that the decision of the ALJ is subject to possible legal review by the courts under the judicial standard. The Proposed Long Range Plan for the Federal Courts (March 1995) addressed this issue by recommending that "Congress should enact legislation to --(a) generally prohibit agencies from adopting a policy of non-acquiescence to precedent established in a particular federal circuit (Recommendation 11 at page 34).

2. Reorganization of the Administrative Hearing Function of SSA.

The Redesign Plan does not contain any recommendations regarding the status of OHA. However, the Redesign Team has proposed a plan to restructure OHA.

The plan contains some positive aspects, which are as follows:

a. The system will continue to operate under the principles of the APA, as it has in the past (but see our concerns about proposed modifications of the APA below)..

b. The SSA Corps of ALJs will be placed under a chief executive officer who will report directly to the Commissioner.

c. The AO will be organizationally separate from the ALJs.

The plan also has some aspects that raise concern. The Association has not been officially contacted by the Agency regarding this proposed reorganization, and we desire to

establish a line of communication with the Agency to express our concerns. The problems are as follows:

a. The plan calls for a chief executive officer who reports directly to the Commissioner. We believe that the chief executive officer should be a chief judge and not an associate commissioner. The appointment should be for a fixed term with removal only for cause.

b. The plan calls for SSA to clarify and refine the APA procedures to fit its mass adjudication needs. This concept is vague and it must be clarified by the agency. We assert that the judges in SSA are the experts in mass adjudication and that this system probably adjudicates more cases each year than any other judicial system in the world. The APA was adopted in 1946 after extensive legislative hearings and debate. The courts have subsequently reviewed this act in many cases and have continued to affirm the protection it provides for the individual citizen. In the case of Richardson vs. Perales, 402 US 389 (1971), the United States Supreme Court was requested to determine if the APA rather than the Social Security Act governed the processing of SSA claims. The court did not directly decide the issue but instead stated that:

> We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act.

This finding by the court is an enormous compliment to the Social Security hearing system, and establishes that the reform act for all administrative hearings was modeled upon its principles. The basic provisions of the Social Security Act and the APA are thereby identical.

In 1983 the Subcommittee on Oversight of Government Management of the Committee on Governmental Affairs in the United States Senate conducted a hearing which inquired into the role of the administrative law judge in the Title II Social Security Disability Insurance Program (S. PRT. 98-111). The Committee issued its conclusions on September 16, 1983, which provided in part as follows:

> The APA mandates that the ALJ be an independent, impartial adjudicator in the administrative process and in so doing separates the adjudicative and prosecutorial functions of an agency. The ALJ is the only impartial, independent adjudicator available to the claimant in the administrative process, and the only person who stands between the claimant and the whim of agency bias and policy. If the ALJ is subordinated to the role of a mere employee, an instrument and mouthpiece for the SSA, then we will have returned to the days when the agency was both prosecutor and judge.

This brief overview demonstrates that the APA provides a shield for the individual, with the rule of law, that protects against the abuses of government. Any attempt to restrict the scope of these protections would amount to a stripping away of basic constitutional safeguards. We also favor continued review of Social Security cases by the Federal courts.

During the initial drafting of the Redesign Plan, an outside the parameters comment raised a concept for consideration that would replace the ALJ with a Hearing Officer (Disability Process Redesign, March 1994). The implementation of this change would be a serious mistake and it would deprive the American citizenry of the due process which it expects from the American legal system. The most important feature of the adjudication process of administrative law is the impartial factfinder. This protection is guaranteed by the constitution and is the cornerstone of due process (see Goldberg vs. Kelly, 397 U.S. 254 [1970]). The work product of the SSA ALJs speaks well for itself. In the 1980's this Corps of judges stepped forward and protected the rights of claimants from an overreaching government. This effort was recognized by the American Bar Association when it awarded a citation to all SSA judges. The citation provided as follows:

> Be It Resolved, that the American Bar Association hereby commends the Social Security Administrative Law Judge Corps for its outstanding efforts during the period from 1982-1984 to protect the integrity of administrative adjudication within their agency, to preserve the public's confidence in fairness of governmental institutions, and uphold the rule of law.

If the judges had not been APA protected factfinders they could not have resisted agency pressure and rendered these decisions under the rule of law. The APA protected the American people in this particular situation and this system goes to the very essence of democracy.

In recent years the SSA judges have again stepped forward to address the current case backlog. They have now increased their average monthly case deposition to over 43 cases. The judges have also provided many suggestions to improve the claims processing system. It is the APA which provides the basic dignity to the administrative law system and provides basic protection to the interests of both the claimant and the government. The Social Security system is the most revered program in the U.S. government and effects the lives of all Americans. This program deserves the very best administrative law system. There is no substitute for the protections and due process guaranteed by the APA. The most efficient method to deliver the protections of the APA is to enact legislation which adopts a unified corps of Federal ALJs (S.486). This reform will provide for greater efficiency by cross training of judges and taking advantage of the economies of scale. The Congressional budget Office has reported that this legislation will result in savings of $20 million in 1995, raising to $29 million by 1998.

c. The plan to restructure the hearing system provides that "The Agency will need mechanisms and a regulatory framework that discourages or precludes ALJ development activity once "certified" cases are handed to them for adjudication." The plan further provides that "the ALJ's simply must accept the cases they receive as matters to be decided and not developed....." (Page 3, Jones memorandum of April 28,1995 [Revised]). This concept is inconsistent with the Redesign Plan which clearly states that "The ALJ will retain the authority and ability to develop the record". The Redesign Plan further provides that "The ALJ hearing will be a de novo proceeding in which the ALJ considers and weighs the evidence and reaches a new decision. A de novo hearing is consistent with the role of an ALJ envisioned under the Administrative Procedure Act. Under that scheme, the ALJ is an independent decisionmaker who must apply an agency's governing statute, regulations and policies, but who is not subject to advance direction and control by the agency with respect to the decisional outcome in any individual claim. ALJs are independent triers of fact who perform their evidentiary fact-finding function free from agency influence" (New Disability Claim Process, page 34). The courts have also spoken on this subject. The case of Sears vs. Bowen, 840 F2d 394 (7th Cir. 1988) is typical of the holding of many courts. In that case the court stated that "there was no dispute that the Secretary has a duty to fully and fairly develop the record." We believe that the ALJ, as the delegatee of the Commissioner in the hearing process, is bound by the case law which interprets the responsibility of the Commissioner under the governing statutes, and thereby has a duty to fully and fairly develop the record. It is in the interest of both the claimant and the government that the ALJ develops the hearing record, because it provides for a fair hearing which protects the interest of both the claimant and the government trust fund. The implementation of the new position of the AO may reduce the record development burden of the ALJ but it cannot completely free the judge from this responsibility. We suggest that the ALJ can only be relieved of this responsibility by the establishment of an adversary or "presenter" type system which allows each party to protect its interest at the hearing.

d. The plan takes the new position of AO into consideration. We believe that there must be a clear line of jurisdiction established between the ALJ and the AO. The AO must not have the authority to schedule ALJ hearings (reasons cited above) and the ALJ must have the authority to remand cases to the AO for further development. This ALJ remand authority will assist the AO in completing its prehearing development responsibility and will strengthen the AO position.

e. The plan calls for a future collocating of ALJs in parent agency office buildings. This concept does not take into consideration the different roles and missions of the various components within the agency. This concept is also not consistent with the long standing SSA policy to maintain a clear line of distinction between SSA and OHA functions. Collocation is not consistent with the theory of a separate Corps of ALJs and may create the perception of a lack of independence. As the plan acknowledges, collocation is undesirable in an APA adjudication environment and could present legal problems.

f. The plan provides that "Administrative Services and policies applicable to all SSA components would, to the extent not already in place, be made applicable to the new ALJ Corps and its headquarters component". This objective does not give consideration to the fact that ALJs have a distinct employee status within the agency. ALJs are FLSA exempt employees who conduct APA protected hearings. This unique status must be considered when establishing the relationship of the judges with the agency.

g. If the proposed plan is established, the size of the hearing office will be reduced. We believe that the remaining support staff should be placed under the supervision of the judge. This structure will be effective because it will place the judge in direct control of his or her work product. This "unit system" is best suited for this smaller more streamlined agency.

III. Summary

The Association shares the concern of both the Congress and the Agency with the large backlog of SSA disability claims. As early as 1993 we prepared a paper for the National Performance Review which set forth our recommendations. We are concerned with the impact that the STDP (particularly Action #7) will have on both the claimants and the trust fund.

Melford O. Cleveland, President
Association of Administrative Law Judges, Inc.
Suite 407, 117 Gemini Circle
Birmingham, Alabama 35209-5861

May 12, 1995

Honorable Shirley S. Chater
Commissioner of Social Security
926 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235 (By Fax (410) 966-2830)

Dear Commissioner Chater:

This letter constitutes my comment as President of the Association of Administrative Law Judges Inc., your ALJs in the Office of Hearings and Appeals, on the proposed amendments to 20 CFR parts 404 and 416, Administrative Review Process, Prehearing Proceedings and Decisions by Attorney Advisors, published April 14, 1995. We are making this comment pursuant to the invitation set out in the proposed amendments. We appreciate the opportunity to express our concerns about this matter which goes to the heart of our work.

We make this comment, with a feeling of futility and sadness. We have the feeling of futility, because for almost a year, this Association has tried continuously, by every means available to it, to express our Judges' reservations and anxieties about this matter. As far as we can tell, these efforts have produced absolutely no results. We are sad, because this is true.

Our concerns are primarily as follows:

A. We believe that the proposed procedures are illegal. It is our view that once a Request for Hearing is filed, the case must be decided by an ALJ who is appointed pursuant to, and proceeds in accordance with the Administrative Procedures Act. However, under this proposal, cases will be decided after a request for hearing is filed, by a staff attorney on his or her own, or on recommendation of a paralegal; neither of whom is appointed pursuant to or is subject to the provisions the Administrative Procedures Act.

B. We believe that the proposed procedures are impractical and won't work. Many of the resources which the staff attorneys will use will be taken from the ALJs, and we have seen no concrete plan to fully replace these resources. Therefore, whatever gain in production of cases is made by the staff attorneys may be lost by the ALJs whose resources have been stripped away.

C. We believe that since these staff attorneys and paralegals will be hired to only PAY cases, and since they are inexperienced and will also have the natural tendency to please their employers who hired them to PAY cases, many cases will be paid that should not be paid. In our view this will result in the improper depletion of the following funds:

1. The Disability Trust Fund will be depleted by whatever amount is required to fund the improperly paid Title II disability cases.

2. The Medicare Fund will also be improperly depleted. Each person who is awarded Title II disability benefits is eligible for Medicare 24 months after the onset of disability. Therefore those who are improperly awarded disability benefits will also improperly deplete the Medicare fund.

3. General Funds of the United States Treasury will be improperly depleted because Title 16 SSI claims are paid from general funds. Therefore, each such claim that is paid that should not be paid will improperly deplete these funds.

4. The Medicaid Fund will also be improperly depleted because each SSI claimant that is awarded benefits is eligible for Medicaid at once. Therefore each SSI claim that is paid which should not be paid will improperly deplete the Medicaid Fund.

In summary, we believe that for the foregoing reasons the proposal is illegal, won't work, and will improperly drain large sums of money from all of the funds discussed above. I am personally convinced that this is true based on my 42 years of government service, 25 years of which has been as an SSA ALJ. Moreover high officials in OHA and SSA who have discussed the matter with us off the record have also expressed grave doubts about the proposal. We, and some of them, are firmly of the opinion that the resources that are going into this project could be better utilized by the ALJs.

We regret that more time was not allowed for comment. We were unable to hear from all our Judges because the proposed regulation did not reach many of the field libraries until about two weeks before the May 15 deadline. Moreover, I suggest with the greatest respect, that since our counsel in this matter, which vitally affects our own work, has been ignored, perhaps you would reconsider your position and endorse the Heflin Bill, S. 486, which would allow us to transfer to a separate corps of ALJs.

cc: Mr. Fisher
Mr. Skoler
Judge Rucker
Judge Anglada
Judge Watkins

With kindest personal regards, I am
Respectfully,

Melford O. Cleveland

Melford O. Cleveland

Judge BERNOSKI. Mr. Chairman, I would just like, if I may, to briefly comment. I might be able to shed some light on several questions that were raised previously, and I will do it very quickly.

Chairman BUNNING. We will get to that in questions.

Judge BERNOSKI. Thank you.

Chairman BUNNING. Mr. Kuchulis.

STATEMENT OF DEMOS A. KUCHULIS, SUPERVISORY ATTORNEY, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, PORTLAND, OREG., AND PRESIDENT, NATIONAL ASSOCIATION OF SENIOR SOCIAL SECURITY ATTORNEYS

Mr. KUCHULIS. Thank you, Mr. Chairman.

My name is Demos Kuchulis. I am a supervisory attorney in Portland, Oreg., working for the Office of Hearings and Appeals. I have been with the Office of Hearings and Appeals for the last 20 years, almost, and I represent the National Association of Senior Social Security Attorneys, which is a professional management association of approximately 150 supervisory attorneys working for the Office of Hearings and Appeals.

This program has been in effect for approximately 13 years and we are subject matter and program experts in processing large volumes of Social Security cases through the hearing process. This includes a wide range of developmental action, prehearing, during the hearing, and posthearing in order to expedite quality hearing decisions. We perform prehearing screening and deciding of cases, recommending off-the-record decisions to administrative law judges, legal research, and supervise staff attorneys and paralegals in all aspects of the legal work required to adjudicate and draft Social Security decisions.

Additionally, we provide OJT, on-the-job training, and mentoring of newly hired ALJs. We deal directly with the claimant representatives and do reviews to determine which cases from the State agency should be paid prior to transferring the cases to the hearing office. While doing this, we interact extensively with administrative law judges, OHA support staff, and OHA's management.

We are in place and ready, willing, and able to help the Social Security Administration keep up with the current initial obligations and also to perform continuing disability reviews. However, we need your assistance in order to better utilize our expertise.

There is a crisis facing OHA today in dealing with the devastating disability backlog of approximately 540,000 cases pending decisionmaking, with claimants waiting up to 1 year for a hearing and longer for the ALJ decision. Bold and innovative rethinking of the entire process is required. A vast number of cases are awaiting continuing disability reviews, as you mentioned, Mr. Chairman, and when the continuing disability reviews are done by SSA, they will represent a large and essentially "new" class of disability cases in OHA, since CDRs have been severely curtailed since the 1984 amendments.

On the issue of the initial disability applications, we would like to state that we support the short-term disability project, which is the foundation of the administration's plan to reduce the existing backlog of disability cases, and we will try to make it as successful

as possible. Although we think that this is a viable alternative, we have a better offer and we have made that available to the administration.

We also have offered additional means not inconsistent with this program to further reduce the backlog and to better utilize our expertise. This consists of an alternative dispute resolution program which is modeled after the magistrate in Federal courts. It will immediately add about 150 magistrates, who are already in place and trained, to augment the existing corps of ALJs. Since this could be a permanent position, after controlling the existing backlog, we will then be able to concentrate on continuing disability reviews.

Congressional authorization of temporary ALJs or hearing officers would be an even greater benefit to OHA. Congress has a track record of authorizing such programs in the past, such as when supplemental security income was implemented during 1974 and also to hear and decide black lung cases.

The important fact to remember is that we are here, trained, and ready to go. All we need is the congressional and Social Security authorization in order to better utilize our skills.

Regarding the continuing disability reviews, Mr. Chairman, as I have previously indicated, there is a huge backlog of continuing disability review cases which must now exceed 1 million claimants. We have had training in processing continuing disability review cases over the years and have provided training to other staff attorneys, paralegals, and new ALJs on how to properly evaluate, decide, and write decisions on such cases. Many of us have the concentrated experience related to continuing disability reviews which were conducted during the early eighties.

If we were appointed as temporary ALJs or hearing officers, we would be able to rapidly move into the productive mode in processing and adjudicating these cases. There will not be any need to substantially expand the existing ALJ corps but rather just a better utilization of existing resources. Such actions will mesh nicely with reducing the existing backlog of both initial and CDRs and will result in a true control of the existing caseload with no significant increase in personnel.

Finally, I would like to address the issue of selection of administrative law judges, as presently conducted by the Social Security Administration by OPM, the Office of Personnel Management. One of the primary deficiencies in the selection of ALJs is that the OPM does not give any significant weight to "agency-specific experience" in the processing and adjudicating of Social Security claims. We have worked for years in processing all forms of Social Security applications at all phases of the hearing process.

However, the Office of Personnel Management will give preference to someone with a totally unrelated legal background in the selection process. In other words, someone who has trial experience as a public defender or as an unemployment compensation hearing officer is given a higher score than an attorney who has extensive experience in Social Security law and regulations and who is engaged in performing all aspects of the adjudication process in order to become a supervisory attorney in a hearing office.

We have the training, the ability, and, again, are ready, willing, and able to carry out the functions of an adjudicator. We are capable of being instantly productive without any long training curve. As part of the Disability Reform Act of 1984, the Office of Personnel Management was congressionally mandated to consider staff attorney experience——

Chairman BUNNING. I am going to interrupt you, because your whole statement will be put into the record.

Mr. KUCHULIS. Thank you.

[The prepared statement follows:]

STATEMENT OF DEMOS A. KUCHULIS
SUPERVISORY ATTORNEY, OFFICE OF HEARINGS AND APPEALS
PORTLAND, ORE.
PRESIDENT, NATIONAL ASSOCIATION OF SENIOR SOCIAL SECURITY ATTORNEYS

I represent the National Association of Senior Social Security Attorneys, a professional management association of approximately 150 supervisory attorneys working for the Office of Hearings and Appeals (OHA) of the Social Security Administration. This program has been in effect for thirteen years and we are subject matter and program experts in processing large volumes of Social Security cases through the hearing process. This includes a wide range of developmental actions prehearing, during the hearing and post hearing in order to expedite quality hearing decisions. We perform prehearing screening and deciding of cases, recommending of the record decisions to Administrative Law Judges, legal research and supervise staff attorneys and paralegals in all aspects of the legal work required to adjudicate and draft Social Security decisions. Additionally, we provide on the job training and mentoring of newly hired ALJs. We deal directly with the claimant's representatives and do ROPIR reviews to determine which cases from the state agency (DDS) should be paid prior to transferring the cases to the hearing offices. While doing this, we interact extensively with Administration Law Judges, OHA's support staff and OHA management. We are in place and ready, willing and able to help the Social Security Administration keep up with the current initial applications and also to perform continuing disability reviews; however, we need your assistance in order to better utilize our expertise.

There is a crisis facing OHA/SSA in dealing with the devastating disability backlog of approximately 540,000 cases pending decision with claimants waiting up to a year for a hearing and longer for an ALJ decision. Bold and innovative rethinking of the entire process is required, A vast number of cases are awaiting Continuing Disability Reviews (CDRs) and when the Continuing Disability Reviews are done by SSA, they will represent a large and essentially "new" class of disability cases in OHA since CDR's have been severely curtailed since the 1984 DBRA.

Initial Disability Applications:

We support the "Short Term Disability Project" which is the foundation of the Administration's plan to reduce the existing backlog of disability cases and will try to make it as successful as possible. However, we also offer additional means not inconsistent with this program to further reduce the backlog and to better utilize our expertise. This consists of an Alternative Dispute Resolution program which is modeled after the magistrate in federal court. It would immediately add about 150 magistrates, who are already in place and trained, to augment the existing corps of ALJs. Since this could be a permanent position, after controlling the existing backlog, we would then be able to concentrate on continuing disability reviews. Congressional authorization of temporary ALJs or hearing officers would be of even greater benefit to OHA and claimants would be examiners to allow us to hear and decide initial applications or continuing reviews in order to gain control of the backlog and to better adjudicate ongoing applications. Congress has a track record of authorizing such programs in the past, such as when Supplemental Security Income was implemented during 1974 and also to hear and decide "Black Lung"

cases. The important fact to remember is that we are here, trained and ready to go—all we need is the Congressional or Social Security authorization in order to better utilize our skills.

Continuing Disability Reviews:

Previously, I have indicated there is a huge backlog of continuing disability review cases which must now exceed a million claimants. We have had training in processing continuing disability review cases over the years and have provided training to other staff attorneys, paralegals and new ALJs on how to properly evaluate, decide and write decisions on such cases. Many of us have the concentrated experience related to continuing disability reviews which were conducted during the early 1980's. If we were appointed as temporary ALJs or hearing officers, we would be able to rapidly move into a productive mode in processing and adjudicating these cases. There would not be any need to substantially expand the existing ALJ corps, but rather, just a better utilization of existing resources. Such actions would mesh nicely with reducing the existing backlog of both initial and continuing disability review cases and would result in a true control of the existing case load with no significant increase in personnel.

SELECTION OF ADMINISTRATIVE LAW JUDGES:

One of the primary deficiencies in the selection of Administrative Law Judges is that the Office of Personnel Management does not give any significant weight to "agency specific experience" in the processing and adjudicating of Social Security claims. We have worked for years in processing all forms of Social Security applications at all phases of the hearing process; however, the Office of Personnel Management will give preference to someone with a totally unrelated legal background in the selection process. In other words, someone who has trial experience as a public defender or as an unemployment compensation hearing officers is given a higher score than an attorney who has extensive experience in Social Security law and regulations and who has engaged in performing all aspects of the adjudication process in order to become a supervisory attorney in a hearing office. We have the training and ability and again are ready, willing and able to carry out the functions of an adjudicator. We are capable of being instantly productive without any long training curve. As part of the Disability Reform Act of 1984, the Office of Personnel Management was congressionally mandated to consider staff attorney experience as qualifying in order to become an ALJ. However, the Office of Personnel Management has never actively implemented this provision of the Disability Reform Act; we are requesting your help in requiring OPM to give staff attorneys in the ALJ selection process significant credit for "agency specific experience". The Social Security Administration is the largest employer of ALJ's in the federal government, and it is totally incomprehensible that OPM has been able to minimize the value of Social Security experience over the years. It is a wasteful situation which you are capable of rectifying.

Chairman BUNNING. Mr. Hill.

STATEMENT OF JAMES A. HILL, ATTORNEY ADVISOR, OFFICE OF HEARINGS AND APPEALS, SOCIAL SECURITY ADMINISTRATION, CLEVELAND, OHIO, AND PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION, CHAPTER 224

Mr. HILL. Good afternoon, Mr. Chairman.

My name is James Hill. I am a staff attorney for the SSA Office of Hearings and Appeals and president of the National Treasury Employees Union, chapter 224, which represents OHA staff attorneys in 96 hearing offices across the United States.

I have served on the reengineering steering committee and am presently a member of the redesign advisory committee. I have also been a member of the short-term disability team since its inception.

The short-term disability project is a well-focused program that is specifically directed at solving one of the Social Security Administration's most intractable problems, the disability backlog at both the State agency and OHA levels. It is predicated on the more efficient use of existing assets and is based upon well-tested concepts.

For example, action number seven conveying limited decisional authority upon senior staff attorneys is an extension of the rigorously tested prehearing conference program and it employs highly trained personnel with extensive hearing office experience to perform adjudicatory functions. Such testing and the use of experienced personnel ensure that the short-term disability project will reduce the backlog without increasing program costs. This program has already reduced backlogs at the State agency level. A similar reduction can be expected at OHA, now that action number seven has commenced.

It is essential that the short-term disability project be provided the assets and the time it needs, and most importantly, that it not be sacrificed in order to vindicate the decision to proceed with a disability process redesign plan.

The disability process redesign plan is a more broadly focused, expensive, long-term plan which does not deal with any of the three major problem areas affecting the Social Security disability system at this time. Many facets of this proposed redesign are both radical and untested, a potentially dangerous combination. No major component of the disability process redesign should be implemented without extensive testing.

I am also concerned that the effect of the redesign on program costs has not been properly considered. For example, the Social Security Administration claims that the program costs will be unaffected by the redesign because the statutory definition of disability remains unchanged. However, the criteria that adjudicators at all levels actually use to determine whether a person is disabled will be replaced by new criteria.

Implementation of major components of the disability process redesign should occur only after an extensive and reliable cost-benefit analysis has been performed which clearly demonstrates the efficiency and economy of the change.

The disability process redesign is a highly integrated plan dependent upon many enabling factors, including technology upgrades, new decisional methodology, organizational changes, exten-

sive training, and process and program changes. All of these enablers must be present for the plan to be effective. Major components of the disability process redesign should not be implemented in a piecemeal fashion without proper enablers.

While the relative merits of the disability process redesign are debatable, premature implementation is certain to result in less than satisfactory results. The Social Security Administration must exercise great care when it proposes to fundamentally alter a program as vital as the disability program. The disability process redesign must proceed, if it proceeds at all, with great caution and without the undue haste which currently characterizes the present implementation effort.

Mr. Chairman, thank you for providing me the opportunity to testify.

[The prepared statement follows:]

TESTIMONY OF JAMES A. HILL
NATIONAL TREASURY EMPLOYEES UNION

My name is James A. Hill. I am employed by the Office of Hearings and Appeals (OHA) of the Social Security Administration (SSA) as an Attorney-Advisor. I am also the President of National Treasury Employees Union (NTEU) Chapter 224 which represents Attorney-Advisors in 96 Hearing Offices across the United States. I served as a member of the Reengineering Social Security Steering Committee and am presently a member of the Disability Process Redesign Advisory Committee. I also served on the original Short Term Disability Project Committee (the Bob Green Committee) which formulated the Short Term Disability Project and am a member on the committee that oversees the implementation of the Project. I wish to thank the Subcommittee for inviting me to testify regarding the state of the Social Security disability insurance program.

The most serious crises facing the Social Security disability process today are the unconscionable delays in the hearing process at OHA and the continued maintenance on the disability rolls of individuals who either are no longer disabled or could be rehabilitated and removed from the rolls. In summary:

- Congress should consider providing the Social Security Administration with clear and explicit instructions regarding what it expects from an SSA disability program. SSA would then be in a position to create a system consistent with the mission established by Congress. **The Disability Process Redesign should not proceed until Congress has clearly enunciated the disability policy for the future.**

- The Redesigned Disability Process specifically excludes rehabilitation or continuing disability issues from consideration, and is not designed to reduce the current hearings backlog.

- Implementation of the Disability Process Redesign should not begin until a Commissioner is confirmed by the Senate.

- The Disability Process Redesign presents a number of radical concepts and mechanisms without evaluating their validity in terms of practicality and coherence with the current situation.

- The Disability Process Redesign appears to be based on conjecture and untested premises. No major portion of the Disability Process Redesign should be implemented in a piecemeal fashion, and no major portion of the Disability Process Redesign should be implemented without extensive testing being conducted.

- Implementation of major components of the Disability Process Redesign should occur only after an extensive, reliable Cost-Benefit-Analysis has clearly demonstrated the efficiency and economy of the change.

- The Disability Process Redesign is not designed to work with a workload backlog, won't resolve the backlog crisis, diverts valuable assets from dealing with the backlog and should not proceed until the long standing, still growing, backlog is resolved.

- Introduction of the Adjudication Officer position should be delayed until the infrastructure which the Disability Process Redesign itself admits is necessary for efficient operation of the Disability Process Redesign is in place.

- The Short Term Disability Project is a highly focused plan designed to achieve specific and attainable goals at the lowest possible cost.

- The most effective and efficient method of reducing the OHA disability case backlog is the Short Term Disability Project.

- Short Term Disability Project Action # 7 will not result in an increase in program costs. (Conveying limited decisional authority upon Senior Staff Attorneys.)

- The Short Term Disability Project is specifically designed to substantially reduce current disability case backlogs at both the state agency level and at the hearings level. Implementation of the Disability Process Redesign must not be permitted to interfere with the accomplishment of the goals of the Short Term Disability Project.

1. **Congress should consider providing the Social Security Administration with clear and explicit instructions regarding what it expects from the SSA disability program. SSA would then be in position to create a system consistent with the mission established by Congress.**

Over the past several years the number of people filing applications for disability benefits under both the Title XVI Supplemental Security Income (SSI) program and the Title II Disability Insurance (DI) program has significantly increased. There are several factors responsible for the increased number of disability applications, not the least of these being the Agency's outreach programs, particularly those involving SSA. Many social-economic and demographic factors such as the aging work force undoubtably play a significant role in the increase in applications.

> "American society has changed dramatically since the DI program began in the 1950's. This is reflected in an increased demand for SSA's services, changes in the characteristics of claimants seeking benefits, and new complexities in claim-related workloads and processes." [1]

While SSA recognizes that the society that it serves has changed significantly since the disability process was first created in the mid-1950's, it has not re-examined the basic tenets, purposes, and missions of the disability program. Given the undeniable extent of the changes in American society, it is appropriate that the whole vista of the disability program, not simply the mechanisms by which it is operated, be re-examined. A fundamental question must be posed and then answered. What is the proper role of the Federal Government and particularly of the Social Security Administration in the disability benefits process at this time? This is a public policy matter of considerable importance, and as such, should be considered by both the Executive and Legislative branches of the Federal Government. The answer to this question could redefine the mission and objectives of the Social Security Administration with respect to the disability program which would in turn exercise considerable influence over the design of the "new disability system". The National Treasury Employees Union believes that a review of the role of the Social Security Administration in the disability process, with the goal of redefining that role and establishing a new mission, is long overdue and should be conducted before the massive expenditure of resources to "redesign" the disability system. Congress should provide the Social Security Administration with clear and explicit instructions regarding what it expects from the Social Security Administration's disability program. Only then would SSA be in a position to create a system consistent with the mission established by Congress. **The Disability Process Redesign should not proceed until Congress has clearly enunciated the disability policy for the future.**

2. **The Redesigned Disability Process specifically excludes rehabilitation or continuing disability issues from consideration, and is not designed to reduce the current hearings backlog.**

Formally announced by Commissioner Shirley S. Chater in September 1994, the Disability Process Redesign (the new title for the reengineering effort) purports to be a

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[1] Plan for a New Disability Claim Process, Social Security Administration, September 1994, p. 6.

highly integrated, comprehensive change in the current processes, organizational structure, and intellectual infrastructure of the disability process designed to achieve marked improvement in the efficiency of that process. Ironically, while the disability backlog is the genesis of the Redesign, the Redesign was not designed to be the vehicle by which the backlog is to be eliminated. In fact, the mere existence of a backlog would render the redesigned system ineffective. Equally surprising, the Redesigned Disability Process specifically excludes the other major crises in the current disability system, rehabilitation and continuing disability issues from consideration.

This lack of overall direction and perspective may account for the fact that the Agency's prime disability initiative, the Disability Process Redesign, does not address the most serious crises currently facing the SSA disability program today. These are the unconscionable delays in the hearing process at the Office of Hearings and Appeals and the continued maintenance on the disability rolls of individuals who either are no longer disabled or could be rehabilitated and removed from the rolls.

> "The continuing disability review system is not included because it is conceptually and practically distinct from the initial disability determination process."[2]

> "Every aspect of the process except the statutory definition of disability, individual benefit amounts, the use of an administrative law judge as the presiding officer for administrative hearings, and vocational rehabilitation for beneficiaries, is within the scope of this reengineering effort. However, analysis and ideas for change should proceed and be presented on two tracks: improvements achievable without changes in statute or regulations and innovations that may require such change."[3]

The Social Security Administration still does not have a comprehensive plan for evaluating the status of those already on the disability rolls, but it has moved effectively to deal with the backlog problem at the State Agency and Office of Hearings and Appeals (hearings) level. The Short Term Disability Project (STDP) has already significantly reduced the level of cases pending at the State Agency level and, with the recent commencement of Action # 7, finally has a coherent plan for addressing the backlog at OHA. However, interference by the Disability Process Redesign Team with the Short Term Disability Project has delayed and threatens to destroy any possibility of significant improvement in the backlog crisis.

3. Implementation of the Disability Process Redesign should not begin until a Commissioner is confirmed by the Senate.

Irrespective of the matters of public policy that should be clarified, it is an undeniable fact that demand for services from the Social Security Administration (both in the disability and the retirement sectors) has significantly increased over the last 10 years, but the staff of the Social Security Administration has significantly decreased from approximately 85,000 to 65,000 during that period of time. The rationale for justifying staff reductions has usually revolved around the use, or the more efficient use, of modern communication, data processing and word processing systems. Unfortunately, the Agency's record in the application of such modern technologies does not inspire much confidence. Viewed in this light, the massive disability backlogs were perhaps inevitable.

The number of applications for disability benefits and the number of applicants who appealed unfavorable determinations by the State Agencies has significantly increased since 1990. While the number of filings has resulted in processing delays and backlogs at the State Agency level, neither the size of the backlogs nor the increase in processing times have been nearly as severe or as intractable as those at the hearing level. It was against the background of intractable backlogs and rapidly decreasing quality of service that SSA sought relief in the form of a variety of new management philosophies.

The Social Security Administration has not been inattentive to the building disability backlogs. Indeed, the Agency attempted to address the disability backlog problem along with a myriad of other managerial problems through a variety of mechanisms such as Total Quality Management (TQM) without any tangible evidence of success. In 1993

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[2]Ibid., p. 52.

[3]Ibid.

the Agency's attention became focused on the then current managerial solution known as "Reengineering". Reengineering as a concept was no doubt seductive to SSA's leaders because it promised spectacular rather than merely incremental increases in productivity with ever smaller workforces and increased reliance upon modern information technology. Considering the growing disability backlog crisis, the promise of spectacular rather than reasonable or obtainable increases in productivity was very attractive.

The decision to reengineer the disability system appears to be primarily based upon the promised results of reengineering rather than an objective look at the likelihood of its success. Even in private industry, where senior management has far greater policy authority and freedom of action than SSA leaders, reengineering fails far more often than it succeeds. The quality, longevity, and unquestioned authority of senior management, especially the CEO, and the ability to accomplish reengineering in an extremely short period of time (less than one year) are key factors in the success or failure of reengineering. It is difficult to imagine an organization less likely to be able to accomplish reengineering successfully than SSA. Unfortunately, SSA changes commissioners with only slightly less regularity than post-war France and Italy changed governments. **Implementation of the Disability Process Redesign should not be commenced until a Commissioner is confirmed by the Senate.** Planned implementation of the Disability Process Redesign extends through at least 1999. The internecine struggles of senior SSA management officials are legendary. Even worse, as regards the disability process, SSA is not one organization but rather 55 (the 54 separately managed State Agencies and SSA itself). The political nature of SSA dictates organizational oversight by both the executive and legislative branches limiting the ability of SSA to quickly formulate and execute any major policy initiative. Finally, the political sensitivity of anything affecting the Social Security Administration (it is not called the third rail of American politics without reason) and the possible deleterious affect that change in SSA can have on the American public render the quick imposition of substantial change an unlikely and certainly controversial action. Indeed, because of these political considerations, it is difficult to imagine any sector of the Federal Government less susceptible to radical change than the Social Security Administration, yet radical change is the hallmark of reengineering.

4. **The Disability Process Redesign presents a number of radical concepts and mechanisms without evaluating their validity in terms of practicality and coherence with the current situation.**

Nonetheless, the allure of spectacular increases in productivity apparently convinced SSA leaders that reengineering was the best possible solution to the disability backlog problem. To that end, a select team of SSA and DDS officials, under the direction of Rhoda M.G. Davis was created, and in October 1993 that team began the task of reengineering the disability process. Consistent with the tenets of reengineering, the Team was not charged with the task of identifying and correcting problems with the current system, but with creating an entirely new system. Consequently, the Team did not address the areas in which problems had developed, but created an entirely new system with little in common with the current system. The Team ultimately created a "utopian" plan in which the many factors that impact upon the disability system were consistent with the requirements of the Plan. Reality would adjust to the Plan rather than the Plan adjusting to reality. Unfortunately, many of the shortcomings of the current system are the result of external and internal factors that SSA has not been able to control. For example the Plan anticipates behavioral changes by claimants, their representatives, and the medical community which are not necessarily consistent with their interests and practices but which would benefit SSA. The current system operated for many years in a reasonably efficient manner indicating that factors external to that system are at least part of the reason for current inadequacies. Many of those factors will not disappear at the fiat of the Social Security Administration; they are realities with which any SSA disability system must contend.

The Team also created a new system that did not take advantage of the lessons which should have been learned from the current system. Therefore, little thought was devoted to understanding why problems developed in the current system because reengineering is devoted to the creation of a completely new system, not understanding or repairing the old. However, the failure to identify and understand the reasons for the poor performance of the current system and evaluate possible corrective mechanisms rendered

SSA incapable of comparing and contrasting the strengths and weaknesses of alternative methods of dealing with the disability crisis. Freed from the constraints of dealing with the real world, the Reengineering Team was free to develop a disability system in which they create and control all the variables and set functional parameters by fiat without regard to plausibility or reality. Accepting the validity of the "parameters by fiat" as representative of the real world, the Team then predicated its plan on those assumptions. The Reengineering Team did in fact create a utopian disability system characterized by the development of innovative (and completely untested) concepts premised all to often upon bare assumptions without proper foundation.

5. **The Disability Process Redesign appears to be based on conjecture and untested premises. No major portion of the Disability Process Redesign should be implemented in a piecemeal fashion, and no major portion of the Disability Process Redesign should be implemented without extensive testing being conducted.**

The justification for use of many of these untested concepts is the end result as predicted by the Disability Process Redesign Model. However, given the revolutionary nature of many of the aspects of the Redesign, in many instances there are no real world analogues which could be used as benchmarks to guide predictions regarding operation of the proposed Redesign. As a result, the Model is quite dependent upon a variety of assumptions about the proposed operation of the new system. Many of the assumptions have no basis in fact and must be accepted as a matter of faith. It is important to note that when SSA officials speak of the efficiencies of the Disability Process Redesign, they are referring to the results of that Model. Estimates of processing times, the effects of the many changes introduced by the Redesign, and the results of the Plan are all highly dependent upon the validity of the assumptions inherent in the Model. Moreover, the Disability Process Redesign is a highly integrated construct; to deliver the results promised, the entire system must be in place and functional. Introduction of the Plan in a piecemeal manner will not produce the results suggested by the Model. The problem with such a highly integrated plan is that the failure, or even less than optimal performance of one part of the plan, imposes severe functional restrictions upon the rest of the Plan thereby greatly diminishing the level of productivity actually achieved.

Many of the assumptions upon which model testing was based are specified on pages 62-68 of the Plan for a New Disability Claim Process. While the assumptions are too numerous to list in any detail, some must be mentioned.

- Electronic files will be used in the process redesign.
- Electronic files will eliminate mail time and allow simultaneous reviews of claims files.
- The process of requesting medical evidence will be fully automated.
- The procurement and payment process for medical evidence will be fully automated.
- Automation will, where possible, allow direct contact between the field component and the CE and/or FA source for scheduling purposes.
- Notices at both level of the process will be prepared using the automated claim processing and the decision support system.
- Percentage of initial denial filing a hearing request. 45% (Currently, approximately 75% of reconsideration denials are appealed to an Administrative Law Judge).
- Representation level at the hearing stage will drop to 50%. (Currently, it is approximately 85%).
- Approximate percent of cases allowed at the ALJ level. 20%

In addition successful operation of the Disability Process Redesign is dependent upon the following factors:

- Installation of the Redesigned Disability System (formerly the Modernized Disability System);
- the creation of the Simplified Disability Determination Methodology, the radically different criteria by which disability is to be determined, which will replace the current system and includes eliminating the present Listing of Impairments and the Medical-Vocational Guidelines (better known as the grids);
- Process Unification
- the adoption of a single decision maker concept;
- the creation of new and radically new positions which will require extensive and expensive training;
- convincing the entire health care, welfare, and insurance communities to adopt unified forms and procedures established by the Social Security Administration not only for their use with Social Security but also for their general use,
- educate the medical community regarding the needs of the Social Security disability systems and

convincing all those in that community to cooperate with SSA; and
- a comprehensive reorganization of the Social Security Administration as well as the State Agencies.

Finally, perhaps the most important assumption of all, at least when considering processing time, **the Model assumes there is no backlog at any point in the process** that would impose delays in addition to those specified in the Model. The effect of backlogs on current case processing time is the cause of the current disability crisis.

None of the above factors currently exist, and some are literally years in the future if they ever occur. Particular note should be made of the simplified decision methodology factor. This involved fundamental changes to the criteria by which the determination of disability is actually made (the Listing of Impairments and the sequential evaluation).

When considering the viability of the Model and indeed of the Disability Process Redesign itself, two very important factors must be recognized. The economies predicted by the Model are completely dependent upon (1) the installation of all aspects of the Disability Process Redesign and (2) the validity of the assumptions upon which the Model is based including the lack of any appreciable backlog. The Model loses all predictive value if either of these factors is missing.

In short, the Disability Process Redesign involves the complete replacement of the current disability process by an entirely new and very different system. These are truly revolutionary changes, which in many cases are based on untested assumptions, and which will require years to create and test. Neither the dangers of piecemeal implementation of tested or untested segments of the Disability Process Redesign nor the importance of fully testing these revolutionary concepts prior to implementation can be overstated. The Model used to justify adoption of the Disability Process Redesign is so completely based upon unsubstantiated assumptions that most neutral observers would conclude that without comprehensive testing, it has little validity. **No major portion of the Disability Process Redesign should be implemented in a piecemeal fashion, and no major portion of the Disability Process Redesign should be implemented without extensive testing being conducted.**

6. **Implementation of major components of the Disability Process Redesign should occur only after an extensive, reliable Cost-Benefit-Analysis has clearly demonstrated the efficiency and economy of the change.**

Like most utopian plans, standing alone, the Redesign is quite attractive. While it may be aesthetically appealing, the Redesign will demand the expenditure of vast sums of taxpayers' money, and the taxpayers are entitled to a fair return on their money. A comprehensive cost-benefits analysis (CBA) would seem in order. However, the utopian nature of the Plan renders the creation of a CBA a virtually impossible task.

> "SSA will move forward on all aspects of the process redesign plan; however, because of the extensive research and development required for implementation of the simplified disability determination methodology, we have not considered the effect of this redesign feature in our cost/benefit planning. In addition, because the ability of single employee to master the disability claim manager position is dependent on full adoption of a simplified disability determination methodology, the impact from that process redesign feature has also been separated out from our cost/benefit planning at this time."[4]

Even more disconcerting than the above sleight of hand is the rationale regarding the effect of the Redesign on program costs.

> "Under the supposition that SSA's current initial claim and administrative appeal process leads to correct disability determinations within the proper universe of people today, and because SSA is not proposing any changes in the statutory definition of disability, the redesigned process in and of itself would have no long-term effect on program outlays."[5]

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[4]Ibid., p. 45

[5]Ibid. p. 45.

This statement is intellectually dishonest at best, deliberately misleading at worst. While the statutory definition of disability remains unchanged, the redesign is to a large extent predicated upon implementation of the **simplified disability determination methodology.** This change in the criteria by which disability is actually determined (the replacement of the current sequential evaluation) will have a direct effect on program costs. Indeed, perhaps no part of the plan with the exception of the new evidentiary designs impacts more upon the area of program costs more than does the still to be determined — simplified disability determination methodology. No part of the Redesign should be implemented until a valid and detailed cost-benefit analysis is presented.

7. **The Disability Process Redesign is not designed to work with a workload backlog, won't resolve the backlog crisis, diverts valuable assets from dealing with the backlog and should not proceed until the long standing, still growing, backlog is resolved.**

The Plan for a New Disability Claim Process was conceived and planned as a long term project (implementation extending from 1994 through 1999) to deal with perceived systemic flaws in the current disability process. While the disability backlog may have been the reason for the redesign effort, the backlog reduction was certainly not one of the missions of the redesign. However, recently the Social Security Administration has advanced the introduction of the Adjudication Officer (AO) allegedly to assist in reducing the current backlog at the Office of Hearings and Appeals. Such an action, inconsistent with the stated policies of the redesign, is unwise and unwarranted. The Short Term Disability Project eliminates any need for the Redesign to involve itself in current backlog reduction efforts. Given the highly integrated nature of the Disability Process Redesign, piecemeal introduction of any major portion of the Redesign will be counter-productive.

It is instructive, however, to examine the rationale given by SSA for the early introduction of the AO position.

> "The AO process will assist SSA in transitioning to the redesigned disability process. When implemented, the AO position:
>
> -improves service to the public by personally working with the claimant and/or representative to explain the administrative appeals process as it applies to their case;
>
> -provides a more efficient process freeing up valuable ALJ resources currently spent on developing the record for hearing. Under the current process ALJs spend significant time updating and developing new issues in the file prior to and during the hearing. The AO will take over most of this activity to allow ALJs additional time to conduct hearings each month.
>
> -establishes SSA as an equal partner in developing the evidentiary record for the hearing. The AO is an (sic) SSA disability adjudication professional and will assure all program issue are developed, documented and available for the parties to the hearing.
>
> The process efficiencies associated with having AOs develop the hearing record assist in reducing pending cases and laying the groundwork for implementing subsequent process and methodology changes that will be a part of the redesign."[6]

This rationale again demonstrates a tendency by SSA to provide statements that are intellectually dishonest at best, deliberately misleading at worst.

Nearly 85% of claimants are represented at the hearing level. Most of those representatives are attorneys and few need explanations of the hearings process.

While a good deal of time and effort is expended at the hearing level to properly develop the record, very little of that work is actually performed by the ALJ. Hearing office staff, primarily GS-8 Hearing Assistants (HA) perform most of the actual work involved in

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[6]Disability Process Redesign: May 1995 Edition, Questions and Answers -- The Adjudication Officer, p. 3.

developing a case. Transferring the case development tasks from a GS-8 HA to a GS-12 AO will have little impact upon how an ALJ spends his/her time and will have minimal impact, if any, on the number of hearings an ALJ conducts.

The courts have already imposed upon ALJs the responsibility of ensuring that each case is fully developed. Currently, both the claimant and the Agency, through the ALJ, maintain the capacity to further develop the record at any time through the issuance of the decision. Under the AO proposal, the Agency's prime case developer, the AO, drops out of the process well before the hearing.

The process efficiencies associated with the AO developing the case are contingent upon the accuracy and completeness of the Model. However, the early implementation of the AO position will be accomplished without many factors which are reported as essential to process efficiency in the Plan for a New Disability Claim Process.

The view of the Disability Process Redesign Team towards the Short Term Disability Project (STDP) is quite interesting.

> "The STDP is designed to provide immediate support to reduce pending workloads in OHA offices. The STDP initiatives provide some efficiencies over the current process but are not as efficient overall as the AO case-processing model provided by the redesign. The STDP initiatives will be phased out as the new AO process is implemented."[7]

At least this time the reference is to the efficiency of the AO in the case-processing model. Given the number of untested assumptions contained in the model upon which the predictions are based, little faith can be placed on the alleged efficiencies. However, even if one considers that the predictions of the model are accurate, the Model and the early introduction of the AO position have little in common. Most of the redesign components upon which the Model is based will be not in existence. That Model has no predictive value regarding the early AO roll out. However, the Disability Process Redesign has certainly deprived STDP of assets that could have more economically be directed at backlog reduction. Given the scenario reported by the Disability Process Redesign Team, the roll out of the untried and inadequately tested AO position will displace STDP regardless of how successful STDP is shown to be by its actual results.

8. **Introduction of the Adjudication Officer position should be delayed until the infrastructure which the Disability Process Redesign itself admits is necessary for efficient operation of the Disability Process Redesign is in place.**

The Disability Process Redesign purports to be a highly integrated, comprehensive change in current processes, organizational structure, and intellectual infrastructure designed to achieve marked improvement in the efficiency of the disability process. The importance of the comprehensive nature of the redesign was emphasized as a distinct departure from the traditional disability process changes that have evolved over time and reflect small, incremental improvements designed to address various pieces of the overall process.

> "Disability process changes that have evolved over time tend to reflect small, incremental improvements designed to address various pieces of the overall process. It has become increasingly clear that incremental improvements are no longer sufficient to achieve the level of service that will make a substantial difference to disability claimants. Thus, SSA needs a longer-term strategy for addressing service delivery problems in the disability claim process."[8]

SSA has consistently stated that the success of the Disability Process Redesign is contingent upon making the correct decision at the earliest possible time. However, "correct decisions" in the new process are dependent upon the interaction of a wide variety of factors.

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[7] Ibid., p. 4.

[8] Plan for a New Disability Claim Process, p. 1.

> "A correct disability decision is one that appropriately considers whether an individual does or does not meet the factors of entitlement for disability as defined by SSA's statute, regulations, rulings and policies. Correct decisions in the new process depend on: a simplified decision methodology that provides a common frame of reference for deciding disability at all levels of the process; consistent direction and training to all adjudicators; enhanced and targeted collection and development of medical evidence; an automated and integrated claim processing system that will assist adjudicators in evidence gathering, analysis and decision making; and a single, comprehensive quality review process across all levels. The goal of the new process is to guide all adjudicators at all levels of the process, who will be using the same standards for decision making, to making correct decisions in an easier, faster, and more cost-effective manner."[9]

SSA has repeatedly stated criteria for a "correct decision".

> "SSA's ability to ensure that the right decision is made the first time depends on a well-trained, skilled, and highly motivated workforce that has the program tools and technological support to issue quality decisions."[10]

SSA has been equally forthcoming regarding the importance of using modern information technologies to the redesigned system.

> "Information technology will be a vital element in the new disability claim process. To the fullest extent possible, SSA will take advantage of the "Information Highway" and those technological advances that can improve the disability process and help provide world-class service. The new process will rely on seamless, electronic processing of disability claims from the first contact with the claimant to the final decision, including all levels of administrative appeal. Existing Agency design plans for Intelligent Workstation/Local Area Network (IWS/LAN) and a Modernized Disability System will provide an integrated system and the electronic connectivity necessary to support the new disability process."[11]

> "The ability of decision makers to conduct thorough interviews and evidence evaluation, and timely and accurate claim adjudication is predicated on the implementation of the functionality provided by the IWS/LAN hardware and software components, and the decision support features of the Modernized Disability System. Expert system software will be included in SSA claim processing systems to assist disability decision makers in the analysis and evaluation of complex eligibility factors, and to ensure that the correct procedures for disability evaluation are followed. While conducting interviews, disability decision makers will rely on decision support features that ask impairment-specific questions. The decision support system will use the accumulated data of the electronic record to assist in the preparation of the predecision notice, the statement of the claim, and decisions rendered on appeal. Where disability decision team members cannot be physically co-located, they can remain in communication by using two-way TV and other video conferencing technologies. Disability policy will be developed and stored in a format that can be integrated into computer systems as the source of context-sensitive help screens and decision-support messages."[12]

As presented in the Plan for a New Disability Claim Process, the success of the AO position is intimately and inseverably associated with many of the fundamental changes that are integral parts of the redesign plan. Therefore, one must question the need for the premature introduction of the AO position. **In the end, the Short Term Disability Project and the need for the Disability Process Redesign to show some tangible result realized from the tremendous expenditure of time and money are the likely reasons for the proposed early implementation of the AO position.**

9. The Short Term Disability Project is a highly focused plan designed to achieve specific and attainable goals at the lowest possible cost.

The sole purpose of this project is to significantly reduce the disability backlog at both the State Agency and hearings levels. A committee, led by then Regional Commissioner Robert Green and OHA Deputy Associate Commissioner, composed of representatives of the various components of SSA involved in the disability process, union

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[9] Ibid., pp. 13-14.

[10] Ibid., p. 36.

[11] Ibid., p. 43.

[12] Ibid., pp. 43-44.

representatives, and representatives from the DDS's met on several occasions in September and October 1994 and crafted nineteen (19) separate initiatives designed to reduce backlogs at OHA and the State Agencies. The Committee operated with an understanding that its initiatives must be suitable for rapid implementation and designed to achieve immediate results. The Committee also understood that the initiatives were limited to using current assets; SSA did not have additional assets which could be committed to this process. STDP is a project that is "being run on a shoe string".

10. **The most effective and efficient method of reducing the OHA disability case backlog is the Short Term Disability Project.**

The initiatives began implementation in October 1994 with the initial focus of attention directed toward the backlog at the State Agency level. Admittedly, this was the less intractable problem. To date the Short Term Disability Project initiatives have been supremely successful in reducing backlogs at that level. The target was to reduce the number of cases pending at the State Agency level by 1000 a week. Through April 1995, we have not only met that goal but are significantly ahead. **STDP works!**

Of course, the more intractable problem is the backlog at OHA. The cornerstone of the effort to reduce the OHA backlog is Action # 7 which will utilize screening criteria designed to distinguish between cases that can be paid on-the-record with little or no development, cases which are probable allowances with further development, and those cases in which an ALJ hearing is required. Action # 7 is a natural extension of the Prehearing Conference Program which demonstrated its effectiveness in a rigorous statistical analysis. Experience gained in the Action # 6 Screening Program further demonstrates the effective and accurate decision making capability of experienced Attorney Advisors. Action # 7 gives adjudicative authority to "Senior Staff Attorneys" (highly qualified and experienced Attorney Advisors at OHA) to adjudicate and draft a decision in those cases which are fully favorable and do not require an ALJ hearing. Action # 7 adds approximately 600 limited (only fully favorable) decision makers at the OHA level. The addition of these experienced decision makers, who will concentrate on those cases that are much more likely to result in a fully favorable decision after an ALJ hearing, frees the Agency's ALJs to concentrate on those cases in which a less than fully favorable decision is more likely. The net result is that not only will many claimants who are in fact disabled and are entitled to receive benefits receive those benefits in a much more timely manner, but claimants in general will receive hearing level decisions in a much more timely manner.

The roll out of Action # 7 began in April. In early June regulatory authority for the Senior Staff Attorneys to make fully favorable decisions will become effective, and the program will begin in earnest. The biggest problem with the operation of Action # 7 is ensuring that sufficient decision drafting capacity is available to draft the ALJ decisions. Senior Staff Attorneys will draft all of their own decisions as well as some ALJ decisions. The Agency has detailed 150 employees (volunteers) to decision drafting positions. They will be located at SSA headquarters and OHA headquarters. Personal computers will be provided to ALJs who have indicated they would draft some of their own decisions. Ensuring sufficient decision drafting is available remains an important factor. Appropriate steps have been taken and will continue to be taken in the future to ensure the production of timely decisions .

11. **Short Term Disability Project Action # 7 will not result in an increase in program costs.**

The Short Term Disability Project is consistent with the Agency's responsibility for ensuring trust fund moneys are properly disbursed. The Senior Attorney Advisors are as knowledgeable and capable as anyone in the Agency at evaluating whether disability exists and are cognizant of the Agency's responsibility to "protect the trust fund". The Senior Attorney Advisors to whom Action # 7 convey limited decisional authority constitute some of the Agency's most experienced disability practitioners. Each Attorney Advisor upon whom decisional authority will be conferred has been intimately involved in the OHA decision creation process for many years and has in fact drafted (literally) thousands of decisions. These individuals have demonstrated an indepth understanding of the laws, regulations, rulings, and medical issues involved in the

decisional process and can reasonably be expected to apply the proper disability criteria to each case they review. The degree of independence granted by the Agency to these decision makers (while not as great as that afforded to ALJs by the APA) is sufficient to ensure that decisions will be based upon the facts and the law rather than administrative fiat. Senior Attorney Advisors will be deciding only those cases most likely to result in a fully favorable decision. These factors ensure that Action # 7 will not increase program costs.

12. **The Short Term Disability Project is specifically designed to substantially reduce current disability case backlogs at both the state agency level and at the hearings level. Implementation of the Disability Process Redesign must not be permitted to interfere with the accomplishment of the goals of the Short Term Disability Project.**

The goal of STDP is to reduce the level of cases pending at OHA to 375,000 by December 31, 1995. Currently, OHA has approximately 530,000 cases and new receipts remain at record levels. OHA has achieved record levels of productivity during the past year (considerably above the increases which can be attributed to increased ALJs and staff). But the backlog continues to grow at an alarming pace. As a result of the backlog, the level of service being provided to claimants is unacceptable. The Short Term Disability Project can provide immediate relief, while the Disability Process Redesign can only provide a questionable promise for the future. The initiatives of the Short Term Disability Project are based on well tested concepts, are already in effect, the results are monitored on a weekly basis, and the initial results have been favorable. It is essential that the Social Security Administration not abandon the Short Term Disability Project.

Chairman BUNNING. Thank you, Mr. Hill.

Judge Bernoski, as an experienced ALJ, what is the most vital aspect of an SSA hearing process?

Judge BERNOSKI. The most vital aspect is the fact that the claimant actually appears before the decisionmaker at that time and has an opportunity to present his case in person. He is often represented by counsel, and most of the cases are, at that time, represented by counsel.

Also, the decisionmaker at that point is an independent decisionmaker who has the protections of the Administrative Procedure Act, which I indicated in my statement.

Chairman BUNNING. Do you believe that that is the main reason for the vast change that occurs from the initial hearing, in other words, the overturning of all the cases at the initial hearing and at your hearing? We are talking about a huge difference here.

Judge BERNOSKI. I understand the question, sir. Yes, in my opinion, the main reason for the difference or the reversal rate is the fact that there is the dual standard that has been referred to frequently today. The DDS examiner, when they look at that file, as Mr. Thomas indicated, they make primarily a medical decision or determination based on the evidence in the record.

When that case finally comes before the administrative law judge, the administrative law judge sees the claimant, hears live testimony, many times from a vocational expert, sometimes from a physician, most always from the claimant, and then makes a decision that is based on the law and the regulation and the Federal court cases.

That is the primary difference between those two determinations. The law specifically provides that the secretary make a decision based on the evidence in the record, where the DDS record——

Chairman BUNNING. Are you talking about the Commissioner?

Judge BERNOSKI. The Commissioner, yes sir, where the Commissioner makes that and we are the delegatee of the Commissioner, where the DDS examiner can use empirical knowledge which they have either acquired through training or even go and obtain other medical sources which are not part of the record.

Chairman BUNNING. You talked about "buying down" the backlog.

Judge BERNOSKI. Yes, sir.

Chairman BUNNING. That is something that really concerns me and many members of this panel. Rather than really getting to the root of what is the problem, if you buy down the disability backlog, you are doing more damage to the system than if you take longer to determine. We have a backlog. We know we have a backlog. We want to solve the backlog, but we want to do it correctly.

Judge BERNOSKI. Yes, sir.

Chairman BUNNING. Are you telling me that if we had your hearing first, in other words, do away with DDS, do away with all the other things and just make them come before an administrative law judge to get a disability, that would be the only hearing we have——

Judge BERNOSKI. I understand.

Chairman BUNNING. Then we could save money and we could get a better job done, is that what you are saying?

Judge BERNOSKI. If that would happen, you would save money because you would only have one hearing. I am not so sure that I can give you an estimate or an opinion as to what the impact would be on the claims ratio because, clearly, the DDS standard is more rigorous than the standard that is applied by the administrative law judge.

As Mr. Thomas indicated in prior hearings, they look at a claim, they deny that claim, and they will know that when this case comes up before an administrative law judge, that sometimes that case is going to be paid. But this is because we have——

Chairman BUNNING. That is very disturbing and very discouraging to the people on the front line, when they are the first people that are making the determination. Is it a fact that most people know that coming in, that they are going to get turned down at the initial level and know full well if they follow through and jump through all the hoops that SSA requires, that eventually they will get approved?

Judge BERNOSKI. I do not know if the individual claimant knows that, but many claimants that are represented by counsel know that. The attorney knows.

Chairman BUNNING. Can we not somehow send the word by either regulation or by changing the law that there is going to be a determination made and that is it?

Judge BERNOSKI. Yes, to the extent——

Chairman BUNNING. Period.

Judge BERNOSKI. Yes, sir, and we agree with that, that there should be one standard of adjudication at all levels. But, I might caution, we believe that that standard must be the legal standard because the courts sit on top of this system and will require that.

Chairman BUNNING. We also are going to eventually pass Andy's and my law that will allow a Social Security court to be in existence. I know that most of the people at SSA would like that and I know that most of the people in the country would like to have a court that handles just Social Security claims. I know you are supportive of Mr. Archer's bill, Mr. Hill.

But we think there ought to be a determination and all the reengineering and all of the things that SSA has proposed does not guarantee to me that we are going to reduce the backlog and be fair with the claimants that are coming in for disability.

Judge BERNOSKI. Yes, sir. With relationship to the Social Security Court, we should also probably look at whether it should be an article III or article I court, also.

Chairman BUNNING. Mr. Jacobs, would you like to question?

Mr. JACOBS. I will give Fred Arner his due here. He and Jake Pickle worked together when Jake was the chairman of the subcommittee. I sometimes thought of them as the Sundance twins. They mixed a lot of medicine and Fred has made some very cogent arguments for this.

Beyond that, I thank the panel for enriching the record.

Chairman BUNNING. Mr. Christensen.

Mr. CHRISTENSEN. I would just probably tend to agree with the chairman's last comment. In light of the fact that the SSA's evaluation of a disability claim, there is only a 3-percent error rate, and then every time it ends up in the hands of liberal elitist judges who

want to pay out everybody's money, they overturn it 80 percent of the time. I would be very much in favor of moving toward a Social Security court to control the costs, because if the figures are accurate, I think that would be a better management of our taxpayers' money.

Just one last comment. Mr. McCaslin, regarding his comment that they serve two customers; yes, they do serve two customers, but both we and the Social Security Administration work for the taxpayer first and foremost and then we work with the customer. I want to make sure that is understood, because we are at the mercy of the taxpayer, both the administration and Members of Congress.

Mr. Chairman, I appreciate your leadership on this issue and I hope we can get this matter resolved.

Chairman BUNNING. Thank you.

Judge BERNOSKI. May I just respond? Mr. Christensen, with relationship to the judges, at the administrative law judge level, we follow the law of the Federal Circuit Court judges and the statute and the regulations. We do not have the discretion to establish or create law.

Mr. CHRISTENSEN. Tell that to the Supreme Court.

Judge BERNOSKI. I understand, but I do not want to have the record indicate that we are the creator of the law. We just simply follow what is given to us.

Chairman BUNNING. Once again, I thank you all for coming. Without anything further, this subcommittee is adjourned.

[Whereupon, at 1:18 p.m., the hearing was adjourned to reconvene on Wednesday, May 24, 1995, at 10 a.m.]

IMPROVING THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

WEDNESDAY, MAY 24, 1995

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

The subcommittee met, pursuant to notice, at 10:02 a.m., in room B–318, Rayburn House Office Building, Hon. Jim Bunning (chairman of the subcommittee) presiding.

Chairman BUNNING. The subcommittee will come to order.

Good morning. I would like to welcome everyone to the second day of hearings on the problems with the Social Security disability program.

As is the custom of the subcommittee, without objection, we will dispense with opening statements except for the chairman and the ranking member. Of course, all Members are welcome to submit statements for the record. Except for Members, all witnesses must limit their testimony to 5 minutes, although they are welcome to submit a longer statement for the record.

Yesterday, we heard some great testimony from front-line people about the problems with disability. Today, I want to focus on suggestions for improvement. There is a lot of interest in improving the current disability program. God knows we need it. Eight Members have taken time today to bring their ideas before the subcommittee, and I really appreciate that.

After what I heard yesterday about backlogs, waiting time, and overdue disability reviews, I would say that the disability problem is big enough for all of us, so I welcome your ideas today.

The size of the problem can be measured in two ways. One is financial. It will cost the Retirement and Survivors Insurance Trust Fund over $275 billion to keep the Disability Insurance Trust Fund solvent, and that is only to the year 2008.

The other is fairness. It is not fair to disability applicants to make them wait 90 days for an initial decision or almost 1 year for a hearing decision if they are truly disabled, and it is not fair to the taxpayers to allow a backlog of almost 2 million overdue continuing disability reviews. As a result, we pay billions of dollars to those who are no longer disabled, which I think is totally unacceptable.

SSA needs to do more on both ends of the process. Those who are truly disabled should get on the rolls as quickly and easily as possible and should be given incentives and assistance to help them

return to work. Those who have recovered should have their benefits stopped.

Members of the subcommittee talked about some ideas for reform yesterday, and now I would like to hear from those who are going to testify today.

I would like to recognize Andy Jacobs.

Mr. JACOBS. Mr. Chairman, my statement with reference to yours is ditto.

Chairman BUNNING. Thanks, Andy.

Now, I would like to welcome our first witness, an esteemed member of the Ways and Means Committee, the Honorable Jim McCrery of Louisiana. Accompanying him is Mark Dakos, vice president of Work Recovery, Inc., Tucson, Ariz.

Jim, go ahead.

STATEMENT OF HON. JIM McCRERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA; ACCOMPANIED BY MARK DAKOS, VICE PRESIDENT, INTERGOVERNMENTAL AFFAIRS, WORK RECOVERY, INC., TUCSON, ARIZ.

Mr. MCCRERY. Thank you, Mr. Chairman. Thank you for the opportunity to appear before your subcommittee this morning.

I will submit some testimony in writing, and since you have covered most of the first page of my testimony in your opening remarks, I will dispense with those. You are well aware of the problems confronting the system.

I think if we could discover some sort of neutral technology to provide an objective, rather than subjective, assessment of an applicant's or a beneficiary's ability to perform work, it would be a clear step forward.

I have recently learned about a company, Work Recovery, Inc., of Tucson, Ariz., which has developed something called ERGOS, a computerized system which measures an individual's functional capacity to work. I was extremely impressed when I heard about the technology and, frankly, just wanted this subcommittee to be aware of it.

ERGOS is already used in the private sector and it is being used on a pilot program basis by the Disability Determination Services in California and Arizona. Installation of the ERGOS technology at a Kentucky Toyota plant, by the way, has decreased annual claims payments from several million dollars to under $1 million.

Work Recovery has also begun to work with the U.S. Postal Service in their proper payment of Workman's Comp. claims and, just as important, to determine the most effective methods to return an individual to work. After utilizing ERGOS to evaluate five injured workers, the U.S. Postal Service was able to return those employees to productive employment at an annual savings estimate of nearly $400,000, including foregone medical costs. A summary of customer satisfaction from the Postal Service will be submitted along with my testimony.

Before I introduce Work Recovery's representative, let me make it clear that I am not here to endorse this company or the product. I do, however, believe that the utilization of technology in the disability evaluation process is something that is worth considering. While technology such as ERGOS cannot address the rapid growth

in awards for mental impairments, and that is something I am sure you want to address as well, I believe that this concept is well worth considering in the context of other impairments.

I have asked Mark Dakos, vice president for Intergovernmental Affairs, Work Recovery, Inc., to join us today to make a brief presentation to the subcommittee. I hope you will be as interested and intrigued as I was when I heard about this. Now I will turn it over to Mr. Dakos.

Mr. DAKOS. Thank you, Mr. McCrery, for your introduction.

Mr. Chairman, Mr. Jacobs, and members of the subcommittee, thank you for allowing our company, Work Recovery, Inc., to speak on the issue of improving the Social Security Disability Insurance Program.

Work Recovery, Inc., is the developer of the ERGOS work simulator, which is a functional capacity evaluation system that is used on an international basis to assess the residual functional capacities of individuals with disabilities. The ERGOS work simulator was developed by an interdisciplinary team that includes occupational medicine, industrial psychology, physical therapy, occupational therapy, vocational evaluation, industrial engineering, and industry.

The system has been employed in Workman's Comp. cases, Americans With Disabilities Act compliance situations, long-term disability claims, courts of general jurisdiction, and even in Social Security disability cases, both at the initial determination level and at the administrative law judge level.

Work Recovery, in noting the new plan for a disability claims process, supports the efforts of the reengineering team with respect to the functional capacity evaluation. Individuals very capable from within industry, from many walks of the disability industry, appear to address the issue and they have done, actually, quite an admirable job.

We were quite surprised to see the plan. Frankly, we did not expect that this was going to be forthcoming from Social Security and we feel it is a bold step to make the changes necessary to develop a more effective disability evaluation system.

A major issue that needs to be addressed is the philosophical difference, though, between functional and disability evaluations. In the disability model, the reinforcement to the worker is what they cannot do. In the functional model, you need to be able to tell an individual what they can do. This is important because if we are going to talk about reintegration of the individual back to the work force, they are put back into the labor force based upon what services they can provide through their capacities to the employer.

Unfortunately, we reinforce the disability model throughout the entire process. The individual is always told what is wrong with them. It is a diagnosis. It can be the doctors that are telling them, it can be the attorneys that are telling them, and, frankly, we have set up a gain issue that exists from the standpoint that if you qualify, you will receive benefits. We need to change that emphasis to reintegration back within the labor force so we can put these individuals back on the productive rolls.

The issue of function versus disability is already presenting itself in the disability determination process. The initial determination at

the DDS level is based upon medical listings. At the ALJ level, however, legal precedent and the discretion of the judge are cited as the reasons for granting an allowance. However, in nearly all of the appealed cases, the determining issue is the residual functional ability of the individual. This appears to be the gap that explains the high rate of overturns of initial denials at the appeal level.

We also recognize that in performing the evaluation, it needs to be standardized, objective, and free from evaluator bias. ERGOS has taken all that into consideration. We do not use normative population groups in our evaluation process. The ERGOS is also capable of being administered in several different languages.

It is also necessary to discuss the importance of establishing a functional baseline for consideration of performing work-related activities. The functional capacity evaluation allows for the basis to accurately assess improvement or deterioration of the condition of the individual in the continuing disability review process.

Finally, I would also like to point out that Work Recovery has reviewed the proposed demonstration project that will be presented to you by a later witness, Mr. Allsup, and we believe that this process, this case management process, is appropriate and actually takes into consideration the necessary steps for appropriate reintegration into the work force of individuals with disabilities.

We also feel that the vocational rehabilitation effort will be more targeted and less costly than conventional rehabilitation services. This is specifically due to the fact that the counselor will have a clear picture as to the extent of the individual's functional capabilities and how they relate to the world of work.

I would like to thank you for your time and your consideration this morning.

[The prepared statements and attachments follow:]

Statement of Congressman Jim McCrery
Before the Subcommittee on Social Security
House Ways and Means Committee
May 24, 1995

Mr. Chairman, first let me thank you for giving me this opportunity to address your Subcommittee this morning.

As you are all well aware, there has been tremendous growth in Social Security disability programs during the past 10 years. The Disability Insurance program has increased more than 41%; the Supplemental Security Income program for adults by 78%; and concurrent (eligible for both DI and SSI) disabled adults by over 100%. The combined cash benefits in both DI and SSI increased from $26 billion to $57 billion during that same time frame. Clearly, these increases are cause for concern and I applaud the Subcommittee's efforts to address this tough issue.

Having spent several months tackling the SSI childhood program, I know just how tough it can be. But I also know that there is a tremendous need for a fair and equitable disability program which is effectively managed, correctly determines eligibility, reviews a beneficiary's record in a timely manner, and clearly promotes a return-to-work approach by both the payer and the payee.

The Disability Reengineering Process which the Social Security Administration has begun is a step in the right direction. However, I hope that this Committee will ensure that the Agency makes every effort to exceed the timetable for reform which it has outlined. We simply cannot tolerate the backlog of more than 1.8 million Continuing Disability Reviews and the annual increase of more than 500,000 cases. I believe there are more efficient and effective ways to manage the new applicants as well as the current caseload. **To this end, exploring the use of additional technology to enhance and speed the disability adjudication and review process is a concept well worth considering.**

I understand that the Social Security Administration now uses computer profiling and beneficiary questionnaires to more efficiently target Continuing Disability Reviews. But given the tremendous advances in technology throughout our society there are many more areas where technology can be used: computerization of an individual's disability application and records, tracking and securing medical evidence as well as determining one's functional capacity to work.

The use of neutral technology to provide an ***objective*** assessment of an applicant's or beneficiary's ability to perform work would be a clear step forward. I have recently learned about a company, Work Recovery, Inc. of Tucson, Arizona, which has developed ERGOS, a computerized system which measures an individual's functional capacity to work. I was extremely impressed when I heard about this technology and wanted the Committee to learn of its attributes.

ERGOS is already used in the private sector and on a pilot basis by the Disability Determination Services in California and Arizona. Installation of the ERGOS technology

at a Kentucky Toyota plant has decreased annual claims payments from several millions to under $1 million.

Work Recovery has also begun to work with the U.S. Postal Service in their proper payment of Workman's Compensation claims, and, as important, to determine the most effective methods to return an individual to work. After utilizing ERGOS to evaluate 5 injured workers, the U.S. Postal Service was able to return those employees to productive employment at an annual savings estimate of nearly $400,000, including foregone medical costs. The summary of "customer satisfaction" from the Postal Service will be submitted for the record.

Before I introduce Work Recovery's representative, let me be clear that I am not here to endorse this company or its product. I do, however, believe that the utilization of technology in the disability evaluation process is something worth considering. While technology such as ERGOS cannot address the rapid growth in awards for mental impairments--something which should also be addressed--I believe this concept is well worth considering.

I have asked Mark Dakos, Vice President for Intergovernmental Affairs of Work Recovery, Inc. here today to make a brief presentation to the Subcommittee. I hope the Subcommittee will be as interested as I am in the possible application of this technology in the disability evaluation process.

Thank you again for the opportunity to be here today.

United States Postal Service

May 15, 1995

Mr. Mark Dakos
Director of Intergovernmental Affairs
2341 S. Friebus, Suite 14
Tucson, AZ 85713

SUBJECT: Results of ERGOS Testing

Dear Mark:

As you are aware, the U. S. Postal Service in Tucson, Arizona has been utilizing the ERGOS in attempts to return injured workers back to productive employment. You have ask that I give you a brief summary of our accomplishments as of this date.

We started your service the first part of January 1995. Since that time we have had the opportunity to send five (5) employees for ERGOS testing. Although I am not at liberty to give names or social security numbers on these individuals, you are aware of those employees who have participated in this examination. You may use the results of the test, however I am asking that you black out the names and social security numbers of those individuals.

The first individual was an employee not working in receipt of $2,511.00 every 28 days. This equals an annual payment of $33,647.00 net to the employee. Her treating physician refused to allow her to return to any form of employment. Once the results of the ERGOS was completed and presented to the treating physician, he agreed she could return to an accommodated position. This occurred in January 1995 and the year to date savings has been over $10,000.00.

The next four individuals were receiving $1,908.00 compensation and unable to perform their bid jobs solely based on subjective complaints of the employees. As a result, the Postal Service was required to replace those employee, with others, in an overtime status of time and a half. This equaled $2,762.00 every 28 days of employee replacement. The results of the ERGOS was presented to the various physicians and three of the employees were released to full duty, with one being released to full duty with a restriction of no lifting over 40 lbs. This was easily accommodated.

To give you a total savings to the Postal Service on the five cases cited above we must take the total compensation being paid every 28 days plus replacement cost in overtime required to service their routes during their absence. Although I cannot give you exact figures, I can provide you with approximate numbers which should accurately reflect the savings. Also in order to give you full credit for these results I will show the annual savings involved in these cases.

Again, these above figures do not include the additional three (3) employees scheduled for testing this month. Those results will be forthcoming should you request those statistics.

1. Payment made every 28 days (5) cases	$10,143.00
2. Replacement cost every 28 days (5) cases	$15,214.50
Total:	$25,357.50
3. The annual savings is (13 payments per year)	$329,647.50
4. Year to date savings is (based on 5 month savings)	$126,787.50

The above estimates are based on the actual earnings of the employees involved. I placed an annual savings on this report as I am confident that these cases would have exceeded a year in duration had it not been for the use of ERGOS.

I am also pleased to announce that our Phoenix District Office has now started to utilize the services of Work Recovery (ERGOS) along with our Denver facility. I am confident their results will be as positive as ours.

I hope this report helps you and if you wish to use our success and share this with others please feel free to do so. If you have any questions regarding this correspondence please feel free to contact me at (520) 620-5073.

Respectfully,

Terry B. Whitmarsh
Human Resources
Tucson, AZ 85726-9431

TESTIMONY
OF
MARK DAKOS, VICE PRESIDENT INTERGOVERNMENTAL AFFAIRS
WORK RECOVERY, Inc.
Tucson, AZ

Committee on Ways and Means
Subcommittee on Social Security
U.S. House of Representatives

May 24, 1995

Thank you Congressman McCrery for your introduction.

Mr. Chairman, Mr. Jacobs, and Members of the Subcommittee, thank you for allowing our company, Work Recovery, Inc., to appear before you on the issue of "Improving the Social Security Disability Insurance Program."

Introduction of ERGOS™

Work Recovery, Inc. of Tucson, AZ, is the developer of ERGOS™ Work Simulator, a functional capacity evaluation system that is used on an international basis to assess the residual functional capacities of individuals with disabilities. The ERGOS™ Work Simulator was developed by an interdisciplinary team that included persons from the fields of: occupational medicine, industrial psychology, physical therapy, occupational therapy, vocational evaluation, industrial engineering and industry.

The ERGOS™ Work Simulator is a five-panel free standing unit which uses computerized testing components to measure an individual's physical and functional capacities as they relate to work performance. The entire system, consisting of five separate testing units, measures the following areas of work performance: static and dynamic strength, whole body range of motion, work endurance, standing and seated work tolerance, upper extremity strength and seated work range of motion.

Each of the ERGOS™ units operates in two separate modes: as a physical/functional capacities evaluation and as an individualized work conditioning/treatment program. Work Recovery-owned facilities and other professional affiliates throughout the world are also able to provide evaluation services, restorative therapy and work re-conditioning using ERGOS™ to ensure controlled measurement and an effective return-to-work environment.

The ERGOS™ Work Simulator allows for direct comparison of the performance of the individual to the specific physical demands of the 12,741 job titles defined by the Dictionary of Occupational Titles (U.S. Department of Labor, 1991) or to the specific standards of performance for any job with an employer. The comparison allows for an appropriate identification of the mismatch that may exist between a worker's capabilities and the performance criteria necessary for the job. It also provides for the appropriate ergonomic modification of the work site or the development of appropriate alternate work in order to return that individual to a productive work life.

The ERGOS™ Work Simulator has been used in worker's compensation cases, Americans with Disabilities Act compliance situations, long term disability insurance claims, courts of general jurisdiction, and in Social Security Disability cases at both the initial determination level and at the hearings level. The objective measurements of ERGOS™ have been upheld in all adversary settings.

With the Social Security Administration's Disability Reengineering Process stated commitment to extensive use of technology to determine an applicant's or beneficiary's functional capacity to work, the ERGOS™ offers a unique and cost-effective opportunity to assist the Disability Determination Services to make the correct decision the first time, based on tangible, measurable data. The use of neutral technology to provide an objective assessment for both initial and CDR determinations could be a tremendous asset to the program.

The Disability Evaluation Process

The Social Security Reengineering Team has begun to undertake the bold steps needed to develop a more effective disability system. Their support of the use of technology to determine an individual's functional capacity to participate in the labor force is especially of interest.

However, a major issue which needs to be addressed in any successful reform plan is the philosophical difference between functional assessments and the current disability evaluation. The disability model serves to reinforce to the individual claimant what is wrong with them and why they are unable to perform appropriate work functions. The functional model establishes the individual's capabilities and, if at all possible, helps them to identify functions that can be performed on a gainful basis in the open labor market.

The issue of function vs. disability already presents itself in the disability determination process. The initial determination at the State Disability Determination Service is based upon medical listings. An individual who meets or equals the medical listing becomes a disability beneficiary.

At the Administrative Law Judge level, legal precedent and judicial discretion are the reasons for granting an allowance. **However, in nearly all appealed cases, the determining issue is the residual functional ability of the applicant. This appears to be the gap that explains the high rate of overturn of initial denials made by the Disability Determination Service level.**

Work Recovery has begun to work with the Disability Determination Services of both Arizona and California, on pilot programs, to provide functional capacity evaluations at the initial determination level. It is important to note that there was some concern among the medical community that an ERGOS™ evaluation of functional capacity would replace the need for medical evidence. However, that is not the case. The ERGOS™ does not provide a medical diagnosis. The ERGOS™ evaluation determines one's ability to perform the functions necessary to obtain and support employment in the labor force, regardless, or in spite of, one's diagnosis.

Questions are often raised regarding the use of ERGOS™ to evaluate those with mental disabilities. The ERGOS™ Work Simulator can be used to evaluate the functional capacity of any individual. The four key factors which are taken into consideration are the observed behaviors of the evaluee, the monitored heart rate, the use of the coefficient of variation in order to measure the consistency of effort, and the methods-time-measurement (MTM) standard for evaluation of the performance according to industrial engineering/industry standards. The objective of the functional capacity evaluation is to determine an individual's ability to effectively function in the work force, not to provide a diagnosis of a particular form of mental illness.

Return-to-Work Approach

The ERGOS™ Work Simulator has been developed based upon the belief that reintegration of a disabled worker into the employer community is dependent upon the ability to perform work, not the nature of the disability. Thus, the functional assessment, a standardized and objective measure, free from evaluator bias, is a tool which can assist the return-to-work plan. Once an employer is informed of the potential for an employee to again become productive, the job site or job can be adapted to the employee's needs and abilities.

The evaluee always has the opportunity to determine whether or not he/she has the capabilities to perform the physical demands of work activities without the potential for embarrassment at a job site, which could further impede that person's drive to return to work.

Many companies throughout the world (the ERGOS™ evaluation can be administered in several different languages) have begun to establish an ERGOS™ baseline of functional capacity to perform specific work-related activities. Such a baseline Functional Capacity

Evaluation (FCE) allows later measurement and accurate assessment should a worker become disabled: this baseline may be used to monitor a worker's physical improvement or deterioration. A baseline can also be utilized by the Social Security Disability process, at the initial and the Continuing Disability Review stages.

Though there is often the temptation to use a functional capacity evaluation instrument to "find fakers," the test is far more useful in providing an accurate assessment of residual functional ability, taking into consideration both the physical and mental demands of work.

The cost of an ERGOS™ evaluation ($450-$795 per evaluation in worker's compensation cases) is significantly outweighed by the benefits that are achieved. In worker's compensation cases the evaluation is equivalent to approximately 2-3 weeks of temporary disability costs. In situations where an appropriate job site modification or accommodation can be achieved, the savings can be tremendous. The additional disability benefit costs, potential for vocational rehabilitation services, and the additional medical costs to monitor an individual while they continue in off-work status can be significant.

Additionally, the cost of being forced into a disabled status, as opposed to a productive status, is significant to the individual with the disability. The opportunity to return to suitable, gainful employment far outweighs the benefits received through Social Security Disability income and Medicare. Unfortunately, the methodology to safely return an individual to the labor force has previously been non-existent. The ERGOS™ Work Simulator provides the answer necessary to achieve the successful reintegration of the worker back into the labor force, and restore that individual as a productive taxpayer rather than a tax/benefit receiver.

Work Recovery Inc. expects to be able to provide within the next several months tangible cost/benefit data regarding disability and return-to-work, in particular, cost-benefit analysis focused upon the Social Security Disability Program and the Disability Insurance Trust Fund.

Proposed Demonstration Project

PAAR: Project Administration, Assessment and Reemployment, a team effort to assist Social Security in its improvement of the Disability program , will be discussed in detail by Jim Allsup of the Allsup Co., the team leader. Work Recovery, through its functional assessment role would participate in the project. We believe that the demonstration project is appropriate, will be successful and would appreciate consideration by this Committee.

From our experience with the ERGOS™ Work Simulator in assisting in the return to work of several hundred thousand individuals with disabilities to the labor force, the proposed project appears to be appropriate and the probability of success appears to be quite good due to the nature of the intervention that will be conducted. Furthermore, the vocational rehabilitation effort will be more targeted, and less costly than conventional rehabilitation services. This is specifically due to the fact that the counselor will have clear picture, through ERGOS™, as to the extent of the individual's functional capabilities and how they relate to the world of work.

The objective of the demonstration and, indeed, all disability programs is to return the individual to work, if at all possible. It is important that the work opportunities be suitable, gainful employment. "Make work" programs often de-motivate individuals and prove costly to that employee when the position ends and he/she is without appropriate skills and the physical abilities to perform work in the open labor market. The result is a return to the Social Security Disability Insurance rolls and a renewed fear of trying to venture from the false security of a disability program.

Work Recovery believes that the ERGOS™ Work Simulator can provide the integral link needed to assess one's functional capacity and return to productive participation in the national work force.

Thank you for the opportunity to present the ERGOS™ Work Simulator.

Testimony
Before the House Committee on Ways & Means
Subcommittee on Social Security
May 24, 1995

Hearing on "Improving the Social Security Disability Program"

By
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- A Three Phase Demonstration Project -

"Moving From Dependency To Rehabilitation and Return To Work"

A Public-Private Demonstration Proposal To Assist the Social Security Administration in its Redesign of the Disability Process

Over the last year, both the general public and their elected representatives in Congress have become increasingly aware that federal disability programs confront major problems. These problems stem from the unprecedented growth in program participation, and media allegations of fraud and abuse in the SSI program by various groups including elderly immigrants and drug and alcohol addicted individuals. Due to shrinking federal resources, a critical review of the federal disability program indicates that like federal welfare programs, its structure may inadvertently trap the disabled in a cycle of dependency from which they have little incentive to escape.

This proposed demonstration addresses these concerns by providing the means for the disabled to move from dependency, to rehabilitation and return to meaningful work. With the cooperation of the Social Security Administration (SSA), this proposal can be implemented immediately. It provides methods to ensure that the truly disabled are assisted expeditiously, while at the same time performing timely continuing disability reviews and establishing fraud and abuse prevention measures.

The Problem

From 1985 to 1994 the number of DI and SSI recipients increased from 4.2 million to 7.2 million, or 70 percent. About 50 to 60 percent of this growth has occurred just over the last three years. The backlog of unprocessed claims now totals nearly one million, with forecasts for new claims showing continued dramatic acceleration over the foreseeable future. The continuing disability review backlog is now at 1.8 million, with about 500,000 additional cases coming due each year. With this growth, total federal costs, including monthly cash benefits and Medicare and Medicaid health coverage, amounted to $107 billion in 1993. Furthermore, in 1994, Congress reallocated FICA payroll taxes to transfer more than $240 billion from the Old Age and Survivors Trust Fund into the DI Trust Fund by the end of 2003. Thus, the disability crisis threatens to further undermine Social Security for retirees, beyond the already rapidly shrinking worker-to-retiree ratio.

Spiraling costs, indicative of an outdated and ineffective disability program, prove that the problems and complexities of 1995 were never envisioned when DI was enacted in 1956. As a result, both program structure and administration must be redesigned. Administration redesign can be accomplished relatively easily and quickly if the Social Security Administration is receptive to and acts on new ideas and measures like those introduced in this proposal. Program structure redesign would be aided in part by the information and results produced from the return to work option demonstration we are proposing. To its credit, the Social Security Administration is moving as fast as it possibly can to address the problems within its control. But unfortunately, its pace is far too slow given the magnitude of these problems; and equally unfortunate, some of the problems are beyond its control.

A Demonstration Project of Public-Private Partnership

Due to this reality, the proposal we make to the Social Security Administration is a challenge to be creative and flexible in a demonstration with us that in some ways radically alters their existing plans and timetables. At the same time, however, our proposal seizes on two major administrative redesign decisions the Social Security Administration has already made and aligns them with other new ideas and already proven successful new measures. These new ideas and measures, in turn, would help the Social Security Administration for the first time exert at least some degree of influence on factors that up until now have been totally beyond the Social Security Administration's control. But rather than insinuate our proposal is the solution to most of SSA's administrative problems, let us show what we know is possible through a demonstration. However, a successful, productive demonstration depends directly on the Social Security Administration's willingness and ability to be bold, creative and receptive to new ideas, some of which go beyond the Social Security Administration's stated plans.

The Social Security Administration has taken the first major necessary step to problem resolution by agreeing that it needs assistance from third parties. It has followed up by commencing discussions with numerous third parties, seeking outside assistance and insight. Though its effort is sincere and absolutely necessary, the current "shot gun" approach to third-party interaction will not suffice. It must be accompanied by a "rifle" approach through the proper coordination and integration of key third-party participants in the Social Security Administration disability process. Our proposal provides this absolutely critical and irreplaceable coordination and integration.

For a demonstration with SSA, we have assembled a group of Fortune 500 employers and private disability service providers representing health care, rehabilitation, disability insurance, health insurance and SSA claimant representation. This group of companies has agreed to work together toward the common goal of identifying and returning disabled employees to work in the shortest timeframe possible through the proper coordination and delivery of our collective services. Our mission is focussed on intervening early in the disability, providing the disabled individual immediate access to the services, education and information that is critical to successful and timely rehabilitation and return to work. This group includes two key components SSA is relying heavily on for assistance--the authorized claimant representative and the rehabilitation provider. SSA's reengineering plans to pay new claims faster call for the "outsourcing" of the development of the medical file to the claimant representative, with the representative being delegated specific duties and responsibilities to assist SSA with its mission. SSA's rehabilitation plans call for the implementation of its new 1994 regulation that is designed to give the rehabilitation provider early access to SSA recipients; access that up until now has been in effect, denied. But not only does our group of providers represent critical components of SSA's existing plans, we also represent the complete range of assistance needed by the individual when he or she becomes disabled. And with our services properly coordinated and integrated in an agreed upon delivery system, this system represents the best possible hope of returning disabled individuals to productive work activity in the least amount of time. This serves the interests of the disabled individual, SSA and the American FICA taxpayer. Our proposal contains that necessary coordinated and integrated delivery system.

Interestingly, all of the disability and health plans in this country are designed to integrate with each other, with Social Security and Medicare serving as the foundations for all other plans to build upon. But true integration has never been possible because no one has ever managed the integration "process." Absent this "managed integration," waste, duplication and unnecessary costs go unchecked, with SSA bearing the brunt of the impact. This proposal applies managed integration while simultaneously protecting and serving the interests of both SSA and individual claimants. It accomplishes this by utilizing SSA's sanctioned private sector "authorized claimant representative" as the core of a new public-private disability service delivery system. The private representative, already regulated by SSA, not only serves SSA's interests by timely and judiciously developing the medical file, but performs "double duty" by also serving as the "connector," or coordinator and integrator, between SSA and the many other disability and health plans.

Work Recovery, Inc.

The "Plan for a New Disability Claim Process" published by the Social Security Administration (September 1994) has taken a bold step in recognizing the need for a *standardized measure of functional ability* to assess an individual's capabilities to perform the baseline demands of work. This assessment process not only enables the Social Security Administration to evaluate whether or not an individual has the baseline abilities to perform occupational demands, but it also provides the basis upon which a re-integration of the individual to the labor force can be made. Although a disability recipient may meet the statutory criteria for benefits, in many cases that individual may be able to return to work with appropriate modifications at the work site or by using transferable skills in an alternate occupation in which the physical demands have been adjusted to accommodate the worker.

The necessity of coordination and integration becomes paramount for whom the *standardized measure of functional ability* takes place. Early intervention measures by the claims representative coordinated with the disability insurer, a rehabilitation provider and an employer can result in appropriate jobsite modifications or consideration of alternate occupational duties which will result in a return to suitable, gainful employment. Unfortunately, the current process of the Social Security Administration uses a limited medical examination that does not provide a functional baseline upon which a return to work plan can be considered or realistically implemented. Even with a denial of DI or SSI benefits the result is a shifting of the financial burden or continuation of the individual on other government-sponsored programs (e.g., AFDC, Food Stamps, General Assistance, etc.). Unfortunately, the allowance of DI or SSI benefits usually signifies the end of all efforts to attempt

to find employment on the part of the individual for who benefits have been granted.

However, in the private sector it is common for employers to work closely with disability insurers and rehabilitation providers to create a disability management "plan" tailored to returning disabled employees to work at the earliest possible point in time. One such plan involves an exclusive arrangement between Work Recovery, Inc., the manufacturer of the ERGOS™ Work Simulator and a provider of employer-employee return to work services, and Fortis Corporation, a major disability insurer. The two have combined their products and services to facilitate the needs of both employers and employees in returning the injured or disabled worker to appropriate employment as soon as possible.

Work Recovery utilizes its new state-of-the-art ERGOS™ Work Simulator to assess, and sometimes improve, an individual's physical capacity for a particular job; it then may work with the employer to alter that job to fit the individual's capabilities. At the same time, the insurer's disability plan pays for most of the employer's expenses associated with making the necessary modifications to comply with the Americans with Disabilities Act (ADA). It also reimburses the employer up to 50 percent of the first month wages when they accept a claimant into a trial work program, and continues to pay the claimant disability payments if the impairment prevents the individual from earning monthly wages of at least 80 percent of pre-disability wages. These same innovative measures in a well coordinated "team" environment can also be applied to DI recipients. The issue is assembling the team and coordinating and integrating their services to create a disability delivery system designed to serve both SSA's and the disabled individual's interests.

Components and details of our delivery system that we propose to use in a demonstration with SSA are listed in the following pages. They have been carefully crafted to address all of SSA's major disability problems that up until now have seemingly defied solution:

(1) The timely payment of legitimate claims.
(2) The establishment of a baseline of functional ability
(3) Early access to rehabilitation services, including both dependency and return to work options.
(4) Timely continuing disability reviews.
(5) Fraud and abuse prevention.

Also listed are our demonstration needs, each of these items having a direct impact on the degree of success of this project. The more SSA responds to meet these needs, the more successful the project. As the demonstration project designed to address all of SSA's disability problems, we can only hope and trust SSA shares our motivation and desire to succeed by striving to meet these needs.

- **Early Claimant Intervention/Access Outside the SSA Field Office.** When DI was enacted in 1956, the sole source of SSA disability assistance was the local SSA district office. Today in 1995, an entirely new, virtually unused alternative distribution system exists. This new system consists of third parties all financially motivated to make SSA disability services available due to the multiple benefits the disability award now produces for third parties. It is important to note this alternate system did not exist in 1956 because these multiple benefits for third parties did not exist. These benefits consist of the monthly income utilized by employers and disability insurers to offset their own disability plan liability. They consist of the 11 month extension of COBRA health benefits guaranteed under COBRA law (from 18 to 29 months), important to all health care providers. They consist of guaranteed Medicare entitlement upon the 30th month of disability, important to health care providers, employers and health insurers. And they will also soon consist of payment for early rehabilitation services via the new SSA rehabilitation regulation. Thus, our demonstration partners are motivated to work together to identify SSA-eligible disabled individuals early. Claimants will be "intercepted" at any one of a variety of points in our delivery system before entering a SSA district office for services. Once intercepted, they will immediately be referred to the authorized claimant representative for interview, screening and application, if appropriate. Since the claimant representative's fees are contingent only, only legitimate claims will be referred to SSA. All claims will be referred to the appropriate SSA district office by mail only, accompanied by the full development and documentation previously made available to the claimant representative by demonstration partners. With each claim file will be a short brief addressing the relevant medical listing(s) and/or vocational rule. SSA's role will be limited primarily to that of adjudication, as currently envisioned in their reengineering plans.

- **Proper/Timely Coordination and Integration Of All Relevant Public and Private, Disability and Health Benefits.** Due to the fragmentation of this country's many public and private benefit plans, proper coordination has become extremely difficult, if not impossible. Disabled individuals routinely fall through the cracks of these many plans, in turn making the task of rehabilitation that much more difficult. How can a disabled individual even begin to psychologically prepare for rehabilitation if he or she has no disability income or health insurance? In this demonstration we will utilize specially trained authorized claimant representatives well versed in all major benefit plans, disability and health, and how they are designed to coordinate and integrate with each other. It is important to note that SSA claim representatives employed by SSA do not receive such training. Our claimant representatives will coordinate DI and SSI benefits with private disability insurance, workers compensation, state disability plans and other relevant public and private disability plans when appropriate. Available documentation from these plans will be accessed and utilized to help develop the file for SSA purposes. Prospective Medicare entitlement will be coordinated with extended employer health plans beyond 30 months of disability, normal employer-provided 18-month COBRA coverage, extended 19 to 29 month COBRA coverage if disabled for SSA purposes, workers compensation, available Medigap plans for the disabled, and other health benefits when appropriate. This comprehensive coordination of multiple public and private disability and health benefits by one entity is unprecedented, but absolutely critical to the ultimate success of SSA rehabilitation efforts. Advocates for "single payer" health insurance envision the single payer as the only solution to simplifying fragmented and complex health insurance systems. This demonstration with SSA will prove there is an alternative. It can serve as the model for others to follow.

  We also want to note that we want to ensure to the greatest extent possible sufficient diversity in the claims we process. As such, we are willing to work with SSA to secure other means of referred claimants if the Agency feels it would be appropriate to reflect the proper diversity.

- **Re-education of SSA Claimants to Minimize Dependency and Maximize Return to Work Options.** Our authorized claimant representative's initial interview with SSA applicants will be totally unlike the interviews currently conducted in SSA district offices. In addition to early access to claimants via an alternate distribution system and comprehensive coordination of benefits, we will simultaneously conduct SSA and rehabilitation evaluations. Our rehabilitation personnel will evaluate the claimant for rehabilitation purposes while our SSA claimant representative evaluates for SSA purposes. For those individuals who appear to be SSA candidates and rehabilitation candidates, prospective SSA benefits will be communicated as a rehabilitation device only. Benefits will be communicated as "financial assistance to help you return to work" in the form of "temporary" monthly income, "potential Medicare entitlement if rehabilitation efforts have not returned you to work within 30 months of the start of your disability," and a "nine month trial work period that will allow you to attempt to return to work and receive both SSA benefits and wages." This specialized message, delivered early by a disability specialist, away from the typical multi-issue SSA district office environment, can play a critical role in motivating the disabled individual to return to work. Coupled with the opportunity to return to work via access to early rehabilitation services, and financial security through the controlled coordination of disability and health benefits and the timely payment of the SSA disability claim, the potential for successful rehabilitation has been maximized absent an absolute requirement to accept rehabilitation services.

- **Immediate Referral By Authorized Claimant Representative To Rehabilitation Network.**

The National Rehabilitation Network

Since current SSA plans call for the heavy reliance on both the authorized claimant representative and rehabilitation provider, this demonstration will directly connect these two SSA partners. Once we have identified a disabled individual as both a rehabilitation and SSA candidate, immediate referrals to both parties will be made. We have agreed to utilize a national network of rehabilitation providers to provide Social Security claimants with both convenience in location and choice of service. The National Rehabilitation Network (NRN) is composed of rehabilitation providers experienced in providing services in workers compensation cases, who are nationally based and will provide approximately 200 service office locations across the nation. The claimant will be referred to a rehabilitation provider in the network within a 50 mile radius of home. If more than one rehabilitation service

provider is within the 50 mile radius, the claimant will be referred from a provider list in rotation to the next available provider. Where more than one provider exists the claimant will have the opportunity to ask for another referral where there is no compatibility with the provider's counselor.

To insure the quality of rehabilitation services, National Rehabilitation Network providers have agreed to the following criteria:

1. To comply with all state licensing requirements for rehabilitation providers.

2. To adopt the Code of Professional Ethics promulgated by NARPS.

3. To comply with national reporting and quality control standards demanded by Social Security Administration.

The key to the success of returning disabled workers to work in the workers compensation arena is early intervention with rehabilitation services at first reporting of the disability. We believe that the Social Security Administration should consider experimenting with early rehabilitation services for individuals as they become eligible for benefits. This model has been very successful in the private sector in workers compensation cases, used by both the employer and long-term disability insurer. We are recommending services to Social Security that we currently provide and know return people to work and to happier and productive lives.

Members of the National Rehabilitation Network have agreed to provide the Social Security Administration with cost effective rehabilitation services, not to exceed a cap of $1,700 to $2,000 per person. This fee would not include the cost of an evaluation by a functional assessment tool, not to exceed $450 per person. These charges to return disabled individuals to work are offset by the average monthly Social Security benefit which is approximately $660 a month and the average benefit duration is six years or $47,520 in total benefits. With early intervention services, at the cost of less than $2,500 per worker, there is the potential of saving nearly $40,000 per worker on the average disabled individual returned to work.

Our authorized claimant representative will submit a fully developed, documented and presented claim file to the SSA district office, while simultaneously referring our rehabilitation analysis to a participating rehabilitation provider. Our claimant representative will then move into a claim management capacity, coordinating and communicating all subsequent relevant activity with both the SSA district office and rehabilitation provider. This claim management "triad" responds to SSA's stated plans to develop a new disability claim manager who will work in the district office. These three entities would then work together to process the SSA claim, provide rehabilitation services, and coordinate and ultimately terminate SSA and Medicare benefits upon the successful return to work.

- **The Case Management Coordination Team: (1) Authorized Claimant Representative (2) SSA Disability Claim Manager (3) Rehabilitation Network.** This three-person case management team will closely coordinate all activities, clearing all previously determined communications and information through the SSA regulated authorized claimant representative. This will allow the SSA disability claim manager to primarily focus on the processing of new claims. Activities will be subdivided as follows:

  - Medical Management Services - designated rehabilitation provider

  - Vocational Rehabilitation Services - designated rehabilitation provider

  - Continuing Benefit Coordination - authorized claimant representative

  - Continuing Disability Reviews - The Disability Team: SSA disability claim manager/authorized representative/rehabilitation provider -- Upon the SSA established diary, SSA would route case through the authorized claimant representative to the rehabilitation provider for review. Authorized claimant representative would monitor diary to ensure timely referral from SSA. If determined no longer disabled by rehabilitation provider in conjunction with SSA established criteria, recommendation

for termination would be routed back through claimant representative to SSA for review and final determination. If determined still disabled, recommendation would be referred and handled in same manner. If the rehabilitation provider is being called upon to intervene early in the disability claim, let's take the next logical step and involve them in the continuing disability review. There is no logical reason not to include them in the process, leaving the final decision to SSA upon review.

- Fraud and Abuse Prevention Through Return to Work Monitoring and Third-party Incentives - authorized claimant representative, in conjunction with demonstration participants. Our authorized claimant representative will remain in regular contact with the SSA disability recipient to monitor subsequent health care treatment to ensure proper and timely primary-secondary health care expense billing. This service is offered to employer, health care provider and health insurer clients/demonstration participants to ensure Medicare is billed as primary when appropriate. Through this regular contact our claimant representative will also explore possible return to work through a designated series of questions. Through this questioning, coupled with an agreed upon regular flow of information from our employer, disability insurer, health insurer and health care provider demonstration participants, in addition to our rehabilitation case manager partner, our claimant representative will serve as an information "clearing house" for SSA. This information network can then be used to report events to SSA on a timely basis that warrants record update, benefit termination or other action. Such an information network readily available at SSA's disposal currently does not exist. Potentially, it could go a long way in securing the public's trust that SSA is proactively doing everything in its power to minimize the likelihood of fraud and abuse. Furthermore, financial incentives to encourage third-party participation in fraud and abuse prevention should also be explored, such as fees contingent on legitimate benefit termination. Since the current SSA administrative system does little to encourage or reward SSA employees to detect and investigate potential fraud and abuse, reward third parties to become involved. If third parties finally are being called upon to participate in claim processing and rehabilitation efforts, let's expand their involvement on all fronts.

- **Immediate Return To Work Reporting To SSA/HCFA.** Upon notification and validation that a SSA disability recipient has returned to work, the authorized claimant representative will immediately report this event to both SSA and HCFA via a previously agreed upon communication format. This will help deter situations where disability payments continue despite a permanent return to work beyond the expiration of the nine month trial work period, and despite alleged requests by claimants to terminate payments (DI recipient Mary Jane Owen in testimony before Senate Special Committee on Aging). It will also assist HCFA in its "Datamatch" program designed to recover overpayments from private health plans that paid secondary rather than primary despite a disabled employee's return to work activity. Such timely reporting by the authorized claimant representative will serve the interests of the disabled beneficiary, SSA and HCFA in preventing both SSA and Medicare overpayments from ever occurring. Such a reporting mechanism currently does not exist. Furthermore, the effectiveness of such a mechanism would be magnified if and when our authorized claimant representative would be granted direct electronic access to the SSA file. Current SSA reengineering plans call for electronic access by the authorized claimant representative by year five of their current plans. If this timetable can be expedited, overpayment prevention can be expedited. It would also allow for the electronic submission of claims, providing additional administrative savings to SSA.

Demonstration Needs

To maximize the effectiveness of this demonstration and the resulting savings to SSA, we are requesting cooperation from SSA in the four areas listed below. The degree of cooperation will directly result in the prospects of a timely demonstration and the degree of savings and the amount of information that can be utilized to assist overall program enhancements. We recognize this proposal in part goes beyond SSA's existing plans and requests them to be extremely creative and flexible. But we also recognize time is at a premium and new ideas must be entertained and implemented now. We are extremely confident of the results this proposal can produce. It simply draws on the current expertise, in a carefully coordinated and integrated manner, of all of our demonstration partners. We simply want the opportunity to show what is possible, what can be done now to help prevent what will surely occur with DI and SSI without the type action we are proposing.

- Assignment of SSA Personnel. We request the immediate assignment of two SSA headquarters personnel to work with us at our location for five weeks to prepare a plan of action. Together we will devise a plan to implement this proposal and report back to Mr. Bunning and SSA headquarters for clearance to proceed. The plan will include how to obtain and achieve in as short a time frame as possible the primary needs listed below for a successful demonstration.

- Funding. Initial funding requirements would be for rehabilitation services. Fees associated with the representation of SSA claimants would primarily come from disability provider demonstration participants, with a minority from individuals directly. Since our proposal calls for an expanded role of the authorized claimant representative, however, funding available through reengineering would subsequently be necessary for these additional services. As regards rehabilitation, funding for rehabilitation provider participants commencing as their services begin is an absolute must. Absent this early funding, there will not be rehabilitation participation. The new SSA rehabilitation regulation currently calls for funding only after the disability recipient has demonstrated nine months of substantial gainful activity. Rehabilitation providers will not and cannot provide their services as this regulation is currently presented. It is entirely prohibitive. We understand that SSA may have the authority to contract for rehabilitation services in a designated demonstration and make such early funding available. We are also aware that the new SSA regulation that applies to their reengineering initiative will make funding available for unique programs. Since our proposed demonstration encompasses both reengineering and rehabilitation, and is unprecedented in nature, funding may indeed be available from two separate components within SSA. As to the amount of funding necessary, the rehabilitation network will provide rehabilitation services at an average cost of $1,850 per case. (Averaged between $1,700 - $2,000 per case, with $2,000 being the maximum fee for rehabilitation services.) Their 1994 performance resulted in 13,719 people returning to work out of 62,741 cases referred for services. However, many of these claims are short term and/or partial disabilities. But lacking the actual percentage of these claims that would meet SSA criteria, and the fact that SSA recipients have never had routine access to rehabilitation services, for simplicity purposes we will utilize their actual past performance for funding request purposes. Therefore, we can estimate that for every 1,000 new claims we would process, 262 would be referred for rehabilitation services at an approximate total cost of $705,042. Assuming at least 15,000 claims would be processed initially, we request at least $10,575,630 in rehabilitation funding, to be adjusted upward, with additional claims volume. Reengineering funding will depend on SSA's flexibility to work with us to maximize claim volume and the proposed expanded role of the authorized representative.

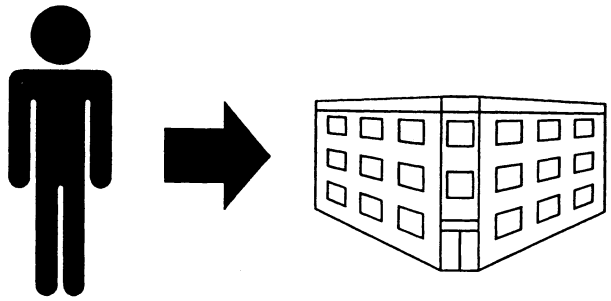
- Centralized Claims Processing. Approximately 45% of the labor force in America is covered by private disability plans that offset their liability against DI benefits. The definition of long term disability in most of these plans is very similar to SSA's definition, making the medical documentation in these claim files extremely valuable for SSA purposes. Upon thorough investigation and payment determinations in these claims, claimants are referred to SSA district offices to file applications for DI. Most of these claims are subsequently awarded by SSA, with the private plan then applying their offset. Disability insurers and employers will voluntarily commit their claimants to our demonstration's distribution system in lieu of referring them to SSA district offices, if motivated to do so. The strongest possible motivation would be an

agreement by SSA to process these claims through one contained geographical area, in lieu of the current processing in all 50 states. This would reduce the amount of "competition" for time these privately insured claims currently face in SSA district offices, DDSs and OHAs. This would in turn speed their processing and payment, maximizing the reduction of the disability liability of these private plans. This is a strong motivation for these private plans to participate in our demonstration. The more they participate, the higher the claim volume in our demonstration, producing higher administrative savings to SSA and higher trust fund savings due to successful rehabilitation. We currently have the concurrence of one SSA region to work with us to provide centralized processing assistance if SSA in Baltimore will provide the approval. I am in constant contact with the Health Insurance Association of America (HIAA) and individual disability insurers, and can virtually guarantee their substantial utilization of the alternate distribution system this proposal contains, if centralized processing of these claims become a reality. Specialized handling of these claims makes perfect sense when it guarantees third-party processing and extremely valuable free medical documentation. Massive savings to SSA is virtually guaranteed, and why duplicate what the private insurer has already performed? SSA and the HIAA are just beginning discussions in very superficial and general areas. We propose leap-frogging ahead and creating a direct "operational link" between SSA and the private disability insurer, with the SSA regulated authorized claimant representative serving as the intermediary to protect the integrity of SSA and the interests of both SSA and the disabled individual. Such "linkage" between SSA and private insurers by authorized claimant representatives has unofficially been in existence for 11 years on a relatively small basis. Let's make it official and massive, especially when guaranteed massive savings to SSA is the return.

- Expedited Electronic Access. Current reengineering plans call for electronic access by the authorized claimant representative in 1999. Given the scope of this demonstration proposal and its potential impact on SSA, we suggest that the current timetable be revisited. It can only help to expedite current electronic access plans. Electronic access to verify insured status, submit claims, update the record, and perform a host of other activities currently performed by SSA, will be of immeasurable value to SSA. Performed by the authorized claimant representative, subject to the necessary safeguards, it also provides SSA and the individual the maximum protection against fraud and abuse. It would be the ideal vehicle to expedite and maximize the growth of the authorized claimant representative in the SSA disability process. An entire new industry and critical SSA partner is available now, and their participation would be radically expedited if electronic access is expedited.

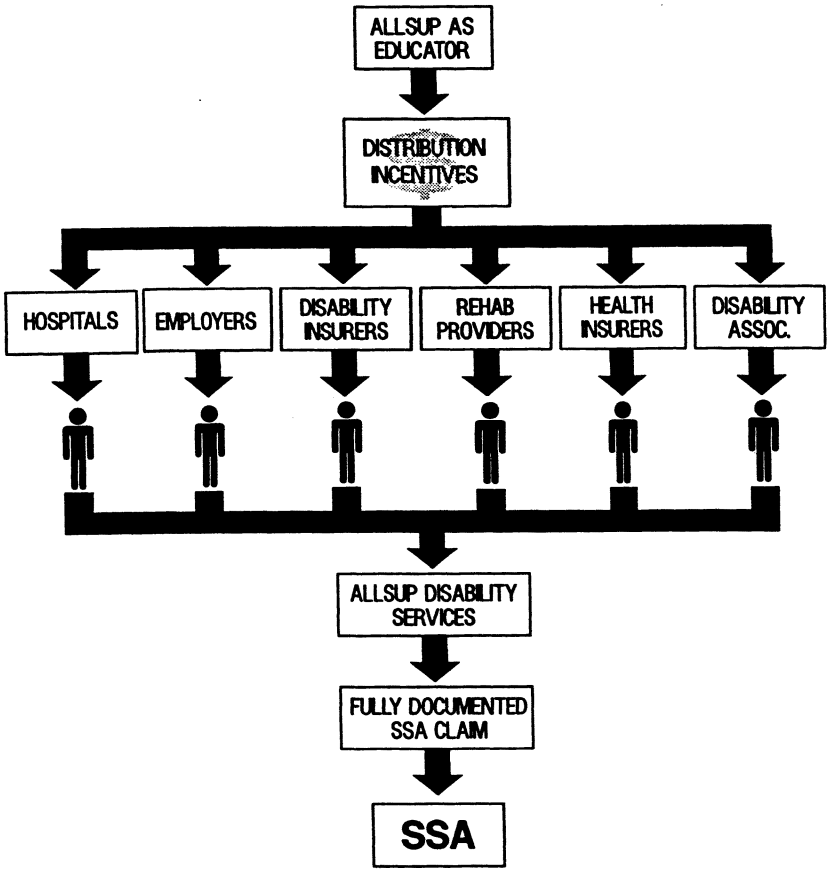
We recognize elements of this proposal may appear radical to many, but quite frankly, radical measures are needed. We stand ready and willing to work with SSA starting now to discuss and implement this proposal. We want to help, we know we can help, if given the opportunity. We request that opportunity.

Traditional SSA Distribution System



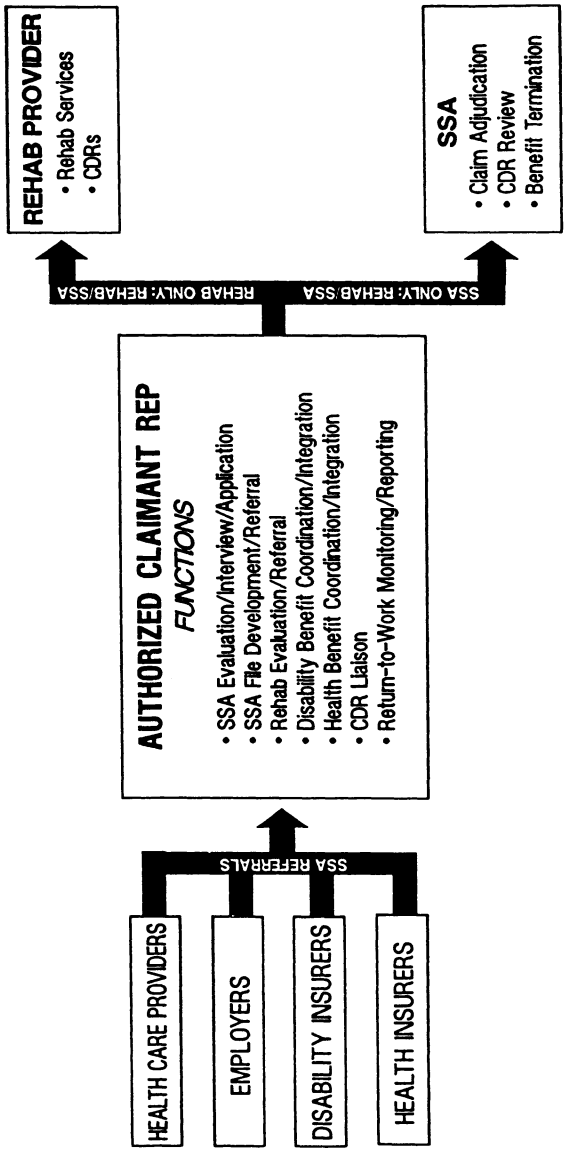
INDIVIDUAL SSA OFFICE

Allsup SSA Distribution System



Distribution Incentives
SSA Award
Monthly Income
COBRA Extension
Medicare Entitlement
Rehab Reimbursement

SSA Disability Management Redesign



Anticipated Demonstration Savings

Both administrative savings through third-party processing assistance and trust fund savings through rehabilitation and return to work will occur. These savings are measurable in advance based on past performance as listed below. What is not measurable in advance because it is unprecedented would be the rehabilitation provider participation in continuing disability reviews and the authorized claimant representative's expanded role into post entitlement management. We will therefore not address these two functions of our proposed demonstration.

- Information obtained from SSA indicates the current average cost for the processing of a disability claim is $1,667 per claim. In our demonstration, our authorized claimant representative will perform every function associated with the processing of a claim other than adjudication and payment. This will include initial evaluation and insured status verification, interview, completion of all relevant application forms, full medical development and documentation and a brief analysis of the relevant medical listing(s) and/or vocational rule(s) supporting a payment decision. Assuming demonstration claim volume of at least 15,000 claims at savings to SSA of $1,667 per claim, administrative savings to SSA in this demonstration would be at least $25,005,000. Additionally, one major disability insurer demonstration partner estimates that for each disability claim it processes, an average of $700 per claim is spent on medical and vocational development and documentation. Since the majority of claims in our demonstration would be referrals from disability insurers and employers, but many do not spend $700 per claim for such documentation, we will assume an average expenditure per claim of $300. Since this documentation would automatically be referred to SSA at no cost to SSA, we will estimate total "added value" in this demonstration at 15,000 claims to be $4,500,000. Thus, total administrative savings and "added value" would amount to $29,505,000.

- Trust Fund Savings. Information from SSA indicates that the average SSA monthly benefit is currently $660, with the average duration for receipt of DI benefits being six years. Based on these averages, 15,000 DI recipients awarded SSA benefits without access to rehabilitation services would yield total trust fund expenditures of $712,800,000 over a six year period. Past performance of our rehabilitation provider participants indicates 22% of their cases return to work within six months of referral. But due to the unknown factors such as short term and partial disabilities in this population, and SSA's nearly non-existent rehabilitation experience, we will utilize various return to work ratios within six months, beginning at a 5% return to work ratio and increments of 10%, 15% and 20% At 5%, a total of 750 individuals out of 15,000 could be expected to return to work. This would result in reduced trust fund outlays of $26,730,000. Subtract from this $1,725,000 for the return-to-work cost of rehabilitation services, net trust fund savings would be $25,005,000 over the expected six year benefit period. Add to this the $29,505,000 in anticipated administrative savings, total savings would be at least $54,510,000 or a 7.6% reduction in total trust fund outlays over the expected six year benefit period. These savings would increase further if our return to work ratio's exceed 5% as portrayed in the attached savings scenarios, and if we are granted the participation we propose in continuing disability reviews and fraud and abuse prevention through return to work monitoring and reporting.

Projected Benefits
SSA Trust Fund Savings Scenario
Based Upon 5% Return to Work Ratio

Total population in demo project = 15,000 people

Cost without project=
$660 month* x 15,000 people = $713 million in benefits paid over six years**

* average Social Security Disability benefit
** average Social Security benefit duration

Rehabilitation Savings

Rehabilitation of 750 people over six years

Gross benefit savings = $26.7 million

Return-to-Work Rehabilitation costs for 750 people =

Cost of Rehabilitation = $1.7 million*

* average rehabilitation cost of $1,850 per case, (averaged between $1,700 - $2,000 per case, with $2,000 being the maximum fee for rehabilitation services) plus $450 per case for full functional capacity evaluation.

Total net benefit savings =

$ 26.7 million gross benefit savings
-1.7 million rehabilitation costs
$ 25.0 million net benefit savings

Social Security Benefit Cost Savings

15,000 cases =

$29.5 million in case development costs and case management savings

Total Savings = Administrative Costs & Benefits Savings

$ 25.0million net benefit savings
$ 29.5 million administrative savings

$54.5 million Total Savings = 7.6% reduction in total trust fund outlays

Projected Benefits
SSA Trust Fund Savings Scenario
Based Upon 10% Return to Work Ratio

Total population in demo project = 15,000 people

Cost without project =
$660 month* x 15,000 people = $713 million in benefits paid over six years**

* average Social Security Disability benefit
** average Social Security benefit duration

Rehabilitation Savings

Rehabilitation of 1,500 people over six years

Gross benefit savings = $54 million

Return-to-Work Rehabilitation costs for 1,500 people =

Cost of rehabilitation = $3.4 million*

* average rehabilitation cost of $1,850 per case, (averaged between $1,700 - $2,000 per case, with $2,000 being the maximum fee for rehabilitation services) plus $450 per case for full functional capacity evaluation.

Total net benefit savings =

$ 54.0 million gross benefit savings
-3.4 million rehabilitation costs
$ 50.6 million net benefit savings

Social Security Benefit Cost Savings

15,000 cases =

$29.5 million in case development costs and case management savings

Total Savings = Administrative Costs & Benefits

$ 50.6million net benefit savings
$ 29.5 million administrative savings

$ 80.2 million Total Savings = 11.2% reduction in total trust fund outlays

Projected Benefits
SSA Trust Fund Savings Scenario
Based Upon 15% Return to Work Ratio

Total population in demo project = 15,000 people

Cost without project =
$660 month* x 15,000 people = $713 million in benefits paid over six years**

* average Social Security disability benefit
** average Social Security benefit duration

Rehabilitation Savings

Rehabilitation of 2,250 people over six years

Gross benefit savings = $80 million

Return-to-Work Rehabilitation costs for 2,250 people =

Cost of rehabilitation = $5.2 million*

* average rehabilitation cost of $1,850 per case, (averaged between $1,700 - $2,000 per case, with $2,000 being the maximum fee for rehabilitation services) plus $450 per case for full functional capacity evaluation.

Total net benefit savings =

$ 80.0 million gross benefit savings
- 5.2 million rehabilitation costs
$ 74.8 million net benefit savings

Social Security Benefit Cost Savings

15,000 cases =

$29.5 million in case development costs and case management savings

Total Savings = Administrative Costs & Benefits

$ 74.8 million net benefit savings
$ 29.5 million administrative savings

$104.3 million Total Savings = 14.6% reduction in total trust fund outlays

Projected Benefits
SSA Trust Fund Savings Scenario
Based Upon 20% Return to Work Ratio

Total population in demo project = 15,000 people

Cost without project =
$660 month* x 15,000 people = $713 million in benefits paid over six years**

* average Social Security disability benefit
** average Social Security benefit duration

Rehabilitation Savings

Rehabilitation of 3,000 people over six years

Gross benefit savings = $107 million

Return-to-Work Rehabilitation costs for 3,000 people =

Cost of rehabilitation = $6.9 million*

* average rehabilitation cost of $1,850 per case, (averaged between $1,700 - $2,000 per case, with $2,000 being the maximum fee for rehabilitation services) plus $450 per case for full functional capacity evaluation.

Total net benefit savings =

$ 107.0 million gross benefit savings
- 6.9 million rehabilitation costs
$ 100.1 million net benefit savings

Social Security Benefit Cost Savings

15,000 cases =

$29.5 million in case development costs and case management savings

Total Savings = Administrative Costs & Benefits

$100.1 million net benefit savings
$ 29.5 million administrative savings

$129.6 million Total Savings = 18.2% reduction in total trust fund outlays

Functional Assessment Rehabilitation Costs For Population Not Returning To Work

5% Return To Work Ratio: 750 individuals return to work
14,250 balance

25% - full functional capacity evaluation
3,562 @ $450 = $1,602.900

45% - upper extremity evaluation only
6,413 @ $225 = $1,442,925

TOTAL Functional Assessment Costs = $3,045,825

Balance of 30% (4,275) receive no functional capacity evaluation because of terminal illness, sever disabilities, etc.

10% Return To Work Ratio: 1,500 individuals return to work
13,500 balance

25% - full functional capacity evaluation
3,375 @ $450 = $1,518,750

45% - upper extremity evaluation only
6,075 @ $225 = $1,366,875

TOTAL Functional Assessment Costs = $2,885,625

Balance of 30% (4,050) receive no functional capacity evaluation because of terminal illness, severe disabilities, etc.

Functional Assessment Rehabilitation Costs For Population Not Returning To Work

15% Return To Work Ratio: 2,250 individuals return to work
12,750 balance

25% - full functional capacity evaluation
3,187 @ $450 = $1,434,150

45% - upper extremity evaluation only
5,738 @ $225 = $1,291,050

TOTAL Functional Assessment Costs = $2,725,200

Balance of 30% (3,825) receive no functional capacity evaluation because of terminal illness, sever disabilities, etc.

20% Return To Work Ratio: 3,000 individuals return to work
12,000 balance

25% - full functional capacity evaluation
3,000 @ $450 = $1,350,000

45% - upper extremity evaluation only
5,400 @ $225 = $1,215,000

TOTAL Functional Assessment Costs = $2,565,000

Balance of 30% (3,600) receive no functional capacity evaluation because of terminal illness, severe disabilities, etc.

Chairman BUNNING. Thank you very much.

We would like to ask you some questions, obviously.

Jim, I know how my constituents feel about the disability programs that we have with SSDI and with SSI. We are trying to deal with SSDI right now. What kind of constituent feedback do you get from your district offices and your constituents about the reliability and the backlog and all the things that occur specifically to your district? I would appreciate if you can give me an idea. If you have the same experience that I have in my district and that other people have, I am sure that we know we need to change the system.

Mr. MCCRERY. There is no question, Mr. Chairman, that for those people who are attempting to get some action through the system, it is a terribly inefficient system. We do get a number of complaints, and I am sure, as you do, we get a ton of case work from people who are attempting to get through the system.

But on the other side, Mr. Chairman, from constituents who are not in the disability system but are in the work force and seeing other people who appear to them to be perfectly capable of working and yet are in the system and receiving disability, it kind of irks them. I get a number of complaints like that, as well.

That is where I think this technology could play a role, ultimately, in providing an objective standard and an objective testing procedure to make sure that those people who are capable do not stay on disability but get back into the work force.

Chairman BUNNING. One of the big problems that came up yesterday was the backlog was in CDRs. We are looking at 2 million people that need to be reviewed in a 3-year period. The Social Security Administration told us that they reviewed like 100,000 or a little over 100,000 last year, and we are not even close to fulfilling the requirements of the law.

My biggest problem, Jim, is what Mr. Dakos has talked about regarding the physical aspects of the ability to work. How would we get around the mental impairments that sometimes create a problem?

Mr. MCCRERY. That is a problem that is not directly related to this technology. It is only in terms of the physical capability of the individual. This technology does not have any direct application to mental impairments, and I do not think Mr. Dakos is putting it forward as that. I will let him address that.

Chairman BUNNING. Go right ahead.

Mr. DAKOS. Thank you, Mr. McCrery.

We actually do address the 20 mental residual functional capacities outlined by the Social Security Administration in the evaluation process. In the ERGOS, we have created cognitive distraction in the evaluation process——

Chairman BUNNING. Meaning what?

Mr. DAKOS. What you need to be able to do so that you do not have an individual focused on the disability but going more to the function that is required in the work. You create a distraction so that you do not have the individual focused upon the disability—if you ask him, how is your back feeling, he is going to tell you, it feels awful. However, if you have him going through an activity that requires the individual to perform functions that may not have him focusing on the back but, let us say, counting, doing part of

a process or a game, what takes place is that the function overtakes the focus on the physical disability.

Chairman BUNNING. But what about the mental impairment that might be creating the physical disability?

Mr. DAKOS. You mean the subjective complaint?

Chairman BUNNING. Whatever it might be.

Mr. DAKOS. We monitor the subjective. We also, during the entire process of the evaluation, allow the individual to self-report what their subjective discomfort is. But we also have the individual's heart rate monitored during the course of the entire evaluation so that if they are experiencing discomfort, there should be an associated increased heart rate that takes place.

We have also built into it the use of the coefficient of variation, which shows the consistency of the effort that takes place during all strength requirement activities. In other words, is the individual trying to deliberately manipulate the evaluation process? So we can discern that, as well.

We have observed behaviors which have been rated by the industrial psychologists on our team, which outline specifically what functions may be impacted on the 20 mental residual functional capacities during the course of the evaluation.

Chairman BUNNING. That have to be measured under the Social Security disability?

Mr. DAKOS. Correct.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. Thank you, Mr. Chairman.

I like the chairman's opening statement, as I may have indicated, because the word "draconian" does not belong in a system of justice. Draconian is if you are not eligible for the granting of a claim, the claim is not granted. Justice means that if you are, it is granted. Determining which is which is the imponderable of civilized society since the dawn of creation to do justice.

I think that, Mr. Dakos, you have a tool that advances by quantums that quest for truth. I note, too, that some of the most genteel organizations who deal with so-called disability adopt as their slogan, "It is the ability, not the disability, that counts."

So I think that if in the seats of authority, if you speak about whether the person does have ability, despite whatever disability there is—I have 10 percent disability from combat in the Marine Corps in the infantry. Some of my critics would say I have some of that other kind of disability, too, I suppose. But somehow or other, a majority has thought that maybe I could fill this job. As Mr. McCrery or any other Member of Congress will tell you, it is not a full-time job, it is an overtime job.

So I think we should say for the record that nobody is being mean, nobody is being cruel, nobody is advocating frontier justice. That has happened on occasion in the past in the Social Security system. There have been suicides as a consequence of it, and it is a sad chapter.

But your invention, this machine, I think, is a wonderful thing, and again, Mr. McCrery, I do not endorse a particular product, but this general technology is one of the best things that has ever come before us, I think, for the Social Security system.

When I was practicing law, I had a case where a young woman was in a filling station while the wheels on her car were being balanced and the machine flew apart somehow or another and struck her in the knee. Boy, I will tell you, she was a pathetic figure. Her limp was very pronounced, and each time she limped, the expression of pain on her face evoked empathy. However, when we had our pretrial conference, the insurance company showed the films they had taken of her as a Girl Scout leader and she was running like a gazelle across a park.

So President Kennedy in his inaugural said, "Sincerity is always subject to proof," and I do not think you insult anybody by subjecting him or her to this kind of objective evaluation.

The question I want to ask, you touched on it and I liked what I heard. The real plague to the system is the subjective. The question of pain has always been the most obscure. You say that you, to some extent, you can monitor pain. I say I cannot walk on my leg and you look into my heart and say I can hardly wait to get out to the park and run. Could you expand on that just a little bit? That is my only question.

Mr. DAKOS. Sure. The way that we take care of that, we always obtain a baseline blood pressure and resting heart rate with an individual. We also monitor the heart rate prior to the commencement of any repetitions necessary for performance of any of the physical tasks and then at the completion. If the individual is experiencing discomfort, there will be an associated heart rate increase.

In fact, I had a specific case that took place with the Postal Service where, frankly, it was thought that maybe this individual was faking it. She went through pushing, pulling, she was doing lifting, and, frankly, when she went down into a lifting position to pick up, on a static force lifting activity at ankle height, all of a sudden her heart rate shot up by 35 beats per minute, which more or less, a good way of putting it, is it objectified the subjective complaint. She was experiencing discomfort, and, in fact, she went through the three-repetition trial for performing lifting at ankle height and it even accelerated a little bit further.

So when I was asked by the Post Office, they said, Oh, was she faking? I said, gentlemen, you have a problem you need to address, and that is this individual cannot perform lifting below the level of the knees on a safe basis. So we are looking at safe capability to perform work. The Post Office, in turn, modified her job duties and it was quite inexpensive. They simply made it so that she did not have to perform lifting on two lower shelves within her delivery truck. This was instead of having to pay significant disability moneys and significant additional medical expenses trying to find the answer.

Mr. JACOBS. So there is a tinge of the polygraph in the procedure.

Mr. DAKOS. We do not like to refer to it as a polygraph, but we do need a heart rate monitoring to take place.

Mr. JACOBS. For purpose of elucidation, though, it does follow President Kennedy's injunction that sincerity is subject to proof.

I think it is a great technology, and I like ERGOS. Thank you.

Mr. DAKOS. Thank you.

Chairman BUNNING. Mr. Portman.

Mr. PORTMAN. Let me just commend Jim McCrery for all the work he has done in the disability area. It is a very difficult area to work in. It is very emotional. It is an area of great controversy, and I think Jim McCrery has rolled up his sleeves and really dug into the program in a responsible way. He has come up with a lot of interesting and provocative ideas, some of which helped us tremendously in the welfare reform debate at the subcommittee and committee level.

I think his bringing you, Mr. Dakos, I assume Mr. McCrery was somewhat responsible for your presence here today, is another example of him forcing us to look at some of the ways in which we can improve the system and get more objectivity in the review process.

My big concern, Mr. Chairman, I think, is the one you shared, which is the tremendous backlog and the inability of us through the CDRs to come up with a way to process people more quickly. If you can do that, obviously, we will see a reduction in the rolls, assuming that there is some objective criteria that can be applied.

So I am very enthused by what I hear today and, again, commend Jim McCrery for pushing the issue.

I would ask one question, and maybe this is, Mr. Dakos, inappropriate to address to you, maybe more to the chairman, and that is what kind of legislative remedy would we be talking about in order to change the redesign process at this point? I understand that by the year 2000, SSA would have a redesign. Do we need legislation to try to——

Chairman BUNNING. We would have a backlog of about 3 million by then, if they do not come up with something a lot quicker.

Mr. PORTMAN. So one of the purposes of this subcommittee hearing today, I take it, is to try to highlight some areas where we might be able to see even more aggressive use of technology, whether it is computerization or Mr. Dakos's technology, to try to come up with a way to get that backlog down.

I appreciate your coming today and hope we will continue to work with you at the subcommittee level and through the SSA.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Payne.

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

Mr. Dakos, I, too, thank you and was very impressed with and enlightened by what you have to say.

I do not know if you have an answer to this, but I was thinking about the impact on the administrative cost if a device or a technique like yours was able to be implemented in the process through which people qualify to be on the system, or if it is utilized for people who are on the system to determine if they should continue to be on the system. Do you have any idea about what the impact might be on the cost of administration and to the disability fund if such a technique were implemented?

Mr. DAKOS. First off, I know in speaking with the reengineering team that they do not have an actual cost in mind. Valuations that have been performed on a full functional basis have run anywhere from $450 to, in the State of Hawaii, it is $795, but this is generally in the Workman's Comp. industry.

So overall costs, I would imagine, coming in with the size of this project and the nature, the costs could be reduced, based upon the sheer quantity of numbers that will be provided in this evaluation process. If you are looking at costs in terms of savings to the trust fund, I think you will be able to reduce the numbers on the disability rolls and reintegrate people back into the labor force who thought they had no chance of getting back, and I think that number is far more significant than the costs of the evaluation process.

Mr. PAYNE. Is there any way to know or to begin to quantify what that number might be so that there is some kind of a cost-benefit ratio?

Mr. DAKOS. We can do it by example that we have through our Workman's Comp. experience and how much they have been able to reduce expenses. From what I have been advised, Toyota was able to reduce by nearly 90 percent, but they have a very active reintegration program at their plant in Kentucky. The experience that we have had with the Post Office, just on five cases, they indicated $329,000, not including additional medical services and their costs which would have been rendered through the continuation of being on disability.

Mr. PAYNE. Are any of those case studies, the numbers, are they available that we might make them a part of this record? If I could have those, I think it would be very helpful as we look into how we best deal with this going forward.

Mr. DAKOS. We will be glad to provide those and Journal of Occupational Medicine studies that have also been conducted using the instrument.

[The following was subsequently received:]

June 9, 1995

WORK RECOVERY, INC.
2341 S. Friebus, Suite 14
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520-322-6634
Toll Free 1-800-332-3746
Fax 520-325-5277

Phil Moseley, Chief of Staff
Committee on Ways and Means
U.S. House of Representative
1102 Longworth Building
Washington DC 20515-6348

RE: Committee on Ways and Means, Subcommittee on Social Security, Hearing on Improving the Social Security Disability Insurance Program, Held on May 24, 1995 - Testimony of Mark S. Dakos.

Dear Mr. Moseley:

Enclosed please find the corrected transcript of my testimony given before the Subcommittee on Social Security, on May 24, 1995.

On page 15, line 324, I noted a correction that probably is intended on the testimony of Mr. Jacobs. The word "abdicating" should probably be changed to "advocating".

On page 21, commencing with line 480, Mr. Payne asked if there were any case studies or numbers which might be made a part of the record. I am including copies of the two Journal of Occupational Medicine studies which were specifically referenced in my testimony. I am also enclosing a copy of a third, yet unpublished, study that was conducted using the ERGOS™Work Simulator.

I have been in contact with the Social Security Administration subsequent to my testimony, and it was indicated that a cost-benefit study has not been conducted on the use of the functional capacity evaluation in the Social Security Disability income determination process. The studies in which we have been involved are not a direct cost-benefit analysis specific to the Social Security Disability Insurance program. We are in the process of soliciting an expert opinion from the actuarial community in order to develop an appropriate projection of the cost-benefit specifically applicable to the Social Security Administration. The results of this study will be forwarded as soon as it is completed.

Once again, thank you for providing Work Recovery with the opportunity to testify before the Subcommittee. Should you have any questions, please feel free to contact me here at Work Recovery.

Very truly yours,

Mark S. Dakos, M.S.

MSD:kmh

Enclosures: Transcript of Mark S. Dakos; JOM Volume 35, Number 8 and Volume 36, Number 7; and "Validity of Mechanical vs. Clinical Evaluations of Worker Fitness and Risk: Psychologic Influences" (unpublished)

The third unpublished study is being retained in the Committee files.

JOM • Volume 35, Number 8, August 1993

Concurrent Validity of the ERGOS Work Simulator Versus Conventional Functional Capacity Evaluation Techniques in a Workers' Compensation Population

Laureen A. Dusik, MSc, MD
Michael R. Menard, MD, PhD
Christopher Cooke, MPE, EdD
Susan M. Fairburn, BSc
Gregg N. Beach, BPE

A prospective blinded cohort study was performed in an interdisciplinary vocational evaluation program to investigate the concurrent validity of the ERGOS work simulator in comparison to current methods of evaluation. Seventy men and eight women, aged 22 to 64 years, who attended for a 2-week physical capacity assessment participated in the study. Physical activity factors as defined by the Canadian Classification and Dictionary of Occupations and the American Dictionary of Occupational Titles were assessed for all subjects under three evaluation conditions: the ERGOS work simulator, an exercise-oriented physical evaluation by a rehabilitation therapist, and performance of project-format industrial tasks. In addition, 17 men and 7 women were assessed with VALPAR standardized work sample tests. The statistical significance of the relationships between results obtained by the various evaluation methods was examined. There was a strong correlation between the ERGOS dynamometry and the clinical assessment of strength for all standard movements tested ($P < .001$). The Methods Time Measurement rating by the ERGOS for dexterity variables, according to industrial engineering standards, tended to rate subjects as more restricted than did the clinical evaluators. There was a significant relationship ($P < .001$) between the "overall physical activity rating" from ERGOS dynamometry, clinical evaluation, and performance in an industrial workshop setting. There was also a significant relationship ($P < .001$) between the "overall physical activity rating" for endurance of a full workday produced by the 4-hour ERGOS evaluation and by the 2-week functional capacity evaluation. The results of this study indicate that a 4-hour ERGOS evaluation yields information on strength and endurance for industrial physical activity that is comparable with the information obtained from a comprehensive interdisciplinary 2-week functional capacity evaluation performed in multiple settings.

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The goal of vocational rehabilitation is to return an injured worker to suitable work. To accomplish this, it is necessary to match the physical tolerances of the worker with the relevant physical demands of the job.[1,2]

Compilations of information on jobs were originally developed for vocational counseling of uninjured workers. This is a process similar to vocational rehabilitation except that, of course, there is a greater likelihood of residual impairment after rehabilitation from an injury. The first formal compilation of information on jobs published by the US Department of Labor (Dictionary of Occupational Titles, or, DOT)[3] presented only a concise description of typical duties for each named job.

Subsequent research in industrial engineering led to the inclusion of the physical capacities, education, aptitudes, interests, etc, that were believed to be required for average successful job performance.[4] To reduce the incidence of "overexertion" injuries, guidelines were created in various jurisdictions concerning the weight a worker should be required to handle.[5] Research in several vocational contexts indicated that the risk of injury was increased if the physical demands of the job were high relative to the physical capacity of the worker.[5,6] The current approach to worker fitness and risk evaluation evolved from these sources, as a special area of occupational medicine.[7]

The current edition of the American DOT and of the Canadian Clas-

sification and Dictionary of Occupations (CCDO)[8] are widely used in vocational counseling. Implicit in such use is the requirement for assessment of the physical capacities of the person being counseled. It was a natural development to use the "government-approved" measurements developed for vocational counseling in this process of assessing risk. The validity of this practice has not been proven; however, it is common practice. The degree to which different methods for assessing the worker agree with each other and with the physical demands of work remains an external and concurrent validity issue.

The accepted approach to evaluation of a worker's strength and endurance follows principles originally developed by Pruitt and coworkers at the University of Wisconsin-Stout[1] and later expanded by Matheson[9] and Blankenship.[10] It involves observation of the worker during performance of realistic work samples of known physical demand, over a succession of days. This can be labor-intensive, time-consuming, and costly.

More recently, similar information on functional capacity has been sought through the use of work simulation devices. The ERGOS (Work Recovery, Tucson, Ariz) uses work elements derived from industrial engineering studies, and compares the worker's performance to international standards that are gender- and race-neutral. Tolerance for activity over a workday is inferred from performance at increased intensity for shorter periods, essentially according to the data in the National Institute for Occupational Safety and Health (NIOSH) Work Practices Guide for Manual Lifting.[5] The ERGOS thus is designed to produce job-relevant capacities and tolerances from a physical evaluation that lasts only a few hours.

The present study examines the relationship between the information provided by the ERGOS and that provided by a more extensive functional capacity evaluation. Workers who were participating in a functional evaluation were reviewed using two techniques: with a 2-week integrated multidisciplinary evaluation, and with the ERGOS. The assessment of functional capacity as indicated by selected dependent variables produced by the two approaches was then analyzed and compared.

Methods

Subjects

All subjects attended the Functional Evaluation Unit (FEU) of the Leslie R. Peterson Rehabilitation Centre of the Workers' Compensation Board of British Columbia between October 22 and December 20, 1991 for a 2-week functional capacity assessment. All subjects were referred for evaluation following rehabilitation from injuries that had arisen during the course of their usual employment, and all were experiencing difficulty returning to their pre-injury occupation.

During the 9-week test period there were 78 ERGOS test slots available, based solely on availability of personnel. Of a total of 128 patients admitted to the FEU during the intake period, 34 men and 9 women were excluded from the study. The reasons for exclusion were: 3 men failed to show up for evaluation; 7 men and 3 women failed to complete the 2-week evaluation; 1 man and 1 woman failed to complete the Rehabilitation Therapy Physical Evaluation (RTPE); 10 men and 3 women had injuries to body areas other than the low back or the limbs; 8 men and 1 woman had significant difficulty speaking or comprehending English; 4 men and 1 woman had significant behavioral difficulties; and 1 man had significant cardiac disease. Of the 85 eligible subjects 6 men and 1 woman were not tested as there were insufficient test slots available, leaving 70 male and 8 female test subjects.

The characteristics of the study subjects are shown in Table 1. Included in the "other" injury area category are: 4 men with injuries to more than one of the area groups (2 subjects with multiple fractures of the upper limbs, 1 subject with multiple fractures of one lower limb and both upper limbs, and 1 subject with fractures of the low back and one lower limb), 2 men with nerve injuries, 2 men with Raynaud's disease, 1 man with multiple trauma to an upper limb, 1 man with a femoral midshaft fracture, 1 man with carpal tunnel syndrome and shoulder bursitis, 1 woman with midshaft fractures of the radius and ulna, and 1 woman with bilateral carpal tunnel syndrome.

Included in the "other" injury type category are: 17 men with intervertebral disc herniation treated surgically, 4 men with intervertebral disc protrusion treated non-surgically, 2 men with Raynaud's disease, 2 men with meniscal tears (knees), 2 men with degenerative joint disease (knees), 1 man with recurrent shoulder dislocations, 1 man with multiple trauma to a limb, 1 man with joint separation (acromioclavicular joint), 1 man with spinal stenosis, 1 man with ulnar neuropathy, 1 man with brachial plexus trauma, and 1 woman with arachnoiditis.

The pre-injury job for each subject was categorized into the CCDO major occupational groups. For the men, the distribution of occupational groups was as follows: 29% in construction trades, 16% in product fabrication, 14% in forestry and logging, 10% in machining, 6% in transport equipment operation, 6% in material handling, 4% in processing, 4% in sales, 4% in mining and quarrying, and 7% in other types of employment. For the women, the distribution of occupational groups was as follows: 37.5% in medicine and health, and 12.5% each in management and administration, sales, processing, material handling, and product fabrication.

Functional Evaluation Unit, Workers' Compensation Board of British Columbia, Richmond, British Columbia, Canada (Dr Dusik, Dr Menard, Dr Cooke, Ms Fairburn, Mr Beach); and the Division of Physical Medicine and Rehabilitation, Department of Medicine, St. Paul's Hospital, Vancouver, British Columbia, Canada (Dr Menard).

Address correspondence to: Dr Christopher Cooke, Functional Evaluation Unit, Workers' Compensation Board of British Columbia, 6951 Westminster Highway, Richmond, British Columbia, Canada, V7C 1C6.

JOM • Volume 35, Number 8, August 1993

TABLE 1
Subject Characteristics

Variable	Men	Women
Sample size	70	8
Age (yr)		
Mean	45.1	43.7
Range	22–64	23–56
Height (cm)		
Mean	178.3	165.7
Range	147–197	155–174
Weight (kg)		
Mean	87.4	70.6
Range	61–137	54–91
Time since injury (mo)		
Mean	53.8	29.0
Range	1–309	11–76
Injury area (%)		
Low back	41.4	50.0
Shoulder	14.3	0
Elbow	4.3	0
Wrist/hand	7.1	0
Knee	8.6	12.5
Ankle/foot	8.6	12.5
Other*	15.7	25.0
Injury type (%)		
Strain	28.6	62.5
Fracture	24.3	25.0
Other*	47.1	12.5
Surgery (%)		
No	37.1	37.5
Yes, this injury	58.6	50.0
Yes, previous similar injury	4.3	12.5

* See text for explanation.

Evaluation Regimen

All subjects completed an intake interview with a vocational evaluator. Based on this interview and referral information from the subject's rehabilitation consultant, an individualized 2-week evaluation program was developed. Of the 78 ERGOS test subjects, all had a physical capacity assessment by a rehabilitation therapist (RTPE) and all were assigned shop tasks in the Industrial Department. In addition, 24 subjects (17 men and 7 women) completed one or more VALPAR standardized work sample tests (Valpar Corporation, Tucson, Ariz).

For some subjects, additional information was obtained through biomechanical testing and occupational therapy testing. Eleven subjects (all men) underwent dynamometry of specific body segments. Seventeen subjects (9 men and 8 women) had occupational therapy testing (including office simulation, clerical tasks, keyboarding, hand dexterity testing, job-specific VALPAR tests, and coordination testing). However, this information was not suitable for direct comparison with the ERGOS tests that were selected for this study and so was excluded.

Upon completion of the 2-week assessment a discharge interview was held between the subject and their vocational evaluator. At this time the subject's performance and the evaluator's recommendations were briefly discussed. A final report was then forwarded to the subject's rehabilitation consultant.

CCDO Physical Activity Factors

Physical Activity (PA) is one of the job requirements characterized in the CCDO[8] and similarly in the DOT[3] used in the United States. The PA rating for a job represents the physical requirements of the occupation as well as the physical capacities a worker must have to fulfill these requirements.[8] In the CCDO there are eight factors that make up the PA. Factor 1 is strength, which includes the activities of lifting, carrying, pushing, and pulling. Strength is categorized into sedentary, light, medium, heavy, and very heavy ratings according to the amount of weight handled and the frequency of handling.[8] The other PA factors are climbing and balancing (factor 2), body dexterity, including stooping, kneeling, crouching, and crawling (factor 3), reaching, handling, fingering, and feeling (factor 4), talking (factor 5), hearing (factor 6), seeing (factor 7), and operation of controls (factor 8). (For a more detailed explanation of the CCDO factors the reader is referred to the CCDO manual.) The American DOT classification system[3] is very similar to the CCDO. The main differences are that talking and hearing are categorized as one factor (factor 5A and 5B, respectively), and operation of controls is not a DOT factor.

Assessment Methods

ERGOS Work Simulator. ERGOS is a computerized functional capacities assessment simulator. It provides objective documentation of the worker's performance compared to the DOT classification system, NIOSH Work Practices Guide for Manual Lifting, and Methods Time Measurements (MTM) standards for workers of the same age and sex.[11]

ERGOS consists of five 7.5-foot × 4-foot panels (or work stations) arranged in a pentagon. A computer monitor and speaker system are incorporated into each panel to provide simultaneous visual and verbal task instructions. Panel 1 measures static strength during isometric lifting, pushing and pulling, and dynamic strength using a progression of free lifts, at various positions from ankle to shoulder height. Panel 2 assesses whole-body range of motion and involves standing, balancing, stooping, kneeling, crouching, reaching, and manual dexterity. Panel 3 assesses work endurance through integrated repetitive selecting/sorting, lifting, carrying, walking, and climbing activities. Panel 4 assesses standing work tolerance using conveyor work activi-

ties. It involves walking, stooping, reaching, handling, and the sorting of pool balls in numerical order. Panel 5 assesses a variety of seated work tasks and upper limb functions. However, for the purposes of this, study Panel 5 was used only to assess grip strength and handling, and to screen vision and hearing. Note that all panels indirectly assess vision and hearing.

During the second week of assessment in the FEU, all subjects underwent an ERGOS evaluation by a diagnostic technician who had been certified in its use. The ERGOS generated a standardized summary report of each subject's performance following testing. Units of measure are as follows: strength activities (factor 1) are in pounds, dexterity activities (factors 3 and 4) are in MTMs, hearing is in Hertz and decibels, and vision is in Snellen equivalents. The particular ERGOS regimen used in this study required 2.5 to 4 hours to conduct, and an additional 15 to 30 minutes for ERGOS to output the summary report.

Rehabilitation Therapist Physical Evaluation. All subjects underwent a physical evaluation by a rehabilitation therapist during the first week of assessment in the Functional Evaluation Unit. This structured, exercise-oriented evaluation was designed to assess individual physical tolerances consistent with the guidelines established by the CCDO in the strength categories of pushing, pulling, lifting and carrying, grip strength, climbing and balancing, body dexterity, reaching, handling, and coordination (C. Cooke, unpublished data, 1990). The subject was questioned as to any difficulties with hearing or vision. Performance of these factors was recorded on a standard report form. Discrepancies or inconsistencies in performance were also documented. Strength factors were measured in pounds. The remaining PA factors were recorded descriptively. The RTPE takes 60 to 90 minutes to conduct and an additional 2 hours to generate the written report.

SHOPS Tasks. More than 60 separate industrial tasks were available in a project format in a variety of industrial work environments (carpentry, inside general, sheet metal, machine shop, welding, automotive, small motor, upholstery, furniture refinishing, outside general, and lifting program) through an Industrial Department Task Inventory Program. These industrial tasks range from sedentary to very heavy in their strength requirements, consistent with the classifications in the CCDO and DOT. The tasks have also been defined by the other PA factors required to perform the project.

All tasks were originally designed to simulate actual working conditions and physical demands of industrial jobs as closely as possible (C. Cooke, unpublished data, 1990). Tasks were administered and monitored by shop instructors who are trained tradesmen. Subjects were assigned to individual programs by their vocational evaluator based on demonstrated capabilities following completion of the RTPE. Over the course of the 2-week evaluation subjects were gradually progressed as tolerated through more physically demanding tasks until maximal demonstrated tolerance levels were achieved.

Task performance was recorded on a standard report form by the shop instructor. Individual strength factors were not assessed and therefore could not be compared to the ERGOS and RTPE results. The other PA factors were recorded descriptively. The overall PA rating was based on the most demanding shop task that the subject was able to complete successfully during the course of the 2-week evaluation.

VALPAR Work Sample Tests. The VALPAR Component Work Sample Series consists of 19 standardized work samples designed to assess worker characteristics from the DOT,[12] which are equivalent to those from the CCDO.

Of the 24 subjects who underwent testing on one or more of the VALPAR work samples, 9 men and 5 women completed VALPAR no. 9, the whole body range of motion work sample; 5 men and 6 women completed VALPAR no. 5, the clerical comprehension and aptitude work sample; 7 men completed VALPAR no. 4, the upper-extremity range-of-motion work sample; 2 men completed VALPAR no. 11, the eye-hand-food coordination work sample; and 1 man completed VALPAR no. 8, the simulated assembly work sample.[12]

In addition, 7 men completed the WEST Bus Bench work sample (Work Evaluation Systems Technology, Long Beach, Calif), designed to assess upper-extremity dexterity and coordination through disassembly and assembly of a metal structure resembling a bus bench.

Performance on these work samples was recorded on standard report forms supplied by the manufacturer. Strength factors were not assessed and therefore could not be compared with the ERGOS and the RTPE strength results. The remaining PA factors that were examined by each specific work sample were recorded descriptively. In addition, performance of the complete work sample or a major portion of the work sample (eg, disassembly, assembly, etc) was timed. However, because performance of several PA factors was included in each of the recorded times, the timed results were not used for this study. An overall PA rating was not produced by VALPAR testing because none of the work samples assessed all of the PA factors.

Comparison of Assessment Methods

Table 2 shows a summary of the ERGOS, the RTPE, the Industrial SHOPS, and the VALPAR physical capacity evaluation methods. The PA factors of fingering and feeling (included in factor 4) were not assessed directly by RTPE testing and therefore were excluded from the study. The PA factors of climbing and balancing (factor 2), crawling (included in factor 3), talking (factor 5), and operation of controls (factor 8) were not assessed formally by ERGOS and therefore were excluded from the study.

Individual strength (factor 1) variables were assessed directly only by the ERGOS and the RTPE testing. However, there were differences between these assessment techniques that might be important. Lifting was performed "dynamically" (essentially,

TABLE 2
Summary of Physical Capacity Evaluation Methods Used in the Functional Evaluation Unit

CCDO PA Factor	ERGOS*	RTPE	SHOPS	VALPAR‡
1. Strength				
Lifting	+ 1(3)	+		–
Carrying	+ 3(4)	+	†	–
Pushing	+ 1	+		–
Pulling	+ 1	+		–
2. Climb/balance				
Climbing	obs (3)	obs	obs	–
Balancing	obs (1–4)	obs	obs	–
3. Body dexterity				
Stooping	+ 2(1,3,4)	obs	obs	V.9
Kneeling	+ 2	obs	obs	V.9
Crouching	+ 2(1,4)	obs	obs	V.9
Crawling	–	obs	–	–
4. Reach/handle/finger/feel				
Reaching above shoulder height	+ 2(1,3)	obs	obs	V.9
Reaching below shoulder height	+ 2(1,3–5)	obs	obs	V.1,4,5,8,9
Handling	+ 5(2–4)	obs	obs	V.1,4,5,8,9,12,WBB
Fingering	+ 5(2)	–	obs	V.1,4,5,8,9,12,WBB
Feeling	+ 5	–	–	–
5. Talking	obs (all)	obs	obs	obs
6. Hearing	+ 5(1–4)	obs	obs	obs
7. Seeing	+ 5(1–4)	obs	obs	obs
8. Controls	obs (2,4)	obs	obs	V.11,12
Other				
Grip strength	+ 5	+	obs	–

+ = PA factor was measured; obs = PA factor was observed only; – = PA factor was not tested.

* Numbers refer to ERGOS panel that directly assessed each PA factor. Numbers in parentheses refer to ERGOS panels that indirectly or secondarily assessed each PA factor.

† Strength factors were assessed in the SHOPS by performance of tasks categorized into the CCDO ratings of sedentary to very heavy (see text). AS = above shoulder height, BS = below shoulder height.

‡ V = VALPAR (number refers to specific VALPAR work sample); WBB = WEST Bus Bench.

isotonically) for both evaluation methods. The distance from the floor to the various test heights was 26 inches for ERGOS and 29 inches for the RTPE bench/hip height, and 55 inches for ERGOS and 54 inches for the RTPE shelf/shoulder height. However, ERGOS testing involved lifting from floor level to test level for both lifting heights, whereas the RTPE assessment involved lifting from floor level to hip level and then from hip level to shoulder level. In addition, the weight containers were of different dimensions and had different handle arrangements for the two testing methods.

Assessment of carrying with ERGOS involved lifting a weighted plastic container from varying shelf heights, carrying the container 10 feet, performing other tasks, and then carrying the weighted container 10 feet back to its original location. The assessment of carrying with the RTPE testing involved carrying a dumbbell in each hand over varying terrain (ramp, stairs, etc), and over a distance of at least 25 feet.

Pushing and pulling were tested "statically" (isometrically) with ERGOS. Although the pushing and pulling tasks were performed using both upper limbs simultaneously, ERGOS measured and recorded the results from each upper limb separately. The average of each upper limb over three repetitions was then averaged to obtain the result for each task. "Shoulder" height was individually set so that the subject's acromioclavicular joint was at a mid-handle position. "Below shoulder" height was fixed at 42 inches. Pushing upwards was performed at "shoulder" height. Pushing and pulling were tested "dynamically" (essentially, isotonically) with the RTPE assessment. The maximum weight that could be pushed or pulled for three repetitions was used for the result of each task. "Shoulder" height was fixed at 50 inches. Pushing and pulling at this level involved moving weights attached to a pulley system. However, for this task alone, only one upper limb was tested at a time. "Below shoulder" height tasks consisted of pushing or pulling a ground-level, weighted sled. Pushing upwards involved using a weighted barbell from the subject's shoulder height.

Grip strength was tested using a JAMAR grip dynamometer (Asimow Engineering Co., Los Angeles, Calif) in both testing situations. However, with ERGOS testing, the maximum of three repetitions at position 2 was used. For the RTPE testing, usually only one attempt was performed but all five testing positions were assessed. Only the results at position 2 were compared in this study.

For ease of comparison, the PA factors other than strength were dichotomized into "unrestricted" and "restricted" categories. The ERGOS results, which were measured in units of MTMs (stooping, kneeling, crouching, reaching, and handling) were categorized as "restricted" for MTM scores of less than 80% ("entry level" performance or poorer). ERGOS results measured in MTM scores greater than or equal to 80% ("competitive level" performance or better) were categorized as "unrestricted." ERGOS results for hearing were coded as "restricted" if the subject heard fewer than 50% of the tones in one ear or fewer than 75% of the tones bilaterally. ERGOS vision results were coded as "restricted" if the subject was unable to see better than 20/40 in one or both eyes. Descriptive results from the RTPE, the Industrial SHOPS tasks, and VALPAR work sample testing were categorized as "restricted" if the

TABLE 5
Comparison of Overall PA Ratings for Men

	RTPE				
	S	L	M	H	VH
ERGOS vs RTPE (n = 68) $\kappa = .629, P < .0001$*					
ERGOS					
S	**2**	3	–	–	–
L	5	**14**	9	–	–
M	–	7	**22**	4	–
H	–	–	–	**1**	1
VH	–	–	–	–	–
RTPE vs SHOPS (n = 70) $\kappa = .385, P = .00035$*					
RTPE					
S	–	**6**	1	–	–
L	–	**12**	14	–	–
M	–	10	**20**	1	–
H	–	–	2	**2**	1
VH	–	1	–	–	–
ERGOS vs SHOPS (n = 68) $\kappa = .407, P = .00025$*					
ERGOS					
S	–	5	–	–	–
L	–	**13**	15	–	–
M	–	8	**22**	3	–
H	–	1	–	–	1
VH	–	–	–	–	–
ERGOS vs FEU (n = 68) $\kappa = .66, P < .0001$*					
ERGOS					
S	**2**	2	1	–	–
L	–	**21**	7	–	–
M	–	6	**25**	2	–
H	–	–	–	**1**	1
VH	–	–	–	–	–

S, sedentary; L, light; M, medium; H, heavy; VH, very heavy.
* Weighted κ analysis (see text).

it means that this information could be more readily available to counselors.

Pairwise comparisons of the overall PA ratings produced by the ERGOS, the RTPE, and the Industrial SHOPS were found to have a "moderate" or better level of agreement, and all were statistically significant at the $P < .001$ level. There were consistently lower PA ratings by ERGOS in comparison with the RTPE and with the SHOPS, and of the RTPE in comparison with the SHOPS. This was because to achieve a particular rating (sedentary to very heavy) from ERGOS testing

TABLE 6
Comparisons of Overall PA Ratings for Women (n = 8)

	RTPE				
	S	L	M	H	VH
ERGOS vs RTPE					
ERGOS					
S	**1**	–	–	–	–
L	–	**5**	–	–	–
M	–	1	**1**	–	–
H	–	–	–	–	–
VH	–	–	–	–	–
RTPE vs SHOPS					
RTPE					
S	–	1	–	–	–
L	1	**5**	–	–	–
M	–	1	–	–	–
H	–	–	–	–	–
VH	–	–	–	–	–
ERGOS vs SHOPS					
ERGOS					
S	–	1	–	–	–
L	1	**4**	–	–	–
M	–	2	–	–	–
H	–	–	–	–	–
VH	–	–	–	–	–
ERGOS vs FEU					
ERGOS					
S	**1**	–	–	–	–
L	1	**4**	–	–	–
M	–	2	–	–	–
H	–	–	–	–	–
VH	–	–	–	–	–

S, sedentary; L, light; M, medium; H, heavy; VH, very heavy.

all requirements for that rating had to have been met. In contrast, the overall PA rating from the RTPE tended to be an "average" of the subject's abilities, and the rating from the SHOPS was based on "maximal performance" (the most physically demanding industrial task the subject was able to complete). Thus it is not surprising that this pattern was seen among these three approaches to PA rating. Based on the assumption that the risk of injury is less when the worker's physical capacity is greater than the physical demands of the job, it seems reasonable to suppose that the injured worker will have a lower probability of re-injury in a job declared feasible on the basis of the ERGOS rating. It will be important to do outcome studies to test this hypothesis.

It is notable that there was a "substantial" level of agreement between the extrapolated PA rating for endurance of an 8-hour workday from the 4-hour ERGOS evaluation, and from the 2-week functional capacity evaluation. The endurance at a particular PA level is inferred from brief intense performance on the ERGOS, but is observed as actual performance during the 2-week FEU evaluation. This finding supports the use of the NIOSH approach of predicting the capacity to work at a certain level of intensity for a whole day, as incorporated in the ERGOS protocol.[5]

Strength (PA factor 1) measurements by ERGOS were found to correlate well with observations of actual manual material handling (RTPE). The results showed that the strengths measured by the ERGOS closely reflect the strengths measured during clinical evaluation according to the CCDO/DOT PA definitions. Furthermore, ERGOS provided additional information on all strength variables (except carrying), since it recorded force production versus time, on serial trials. This additional information is not generally used in the context of vocational counseling. However, it is widely believed to provide useful information on physical capacity and on sincerity of effort during testing.[9] Therefore, its use in this context deserves further study.

The assessment of dexterity variables (PA factors 3 and 4) by ERGOS was found, overall, to relate poorly with the assessments by the other evaluation methods. One explanation for this may be because the ERGOS, using the MTM standards, classified subjects as "restricted" much more frequently than did the other (clinical) evaluation methods. For example, for Stooping, ERGOS classified 35 of 65 subjects as "restricted" (MTM < 80), whereas the RTPE classified only 1 subject as "restricted." If the analysis is repeated with "restricted" defined as MTM < 70 (below "entry level" for competitive employment) for ERGOS, then 23 of 65 subjects are classified as "restricted," the statistical significance increases from $P = .18$ to .08, and the κ increases from .03 to .06.

The significance of this pattern for vocational rehabilitation is not clear. For the subjects in this study, medical treatment and physical rehabilitation had been completed, and they were believed to be ready to return to work. Therefore, it could be argued that they should, at a minimum, be expected to satisfy the 'entry level' MTM standard (MTM score of 70 to 80). The MTM has been validated as an industrial engineering standard,[11,15] and it seems reasonable to hypothesize that it is valid in the context of vocational rehabilitation. However, the validity of the more restrictive MTM assessment versus the "clinical" assessment in the context of vocational rehabilitation can only be determined from a different type of study, with examination of relevant outcomes such as success in returning to work.

The assessments of hearing and vision (PA factors 6 and 7, respectively) by ERGOS were also found to relate poorly to the assessments by the other evaluation methods. ERGOS assessed these variables "directly" using standard vision and hearing screening tests. The classification into "restricted" and "unrestricted" categories was based on the "functional limits" set by the ERGOS manufacturers. Although the other evaluation methods used a "functional limit" to categorize these variables, a "restricted" rating depended upon the observation, during the performance of tasks, of difficulties that could be attributed to visual or auditory problems (SHOPS and VALPAR evaluations), or to questioning the subject as to whether they had any problems with their vision or hearing (RTPE). It is known that people tend to accommodate to minor visual or auditory impairments that develop gradually. The direct testing by ERGOS classified subjects as "restricted" more frequently than did the other evaluation methods. Thus ERGOS testing probably detects sensory deficits that would be missed by a nonspecific clinical evaluation.

In conclusion, the results of this study demonstrate the concurrent validity between the ERGOS and the conventional functional capacity evaluation for acquisition of the specific information on physical ability that is currently used in vocational rehabilitation. However, it should be noted that these results do not show whether the ERGOS and the conventional functional capacity evaluation are "equally correct" or "equally incorrect" in terms of the final outcome of the process of vocational rehabilitation in which they are used. Unfortunately, few validity studies have been done in this field and there are no "gold standards."

Future studies should address the issue of outcome. In vocational rehabilitation, the critical outcome is successful return to work. Of particular importance to the present study is the finding by Cooke (unpublished data, 1990) that in a workers' compensation setting, a group of 25 workers who underwent a physical capacity assessment were significantly more successful in vocational placement than were a group of 25 workers who had only job search training (72% vs 28%, respsectively). However, studies of outcome are complicated by the strong influence of psychosocial factors. Indeed, even the "objective" measurement of physical strength and movement by dynamometry is confounded by behavioral factors.[16,17] It will be important to study the influence of behavioral factors on the PA assessment produced by the ERGOS, and to determine how the availability of information on PA influences the outcome of vocational rehabilitation.

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References

1. Pruitt WA. *Vocational Evaluation*, 2nd ed. Menomonie, Wisc: Walter Pruitt Associates, Publishers; 1986.
2. Grandjean E. *Fitting the Task to the Man: A Textbook of Occupational Ergonomics*, 4th ed. Basingstoke, Hants, UK: Taylor and Francis Ltd; 1988.
3. *Dictionary of Occupational Titles*, 4th ed. US Department of Labor, Washington, DC: U.S. Government Printing Office; 1977.
4. Jacobs K, Wyrick J. Use of Department of Labor references and job analysis. In Hertfelder S, Gwin C, eds. *Work in Progress*. Rockville, Md: American Occupational Therapy Association; 1989;23–51.
5. National Institute for Occupational Safety and Health. U.S. Public Health Service publication no. 81-122: *Work Practices Guide for Manual Lifting*, 1981.
6. Troup JDG, Edwards FC. *Manual Handling and Lifting*. London, England: Her Majesty's Stationery Office; 1985.
7. Himmelstein JS. Worker fitness and risk evaluation in context. In Himmelstein JS, Pransky GS, eds. *Occupational Medicine State of the Art Reviews*. Philadelphia: Hanley & Belfus, Inc; 1988;3: 169–178.
8. *Canadian Classification and Dictionary of Occupations*. Ottawa, Ontario: Employment and Immigration Canada; 1987.
9. Matheson LM. *Work Capacity Evaluation: A Systematic Approach to Industrial Rehabilitation*. Anaheim, Calif: Employment and Rehabilitation Institute of California Publications; 1987.
10. Blankenship KL. *Industrial Rehabilitation*. Macon, Ga: American Therapeutics Inc; 1988.
11. ERGOS Work Simulator Administration Manual. Tucson, Ariz: Work Recovery Centers, Inc; 1987.
12. VALPAR Component Work Sample Series Manuals. Tucson, Ariz: Valpar Corporation; 1986.
13. Landis RJ, Koch GG. The measurement of observer agreement for categorical data. *J Biometrics*. 1977;33:159–174.
14. Fleiss JL. *Statistical Methods for Rates and Proportions*. New York: John Wiley & Sons; 1981:219–232.
15. Dales HE. *Work Measurement*. New York: Pitman; 1972:219–239.
16. Hirsch G, Beach G, Cooke C, Menard M, Locke S. Relationship between performance on lumbar dynamometry and Waddell score in a population with low-back pain. *Spine*. 1991;16;1039–1043.
17. Cooke C, Menard MR, Beach GN, Locke SR, Hirsch GH. Serial lumbar dynamometry in low back pain. *Spine*. 1992;17:653–662.

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Relationship of Performance on the ERGOS Work Simulator to Illness Behavior in a Workers' Compensation Population with Low Back versus Limb Injury

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A prospective blinded cohort study was performed to test for a difference in the pattern of physical activity factors measured with the ERGOS work simulator in subjects with low back injuries versus those with limb injuries. Also tested was the relationship between physical activity factors measured with the ERGOS and several psychological tests and measures of nonorganic pain behavior in subjects with low back pain. Subjects were 70 men, 22 to 64 years old, who attended a 2-week physical capacity assessment after undergoing rehabilitation for a work-related injury. In subjects with a complaint of low back pain, nonorganic pain behavior was measured with the Waddell score. In addition, two brief psychological tests, the Coopersmith Self-Esteem Inventory and analog self-rating of wellness, were administered. It was found that subjects with low back complaints underperformed globally in comparison with subjects with limb complaints. This underperformance was statistically significant ($P < .05$) for 7 of 13 strength variables and 2 of 7 dexterity variables. In the subjects with low back complaints, those who exhibited excessive illness behavior (Waddell score, 3 to 5) performed significantly worse on all 13 strength variables and on 3 of 7 dexterity variables. In the subjects with low back complaints, those with low self-assessment ratings were found to have a high Waddell score ($P < .01$) and to perform significantly worse ($P < .05$) on 12 of 13 strength variables and 6 of 7 dexterity variables. There were no significant relationships ($P > .05$) between Coopersmith Self-Esteem score and Waddell score or performance on ERGOS testing. The results indicate that disability behavior in injured workers tends to be greater after a low back injury than after a limb injury.

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Of the various types of work-related injuries, it has been reported that the likelihood of return to work is lowest for back injuries, regardless of the vocational rehabilitation interventions applied.[1] The reasons for this are not well understood, but it has been noted that in the majority of chronic low back complaints a physical cause is not detectable even if a thorough medical work up is done.[2-4] Thus it is not possible to direct a specific treatment at an organic process in these patients.

The recommended approach for such chronic pain conditions is to acknowledge that any organic process that might be responsible for the pain in this situation is not going to lead to skeletal or neurologic impairment. The focus is then shifted to the disability behavior, rather than to the experience of pain, and therapy aims to encourage and facilitate an increase in the level of physical activity in the patient.[5,6] That is, a behavioral approach to treatment is taken for patients with this type of problem.

There is evidence that, whatever physical factors might be involved, purely behavioral factors are important in low back pain.[7] In particular, we recently found that motor performance on lumbar dynamometry correlates with certain psychological measurements in people with chronic low back pain.[8,9] We found a similar correlation of physical performance to psychological measurements during "nonback" dynamometry testing in people with chronic low back pain, although the effect is less prominent than that found on back-related dynamometry.[10]

These results have important implications for vocational rehabilitation. The goal of vocational rehabilitation for injured workers is to recover the former capacity and tolerance for a specific vocational activity.[11-13] Capacity and tolerance are evaluated by observing the worker's performance on work samples of known physical demand over the course of several days. Recently, work simulation devices have become available to assist in the evaluation process.

The ERGOS work simulator is such a device. We have reported that the ERGOS provides information comparable with that obtained during observation of work sample performance.[14] Because the ERGOS evaluation is similar to a battery of dynamometric tests, we hypothesized that there would be a correlation between performance and psychologic variables during motor performance evaluation on the ERGOS. We tested this hypothesis by analyzing the performance on the ERGOS work simulator of a cohort of workers' compensation patients with low back or with limb ("nonback") complaints.

Methods

Subjects

The study population was a representative sample of subjects who had been injured during the course of their work, but who were experiencing difficulty returning to their preinjury employment and who had been referred for a 2-week functional capacity assessment. Details of the inclusion criteria and subject characteristics have been given previously.[14] Only the results for men are considered here (Table 1).

Included in the "other" injury type category in Table 1 are 17 men with intervertebral disc herniation treated surgically, 4 men with intervertebral disc protrusion treated nonsurgically, 2 men with Raynaud's disease, 2 men with meniscal tears, 2 men with degenerative joint disease (knees), 1 man with repetitive shoulder dislocations, 1 man with multiple trauma to a limb, 1 man with joint separation (acromioclavicular joint), 1 man with spinal stenosis, 1 man with ulnar neuropathy, and 1 man with brachial plexus trauma.

TABLE 1
Subject Characteristics for Men

Variable	Limbs	Backs		
		All	Low Waddell Score	High Waddell Score
Sample size	41	29	22	7
Age (y)				
Mean	45.66	r 44.28	42.27	50.57
SD	11.06	10.0	9.95	7.72
Height (cm)				
Mean	177.05	180.00	181.14	176.43
SD	7.85	7.80	7.36	8.62
Weight (kg)				
Mean	86.12	89.31	91.55	82.29
SD	13.90	15.22	16.18	9.43
Time since injury (mo)				
Mean	38.93	74.93	62.41	114.29
SD	52.44	91.15	74.82	129.60
Injury type (%)				
Strain	34.1	20.7	13.6	42.9
Fracture	39.0	3.4	0	14.3
Other	26.8	75.9	86.4	42.9
Surgery (%)				
No	39.0	34.5	22.7	71.4
Yes, current*	58.5	58.6	68.2	28.6
Yes, previous†	2.4	6.9	9.1	0

* Surgery after current injury.
† Surgery after a previous similar injury.

Evaluation Regimen

As described previously,[14] all subjects underwent ERGOS evaluation during the second week of the 2-week evaluation. Physical activity (PA) rating from the Canadian Compendium and Dictionary of Occupations (CCDO)[15] is almost identical to that in the US Dictionary of Occupational Titles.[16] The individual activities are shown in Table 2. The ERGOS computerized functional capacities assessment simulator was described previously.[14]

Tests of Nonorganic Pain Behavior and Psychological Tests

Waddell Score. A screening examination was performed of all subjects by one of the authors (LAD) before ERGOS testing. During the course of the examination of the subjects with back complaints, the worker's response to the maneuvers described by Waddell and coworkers[17] was recorded.

Coopersmith Self-Esteem Inventory. A modified, short form of the Coopersmith Self-Esteem Inventory[8] was administered to all subjects after the screening examination. Verbal assistance for administration of the test was provided when the subject had difficulty for whatever reason.

Self-Assessment Rating. At the time of examination, subjects were asked to rate their general feelings about their current overall state of health on a scale from 0 to 100, with 100 representing full recovery. Responses were recorded as percentages.

Blinding

The diagnostic technician responsible for collecting ERGOS data was not aware of the results of the clinical examination nor of the psychological tests when performing the ERGOS testing. The clinical and ERGOS evaluations were recorded on separate data forms at the time of assessment. Statistical analysis of the data was not performed until all subjects had been tested.

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TABLE 2
Means and Standard Deviations for ERGOS Physical Activity (PA) Variables in Men Grouped by Injury Area

Ergos PA Variables	Backs, Mean (SD) (n = 29)	Limbs, Mean (SD) (n = 41)	P
Strength (lbs)			
Lifting*			
SL knuckle	52.28 (33.48)	86.51 (44.91)	.0003
SL bench	45.62 (27.71)	58.07 (25.85)	.0165
SL ankle	52.58 (32.59)	67.46 (30.63)	.0428
SL shoulder	44.52 (31.42)	59.80 (27.96)	.0133
DL bennh	39.07 (21.88)	58.66 (24.90)	.0022
DL shelf	27.50 (14.37)	31.76 (11.80)	.220
Carrying	51.48 (21.70)	61.95 (23.34)	.0694
Pushing			
Cart push	33.55 (19.82)	39.80 (15.37)	.0138
Shoulder push	27.79 (13.77)	32.17 (11.50)	.0826
Pulling			
Cart pull	30.59 (12.93)	34.88 (7.62)	.0608
Shoulder pull	23.41 (8.69)	26.93 (4.79)	.0222
Grip strength			
Right	107.12 (43.92)	100.92 (43.04)	.542
Left	108.77 (48.21)	104.85 (38.12)	.644
Body Dexterity (MTMs)			
Stooping	60.71 (21.86)	87.59 (21.53)	.000
Kneeling	69.59 (24.79)	88.77 (27.00)	.0075
Crouching	71.76 (24.90)	87.27 (27.90)	.0730
Reach/handle (MTMs)			
Reaching			
Above shoulder height	69.70 (15.61)	69.12 (14.88)	.930
Below shoulder height	66.57 (16.23)	65.88 (13.61)	.946
Handling			
Right	98.00 (22.10)	95.44 (26.67)	.773
Left	97.42 (22.59)	100.10 (19.43)	.957
Hearing†	20/7	32/7	.636
Vision†			
Far	25/2	36/2	1.00
Near	24/1	35/3	.926

* SL, static (isometric) lifts; DL, dynamic lifts.
† Numbers of subjects with "unrestricted"/"restricted" ratings for hearing and vision.
MTM, method-time measurement unit (14).

Data Analysis

Raw scores were entered from the data forms into a database program (dBaseIV, Ashton-Tait, Torrance, CA, 1984) on a Compaq 386 personal computer (Compaq, Houston, TX) and analyzed with the SPSS/PC+ (Version 3.1, SPSS, Chicago, IL, 1989) using Pearson r correlation analysis or the Mann-Whitney U test for continuous data and χ^2 analysis for categorical data.

Results

Biodemographic Variables

Each of the biodemographic variables shown in Table 1 for the "limb" and "back" groups was compared using the Mann-Whitney U test or χ^2 analysis. The subjects with low back complaints had been off work significantly longer ($P < .05$) than those with limb injuries. There was a highly significant difference ($P < .001$) in the injury type between the two groups. This is partly because few of the people with back injuries had a fracture, but also because of the nature of the classification scheme, where disc protrusions could only be sustained by those in the back group.

Distribution of Waddell Scores in Low Back Injuries

Of the 29 men with a history of low back complaints, 3 had a Waddell score of 0, 10 had a score of 1, 9 had a score of 2, 3 had a score of 3, 4 had a score of 4, and none had a score of 5. Following the recommendation of Waddell and coworkers,[17] scores were dichotomized into low (0 to 2) and high (3 to 5) categories. This resulted in 22 scores in the "low Waddell score" group, and 7 scores in the "high Waddell score" group. This distribution of Waddell scores is similar to that for previous studies.[8–10,17]

For each of the biodemographic variables shown in Table 1, the values for the "low" and "high" Waddell groups were compared using the Mann-Whitney U test or χ^2 analysis. There was a significant difference ($P < .05$) in the type of injury between the two groups, where for the low Waddell group, none had had a fracture and more had had an identifiable condition such as disc protrusion. No significant differences ($P > .05$) were found for the other biodemographic variables, although the high Waddell group tended to have fewer surgical interventions and a longer time interval since injury (Table 1).

Waddell Score versus ERGOS PA Variables for Back Subjects

Table 3 shows the mean value for the PA variables (Strength, Body Dexterity, and Upper Limb Dexterity) for the 22 male subjects with a low Waddell score versus the 7 with a high Waddell score. The Mann-Whitney U test was performed for each of these variables. For all 13 strength variables, the low Waddell group performed significantly better than the high Waddell group ($P < .05$). Of the 7 dexterity variables, 3 showed significantly better performance in the low Waddell group. There was no significant difference ($P > .05$) for the dexterity variables of crouching, reaching above or below shoulder level, or handling with the right hand.

Logistic regression was performed on all strength and dexterity variables that showed a significant difference between the high and low Waddell groups to determine which variables showed the strongest differentiation. The analysis was controlled for age, height, weight, time since injury, and CCDO job type. It was found that when kneeling, static lifting at bench

TABLE 3
Means, Standard Deviations, and *P* Values for ERGOS Physical Activity (PA) Variables in Low and High Waddell Groups

Ergos PA Variables	Low Waddell, Mean (SD) (n = 2)	High Waddell, Mean (SD) (n = 7)	*P*
Strength			
Lifting*			
SL knuckle	60.36 (34.18)	26.86 (12.21)	0.13
SL bench	53.23 (27.48)	21.71 (7.78)	.0024
SL ankle	58.20 (31.47)	24.50 (24.66)	.025
SL shoulder	52.05 (32.03)	20.86 (12.51)	.0086
DL bench	44.29 (21.75)	20.83 (9.17)	.013
DL shelf	30.24 (14.27)	16.00 (8.22)	.036
Carrying	55.68 (21.40)	33.00 (11.51)	.024
Pushing			
Cart push	37.86 (20.54)	20.00 (8.62)	.015
Shoulder push	30.55 (14.27)	19.14 (7.54)	.039
Pulling			
Cart pull	33.91 (12.82)	20.14 (6.07)	.0039
Shoulder pull	25.73 (8.32)	16.14 (5.37)	.0069
Grip strength			
Right	117.75 (35.72)	71.67 (53.27)	.044
Left	120.60 (40.33)	69.33 (54.91)	.033
Body dexterity (MTMs)			
Stooping	65.60 (19.65)	36.25 (16.19)	.015
Kneeling	75.36 (21.23)	44.20 (25.25)	.016
Crouching	74.47 (24.14)	46.00 (21.21)	.072
Reach/handle (MTMs)			
Reaching			
Above shoulder	71.36 (16.46)	62.40 (8.88)	.33
Below shoulder	69.68 (16.54)	55.17 (8.66)	.061
Handling			
Right	102.35 (20.06)	83.50 (24.19)	.10
Left	102.80 (20.17)	79.50 (22.44)	.026
Hearing†	15/6	5/1	.953
Vision†			
Far	19/2	6/0	1.00
Near	20/1	4/0	1.00

* SL, static (isometric) lifts; DL, dynamic lifts.
† Number of subjects with "unrestricted"/"restricted" ratings for hearing and vision.
MTM, method-time measurement unit (14).

height, and static lifting at ankle height were entered into the analysis, no other variables had significant predictive value.

For completeness, the CCDO PA factors that do not involve motor performance, the "coded" factors of vision and hearing, were analyzed with χ^2 analysis. No significant difference was found between the Waddell groups ($P > .05$).

Psychological Tests versus ERGOS PA Variables

Significant correlations were found between Self-Assessment and 12 of the 13 ERGOS strength (PA Factor 1) variables (Pearson $r = .44$ to $.60$, $P < .01$, except static lift at knuckle and bench heights, $r = .40$ to $.42$, $P < .05$). Only one variable, carrying, was not found to be significant ($r = .32$, $P = .052$). Significant correlations were also found between Self-Assessment and 6 of the 7 ERGOS dexterity (PA Factors 3 and 4) variables ($r = .53$ to $.63$, $P < .01$, except crouching and reaching below shoulder level, $r = .33$ to $.44$, $P < .05$). Only one variable, reaching above shoulder height, was found not to be significant ($r = .19$, $P > .05$).

No significant correlations were found between the Coopersmith Self-Esteem score and either the ERGOS strength variables ($r = -.025$ to $-.21$, $P > .05$), or the ERGOS dexterity variables ($r = -.19$ to $.29$, $P > .05$).

No significant correlations were found between the Coopersmith Self-Esteem score or the Self-Assessment score and the ERGOS results for vision (factor 6) or hearing (factor 7) ($P > .05$, Mann-Whitney U test).

Psychological Tests versus Waddell Score

The mean score for the Coopersmith Self-Esteem test was not significantly different between the low and high Waddell groups (93.7, SD 14.6, and 95.7, SD 10.1, respectively). The mean value of the Self-Assessment rating was significantly different between the low and high Waddell groups (45.2, SD 25.1, and 12.0, SD 12.5, respectively). Significantly more subjects with low Self-Assessment ratings also had high Waddell scores ($P = .004$). The statistically significant positive relationship between Self-Esteem and Self-Assessment found in a previous study with more subjects[8] was not confirmed in the present study (Pearson $r = -.38$, $P = .022$, n = 28).

Limb Injuries

Similar analyses were performed for the group of subjects with injuries to the limbs but no complaints related to the back. Statistically significant relationships were found between Self-Assessment score and 9 of the 13 ERGOS strength variables, and 5 of the 7 ERGOS dexterity variables ($P < .05$).

No significant correlations were found between the Coopersmith Self-Esteem score and either the ERGOS strength variables ($r = -.18$ to $.23$, $P > .05$), or the ERGOS dexterity variables ($r = -.043$ to $.16$, $P > .05$).

No significant correlations were found between the Coopersmith Self-Esteem score or the Self-Assessment score and the ERGOS results for vision (factor 6) or hearing (factor 7) ($P > .05$, Mann-Whitney U test).

Discussion

The results show a statistically significant difference between subjects

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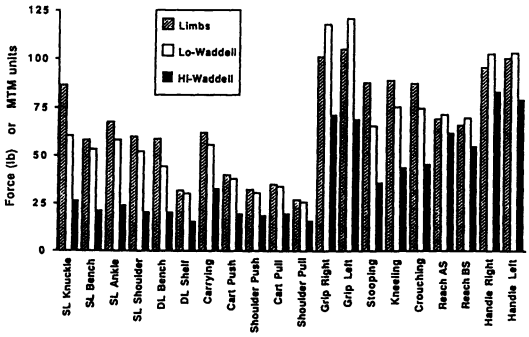

Figure. Mean value of the ERGOS variables for the three subgroups of subjects: 41 with limb injury, 22 with low back injury, and Waddell score less than 3, and 7 with low back injury and Waddell score of 3 or more.

with low back injuries versus those with limb injuries in the pattern of PA factors measured with a state-of-the-art computerized work simulator. The subjects with low back complaints underperformed globally, on all strength variables and on all dexterity variables, in comparison with the subjects with limb complaints. This pattern is shown clearly in the figure.

Previously we have shown that the same pattern of underperformance seen with the ERGOS is seen in all types of functional capacity evaluation, including clinical examination, work under observation, and dynamometry of isolated limb segments.[8-10] This is in accord with the experience of other clinicians and evaluators. Altogether, it seems reasonable to conclude that special attention should be given to behavioral and psychosocial factors that might be limiting the performance of injured workers during their vocational rehabilitation.

Unfortunately, it is difficult to determine when underperformance is due to psychologic factors during functional capacity evaluation. Rothstein et al[18] have identified "sincerity of effort" as the single greatest threat to validity in dynamometry. The problem is that, although the associations that have been seen between psychologic tests of various sorts and objective measurements of performance, by us and by others, are statistically significant when comparing groups, the particular tests have no useful predictive value when applied to an individual. This is because the range of performance in normal subjects is so wide.[19]

In clinical practice, the usual approach is to look for inconsistency of performance during repeated testing under different circumstances: during apparently different tests that actually should be limited by the same physical factor, during testing with and without distraction, or during testing with simulated loads.[4,20] The presence of inconsistency indicates that abnormal illness behavior is present, but usually does not reveal the specific reason for the observed behavior.

It should be noted explicitly that when one observes abnormal illness behavior, one cannot immediately conclude that there is no significant biologic injury or disease present. Such behavior only indicates that the patient has a tendency to "over-react." Psychologic and behavioral studies have shown that most people have a recognizable habitual pattern of response to stress or challenge, and that the type of response a person will show can be predicted to some extent from their performance on certain psychologic tests. In the Minnesota Multiphase Personality Inventory (MMPI), a particular pattern indicates a tendency to somatize.[21] The MMPI,[22] the Coopersmith Self-Esteem Inventory,[8,9] and the Self-Efficacy measure[23] each have been found to correlate with the response to illness when the responses of groups of patients were studied.

The implication for functional capacity evaluation is twofold. First, for each test session, the tester should record a judgment of the validity of the results as indicators of maximal physical capacity, based on clinical experience. Second, those who use the results of "objective" testing to make decisions about the patient must take care to interpret the results only in the context of the complete clinical picture, which has biological, psychological, and social aspects. In summary, the conduct of objective tests, and the correct utilization of the results in vocational rehabilitation, require the judgment of an experienced clinician/evaluator.

References

1. Tate DG. Workers' disability and return to work. *Am J Phys Med Rehab.* 1992; 71:92–96.
2. Hadler NM. Regional back pain (editorial). *N Engl J Med.* 1986;315: 1090–1092.
3. Pope MH, Rosen JC, Wilder DG, Frymoyer JW. The relation between biomechanical and psychologic factors in patients with low-back pain. *Spine.* 1980; 5:173–178.
4. Waddell G. A new clinical model for the treatment of low-back pain. *Spine.* 1987; 12:632–644.
5. Fordyce WE, Roberts AH, Sternbach RA. The behavioral management of chronic pain: a response to critics. *Pain.* 1985;22:113–125.
6. Hazard RG, Genwick JW, Kalisch SM, et al. Functional restoration with behavioral support: a one-year prospective study of patients with low-back pain. *Spine.* 1989;14:157–161.
7. Coste J, Paolaggi JB, Spira A. Classification of nonspecific low back pain. I. Psychologic involvement in low back pain. *Spine.* 1992;17:1028–1037.
8. Hirsch GH, Beach GN, Cooke C, Menard MR, Locke SR. Relationship between performance on lumbar dynamometry and Waddell score in a population with low-back pain. *Spine.* 1992; 16:1039–1043.

9. Cooke C, Menard MR, Beach GN, Locke SR, Hirsch GH. Serial lumbar dynamometry in low back pain. *Spine*. 1992;17:653–662.
10. Menard MR, Cooke C, Locke SR, Beach GN, Butler TB. Pattern of performance in workers with low-back pain during a comprehensive motor performance evaluation. *Spine*. 1994, in press.
11. Pruitt WA. Vocational evaluation, 2nd ed. Menomonie, WI: Walter Pruitt Associates; 1986.
12. Matheson LN. Work capacity evaluation. Anaheim, CA: Employment and Rehabilitation Institute of California; 1987.
13. Blankenship KL. Industrial rehabilitation: functional capacity evaluation. Macon, GA: American Therapeutics Inc; 1988.
14. Dusik LA, Menard MR, Cooke C, Fairburn SM, Beach GN. Parallel reliability of the ERGOS work simulator versus conventional functional capacity evaluation in a workers' compensation population. *J Occup Med*. 1993;35:759–767.
15. Canadian classification and dictionary of occupations. Ottawa, Ontario: Employment and Immigration Canada; 1987.
16. Dictionary of Occupational Titles, 4th ed. Washington, DC: US Department of Labor; 1977.
17. Waddell G, McCulloch JA, Kummel E, Venner RM. Nonorganic physical signs in low back pain. *Spine*. 1980;5: 117–125.
18. Rothstein JM, Lamb RL, Mayhew TP. Clinical uses of isokinetic measurements: critical issues. *Phys Ther*. 1987;67: 1840–1844.
19. Chaffin DB, Andersson GBJ. Occupational biomechanics, 2nd ed. New York: Wiley-Interscience; 1991;464–474.
20. Anderson TP. Positive physical findings confirming chronic pain syndrome. *Am J Phys Med Rehab*. 1991;70:157–158.
21. Turner JA, Herron L, Weiner P. Utility of the MMPI pain assessment index in predicting outcome after lumbar surgery. *J Clin Psychol*. 1986;42:764–769.
22. Dvorak J, Valach L, Fuhrmann P, Heim E. The outcome of surgery for lumbar disc herniation: a 4–17 years' follow-up with emphasis on psychosocial aspects. *Spine*. 1988;13:1423–1427.
23. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. *Psychol Rev*. 1979;84:191–215.

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Mr. PAYNE. Thank you very much.

Chairman BUNNING. Mr. Hancock will inquire.

Mr. HANCOCK. Thank you, Mr. Chairman.

I have a couple of real quick questions. The equipment that you use only measures physical disability, am I correct?

Mr. DAKOS. No. We also, in the evaluation process, measure the mental residual functional capacities. However, there is no piece of equipment that you can "strap to the individual's brain" to ascertain the sincerity of effort in relation to organic brain disorder or function. But the evaluation takes into consideration the factors of coefficient variation, the consistency of the effort, the monitored heart rate when the individual is describing discomfort, the observed behavior, using the 20 mental residual functional capacities outlined by Social Security. Those are the primary measurements that we report as the behaviors during the course of the evaluation.

Mr. HANCOCK. But, in other words, there is no psychological evaluation actually. I would assume that if the person had in their head a psychological problem that convinced them that they were disabled, that it would show up on your machine that they were disabled?

Mr. DAKOS. It will if the consistency of the effort is good. We can interpret in terms of the inconsistencies whether or not the individual is putting forth an appropriate effort. All detail during the evaluation process is documented. An entire record is completed. In fact, it goes to the point that during every trial an individual gives, we have 2,000 data points that take place just on one repetition. Frankly, we cannot even go in and alter the record unless we want to spend years just trying to change one case.

Mr. HANCOCK. Do these people sign a release? Do you give them a full explanation of what you are going to do, and have you had anybody refuse to be evaluated?

Mr. DAKOS. They are given an implied consent release. They are also, during the course of the entire evaluation, given computer generated instructions, written and auditory, written at a sixth grade level, auditory at a third grade level of comprehension. There is a red button that they push in order to show their implied consent to proceed with the evaluation process.

What was the second part of your question?

Mr. HANCOCK. Have you had people refuse? Maybe the Workman's Comp. carrier or the business asks you to go in and be evaluated to see whether your back is really hurting. Have you had people refuse to do it?

Mr. DAKOS. I personally have not, and in the company, I am sure there have to be a couple of instances. We have done over 750,000 evaluations on ERGOS. But the individual goes through an intake interview. We do not put them on the machine immediately. We want to find out the nature of the disability, their self-report. We need to do the heart rate, resting heart rate, the blood pressure. Frankly, we need to bring down any level of anxiety prior to commencing the testing procedure.

Mr. HANCOCK. We know that there is a lot of misrepresentation and fraud. In fact, you can almost pin it down. You can go to a specific company and you will find that, repeatedly, the same things happen to different employees because the word got out. I am a

small businessman. I used to write an awful lot of Workman's Comp., even to the extent of where people would actually cut off tips of their fingers because they knew that tip was worth *x* number of dollars and they actually would abuse themselves in that manner on the job. That was the point I was trying to make.

Have you had, to the best of your knowledge, any documentation with your customers where some individual claimed to be disabled and when told they were going to be sent into your organization, all of a sudden they got well?

Mr. DAKOS. We have had a few that have not shown up, if that is the answer you are looking for.

Mr. HANCOCK. Thank you.

Chairman BUNNING. Mr. Neal.

Mr. NEAL. Thank you, Mr. Chairman.

I have just a couple of quick questions as a followup to Mr. Payne and Mr. Hancock. Is the problem, in your experience, more pronounced at the State and local level than it is with the Social Security program?

Mr. DAKOS. It is interesting. We have experience on an international basis. Frankly, the worst is in Australia. There, they have a postal system where 30 percent of their workers have an ongoing Workman's Comp. case. But we are seeing it in several States, where they are complaining about Workman's Comp., if that is the question that you are asking.

Mr. NEAL. It is, yes.

Mr. DAKOS. In fact, I will be testifying before the State of California Commission on Health, Safety, and Workman's Comp. because they are looking at changing their permanent disability evaluation system to an objective standardized system and they have asked me to be the speaker there on June 8.

Mr. NEAL. As just a followup to the question I asked, in your experience is it more pronounced at the State and local level than it is at the national level?

Mr. DAKOS. I would say it is actually running pretty even. There is one State, New Mexico, where they have changed their permanent disability system over to a functional capacity evaluation in nonscheduled disabilities, and the experience that has been reported is that people are getting along a lot better and they use the functional capacity to help reintegrate the individual back to work. So they have a model that, frankly, needs to be looked at.

Mr. NEAL. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. Mr. Chairman, I regret that I missed this gentleman's presentation.

Chairman BUNNING. So do we.

Mr. COLLINS. I have enjoyed listening to the questions and just briefly scanning his comments in the report here on the procedure. I find it very interesting and I continue to read that. If I have any further questions, we will correspond with you.

Thank you, Mr. Chairman.

Chairman BUNNING. We thank you, Mr. Dakos, for your testimony.

Mr. DAKOS. Thank you, Mr. Chairman.

Chairman BUNNING. My colleague from Pennsylvania, if he will step forward, Mr. Gekas, accompanied by Robert Lancaster and Debbie Standon.

Mr. GEKAS. Debbie has not made it, but we will try to speak on her behalf.

Chairman BUNNING. George has been interested and concerned about disability issues for quite some time. I appreciate your coming today. You may proceed.

STATEMENT OF HON. GEORGE W. GEKAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA; ACCOMPANIED BY ROBERT LANCASTER, COORDINATOR, NATIONAL REHABILITATION NETWORK, VANCOUVER, WASH.

Mr. GEKAS. Thank you, Mr. Chairman.

Last term, as we all recall, we did yeoman work with respect to the drug dealers and drug users on disability and prisoners receiving benefits, that kind of thing. I want to thank now the gentleman from Kentucky and the gentleman from Indiana, Mr. Jacobs, who accommodated me in many different ways in presenting my views on those subjects at that time. This is a kind of a followup, even though it is on a different specific subject matter.

The disability program with which you are grappling suffers from the backlog situation which has been well articulated in so many different ways. One added element that I think should come before your subcommittee is that some of us have introduced legislation to create an administrative law judge corps which, with the reorganization of the administrative law judges in the entire Federal system, we believe, will be able to focus on existing problems like backlog by a more centralized and more focused way of bringing judges to the cases. Now, we bring cases to the judges, and that may be a convoluted manner that is now obsolete.

So we ask you, as part of all of this, in a separate vein, to consider our legislation on an ALJ corps. On backlog, it would be a great help, we believe.

The second portion of the accent on disability has to do with—in my judgment, one of the big problems is how do we get people off disability once they get on, if, indeed, they no longer are disabled or as disabled as when they went on the program. That is what the testimony that we want to present here will cover, so that we can take advantage of what in the private world—like in Workman's Comp. and other situations, although that is State-related in most cases, there have been some success stories in being able to end the cycle for individuals who are receiving disability payments, where we have the converse happening. So often, people get on disability and we never have the day come when they are off disability and off the receipt of benefits for it.

In that regard, we want to bring to you, as the chairman has indicated, Mr. Robert Lancaster, who is a coordinator of the National Rehabilitation Network. He will speak for Debbie, who will communicate with the subcommittee later.

Thank you, Mr. Chairman.

Chairman BUNNING. Thank you.

Mr. Lancaster.

Mr. LANCASTER. Thank you, Mr. Gekas, Mr. Chairman, Mr. Jacobs, subcommittee members. I am going to find myself as an educator here today. I think I am going to be a teacher here today to let you know that the private rehabilitation companies around the country have been working with the private disability companies for over 15 years and that is putting people back to work, that we are not a concept, we actually exist, and the network has 200 offices around the country. We have masters' level counselors that do well at what they do, and that is putting people back to work.

We are a tried and true kind of industry. We have found what works and what doesn't work. Right now, our average case cost around the country is anywhere from $1,700 to $2,000.

From my point of view, the Social Security Administration has not yet utilized some of the models that we have found that are working in finding people jobs.

What is it that we do? There is no great secret, with the exception that we understand the capabilities of our clients. We work with their transferrable skills and we work in tandem with them in creating a goal for placement. We have found that working in partnership with our people, that they can sign off on a plan, the more likelihood we are going to have a return-to-work person. We found, on the disability syndrome, the counseling techniques and this kind of approach work.

We have found most successful is the intervention early, that our return-to-work ratios within the Workman's Comp. market and the LTD market is the sooner we get a case, the more likely the person is going to go back to work. We work with older cases, but there is an understanding that it takes longer and it costs more money.

The industry in Workman's Comp., the savings that they are recognizing as true savings is for every $1 that is spent in returning a person to work is actually $10 saved. In our proposal, we are suggesting that there be 15,000 referrals, which would be a savings to the fund of hundreds of millions of dollars.

I think our proposal is worth examination. I think it has benefits. I believe that there are true savings to the fund. I think it puts Americans back to work, because when we are dealing with these folks, they would rather work than be on disability. We disagree with people that want to be on disability. After you are working with them a little bit on a masters' level, they turn around and say, yes, if you find me a job I can do that I like, I will actually go back to work, and that is what we try to do.

The project we are talking about is a voluntary project on the part of the client, that even if he volunteers for the program, if at some point he does not like the counselor or the company, they can raise their hand and then the transfer will be executed to another partner within the network.

If you could remember that this is actually a private program, that in the network we will be very competitive with each other, that the numbers will be known on the placement rates and the dollars charged for those, and the companies that are not performing will be dropped off the provider list and another one added. So we want to create the competition, I think, that makes us in the rehabilitation field very healthy.

We are ready for the program. As mentioned, we have the offices there. The people are staffed. Someone asked, when can we start such a program on putting Social Security recipients back to work. I would say, July 1, we could start doing that, if we had a method of getting this to us.

There was some discussion about Social Security and their Project Network, which was a proposal that Cascade looked at in 1991 when it was issued. Instead of responding to that RFP, request for payment, I sent the Associate Commissioner a letter saying that in doing business with the private sector, we expect to be paid within 30 or 60 days and that for us to wait for payment for over 9 months would exclude all the private sector companies from participating. I never did get a response on that. So there is, as offered into evidence and into the record, I have that letter here saying that the private sector was not actually invited to participate in such a program and cannot get paid for 9 months.

[The prepared statements and attachment follow; Mr. Lancaster has additional comments in a joint statement on page 175.]

HON. GEORGE W. GEKAS
May 24, 1995

STATEMENT
BEFORE THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

"MANAGING THE SOCIAL SECURITY DISABILITY
INSURANCE PROGRAM"

Mr. Chairman, I want to commend you and the Committee for conducting this important hearing to look at methods to improve the Social Security Disability Program, a vital resource for disabled Americans. Redesigning the Social Security Disability Program to offer new services and resources to assist disabled workers in living productive and more fulfilling lives would offer a much needed improvement. The program currently confronts many problems: the large number of claims being filed without speedy processing while the disabled wait for decisions and services; the lack of services to assist the disabled with implementation of the Americans With Disabilities Act; and, the relatively few number of individuals who receive disability payments who ever achieve greater future earnings and leave the program. The program is an important financial resource for the disabled, but due to the lack of early intervention services for the disabled, many individuals lose meaningful contact with the world of work and their colleagues. They find themselves inadvertently trapped in a spiral of inaction and dependency that increases their frailty and does not encourage the individual to fulfill his or her potential.

I do not believe that the Social Security Administration can or should become an agency that directly provides services to the disabled other than income replacement, but it can look at the practices of private disability insurers and employers who work with the disabled. In state worker compensation cases, long-term disability insurers and employers offer early in the disability claims process services such as rehabilitation and evaluation of skills to help the individual with future plans.

To further this argument, I now introduce Robert Lancaster, Coordinator, National Rehabilitation Network; and, Debbie Standon of Harrisburg, PA, who is Director, Medical Management Services, AIG Claim Services.

Mr. LANCASTER. Mr. Chairman, do you have questions?

Chairman BUNNING. Yes, we will have questions. First of all, your program would be voluntarily done by recipients?

Mr. LANCASTER. That is correct.

Chairman BUNNING. We have a law that requires Social Security to do it within the 3-year period for CDRs, anyway.

Mr. LANCASTER. Right.

Chairman BUNNING. It is my understanding that past rehabilitation efforts spent large sums of money educating people who never ever returned to work. How would your approach differ from that?

Mr. LANCASTER. Private sector rehabilitation trains less than 1 percent of the population we deal with. We take a person where they are standing and the experiences they had in life, in other jobs, and we put them through a transferrable skills analysis and we find out what things they can do today and relate it to the current market. So the idea that we train people, in the thousands of cases that I know personally in our company, one or two actually go to junior college.

We do not believe that putting people in college or junior college leads to employment. In fact, it just stalls some of these people. Back 15 years ago, when this business started, the way the Workman's Comp. dealt with the problem was they sent the cases to State vocational rehabilitation.

Chairman BUNNING. There is another problem. The Federal Government never pays any of their bills within 120 days. I want you to know that to start out.

Mr. LANCASTER. That is better than 9 months, sir.

Chairman BUNNING. Yes, but that is a minimum. From 4 months on or 3 months on, we never pay. It goes up to 1 year or whatever they feel like doing. They are the only group of people or only entity that I know that never pays for the first 120 days, and then they pay no interest.

Mr. LANCASTER. We experienced that when working with State funds.

Chairman BUNNING. I know from just personal office expenses that people are waiting for 3 or 4 months for their money. So how would you get paid and how would that be possible if we have a problem there?

Mr. LANCASTER. We have the capital to go ahead and invest, and even if it is 120 days——

Chairman BUNNING. What if it is 1 year?

Mr. LANCASTER. We would have trouble with that, sir.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. I have no questions, but I do want to express my appreciation to Congressman Gekas, who is one of the more thoughtful and hard working members, I think, of the Congress. I note that in the bullpen is another Pennsylvanian who falls into the same category, Mr. Kanjorski; and Mr. Lancaster, somehow or another, Pennsylvania sounds right in your case, and we appreciate your testimony.

Chairman BUNNING. Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman.

This is fascinating. Why is it that currently your network, Mr. Lancaster, cannot be plugged into the review process, in particular, to fix our backlog problem?

Mr. LANCASTER. I see no reason why we cannot.

Mr. PORTMAN. You said you are ready to go by July 1?

Mr. LANCASTER. Yes, sir.

Mr. PORTMAN. That indicates to me that you are in the process of putting together various private countries around the country so that you could be able, on a national basis——

Mr. LANCASTER. That network exists today.

Mr. PORTMAN. Is that network contracting currently with the Federal Government to provide any service?

Mr. LANCASTER. No, they are not. Individually, I do VA work, I would do some Social Security work on the diagnostic stuff or the evaluations.

Mr. PORTMAN. Are you doing some State Workman's Comp. work?

Mr. LANCASTER. I am sorry?

Mr. PORTMAN. Are you doing some work for individual States?

Mr. LANCASTER. Yes, 21 States.

Mr. PORTMAN. So you have a track record with those 21 States upon which you can base your proposals?

Mr. LANCASTER. We do that regularly. In other words, outcomes are a big, important part in the Workman's Comp. market. If I work with State funds or the other customers, I have to go back to them on a regular basis and tell them how I spent their money, the outcomes that they can receive, and what they did get.

Mr. PORTMAN. You mentioned the figure, $1 in rehabilitation in terms of costs and there would be a $10 return. Are you talking about a return in terms of revenue to the Federal Government or are you talking about a return to the individual?

Mr. LANCASTER. No, we are talking about for $1 spent in a return-to-work process, it will save the fund, or where I was discussing, it would be the insurance company would save $10, and usually that is indemnity payments.

Mr. PORTMAN. So it is a savings that the person is not continuing on disability rather than going back to work.

Mr. LANCASTER. That is the savings.

Mr. PORTMAN. That does not take into account the fact that the person is then earning money which is then taxed and then goes back to the Treasury?

Mr. LANCASTER. Oh, absolutely.

Mr. PORTMAN. So, in fact, it could be even a higher ration than 1 to 10?

Mr. LANCASTER. It is considerably higher.

Mr. PORTMAN. You also mentioned the $1,700–$2,000 figure. I do not have that in your testimony. Was that an average——

Mr. LANCASTER. That is the figure that when we talk about average case cost, that is the number that I get. I know that my competitors average about the same thing because I am competing with them head to head with each of those insurance companies or those State funds.

Mr. PORTMAN. Can you put that in context for us? In other words, if it is $1,700–$2,000 on average, does that mean that the average person goes back to work?

Mr. LANCASTER. Our success rate is dependent on the jurisdiction. We are anywhere from 30 to 50 percent successful in jurisdictions where we are able to work with the client on placement.

Mr. PORTMAN. Of those where you are successful, in other words, between the 30 and 50 percent, what is the average cost?

Mr. LANCASTER. That is the $1,700–$2,000.

Mr. PORTMAN. You still stay with the $1,700–$2,000?

Mr. LANCASTER. Yes.

Mr. PORTMAN. What I am trying to get at is, is it $1,700–$2,000 in the cases where you are not making any progress and therefore it is a couple hundred bucks and you leave that person to continue on Workman's Comp. or disability?

Mr. LANCASTER. Within Workman's Comp., there are other closure types besides working or not working. Usually, we will be out of it because of new medical information, pending surgery, some of those kinds of things.

Mr. PORTMAN. But among those cases where you are successful, the average is under $2,000?

Mr. LANCASTER. Yes, sir.

Mr. PORTMAN. Thank you. It is very interesting. I hope that, come July, you will be part of the process.

Mr. LANCASTER. Yes, sir.

Mr. PORTMAN. Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman.

I want to thank Mr. Gekas and Mr. Lancaster for their testimony. I have no questions and yield back my time.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

I just wanted to follow up on the chairman's comment about the 120-day lag time in payments. That is what accounts for a lot of the deficit that we have, because a lot of people in the government do not understand that if you hold back that cash flow of the entrepreneur out there who does the service, that you are trying to save 8 percent in bond fees but you are paying about 10 percent or better in inflated prices. I wish we could get better control on how we handle the cash flow and payments. It would probably help everyone.

I have no questions, but I am impressed by your operation. Thank you.

Chairman BUNNING. Mr. Neal, please.

Mr. NEAL. Thank you, Mr. Chairman.

You noted in your testimony that you thought your approach was different, Mr. Lancaster. Maybe you could give us a description of the typical claimant that comes before you.

Mr. LANCASTER. A typical claimant, we would do an evaluation and we would gather the medical information. We would have a 2-hour or so interview to find out what are all the issues around the particular case, and how he feels about his disability.

Then we would probably set another meeting in 1 week or so, maybe 2 weeks after we get the other data that we had not re-

ceived yet and we would sit him down and it would be called vocational exploration, and it is actually a process that these masters' level counselors do. I do not know if it is a manipulation, but I know that it works, that they actually sit down and agree upon what occupations they would like to do and how they might get there and what kind of money they think they would make.

They would write up a plan where both parties would commit to doing certain things. The claimant would agree to go to interviews on time and help write the resume and do those things, and the counselor would agree to give him so many job leads in 1 week and that kind of thing.

What we are careful about, because of some liability, is that we do not want to put anybody back to work above their restrictions. So if we do find somebody a job, one of the first things that a counselor does as part of their training, is to do a job analysis, which will be done onsite. If there is a physician involved, they will take that job analysis and say, what do you think? Can this person do this or not? Usually, on the side, the doctors turn around and ask the client, can you do the job? If our counselors were good enough, the clinet will say, yes, sir, I think I can do it and I want to start tomorrow.

On the longer cases, we know that there are—if you are waking up at 10 o'clock in the morning for 2 or 3 years and you are starting to go to work at 7 o'clock, we have some work to do as far as the followup, making sure the thing does not fall apart and that kind of approach.

Mr. NEAL. How would you contrast that with how Social Security might handle a disability case?

Mr. LANCASTER. To my knowledge, the State vocational rehabilitation program is a training program. In other words, when we went head to head with them some years back, I finally understood why we were doing better, and that was that their goal was to maximize their clients' abilities and that usually meant upgrading them by education, et cetera. I know the private sector does not believe that. We bring the person to employment status as close as they can to the wage at the time of injury. So training, we found, does not work.

Now, OJT training, on some clients, I think is very beneficial. We are talking about the insurance company sharing part of the first 90 days' salary, and so it would be an employer look-see at this claimant with a benefit. I think that is the way it is going to be in the future, too, as we are taking a look at temporary services and why they are doing so well. It is because it is an introductory period for the client and the employer. I think we will see more of OJT or an employer incentive program.

Mr. NEAL. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Thank you, Mr. Gekas and Mr. Lancaster, for your testimony.

Mr. LANCASTER. Thanks very much.

Chairman BUNNING. The next to testify is Congressman Paul Kanjorski from Pennsylvania. Welcome to the subcommittee, Paul. It is good to see you.

STATEMENT OF HON. PAUL E. KANJORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

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

It is funny. It is almost reliving your life. Just before I came to the Congress, I had the opportunity to be an administrative law judge for 9 years in the Commonwealth of Pennsylvania in the fields that Mr. Lancaster just testified on, and at that time, I handled more than 8,000 cases. I am familiar with how this process works and how it can work much more efficiently.

First and foremost, what I am testifying about today is the staffing problem at the Social Security Administration. We all talk about reinventing government. We tend to think that just means cutting the number of employees. Sometimes reinventing government means getting the job done on a timely basis and making sure we meet the needs of our citizens, rather than just downsizing.

Particularly, I would call to the subcommittee's attention the present program of the administrative law judge situation in the Social Security Administration. What I would like to address in particular is the situation in the district I represent, northeastern Pennsylvania. The Wilkes-Barre office of Social Security has a backlog of 2,000 appeals. They have only five administrative law judges to handle those appeals. Each case takes a considerable amount of time, much longer than they should.

The situation in northeastern Pennsylvania is probably best pointed out by the case of Betty Frisbie. Mrs. Frisbie, of Wyoming, Penn., suffered a brain stem stroke in December 1993. She filed with the Commonwealth of Pennsylvania for Social Security and was denied twice in that period of time, for various reasons. Finally, we got her to a hearing that was set for this past March. The judge decided the matter in April and he made an award, but I have to say that after 18 months, she still is not in possession of that money because there is a backlog in the payment in Baltimore.

Here is a lady, 51 years of age, clearly incapacitated, totally disabled for 18 months of her life. The pathetic side of the story is that in the meantime, her husband was involved in, and lost his job as a result of a strike, so they have been living on $60 a week.

What are we doing to the American people? We promise them Social Security, but we probably shorten their life because of delays in benefit distribution. If that is our psychology, we will definitely cut down the obligations of the Social Security disability program, but I do not think that was the intention of the framers of this law.

What can we do about it? I was pleased to testify after Mr. Gekas because Mr. Gekas and I are cosponsors of a relevant piece of legislation. I wish the subcommittee would consider it. The legislation is so clearly needed.

I believe there is not a need in this country for administrative law judges in every specialty area. Clearly, such judges have the capacity, legally and intellectually, to understand more than just special areas of law. The Federal District courts handle cases of all jurisdictions.

There is absolutely no reason why administrative law judges cannot be referred to an agency in a region of the country where a

backlog exists. If it is an EPA hearing that is backlogged, send judges over to EPA. If it is Social Security that is backlogged and a specific problem exists in Michigan, send them into Michigan.

The administrative law judge legislation I originally drafted when I first came to Congress more than 8 or 10 years ago has bantered around the Congress with many cosponsors but still has not been considered. Let me tell you this. With the addition of more judges within the system, and the ability to transfer judges to where the caseload is, and by broadening the subject matter of the caseloads that these judges can review, we can reduce the time it takes for a case to work its way through the appeals process.

These cases are not difficult cases for the judges. For 90 percent of them, you sometimes wonder why a person was rejected to begin with, or why a person filed to begin with; they are very clear. A judge considers just a small margin of cases that really give them problems in deciding the case according to law and the facts of the case.

When I served as an administrative law judge, I did it part time with a full legal practice, handling more than 1,000 cases in 1 year. I did not have any complaints from the process.

Let me tell you about the experience we had in Pennsylvania, which I think the subcommittee should take into consideration. We had the very same problem Social Security is having today. What we did is sit down and organize our caseload. We decided that there were inappropriate advantages and disadvantages in the system, whether they were on the employers' side or the employees' side. We analyzed what it would take to put judges in the places they were needed most.

During my tenure as as judge, I traveled within a radius of 250 miles of my home office to try cases. When we had a backlog, we just deluged the area with judges and we cleared the backlog up. By the time I left that office, doing Workman's Comp. cases, that is, you could file a petition and were entitled to a hearing within 21 days. You would be given payment if we did not provide a timely hearing, so we were under pressure to schedule timely hearings. You can probably understand that the insurance companies were not satisfied to begin payment just because judges were not doing their job, so you had the initial hearings in 21 days. It solved the problem. We brought the backlog down. This problem is curable.

The other thing we did in Pennsylvania which I suggest you look into, is we looked into the concept of total disability versus partial disability. There is a big difference, let me tell you. Mr. Lancaster testified on this matter, and I have gone through experiences with experts like this all my life. You cannot take an orthopedic surgeon who has become disabled as a result of a work injury or a natural occurrence and turn him into a hamburger flipper in a McDonald's. It just does not work.

So very often, what we found in Pennsylvania was that when we had the issue of total disability versus no disability, it was very difficult to place people. What we did is compromise, and established the concept of partial disability. Two-thirds of disability could be paid to you if you were earning under the wage level that you were previously paid under your vocation. A lot of people saw the opportunity to take a lesser job and maintain their economic position in

life because they were getting a differential payment. The new process closed the whole backlog of cases that were based on whether a 100-percent disability or 90-percent disability existed.

There is one other thing that I would like to call to your attention. I believe it comes out of the Workman's Comp. system. There is a conspiracy in the country between employers who utilize Workman's Comp. to pay total amounts, settle a Workman's Comp. case, and shove the employee into the Social Security system. It should not be allowed to happen.

If a person is injured at work, they should not get a windfall in one settlement from the Workman's Comp. insurer, then become a Federal Social Security disability case. All we have to do to prevent that from happening is look around the country, see what is happening, and attend to such problems with proper legislation.

I would suggest that, in finally wrapping up, whether it is Mrs. Frisbie's case of delay, whether it is the failure to put the proper staffing in place, or it is the failure to finally pay a check, there is not any question that we have not accomplished anything by downsizing government or making government more efficient if the system does not work for people. The Social Security system is a vital system, not only in my district but throughout this country. Keep in mind that the system lends itself to reform and change. With great reform and change, we can decrease fraud, we can decrease abuse, we can increase efficiency, and I believe we can bring down the cost of the Social Security system to the American people.

[The prepared statement follows:]

STATEMENT OF CONGRESSMAN PAUL E. KANJORSKI

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

on the problems of the Social Security disability system

May 24, 1995

Mr. Chairman, I appreciate the opportunity to appear before you today. The subject of this hearing is a very important one, and I congratulate your decision to more closely examine this issue so that we can, among other things, find solutions to the delays faced by the thousands of citizens who apply for Social Security disability.

Let me begin my testimony by explaining the reason why immediate action in this area is imperative. Immediate action is imperative because of people like Betty Frisbie of Wyoming, Pennsylvania. In December 1993, Mrs. Frisbie suffered a massive, debilitating, brain stem stroke. She applied for Social Security disability shortly there after, but despite her incapacitated condition, she was denied benefits both in the initial application and reconsideration by the State Bureau of Disability Determination. The second denial of benefits occurred by the middle of July, 1994, more than seven months after her injury.

Immediately after her second denial, Mrs. Frisbie applied for an administrative hearing with the Social Security Administration (SSA). Her hearing with an administrative law judge was not scheduled until March 22, 1995, more than 10 months later, because of the slow initial consideration of her case, and the judge's request for additional "pre-development" information. After reviewing all of the evidence, the administrative law judge handling the case issued a decision in favor of Mrs. Frisbie on April 18, 1995, nearly a month later.

While I would like to say to you that this long journey from injury to benefits has ended after almost a year and a half, it has not. Mrs. Frisbie's benefit payments have still not been disbursed by the Social Security office in Baltimore. More than 500 days have passed since she was disabled by a stroke, yet she has not received a dime's worth of benefits from the federal government.

Mr. Chairman, this case is by no means the worst case I have seen; I have helped resolve problems in many similar cases over the years. It does, however, provide a good example of the delay working Americans increasingly face when they try to utilize a system which exists for their benefit. I am currently helping handle about 75 other Social Security disability cases in a Congressional district that spans six Northeastern Pennsylvania counties.

From the knowledge I gained from my job as an Administrative Law Judge for the workers compensation program in the State of Pennsylvania prior to coming to Congress, and in my current job where I help constituents break through bureaucratic red tape in the Executive Branch, I have come to learn one simple thing – there are not enough people to help handle appeals within the SSA. I would include both regular staff and administrative law judges (ALJ's) in this category. The loss of regular staff is occurring in part because of increased automation of the agency and the overall effort to downsize the federal government.

We must be careful that when we reduce staff for the sake of efficiency we do not sacrifice effectiveness. Reinventing government does not just mean fewer workers, it means getting the job done better and more expeditiously. I would urge that this Committee and the SSA review the personnel situation of the agency to determine if it can target more staff to regions where there is an appeals backlog.

The need for more ALJ's, or at least better use of existing ALJ's, is perhaps even more pressing. The SSA office in Wilkes-Barre, in Northeastern Pennsylvania, currently handles disability cases from individuals living within a geographic area covering almost one-quarter of Pennsylvania. The office presently has about 2,000 appeals pending before its five administrative law judges. While these are not all disability appeals, the

workload has significant implications for the speed by which disability cases are handled by this very small group of judges.

This past April, ALJs in Wilkes-Barre were scheduling hearings for July on appeals that were filed last October. I'm sure you would agree, this is simply too long. Persons seeking Social Security disability, like Betty Frisbie who pays $150 a month just on prescription drugs, have expenses to meet and literally cannot afford to wait under the current time frame.

In the spirit of reinventing government, I support a proposal that may help address this horrendous backlog without imposing any major new cost on the federal government. For some time now, bipartisan legislation has been introduced into Congress, which I have cosponsored with Congressman George Gekas, which would reorganize the existing ALJ system. Our bill would essentially replace the current system of separate administrative law judges in each federal agency, and create one unified, government-wide ALJ corps. Judges would be assigned to a division within the corps based on legal specialization, and a chief judge will be responsible for developing programs and practices, in coordination with the agencies using administrative law judges, which foster economy and efficiency in processing cases, including training of judges in more than one subject area.

The benefit of this legislation to the subject we are discussing today is that this corps of judges would help fill ALJ shortfalls that exist around the nation. Judges would work on temporary assignments in agencies within regions of the country where they are needed, and transfer to other locations when case backlogs are eased. Under the current system, each agency has a set number of judges who are beholden to that agency, and who work only on certain specific subjects.

Under the new system, it would be much easier to reassign judges from one subject area to another to fill shortfalls where they are needed. The reorganization will permit the utilization of economies of scale, permit the cross training of judges, and allow federal agencies and the ALJ corps to more efficiently manage fluctuating caseloads.

The private sector has successfully utilized similar workload management programs for many years. There is no reason why these simple principles cannot be equally effective in the public sector. The bill has not yet been introduced this year, but it is expected to be introduced soon by Congressman Gekas, and I expect that as in past years, it will be supported by members of both sides of the isle.

Today, you will probably hear about measures that will help get rid of waste, fraud, and abuse in the disability program. I support actions to do so. I would hope, however, that the less provocative, but crucial, issue of staffing does not get lost in today's discussions.

Thank you.

Chairman BUNNING. I just have a couple of questions. Does the Administrative Law Judges' Association support your proposal?

Mr. KANJORSKI. Yes, they do.

Chairman BUNNING. They do? Do you favor creating a Social Security court to hear only Social Security cases?

Mr. KANJORSKI. No. They can have a much broader range. What we do in our proposal is we detach administrative law judges from the agencies. We did that in Pennsylvania. When I first became a judge, we fell under the jurisdiction of the Department of Labor and Industry in Pennsylvania. We were quota systems, which made it difficult to establish ourselves as independent deciders of fact. I think that has happened, to some extent, in the administrative law judge system of the Federal Government.

You cannot mix the judiciary with the administrative and have it really work with a clear mind. Suddenly, somebody in an agency starts coming up with numbers and performance, and these people are just human. Judges are going to respond to the people that pay their check, that account for their promotions.

So what our bill calls for is a detachment and an establishment of an Administrative Law Corps, so it is a separate agency of the government. It would be under the judiciary branch of the Federal Government. Judges would not be barred from being shifted around.

As to the specialization issue, it really astounds me that you have to have some adult individual that went through law school know, for example, only Social Security. If you said a Federal judge can only sit on Social Security cases, he would probably be astounded. These people have great abilities. Most administrative cases are decided on evidence and conclusion of law, and I think most people that go through law school have the ability to interpret law rather well. If they do not, we could prime them. These are some technical specialty areas, but most judges can be brought up to speed quickly. We had a very wide range of jurisdiction when I was a judge.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. Paul, what do you think about the Court of Appeals, the proposal for a Social Security Court of Appeals so you do not get a different direction in every circuit?

Mr. KANJORSKI. We have that system in Pennsylvania. For Workman's Comp., we have an appeals commission on Workman's Comp. and it works very well. It clears the process through. Again, cases can be handled very swiftly if you take them out of the general system. You put a tremendous burden on people by going through the normal judicial system. It is very expensive. You cannot get lawyers to do it. Nobody wants to handle these cases. They get caught in the backlog. Quite frankly, a lot of these judges are not as specialized. So if you had a uniform region, a region would be better.

Mr. JACOBS. Thank you very much, and I will not say for the record the special favor you did for my wife and me.

Chairman BUNNING. Let me inform the members of the subcommittee, we have a member that has a time constraint that would like to follow up Mr. Kanjorski. If you could keep your ques-

tions short, I would appreciate it, because we have about a 20-minute timeframe.

Mr. Portman.

Mr. PORTMAN. I do not know why he is looking at me when he says that. [Laughter.]

Paul, I had about 30 questions for you. I will try to condense them into one. First of all, I commend you for again rolling up your sleeves and getting into this situation. You have the background to do it and understand it.

In terms of your national corps idea, the chief judge, I take it, would have a tremendous amount of discretion in terms of assigning people to both various regions and various areas of law, including this area.

Mr. KANJORSKI. Yes.

Mr. PORTMAN. Does that concern you, that the chief judge would have that kind of discretion? Is there an issue there?

Mr. KANJORSKI. You would probably have to have two or three tiers of discretion. I am not sure it could not all be done by one judge, because there are, I do not know exactly, about 1,600 administrative law judges in the country. It is a very large corps.

Mr. PORTMAN. Was this brought up in terms of the reinventing government proposal?

Mr. KANJORSKI. Oh, no. We introduced a similar bill 10 years ago.

Mr. PORTMAN. But this was not part of the Vice President's National Performance Review?

Mr. KANJORSKI. No, no, it was long before it. I did it because when I originally got here, I was so annoyed with the Social Security system and I saw how inefficiently it operated, compared to what we were doing in Pennsylvania on Workman's Comp., and I could not understand why they did not apply the same concept. We had run through the same problems that existed in the Federal system.

Mr. PORTMAN. The National Performance Review did look at some of these issues, but they chose not to set up a national corps. Do you know whether they looked at this or reviewed this specific proposal?

Mr. KANJORSKI. I doubt whether they would have because it has been stuck in legislative process. They probably recognized that since we have been considering this proposal for 10 years, enacting the proposal quickly would be difficult.

Mr. PORTMAN. I look forward to looking at the legislation more closely. I am inclined to support it, and I hope you will introduce it soon and we can get going on it.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Payne.

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

I just wanted to thank Paul for being here, for his testimony, and for helping us with your special expertise. I do not have any questions. Thank you.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. I heed your warning.

Chairman BUNNING. Thank you, Paul, for appearing.

Mr. KANJORSKI. Thank you very much.

Chairman BUNNING. The next witness is Hon. Jerry Costello, a Member from Illinois, accompanied by Jim Allsup, president and chief executive officer, Allsup, Inc., Belleville, Ill.

Go ahead, Jerry.

STATEMENT OF HON. JERRY F. COSTELLO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS; ACCOMPANIED BY JIM ALLSUP, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALLSUP, INC., BELLEVILLE, ILL.

Mr. COSTELLO. Mr. Chairman, thank you. I appreciate your expediting things to accommodate my schedule. It is very kind of you.

I want to thank you and commend you and the members of the subcommittee for holding these hearings to try and find ways to improve the disability claims process. I hope that the testimony that you hear from Mr. Allsup and all of the other witnesses that have testified during these hearings prove to be helpful and provide some information to find ways to improve the system.

I am pleased today to introduce a constituent of mine, Jim Allsup. Jim is one of my constituents who is strongly committed to seeing reform in the Social Security disability process. Jim is a former employee of the Social Security Administration. He was a claims representative, as well as a field service representative in various field offices for the Social Security Administration. It was because of that experience that he saw firsthand the frustrations that my constituents and all of your constituents have when dealing with the Social Security Administration and the disability program in particular.

As a result of his experience and recognizing the problems, in 1984 Jim formed his own company, Allsup, Inc., and it was the first private nationwide Social Security disability claims service program in the country. Over the past decade, Allsup, Inc., has assisted over 17,000 Social Security recipients in receiving their claims. The demand for his services continues to increase. He has opened offices in other locations in the Nation. I am sure he will address that during his testimony. Between the period of time from 1990 to 1992, Allsup, Inc., was recognized by Fortune 500 as one of the fastest growing companies in the Nation.

Jim is proposing a demonstration project. I will not go into the details; he will. It is a demonstration project that is very intriguing to me. I think it can be very successful. It is a strong partnership between Allsup, Inc., other private sector companies, and the Social Security Administration. I believe that he will testify today that there are at least 15,000 disability claimants that he believes could receive comprehensive service from this demonstration project. He believes that it will reduce fraud and bring about a more efficient system.

With that, Mr. Chairman, again, I thank you for your consideration in allowing me to testify and Mr. Allsup to be here today. With your permission, we will turn it over to Mr. Allsup.

Chairman BUNNING. Mr. Allsup.

Mr. ALLSUP. First of all, thank you, Mr. Chairman and members of the Social Security Subcommittee for the opportunity to comment and offer my ideas.

Yesterday, you heard testimony during the day regarding the existing problems in managing the Social Security disability program. Today, you are hearing proposed solutions to managing the Social Security disability program. I might want to add that though the problems appear complex, I do not believe the solutions are complex.

You heard previously from Mr. Dakos, introduced by Mr. McCrery, regarding the functional capacity assessment instrument his particular company has developed. You also heard previously from Mr. Lancaster, introduced by Mr. Gekas, regarding the National Rehabilitation Network that has been put together. What I want to do is tie the pieces together as the case manager in the demonstration proposal we are proposing to Social Security.

I have drafted a comprehensive demonstration proposal, right here, that is available on the table over there for distribution. In essence, what I did is, I took my 17½ years' experience in processing Social Security claims, both within the Social Security Administration and subsequently outside of the Social Security Administration as a private service provider.

What I want to emphasize is that the proposal that we are submitting to Social Security is a public-private partnership that simply applies existing private sector resources—existing resources, in a properly coordinated manner to help SSA solve its problems.

The proposal itself contains proven solutions, not conceptual solutions. It contains solutions based on improved service delivery, not additional costs. Service delivery that is focused on preventing problems rather than attempting to solve problems after they occur.

The central focus of our demonstration proposal is, very simply, giving the individual immediate access to the information, the education, and the services that they need as soon as they become disabled.

Our proposal basically contains three features, all of which happen to tie into Social Security's reengineering plans. No. 1, comprehensive third-party claim development. No. 2, functional capacity assessment via a standardized instrument, as Mr. Dakos introduced with the ERGOS equipment. No. 3, early referral for rehabilitation services, as Mr. Lancaster addressed.

The disability processing procedure itself, No. 1, would be accessing the individual early in their disability, providing Social Security services outside of the existing Social Security district field offices. Services can be accessed from a variety of different sources; employers, disability insurers, health insurers, health care providers. We are doing it as we speak today.

No. 2, once the individual has accessed services, third-party services, the vast majority of all subsequent claim and appeal work will be conducted via the telephone and mail in lieu of visiting a Social Security office.

No. 3, as soon as we access the individual, we focus immediately on providing a comprehensive disability orientation based on that particular individual's circumstances. This orientation would consist of information regarding what that individual could expect and anticipate regarding a variety of upcoming disability related issues based on his or her particular situation. This would be followed up

with the coordination of all public and private disability and health benefits, which includes the comprehensive development of the Social Security file and submission of the claim on a timely basis.

The next step in the process is the reeducation of qualified rehabilitation candidates. People that we feel are rehabilitation candidates, Social Security will be communicated to these people as a temporary income replacement that you can receive as you attempt to return to work with the proper rehabilitation services. If you cannot return to work within 30 months of disability, you would also qualify for Medicare entitlement, which also assists in the process of disability.

In addition to that, the individual will then be referred for functional capacity assessment via the ERGOS equipment. From that report, then, the baseline of functional ability and limitations that is established, we will submit that report with comprehensive medical documentation to Social Security for claim decisionmaking purposes, and submit a similar file with the ERGOS report to a participating rehabilitation provider to develop and implement a rehabilitation plan.

Finally, we will provide post-entitlement case management coordination by helping to expedite continuing disability reviews and also working in partnership with Social Security to monitor and report return to work of claimants.

We are ready to proceed as of July 1, as Mr. Lancaster indicated. We can have initial data back to the subcommittee by January 1. We are ready to proceed as of right now. We are ready to move. Again, these are existing solutions in the private sector where there is no startup time required. They are here, we are here, and we are ready to use what we know to help the process. Thank you.

[Mr. Allsup's prepared statement appears on page 175.]

Chairman BUNNING. First of all, I would like to make just a comment, as the privilege of the chair. I see a lot of people who testified yesterday sitting in the audience, the people who actually are on the front lines servicing some of the claims, but I do not see any of the policy people here that these changes might affect. It disturbs me that it is kind of an incestuous policymaking situation, where when we are trying to get new ideas into the system, the policymakers are sitting on the sidelines. They wonder why we change the laws and then they come and scream to us after the fact. There is one that entered.

But all I can tell you is that the fact of the matter is that these are new changes that we would like to look at and at least have them see and hear, and none of them happen to be here today. I comment only as a matter of fact.

Mr. Jacobs.

Mr. JACOBS. Mr. Chairman, I move that we forward the hearing record for today to those very policymakers.

Chairman BUNNING. We will do just that.

I have a couple of questions. Let me ask you the basic question. How do the people that you are dealing with now see the present situation when they come to see you as a consultant?

Mr. ALLSUP. Mr. Chairman, it is very disturbing from the standpoint of the people that we provide services to, when you deal with these people firsthand and on the front lines as a private provider,

to see how they suffer from a process that has deteriorated so much. When we provide assistance to these people, I constantly get letters from claimants throughout the country, all 50 States, that thank me for making our services available to them as an alternative. They commend my employees for providing assistance, providing the support, the encouragement, the processing. I cannot even begin to explain the reaction of people as far as their gratitude for this assistance.

Chairman BUNNING. Why do you believe that private disability insurers, health insurers, SSA, and so forth, are not coordinating services now?

Mr. ALLSUP. What you have, Mr. Chairman, is a very simple situation. I left Social Security 13 years ago. I started this particular service 11 years ago. When I worked for Social Security, I did not know anything other than Social Security and Medicare. I did not know anything at all about private disability plans, and nearly one-half the people in this country are covered by private disability plans.

I went out and started and applied the Social Security knowledge that I had to serve the needs of private disability plans, then took my knowledge of Medicare and applied it to the needs of health plans.

The issue is that Social Security now recognizes it needs assistance from third parties, but because Social Security itself has not been involved directly with these other benefit plans, private benefit plans, other public benefit plans, it is hard for them to determine how to properly coordinate these services. We have done that. I personally have been exposed to virtually every type of benefit plan in this country, public and private, disability and health, which is why we propose a partnership demonstration with Social Security to share the knowledge that we have with SSA to help solve these problems.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. I am already well aware of your work. Therefore, I will make my ample contribution to the chairman's aspiration for brevity and thank you for testifying.

Chairman BUNNING. Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman.

Mr. Allsup, thank you for being here today. I want to commend you for putting together the troika here, for putting together this document, which I find very interesting. I look forward to looking at it more closely after the hearing.

I have a few questions for you as to the specific program you have laid out, which is one, I think, we do need to forward to the policymakers. We all need to look at it. It has a lot of very interesting and provocative ideas.

The income supplement part of it, could you go over again how that would work and, more specifically, where those funds would come from in order to provide that incentive for employers to rehire people or to hire people for the first time who were coming off disability?

Mr. ALLSUP. Income supplement?

Mr. PORTMAN. Yes.

Mr. ALLSUP. Would you repeat that again?

Mr. PORTMAN. You had spoken in your oral statement about coming up with a way to supplement people's income as they are getting back into the system, and I wondered if you could expand on that. Did I mishear you?

Mr. ALLSUP. That was actually Mr. Dakos, and I think Mr. Lancaster referred to that.

Mr. PORTMAN. They referred to it, but I thought in your testimony, toward the end, you talked about that as one of the elements of the program that you all had put together.

Mr. ALLSUP. The issue really is to provide the incentives to the individual to want to go back to work, and it starts with getting access to the assistance. What I find intriguing about the ERGOS demonstration, for instance, they are engaged in a demonstration with a private disability insurer, where you actually have a team of entities working together to help the individual return to work.

From the standpoint of the employer, he is motivated from liability issues as well as ADA compliance issues. So they are in a position where they want to—have to, in some situations—modify the job and job site to allow the individual to return to work.

The ERGOS equipment, what happens in the situations there, is they establish a baseline of functional ability as well as limitations, and then work with the employer and the individual to increase functional abilities in areas needed so that the individual as well as the employer are moving together to ultimately allow the individual to return to work.

In addition to that, you have the private disability insurer. Interestingly enough, they provide a benefit plan that reimburses the employer for the costs of ADA compliance. It also reimburses the employer a portion of the first month's wages when the individual returns to work. Finally, what happens is that if the post-disability employment, the return-to-work wages is less than 80 percent of predisability wages, then the benefit will be continued to pay.

I guess the reason I point this out is that you have a situation here where the disability insurer, the employer, and ERGOS work together for a common objective, to put people back to work. So the issue is accessing the private sector resources, but to coordinate their activities in a way that everybody is working toward a common objective, and that is to get the individual to work.

Mr. PORTMAN. Can you quickly contrast that to the current system?

Mr. ALLSUP. Right now, you have a situation where when an individual receives disability benefits from Social Security, in essence, they do not have access to rehabilitation services. It does not occur from the standpoint that State vocational rehabilitation agencies—not to criticize them, but we have a situation where people do not have access to services because the referrals are not made to the private rehabilitation providers. Even if they were made, as Mr. Lancaster referred to earlier, the current system is such that they cannot even be paid for their services until the individuals return to work for at least 9 months.

Mr. PORTMAN. How about the current system as to private disability insurers and the employer? Are there those same incentives you talked about, to cover the ADA liability, as an example, first months' wages? Those are currently in place?

Mr. ALLSUP. Yes, and it is fascinating from the standpoint that you have all three working as a team for the same objective, to get people back to work. So they are coordinating the benefit plan itself, with the ERGOS machinery, in addition to the employer working to modify the job site and the job itself.

Mr. PORTMAN. Thank you very much.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Mr. Allsup, what percentage of the private sector disability insurance market is the private sector the primary payer for disability?

Mr. ALLSUP. You have roughly 45 percent of the employees in this country that are covered by private disability plans. The typical private disability plan offsets against Social Security. The reason for the offset is that the employer and/or the employee pay insurance premiums for the disability insurance coverage but they are also paying FICA taxes for the Social Security coverage. So the natural integration of the benefit plans is such that it is designed to integrate that way.

What I find interesting and what this proposal proposes is that even though all of the public and private disability and health benefit plans in this country are designed to integrate with each other, with Social Security and Medicare serving as the foundations upon which all of the other benefit plans are supposed to integrate with, you never have had anyone manage the integration process. As a result, you have what I refer to as disability bumper pool. The individual becomes disabled. They, then, have to deal with a variety of different issues at a point in their life when they do not have the ability to deal with these different issues.

What our proposal calls for is the managed integration of these benefit plans, managing the integration process, because in the past, you have had each benefit plan focused on only its particular plan; Social Security on Social Security, the employer disability plan on their plan, Medicare on Medicare, the employer health plan on the employer health plan, Workman's Comp. on Workman's Comp.

Put yourself in the position of the individual who becomes disabled and sees the physician, goes to the hospital, has to deal with the laboratory testing, goes into the employer either filing for the disability plan that the employer has, or if they do not have it, applying for extended sick leave. What happens, then, is they have to jump through the hoops of the employer disability plan. They have to jump through the hoops of the Social Security plan. They have to jump through the hoops of the employer health plan, the hoops of the Medicare plan, the hoops of Workman's Comp.

They do not know one from the other and they are so befuddled and confused, you have a process where they have already been beaten up before they get to Social Security. So then they get to the Social Security process, after they have already been beaten up, and everybody wonders why people get frustrated and get upset.

The issue is giving them access to the assistance that they need so they do not drop out of the process, the process of returning to productive work. What happens is if you do not provide the assistance, they drop out of the process and that costs everybody, which

is why our proposal says, give these people access to the assistance they need because you are saving money on the bottom line when you do that. It is just as simple as that. It is access to assistance and services.

Mr. COLLINS. That was a good sales pitch. I will go back to my question. [Laughter.]

What percent of the 45 percent of the private sector that is insured is the private sector insurance company primary payer?

Mr. ALLSUP. In those situations, what happens is under the health plans, Medicare is primary to the employer plan if the individual is not working. Under the disability plan, the disability plan offsets its plan, its benefits, by the Social Security amount.

Mr. COLLINS. Some disability private sector insurance, though, is the primary payer. It is not offset by Social Security. Both will pay. Do you know what percentage that is?

Mr. ALLSUP. I do not. I cannot answer that question.

Mr. COLLINS. That was the question I was looking for, but you did a good sales pitch and I appreciate that.

Mr. ALLSUP. Those are comments I wanted to get on the record that I did not have a chance to admit before.

Mr. COLLINS. I was enjoying your sales pitch, and you do talk loud and I appreciate that. Thank you.

Mr. ALLSUP. I thank you for the comment. I enjoyed your comment.

Chairman BUNNING. Thank you both for coming and for your testimony.

Mr. COSTELLO. Mr. Chairman, thank you. I would just ask the subcommittee to seriously consider this proposal. It makes a lot of sense to me.

Chairman BUNNING. Thank you.

Mr. ALLSUP. Thank you, Mr. Chairman.

Chairman BUNNING. I think the next member that is here is Hon. Charles F. Bass, a Member from New Hampshire. First of all, I want to welcome you to the subcommittee. I know you are going to speak about SSI, but everything that you say about SSI can be applied to SSDI, which we are taking testimony on. SSA runs both programs, so we can listen to your testimony and welcome you to the subcommittee.

STATEMENT OF HON. CHARLES F. BASS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE

Mr. BASS. Thank you very much, Mr. Chairman, for the opportunity to appear here today. I do not appear here today as an expert in SSI or SSDI. For that matter, in the Social Security Administration issues itself I would wish to defer to the superior knowledge and background of the members of this subcommittee for the specifics.

However, as a former member of the New Hampshire Senate and New Hampshire State Legislature, I have had the opportunity to deal in many respects with SSI and how it affects State budgets as well as, obviously, how it affects the Federal budget.

As a result of that, I have worked in my first few months here in Congress on an effort to make certain changes in SSI eligibility, many of which were addressed in the welfare reform package. How-

ever, my legislation which I plan to introduce will expand what was done in the welfare bill to apply to a greater segment of the population.

I would like to, at this time, offer my written testimony for the record and I will very briefly summarize some points that are important.

Chairman BUNNING. Without objection.

Mr. BASS. As the members of this subcommittee know well, the Supplemental Security Income Program has grown dramatically over the last 10 years, and that has been primarily in the nonaged, nondevelopmentally disabled population. I think it can be said that the reason for this has occurred for many reasons but perhaps because the eligibility criteria have been expanded and liberalized not only by the courts but by the legislature and by the regulators, to the extent now that in my own environment, I see individuals who are receiving SSI payments that, by any stretch of the imagination, would hardly qualify.

In fact, I would suggest that many members of my staff on occasion would qualify for SSI. I think Governor Weld spoke to a group of Republicans a while back and he talked about the fact that there was eligibility in Massachusetts for people with cabin fever.

I think that the time has come for this Congress to review SSI eligibility, not only for purposes of tightening up the program and to make the program more cost effective, as it is, I think, the fourth largest entitlement program now in Congress, but also to make it possible for those individuals who truly need SSI payments because they do suffer from true mental impairment and they are aged or they are developmental disabled, to qualify for those funds and receive those funds and to do so justly.

That is the direction with which I come to this issue. I plan to introduce a bill which I hope this subcommittee will consider that will make certain changes which follow on to the changes that were proposed and passed by the House in the welfare reform package, most notably, mandating that SSA narrow the regulations encompassing the mental impairment categories, which is what I just discussed; refocus the supplemental security income payment as a temporary assistance program for those not permanently disabled, and my bill goes into quite some detail about how that would occur; and protect those recipients who should remain on the rolls by undertaking certain protection requirements, such as a 1-year notice and 180-day application period, with the idea that this type of reform will not only pay for itself, obviously, but save money over the long run.

I am hopeful that if the subcommittee takes up this piece of legislation or anything similar to it, that the areas of huge growth that have occurred will be addressed and, perhaps, reduced without necessarily reducing the quality of or the need for payment to individuals who truly need those payments.

By requiring the Commissioner to narrow the definition of mental impairment, I think that the amendment will require administrators to more closely scrutinize applicants to protect SSI resources for those who are actually disabled and in need of assistance and prevent such abuses as those described above.

I believe, Mr. Chairman, that regardless of whether my bill is enacted, that this issue needs to be addressed, and I commend the subcommittee for having this hearing here today. Thank you.

[The prepared statement follows:]

TESTIMONY BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY,
COMMITTEE ON WAYS AND MEANS COMMITTEE
MAY 24, 1995
Prepared By Congressman Charles F. Bass

Mr. Chairman and Members of the Subcommittee:

Although I realize that this hearing is also on Disability Insurance (DI), I appreciate the opportunity to be here today to discuss possibilities for further reforming the abuse problems that exist in the Supplemental Security Income (SSI) program. Together DI and SSI make up the fourth largest entitlement spending category in the Federal budget, and both are administered by the Social Security Administration (SSA). SSI differs from the DI program in that, unlike DI, SSI does not require the recipient to have a previous work history.

I. BACKGROUND OF THE SSI PROGRAM

While you are well aware of the fundamentals of the SSI program, for the purposes of my testimony the following facts bear repeating.

- **SSI was established in 1972 to serve the elderly, blind and disabled.**
  - When SSI was enacted in 1974, most recipients were elderly people, who were usually not eligible for Social Security or whose pensions left them in poverty.
  - However, as incomes have risen, the number of elderly people on the rolls has fallen. At the same time, the number of disabled has soared.
- **Between 1980 and 1990, SSI spending increased from $5.7 billion to $11.5 billion in real dollars.**
- **Over just the past four years, however, the costs have again more than doubled to $23.7 billion.**

II. WHERE THE SSI PROGRAM IS GROWING

The United States General Accounting Office (GAO) reported that since 1991, three groups have accounted for nearly 90 percent of SSI's caseload growth. Those groups include disabled children, legal immigrants and adults with mental impairments. This Congress, and this subcommittee, addressed the first two areas of growth in the House welfare reform bill, and began the process of reforming the program to protect SSI resources and target benefits towards those in real need. I would like to expand that protection for recipients between the ages of 18 to 65, by eliminating the unaddressed abuses in the SSI program in the mental impairment category. This is one of three areas in SSI identified by GAO where the rate of growth is significantly outpacing the growth rate of other SSI recipients.

The following facts illustrate the rate of growth in the non-elderly adult population:

- **In 1975, 2.1 million of 3.1 million SSI recipients were elderly.**
- **By 1993, only 1.5 million persons receiving SSI were elderly, whereas 4.4 million were receiving SSI on account of attaining disabled status.**
- **Non-elderly persons with mental disorders are the fastest growing segment of SSI recipients.**
  - By 1994, over half of all non-elderly recipients on SSI disability were receiving benefits based on a mental disorder.
  - Of those, 32.2 percent had mental disorders other than mental retardation.

The "mental impairment" category now accounts for more than half of all NEW SSI disability awards. Three categories that I am particularly concerned with are the affective disorders, anxiety related disorders and personality disorders. Each has experienced tremendous growth in the last five years.

Affective disorders are basically emotional disorders, which depend on such factors as loss of interest in activities, trouble sleeping, agitation, decreased energy, feelings of guilt, uncontrollable talkativeness, inflated self-esteem, etc. Most of my staff could qualify under this category! This program has grown by 120 percent according to the SSA in the last 4 years and I believe can easily be subject to fraud and abuse.

Anxiety related disorders are another category under which my staff would probably qualify for SSI benefits. The category looks at such factors as a persistent irrational fear of a specific objective, activity, or situation which results in a compelling desire to avoid the dreaded objective, as well as factors such as marked restriction of activities of daily living or difficulties in maintaining social functioning. From 1990 to 1994, this category has grown by 59 percent and again, I believe the criteria of this category can too easily lead to fraud and abuse.

The third category is personality disorders. I might suggest that for benefits under this category most attorneys could qualify for SSI. Here, for example, SSA looks at such factors as whether a person is pathologically suspicious or has oddities of thoughts. This category grew by 53 percent in the last four years.

I don't mean to make light of this situation. We have an increasing number of fraudulent claims because of these slack criteria. We need to tighten the criteria and ensure that those who should receive SSI are actually receiving the benefits.

III. REASONS FOR THE RAPID GROWTH IN EXPENDITURES AND CASELOADS

Changes to the SSI program by the courts, Congress, and SSA have transformed SSI into a permanent benefit program for temporary problems. These changes encourage people to apply for SSI as a means of welfare rather than disability payments. Without reforms that affect these factors, the growth in SSI expenditures will continue to increase ever more rapidly, providing benefits for those who should not be on the rolls, and denying resources to those actually in need.

Some of the more apparent factors contributing to the increase in the SSI rolls and the increase in spending are the following:

- **The cost and growth in SSI continues to increase because the Congress, SSA, the States and the courts continue to liberalize the regulations that define disability.**
  - The changes SSA made in the mid-80s to the eligibility standards have also been a major contributing factor in the increased number of mental impairment cases.
- **Another reason SSI has grown so rapidly, which is closely related to the regulatory liberalization, is the fact that about 80 percent of the appeals of SSA decisions are overturned by the courts.**
  - As presently structured, SSA faces a virtually impossible task on appeal because the agency has the burden of affirmatively proving that a recipient has medically improved, whose initial disability determination was largely subjective.
- **Several States have pushed disabled residents from State relief programs onto SSI.**
  - On May 13, 1994, June Gibbs Brown, the Inspector General, U.S. Department of Health and Human Services, testified before the Senate Appropriations Committee that several states, including Illinois, California, and Michigan, have taken steps to push "disabled" residents from state relief programs to SSI.
  - This tendency to push state relief recipients onto SSI could be magnified by Federal welfare reform efforts, particularly reforms that place time limits on benefits and require people to work, as would the House welfare bill if signed into law.
  - For example, while recipients of SSI may also receive a Social Security check, SSI recipients may not also participate in AFDC. However, with the reforms of AFDC which require individuals to work after 2 years, some former AFDC recipients may attempt to receive SSI benefits.
- **The system is inducive to fraud.**
  - The recent loosening of regulations has expanded the traditional medical impairment criteria to include a host of subjective, social handicaps that no doctor could cure, such as stress. A few of these liberalized criteria were discussed above. These expanded criteria facilitates fraud. A well known example was described in Welfare's Next Vietnam, City Journal, Winter 1995 by Heather MacDonald. MacDonald describes the Riveras family which includes one grandmother, her 16 children and their 89 progeny who together collect benefits for their "nerves" at a cost of $750,000 to $1 million a year. While this is just one anecdote, it illustrates the problem quite well.

- **SSA's outreach program.**
  - On top of all this, SSA has spent billions in outreach efforts to assist people onto the SSI rolls.
- **Once a recipient is on SSI, it is unlikely that he or she will leave the rolls.**
  - In 1983, the ninth circuit court ordered SSA to show that a beneficiary had "medically improved" before benefits could be terminated, instead of a beneficiary proving that he or she was still disabled.
  - Concerns about the review process prompted some states to adopt the medically improved standard as well.
  - In 1993, Congress directed SSA to perform a certain number of continuing disability reviews (CDRs). A CDR is a review to determine if an individual on the SSI rolls is still disabled.
  - SSA is supposed to perform a CDR every three years where "medical improvement is possible or expected". Few CDRs were performed.

GAO reports that the lack of review combined with the growing number of applicants and the tendency for SSI recipients to remain on the rolls has had a profound impact on SSI expenditures.

IV. A POSSIBLE SOLUTION

I am proposing legislation that would address these problems. I briefly outline my bill below:

- **Mandate that SSA narrow the regulations encompassing the mental impairment categories.**

By mandating the Commissioner to revise the regulations that encompass the mental impairment categories, my bill would require SSA administrators to more closely scrutinize applicants. This would protect SSI resources for those who are actually disabled and in need of assistance and prevent such abuses as those described above. Because I do not believe that Congress can or should micromanage the SSA, and because I believe that SSA knows specifically where the problems exist, the bill does not specify how SSA should narrow its regulation. In this way, SSA can do what it knows should be done. However, one possible way to narrow the regulations would be for SSA to place less weight on such mental impairment factors as "concentration" or "persistence (or pace)".

- **Refocus SSI as a temporary assistance program for those not permanently disabled.**

SSI has experienced substantial growth in applicants in the last 4 years but the number of recipients leaving SSI is low. It appears that even for recipients with temporary disabilities, SSI is viewed as a permanent benefit. We need to change this culture. By requiring SSI recipients with temporary disabilities to reapply, those recipients may begin to view SSI as temporary and begin to seek work or rehabilitation to prepare for the day they no longer depend on the government.

The bill also ensures that the agency will review NEW SSI recipients and those that have been on the rolls for 5 years or less. This is done by requiring beneficiaries deemed to have a disability where medical improvement is expected or is possible to reapply for benefits every 3 years, thereby encouraging personal responsibilities and placing a time limit on the benefit. This will ensure that administrators and beneficiaries again begin to think of SSI as temporary assistance for those not permanently disabled. The bill also eliminates the impossible standard set by the courts of having SSA prove that a recipient has medically improved.

Under these changes, benefits would terminate and reapplication would be required for SSI recipients in a graduated process as follows:

- **Recipients on the rolls for 5 years or less, but for more than 3 years.** Benefits terminate 1 year from effective date unless beneficiary reapplies.
- **Recipients on the rolls for 3 years or less**. Benefits terminate after a recipient has received a total of 3 consecutive years, as of the bill's effective date. The beneficiary has the option to reapply.
- **Recipients on the rolls for more than 5 years remain under a continued review process.** These recipients do not have to reapply because they were deemed eligible before the disability criteria were expanded and program growth exploded.

- **Protect those recipients who should remain on the rolls by the following:**
  - **Requires 1 year notice** from SSA to recipient of pending termination.
  - A **recipient then has 180 days to reapply** for benefits.
  - If a recipient reapplies within the 180-days time period, the administrator must evaluate the application within the subsequent 180 days.
  - If the administrator fails to act within this time period, the recipient will remain on rolls until the administrator has acted. If the administrator fails to meet the deadline, such failure must be published in the Federal Register.
  - If a recipient fails to reapply within 180 days of notice, benefits are terminated at the end of the year. Recipients who fall under this category and reapply after the 180-day period should be placed on lowest priority behind new applicants and applicants who meet filing requirements.

- **The reform pays for itself and saves money.**

  - The Congressional Budget Office has done an illustrative estimate that this bill would save $3 billion over the next five years. It appears that CBO used an incorrect assumption that when corrected will result in substantially larger five year savings. We are currently in the process of resolving this issue with CBO.

V. CONCLUSION

In conclusion, this bill is designed to address the areas within SSI that caused the huge growth in spending in the last few years. By requiring the Commissioner to narrow the definition of mental impairment, the amendment will require the administrators to more closely scrutinize applicants to protect SSI resources for those who are actually disabled and in need of assistance and prevent such abuses as those described above. Whether this bill is enacted or not, we must address these problems or those who truly need SSI will suffer.

Chairman BUNNING. Thank you, Charlie, for coming.

At this time I would like to recognize two people from the Social Security Administration, Alan Beyer and Pete Spencer. I did not know that you were here, but we welcome you to hear these great ideas that we are getting so that you can relay them to the administration. We will get plenty of opinions when we turn over our transcript to the Social Security Administration.

Let me comment about your bill. First of all, we do have jurisdiction over SSA, but SSI is in the Human Resources Subcommittee, so that bill would probably be referred to the Human Resources Subcommittee. It is a lot like the Social Security Administration. We have different jurisdictions. But, in fact, if there is a hearing on the bill, it would be kind of a joint hearing that we would have.

Let me address just a couple of things in your testimony. Yesterday, we heard testimony regarding the mental impairment criteria and time-limited benefits. SSA administers both the SSI program and the SSDI program. Currently 1.5 million disabled people get both SSI and SSDI benefits. Given the fact that SSA seems to be having enough problems administering one definition of disability now, would you agree or disagree that it is important to try to keep the same definition for both programs?

Mr. BASS. I agree that that constitutes a problem, and should you establish different criteria for mental impairment, you might have to have two sets of regulations. I think that is a problem that this subcommittee needs to address. I agree.

Chairman BUNNING. In other words, that is addressed in your legislation?

Mr. BASS. The issue is not addressed in the legislation in that there might be a duplication of regulations in SSDI versus SSI. I think that is a problem that does need to be addressed and is not answered in my bill.

Chairman BUNNING. Maybe you would like to add it in, because we discussed the definition yesterday. The administration currently likes the definition. A lot of the other testimony we received yesterday did not like the present definition.

Mr. BASS. It has been my observation that the Social Security Administration, from my perspective, has not had significant objections to the definitions. In fact, the effort on the part of SSA has been to encourage more people to apply and process the applications faster. For better or for worse, that may be one of the causes for the rapid escalation, or one of the minor causes of rapid escalation.

Chairman BUNNING. I do not think there is any doubt about that, Charlie. I think you are right.

Mr. Portman.

Mr. PORTMAN. Just to thank you, Charlie, for coming forward and for this testimony. We look forward to working with you on it.

Mr. BASS. Thank you.

Mr. PORTMAN. Everything you say, I think, is something that this member and others on this panel would agree with in terms of the general problem. The question is how to get at the problem and to narrow it. We heard some good testimony yesterday and today. Based on what the chairman said, it sounds like we are going to be involved, at least as one of the two subcommittees on

the problems that you note in terms of narrowing the definition, particularly with mental impairment.

So thank you for your testimony and we look forward to working on it.

Mr. BASS. You are very welcome, Congressman Portman. I would just like to stress that I am not an expert in a very technical area. However, I do perceive a problem and I want to support this subcommittee and any other subcommittee in its efforts to address the problem in a fair and equitable fashion. Thank you.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

To clear up what you were saying about the definition of disability, did I understand you to say that Social Security has an inability to define disability? Is that what you were saying?

Mr. BASS. Well, they have a different opinion on one side than they do on the other.

Chairman BUNNING. Mr. English, welcome.

Mr. ENGLISH. Thank you, Mr. Chairman.

Mr. Bass, I would like to simply thank you for taking the time to appear here today to testify on disability issues. As a member of the Human Resources Subcommittee as well, I look forward to working with you on your legislation.

Thank you, Mr. Chairman.

Mr. BASS. Thank you, Congressman English.

Chairman BUNNING. Thank you very much, Charlie, for your input.

There are three other Members that have testimony that was due, Mr. McHugh, Mr. Smith of Texas, and Mr. Davis of Virginia. We would like to allow their statements to be entered into the record.

[The prepared statements and attachments follow:]

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24TH DISTRICT, NEW YORK

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SUBCOMMITTEE ON THE DISTRICT OF COLUMBIA

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House of Representatives
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STATEMENT OF
CONGRESSMAN JOHN M. McHUGH
BEFORE THE
SUBCOMMITTEE ON SOCIAL SECURITY
OF THE
HOUSE COMMITTEE ON WAYS AND MEANS

May 24, 1995

Mr. Chairman, I appear before the Subcommittee today to express my deep concern over the state of the Social Security disability benefit program. I sincerely appreciate this opportunity to share with you and the Members of your Subcommittee my observations on this extremely important issue.

This program was designed to assist individuals who have worked under the Social Security system for a number of years and have been compelled to withdraw from the workforce due to a disability. Usually, these people are facing a severe financial hardship due to a sudden loss of income. Many times, they fall behind in their mortgage payments and other everyday expenses. Some even lose their employment-sponsored health insurance coverage and must face exorbitant medical expenses. This is a devastating time in their lives yet the Social Security Administration subjects them to delays of several months just to obtain an initial decision. If appeals are involved, the claimant may face well over a year before the claim is brought to a conclusion.

I feel there are two major problems with the administration of the Social Security disability program that require the Subcommittee's attention. The first is the length of time required to render decisions at each level of the appeal process. With delays of many months, claimants simply do not know where they stand. They are in a constant state of frustration and anxiety which may exacerbate their disabilities.

The second problem involves improper disability determinations. I believe statistics will show that favorable decisions are rendered most often at the hearing level. If State Disability Determination Offices are applying the same laws relating to the definition of disability as the administrative law judges, then why are claims most often reversed at the hearing stage? State agencies should be counseled on the disability standards so that proper decisions are made at the onset. Further appeals would then become unnecessary. This would greatly alleviate the backlogs administrative law judges are now facing.

State agency decisions are based on the written record. Much more time and manpower is required at the hearing level because of travel, personal interviews, research and clerical duties. Administrative law judges must oftentimes travel to hold hearings, especially in my vast rural Northern New York Congressional District, and valuable time is used to interview claimants and their witnesses. Administrative law judges must compose lengthy, detailed decisions and clerical staff must devote many hours to the task of preparing the written determination. When this process is multiplied by the hundreds of claims assigned to each administrative law judge, it is obvious that appeals pending at the hearing stage require the most time.

Additional effort should be placed at the initial level to develop claims to ensure that all available medical evidence is in the file so a proper determination may be made at the onset. In some instances, I realize that it is necessary to ask personal physicians to provide medical data. If this is the case, a claimant's doctor should be contacted by phone to obtain information if a written request does not produce a prompt response. This would alleviate the delays considerably because months are often lost while awaiting medical reports.

There is another problem involving medical evidence which concerns me, as well. I cannot begin to tell you how many constituents have complained to me about the process of consultative examinations for the Social Security Administration. I have been advised countless times of five-minute consultations with little or no review of the claimant's medical records. I do not see how a consulting physician can render a valid medical opinion without a thorough examination of the patient and adequate time to devote to often complicated medical files. I feel something must be done to ensure that the physicians selected to perform these consultative examinations do so with greater attention to individual cases and full knowledge of the Social Security disability benefit eligibility criteria.

I fully realize that the Social Security Administration has undertaken a major effort to redesign and improve the disability benefit consideration process and that many of my concerns are being addressed during this reengineering project. I have read the information Social Security Commissioner Shirley Chater has provided regarding these proposals and found it to be most encouraging. However, once again, time is the problem. It will take years to fully implement the changes the Social Security Administration is suggesting. Action must be taken to expedite the implementation of this plan. Even minor improvements, if implemented as soon as they are refined, could produce a significant reduction in processing time. While it may be preferable to wait until the reengineering project is fully completed, I do not believe we have that luxury. We must act now.

Claimants have contributed to the Social Security system with the firm belief that this benefit program would be available to them and they depend on that assurance. Too often, they are disappointed and frustrated by the lackadaisical manner in which they are treated. We must reform the process to convince the public that the Federal Government is making every effort to fulfill their needs in a prompt and compassionate manner. The program, as it now exists, is in dire need of improvements and the proposed changes must be implemented as rapidly as possible. This will not be an easy task, but I am convinced that we must use every available resource to ensure that the deficiencies in this much-needed program are corrected as quickly as possible. With the diligent efforts being undertaken by this Subcommittee, I know we will reach that goal.

Testimony of Congressman Lamar Smith
Hearing on the Social Security Disability System
May 24, 1995
Ways and Means Subcommittee on Social Security

Making the Social Security System Serve the People Again

Chairman Bunning, thank you for the opportunity to testify before this Subcommittee and to share with you some serious concerns I have about the Social Security disability insurance system. I've had the pleasure of working with you on the Budget Committee, where we've now developed a balanced federal budget that once again makes the government serve the needs of the people. Today I'm pleased that this Subcommittee is conducting a thorough review of how to make the Social Security disability system serve the real needs of the people.

I felt compelled to come here today because of the unacceptable experiences too many of my disabled constituents in Texas have had in trying to deal with the system. It is a system that too frequently appears devoid of common sense and basic human dignity and too focused on the bureaucratic book.

As a result, people who are already suffering critical, disabling illnesses and injuries are made to suffer even more at the hands of a government system that is charged by law with providing them assistance but prevented from doing so by government rules and red tape. At the same time that these real victims are denied relief, this system provides disability relief to persons who are not disabled. Alcoholics, drug addicts, and others who claim that they are

unable to work as a result of personally destructive behavior are compensated for their harmful activities. Such a system is unacceptable.

- It is unacceptable that a constituent of mine in San Antonio -- a 36-year-old woman with lupus, heart disease and a degenerative bone disease who had escaped an abusive husband and was sleeping with her four young children in their broken down car -- had to wait six months, despite her "dire need" appeal, before she was granted Social Security disability.

- It is unacceptable that another constituent, a 40-year-old man with severe heart disease and disabling rheumatoid arthritis, had to wait almost two years for approval. By that time, the home he had worked hard for many years to buy for his wife and five children had been lost. This family of seven had been reduced to a state of abject poverty because the "safety net" of Social Security disability, a "safety net" this husband and father had contributed to, took two years to make a determination in his case.

- It is unacceptable that a woman in her early 50s who applied for Social Security disability in mid-1993 died only weeks after securing a positive determination 18 months later.

It is unacceptable that these cases, these examples of a system that clearly is broken, all represent "speedy" resolutions when compared to the norm. Most Social Security disability claims filed by my constituents in Texas that are not approved at the first two levels now take a minimum of two to two-and-a-half years to work their way through the Office of Hearings and

Appeals. In the meantime, eviction notices are filed, families are destroyed and, too often, hope is lost.

These cases are among the hundreds in which my office lends assistance, cases in which my office attempts to speed the process for constituents truly in need. These are cases in which my office attempts to make sure that a program designed to help those who no longer can help themselves does the job it is charged by law with performing. And these cases -- and many, many more which we could discuss -- involve people who have no where else to turn.

Social Security employees are good, hard-working people. But too often their hands are tied by a bureaucracy that continues to put obstacles in their way. In emphasizing the need to weed out those who seek to take unfair or even illegal advantage of the Social Security Disability system, the system appears to be penalizing too many of those citizens whom it should be serving.

At the same time, the system has also failed to discourage fraud and abuse by people who are not disabled or whose disability has resulted from irresponsible or illegal behavior. For too long, drug and alcohol addicted persons have relied on the Social Security disability system to subsidize their destructive behavior and addictive lifestyle. It is irresponsible, unfair, and appalling that a government would permit these mendicants to obtain benefits at the same time that real victims of accidents, illness, or other circumstances beyond their control are forced to endure lengthy delays before receiving needed benefits. The Republican Contract with America contains welfare reform provisions that would deny Social Security disability to persons who

claim that their disability is their drug addiction or alcoholism.

The fraud by non-disabled persons, alcoholics and drug addicts and inhumane treatment provided to real victims are opposite sides of the same bureaucratic coin. It's a system in which the people who really need help-- the people who play by the rules-- are denied assistance or forced to endure debilitating delays before receiving assistance. And others who are not disabled or whose "disability" is self-inflicted unfairly receive taxpayer subsidies. The answer to both of these wrongs is to make the Social Security disability system less bureaucratic and more reliant on incentives. It's to make the system serve the people, not the people serve the process.

After all, what's really at stake is people, human beings across this nation. Let me read you excerpts from a letter sent to me by a 20 year-old wife and mother from the Texas Hill Country. Her letter provides a classic example of what's at stake here. She and her husband were critically injured in a grinding car crash. She would eventually recover enough to go to work. But the outlook for her husband, who suffered a serious brain injury, was not positive. "We have tried everything we know to do," she wrote. "Everyone tells us you have to lie to get help. That's not right. We really do need some help and if you have to lie to get it, then I guess we will starve and live on the streets with the others who can't lie either."

Chairman Bunning and other members of the Subcommittee, I commend you for focusing attention on the Social Security Disability insurance system. I know you heard testimony yesterday from numerous witnesses concerning the causes of the tremendous backlog in dealing

with disability claims and possible ways to erase it.

I appreciate that today you afforded time for me to share with you the evidence that backlog is not just numbers and data; not just statistics and monthly reports. It's people. People in need and people deserving of fairness and basic human dignity. It is unacceptable to all of us, that we not take the steps we must to assure them that a system designed to serve them will do just that. Thank you again.

Statement of Rep. Tom Davis
before
The Subcommittee on Social Security
of
The Committee on Ways and Means
U.S. House of Representatives
May 24, 1995

REDUCING THE SOCIAL SECURITY DISABILITY BACKLOGS

Introduction

Mr. Chairman and members of the subcommittee let me begin by commending the subcommittee on their decision to hold a hearing on this important topic. I would also like express my appreciation for the opportunity to contribute to your deliberations on how to improve the administration of the Social Security Disability Program, as it relates to the disability claims backlogs.

The Social Security Administration also deserves applause for their reengineering efforts. Everything in my background - - from my current position on the House Government Reform and Oversight Subcommittee on Management, Information and Technology and Human Resources and Intergovernmental Relations, to my past positions as a County Government Supervisor and a technology consultant - - tells me that the disability program would benefit from establishing firm goals and expectations about customer services and coordination of activities. As reengineering precepts tell us, establishing firm goals and expectations is the best way to achieve cost-effective process changes for the agency's workload.

I am not convinced, however, that the agency's schedule for change, which runs into the next century, will reach appropriate fiscal and service improvement goals within an acceptable timeframe. It is clear that we can not reach desired goals in the near term by following the status quo with the small scale increments suggested in the agency's reengineering plan. The agency is also sponsoring an initiative to distribute the workloads of state DDS's with high disability backlogs, among state DSS's with low backlogs, to the extent these resources are and remain available. Though this is a good first step, I expect its positive effects on the backlogs will quickly level off when those participating DDS's reach their workflow capacity.

I believe we can do better than that; social security shouldn't be "off-the-table" when it comes to making customer service processes better, especially when the outcomes could be faster and fairer processes for the eligible population and improved Trust Fund integrity. Let us take direct steps now to reach some good stretch goals. We know a lot about what to do now - - it is time to discuss alternative initiatives that could begin reaping the benefits as soon as possible in fiscal year 1996.

The Problems

It is my understanding that the disability claim process has been under study for some time now and that, beginning in the prior Administration, the agency has acknowledged the need to improve the process and has taken steps toward positive change. Unfortunately, these laudable efforts have been hindered by

the effects of court decisions, policy changes, and changes in our country's economy and demographics, all of which have resulted in an explosion in the work effort.

I am greatly concerned that the current delivery structure can not be reengineered easily when it is under so much pressure, not only from the surging pace of new applications and the backlog of applications, but also from the critical Continuing Disability Review (CDR) requirements. I am also made more skeptical about the planned reengineering effort by my experience in government and my understanding of how long it takes a program rooted in an intergovernmental structure to adapt to needed changes. The stretched-out time frame in the current agency plan should be a signal to us all.

I think that if we want to continue the intergovernmental structure we have and help it reengineer itself to new process models, we should help take some meaningful heat off the workload. This would permit change to occur without major disruptions to the program. I also think the reengineering effort would benefit from having a few competitive models of efficiency, customer service and technology supports from which to choose "best practices" for the future.

What is at stake here, of course, is not just the preservation of a long-standing Federal/State delivery structure but the integrity of the program and the Trust Fund. I complement the subcommittee for its continuing concerns about customer service improvements and the creation of uniformly fair dealings in the program. We want to assure that eligible people are served as soon as practicable, but that ineligible people do not receive trust fund payments in error. These are results which the beneficiary community and taxpayers both support. This builds trust in the integrity of the program and in the Trust Fund itself.

After years of study the agency and Administration already know the basic problems and the solutions:

- improve customer service
- raise productivity
- reduce the backlog of work
- lower error rates and reach more uniformity in beneficiary treatments
- remove ineligibles from the program
- improve financial performance as well as agency integrity and public confidence

Congressional Goals

The agency has adopted a plan to change or reengineer the claims process to accomplish such improvements. We all probably support these efforts. But in concept, reengineering should challenge us to accomplish goals that force us to look beyond or to look around the current way we do things. The agency's April 1994 report actually borrowed from the popular reengineering book on this:

> **"reengineering, we say it means 'starting over.' It *doesn't* mean tinkering with what already exists or making incremental changes that leave basic structures intact."** — Michael Hammer and James Champy, Reengineering the Corporation: A Manifesto for Business Revolution

I see no reason why the agency can not take steps in Fiscal Year 1996 to accomplish, not incremental improvement results, but improvements on a larger scale. Let me recommend that the Subcommittee establish a congressional

expectation for change next year and use the reconciliation process to put this into motion now. Service level improvements can occur sooner rather than later while the Trust Fund reaps the benefits of costs avoided. Other benefits could also accrue such as the potential for improvements in our supported return-to-work expectations.

We should take a second look at an option that I thought the agency was considering; that is, to invite a competition among private companies (profit and non-profit) to take the heat off the delivery structure by outsourcing some of the work to reduce the DDS's backlogs. This also has the advantage of helping accomplish some goals sooner rather than later.

This Makes Sense

This temporary outsourcing of the workload to new delivery entities makes a lot of good sense. First, we should realize that this approach is not new to government. We have examples like the Medicare program where most customer services and provider relations are performed by private parties.

The fiscal agent efforts of 40 or so of the State Medicaid programs is another example of a federal-state program employing outside partners. And, of course, from the Federal perspective, the disability claims process is already outsourced to State-hired and established organizations. Finally, we need to note that private parties are critical to the program's success now. The law already permits a number of authorized representatives to assist clients and, almost the entire medical review component is performed by private parties now.

We should be clear about the fact that we have many options available to us to develop an improved delivery structure. It may not make any sense to replace the entire Federal-state structure as it represents a solid existing investment that we can retool to enhance performance; but it does make sense to supplement the current structure and to provide additional capacity now.

The additional capacity can reduce backlogs rapidly which would allow the State-based structure to quickly improve customer services and shift attention to other efforts including the reengineering. These new entities and the competition for the awards would also produce new work practices and models which the agency could consider in its reengineering efforts.

Of particular interest to me are new information management approaches as models for the currently planned Redesigned Disability System. We should have a clearer picture of modern integrated approaches before we fund a massive nationwide investment in any new infrastructure. I also think we can investigate new case management techniques, including preferred-provider network approaches, that can focus better on improving the actual medical and social service responses to disability.

Finally let me make a point which is very important to me and, I think, to this Congress. The interim contracting approach would be introducing competition into the delivery process for the first time. Bringing new ideas and concept to bear on a long standing problem can do no harm. This concept, if adopted, has the potential to encourage improvements throughout the entire system.

Interim Contracting Approach

Let me lay out the interim contracting approach in more concrete terms:

- the scope of work should cover initial applications, case management, medical review management, CDRs, and so forth; we should treat these entities as our agents and provide a limited decision making authority subject to appeal routes

- the services to be provided should be "transparent" to the customer; that is, private contractors will be agents of the government subject to all the standards of service required of SSA's employees

- people should be assigned on a random basis so we can avoid favoritism or the creaming of case loads, but we should expect and make it possible for people to request a change in their service provider at some early stages

- we should use a meaningful level of work effort which have no economies of scale or measurable budgetary impact

- regional, competitive procurements can provide for better competition and wider coverage while maintaining local levels of service

- we should target budget savings and new revenues into the program

- procurements should be fixed-price, performance based, probably capitated too, and we should authorize performance based activities such as customer services, return-to-work improvements, appropriate care and health care services coordination (like managed care), rehab and other services coordinations, and cost recovery from other insurers

- procurements would probably need to be four years in duration in order to cover the reengineering period and also to secure a return on the investment in plant, people, and the information systems needed to provide a modern level of services

- we would want the agency to evaluate these proposals on the ability of the service provider to improve customer service, deploy modern information management techniques, and to get up and running within a short ramp-up period without major disruption to the program; costs are less important as these should be controlled by the competition and they will be far overshadowed by the benefits

- we should move on these procurements as soon as possible with the hope that at least the first regional competition could be competed early next year

How the Approach Would Work

None of this makes good sense, however, unless it can actually be done in a practical manner. Let me offer a view of how this whole process might work so the subcommittee would feel comfortable in sponsoring it. The pathway might include:

- a draft RFP for comments as soon as practicable after enactment, perhaps in November

- the first regional solicitation could be released in January with award in April

- providers would be required to establish operations within 6-8 months to handle a set of backlogged applications and CDRs while the organization gears up to handle the new applications

- cases would be assigned randomly through automated processes on the toll-free lines, or through planned assignments from the field

- at the service provider level, intake, registration, eligibility screening, medical review, case management, service delivery coordination, and so forth would all be uniformly supported by automated tools and targeted toward accomplishing the reengineering plans performance goals

- the agency's contractors would be provided with secure connections with SSA's data centers for the purposes of inquiries and reporting so as to avoid duplicate data collections and to speed processes (we will need to authorize this)

- the agency would be able to renegotiate some performance based measures each year to ensure consistency with the laws and new policies properly adopted by them

- if a claim is denied (following agency guidelines), an applicant can make an appeal (probably through an automated noticing capability) to SSA which would be treated like any other appeal but it would be more timely presented and the records would be more uniformly established and provided. This fact-based, timely process should not only reduce the number of appeals but also make appeals more efficient and user friendly

- if an appeal is successful, the eligible recipient would be offered the choice of case management at the service provider or through the existing structure in any case, the service provider would be supplying regular automated reports on activities to SSA, and be subject to audits, and so forth

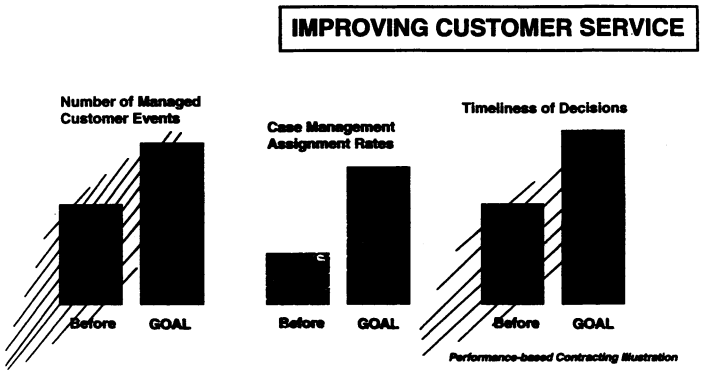
- benefit payments would be sent by SSA in the normal manner

- safeguards would be establish to assure privacy and confidentiality of information and records

Customer Service Benefits

The benefits of this interim contracting approach are many; but I have tried to highlight and illustrate in two graphics the type of outcomes which the agency can call for in its procurements.

Social Security Disability Program
Reengineering with Interim Contracting Model



Managed care techniques in the health care delivery system are essentially "metrics-based," meaning that the things you measure tend to improve. We ought to consider adopting this concept and applying it to the Social Security disability program. We should want to manage customer service contracts better than we do today; we should want to use more case management practices where they are cost-effective; and we should want to speed up the pace for determining eligibles vs non-eligibles. The Inspector General's report of November 1994, "Getting Through the Social Security Disability Claim Process -- Initial Applicants" reported "only 32 percent found the process very or somewhat easy." The agency should seriously consider which of the IG's recommendations should be part of their performance metrics or be built into the agency's complementary activities. I think we would all like to see a better report from the Inspector General next time.

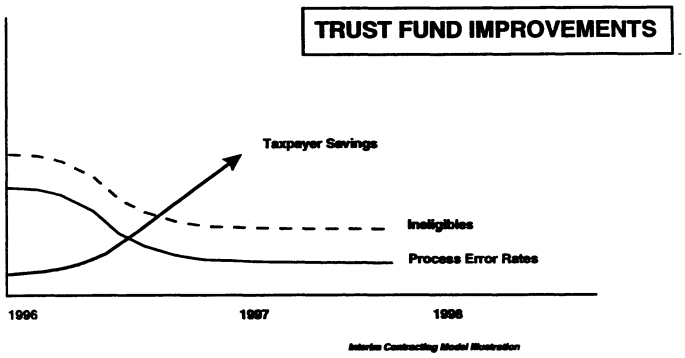
Let me also comment on some of the specialized nature of customer service. Children's disability cases, people with language and reading difficulties, mental disability claimants and beneficiaries, are some of the subsegments of the claimant population where we can use performance expectations and mandatory requirements of a procurement to ensure the capacity to respond more efficiently and effectively. There can be significant customer benefits which the agency can now control more directly with the authorities we provide.

Finally, we should direct that the agency use these procurements to ensure the coordination of health and social service delivery as well as coordination with other insurers.

Budget Savings

The Trust Fund will be the major beneficiary of the interim approach. We should establish incentives to improve on error rates in processing and on identifying ineligibles. The benefits side of the budget will accrue these savings soon after activity starts. Overall, I would expect outsourcing to have a significant return on investment for the taxpayer, and the Trust Fund.

Social Security Disability Program
Reengineering with Interim Contracting Model



On the administrative side of the equation we would have to acknowledge implementing some new tasks in order to manage the procurements and to establish the new organizations; however, I actually expect the agency can substitute this initiative for other currently planned initiatives which have already been acknowledged in their base funding. We would need to assure that the agency is leveling work across the current structure to avoid over-capacity, and assure that the procurement process is designed so that the bids can come in at prices lower than the current approach over the life of the contracts. We need a "capitated approach" to the procurements, not "mil-spec" detail. One example may be to use the procurement process and the new organizations' computer systems instead of agency pilots of the massive RDS. There should be no need for new money and pay-go reactions to support the approach.

Finally, the subcommittee is aware that Social Security Disability activities and payments affect other insurers programs. These other parties have already demonstrated their interest in paying for coordination services which the new outsourced contractors can also offer. We should authorize and provide incentives for these new entities to establish these services. The administrative services side of the equation may actually become a revenue generator for the taxpayer.

Discussing Issues

In discussing this approach with people a number of issues have come up which should be of interest to the subcommittee.

It is clear that there may be some who are opposed to "outsourcing". I would hope that the Congress can stay balanced about this approach. There are great merits to this approach for both the claimants and for the SSA employees. Improved service levels will not only enhance the solvency of the Trust Fund, but will also involve the creation of different jobs than the agency has now, probably better jobs. This should be seen as opportunity for employees to pick up skills and practices which the marketplace is valuing more and more.

Should we expect to make the interim approach permanent? Congress should plan to continue the supplementary program if it appears that it is a better approach and the case loads require it.

Isn't the approach contrary to a trend of reliance on State government? Nothing in the proposal is intended to replace the Federal/State structure. As a nation, we have a long-standing investment in the structure and we understand more and more that we can rely on it for federally-devised program delivery. But needed improvements are acknowledged by just about everyone. If the intergovernmental delivery structure is to adopt the current reengineering, it will need time and a lot less pressure from the current workload. It also won't hurt to have a little competitive stimulation.

Finally, we in Congress are aware that Governors and legislatures have many of the same "rightsizing goals" we have and that they are not always enamored with having to deal with Federally bound work areas. I am hopeful that States themselves might take advantage of the outsourced capabilities and we should enact legislation to permit them to do so.

If the administration has, for whatever reason, dropped the option of "outsourcing" the SSA's disability backlogs then I believe the Congress should examine it as an option. I encourage this subcommittee to do so; legislation may even be needed. We have the opportunity of the reconciliation process to embrace such an initiative, move forward to improve the process and reap the benefits as soon as next year. The agency could be provided explicit authority to proceed.

Closing

A little competition can go a long way to providing incentives to the existing intergovernmental delivery structure to improve while increasing customer services and trust fund integrity as soon as next fiscal year. I believe outsourcing to be a viable option in this situation.

We can help the current structure with its reengineering effort by providing temporary relief for a portion of the agency's workload, while at the same time providing the agency a vehicle to control the development of new models of delivery, workload and information management.

Let me also offer the suggestion that Congress will see additional benefits from the possibility of a more organized approach to the coordination of medical review capabilities while SSA will gain the benefit of new lessons on how to coordinate better the medical and social services for the disabled.

I am very much looking forward to discussing this initiative with members of the subcommittee.

Chairman BUNNING. With that, the subcommittee is adjourned.

[Whereupon, at 11:41 a.m., the hearing was adjourned to reconvene on Thursday, August 3, 1995, at 9 a.m.]

MANAGING THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

THURSDAY, AUGUST 3, 1995

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

The subcommittee met, pursuant to notice, at 9:04 a.m., in room B–318, Rayburn House Office Building, Hon. Jim Bunning (chairman of the subcommittee) presiding.

Chairman BUNNING. The subcommittee will come to order.

I have an opening statement, but I will put it into the record so that we can get on with the hearing. Not too many people came today to hear what I have to say, so I will listen to what you all have to say.

[The prepared statement follows:]

OPENING STATEMENT
CHAIRMAN JIM BUNNING
Before the Social Security Subcommittee
August 3, 1995

GOOD MORNING. FIRST, LET ME WELCOME OUR WITNESSES AND GUESTS TO DAY THREE OF OUR CONTINUING HEARING ON PROBLEMS WITHIN THE SOCIAL SECURITY DISABILITY PROGRAM

MANY OF OUR WITNESSES HAVE COME A LONG WAY AND MADE GREAT EFFORTS IN PREPARATION FOR THIS HEARING. ON BEHALF OF THE SUBCOMMITTEE, WE THANK YOU. YOU ARE THE EXPERTS, AND YOUR TESTIMONY IS IMPORTANT TO US. WE NEED YOUR HELP IN GETTING THIS TRAIN BACK ON TRACK.

AS THIS SUBCOMMITTEE KNOWS TOO WELL, THE SOCIAL SECURITY DISABILITY PROGRAM IS IN REAL TROUBLE.

IN MAY, WE LISTENED TO TWO DAYS OF TESTIMONY FROM EXPERT WITNESSES FROM GAO, THE DISABILITY DETERMINATIONS SERVICES, AND HEARING OFFICES, AS WELL AS FROM MEMBERS OF CONGRESS. THEY DESCRIBED FACTORS WHICH CONTRIBUTED TO THE BREAKDOWN OF THE DISABILITY PROCESS, AND SUGGESTED SOLUTIONS.

TODAY WE ARE GOING TO HEAR MORE ABOUT THE PROBLEMS -- AND BE OFFERED SOME SOLUTIONS, I HOPE.

FIRST, THE GENERAL ACCOUNTING OFFICE IS GOING TO REPORT ON THE RESULTS OF ITS LATEST WORK ON THE PROBLEMS WITH THE DISABILITY PROGRAM.

THEN, WE ARE GOING TO HEAR ABOUT HOW BADLY S.S.A. IS DOING REHABILITATING PEOPLE. S.S.A IS SIMPLY NOT HELPING PEOPLE GET BACK TO WORK AND OFF THE DISABILITY ROLLS. I UNDERSTAND THAT OF OVER 9 MILLION PEOPLE WHO WERE ON THE D.I. AND S.S.I. DISABILITY ROLLS LAST YEAR, S.S.A. REHABILITATED FEWER THAN 6,000 -- A WHOPPING HALF OF ONE PERCENT SUCCESS RATE!

THIS IS DUE, IN PART, TO THE FACT THAT STATE V.R. AGENCIES CURRENTLY HAVE A MONOPOLY ON PROVIDING REHAB SERVICES TO SOCIAL SECURITY BENEFICIARIES.

IT'S ALSO DUE TO THE FACT THAT RECIPIENTS HAVE LITTLE INCENTIVE TO PARTICIPATE IN REHAB, BECAUSE S.S.A. RARELY TAKES ANYONE OFF THE ROLLS. THAT HAS TO CHANGE.

FINALLY, WE ARE GOING TO HEAR ABOUT WAYS TO UNCLOG AND IMPROVE THE PROCESS. ANDY JACOBS AND I HAVE ALREADY EXPRESSED OUR STRONG COMMITMENT TO CREATING A SPECIALIZED SOCIAL SECURITY COURT TO BRING SOME CONSISTENCY TO COURT DECISIONS.

WITH 89 FEDERAL DISTRICT COURTS AND 13 CIRCUIT COURTS REVIEWING S.S.A. DECISIONS AND ISSUING INTERPRETATIONS OF REGULATIONS, WE HAVE A HODGE PODGE OF RULES LACKING ANY SEMBLANCE OF UNIFORMITY.

EVEN MORE DISTRESSING THAN ALL THE PROBLEMS I HAVE JUST OUTLINED, IS THE FACT THAT S.S.A. HAS BEEN WORKING FOR OVER TWO YEARS ON A DISABILITY PROCESS REDESIGN PLAN WHICH DOES NOT ADDRESS ANY OF THESE ISSUES.

FROM THE FIRST DAY I BEGAN LOOKING INTO THE DISABILITY PROGRAM, I HAVE HAD ONE OBJECTIVE.

THAT IS TO MAKE SURE THAT PEOPLE WHO ARE TRULY DISABLED RECEIVE BENEFITS QUICKLY AND EASILY, AND THAT PEOPLE WHO HAVE RECOVERED ARE TAKEN OFF THE ROLLS.

THIS IS ONLY FAIR.

AND I CAN'T IMAGINE THAT ANYONE COULD DISAGREE WITH THAT OBJECTIVE.

Chairman BUNNING. If the first panel, the GAO, would please step forward. The subcommittee welcomes Jane Ross, Director, Income Security Issues; and Cynthia Bascetta, Assistant Director for Income Security Issues.

For the benefit of our guests, GAO is an arm of the Congress which does its audits and investigative work. GAO has already done a considerable amount of work on Social Security disability problems, which we appreciate very much. They testified on May 23 and are presenting additional findings today.

Welcome. Ms. Ross, would you please begin.

STATEMENT OF JANE L. ROSS, DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY CYNTHIA BASCETTA, ASSISTANT DIRECTOR, INCOME SECURITY ISSUES

Ms. ROSS. Yes, Mr. Chairman. Mr. Chairman and members of the subcommittee, this morning I would like to focus my remarks on two issues related to the DI and SSI programs, issues that require action to improve program operations and to place more emphasis on returning beneficiaries to work. In particular, I want to talk about improving the timeliness and consistency of disability decisions and helping more people reduce their dependence on cash benefits.

First, I will describe the current decisionmaking process, using the chart. It shows the multilayered structure that is in place at this point to handle decisions and appeals, and it highlights the five levels at which new evidence can be introduced.

SSA's administrative cost to manage the disability claims process is about $2.7 billion annually. If you look at the chart, the initial determination of whether or not you are disabled starts at the bottom. The initial determination is made in the State agency. If a person is denied there and decides he wants to have an appeal, he first goes through reconsideration at the State level. Then he moves on to the administrative law judge and can appeal as well through the appeals council and up through the Federal court system.

The boxes that are colored in that line, the first five, are all places at which new evidence can be introduced into the process.

SSA has had a longstanding problem about making consistent decisions, especially with regard to the DDS level, which is the bottom level on the chart and the administrative law judge level.

DDS examiners view cases quite differently from administrative law judges. The negative consequence of this inconsistency is that people whose applications are denied initially are quite likely to appeal because such a high percentage of appealed cases are actually approved.

If you look at the pie charts that we have on the right-hand side of the chart, and you look at reconsideration, it shows that 63 percent of the people at the reconsideration level appeal up to the administrative law judge level, and you can see with the green that 67 percent of the cases heard by administrative law judges are actually accepted when they have been denied earlier on. So that 67 percent tells you why moving to the administrative law judge level

is such an appealing thing for people to do. You can also see why it presents such a problem.

At present, administrative law judges allow benefits in about 75 percent of the disability cases they decide—quite a magnet for people who are trying to become eligible for benefits. This is partially explained by the introduction of new evidence, especially at the administrative law judge level, and the ALJ's ability to meet directly, face to face, with applicants. This is the first time in the process that an applicant has a face-to-face meeting.

We and many others have called for changes to the appeals process to improve consistency. In late 1993, SSA began a long-range project to reengineer the entire disability decisionmaking process. Some of their actions are intended to bring about more consistent decisions between that initial level and the ALJ and therefore reduce the likelihood that cases will be appealed.

But there are other reforms of the appeals process that could also be considered in order to reduce inconsistency. In particular, many experts have called for closing the hearing record and changing the scope of the administrative law judge review. Closing the record means that at some point in the process—in this case, before the administrative law judge holds the hearing—the claimant would not be able to introduce any new evidence into the case file. Today, about 25 percent of the administrative law judge allowances are based on new evidence not previously presented.

The scope of the administrative law judge review could also be limited by assuring that the DDSs followed the law and regulations correctly, rather than completely reevaluating the DDS decision and all of the evidence.

Besides improving decisionmaking, SSA needs to do more to help beneficiaries reduce their dependence on cash benefits. This is the second issue I would like to discuss.

SSA's lack of aggressive efforts to refer beneficiaries for rehabilitation services has been well documented for years. In 1994 SSA paid about $64 million for rehabilitation services, or about one-tenth of 1 percent of total benefits. Less than one-tenth of 1 percent of all the beneficiaries are successfully rehabilitated.

There are many proposals that people have made through the years of ways to move people off the rolls through rehabilitation. I will just mention a couple.

Time-limited benefits is one proposal that is intended to set the expectation that disability benefits are temporary. Proponents of this particular proposal hope that it will encourage beneficiaries to take responsibility for obtaining treatment, pursuing rehabilitation, and finding ways to overcome their disabling conditions and return to employment.

In addition, using more private vocational rehabilitation firms has been suggested as a way to expand and improve rehabilitation efforts. Currently, virtually all vocational rehabilitation efforts are channeled through State vocational rehabilitation offices.

Also, many experts believe that faster access to rehabilitation is critical to successful outcomes. Currently, SSA refers beneficiaries to rehabilitation just after they have convinced SSA that they cannot work and should receive benefits. Sounds a little too late.

In addition to persons leaving the rolls in order to enter employment, some persons should be removed from the rolls because they have recovered. This is the purpose of continuing disability reviews. SSA is required to review the medical eligibility of DI and SSI beneficiaries through these continuing disability reviews. For a variety of reasons, SSA has not performed all the CDRs that the law requires, and a substantial backlog has resulted. The net savings from eliminating this backlog could amount to about $1.7 billion in cash and medical benefits.

In order to provide more adequate funding for conducting all required CDRs, some have proposed establishing a special CDR budget account. An amount representing the projected cost savings from performing CDRs in a previous year could be transferred into the fund annually, to be used solely for additional CDRs.

In conclusion, although the problems we cite are serious, both short- and long-term solutions are available. SSA acknowledges and has plans to address some of the issues, and other experts have raised additional proposals that also warrant consideration. We believe that relatively quick action could be taken to reduce decisionmaking inconsistencies, to improve rehabilitation outcomes, and to step up the reviews of beneficiaries who may be able to return to work.

Mr. Chairman, that completes my statement. I would be glad to answer any questions you may have.

[The prepared statement and attachments follow:]

STATEMENT OF JANE L. ROSS, DIRECTOR
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to testify on issues related to the Social Security Administration's (SSA) management of the Disability Insurance (DI) and Supplemental Security Income (SSI) programs. These programs have grown rapidly with costs now approaching $60 billion a year in cash benefits to almost 10 million disabled beneficiaries. Moreover, the characteristics of the beneficiaries are changing; they are younger people with different types of impairments than in the past.

Today I would like to focus my remarks on three areas that require action to improve SSA's management of these programs and to make their design conform to a more contemporary concept of disability:

-- improving the timeliness and consistency of disability decisions,

-- helping more people reduce their dependence on cash benefits, and

-- ensuring that benefits are going only to those least able to work.

To develop this information, we relied on our previous work (see app., Related GAO Products), reviewed the work of other researchers and experts, and incorporated, where appropriate, data we have obtained as part of ongoing work we are conducting at your request.

In summary, our work shows that SSA has serious problems managing the disability programs on several separate but related fronts. First, the lengthy and complicated decision-making process results in untimely decisions, especially for those who appeal, and shows troubling signs of inconsistency, which compromise the integrity of the process. Second, SSA has a poor record of reviewing beneficiaries to determine whether they remain eligible for benefits and an even worse record of providing rehabilitation to help people move off the disability rolls and into employment. This reinforces the public perception that SSA pays disability benefits to people who may not qualify for them. Third, and related to the first two problems, SSA needs to make better decisions about work capacity to restore public confidence and better serve the beneficiaries.

Although the problems we cite are serious, both short-term and long-term solutions are available. SSA acknowledges and has plans to address some of the issues, but others have raised additional proposals that also warrant consideration. We believe that relatively quick action could be taken to reduce inconsistent decision-making, step up reviews of beneficiaries who may be able to return to work, and improve rehabilitation outcomes. In some cases, SSA has the authority to take action; in others, decisionmakers may need to rethink the goals and objectives of DI and SSI. In particular, more deliberation may be necessary to better manage beneficiaries' entrance and exit from the rolls over the long run.

BACKGROUND

In 1994, 5.6 million disabled workers and their dependents received $38 billion in DI benefits, up from 3.9 million at the end of 1985--a 43-percent increase. Most of this growth occurred in the last 3 years when 1.1 million beneficiaries were added to the rolls. The SSI program has grown even more. Over the last decade, the number of disabled SSI recipients doubled, from 2.1 million to 4.2 million. They receive about $20 billion in benefits per year. In 1994, it cost SSA $2.7 billion to manage the disability claims process for these programs. These administrative costs account for more than half of SSA's total

administrative budget but only about 3 and 7 percent of DI and SSI benefit payments, respectively.

The DI program was enacted in 1956 and provides monthly cash benefits and Medicare eligibility to severely disabled workers. SSI, on the other hand, was enacted in 1972 as a means-tested income assistance program for aged, blind, or disabled people. The Social Security Act defines disability as an inability to engage in substantial gainful activity by reason of a severe physical or mental impairment. The impairment must be medically determinable and expected to last at least a year or result in death. Both DI and SSI use the same criteria and procedures for determining whether the severity of an applicant's impairment qualifies him or her for disability benefits.

DI is funded through Federal Insurance Contributions Act (FICA) taxes, which are paid into the DI Trust Fund by employers and employees.[1] In contrast, SSI program costs are funded from general revenues, not the Trust Fund. Applicants for DI must have worked long enough and recently enough to be insured for disability benefits. Once found eligible for benefits, disabled workers continue to receive them until they return to work, reach full retirement age (when disability benefits convert to retirement benefits), die, or are found to have medically improved or regained their ability to work. SSI benefits are based on income rather than work history, but like DI, SSI terminates benefits to people who die, medically improve, or are able to return to work.

People can receive both DI and SSI benefits. If a beneficiary's DI benefit--based on work history--is less than the maximum SSI benefit, the DI benefit is supplemented with SSI. There are about 1.5 million of these concurrent beneficiaries, and they represent a growing percentage of the caseload.

Both DI and SSI are administered by SSA and state disability determination services (DDS). SSA field offices determine whether applicants meet the nonmedical criteria for eligibility, and DDSs make the initial determination of whether applicants meet the definition of disability. Applicants who are denied benefits at the DDS level may request a hearing before one of SSA's 1,011 administrative law judges (ALJ) and may subsequently pursue denials at this level in the federal courts.

Statute Requires Measures That Could Reduce Dependence on Cash Benefits

DI was originally established to extend Social Security old age and survivors assistance to workers who became too disabled to work. Although many of the early beneficiaries received disability payments until they retired, original legislation also promoted the rehabilitation of disabled beneficiaries. When the Congress enacted DI legislation, it recognized the great advances in rehabilitation techniques and the importance of rehabilitation efforts on behalf of disabled persons. DI legislation, and subsequently the SSI law, required that those who apply for disability benefits be promptly referred to vocational rehabilitation agencies for services to maximize the number of such individuals who could return to productive activity. In addition, current law requires SSA to suspend benefits to

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[1]FICA payroll taxes are divided into the Disability Insurance Trust Fund, the Old Age and Survivors Insurance Trust Fund, and the Medicare Hospital Insurance Trust Fund. Because the DI Trust Fund was projected to be insolvent in 1995, last year the Congress reallocated payroll tax receipts to it from the Social Security Old Age and Survivors Trust Fund. This will result in a transfer of almost $500 billion by 2016, when the DI Trust Fund is again projected to be insolvent.

beneficiaries who fail to cooperate with rehabilitation efforts. In 1965, the Congress authorized payment of state costs for rehabilitation from the DI Trust Fund.

SSA is required by law to conduct continuing disability reviews (CDR) to determine which beneficiaries have recovered to the point that they no longer qualify for benefits. The law requires CDRs at least every 3 years on DI beneficiaries for whom medical improvement is expected or possible. SSA is also required by regulation to perform CDRs at least once every 7 years on beneficiaries for whom medical improvement is not expected. In addition, the Social Security Independence and Program Improvements Act of 1994 requires SSA to conduct CDRs on 100,000 SSI adults and on one-third of SSI children reaching age 18 in each of the years 1996, 1997, and 1998.

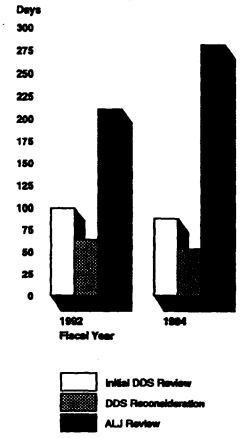
MAKING TIMELY AND CONSISTENT DISABILITY DECISIONS

Long waits for disability decisions and high reversal rates on appeal have been a subject of concern for many years. Currently, decision-making backlogs continue to grow and inconsistencies persist between initial decisions made by DDSs and those that are appealed to ALJs. SSA has attempted to address these problems in the past, and the agency and others have recent proposals directed at improving timeliness and reducing inconsistency.

Workload Pressures and Delays

Rising rates at which applications and appeals are being filed have caused tremendous workload pressures for the DDSs and ALJs. As we testified before you on May 23, 1995, backlogs and processing times at the ALJ level continue to grow. Between 1985 and 1994, the number of new appeals to ALJs more than doubled to 549,000, and the backlog of pending appeals more than quadrupled. As of March 1995, over 500,000 cases--or more than a year's worth of cases--were currently awaiting decision. As shown in figure 1, these large backlogs mean DI beneficiaries wait an average of 281 days for a final decision on appeal, which can result in hardship for claimants. From the first time they apply, some claimants may wait as long as 550 days for a decision.

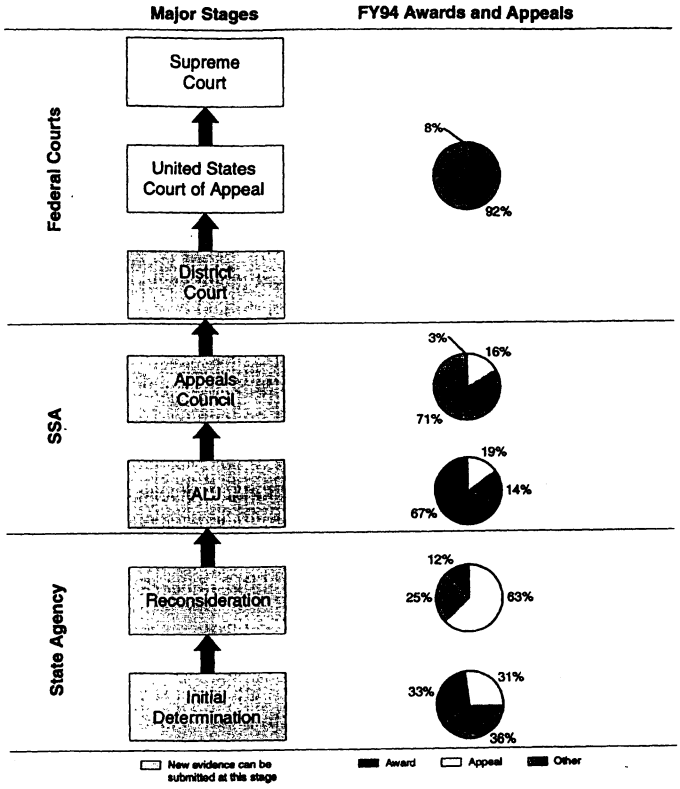
Figure 1: Processing Times



Current Process Is Long and Complicated

Figure 2 is an overview of the current decision-making process. As you can see, the process includes a multilayered administrative structure to handle appeals. The shaded boxes show that new evidence can be introduced at many points in the process, and the pie charts show that each decision level can lead to new awards, most notably at the ALJ level.[2]

Figure 2: The Decision-Making System and Results



For both DI and SSI, the disability determination process starts at the state DDS with the initial decision. An applicant whose claim is denied can ask to have the initial decision reconsidered. Reconsideration is conducted by different DDS personnel from those who made the initial determination; the criteria and process for determining disability, however, are the same.

[2]Other results can include denial, remand, or dismissal (for example, if a claimant fails to pursue the case).

Applicants whose claims are denied at the reconsideration level may request hearings before one of SSA's ALJs. About 70 percent of applicants are represented by attorneys at these hearings, and additional evidence may be submitted by medical and vocational experts as well as the applicant. Applicants whose claims are denied by ALJs can request a review by SSA's Appeals Council and then may pursue further appeals in the federal courts--first in the district courts[3] and the courts of appeal, and finally the Supreme Court.

The decision process is lengthy for those who appeal, but more than three-quarters of all awards are made by DDSs and less than one-quarter are made at the ALJ level or higher. In fiscal year 1994, DDSs awarded benefits to about 961,000 applicants in total, and ALJs awarded benefits to 264,000, while the courts awarded benefits to far fewer applicants.

Inconsistent Results Between DDSs and ALJs

SSA has had long-standing problems with consistency of its disability decisions. In 1994, ALJs allowed benefits in 75 percent of the disability cases they decided.[4] This high rate of awards to applicants denied at the DDS level raises concern about whether DDS and ALJ decisions are made on a consistent basis.

In part, this difference reflects the program's design. The ALJ does not explicitly consider and rule on the DDS's original decision. Instead, the ALJ makes a "fresh" decision based on the ALJ's own view of the evidence in the case.[5] In addition, the evidence considered by the ALJ can be very different from that considered by the DDS. A claimant has a right to introduce any new evidence to the ALJ, whether or not the claimant presented it to the DDS.

However, these differences do not fully explain the disparity between the two levels. Available research indicates that the two decision-making levels do not agree even when faced with the same evidence. In 1982, SSA published the results of a study that tested the consistency of DDS and ALJ decision-making.[6] As part of this study, the agency presented the same evidence to two different groups of decisionmakers--one representing the ALJ policy and procedures and the other representing the DDS policy and procedures.[7] The ALJ representatives concluded that 48

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[3]At the district court, the applicant can ask to submit new evidence for the record. If the court agrees that new evidence should be considered, it remands the case to SSA. The law provides that additional evidence may be taken before the agency on remand, but only on a showing that this is new material evidence and that there was good cause for the failure to incorporate the evidence at a prior proceeding.

[4]Approximately 11 percent of ALJ cases were dismissed before a decision was reached.

[5]Technically, the ALJ's decisions are said to be de novo, or "afresh."

[6]Implementation of Section 304(g) of Public Law 96-265, Social Security Disability Amendments of 1980: Report to the Congress by the Secretary of Health and Human Services ("The Bellmon Report") Department of Health and Human Services, Social Security Administration (Jan. 1982).

[7]The evidence included all documentary evidence presented to the DDS, as well as all supplementary evidence presented to the ALJ, along with a transcript of the hearing before the ALJ. Neither group participating in the test knew what the ALJ had decided on

percent of the test cases should have resulted in awards, while the DDS representatives concluded that only 13 percent of the same cases should have been awards. The study concluded that "significant differences in decision results were produced when these different decision makers were presented with the same evidence on the same cases."

All the reasons for this disparity are not conclusively known, but some causes have been identified. The introduction of new evidence, for example including claimant allegations that their condition has worsened over time, and face-to-face contact at the ALJ level are two significant aspects of the current process that explain some of the disparity. Notably, SSA found that when an applicant appeared in person before a decisionmaker, there was a substantial effect on the final decision. Specifically, the 1982 study showed that evidence from the personal appearance increased the allowance rate by 17 percentage points. The results of a more recent SSA study published in 1994 suggest that disparities between DDS and ALJ decisions remain wide.[8] In addition, both the 1982 and the 1994 studies found that DDS and ALJ staff differ significantly in their conclusions about the claimant's ability to work at sedentary (sit-down) jobs.[9] Also, in the opinion of experts, reports prepared by treating physicians and claimants' allegations about pain are much more likely to influence ALJ decisions to award benefits.[10]

The 1994 report also pointed to another significant source of appellate reversals--DDS errors in making denials. In the study, a group of SSA medical consultants and disability examiners--using DDS standards and procedures--concluded that for about 29 percent of the cases appealed to the ALJs, either they should have been decided differently or better evidence should have been obtained by the DDS.

Heavy workloads at the DDS level and resource constraints may have contributed to weak documentation of denials. In addition, greater emphasis in the quality assurance process on ensuring the accuracy of awards rather than denials could account for the lower quality of denials. Improving DDS level documentation is the foundation for making correct decisions at the initial level. For example, an SSA study found that decisionmakers were more likely to reach different conclusions for cases in which development of evidence was weak.[11]

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the case.

[8]Findings of the Disability Hearings Quality Review Process Office of Program and Integrity Reviews, Social Security Administration (Sept. 1994).

[9]Claimants can qualify for disability in two ways: (1) their medical condition by itself meets or equals medical criteria generally considered by medical experts to be severe enough to prevent a person from engaging in "any gainful activity," or (2) an assessment of their remaining ability to function (for example, ability to lift or bend) combined with their age, education, and work experience, leads to the conclusion they cannot engage in "substantial gainful activity." A person's ability to perform sedentary work is a factor in determining eligibility under the latter.

[10]This Subcommittee has asked us to provide a more complete report on these decision-making disparities.

[11]Sal Gallicchio and Barry Bye, Consistency of Initial Disability Decisions Among and Within States, Department of Health and Human Services, Staff paper No. 39, SSA Publications No. 13-11869 (July 1980).

Identifying and resolving these sources of disparity may help reduce decision-making inconsistencies. However, because the cases reaching ALJs are frequently those involving subjective judgments, some level of continuing disparities would be expected. For example, about half the cases ALJs hear are musculoskeletal cases--frequently back injuries--and another 16 percent are mental impairment cases. Such cases often turn on pain, depression, fatigue, or other more subjective symptoms that could affect ability to function in the workplace.

Prior Efforts to Increase Timeliness and Consistency

SSA and the Congress have taken action in the past to increase the timeliness and consistency of disability decisions in the past. These efforts, which related to the appellate part of the process, have either been blocked by court action or substantially reduced because of workload pressures.

Three prior attempts to improve productivity and quality assurance reviews of ALJ decisions have been made. First, 1980 legislation required SSA to establish a process known as "own motion review" to oversee the quality of ALJ decisions. In some cases, this action leads to the ALJ's being overruled. However, the agency only reviews about one-half of 1 percent of ALJ allowances today, mainly because of workload pressures. Second, beginning in 1975, SSA embarked on several efforts to "target" for corrective action ALJs who had relatively high award rates or relatively low productivity. Decisions of ALJs with relatively high award rates would be subject to special review, and ALJs with low productivity would be reported for personnel actions.[12] ALJs sued to enjoin the productivity initiative, claiming it would interfere with the ALJs' decisional independence. SSA settled the suit and has not attempted major initiatives in this area again.[13] Third, in the late 1970s, a federal district court in Western Kentucky attempted to impose time limits on ALJ decisions. The court sought to require SSA to ensure that all cases would be scheduled for a hearing by an ALJ within 90 days after appeal. SSA stated that it lacked the resources to achieve this goal and also lacked the legal authority to pay benefits without an ALJ's favorable decision. As a result of the case, a 165-day time limit went into effect in Kentucky. However, no national time standard exists today.[14]

In 1982, SSA established a pilot project in which it assigned staff to represent it in proceedings before the ALJs. SSA reasoned that since claimants with attorneys were frequently successful, it, too, should be represented.[15] However, SSA was forced to abandon this effort after the decision in Salling v.

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[12]The Administrative Procedures Act protects the independence of ALJs by limiting agency authority over certain personnel actions, such as promotions, reassignments, and transfers.

[13]Bono v. Social Security Administration, No. 77-0819-CV-W-4 (W.D.Mo., July 24, 1979).

[14]Blankenship v. Secretary of HEW, 587 F. 2nd 329 (6th cir. 1978).

[15]In 1994, approximately 71 percent of claimants had attorneys present at their hearings. Claimants with either attorneys or other representation were successful 71 percent of the time, while unrepresented claimants had only a 50-percent success rate. Some of this difference may indicate that claimants with weak cases have difficulty obtaining representation.

Bowen.[16] In his decision, the judge pointed out that the ALJ process was not designed by legislation to be an adversarial process and that changes in the law would be necessary if the process were to become adversarial.

New Proposals for Reforming the Appeals Process

We and many other experts have called for process changes to streamline the decision-making process, especially the appeals process. Recognizing the importance of making quicker and better decisions as early as possible, SSA has recently embarked on a long-range project to reengineer the disability decision-making process. Under reengineering, SSA plans for earlier face-to-face contact and better development of the record before the ALJ hearing. Central to this effort is the adjudication officer, a new focal point for prehearing activities such as identifying issues in dispute, assessing whether there is a need for additional evidence, and developing the record. SSA believes that this process will permit the ALJs to conduct more hearings and render prompter decisions. In addition, SSA plans to develop a single presentation of policies for all decisionmakers, including ALJs, to follow in determining disability. Other suggested reforms not included in SSA's reengineering plan are closing the record and changing the scope of the ALJ review.

Having claimants meet face-to-face with the decisionmaker earlier in the process has been proposed by both SSA and us to improve the process.[17] Generally, early dispute resolution is considered desirable to expedite the process by helping to ensure the earliest possible development of a complete record. An earlier face-to-face meeting, for example, can help target the collection and development of medical and other evidence necessary for making a correct decision more quickly. Providing an opportunity for earlier face-to-face contact may place heavier workload demands on the front end of the process, however, if applicants request this option.

Closing the record means that after some point early in the process the claimant would not be able to introduce new evidence to the case file. This would encourage the claimant to make sure that as much evidence as possible was presented as soon as possible. Today, SSA estimates that about 25 percent of ALJ allowances are based on new evidence not previously presented to the DDSs. With appropriate development of evidence earlier in the process, closing the record holds promise for tightening the focus of hearing decisions and avoiding the "do it over" aspect of the ALJ decision. In 1982, legislation was introduced that, if enacted, would have closed the record after the reconsideration stage of the process. The Grace Commission made a similar recommendation in 1993.

The Grace Commission also recommended limiting the scope of the ALJ review. Under this limited review, the ALJ would rule only on whether the DDS had complied with law and regulation when it made the original decision. This, in combination with a closed record, would most closely resemble a true appellate process and could considerably reduce the number of reversals made by ALJs. In fact, closing the record without narrowing the scope of ALJ review would not be likely to reduce their higher award rate unless ALJs were restricted in substituting their judgment for that of the DDS.

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[16]Salling v. Bowen, 641 F.Supp. 1046 (W.D.Va. 1986).

[17]Plan for a New Disability Claim Process, Social Security Administration (Sept. 1994); and Social Security: Selective Face-to-Face Interviews With Disability Claimants Could Reduce Appeals (GAO/HRD-89-22, Apr. 20, 1989).

HELPING MORE BENEFICIARIES REDUCE THEIR DEPENDENCE ON CASH BENEFITS

Since 1992, we have been reporting that the characteristics of disability beneficiaries are changing and that beneficiaries leave the rolls less often.[18] For example, in 1985, the number of new entrants on the rolls was roughly equal to the number of people who left. Today, new entrants are roughly double the number of those departing.

Several factors have fueled this trend. First, people are being added to the rolls at a younger age--on average at about 48 years old. Second, those with mental impairments have come to represent higher percentages of the rolls and may stay on the rolls longer because, unlike many physical impairments, mental impairments generally do not shorten life expectancy.

Rehabilitation Has Had Negligible Impact

SSA's lack of aggressive efforts to refer beneficiaries for rehabilitation services has been well documented for years. In addition to the lack of program emphasis on improving the work prospects of beneficiaries, leaving the rolls has been unattractive financially. Many beneficiaries might be unable to replace their cash benefits, health insurance, and other in-kind benefits with earnings and fringe benefits in the workplace.

In recent years, about 1 of every 500 DI beneficiaries has been terminated from the rolls because they return to work. SSA does not measure the number of SSI recipients terminated because they return to work, but its information indicates that very few do so. Today, SSA refers about 8 percent of new beneficiaries--almost 300,000 individuals--to state vocational rehabilitation agencies for appropriate services administered by the Department of Education's Rehabilitation Services Administration (RSA). These state agencies, however, only accept about 10 percent of SSA's referrals. SSA pays the cost of the rehabilitation for successfully rehabilitated DI beneficiaries from the DI Trust Fund and for successfully rehabilitated SSI recipients from general revenues. In 1994, SSA paid RSA about $64 million for rehabilitation services, or 0.11 percent of total benefits. Of the more than 7 million disabled beneficiaries on the rolls in 1994, only 5,653--less than one-tenth of 1 percent--were successfully rehabilitated at an average cost of about $11,300 per case.

Since state RSA offices are 80-percent federally funded, the practice of again paying additionally the entire cost of rehabilitating DI beneficiaries would seem to be a strong incentive to RSA offices to seek out more beneficiaries for rehabilitation. However, this incentive has not apparently achieved this purpose. Recently, the Department of Health and Human Services (HHS) Inspector General reported finding little evidence that the reimbursement system was inducing states to increase the number of SSA clients served. With few exceptions, states made no special efforts to enroll SSA beneficiaries in vocational rehabilitation programs and established no special rehabilitation programs for them.

Savings From CDRs Not Fully Realized

SSA is required to periodically review the medical eligibility of DI beneficiaries through CDRs. The frequency of these reviews is based on the beneficiary's age and impairment.

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[18] Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

The law requires beneficiaries for whom medical improvement is expected or possible to be reviewed at least once every 3 years. SSA regulations require review of all permanently disabled cases at least once every 7 years.

Staff and budget limitations, combined with the dramatic increase in applications for disability benefits, have prevented DDSs from performing all the required examinations. For example, each year from 1991 through 1993, DDSs performed fewer than 74,000 CDRs, while as many as 490,000 CDRs come due each year. As a result, a CDR backlog now totaling about 1.5 million disabled worker cases has developed. The CDR backlog may increase because the agency is now required to conduct CDRs on 100,000 SSI adults in addition to reviewing one-third of SSI children reaching age 18 in each of the years 1996, 1997, and 1998. These new requirements--which will be absorbed within existing budgets--may further affect SSA's ability to reduce the DI backlog.

SSA is refining techniques to improve its CDR efficiency. It originally performed CDRs by referring all beneficiaries to state DDSs for medical review on the basis of fixed schedules. In May 1993, SSA started profiling beneficiaries on the basis of information in computerized databases about their characteristics. These profiles were intended to better predict the likelihood of medical improvement, and beneficiaries were referred for DDS review primarily when their profiles indicated that medical improvement would be likely.

In addition, SSA is currently studying what SSA and DDS resources might be required to eliminate the backlog over a 2-, 3-, or 4-year period, including the impact on SSA's ability to process initial claims and handle appeals at the ALJ level. As part of this effort, SSA is also studying the feasibility of contracting out part of its CDR activities to private organizations.

Conducting CDRs has profound implications for expenditures because of the combined effect of the surge in applications and the growing tendency of beneficiaries to remain on the rolls longer. If SSA were to perform CDRs on its backlog of 1.5 million disabled worker cases, it would obtain nearly all of its savings from eliminating about half of the backlog, which is made up of beneficiaries for whom medical improvement is expected or possible. The remainder of the backlog is permanently disabled cases; most of these beneficiaries are over 50 years old and about half have been on the rolls for 11 or more years. Taking all of this into account, however, the net savings could amount to about $1.7 billion for cash and medical benefits that would have been paid over the beneficiaries' average length of stay on the rolls. This figure is based on SSA's estimate that about 3 percent of the cases for whom medical improvement is expected or possible would be terminated. Each termination would cost an average of $500 for performing the CDR, but would save an average $90,000 in lifetime DI and Medicare benefit costs.

Proposals to Reduce Dependence on Cash Benefits

Like the proposals to improve timeliness and consistency in the process of enrolling people in DI and SSI, proposals to improve the system's ability to remove people from the rolls have come from a number of sources. These proposals generally include time-limited benefits, private sector rehabilitation, faster access to rehabilitation, and more CDRs financed by a revolving fund. Some of these proposals would require legislative action.

Time-limited benefits are being discussed in the Congress and by researchers and other experts. Time limits are intended to set the expectation that disability benefits are to be considered

temporary. This expectation is intended to encourage beneficiaries to take some responsibility, such as obtaining treatment and pursuing rehabilitation, to overcome their disabling conditions and return to productive employment. Generally, such proposals establish criteria for deciding which disability cases would be subject to the time limits.

In pursuing the time-limited approach, the CDR profiles might provide useful guidelines for deciding when to apply time limits and for what duration. Funding treatment and rehabilitation services could also help to facilitate recovery, maximize work prospects, and limit reapplications. In addition, establishing criteria for extending or terminating benefits at reapplication would need to be developed.

Private sector rehabilitation has been suggested as a way to increase the availability and effectiveness of rehabilitation efforts. SSA is testing such approaches under its Project Network initiative, which involves intensive outreach, liberalized work incentives, and case management. In addition to the evaluation of Project Network now under way, more needs to be done to assess the potential impact of a vigorous employment assistance program, particularly when integrated with other aspects of DI and SSI programs.

In 1976, we reported that most of the funding for rehabilitation had not achieved its intended effect, and in 1981, the Congress amended the Social Security Act to restrict funding for rehabilitation to cases in which the beneficiary returned to substantial gainful activity for 9 continuous months.[19] While the principle of paying only for rehabilitation successes remains a good one, better reimbursement mechanisms to tie rehabilitation funding to return-to-work outcomes need to be developed and tested, whether public or private agencies are the service providers. One proposal to address this problem would give private and nonprofit rehabilitation providers a long-term share of the savings that might accrue from a successful effort, especially if it yielded sustained results. For example, some disabilities, such as multiple sclerosis or certain mental impairments, cause intermittent impairment possibly necessitating renewed rehabilitation interventions and support during reoccurrences.

Faster access to rehabilitation is believed by many private sector experts to be a key to successful rehabilitation. But SSA refers beneficiaries at the same time it notifies them that they have been awarded benefits. At this point, the beneficiary has been through a lengthy determination process, especially if the case was appealed. Moreover, the process requires an applicant to emphasize his or her incapacity. And, because the applicant is unlikely to work during the determination process, it is not unreasonable to expect that skills, motivation, and work habits will erode during this extended period, reducing the beneficiary's receptivity to rehabilitation. Although early referral is an important predictor of successful rehabilitation, overcoming the disability mindset fostered by the decision-making process will also be necessary to greatly improve rehabilitation outcomes.

Conducting more CDRs has been suggested in many of our reports.[20] Experience to date suggests that CDRs can be part of

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[19]These 9 months correspond to the trial work period allowed by work incentive provisions for DI beneficiaries.

[20]Our most recent reports on CDRs are Social Security: SSA Needs to Improve Continuing Disability Review Program (GAO/HRD-93-109, July 8, 1993); Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-

a well-balanced plan for reducing the number of people on the rolls, and new techniques--such as profiling--show promise to improve CDR efficiency. However, because of lack of funding, SSA continues to fall short of conducting all required CDRs. Also, even though the new profile process has increased its effectiveness and better targeted its limited resources, SSA is still making improvements to this process.

To provide additional funding for CDRs, proposals have been made to establish a special CDR budget account. Under one such proposal, an amount representing projected cost savings from performing CDRs in the previous year would be transferred to the CDR account annually to be used solely for additional CDRs. In concept, such a fund would be similar to the Medical Care Cost Recovery Fund in the Department of Veterans Affairs (VA). The fund provides administrative support to obtain copayments from certain VA beneficiaries and payments from veterans' health insurers to cover care provided in VA hospitals. The VA fund is self-sustaining and provides almost $600 million in recovered revenue every year at a cost of about $100 million.

ENSURING THAT ONLY THOSE WHO CANNOT WORK GET BENEFITS

Ensuring that those receiving benefits are unable to work--permanently or for an extended period of time--is critical to protecting the taxpayers' dollars and to improving public confidence. This would also be consistent with society's shift toward recognizing the productive capacities of people with disabilities. Yet decisions about who is eligible for benefits and who is not are not easy and require a great deal of judgment in many cases. In part, the inherent subjectivity of these decisions accounts for some of the disparities between DDSs and ALJs. It also helps explain the complexities involved in targeting CDRs and rehabilitation to those most likely to leave the rolls.

Managing the Caseload Requires Refocusing From Disability to Work Capacity

In accordance with the Social Security Act, which requires that an applicant's work incapacity be based on the presence of medically determinable physical and mental impairments, SSA developed the Listing of Impairments (the listings) as part of its process for determining eligibility. The listings represent a consensus of medical experts about the signs, symptoms, and laboratory findings as well as some functional criteria, which, according to SSA, are severe enough to ordinarily prevent an individual from engaging in any gainful activity. Applicants who do not meet or equal the listings are further evaluated by nonmedical factors.

Medical impairments alone are poor predictors of work capacity, although they might have been better predictors decades ago in a largely manufacturing economy. In fact, about 65 percent of awards are based on the medical listings, yet people with identical impairments are working. For example, any person who has lost the use of both feet is qualified under current listings. Thus, any individual in a wheelchair could qualify for benefits, even though people in wheelchairs have proven capable of earning a living. Similarly, a person who might be capable of work, but only on a part-time basis, can be granted benefits. For example, under the listings, people with mental impairments who experience repeated episodes of deterioration can be eligible for disability benefits, although

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94-121, Mar. 10, 1994); and Social Security: New Continuing Disability Review Process Could Be Enhanced (GAO/HEHS-94-118, June 27, 1994).

there may be periods when they are capable of working. SSA has updated several of the listings to keep pace with advances in medicine but has not done a comprehensive evaluation of their validity.

Research also suggests that SSA's listings overestimate inability to work and are limited in distinguishing accurately between people who can and cannot work. For example, one study identified a sample of adults living in the community who had physical impairments that met or equaled the listings.[21] When their work histories were tracked, it was found that about 60 percent of men and 30 percent of women were employed 2 years after diagnosis. For adults under age 55, employment rates were even higher--over 80 percent for men and over 40 percent for women.[22]

More emphasis on functional rather than diagnostic measures is considered necessary to better assess work capacity. In its reengineering effort, SSA concluded that its methodology for making disability determinations under current law is excessively complex and does not permit the best assessment of a claimant's functional ability. Part of its reengineering effort is focused on simplifying its process and providing more standardized ways to assess medical impairment and resultant functional ability. Considerable research, however, will be needed to improve the measurement of applicants' ability to function. SSA is starting a study of disability in the general population (including the working population) that should provide some of this type of information.[23]

In addition, both the law and SSA policy generally allow benefits to be awarded to applicants whose impairments would not preclude work if they were to receive treatment.[24] In many cases, providing treatment would be a lower cost alternative to DI and SSI if the applicant were able to work. Moreover, the current policy yields inequitable treatment of applicants with similar conditions. For instance, if an applicant is receiving treatment at the time of application, then the effect of the treatment on functioning is considered in the disability determination process, and benefits could be denied appropriately. However, if the applicant is not receiving treatment, the disability determination is made without considering whether treatment could improve the condition. In these cases, benefits could be awarded even if the applicant would not qualify for benefits if treated.

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[21]Henry P. Brehm and Thomas V. Rush, "Disability Analysis of Longitudinal Health Data: Policy Implications for Social Security Disability Insurance," Journal of Aging Studies, Vol. 2, No. 4 (1988), pp. 379-99.

[22]Employment percentages exclude the 27 percent who died during the 2-year period.

[23]The study, called the Disability Exam Study, is also designed to determine the characteristics of and special accommodations made for people who continue to work and who would be considered disabled under alternative definitions of disability.

[24]The medical listings for cardiovascular disease and epilepsy require that the applicant's condition be assessed under the listings after the applicant has been under prescribed treatment for at least 3 months. However, applicants not under treatment can still be found eligible on a basis other than meeting the listings.

CONCLUDING OBSERVATIONS

Many long-standing problems need to be addressed to improve the administration and outcomes of SSA's disability programs. SSA has acknowledged many of its management problems regarding the timeliness and consistency of disability decisions and has plans to address some of them in its reengineering effort. It has paid little attention, however, to the rehabilitation components of the DI and SSI programs and lags behind in conducting enough CDRs because of budgetary limits.

It is imperative that SSA's decision-making process reach much quicker and more consistent disability decisions. This process--the core of SSA's disability programs--is an inherently difficult one that requires a significant level of judgment in many disability cases. Although the process may never be completely objective, it can be improved by paying more attention to making the best possible decision as early in the process as possible. For example, better case development at the initial level would help remedy this, and narrowing the scope of subsequent reviews would help reduce inconsistencies.

Conducting effective CDRs and determining whether and what type of rehabilitation is appropriate are complicated by the need to make difficult professional judgments about the work capacities of people with disabilities. Better ways to assess the relationship between impairments and functioning in the workplace will be crucial for effective interventions that can help beneficiaries reduce their dependence and keep them off the rolls in the first place. For example, assessing the work prospects of people with disabilities will require knowing about more than their medical impairments, which alone poorly predict work capacity. Moreover, since the DI and SSI programs were enacted decades ago, major changes have occurred in the expectations of society and people with disabilities themselves regarding work. More importantly, the potential to realize these expectations may be greater because of significant advances in medicine, such as new medications to control the symptoms of certain mental illnesses, and changes in technology, such as assistive devices that can be used to accommodate people with disabilities at work.

Many of the problems we have documented are rooted in poor program administration, but corrective actions in these areas alone are not enough to ensure that all those who can work do so. While it is crucial to act expeditiously on certain fronts--reducing inconsistency in decision-making, decreasing CDR backlogs, and improving rehabilitation, for instance--over the long run, decisionmakers may need to rethink the fundamental design of DI and SSI to minimize the dependence of people with disabilities on cash benefits.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or the other Subcommittee members may have.

RELATED GAO PRODUCTS

Supplemental Security Income: Growth and Changes in Recipient Population Call for Reexamining Program (GAO/HEHS-95-137, July 7, 1995).

Disability Insurance: Broader Management Focus Needed to Better Control Caseload (GAO/T-HEHS-95-233, May 23, 1995).

Supplemental Security Income: Recipient Population Has Changed as Caseloads Have Burgeoned (GAO/T-HEHS-95-120, Mar. 27, 1995).

Social Security: Federal Disability Programs Face Major Issues (GAO/T-HEHS-95-97, Mar. 2, 1995).

Supplemental Security Income: Recent Growth in the Rolls Raises Fundamental Program Concerns (GAO/T-HEHS-95-67, Jan. 27, 1995).

Disability Benefits for Addicts (GAO/HEHS-94-178R, June 8, 1994).

Social Security: Most of Gender Difference Explained (GAO/HEHS-94-94, May 27, 1994).

Social Security: Major Changes Needed for Disability Benefits for Addicts (GAO/HEHS-94-128, May 13, 1994).

Social Security: Continuing Disability Review Process Improved, But More Targeted Reviews Needed (GAO/T-HEHS-94-121, Mar. 10, 1994).

Social Security: Disability Rolls Keep Growing, While Explanations Remain Elusive (GAO/HEHS-94-34, Feb. 8, 1994).

Social Security: Increasing Number of Disability Claims and Deteriorating Service (GAO/HRD-94-11, Nov. 10, 1993).

Vocational Rehabilitation: Evidence for Federal Program's Effectiveness is Mixed (GAO/PEMD-93-19, Aug. 27, 1993).

Social Security: Rising Disability Rolls Raise Questions That Must Be Answered (GAO/T-HRD-93-15, Apr. 22, 1993).

Social Security Disability: Growing Funding and Administrative Problems (GAO/T-HRD-92-28, Apr. 27, 1992).

Social Security: Racial Difference in Disability Decisions Warrants Further Investigation (GAO/HRD-92-56, Apr. 21, 1992).

Vocational Rehabilitation Program: Client Characteristics, Services Received, and Employment Outcomes (GAO/T-PEMD-92-3, Nov. 12, 1991).

Social Security Disability: Action Needed to Improve Use of Medical Experts at Hearings (GAO/HRD-91-68, May 20, 1991).

Social Security: SSA Could Save Millions by Targeting Reviews of State Disability Decisions (GAO/HRD-90-28, Mar. 5, 1990).

Impact of Vocational Rehabilitation Services on the Social Security Disability Insurance Program (GAO/T-HRD-88-16, May 26, 1988).

Chairman BUNNING. Thank you.

Ms. Bascetta, do you have a statement?

Ms. BASCETTA. No, Mr. Chairman.

Chairman BUNNING. Ms. Ross, you mentioned time-limited benefits, which Commissioner Chater said she was in favor of considering when she appeared before the subcommittee on May 23. Why do you believe that it may be time to consider time-limited benefits to certain new awardees who could go back to work?

Ms. ROSS. Let me begin by saying that we have been evaluating SSA's return-to-work efforts for some time, but we have not evaluated specific proposals. But I would be happy to tell you what I know about what proponents are saying about this and also some of the issues involved.

The most important thing people are trying to get at is to change the climate, change the beneficiary expectation from one of lifetime benefits to asking people to make plans to return to work. The message would be that there is some expectation that people try to work; that the entire society is moving toward a situation where people look at their capacity to do work rather than at their disabilities.

If you were going to do something like time-limited benefits, obviously, it needs to be done in a package with things like extending Medicare coverage to people who might leave the rolls and perhaps other provisions such as certainly, aggressive vocational rehabilitation, so that they have some way of getting help while they are on the rolls.

So it needs to be incorporated with a variety of other proposals.

One other point is that I think you need to consider at the end of this 3 years how you are going to decide about terminating benefits or continuing people on the rolls. It is clear that if you have a time-limited benefit system—well, it is not clear at all, actually—it might be that if you had a time-limited benefit system, you would not continue to do continuing disability reviews, because they look only at people who have recovered, and you now would be moving to a system where you are trying to figure out people's ability to move beyond the rolls and into the work force. So you might have to have a totally different standard of evaluation. That would just be something that needs to be worked on.

Chairman BUNNING. Well, there would have to be an interim period, though, when we go from the CDRs that we presently have to a time-limited benefit schedule.

Ms. ROSS. Yes, sir, because I believe people are talking about time-limited benefits for new people on the rolls, and you already have this set of people.

Chairman BUNNING. That is correct, so that we have this backlog of 1.7 million people that we are not getting to as far as CDRs.

Ms. ROSS. Right.

Chairman BUNNING. If we put time-limited benefits on new people going on the rolls, we can then have a better review of those people who are presently backlogged and not getting timely CDRs.

Ms. ROSS. Right.

Chairman BUNNING. What kind of legislative action do you think the Congress should take now to fix the serious problems with the disability?

Ms. ROSS. Again, these are preliminary observations. We are talking about things that various experts have said that appear to have a lot of promise and not necessarily things that GAO is recommending directly at this point.

But if you are looking at the——

Chairman BUNNING. Well, if GAO does not recommend them, how about you personally?

Mr. JACOBS. We want to get to know you better.

Chairman BUNNING. We know how reluctant GAO is to recommend.

Ms. ROSS. Let me tell you something about some of the proposals people have made to reduce inconsistencies, and some of them are in the SSA reengineering proposal, and some of them are not.

One of the things that might reduce inconsistency, as I said, between the way decisions are made at the initial level and at the administrative law judge level, is to have face-to-face interactions with the claimants much earlier in the process. This is something that SSA is talking about in reengineering. But a great many people and some fairly significant research suggest that face to face is a way to really fill out the evidence you have, and doing that earlier seems to make a lot of sense.

In addition, a lot of people have talked, and research suggests that closing the record could have a terrific effect on reducing the inconsistencies. Again, that might force the evidence to be more fully developed earlier in the process so that you get better initial decisions. So closing the record is something that a lot of people would think would be a wise move.

If you are talking not about inconsistencies anymore, but about moving people off the rolls, again, the kinds of proposals I talked about earlier are things that warrant some thorough discussion, things like time-limited benefits, changes in the vocational rehabilitation program so that you are talking about expanding the set of people who could offer vocational rehabilitation beyond the State agency to private vocational rehabilitation firms. You might also want to establish a better funding mechanism for vocational rehabilitation. That, we do not have worked out at this point, but you want to make it feasible for a broad set of people to offer vocational rehabilitation, because you are going to have a tremendous demand for it.

Also, we believe that vocational rehabilitation probably should be done earlier in the process. By the time a person has invested all of this time and effort proving his or her inability to work, they just cannot be very receptive at that point to suggestions for vocational rehabilitation. Many other systems, including private disability systems, do vocational rehabilitation much earlier after the onset of a disability.

Again, if you are really going to focus on returning people to work, you have to look at things like extended Medicare coverage.

Chairman BUNNING. I want to clear this up so that there is no misunderstanding about what you mean by "closing the record," because that seems to be one of the reasons we have so many initial DDS decisions overturned at the administrative law judge level. By "closing the record," do you mean that all evidence must be presented before the hearings? In other words, I am coming to SSA be-

cause I am totally disabled. I have this evidence, medical and physical evidence, that I am totally disabled. I must present all evidence before the decision is made. This would be before the hearing. Is that correct?

Ms. ROSS. That is correct. One of the reasons that I think if you are going to consider closing the record, you probably also want to talk about having a face-to-face interaction before that, is that you want to have the fullest, most complete possible record before you close it.

But when you continue to introduce new evidence at each of those five steps, all the way up through the district court, the case changes its character over time, and people are not deciding on the same thing.

Chairman BUNNING. The initial claim for disability may be altered at each of the five review stages by adding additional information to the record?

Ms. ROSS. It certainly can be.

Chairman BUNNING. If we close the record we say to the person seeking disability, "You must present for the record all medical evidence that is available now, and we are going to examine this evidence for a disability determination." The reason I would like to see this done is because we must speed up the 13-month wait for those who actually should be on disability. If we are going to shorten that 13-month wait, we cannot allow claimants to add new information to every record at every level of the process. That is one of the big causes for the 13-month delay in getting people on disability. I think it is very important that we get a system in place that speeds up the process for those people who should be on the SSDI. By closing the record, or requiring all evidence to be present at the initial hearing I think can really help us do that.

Ms. ROSS. Earlier in my statement, I said that we had information from SSA indicating that about 25 percent of the allowances by administrative law judges are based on new evidence introduced. One-quarter of the cases seems like a substantial number.

There is also discussion, although I do not know how pervasive or how true it is, that some people think about withholding some of the evidence until they get to a point to be in front of an administrative law judge, because that happens to be the first occasion where you are having a face-to-face interaction. I do not know the degree to which that is true, but if that is an issue, then you could move the face-to-face interaction earlier on.

Chairman BUNNING. You would have to move the face to face up in the hearing process.

Let me ask you one more question, and then I will turn it over to Andy. You talked about how much SSA is costing the trust fund by not doing CDRs in a timely fashion—about $2 billion. If Congress sets up some type of revolving fund, and SSA did the CDRs, wouldn't the savings pay for the CDRs over the next 10 years or longer?

Ms. ROSS. Our sense is that as long as continuing disability reviews are cost effective, that you get more back in benefits than you spend to do them, that the fund stays in business for as long as you need it; that you could continue——

Chairman BUNNING. So you would then agree with what I just said.

Ms. ROSS. Yes, yes, I agree with you.

Chairman BUNNING. OK.

Andy.

Mr. JACOBS. Thank you, Mr. Chairman.

You intrigue me somewhat with the concept of the person who withholds part of the evidence until the administrative law judge level. What is to be gained? Why would a person do that? What is the motivation?

Ms. ROSS. Part of the reason why this could happen is because the way that administrative law judges deal with some of the evidence is different from the way it is done at the DDS level. We are actually working on a study right now for Mr. Bunning, looking at these inconsistencies.

I will give you some examples of the kinds of things I am talking about. The way that you give evidence related to pain is different if you are giving that kind of evidence at the DDS level than what you can allege in an ALJ hearing.

Mr. JACOBS. Same case.

Ms. ROSS. Right.

Mr. JACOBS. That seems like fruitful territory for reform right there—apples and oranges. By the way, I enjoyed my apple, Mr. Chairman—and the core.

Well, in regular law, you do close the record at the trial level. They used to call it a motion to amend the facts. After that, you do not present new evidence on the appeals level process; isn't that right, or would you agree? Do you doubt my word? I think that is the way it is.

Ms. ROSS. I do not doubt your word. [Laughter.]

Mr. JACOBS. There are three implications that occur to me—and I will say for the record I do not reject the idea out of hand at all—but three things occur to me. The first is a Bill Mauldin cartoon from World War II, where one of the GIs is reporting to some officer sitting at a card table out in the field, and the GI has four fingers sticking through holes in his helmet, and the officer is saying, "Nonsense. G–2 reported that gun silenced hours ago, and stop wiggling your fingers at me."

The implication of that would be that additional evidence would show that G–2 was wrong, that the initial consideration was wrong, and maybe the applicant himself or herself did not know about the additional evidence.

There is another factor which occurs to me, and that is what if the person were in a traumatic condition on the initial consideration and were not later? I mean, the administrative law judge is looking at the person, who looks as healthy as can be, and yet you close the record, and any additional evidence of recovery, even within the months or whatever it might be, is excluded from the record. I think that is something that ought to be taken into account as well.

When I practiced law, I had a client, a woman, whose knee was injured because a wheel-balancing machine flew off the wheel of her car in a filling station and struck her knee. I will tell you, when she came in to see me periodically, I felt like burning votive

candles for her; she was messed up badly. However, the insurance investigator was kind enough to share with me a videotape that they had made of my client—a Girl Scout leader—who in the tape was running like a gazelle out at a park with the kids—which leads me to my next question.

Have you given any thought to a quasi-adversarial procedure for applicants—I mean, like taking pictures of Girl Scout leaders in parks—wouldn't that be worthy evidence?

Let me just say parenthetically, I do not think anybody on this subcommittee or most people in the country want anything else in this system but justice. Justice means awarding it where it is desperately needed. It also means not awarding it where it can be established that it is not needed.

Would that be too expensive? Would it be counterproductive? Would it be unproductive? What would you think about that?

Ms. ROSS. Well, you have probably put your finger on a slightly different issue than I thought you were starting with.

Mr. JACOBS. Is that right?

Ms. ROSS. The additional evidence that is now given in a hearing——

Mr. JACOBS. By the way, Kato Kaelin was on the "Today" show today, and he said exactly the same thing, that the prosecutor had talked to him about something entirely different than what she asked. I wonder why she would do that? But please go ahead.

Ms. ROSS. I will try to remember what I was going to say now. [Laughter.]

Mr. JACOBS. It is kind of a serious question, though. The question is what about an adversarial proceeding? Is that too expensive? Would it be unproductive? I do not think it could possibly be counterproductive unless it were too expensive.

Ms. ROSS. There is a provision in the law as I understand it that the Social Security Administration can take cases——

Mr. JACOBS. How about "must"?

Ms. ROSS. It does not say "must," but there is something called "own motion review," which used to happen a good deal more frequently than it does now. I am not an expert on what happened over the years and why it is being done less, but I would be glad to find out for you.

Mr. JACOBS. Well, you understand what I am saying. I mean, suppose I come in, and I am really down and out and can hardly move. Would you go so far as to say the security guard at the front door, six stories down, might be asked to see how I walk out of the place? Do you understand what I am saying? That is what I am getting at.

Ms. ROSS. I understand.

Mr. JACOBS. Well, maybe the subcommittee might kick that around a little bit with other witnesses.

Thank you, Mr. Chairman.

Chairman BUNNING. Thank you, Mr. Jacobs.

Mr. Collins.

Mr. COLLINS. Ms. Ross, in your view, what are some of the main reasons why people tend not to return to work once they are on DI or SSI after rehabilitation?

Ms. ROSS. I am going to ask Ms. Bascetta to answer that question because she has done a good deal of work on that.

Ms. BASCETTA. First of all, for those who are able to work, as we have already pointed out, they get very little help in the way of vocational rehabilitation, and that is a very significant factor. But in addition, there is a host of disincentives that prevent people from seeking return to work, and the first is a loss of cash benefits. This is especially serious for DI beneficiaries who face an abrupt loss of cash benefits at the end of their trial work period; they go from their full benefit to zero. For those of them who are only capable of earning relatively low wages, they may be better off not working, or limiting their earnings to below substantial gainful activity.

Second and perhaps more important is the loss of medical coverage. The DI beneficiary can retain Medicare for 4 years, but then they have to pay for their coverage, and it is a little over $300 per month, which can be a substantial amount, especially again for the low wage earner.

Mr. COLLINS. The Medicare disability program is not only a disincentive to the person who is on the disability to return to work, but is it also not a disincentive for the employer to hire that person, based on the fact that he may have to pick him up under the employer's health care plan?

Ms. BASCETTA. Yes, that could be a problem as well.

Mr. COLLINS. So a continuation of the Medicare coverage could work very well in the rehabilitation and return-to-work program; is that not true?

Ms. BASCETTA. We think so, and if those people remain on the rolls because they are not going to work, we are incurring their Medicare costs anyway.

Mr. COLLINS. In the area of rehabilitation, should there be any type of incentive placed, other than just in the Medicare and the health care benefits or the group health care plan of the employer, in the area of employment, or in the area of the employer to hire a disabled person?

I have a lot of problems with rehabilitation and rehabilitation units and people who claim to be able to rehab someone back to work. I see that as an interim cash flow that goes in a different direction than oftentimes and history has shown has not worked as far as the disabled person, but has enabled the person in the middle, the rehab organization, to enhance their cash flow and their revenue, but with very little results to the disabled and no incentive to the employer. The contract of employment is between the employer and the employee.

Do you have any suggestions as to how we could improve the incentive for an employer, other than in the health care area, to hire the disabled?

Ms. BASCETTA. We have not done any work specifically looking at the employer side, but I agree with you that there are risks——

Chairman BUNNING. Would you please pull the mike up so that the people in the room can hear what you are saying, also? Thank you.

Ms. BASCETTA. Certainly. We have not done any work on the employer side of the equation, but I agree with you that we need to be very careful about the way we expand rehabilitation. In particu-

lar, we are concerned that to protect the trust fund moneys, we really have to be focused on positive outcomes and have a way of ensuring that in fact people do go back to work, or that they work as much as they can, because even if they just reduce the amount of cash benefits they are getting, that could amount to significant savings.

Especially if we were to do something like go to an expanded pool of providers in the private sector, one measure of success would have to be sustained employment, because the evidence shows that a first return to work is not a good measure, that you really need to look over time to ensure that the person sustains his or her labor force attachment.

Some people have proposed giving the rehabilitation providers a share of the continued savings that would be realized if people in fact did return to work to give them an incentive to stick with the client and to ensure better results over the long run.

Mr. COLLINS. I have no problem with what you are saying, but to those in this room who are in the rehabilitation business, I just have a lot of reluctance for those who come bearing gifts, and by that I mean those who come to say, "If you pay us *x* amount of dollars, we can save the system *x* amounts of dollars." That has not worked in the past, and I have real doubts about it ever working in the future if you do not tie together some way the employer and employee concept.

Thank you, Mr. Chairman.

Chairman BUNNING. Thank you.

Ms. Kennelly.

Ms. KENNELLY. Thank you, Mr. Chairman.

Quickly reading over the GAO report, I notice that applications for disability are happening at a much younger age; in fact, I think 48 is given as the age now. Could you answer why that is? The other thing I am concerned about is if in fact we do change the system, or if in fact people do get the rehabilitation or do get back to work, their health benefits—if someone has been ill, quite ill, and then manages to get back to work, the health benefits could be very important in keeping them at work. I am wondering, if legislation were brought forth and passed, how you would address the health benefits system in relation to getting the person back. There is a long time between 48 and 65, and people often when they are sick cannot go back to the same level of employment, occupation, or pay that they had previously.

The other thing I would be interested in—I see here that when the applicant appears in person, often the decision is changed. Is it usual that the applicant has a lawyer with him during a personal visit?

Ms. ROSS. Let me try to answer all three of the things you ask about. In the first instance, at least some important part of the reason why the average age of the disability beneficiary is declining is because the kinds of impairments that people come to SSA with, the mix is different. There are more mentally impaired cases now than there were many years ago. There are also many kinds of things like traumatic head injuries and things where accidents probably previously resulted in death and no longer do, that have brought down the average age. It does raise the issue that you

have talked about, which is that at one point, the disability program was considered more of an early retirement program—you were talking about people in their mid to late fifties, and they had sort of worn out on a manufacturing job. In those circumstances, perhaps you did not worry nearly as much about moving people back into the work force.

Ms. KENNELLY. They were almost ready.

Ms. ROSS. You had early retirement. But now, if you are talking about people who could be on the rolls for 20 or 30 years, how they spend that portion of their lives seems very important not just for the trust fund, but for their own well-being.

That takes me to the second piece, which is about medical insurance. If the person were to stay on the rolls from the time he or she was 45 to 65, they would have Medicare the whole time, and it would seem sensible to me to start thinking about, if people left the rolls, couldn't they continue Medicare.

Ms. KENNELLY. I agree we should consider doing that.

Ms. ROSS. Research seems to suggest that fear of losing health insurance for disabled persons is a terrific disincentive to trying to go back into the work force.

Ms. KENNELLY. That is what I was leading into, and obviously, you realize that—it is not just the disabled community that is impacted. It is everybody. You do not want to leave your job for another job.

Ms. ROSS. Absolutely.

Ms. KENNELLY. We are all afraid about health insurance. You are saying that if someone is on disability, and they are thinking about going to work and hoping they can go back to work, but then the thought that they could lose their health care could make them hesitant about finding employment.

Ms. ROSS. Right.

Ms. KENNELLY. What I am saying, Ms. Ross, is that it is a fact that the possibility of the loss of health care certainly is holding people back from wanting to reenter the workplace.

Ms. ROSS. I agree with you. Just in answer to your third question about attorney representation at the administrative law judge level, our information says that about 70 percent of people who are appealing at that point have either an attorney or some other sort of representative.

Ms. KENNELLY. Do you have any figures on the initial determination, how many have an attorney?

Ms. ROSS. Very few.

Ms. KENNELLY. Very few. They just fill out the form and hope for the best—and then when they get turned down, they get the lawyer.

Ms. ROSS. Yes, ma'am.

Ms. KENNELLY. Ms. Ross, do you think we should write legislation and pass legislation on this program, or do you think it could be done by the department? What do you see as the best avenue to improve the system as it is today?

Ms. ROSS. Well, I think there are a variety of areas where legislation would be a very positive thing. I think the area of reducing inconsistencies in the decisions is critical if you are trying to reduce the time that is taken in the current process and also trying to be

sure that you have the best possible decisions. So I think that that kind of operational issue is important, but at least as important is, Are we going to do anything more to try to encourage people to move back into the work force? It is one thing to do these continuing disability reviews which I think are very important, to measure did someone recover. But we have a lot of evidence today that people with tremendously marked impairments are working, and the society seems to be encouraging that sort of thing, and so does technology and medicine. I do not think SSA has caught up with all of that, so I think that is a really critical area for vocational rehabilitation and things like continued Medicare.

Ms. KENNELLY. Are you saying that SSA is being asked by present law to do certain things, and that is taking up all of their time, and as a result, they are not able to do things that you think could probably be more helpful to the individuals to get off the system?

Ms. ROSS. If you are asking me what SSA thinks, there has been relatively little emphasis on vocational rehabilitation and returning people to work until at least the last several months, when some initiatives at SSA seem to have started in earnest.

Ms. KENNELLY. Thank you very much for your work.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Payne.

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

Ms. Ross, thank you for this report. I want to go to the first page, where you comment that, "SSA has serious problems managing the disability programs," and you then enumerate several concerns. You then go on to say, "SSA acknowledges and has plans to address some of these issues."

In your view, is SSA planning to address these issues adequately, and are they planning to do this in a timely fashion? What is your view, not of what has gone on in the past, but rather what does SSA intend to do in the future, and how effective do you think it will be?

Ms. ROSS. SSA is currently working on a major initiative in the disability area called disability reengineering or redesign. We are looking at that at GAO. It appears that many of the initiatives they have in there are very sensible and ought to go some important length to reducing backlogs, reducing the time, and perhaps improving inconsistencies in the way decisions are made.

I think there are other things that other experts have talked about which are not in their package, and one of the things that you hear most among professionals that is not in the SSA package is closing the hearing record. So just in that area of improving the process, I think SSA has a package that is worth their pursuing, but there are other things that ought to be done additionally.

But in the area of returning to work——

Chairman BUNNING. Mr. Payne, would you yield for just a moment?

Mr. PAYNE. I will yield.

Chairman BUNNING. According to the Commissioner of the SSA, she said the earliest that they could get to this would be the year 2000, unless I misunderstood what she said at our hearing. Do you think that that is a timely fashion to address this problem?

Ms. ROSS. The year 2000 is a long way from now. I am not trying to be cute about it——

Chairman BUNNING. No, no. I yield back.

Ms. ROSS. There are many proposals in the reengineering plan that are meant to get started fairly soon, but some of the more important ones may take a little more time. I do not work at SSA, and I cannot tell you the exact timetable. If you are going to look at things like how are you going to assess people's ability to function, they probably do need to pull together some research. I just hope they have a sense of urgency about it.

Mr. PAYNE. If I may follow up, you are saying that in some instances, there are some things that are being implemented that may in fact address these concerns in a timely fashion, but as the chairman points out, some of these may not be. Are there specific issues that are not being addressed that we need to have at the top of the list in terms of the priorities?

Ms. ROSS. I think in the area of consistency, you would want to at least consider closing the hearing record.

Mr. PAYNE. Consistency in terms of this process, you are saying?

Ms. ROSS. Yes, yes. So that people would make the same decision with the same facts, regardless of where they sit in the process. But more importantly, I think, an area that SSA is not working on as actively as they are the decisionmaking process is the area of returning people to work. I think that that is an area where a lot more emphasis could be placed.

Mr. PAYNE. But the law says—and this is in your testimony as well—that the continuing disability review will be done every 3 years for beneficiaries for whom medical improvement is expected or possible. There is a requirement that the CDRs be done at least once every 7 years on beneficiaries for whom medical improvement is not expected.

Is that currently being done by the SSA?

Ms. ROSS. At the current time, SSA is not doing the number of continuing disability reviews that the law requires them to do; so they are not meeting that standard in the law. That is important for program integrity, for sure. But another area that they have not done very much on is trying to improve vocational rehabilitation, looking again at the work incentives to see if there are other ways to encourage people to return to work.

Mr. PAYNE. Thank you. I yield back the balance of my time.

Chairman BUNNING. Mr. Laughlin.

Mr. LAUGHLIN. I will pass, Mr. Chairman.

Chairman BUNNING. I would like to continue with just a couple more questions. We have heard a lot about how much SSA's disability reengineering process will do to improve the program. In your view, will it fix some of the most serious problems, such as the high administrative law judge reversal rate, or the open record problem? In other words, are they considering that in their reengineering process?

Ms. ROSS. I think they have proposals to do some things that ought to reduce the inconsistencies, and I think having face-to-face interactions earlier in the process is something that they are proposing that makes sense. They are also planning to look at the areas that have the most disagreement between the initial level

and the administrative law judge level, determine what those are—and those include the way that people determine residual functional capacity and how they assess pain—then develop rulings, which is one mechanism that SSA has that all levels of the decisionmaking process are supposed to abide by. They are going to try to develop rulings there and do training for everybody on these rulings.

But my sense from my reading and that of the people we have working in this area is that that may not be enough to make the decisions consistent, and that some more serious consideration ought to be given to closing the record and changing the way administrative law judges make their decisions.

Chairman BUNNING. So, some kind of legislation to shorten the process, to have a face to face early on in the process, and to make sure that the record is complete before it is started through the process—all of those things could really assist us.

Ms. ROSS. Yes, sir.

Chairman BUNNING. Tell me if I am correct on these numbers, because I know that the GAO is very, very good with numbers. The approximate administrative cost to the Social Security Administration is about $2.7 billion to handle the disability program?

Ms. ROSS. That is correct.

Chairman BUNNING. That is one-half of their budget.

Ms. ROSS. Half of their administrative budget, yes, sir.

Chairman BUNNING. Is spent on the disability programs.

Ms. ROSS. That is correct.

Chairman BUNNING. What effect do the problems with the disability program have on the retirement program? Since money is being transferred out of the retirement fund to the DI program, I would like for you to project how much money this is costing the retirement program.

Ms. ROSS. Last year, the Congress actually reallocated some of the tax money from the Old Age and Survivors' Fund to the disability fund.

Chairman BUNNING. I understand; to make sure that DI had enough.

Ms. ROSS. That is right. That was a reallocation that goes on—it was to extend the life of the DI program from 1995 through I think 2016. If you added up all of the dollars that that reallocation would bring about, the result is that you have enacted into law a move of $1/2 trillion from the retirement funds to the disability fund.

I would not believe these numbers, but they came from SSA. I mean, we are good at numbers, but these are their numbers.

Chairman BUNNING. We are taking $1/2 trillion coming out of the retirement fund, which will make it go insolvent quicker, to take care of the disability program until the year 2016. Is that what you just said?

Ms. ROSS. Yes, sir.

Chairman BUNNING. Let me address one of the problems that Ms. Kennelly brought up. If we would somehow allow Medicare to cover someone who goes back to work and be the primary coverage of that person, while allowing the individual employer's coverage to be secondary, do you think that would be an incentive for that per-

son to go back to work? Now the primary coverage is provided by the employer and then Medicare is a secondary coverage. What if it were the other way around?

Ms. ROSS. I think it makes the disabled person trying to move back into the work force a lot more attractive to an employer who is facing some unknown set of medical expenditures. This ought to really ease the way, and as we said earlier, also ease the fear of the beneficiary in trying to move off the rolls.

Chairman BUNNING. Well, in dealing with the changes that we are going to have to deal with concerning Medicare, that might be one of the things that——

Ms. KENNELLY. Would the chairman yield?

Chairman BUNNING. Yes, surely.

Ms. KENNELLY. Ms. Ross, with all your vast experience, do you think that when someone is hiring, and they know someone has been on disability, that there is a real disinclination to hire?

Ms. ROSS. I am sure that they must look at things like the expenses that that may mean for them, and health care would certainly be a major expense.

Ms. KENNELLY. So the chance for the person getting the job is limited.

Ms. ROSS. I think it makes this person much less attractive, yes.

Ms. KENNELLY. Thank you, Mr. Chairman.

Chairman BUNNING. Andy, do you have anything else?

Mr. JACOBS. No further questions.

Chairman BUNNING. Mr. Laughlin, go ahead.

Mr. LAUGHLIN. Mr. Chairman, I would like to follow up on that.

Ms. Ross, following that, has anyone at GAO or your office calculated how much money the system would save by the inducement of people going to work with the Medicare continuing for a period of time? Apparently, you think there would be monetary savings to the system if people were encouraged to go to work by being able to carry their Medicare with them—or would you agree there would be savings, or money left in the reservoir?

Ms. ROSS. I agree there would be savings if people either moved out of——

Mr. LAUGHLIN. There would be more money available for other disabled people.

Ms. ROSS. Yes, either because people left the rolls entirely, or because they had a different combination of work and benefits so that they reduced the amount of benefits they were actually drawing down.

We have not done the kind of calculation that you talk about, but we could do for you something that at least gave you some idea about, if so many people left the rolls—1 percent, a couple of percentage points—how much difference that would make. The numbers can be very dramatic.

Mr. LAUGHLIN. I think that would be an important number for us to know, and I would ask you to do that and supply it to the chairman and the subcommittee.

Ms. ROSS. We would be glad to do that.

Mr. LAUGHLIN. Thank you.

Thank you, Mr. Chairman.

[The following was subsequently received:]

Given the average yearly DI benefit, a 1-percent reduction in the rolls would save about $425 million a year, while a 2-percent reduction would save twice that, or about $850 million a year. Any effort to reduce the rolls through additional CDRs or rehabilitation would have some costs, which would have to be offset against these savings.

Chairman BUNNING. Thank you all for coming. Thank you for your testimony.

I would ask the second panel to come to the table: Yvonne Johnson, Jerry Thomas, Tony Young, Kenneth Shaw, George Watters, Fred Tenney, and Steve Start.

This panel includes professionals and experts in rehabilitation services. Ms. Johnson, would you please start, state your name for the record and what you do, and then go on with your testimony, please.

STATEMENT OF YVONNE JOHNSON, DIRECTOR, DIVISION OF REHABILITATION SERVICES, DEPARTMENT OF HUMAN RESOURCES, ATLANTA, GA.; ACCOMPANIED BY JERRY THOMAS, DIRECTOR, DISABILITY ADJUDICATION SECTION, DECATUR, GA.

Ms. JOHNSON. My name is Yvonne Johnson. I am here in my role as director of the Georgia Division of Rehabilitation Services, Department of Human Resources. I want to thank you for the opportunity to be here today.

It will help to explain my conceptualization of current public policy regarding people with disabilities in employment if you would visualize with me a large tent, like the ones under which concerts and other events are held. Generally, a tent like this has three large supporting poles in the center that give it form and substance.

It is my observation that this country has three major tent poles that give form and substance to our beliefs and supports for our citizens with disabilities.

The first pole is the Americans With Disabilities Act. This says each of us has the right to work. The second pole is title I of the Rehabilitation Act. This act says each of us can work if given the appropriate supports. The third pole is the Social Security disability program. It is there to give stability to the other poles when it is not possible for an individual to work or not possible to work at a level that can support the individual's basic needs.

In theory, our tent should stand tall. However, the Social Security disability pole is out of kilter, and thus our tent is in jeopardy of falling.

People want to work if the system is present to let them meet their most basic needs of food, clothing, shelter, and safety. Our current system causes them to make compromises to their own values. The system forces people to make choices between their value of independence and self-sufficiency, on the one hand, and meeting their basic needs, on the other.

Time and time again, we see individuals who would receive less money if they returned to work than if they continued to receive the disability benefits, because we do not have things in place such as access to affordable health care, personal assistance, and rehabilitation technology.

While Social Security's work incentives, such as the plan to achieve self-sufficiency, help, they are only a very limited response to the problem. Unless and until our three tent poles work in a coordinated manner to provide support for people with disabilities and their employment in the workplace, we will continue to send mixed messages to all of our citizens.

On any given day in the agency for which I am responsible, a person can enter one of two doors—the vocational rehabilitation door or the disability adjudication door. Each of the two staffs that work with this individual operate under two very different sets of assumptions.

The adjudicator at the disability adjudication section will make a decision based on the assumption that, given a certain set of medical findings or set of functional limitations, this person cannot work. The vocational rehabilitation counselor will greet the person with the assumption that the person can work, and regardless of the same set of medical findings or the set functional limitations.

The person who walks through both of these doors may well be faced with an ethical dilemma, that is, the question of ability or inability to engage in work. The person gets a U.S. stamp of approval for disability benefits from one system that says, "You are disabled," while at the same time, the other system says, "You can work."

Consequently, the person must choose between what appears to be certain income from the disability program, or pursuing a longer and perhaps less certain course that leads to gainful employment.

It is my belief that we must be more explicit in our assumptions about people with disabilities. With the passage of the ADA and the Rehabilitation Act, this country said that we believe people have the right to work and, given appropriate support, can work. If these are our beliefs, then we must approach the Social Security Administration and strongly encourage them to support changes in some of the contradictory assumptions in the disability program.

Today, SSA is mandated to review periodically the continuing eligibility of those receiving these benefits. The length of time a person receives benefits before the continuing eligibility review is scheduled is dependent on the prognosis for improvement in the person's medical condition. In theory, the system should work. It does not.

The disability adjudication section is required to process an ever-increasing number of applications. The backlog of eligibility reviews is growing and is currently at an impossible level. At the present time, it is highly unlikely that a person who has improved medically and can now work will ever be removed from the disability rolls unless they so choose.

Therefore, I have two recommendations to address this issue. No. 1, include in any continuing eligibility review process a consideration of all advances in the field of rehabilitation technology. No. 2, supplement the continuing eligibility review process with the implementation of time-limited benefits for appropriate beneficiaries.

In summary, I have attempted to address five areas about which I have strong opinions and feelings: No. 1, people with disabilities can work and have a right to do so; No. 2, we must provide appropriate supports, such as health care, personal assistance, and reha-

bilitation technology to ensure that the choices people have to make do not jeopardize their ability to meet their basic needs; No. 3, we must utilize the current knowledge in the field of rehabilitation; No. 4, we must send consistent messages with our laws; and No. 5, for those people who cannot work or who cannot work without a significant investment of time and resources, it is my belief that our third tent pole shall be maintained by the assurance that the disability program will be there when they need it. In order for that to be assured, those who can work must.

Thank you.

Chairman BUNNING. You beat the red light. Congratulations.

Mr. Thomas, do you have something that you would like to add?

Mr. THOMAS. No.

Chairman BUNNING. Tony Young.

STATEMENT OF TONY YOUNG, DIRECTOR, RESIDENTIAL SERVICES AND COMMUNITY SUPPORTS, AMERICAN REHABILITATION ASSOCIATION, WASHINGTON, D.C.

Mr. YOUNG. Good morning, Mr. Chairman. I am Tony Young, director of Residential Services and Community Supports at the American Rehabilitation Association. American Rehab is the largest national organization representing providers of medical, vocational, and residential rehabilitation to Americans with disabilities. Our members serve more than 4 million individuals with disabilities yearly and employ nearly 400,000 professionals and paraprofessionals, dedicated to assisting individuals with disabilities to maximize their independence and productivity.

In recent testimony before this subcommittee, the low rate of individuals leaving SSDI or SSI to go to work was documented. To enable these individuals to return to or enter the work force, public policy must address the reasons why it is so difficult for them to leave these programs. Building a bridge off cash assistance and delivering services that enable people with disabilities to cross that bridge are critical solutions.

To enable individuals to cross the bridge into employment, the beneficiary rehabilitation program must be improved. We recommend that Congress modify the beneficiary rehabilitation program to enable beneficiaries to choose from among public or private vocational rehabilitation service providers. It should also modify the program to pay providers based on a series of outcomes that lead directly to employment, rather than the all-or-nothing reimbursement mechanism currently in use.

However, vocational rehabilitation services, even those tied to employment, are not enough. The current benefit structure punishes rather than rewards people with disabilities who attempt to leave entitlement programs. The system essentially eliminates eligibility for both cash and noncash benefits, such as health care and long-term services, before the individual can earn a living wage. This total loss of support, well known by people with disabilities as "the earnings cliff," is the greatest work disincentive.

A bridge that spans the chasm from dependence to self-reliance should be constructed. Congress should empower individuals with disabilities through these four actions: No. 1, enable individuals with disabilities to buy into Medicare, Medicaid, or the Federal

Employee Health Benefit Plan on an income-based sliding scale, using deductibles and copayments to control the utilization; No. 2, extend the earned income tax credit to low-income workers with disabilities so that it helps to bridge the gap between SGA and an income level sufficient to cover the expenses of living with a severe disability; No. 3, establish a tax credit for assistive technology and personal assistant services for any individual with a severe disability who is working; No. 4, create a safety net for individuals with disabilities that addresses the unique needs of these workers who, due to the nature of their disability or the effects of aging with a disability, are unable to continuously work full time.

I am one of the one-tenth of 1 percent of SSDI beneficiaries to leave the program to go to work. In fact, I have done this twice, which has probably distorted the statistics.

I participated in the beneficiary rehabilitation program prior to 1981, when it was changed to an all-or-nothing outcome reimbursement system. I received a degree in business administration that enabled me to qualify for a position as a budget analyst. This position paid enough to cover my living expenses as well as my extraordinary expenses of living with a severe disability. In this way, I was empowered to make the rational economic choice of working.

Since then, I have worked as the executive director of a center for independent living, a consultant in public policy, and in my current position with the American Rehabilitation Association.

In 1984 I was forced to return to SSDI and Medicare due to the onset of a secondary disability. It took 8 months for my reapplication to be approved. Without the support of my family and the good fortune of their having excellent family health coverage, I might not have survived this period.

In both instances, my return to work took many years, quality medical and vocational rehabilitation, and a good measure of luck to accomplish. Going to work should not be based on good fortune, but on good public policy that empowers individuals with disabilities to make the rational economic choice of working.

Congress should take one additional step to improve the SSDI and SSI programs. SSA should be directed and provided with the resources to conduct continuing disability reviews required by law. Over the last decade, SSA has not requested and Congress has not provided sufficient resources for this important program.

As a nation, we must allow individuals with disabilities who need to leave the work force to do so; but we must also empower those who can work to accept employment. Congress has an opportunity to build an empowerment bridge from dependency to self-reliance for individuals on SSDI and SSI, and to enable them to cross this bridge. I strongly encourage you to take this opportunity.

Thank you for this occasion to testify, and I would be happy to answer any questions you might have.

[The prepared statement follows:]

STATEMENT OF TONY YOUNG, DIRECTOR
RESIDENTIAL SERVICES AND COMMUNITY SUPPORTS
AMERICAN REHABILITATION ASSOCIATION, WASHINGTON, D.C.

Good morning, Mr. Chairman. I am Tony Young, Director of Residential Services and Community Supports at the American Rehabilitation Association. American Rehab is the largest national association representing providers of medical, vocational and residential rehabilitation services to americans with disabilities. American Rehab's members serve more than 4 million individuals each year with rehabilitation services. Our members employ nearly 400,000 professionals and paraprofessionals dedicated to assisting individuals with disabilities to maximize their independence and productivity.

A 1994 Harris poll showed that two-thirds of working age people with disabilities are unemployed. Of this number, 79% want to work. Yet, only .01% of individuals receiving Social Security Disability Insurance (SSDI) leave the program to return to work. In order to enable these individuals who have expressed a desire to work to return to the workforce, public policy must address the reasons why it is so difficult for individuals to leave Social Security Disability Insurance and Supplemental Security Income (SSI). American Rehab recommends constructing a transition to employment strategy to build bridges that beneficiaries may cross into the workforce and thereby gain tax-payer status.

Constructing a transition to employment strategy requires building a bridge mving people off income support programs and delivering services that enable individuals with disabilities to cross that bridge. Building a bridge off income supports requires: 1) extending health coverage to working individuals with disabilities, 2) establishing wage supports to raise net income, 3) providing access to personal assistance services and assistive technology, and 4) maintaining a reliable disability safety net. Delivering services to enable individuals with disabilities to cross the bridge from dependency to self-sufficiency requires the overhaul of the current Beneficiary Rehabilitation Program. Please allow me to illustrate these points with a personal example.

I became a C-4 quadriplegic in 1970 as a result of a body surfing accident. I was 18 years old, and just graduated from high school. My work skills and experience included mowing lawns, raking leaves, washing cars and dishes, and three summers as a life guard, swimming instructor and swim team coach. Not exactly what you would call high skill, high wage jobs, especially with a disability as severe as mine. After medical rehabilitation, I was evaluated by the Virginia Department of Rehabilitative Services in 1971, determined to have no work potential, and sent home to live with my parents.

In 1975, I was again connected by a physical therapist working with me through a home health agency with the Virginia Department of Rehabilitative Services and evaluated for work potential. In the few years between 1971 and 1975, the expectations of the potential of severely disabled persons changed substantially, mainly due to the emergence of the Independent Living Movement, and I was determined to have work potential under these new expectations. I wanted to earn a college degree, and agreed to a program of study to become a computer programmer. After one year of study, during which I demonstrated a complete and utter lack of talent or aptitude for programming computers, I realized that I could be successful not by accomplishing tasks directly, but by managing human and other resources to accomplish tasks, and changed my major to Business Administration. I completed my degree program and went to work at the Department of Agriculture as a Budget Analyst. Since then I have worked as the Executive Director of a Center for Independent Living, a consultant in public policy for persons with disabilities, and in my current position with American Rehab.

This has not been a smooth, uninterrupted path. In 1984 I was forced to return to the SSDI and Medicare programs due to the onset of a secondary disability that required multiple surgeries and an extended recuperation time. It took over eight months and a letter to my Senator for my reapplication to be processed and approved. Without the support of my family and the good fortune of having an excellent family health coverage policy I might not have survived this period.

I have had a successful career over the last 15 years, working in jobs that I enjoyed doing and that I felt were accomplishing something worthwhile. I have paid federal, state and local taxes, invested in my future through savings and retirement, and contributed significantly to the conspicuous consumption of consumer goods, especially assistive technology. As opportunities

arose and as technology, especially personal computers and wheelchairs, became more sophisticated, I was able to assume more responsibility, therefore acquiring more rewards for my labors. I enjoy not only a satisfying work life but also a full social life including activities with friends and time contributed as a volunteer to community activities.

None of this would have been possible without a significant investment in my potential as a human being. I had the opportunity to train for not just any job, or the first job available, but for the right job for my abilities, skills, talents, and interests. I could have been trained to be a receptionist or other low skill, low pay position, but I would have not been able to earn enough money through wages to purchase the medical equipment and services, assistive technology and personal assistance that I require in order to work. Instead of paying taxes and purchasing consumer goods as I do now, I would still be on SSDI and SSI as well as Medicare and Medicaid. The investment made in me by vocational rehabilitation has been paid back many times over in the last 15 years.

My experience with successful medical and vocational rehabilitation is not unique. There are other, more notable individuals who have benefited from these services, including Senate Majority Leader Bob Dole, Former Representative Barbara Jordan, Umpire Steve Palermo, Secretary of Veterans Affairs Jesse Brown, and Actor Ben Vereen. Aside from these famous individuals, many others have benefited from rehabilitation services. Rehabilitation — by returning people to home, to school, to work — not only improves the quality of life for severely injured people but saves money — for payers, consumers and providers. Rehabilitation results in:

- Overall savings in long-term disability costs to both private providers and public programs, ranging from $1 billion to $2 billion annually.

- Cost savings from reduced hospital stays, estimated in the hundreds of millions of dollars. For traumatic brain injury patients alone, the length of hospitalization due to new rehabilitation treatments has been reduced between one-half and one-third.

- Savings of $500 millon to $1 billion per year by returning 50,000 to 100,00 people a year to home care rather than alternative care, such as nursing homes.

- The return to work of 350,000 each year, according to U.S. Department of Education figures and industry surveys. Even calcualated at an average wage, earnings on the order of $3.5 billion a year are attributed to these individuals, meaning some $700 million in additional federal, state and local tax revenue is received annually.

CROSSING THE BRIDGE

The vehicle for crossing the bridge is job training and vocational rehabilitation. There are several strategies for enhancing access to these services by individuals with disabilities. I will concentrate my remarks today on improving the Beneficiary Rehabilitation Program and providing incentives for small employers to hire individuals with disabilities.

- **Social Cecurity Agency (SSA) Alternate Providers Program.** The SSA Alternate Provider Program is an effort to create a market for the delivery of vocational rehabilitation services from private sector providers that will expand the choices available to individuals with disabilities and improve the return of individuals on SSDI and recipients of SSI to gainful employment. This fledgling program must be modified with a new type of outcome-based reimbursement system for it to be productive.

- **Tax Incentives for Small Employers.** To assist small employers, which create the majority of new jobs in the American economy, there are several tax credits that are incentives for these employers to hire and accommodate individuals with disabilities.

ALTERNATE PROVIDERS

Revise the current Beneficiary Rehabilitation Program by allowing consumers to select their Vocational Rehabilitation providers from among private or public agencies.

SSA has spent more than $30 million in demonstration programs involving over 100 primarily private rehabilitation providers during the last few years to investigate ways to increase placement of SSDI beneficiaries into jobs. Mandated by Congress in Section 505 of the Social Security Amendments of 1980, Congress directed SSA to conduct a series of demonstration projects designed to increase the number of beneficiaries who return to work and to produce savings to the Federal government. SSA has collected large amounts of invaluable information concerning the problem of placements, but SSA has done nothing to implement any of the proven techniques that could be used to increase the placements of SSDI beneficiaries into jobs.

We propose two initiatives: A) allow direct contracting by SSA to any public or private provider of rehabilitation services selected by the consumer, and, B) the establishment of an outcome-based risk/reward system for reimbursing rehabilitation service providers.

A. Direct contracting with consumer selected rehabilitation providers.

People with disabilities who are SSDI beneficiaries and consumers of vocational rehabilitation and placement services have no choice in the providers of their services. Consumers are assigned to a service provider by SSA, which by law must be a state vocational rehabilitation agency, usually by type of disability rather than type of services required. Consumers who determine that they are not receiving appropriate or quality services generally have no recourse other than to purchase services themselves from private vendors. Given the cost of private services and the state of most consumers' finances, this is an option few can afford.

Active participation in rehabilitation increases the chances of a successful outcome, in this instance, a successful return to work that ends reliance on cash assistance. Enabling consumers to choose their rehabilitation providers gives the individual a feeling of ownership in the process. This choice of service providers treats the beneficiary as an adult, capable of making significant life choices, thereby enhancing the individual's self-esteem and confidence. Choice eliminates the conflicting signals currently sent by the referral system, which tells beneficiaries they are capable enough to work, but they are not capable to select where to go for vocational services.

In order to enable consumers to select their own providers, SSA must be able to refer to and contract with providers of rehabilitation services in addition to State Vocational Rehabilitation Agencies. By restricting referral and contracting only with state vocational rehabilitation agencies, SSA does not allow consumers to exercise informed choice in the selection of their vocational rehabilitation provider. Given the diversity of individuals with disabilities and their individual needs, and the other extensive responsibilities these agencies have, it would be much more productive to utilize the vast capacity of the private rehabilitation service providers available throughout the nation to assist SSI recipients and SSDI beneficiaries to return to work.

B. Establishment of a Risk/Reward system.

There is tremendous potential for reduction of dependency and cost savings that is not being realized because so few SSDI beneficiaries and SSI recipients receive effective vocational rehabilitation services.

The present authority for delivery of rehabilitation services under the Social Security Act is inadequate for two reasons. First, all services are provided through referrals from state Disability Determination Service to the vocational rehabilitation (VR) agencies. Second, the state VR agency is reimbursed for services only when the SSDI beneficiary receiving such services is placed in a job, earns more than the Substantial Gainful Activity (SGA) rate and does so for more than the trial work period. The state VR must use money from other sources and programs up front for the SSDI beneficiary with the hope of being reimbursed by SSA. Hence, there is little incentive for state agencies to expend VR funds to help SSDI beneficiaries. At best, the cost can be recovered in successful cases. There is no payment for services when they do not result in SGA. Thus, the net effect is a loss for the state agency. The policy of reimbursing state agencies

only for successful cases has been the law since 1981. The policy of making all referrals through state VR agencies dates from the origin of the Beneficiary Rehabilitation Program (BRP) in the 1960s.

We believe that the volume of rehabilitation services and return to work of SSDI beneficiaries can be expanded with net savings in cost through a combination of direct referral of beneficiaries to rehabilitation providers and payment for services based on outcomes leading to employment and savings to the government, rather than the cost of services.

Consider this. If a beneficiary is returned to work and goes off cash assistance there is a savings to the government. The value of the rehabilitation services should be determined by such savings. Apart from humanitarian considerations, if the cost of rehabilitation is less than the cost of maintaining benefits, then it makes sense to spend money for rehabilitation services. Various studies have addressed this cost/benefit relationship. We suggest that it is not necessary to theorize about it and, indeed, that the relationship can be made explicit—with benefits for all concerned.

This can be done in two ways. One is through a milestone reimbursement system, and the other is through a pure risk/reward system. American Rehab recommends that Congress direct SSA to develop and implement both payment systems.

A milestone reimbursement system pays providers only upon achievement of milestones, or goals, in a written rehabilitation plan that is agreed to by the provider and the consumer. Although plans would be individualized to the consumer's skills, talents, interests, and needs, plans would contain at least four employment related milestones. These milestones would include: 1) an initial assessment and plan development; 2) acquisition of job skills and related competencies; 3) job placement; and, 4) completion of 9 months at SGA and departure from cash assistance. Providers would receive a partial payment at the successful completion of each milestone. Additionally, a payment at completion of SGA of a percentage of savings to the government may be made to the provider as an incentive to assist the individual to remain employed.

A risk/reward system would operate by providing for direct referral of beneficiaries to rehabilitation providers and for payment to such providers based on savings to the trust fund, as such savings accrue. Providers would bear the risk for the effectiveness of services, but be compensated not on cost, but on savings to the trust fund. This can be achieved by providing for payments to be made for service when a beneficiary goes off the rolls and continues so long as the beneficiary is employed and does not return to the income support rolls. Payment should be based on a percentage of the cash assistance that would otherwise be paid to the individual. A reimbursement system that rewards outcomes during the rehabilitation process, at job attainment, and throughout the employee's tenure in the workforce and off the disability roles, would benefit all parties.

Obviously, the higher the percentage and the longer the duration of payment the greater the incentive for providers to accept the risk of providing services under such a contingency arrangement. Providers would have to make very explicit judgements about the potential for rehabilitation and the costs of services. Furthermore, there would be an incentive to provide continuing assistance to beneficiaries since payment to the provider would continue only so long as the beneficiary stayed off the income support rolls. This approach is a win-win-win situation — for the beneficiary, the rehabilitation provider, and certainly the American taxpayer.

TAX INCENTIVES FOR SMALL EMPLOYERS

It is necessary to provide incentives for employers, especially small business owners, to hire people with disabilities. Small businesses have created 100% of new jobs from 1987 to 1992, and were 99.7% of all employers in 1990. We are particularly concerned that small businesses need tax incentives, especially if health care coverage is expanded and the minimum wage is increased. For small businesses, with 25 or fewer employees, a Targeted Jobs Tax Credit should be established. The TJTC would offer employers a credit against their tax liability if they hire

people with disabilities. The credit could be equal to 40% of the first year wages up to $6,000 per employee for a maximum credit of $2,444 per employee for the first year of employment. Individuals must be employed by the employer at least 90 days (14 days for summer youth), or have completed at least 120 hours (20 hours for summer youth). Employers' deductions for wages must be reduced by the amount of the credit. Individuals with disabilities could receive a voucher from their state VR agency. The voucher could be presented to the employer who completes a small portion and then receives a certificate which validates the tax credit and which the employer uses when filing federal tax forms (NOTE: This is the model used by the TJTC Program which was recently not reauthorized; Section 51 of the Internal Revenue Code [IRC]).

Another tax incentive for small employers could be to waive the employer portion of the FICA tax for newly hired employees with disabilities for one or two years. This would have the effect of lowering the cost of hiring employees with disabilities for small businesses.

The SSA and VR agencies should also more aggressively publicize the Architectural and Transportation Barrier Removal Deduction, Section 190 of the IRC, and the Disabled Access Credit (DAC), Section 44 of the IRC. DAC is available to an eligible small business and is equal to 50% of the eligible access expenditures which do exceed $250.00, but do not exceed $10,250, for a maximum credit of $5,000 per year. DAC is included as part of the General Business Credit and is subject to the rules of current law which limit the amount of General Business Credit that can be used in any taxable year. An eligible small business is defined as gross receipts not exceeding more than $1.0 million, for the preceding tax year, or one which employed not more than 30 full time employees during the preceding year. Expenditures permitted are for: removing architectural barriers, providing qualified interpreters, modifying equipment, etc.

Although, employers are using the DAC, the IRS has not yet developed regulations for it. DAC went into effect November 5, 1990. The IRS does have a publication and forms for the DAC. However, it would be easier for employers if there were regulations for this Credit. The IRS should promulgate regulations as soon as possible to encourage the use of the DAC.

Under the Architectural and Transportation Barrier Removal Deduction, businesses may chose to deduct up to $15,000 for making a facility or public transportation vehicle, owned or leased for use in the business, more accessible to and useable by people with disabilities. There are regulations issued for this Section.

The Service Members Occupational Conversion and Training Act (SMOCTA) of 1992, which provides an employer a reimbursement of up to $10,000 for the trainee's wages, if he/she hires and needs to train an ex-serviceperson, or up to $12,000 if the trainee is a veteran with a VA service-connected disability rating of 30 percent or more. Employers may receive up to $500 toward tools and other work-related materials necessary for training, as well; SSA and VR agencies need to publicize SMOCTA to small businesses also as an incentive for hiring people with disabilities.

BUILDING THE BRIDGE

Enabling individuals who have been reluctant to re-enter the workforce due to the economic disincentives inherent in the current system requires establishing mechanisms to maximize net income to a level that enables them to survive. The current structure punishes rather than rewards people with disabilities who attempt to leave entitlement programs to work. The system essentially eliminates eligibility for both cash and non-cash benefits (health care) **before** the individual can earn a living wage. This total loss of support, well-known by people with disabilities, is called "the earnings cliff" and is viewed as the greatest work disincentive.

This structure forces people to choose between taking employment that typically does not even cover basic necessities (food, clothing, shelter) and does not provide health coverage (much less extraordinary disability-related expenses) versus remaining on the entitlement programs supports. Through this entitlement they receive barely sustainable cash assistance and vitally needed medical coverage. Given the absolute need for health care, many people with disabilities make the rational choice to continue to receive cash assistance and other supports. This coupling of

income support and health care policy frequently traps people with disabilities in an endless cycle of poverty.

There are several **fundamental** elements that must be constructed to achieve the transition from dependency to self-sufficiency. These fundamental elements consist of : extending health coverage to working individuals with disabilities, establishing wage supports, providing access to personal assistance services and assistive technology, and maintaining a reliable disability safety net.

HEALTH COVERAGE

In the private sector, health coverage is linked to employment. In the public sector, health coverage is linked to income supports. Linking eligibility for in-kind services such as health insurance to the lack of employment is unnecessary and counterproductive. The lack of health coverage serves to create a substantial barrier to taxpayer status for individuals who have difficulty finding affordable health insurance. Numerous studies have documented the fear of beneficiaries and recipients in leaving SSDI or SSI because they cannot afford or cannot find health insurance. Allowing disabled workers to "buy-into" health coverage by paying the required premiums and deductibles will ultimately save money by removing the risk of loss of their health insurance and giving them an incentive to reduce their reliance on cash assistance and enable them to become tax payers instead of tax users. In lieu of reforms to the health insurance market that eliminate preexisting conditions, guarantee portability, and reduce the cost of coverage for individuals with disabilities, opening Medicaid, Medicare, or the Federal Employee Health Benefit Plan for disabled workers would eliminate a major disincentive to employment.

Individuals with disabilities should be allowed to buy into Medicare, Medicaid, or the Federal Employee Health Benefit Plan (FEHBP) on an income-based sliding scale. The scale should adjust for the extraordinary expenses related to disability for the individual with a disability or for the household in which the individual with a disability resides. Deductibles and co-payments may be used to reduce costs and control utilization.

WAGE SUPPORTS AND WORK INCENTIVES

Individuals with disabilities incur substantial expenses in the conduct of their everyday lives as they try to learn, work, recreate, and live in the community. The cost of personal assistance to enable individuals with severe disabilities to work can be a barrier to employment, as individuals with disabilities often do not earn enough in wages to afford to pay for personal assistance in addition to a rent or mortgage, utilities, food, and related life expenses. Other examples of extraordinary expenses include the cost of accessibility modifications such as a wheelchair lift for a van or hand controls for a car; a wheelchair ramp, or alternative signaling device for an accessible home; or medications and medical supplies. There are major expenses for assistive technology, including wheelchairs, hearing aids, animal companions, computers, augmentative communications devices and the training and maintenance costs of the equipment. Not the least of these extraordinary expenses is for health specialists above and beyond the typical health expenses incurred by the average person. All of these expenses conspire to trap individuals with disabilities in a cycle of poverty and total government dependency from which most cannot escape without tax assistance to level the economic playing field.

In order to promote the goal of employment and increased self sufficiency for individuals with disabilities, there must be financial incentives for beneficiaries and recipients to take the risk of leaving the disability roles for payrolls. Wage supports can be used to maximize the net pay of a worker through tax incentives and deductions. This could be accomplished by extending the current Earned Income Tax Credits for low-income workers to individuals with disabilities, and by creating a Personal Assistance Services Tax Credit for working individuals with disabilities who have significant needs for personal and technological assistance in order to work.

The Earned Income Tax Credit should be extended so that it helps bridge the gap between the Substantial Gainful Activity level and a minimum income level for low-income workers with

disabilities. The present Substantial Gainful Activity level for non-blind beneficiaries is $500 per month, or $6,000 per year — less than the federal poverty level. It is impossible for an individual with a severe disability to live on this level of income, especially given their extraordinary expenses of living with a disability.

PERSONAL ASSISTANCE SERVICES AND ASSISTIVE TECHNOLOGY

We recommend changes to address the cost of long-term services for working persons with the most significant disabilities. To do this, we propose a tax credit of one-half of all personal assistance services up to $15,000 for any individual with a disability who is working. Expenses for personal assistance services beyond $15,000 per year should be deducible as a medical expense.

Personal assistance is defined as one or more persons or devices assisting a person with a disability with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

With the benefits of assistive technology and new service delivery approaches, children and adults with disabilities are more independent, productive and integrated than ever before. The assumption that an incapacity to work could be predicted from the severity of an impairment has been widely discredited. Advances in medical and biomedical technology, adaptive equipment, training techniques, and behavioral management are making it possible for persons with the most severe impairments to engage in productive employment. Accordingly, federal disability programs should help finance the support services that are necessary to help individuals with severe functional limitations get back to and stay at work by removing all physical, communication, transportation and attitudinal barriers and providing the necessary supports to focus on achievements.

The proposed tax credits and changes in medical care deductions for Personal Assistance will help to offset the extraordinary expenses of living with a disability and assist people with severe disabilities to enter the workforce by giving them a measure of economic equity with those wage earners and tax payers who do not need to pay these extraordinary costs. Encouraging people with disabilities to become tax-payers rather than tax-takers would reduce the out-flows of the SSDI Trust Fund and increase the revenues to both the General Fund and the SSDI Trust Fund.

MAINTAINING A DISABILITY "SAFETY NET"

Individuals with disabilities need a safety net similar to that provided to individuals without disabilities through the unemployment insurance system. This safety net would address the unique needs of workers with disabilities who, due to the nature of their disability or the effects of aging with a disability, are unable to work continuously. Further, individuals with disabilities occasionally experience acute episodes or the onset of secondary disabilities that require them to leave the workforce for the period of time necessary to alleviate these conditions. The development of an "easy-on, easy-off" method of re-entry to benefits is imperative to the success of individuals attempting to cross the bridge.

Social Security should change its thinking to a more individualized functional assessment determination of disability which recognizes the ability of some eligible individuals to return to the workforce. For many of those who have contributed to the Social Security system, disability payments from the time of injury until the age of 65 is not the desired goal. A "safety net" which helps the individual to transition from pre-disability employment to a new career which utilizes the capabilities extant in the individual as well as technology would better serve the United States. SSA must recognize that medical and technological advances have extended the post-injury lifespan and expanded work opportunities for people with disabilities.

Cash assistance and medical benefits should be continued for individuals with disabilities, who, due to the nature of their disabilities, can work only intermittently. Modifying the standards of eligibility to take into account the nature or relapsing/remitting diseases such as multiple sclerosis (and other relapsing/remitting conditions such as some forms of mental illness) would enhance the ability of individuals with disabilities which can be intermittent in nature to take the risk of entering the workforce. All individuals should be encouraged to attempt to return to work, regardless of disability, without the fear of losing financial and medical support if the attempt is unsuccessful due to a recurrence or worsening of their condition.

CONCLUSION

Unemployment among working age persons with disabilities is due to a combination of factors, including lack of health coverage; lack of long term supports for severely disabled persons; a continuing misconception that people with disabilities cannot work; inadequate opportunities for medical and vocational rehabilitation; the failure of our educational system to adequately prepare young persons with disabilities for a lifetime of work; lack of easily accessible, reliable, and affordable public transportation; lack of affordable, accessible housing; and the difficulties in transitioning from dependence on disability related cash assistance and in-kind support programs to financial independence and self-reliance. Americans with disabilities expect to participate fully in society with all the opportunities, privileges and responsibilities of other citizens.

Congress can facilitate this full participation through constructing a transition to employment strategy that builds a bridge off of income support programs and delivers services that enable individuals with disabilities to cross that bridge. Building a bridge off income supports requires extending health coverage to working individuals with disabilities, establishing wage supports to raise net income, providing access to personal assistance services and assistive technology, and maintaining a reliable disability safety net. Delivering services to enable individuals with disabilities to cross the bridge from dependency to self-sufficiency requires the overhaul of the current Beneficiary Rehabilitation Program.

Chairman BUNNING. Thank you, Mr. Young.
Kenneth Shaw, please.

STATEMENT OF KENNETH J. SHAW, DIRECTOR, PROGRAM DEVELOPMENT AND RESEARCH, GOODWILL INDUSTRIES INTERNATIONAL, INC., BETHESDA, MD.

Mr. SHAW. Thank you, Mr. Chairman.

I am Kenneth Shaw, and I am the director of Program Development and Research for the corporate office of Goodwill Industries, which is the largest provider of vocational rehabilitation and employment services to people with disabilities in the world.

I am pleased to be here to offer some suggestions on three specific areas of concern. The first is related to the disability determination process itself.

The present system, as you have already heard, requires people to prove incapacity. It also indicates or causes to be perceived by the beneficiary that there is regular income maintenance and medical benefits to be provided. It also instills in the person the belief that work is not a viable option.

We believe that this system should be replaced by a two-tiered system in the disability determination process. At tier one, we would make the determination that individuals with permanent disabilities, with no expectation of improvement, such as progressive disabilities or terminal illnesses, be put on a permanent disability tier.

Tier two would be all other applicants. Most of us in vocational rehabilitation believe that people with disabilities can work if given appropriate services and supports. Three possible outcomes could be achieved on tier two. The first is that individuals would go to work as a result of the services they receive; they would achieve SGA, substantial gainful activity, and they would terminate cash benefits. The second possible outcome is that the individual is determined to be eligible for tier one and would be referred back for permanent benefits. The third outcome is termination of cash benefits when the individual chooses not to accept or seek employment, with the provision that the individual has the right to appeal any decision.

Our second concern relates to service provider reimbursement. The present system asks all providers to assume all of the risk, with little opportunity for benefits, since the reimbursement is provided only for those who are successful. The person is served, he or she achieves SGA, which is 9 months later, and from time of service to SGA could be greater than 1 year, with only payment for those who achieve SGA.

We suggest a system that shares risk and shares benefits. For illustrative purposes, we will assume that an average cost for rehabilitation would be $2,000 per individual. We suggest that the reimbursement be made at various stages. We would take the $2,000, and we would start with the person going through an intake and an assessment process where the provider would be reimbursed for 10 percent of what the expected average cost would be, or $200. After vocational rehabilitation or skills training, the provider would be reimbursed at $400, which is an additional 20 percent of the total amount. At placement, the provider would be provided an ad-

ditional $600, or 60 percent of the total money available, and the final 40 percent, or $800, is provided at SGA.

Since the purpose of the program is to keep people employed, we would also suggest a bonus system to give the provider incentive to do followup and follow along and intervention services, so that after an individual has achieved SGA for 12 or 18 months, an additional $1,000 or some bonus system be provided to the provider.

We are also proposing an innovative method to fund this system. For each successful rehabilitation, a portion of that person's FICA contribution would be reserved in a new vocational rehabilitation trust fund to pay for services to future recipients. Over time, the system will become self-funding.

Our third and final area of concern is related to the medical coverage, which has already been addressed. Medical coverage is extremely important to people with disabilities, and the fear of losing or not accessing medical coverage may be the single biggest impediment to working. Our recommendation offers the opportunity to individuals to purchase the Medicaid/Medicare coverage. Premiums could be calculated based on earnings. This is only in the absence of employer-provided medical insurance.

I thank you for the opportunity to make these observations.

[The prepared statement and attachment follow:]

STATEMENT OF

KENNETH J. SHAW
DIRECTOR
PROGRAM DEVELOPMENT AND RESEARCH
GOODWILL INDUSTRIES INTERNATIONAL, INC.

BEFORE THE

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

AUGUST 3, 1995

Mr. Chairman and Members of the Subcommittee:

On behalf of the Goodwill Industries network, I am pleased to offer our views on the Social Security system's failure to provide effective vocational rehabilitation services to individuals with disabilities, and our recommendations on how to remove these disincentives. We commend the Subcommittee for conducting this hearing into a critically important issue and look forward to working with you in the development of a legislative proposal to correct the system's problems.

Goodwill Industries International, Inc. (GII) is the corporate office of a network of 184 autonomous, tax-exempt, adult employment training centers operating throughout North America, with associate members in 37 other nations. In 1994, these 184 North American organizations provided a variety of vocational rehabilitation, training and employment services to more than 125,800 individuals with disabilities or other vocationally disadvantaging conditions. Of the 34,000 individuals referred to Goodwill Industries for job-placement assistance, 23,307 people were placed into competitive employment as a direct result of Goodwill's efforts, thereby creating significant economic and social benefits as formerly unemployed people became American taxpayers. Goodwill Industries also is unique in the nation's nonprofit human service system. In 1994, only 18.5 percent of Goodwill's revenues of $951 million came from federal, state or local government sources (either grants or fee-for-service agreements). The remaining operating funds came from the sale of household goods donated by a generous public and industrial contracts utilized in job training programs.

Significantly, of the more than 104,600 people referred by public and private agencies to Goodwill Industries for services last year, only 667 (0.64 percent) were referred by the Social Security Administration, with a considerable portion of those referrals only for purposes of disability determination - not for services leading to employment.

We have identified five structural problems that are largely responsible for the insignificant number of Social Security Disability Insurance (SSDI) beneficiaries and Supplemental Security Income (SSI) recipients who are successfully rehabilitated and returned to the nation's work force annually. Those problems and Goodwill Industries' recommendations for addressing the problems follow.

Disability Determination

In order for individuals with disabilities to qualify for Social Security assistance, they must go through a rigorous process to prove that they do not have the ability to engage in "substantial gainful activity" (SGA). In effect, the "system" requires them to demonstrate that, because of their disabilities, employment is not a reasonable

expectation. Immediately following a determination of disability, the system then attempts to encourage these individuals to enter or re-enter the work force through referral to vocational rehabilitation services. Through the eligibility determination process, people are conditioned to accept the fact that employment is not a viable outcome because they have just proven that work at or above SGA is not possible.

We believe that this "all or nothing" eligibility process should be replaced with a two-tiered intake and disability determination process. "Tier 1" would be comprised of individuals with a permanent disability with no expectation of improvement for whom employment is unlikely (e.g., a person with a terminal illness). "Tier 2" would include individuals with disabilities for whom employment may be a reasonable expectation. Within this category, three outcomes could result, where the individual:

- receives vocational rehabilitation/skills training services and becomes employed. Cash benefits terminate when earnings exceed SGA;
- transfers to the "Tier 1" permanent disability category because of the nature of the disability (e.g., a progressive illness); or
- receives vocational rehabilitation/skills training services and chooses not to seek or accept employment. Benefits terminate, with the individual permitted to appeal that determination.

Conditioning Dependency

Under the Supplemental Security Income program, dependency is often fostered at an early age when a child is determined to have an impairment of comparable severity to that which would preclude an adult from engaging in substantial gainful activity. Children are therefore conditioned to expect life-long support because employment is never considered to be a viable option.

While recognizing that a family of a child with disabilities will at times incur extraordinary expenses as a direct result of those disabilities, we believe that monthly cash SSI benefits should not be provided to children. As an alternative to the current system, Social Security should pay only for those extraordinary expenses directly related to the child's disabilities. These would include payment for ongoing therapeutic services, adaptive equipment, in-home treatments and prescription medication. The Social Security Administration (SSA) should also require that a recipient of service reimbursements has in place a practical, individualized plan of education and skills training that will result in employment at or above SGA following the completion of education/training. To construct a realistic plan, the active involvement of the child, the child's family, appropriate school system representatives and SSA is necessary. A young adult exiting the education/training system who is unable to achieve SGA would be placed into the "Tier 1" category of permanent disability discussed above.

Service Provider Reimbursement

It came as no surprise to Goodwill Industries that in 1981 when Congress amended the process of payment to providers for vocational rehabilitation services for SSDI beneficiaries and SSI recipients that few individuals would actually receive services. Neither public nor private vocational rehabilitation agencies have sufficient economic resources to finance the provision of services, receiving reimbursement only after an individual is employed at or above SGA for nine consecutive months. The delay in reimbursement occurs regardless of the quality of vocational rehabilitation/job-training services provided. In effect, vocational rehabilitation agencies are asked to assume all of the cost and all of the risk.

Goodwill Industries believes that a revised reimbursement system should incorporate incentives for service providers that assists in ensuring long-term employment at or above SGA. This system would provide payment for services (based on local market conditions) as an individual moves through the vocational rehabilitation process, with additional financial incentives to service providers for positive outcomes. Using an illustrative example of an average $2,000 cost for rehabilitation, we propose the following service provider reimbursement schedule:

Service	SSA Payment to Service Provider
Intake & vocational assessment	$200
vocational rehabilitation/skills training	400
Placement in employment	600
Achieving SGA	800
Total	$2,000

As an incentive to the vocational rehabilitation agency to provide "follow along" services to facilitate long-term employment, SSA should pay an additional "bonus" to the service provider of perhaps $1,000 if the individual has successfully maintained SGA for 12 or 18 months after initially reaching that goal.

Goodwill Industries also proposes to fund this incentive payment system in an innovative manner. For each individual successfully rehabilitated, a portion of that person's FICA contribution would be reserved in a new vocational rehabilitation trust fund to finance future payments for services to others. Essentially, those who benefit from Social Security's vocational rehabilitation program through achieving and maintaining employment will fund services for other beneficiaries/recipients. Over time, this system becomes self-financing with no appropriated funds required.

Reforming the SSA Bureaucracy

The House of Representatives will soon consider the Consolidated and Reformed Education, Employment, and Rehabilitation Systems (CAREERS) Act (H.R. 1617), legislation to substantially reform federal job-training efforts. A key feature of the measure is the establishment of "one-stop" service delivery system at the local level for individuals in need of vocational rehabilitation, job training and labor market information. Currently, the Social Security Administration is largely consumed with determining eligibility and writing checks, with no incentives to reduce disability rolls. With the implementation of these one-stop centers, we believe a Social Security representative should be present in every center to assist SSDI beneficiaries and SSI recipients to access appropriate services from certified providers. All "Tier 2" beneficiaries/recipients (disabled, but employment outcome achievable) should be immediately referred to the local one-stop center following determination of disability.

Medicare/Medicaid Incentive

Although in certain situations SSI recipients may be eligible to continue Medicaid coverage when earnings exceed SGA, no similar incentive is available to SSDI beneficiaries. This lack of access to medical insurance may be the primary impediment to someone attempting to enter or re-enter the labor force. The solution to this disincentive is, we assert, a simple one. Individuals should be offered an opportunity to purchase Medicare/Medicaid coverage. Premiums should be calculated on a sliding scale based on earned income, with the option to purchase available until employer-provided medical insurance is obtainable.

Again, Mr. Chairman, Goodwill Industries International appreciates this opportunity to discuss our recommendations on reforming the Social Security vocational rehabilitation program. We believe these proposals, if enacted, will result in substantial benefits for individuals with disabilities, while providing significant direct and indirect economic benefits to the nation. We look forward to working with you, the members of the Subcommittee and your staffs on this important issue.

Chairman BUNNING. Thank you very much, Mr. Shaw.
Mr. Watters.

STATEMENT OF GEORGE M. WATTERS, CHAIRMAN, BOARD OF OCCUPATIONAL MANAGEMENT SYSTEMS, INC., SPOKANE, WASH.

Mr. WATTERS. Thank you, Chairman Bunning and members of the subcommittee.

The return-to-work problem of Social Security is well documented. My testimony concentrates on solution strategies. Details of legislative and policy proposals are contained in the written testimony which was submitted. Today I want to highlight some recommendations discussed in this document.

Parenthetically, Social Security redesign specifically excludes rehabilitation from its scope.

My purpose is to provide a basis for continued discussion and dialog toward necessary legislative reform.

Recommendations: It is necessary to reaffirm our fundamental contract with taxpayers and people with disabilities, to provide disability benefits only to those who cannot work because of disability, and to ensure that those with potential to return to work have the opportunity and incentive to do so.

Time-limited disability benefit awards linked with return-to-work assistance is a strategy which could help get Social Security disability beneficiaries back to work.

Periodic vocational assessments should be conducted for those receiving benefits who have the potential for return to work.

An equal playingfield for competition among service providers will stimulate the most efficient and cost-effective strategy for return-to-work assistance.

Those providing help with return to work should be compensated based upon outcome milestones rather than service process.

Client choice and advocacy-based outcome evaluation are essential to monitoring the quality and success of return-to-work efforts at the least cost.

Those returning to work after disability benefits need continuity of medical insurance at little or no additional cost burden to employers.

Employers need help with funding of accommodations necessary to employ many people leaving the disability rolls.

These recommendations come from extensive dialog with return-to-work service providers, people with disability and advocacy organizations, and from my personal experience as a provider of return-to-work services and one who has received rehabilitation assistance.

These recommendations do not have universal appeal or support from stakeholder groups. They do represent a best effort to propose a reasonable and balanced agenda for reform.

Decisive action is required for all stakeholders because the disability benefit system is one way and out of control, providing neither incentive nor opportunity for return to work. But the devil is in the details, and so is the solution, and a balanced perspective is essential for success.

Thank you.

[The prepared statement follows:]

Testimony of George M. Watters
to
The Subcommittee on Social Security
House Ways and Means Committee
Public Hearing of August 3, 1995

Introduction

Thank you Chairman Bunning, the Subcommittee, and Subcommittee staff for the opportunity to present views regarding the need for Return To Work (RTW) of Social Security Disability applicants and beneficiaries. Also, thanks to the many RTW service providers and hundreds of people with disability who have contributed to the policy perspectives of the RTW Group which I represent.

The RTW Group is an informal coalition of people with disability and service providers who assist in helping people get jobs. This "ad hoc" committee is devoted to the sole purpose of enhancing the work potential and/or Return To Work of SSDI and SSI applicants and beneficiaries. The group was founded in 1993 by myself and Ed Roberts, an internationally known activist and model for the independence and human rights of people with disability. Ed was a founder of the "Independent Living Movement" in the U.S., a founder of the World Institute on Disability, and a former California State VR Director. He also lived much of his life in an iron lung and used a power wheel chair and other advanced technology strategies to support his personal and economic freedom. Ed Roberts died in March 1995. The group was "temporarily disabled" by his devastating and unexpected loss. And, it is now left to those of us who understood his goals and spirit to mobilize the power to help insure essential balance for RTW initiatives. This testimony attempts to embody many of the independent living and human rights perspectives which Ed lived for. He was a firm believer in, and staunch advocate for, the employability of people with profound physical and mental disabilities. He also knew the safety and security needs of those with severe disability because he lived them. His influence guided the mission of our RTW Group. His influence guides my perspective as a surviving group founder. And, I therefore dedicate my testimony in his honor and memory.

The founding strategy of the RTW Group was to stimulate effective employment related public debate and resultant policy by bringing the RTW interests of people with disability together with the interests of employers and those who provide services to assist in employment. After extensive policy discussion and debate, the group met with Social Security senior staff in January 1995 to make preliminary recommendations for employment / re-employment related goals and strategies.

On April 1, 1995, Ed and I had planned to "roll out" RTW Group initiatives to consumers at a conference of people with disability sponsored by the California Coalition of Citizens with Disabilities. His death prevented his attendance in all but spirit. It will take many of us to infuse RTW with the wisdom, courage, and spirit typified by Ed. We now need the attention, dedication, input and assistance of a broad coalition of citizens with disabilities in consideration of RTW Group initiatives. If we do this, Ed's influence will continue to live. If we do so, millions of people with disability will take their rightful roles as working, independent and self-supporting citizens. That is our "bottom line".

Because the RTW Group has been a "loose coalition" the testimony which I present, as the current titular chairman of the group, must be disclaimed as "personal / professional opinion". However, I have done my best to distill policy perspectives from a review of research and from extensive involvement of RTW service providers and consumer input.

Needs of Taxpayers

Escalating disability costs, a dramatic increase in the number of people receiving disability benefits, instances of apparent abuse, and debate over what types of disabilities should warrant disability benefit eligibility have stirred taxpayers to question their disability related tax contributions and to fear that the "disability support system" will not be available to them in the event of real personal need. I am confident that you as Congressional Representatives are acutely aware of the growing unrest. From a taxpayer perspective, why continue to contribute to a disability benefit system which is escalating in costs to the level that it jeopardizes not only its own continuance but also the financial stability of retirement and survivor funds (requiring such strategies as re-allocation of tax rates). Many taxpayers relate anecdotal stories about people who they know personally who are receiving benefits but who can work. They do not trust that disability decisions are made on the basis of who can and can not work. And, they believe that once benefits are awarded there is no strategy to get people back to work. **The taxpayers' bottom line is that they do not want to continue supporting those who can support themselves. But, they do want insurance based upon their history of contribution in the event that they become unable to work.**

A General Recommendation Regarding Taxpayer Concerns

Congress, especially in those committees responsible for Social Security related legislation, needs to reassert and clearly articulate its fundamental contract with the taxpayer regarding disability benefits. The current "disability benefit delivery system" is broken - replete with inertia and complex processes to consider only one aspect of an agreement with the taxpayer - Is the applicant "totally disabled" according to a complex set of regulations and procedures developed over thirty years of compromise and litigation. However, the taxpayer needs a more fundamental contract, one in which:

- **Benefits will be paid on a timely basis only to those unable to work because of disability;**
- **The potential of applicants and beneficiaries to become self-sufficient will be accessed, strengthened and encouraged;**
- **Benefits will cease when people can work and jobs are available; and**
- **Disability benefit insurance is stable, reliable and balanced in the long term.**

The complex array of initiatives facing the Social Security Subcommittee and Senate Finance Committee must be distilled and balanced to facilitate such simple fundamental principles. The taxpayer has not consented to a complex and process-bound benefit system that ignores or convolutes these concepts. However, as legislators you must sort through truly complex problems, disincentives and initiatives. Political courage and attention to detail on a bi-partisan basis will be necessary to distill to the fundamentals of a contract with taxpayers while considering nuances which affect basic life support for people in great need. "The devil is in the details", but so is the solution.

Needs of People with Disability

Last week in DC there was a fifth anniversary celebration of the Americans with Disabilities Act (ADA) - a statute which "liberated" those with disability for equal employment opportunity (Title 1). But, this liberation is interpreted by many employers as their enslavement - an additional set of procedural mandates and costs of doing business. And, since the passage of ADA, there has been no net gain of employment for people with disability. Many employers carefully consider the perceived liabilities before hiring a person with disability - i.e. the cost of accommodation and difficulty with performance appraisal and termination. The dilemma for people with disability:

- Do they fight for support benefits to compensate for lost employment opportunity
- Do they assert their rights, display assets and skills, and take their rightful place in the economy, or
- Do they "hedge their bets" and simultaneously try for both benefit protection and equal employment opportunity.

There are those with disability who can not work, even with rehabilitation and/or opportunity. Do we have an obligation to protect benefit support for them? Or, put more bluntly, do those with potential to work have a right to take essential life support from those who can not work? I think not! Those with severe disability who can work or "rehabilitate" shouldn't "have their cake and eat it too".

Those who want independence, self-sufficiency and an equal economic status must risk benefit security. Public benefits and poverty go hand in hand. Public benefit dependence and equal opportunity co-exist with tremendous friction and conflict.

However, I am not suggesting that we ignore the reality of employment opportunity and availability of work; and that people move blindly from benefit rolls, as automatons, off the cliff from basic life security. If people give up the "net" of medical and cash benefits without real work opportunity most will fall from basic security to the depths of poverty and despair. They must have a chance to adjust to disability. They must have a chance to hone work skills. And, they must have real job opportunity. These requirements are "bottom line".

The current "de facto" definition of disability not only allows but encourages permanent dependence on benefit support. At the front end, claimants need to define themselves as "totally disabled" for at least a year. And, the system encourages helplessness as a strategy for continued support. There is no clear time when those seeking or receiving benefits can safely say "I have potential. I want to make it on my own. I want to work. Give me a chance." Instead, they face a convoluted network of disincentives and "work incentives". If the incentives are understood, interpreted, and pushed through complicated bureaurocratic procedures they may provide some direction toward work (A friend who is an SSDI beneficiary said to me recently "I don't understand George. Tell them to keep it simple"). Work Incentives and the procedures necessary for return to work are not simple. They are barely intelligible and quite cumbersome even for trained professionals. It is much harder to go to work than continue receiving benefit support.

Recommendation for "Time Limited Benefits"

Subject to the cautions cited below, those with severe impairment/s who are medically stable, meet the definition of disability, who can be expected to adjust to disability, and who have vocational potential should initially be awarded "time-limited" disability benefits. After an initial period of disability, continuance of benefit support should be conditional to participation in a managed RTW plan or to a re-determination that vocational options are not feasible.

With such conditions, most people with severe disability can start receiving benefit support with hope and the expectation of a return to self-sufficiency. To quote Ed Roberts: "All people are only temporarily able bodied". And, as we also know most of us with severe disability are only temporarily totally disabled.

Cautions Concerning "Time Limited" Benefits

If "time limited" benefit eligibility is not phased into the disability benefit program over time and with great care, virtually millions of people will lose essential support and the disability adjudication administrative process will almost certainly be "brought to its knees", overburdened to the point of chaos.

As we know, Social Security disability eligibility and appeals processes are now in a state of crisis: backlogged, cumbersome and often perilously slow and ineffective in meeting the needs of people with severe disability. **Current SSA "Re-design" efforts are aimed at speeding up adjudication processes and providing the basis for more accurate decisions requiring less appeal. However, these efforts do not factor in additional work load considerations which would be required by time-limited awards.** We should consider that the current average stay of a person on the disability rolls is now over

eleven years. And, effective time-limited benefits would likely demand re-adjudication procedures for most beneficiaries every three years.

Also, other relevant aspects of current adjudication process "re-design" are untested. Many (myself included) believe that a shift from adjudication based on "medical listings" and "vocational rules" to a strategy for individualized "functional assessment" will require an extensive new front end administrative burden. And, since functional assessment is intended to more accurately gauge a person's current and future ability to work, linkage to time-limited award conditions will be essential. Because the development of refined vocational rehabilitation procedures was specifically excluded from the scope of SSA's approved "Re-design Plan", the development of a detailed link between time-limited awards and vocational rehabilitation procedures is even more critical.

Increased competitive RTW assistance (discussed elsewhere in this testimony and in other testimony today) is feasible and should provide access to real work opportunity for those who would be granted time-limited benefits. However, implementation of such RTW efforts must be "ramped up" over several years. **Requiring time-limited benefits before there is RTW opportunity would have devastating impact on people whose benefits would be terminated based upon the expectation that they can and will work.** Research indicates that, historically, those who have applied and been denied SS disability benefits still have a very low RTW rate. It is quite possible that RTW rates would be similar for time-limited terminations if there is not adequate RTW assistance.

Time-limited awards should not be used for people whose conditions are not expected to improve and who have little or no vocational potential. To require time-limitation in such cases would demand unnecessary administrative burden and subject those with the most severe disability to increased vulnerability for benefit threatening administrative error. And, SSA is not experienced in determining who has vocational potential (current VR referral procedures and outcome success rates demonstrate this). Also, continuing disability review processes (when used) are based on a medical improvement model which does not consider many factors essential to judging vocational feasibility.

Retroactive application of time-limited award standards would certainly create havoc among people currently receiving disability benefits. It would instantly burden SSA with an immense administrative problem. And, it would quickly change the global dynamics of labor supply and demand pressures in our country (considering that several million people would be involved). To change the expectation of people currently receiving benefits to an expectation that they are generally able to return to work would be extremely difficult (considering that current statistics indicate that only about one in five hundred are now terminated from benefits based upon RTW). Those who have been on the rolls for a long period of time have lost work skills and gained an attitude of "permanent disability". Such people would be unlikely to compete for jobs but would be without support.

Recommendation for Periodic Vocational Assessments (PVAs)

As is well known, there is a huge backlog of un-conducted Continuing Disability Reviews (CDRs). Recent SSA administrative efforts are targeting this population with computer assisted strategies to help determine the likelihood of medical recovery and hence the efficacy of conducting full scale reviews. Initial results indicate that this effort is helping and is cost justified by terminations based upon medical recovery.

However, it should be noted that **the largest SS disability population with potential for RTW is generally not being addressed by CDRs.** People who are medically stable and who have RTW favorable "vocational factor" profiles, are not directly targeted for review. It is suggested that another category for review, the Periodic Vocational Assessment, (also conducted with computer assistance to minimize identification costs) be used to target those beneficiaries for whom vocational improvement can be expected and, secondarily, for whom vocational improvement is possible. **Those with favorable vocational profiles could be referred to RTW services with the possibility of**

termination based upon vocational adjustment to available work. Available work would be defined as that provided from the competitive RTW service network described later and in other testimony today. Such a strategy could provide great trust fund savings while insuring that those terminated because of vocational adjustment had real job opportunities. Trial work period provisions and "work incentives" would apply to this population, unless otherwise precluded by "medical improvement expected" criteria. Because of SSAs current administrative burden, and to minimize the cost of PVAs, it is further suggested that they be conduced by RTW network providers as a work assessment milestone.

Need for RTW Assistance

Research indicates that over 75% of people with severe disability are unemployed or under-employed. As indicated earlier, very few people leave Social Security disability rolls for work. Social Security Work incentives are complex, vary between programs, and are generally under-utilized. The conditioned attitude of "total disability" is difficult to overcome. In spite of the passage of the Americans with Disabilities Act in 1990, recent findings indicate that people with disabilities have not had an increase in rate of employment over the last five years. Employers burden immense costs of disability and are reluctant to hire people who they think may add to these costs. Cost shifting and re-definition of the work responsibilities of AFDC, GA and other people receiving welfare are flooding the labor market with additional labor supply. People with severe disability have special needs for accommodation, job matching strategies, training, and continued medical coverage. These and many other factors contribute to the need for RTW assistance.

RTW services can provide a "relationship edge" which gives a person enhanced opportunity to be hired in a very competitive labor market. RTW case management services can also be used to monitor employer and employee needs to assure that employment is maintained.

However, for RTW services to work, providers of such services must have the motivation and incentive to achieve clear success outcomes. Payment for the "process" of RTW assistance may spur the development of a cottage industry for providers but experience indicates that such efforts are expensive and often do not achieve desired results. The failure of "fee for service" based rehabilitation to demonstrate cost-benefit in many State Worker's Compensation systems illustrates the problem of paying for process without outcome.

"Final outcome only" reimbursement models, such as that proposed by Monroe Berkowitz, entail no risk to Social Security because all risk is passed to providers and people with disability. However, competition cannot survive in this model because most RTW service providers can't afford to wait for a year after job placement before receiving any reimbursement for achieved outcomes. Also, in a limited sense, aspects of this model have already been attempted and have failed dismally. In 1980, State VR reimbursement was changed from a "fee for service" model to a "final outcome only" model. During the period from 1980 until the present, the RTW rate declined from a poor one in seventy to an abysmal one in five hundred. Although it can be argued that other factors contributed to this decline, it can also be argued that extensive time between service and reimbursement diminished State VR agency motivation to target the SS population. Whatever the arguments and counter arguments, the switch to "final outcome only" reimbursement was not successful in raising the RTW rate.

Recommendations for Provider Competition and Compensation

Because other testimony today discusses RTW service reimbursement models at great length, my recommendations are brief. A viable RTW service system should be highly competitive. The model should share the risk of failure and spread the incentive for success among all participants. **The reimbursement model which pays for RTW service must support and enhance this competition - attracting a broad range of providers to assist with difficult job placement and**

retention issues. The model should encourage working with people who can result in the greatest trust fund savings. **Provider reimbursement should pay for outcomes rather than process.** Essential outcome milestones include: completion of an adequate assessment for work (including a plan for employment); obtaining a job; retention of a job until termination of cash benefits; and retention of work to achieve lasting trust fund savings. All of these incremental RTW service milestones are measurable with minimum process and are essential to the end result of trust fund savings. Because of historical inertia which has ignored RTW as a major need, and due to considerable administrative burden in other areas, **SSA's role in administration should be minimized.**

Recommendation for Client Choice of Providers and Services

To facilitate competitive RTW service, minimize the need for administrative process and enhance participation and outcome ownership by people with disability, it is recommended that a "client choice" model of vendor and service selection be used. **If clients are free to choose among providers based upon information concerning the vendor's success rate, type of service provided and record of working with people who have similar problems or disabilities, chances for success are much greater.** Vendors should be free to advertise their services and outcomes to clients. To facilitate informed choice, it is also suggested that advocacy organizations have a formal role in oversight of the vendor selection process and that they be given responsibility for providing clients with performance statistics and counseling as to the nature and extent of service need. Carolyn Weaver, member of the Social Security Advisory Board, and Monroe Berkowitz, an economist on the Social Security disability reform advisory panel of the National Academy of Social Insurance, are among the many who support the notion that quality and service outcome are enhanced by a client choice-based service model. Many providers, including Steve Start and Fred Tenney, who are also at today's hearing, are experienced and successful with this model. I, as a person who has been caught in the tangled web of rehabilitation options and disincentives, know first hand that client choice is essential, but that informed choice is enhanced by outcome oversight and neutral third party consultation. To help insure a bottom line orientation for quality assurance, oversight and advocacy group based client counseling, it is suggested that reimbursement for involved services be based upon trust fund savings.

Cautions Regarding Client Choice

Client choice based services (especially when combined with outcome-based reimbursement) do not allow much room for mistakes in client judgment (e.g. If a completed assessment was poor, re-assessment is difficult to fund or justify when a milestone payment has already been made). This enhances the need for a network to assist with informed choice regarding vendors and services.

Client choice models should be based upon a client provider contract of milestone deliverables rather than a "single ticket system" which pays the final ticket holder a lump sum award after trust fund savings have been realized. The lump sum, final ticket holder approach encourages abuses by both clients and potential ticket purchasers. Clients could pull tickets and sell them to the highest bidder after all services have been rendered but before trust fund savings are realized. Competition would move toward bidding for tickets rather than achieving necessary outcome milestones. And, the illusion of enhanced client choice would turn to a decrease in provider investment in the costs of quality services.

Recommendation for Continuing Medicare Coverage after Work

Recent research (Lewin-VHI, 1995) makes it abundantly clear that the fear of loss of medical insurance is a primary factor in keeping people on the SS disability rolls. Research also indicates that most beneficiaries are unaware of extended medical insurance benefits which can provide as much as thirty-nine months of medical coverage after a

beneficiary goes to work. Though continuance of Medicare after the extended period is also possible if the beneficiary pays the costs, it is usually unfeasible (costing over $300/month) given the low entry level wages of many ex beneficiaries. Medical insurance protection is unequal for the SSDI and SSI populations and many beneficiaries do not understand their basic benefits or, in concurrent and SSI cases, their medicaid supplements. The expected expenses for medical care of people with severe disability and work potential can be quite a lot higher than the average for non disabled people. The potential for pre-existing condition exclusions from private insurance also threatens medical security.

It is suggested that Medicare be continued indefinitely after termination from cash benefits due to employment. Cost sharing alternatives, including a relatively small co-payment for the ex-beneficiary should be explored. However, it is felt that asking employers to burden any of the costs of continued Medicare would be difficult to administer and would discourage the hiring of people from the disability rolls. The continuance of Medicare after employment should be considered as an incentive for cash benefit savings. Because, only about one in five hundred currently leave the rolls through work.

Recommendation for Employer Incentives

From an employer perspective the costs of disability are extremely high - including such areas as worker's compensation, long term disability (LTD) insurance, medical coverage, the disability share of FICA, potential accommodation expenses under ADA, human resource related compliance costs, etc. A person with a known disability is therefore considered by many employers as a known risk for additional disability related costs. Although employers are barred by the ADA from discrimination regarding hiring and other employment related practices, they do not have an affirmative action mandate. When a person with disability has equal qualifications to one who does not, the employer is free to select based upon personal preference. ADA related claims and litigation have centered around the issue of retaining employment rather than hiring - unlawful termination, failure to accommodate, failure to promote, etc. Many employers fear that it is impossible to terminate an unsatisfactory employee who has a disability without the risk of litigation.

RTW service providers can help establish the relationship necessary to demonstrate the assets of a person with disability. But, this often will not be seen by the employer as sufficient to compensate for his/her concerns. Of immediate importance to many potential employers at the time of hiring is the fear of accommodation expense. A person with disability can wait until he/she has an offer of employment before requesting accommodation - the employer is then required to provide "reasonable accommodation" or demonstrate "undue hardship".

It is suggested that money be set aside from trust fund savings for employer use to offset the potential costs of accommodation and or to provide training assistance associated with hiring a person from the disability rolls. This incentive would be paid only after the person with a disability had been employed for a continuous period of one year. Unused accommodation assistance would be paid to the employer if employment had been successfully maintained for a continuous period of three years (giving the employer credit and incentive for having provided an accessible work environment which required no further accommodation). Authorization for accommodation funding would require a statement by an RTW service provider that accommodation was provided according to the guidelines in the ADA Technical Assistance Manual published by EEOC. No other process control or documentation would be necessary. However, advocacy groups providing quality assurance of RTW services would have available statistics on the use of accommodation incentives managed by RTW providers.

Chairman. BUNNING. Thank you, Mr. Watters.
Mr. Tenney.

STATEMENT OF FRED TENNEY, PRESIDENT, SOUTHWEST BUSINESS & INDUSTRY REHABILITATION ASSOCIATION, SCOTTSDALE, ARIZ.

Mr. TENNEY. I represent an organization and indeed a system that not only says we can provide successful rehabilitation services to recipients, but more significantly, we have. No longer should we assume a passive role in the service delivery continuum. We have demonstrated consistently that we have the level of sophistication and accountability to successfully provide return-to-work services.

The system I allude to is commonly referred to as the PWI, or Projects With Industry model. This is a system of vocational placement that has been in place for well over 10 years and involves business and industry in the direct placement of handicapped people.

No longer must we rely on speculation that a large number of persons with disabilities wants to and can work. In the most recent contract we had with the Social Security Administration Project Network, we demonstrated return-to-work interest beyond any reasonable doubt. Of the more than 13,000 postcard solicitations made to the Social Security recipients, more than 2,000 returned their cards, indicating their interest in pursuing employment. The Social Security Administration had expected a response rate of 3 to 6 percent. Southwest Business & Industry Rehabilitation Association experienced a 16-percent return rate.

In fact, so many people volunteered to participate in our return-to-work effort that we had to shut off solicitations early and deny access to the research project. In short, there was no shortage of interested applicants from the Social Security disability rolls wanting to participate in a return-to-work program—not speculation—documented fact.

The bottom line, at least as far as we carried it, was that 540 participants entered our project, and more than 160 were placed in employment. These results are consistent with the four other projects we conducted for the Social Security Administration.

There is sufficient data in the results of the research and demonstration projects conducted by the Social Security Administration. In fact, they conducted 28 initial RDP projects, 110 projects under RDPs 1, 2, and 3, and 6 projects within the Project Network system.

Thank you.

[The prepared statement follows:]

TESTIMONY FOR SOCIAL SECURITY SUBCOMMITTEE
OF
HOUSE WAYS AND MEANS COMMITTEE,
REPRESENTATIVE JIM BUNNING KENTUCKY, CHAIRMAN

PRESENTED BY:
FRED TENNEY,
PRESIDENT, SOUTHWEST BUSINESS INDUSTRY AND REHABILITATION ASSOCIATION [SWBIRA]

Good morning. My name is Fred Tenney. I am President of SWBIRA a not for profit organization located in metropolitan Phoenix, Az. Our primary mission is to provide "return to work services" to the disabled population. We are a small company with less than 50 employees. I have been personally involved in this field of rehabilitation for 30 years. Specific to this subcommittee we have been the recipient of 6 SSA grants and contracts. SWBIRA has often been referred to by SSA staff as their "flagship provider". Most recently we were the contractor for the "Provider Model" in their Project Network initiative. I welcome the opportunity to share some thoughts with the people who have the power and responsibility to make a change.

The House Report on CAREERS Act rightfully concluded that the public rehabilitation system has not demonstrated enough overall success in serving the Social Security recipients to warrant continuing the status quo. Maintaining a segregated system of rehabilitation will allow the public vocational rehabilitation system to remain insulated from scrutiny and accountability. This system has maintained a dependence on "process" or form over substance. To the degree you are satisfied with the public rehabilitation system you should be encouraged to keep it, however a healthy dose of competition would be welcomed by all concerned. I suggest ever so strongly that you allow the private sector providers to participate in the rehabilitation system. This would not only allow for the free market to surface but also it would empower consumers in this process. A responsible cost effective alternative to the status quo is essential to this committee's objectives.

I represent an organization and indeed a system that not only says we can provide successful rehabilitation services to recipients but more significantly WE HAVE. No longer should we assume a passive role in the service delivery continuum. We have demonstrated consistently that we have the level of sophistication and accountability to successfully provide return to work services. The system I alluded to is commonly referred to as the PWI [Projects With Industry] model. This is a system of vocational placement that has been in place for over 10 years and involves business and industry in the direct placement of handicapped people

Fewer than 1% ever leave the roles for work. This despite dramatic changes in medical technology, improvements in the legal rights affecting access to the work place and a broader public and employer support for people with disabilities in the work place.

However, no longer must we rely on speculation that a large number of persons with disabilities want and can work. In the most recent contract we had with SSA, Project Network, we demonstrated return to work interest beyond any reasonable doubt. Of the more than 13,000 postcard solicitations made to SSA recipients more than 2,000 returned their card indicating their interest in pursuing employment. SSA had an expected response rate of 3 to 6 per cent. SWBIRA experienced a 16 per cent return rate. In fact so many people volunteered to participate in our return to work effort that we had to shut off solicitations early and deny access to the research project. In short there was no shortage of interested applicants from the SSA disability roles wanting to participate in a return to work program. Not speculation....documented fact. The bottom line, at least as far as we carried it, was this : 540 participants entered our project and more than 160 were placed in employment. These results are consistent with the other 4 projects we conducted for SSA. There is sufficient data in the results of the research and demonstration projects

conducted by SSA. In fact they conducted 28 initial RDP projects ,116 projects under RDP's 1, 2, 3 and 6 projects in Project Network.

Significant observations of SWBIRA's case managers when dealing with SSA beneficiaries were that the most successfully rehabilitated participants were those that had the best family support and those who were married and had children. The type of impairment impacted on successful outcome as well. Clients with less severe, physical disabilities--such as cardiac, back, and musculoskeletal -- were less difficult to work with as compared to clients with mental disabilities. Furthermore, within the subgroup of mental impairments, those clients who were self-refered as opposed to those who were involved in the mental health system, had more positive outcomes. The most difficult subgroup to serve were substance abusers.

When asked to characterize the typical successful client that is most likely to be rehabilitated I give the following example: He's the 40 year old man who is married and with children. He once worked but through circumstances no longer is employed. The system somehow made him dependent and in fact a ward of the government. The system forced him to prove he was to impaired to work.... ever. He has spent several years on the roles and has perpetrated the myth to himself , his family and his friends that work and all the self worth it carries with it are beyond his grasp. He has had to explain to his wife and children why they cannot afford the school pictures this year and answer the questions from his children's playmates as to why their dad doesn't work. He's confused and somehow thinks that maybe, just maybe, with some help and more importantly guidance he just might be able to "do something". And, if he hears about us, and if we have room for him in our program, and if he gets the family support he needs, and if he is realistic and doesn't give up, and if all the pieces fit he will go back to work again and once again hold his head high and buy those school pictures.

Chairman BUNNING. Thank you, Mr. Tenney.
Mr. Start.

STATEMENT OF STEPHEN L. START, CHIEF EXECUTIVE OFFICER AND PRESIDENT, S.L. START & ASSOCIATES, INC., SPOKANE, WASH.

Mr. START. Mr. Chairman, members of the subcommittee, I would like to thank you for the opportunity to discuss with you today ways to significantly increase the number of individuals who leave the SSDI rolls to return to work and self-sufficiency.

My name is Steve Start, and I am the chief executive officer of S.L. Start and Associates. S.L. Start is one of the largest providers of residential and employment support services for people with disabilities in the Pacific Northwest. We were one of the original Social Security-related return-to-work projects and have been involved in the national Project With Industries effort for the past 20 years.

There are four key stakeholders in the return-to-work effort: people with disabilities, employers, providers of return-to-work services, and the Social Security Administration.

A successful return-to-work effort requires that key features are included to build upon the strengths of each stakeholder and to minimize their fear of participation.

Studies indicate that 15 to 40 percent of the people on the disability rolls would return to work if given the opportunity. Many, however, are highly fearful of losing their medical benefits. They also want to achieve active participation in developing and implementing their rehabilitation plan, using professionals as facilitators, but not as controllers. They lack the personal connections necessary to access employment.

Some may best be returned to work after specific vocational training. Many, however, can benefit from employer-based training initiatives such as those developed by the 100-plus Projects With Industries across our country.

Employers are concerned about economic survival and getting the job done. The key qualities they look for in hiring people are people who display positive attitudes, work habits, and a willingness to learn. Secondary in importance are basic literacy skills followed by specific technical skills. Prior work history or personal references are critical in assessing work habits. Over 80 percent of employees terminated nationally are terminated because of poor work habits, not because of lack of skill.

Some critical factors about jobs: Over 70 percent of the net job activity in our country occurs in small, medium, and startup companies. Only a small percentage are in Fortune 500 companies. Less than 12 percent of the job openings nationally are posted with public employment agencies such as employment security. Approximately 80 percent of the jobs filled nationally are through word of mouth or personal relationships in the community. Employment experts dub this phenomenon "the hidden job market."

Employers provide more training to more people than all the trade schools and universities in our country combined. The placement rate for employer-based training is incredibly high.

The use of OJT and tax incentives increases access to jobs, and access to jobs that require more than entry level skills and pay higher wages.

Projects With Industries, vocational rehabilitation firms, and rehabilitation facilities exist in the vast majority of communities across our country. They are well connected in their employer communities, with ready access to thousands of jobs. Many of these providers are ready, willing, and they are able to participate in a return-to-work effort for people on SSDI.

Unfortunately, current plans being considered by SSA to pay providers only after people have come off the rolls is financially impossible for the vast majority of these providers. Such an approach will provide very limited choice for consumers and will fail to access the small and growing employers within our communities.

In the process of attempting an approach that is doomed to failure, the trust fund will literally lose billions of dollars of lost opportunity costs.

Many providers will actively participate in an approach that shares some risk by paying for milestone performance outcomes in combination with long-term payment for keeping people off the rolls.

On behalf of the return-to-work group, we designed a national phase-in model that implements a full-scale national return to work over a 7-year period of time. We have used a milestone model of performance payments that incorporates all the key features I have mentioned. We then developed a computer model to assess the cost benefit and outcome performance of this initiative. We used outcome assumptions that came directly from research projects sponsored by Social Security. We believe the assumptions to be realistic and conservative.

The model results indicate that such an approach would be highly cost effective. Over the 7-year implementation period, it would result in over 400,000 people coming off the rolls, at a total saving to taxpayers of $43.5 billion over a 10-year period, with a benefit-to-cost ratio of $10.17 saved for every $1 invested.

The key ingredient to an active and successful national model is a clear directive from the Congress to proceed. We ask that you move forward with such a national initiative. The sooner we proceed, the sooner thousands of people can return to self-sufficiency, and billions of trust fund dollars can be saved.

Thank you for your attention to this matter.

[The prepared statement and attachments follow:]

Testimony of Stephen L. Start
to
The Subcommittee on Social Security
House Ways and Means Committee
Public Hearing of August 3, 1995

Mr. Chairman and Members of the Subcommittee:

Thank you for providing me the opportunity to discuss with you today the development of a Return-To-Work Program that will assist individuals on the Social Security Disability rolls return to substantial gainful employment. I have been involved in the provision of vocational rehabilitation, employment placement, and supported residential living services for people with disabilities for the past 23 years. My company provides services in the states of Washington, Oregon and Idaho. During that 23 years, I have managed in excess of 300 grants and contracts focused on developing and providing innovative approaches to assist individuals with significant barriers to employment, to maximize their ability to engage in employment activities that will provide a stable and desirable standard of living. I have also designed, developed, and operated numerous programs to assist disabled people to leave institutional settings and live independently in their communities. Services we have provided have been funded through a wide range of contract relationships with a broad array of government agencies. A small sample would include Social Security Administration, Rehabilitation Services Administration, Department of Labor, and Department of HEW at the Federal level. Many of our contracts are with agencies of the State and local Government. A project that I am especially proud of and from which have learned many lessons about Return-To-Work practices is the Inland Empire's Projects With Industries. Our Projects With Industries (PWI) is part of a national initiative funded under the Rehabilitation Services Administration that has resulted in the development of a national network of projects that represent an activity partnership between rehabilitation, return-to-work organizations and the private industry. For the past 20-plus years, PWI across the country have provided the most cost-effective, outcome-based, Return-To-Work effort of any initiative in our nation that I am aware of which has been undertaken by the public sector. My firm participated very actively in the Research and Demonstration Project (RDP) found by Social Security Administration (SSA). Later in my testimony, I will share with you some important lessons that I and others have learned from PWI experience and participation in the Research and Demonstration Project process.

In testimony today, I want to focus on what we in the field of Return-To-Work have learned over the years about the four stakeholders in this process. Namely employers, people with disabilities, providers of service, and the Social Security Administration. I will then focus on the implications of those lessons for policy and program development, and finally outline for you a cost-effective approach to a National Return-To-Work effort that draws on the lessons that we have learned from the stakeholders.

WHAT WE HAVE LEARNED

About People with Disabilities in Relation to the Job Market:

Many individuals even with severe disability sincerely want to Return-To-Work, take control of their own lives and be productive self-sufficient citizens. Various studies have indicated that from 15 to as high as 40 percent of those on the Social Security rolls would like to return to employment.

Want to have a choice of providers, methods of Return-To-Work and type of the occupation they pursue.

Want to be able to exert real and meaningful control over their Return-To-Work effort and their lives.

A significant percentage of people on the rolls cannot return full-time employment and desperately need income and medical support.

Are very fearful of loosing their medical support. This fear transmits into placement counselors, mental health professionals, and social workers who interact with these individuals to such a degree that the service community will often help disabled people strategize ways to maximize their personal income while avoiding the loss of benefits. Counseling staff are placed in the untenable situation of asking someone to essentially risk their lives to pursue employment that may turn out to be temporary.

Most individuals with disabilities lack the specific skill and knowledge necessary to adequately seek out and obtain employment in the competitive workplace. The behaviors and attitudes that are required for an individual to secure Social Security benefits are the exact opposite of the behaviors and attitudes required to convince an employer that the individual is the right person for a job. The current eligibility

system requires a focus on disability, inability, and dependency. Employers are looking for independent, positive, and upbeat employees who focus on what they can do not what they can't do.

Without Return-To-Work assistance the employment rate for people coming off the rolls will continue to be incredibly low.
The onset of disability and the system to access benefits is often demoralizing and inadvertently takes away from the individual a sense of self-confidence and focus on goal-oriented, productive behavior, essential to obtaining and retaining employment.

Some individuals believe that, as a result of the Americans with Disabilities Act (ADA) and Affirmative Action, employers have an obligation to employ them, and that fear of government intervention will motivate employers. Using the ADA as a threat to gain access to employment for a specific individual virtually guarantees that an employer will not hire that person.

Many people believe that, to compensate for their disability, they must have highly developed expenses and specific vocational skills to compete effectively in the work force.

Many people with disabilities tend to believe that employers basically do not like people with disabilities and are concerned only about the bottom line and require significant financial incentive to motivate the employment of people with disabilities.

THINGS WE HAVE LEARNED ABOUT EMPLOYERS

The primary motive or objective of most employers is to get the job done: operate a healthy, positive work environment and produce a reasonable return on investment. While profit is an important consideration and essential to survival, many businesses, especially smaller businesses, started because of the employer's personal attachment to the profession or interest in producing particular goods or services.

Employer's primarily want to hire employees who display a positive attitude, have good dependable work habits, the ability to work as a team player and display a willingness to learn. Individuals, whether disabled or not, who appear to be litigious in their approach are avoided at all costs. Some employers are willing to make significant levels of accommodation to facilitate the productivity problem encountered by a person with a disability if they display the work habits previously mentioned.

Many employers take pride in their corporate citizenship and their ability to assist disabled people to become productive and gain independence from the tax dole.

Employers are highly intimidated by and afraid of large government agencies such as Employment Security, The Department of Labor, and Vocational Rehabilitation, etc. Employers feel such organizations do not understand value or appreciate the private sector and stand ready at a moment's notice to trigger legal action if something goes wrong with the employment of a disabled individual or other protected classes of employees. The vary programs and laws we have created to help individuals with significant barriers to employment, gain acceptance into employment have created what is perceived as an immense threat to business. This phenomenon may explain why, since the enactment of the ADA there has been essentially no net gain in employment in our country for people with disabilities.

Some policy makers and advocates believe that the key to employment is targeting large Fortune 500-style companies. The reality is that over 75 percent of the net job activity in the United States comes from small and medium-sized employers. Employment experts have dubbed this the invisible job market. Eighty percent of those jobs are filled by informal word-of-mouth and through personal relationships within a local community. Less than 15 percent of the job openings available nationally are posted with public employment agencies.

Employers provide more job training to more individuals than all the vocational-technical schools and universities in our nation combined.

Tax incentives and on-the-job training dollars are useful tools, especially with middle-sized and large employers, in helping individuals obtain employment. Some employers are more focused on getting a good employee, dependable follow up and a honest relationship with the Return-To-Work provider, and

will choose not to utilize such incentives because of their fear of government intervention in their daily affairs.

- Employers and disabled employees sometimes rely on the Return-To-Work Provider as mediator to help solve problems and decrease the chances of litigation. If for example a job simply doesn't work out for a person, a good provider will quickly facilitate transition into a new job somewhere else. The disabled employee avoids financial harm and the employers chances of facing litigation are greatly decreased.

There is a significant movement on the part of employers in this country to move away from well-funded benefit packages for full-time employees toward use of part-time employees who receive little or no benefit package. While this tendency disturbs me on a personal level, it has create opportunities for people with disabilities to enter the job market and gain experience. This phenomenon could be especially useful if a working mechanism is in place to allow beneficiaries to sustain their benefits. Some of the most successful PWI's have aligned themselves with temporary employment agencies to capitalize on this opportunity.

Organized labor has worked as a consistent supporter over the past 20 years of the PWI employment initiative and, in many cases, has actually taken the lead in building the bridge between people with disabilities and the employer community.

Many, especially large employers, have come to the realization that disability and its related unemployment is extremely expensive. Such employers are developing the internal capacity to do job station modification and return-to-work interventions. These efforts may off set some of the growth in utilization of the SSDI system. More over, it provides a mechanism inside of industry to link to a Return-To-Work program for those currently on the rolls.

WHAT WE HAVE LEARNED ABOUT PROVIDERS OF REHABILITATION AND RETURN-TO-WORK SERVICES:

The vast majority of professionals employed in these fields entered their profession out of a sincere commitment to help people with disabilities maximize their ability to be self-sufficient in our society. Most counselors possess a sincere interest in the welfare of the disabled individual and, if placed in a situation where welfare of the client is pitted directly against the potential for their company to secure profit, will air on the side of the client.

The provider community across the country has developed a highly refined set of skills to evaluate individuals employability, develop cost-effective Return-To-Work plans, and methods to reengage people in competitive employment. Unfortunately, many state workmen compensation systems efforts have focused vocational rehabilitation professionals on empirically determining on paper that disabled people are ready to return to employment. Outcomes have not focused on return to gainful employment. This phenomenon gets people off the state workmens compensation rolls but doesn't return people to work. It also results in the development of statistical surveys across our country that significantly understates the power of rehabilitation to actually return people to gainful employment.

Providers are ready, willing, and able to participate in an effective Return-To-Work effort for SSDI beneficiaries. Unfortunately, the current initiative by the Social Security Administration to "level the playing field" with private providers and state vocational rehabilitation agencies is more artificial than real and will not attract significant levels of providers to the Return-To-Work effort. The current proposed method of paying for rehabilitation costs after placement, plus a percentage of profit, ignores the substantial cost of those that fail in the rehabilitation process and would require substantial amounts of working capital. It places all the risk on the provider and fails to level the playing field because the state vocational rehabilitation agencies are fully funded for all their efforts, both successful and unsuccessful, through the Rehabilitation Services Administration. The reimbursement that they currently receive upon successful termination from Social Security Administration is a bonus payment or profit for the state agency. If Congress were to truly create a level playing field and pay all expenses out of general fund revenues for attempting to rehabilitate Social Security recipients and then pay Social Security Trust Fund dollars for successful outcomes, thousands of providers would participate. Such an effort would be prohibitively expensive and would not represent a balanced approach of sharing risk between the Government, the provider, and the person with disability.

Through the RDP projects, we learned that returning beneficiaries to work is hard work but

doable. Successful projects would place 5 to 15 percent of those originally contacted at the SGA level of employment.

Event a 5 percent placement rate, RTW is highly cost effective, and is more than a ten fold improvement over the current practice.

Beneficiaries participating in the CDR process seem to display a significantly higher employment rate than the general caseload or applicants.

Providers across the country are willing to participate in milestone-based payment systems that focuses on a combination of outcomes and savings to the Trust Fund. Literally thousands of Return-To-Work rehabilitation counseling firms, worker compensation, rehabilitation professionals, Project With Industry, and rehabilitation facilities are in place and process the basic prerequisite still to participate in a National Return-To-Work effort.

Social Security Administration is currently reviewing another strategy that would pay providers a percentage of the savings to the Trust Fund after a person leaves the rolls. Such rear-end loaded strategies would place impossible operating capital requirements on providers. Only very large providers could even consider participation.

Many providers throughout the country especially PWI operators and private worker's compensation firms have very well-established relationships with literally thousands of employers throughout our country. They provide immediate, readily available access to small-middle-and large employers throughout the entire economy.

WHAT WE HAVE LEARNED FROM WORKING WITH SOCIAL SECURITY ADMINISTRATION

The vast majority of employees we have worked with in the Social Security Administration, both locally and at the national level, are hard working, intelligent, and dedicated. They possess a sincere and heart-felt commitment for people with disabilities and shoulder a serious sense of responsibility towards the trust funds that they administer.

By design and practice, the Social Security Administration and its staff know very little about the specifics of Return-To-Work. Their corporate culture has been designed around the mission of protecting those who, as defined by the listings and regulations, are incapable of work.

Lessons learned by well intentioned research conducted, under the Research and Demonstration Project and Project Network, experiences a very short memory cycle within the agency due to personnel moves and are not widely distributed or understood.

The very nature of the experimental model drives up the cost of projects substantially and tends to retard their productivity. It seems clear, however, that the research and demonstration projects have shown that, while SSDI recipients pose significant challenges, they can be returned to work in significant numbers by utilizing private organizations and networks within local communities.

The well-intentioned tendency of the agency to prove unequivocal through scientific study, the hows, whats, whens, and wheres of a successful Return-To-Work effort will never, given the nature of Return-To-Work, itself be truly successful. The fact that much employment happens within the hidden job market, is the result of relationships, attitude, and motivation moves the implementation of successful programs into a subjective realm that defies empirical analysis. While the research we have conducted is useful, waiting for clear decisive answers from a research model before implementing a National Return-To-work effort will result in literally tens of billions of dollars being lost through missed opportunity. Literally hundreds of thousands of individuals who could be returned to substantial, gainful activities will be left to sit in idleness and dependency while we engage in a never-ending effort to empirically prove what people in the Return-To-Work and placement field have known for years.

SSA reticence over the years to move forward with a more aggressive approach to Return- To-Work is, in part, a response to fear of retaliation and criticism from Congress and others, if such a decision is not based upon solid, documented, statistically significant findings.

IMPLICATIONS FOR THE DEVELOPMENT OF AN EFFECTIVE AND COST- BENEFICIAL RETURN-TO-WORK PROGRAM

People with disabilities:

To assist those who have a sincere interest in returning to work we must provide a safe and understandable protection of medical benefits. The program must encourage and develop individual consumer choice and control throughout all aspects of the Return-To-Work effort. The effort must be grounded in organizations that have existing relationships with small, medium, and large employers in every community of our country. Counseling and case coordination must focus on the ability to instill positive work habits and attitudes in guiding people back to employment. Programs must help individuals package themselves in a way that is desirable and nonthreatening to the employment community. The system must provide incentive for providers to develop service plans and move individuals quickly and effectively toward Return-To-Work, and also provide long-term, ongoing support to assist individuals in retaining employment and developing a positive career ladder approach. Emphasis on simply finding individuals jobs will not result in a long-term positive effect of keeping people off the rolls.

The program must provide adequate support to facilitate training, both on the job and to a lessor extent, in specific technical school or college settings. The model must be designed to ensure that people with disabilities are responsible for following through on their Return-To-Work plan and enablers of their own success. Each individual should participate and have active control in the development and sign off on a return-to-work plan that contains specific employment goals both long-term and short-term, specific objectives necessary to reach those goals and an individualized economic analysis of the individuals plan to demonstrate the plans ability to move the person toward financial self-sufficiency.

The use of time, limited benefits coupled with an active dynamic Return-To-Work program should serve to refocus some beneficiaries attention from proving life-long disabilities to a focus on obtaining self-sufficiency. If, however, time-limited benefits are implemented <u>without</u> a viable return-to-work effort, <u>it may backfire</u> and result in individuals solidifying and perfecting their case for life-long benefits.

Employers:

The Initiative must include providers of service who have a direct, ongoing relationship with employers of all sizes throughout our economy. Employer incentives should be available to assist in the cost of training and job modification. While all employers may not utilize these benefits, they serve to attract a large segment of marginally interested employers who will not otherwise participate. The return-to-work effort must be viewed as a method to assist employers in being good corporate citizens and not be used as a method to threaten and intimidate employers into employing people with disabilities. A negative approach will guarantee utter failure.

Providers:

The initiative should utilize reimbursement methods that place heavy emphasis on rewarding outcomes and provide some incremental payment for completion of milestones such as-the development of a mutually agreeable Return-To-Work plan, obtains and retains employment for a reasonable period of time, reaching SGA/coming off the rolls, and long-term payment (3 to 5 years) for keeping individuals off of the rolls. Such a system should be designed to encourage providers to find initial jobs that provide stair steps to more long-term, career-oriented employment and provide the incentive to encourage ongoing support of the individual to ensure the maintenance of employment. Approximately 80 percent of people who lose jobs in our economy do so because of poor work habits and "bad attitude." The payment system must encourage providers to deal with these and ancillary issues that have a dramatic effect on long-term employability.

The primary measure of program quality should be a job that is chosen by the consumer that provides a level of support financially, intellectually, and otherwise that is acceptable <u>to the customer</u>. Attempts to externally define quality by imposing processes, approaches, or income levels to employment will retard individual abilities to Return-To-Work, limit their access to jobs that provide a platform for reentry, diminish individual choice, and, in affect, say that people with disabilities are incapable of making their own informed decisions.

Quality assurance monitoring should be in place that ensure that funds are spent for allowable outcomes, and that individuals are offered a full array of providers to develop their plans, have meaningful employment options, and exercise power and choice throughout the Return-To-Work effort. The initiative must encourage the development of local and regional networks that maximize access to the

hidden job market and existing training and support services within local communities. Provider should have built in quality improvement programs, have public report cards done on a semi-annual basis, conduct standardized satisfaction surveys published in their report card, and be reviewed periodically by an external quality assurance team.

SUMMARY OF A NATIONAL IMPLEMENTATION MODEL

The following summary represents an overview of an implementation model for the development of a full-scale, National Return-To-Work effort stage over a seven year period. The model attempts to establish a balance in dealing with the needs of all the stakeholders, balance risk across all partners and is based on demonstrated outcomes from a recent Research and Demonstration Project and Project Network. The model produces results that are highly cost-effective. The model incorporates performance-based milestones and incentive payments for keeping individuals off the rolls. This payment method substantially limits the trust funds financial exposure in developing this effort and essentially assure that SSA does not end up buying process instead of outcome. It is also designed to ensure that even with very conservative or poor results, SSA would receive a positive cost benefit from their investment in the return-to-work effort. It is presented a a plausible balanced approach but not intended to be viewed as the finished and final product. The model has been designed as part of the Return-To-Work group's initiative to stimulate aggressive pursuit of an effect on Return-To-Work programs for Social Security Beneficiaries.

FULL NATIONAL IMPLEMENTATION MODEL

This full national implementation scenario is broken into four phases that progressively increase the degree of sophistication and the volume of services provided. It looks at the provision of services to applicants, CDR's, and general caseload. Different assumptions were used in computing enrollment and success rates for each of these discrete populations. Cost benefit savings are calculated over the ten-year-average life of a case as currently reported by the Social Security Administration. The model includes costs for expanded medical coverage, support costs, training costs, and employer incentive.

Overview

Phase I - Preparation Phase

Objective: - Complete basic regulatory development referral mechanism design and set up initial provider network to begin RTW services. Establish four tier implementation and refinement plan, one in each quadrant of the country should use ADP/Project Network or PWI who have experience for this task. Notify public change is coming. Disability does not equal unemployability and/or retirement.

Timeline - 1 year
Total elapsed time - 1 year

Key Activities

- Set up consumer, employer, provider network, and oversight committee.
- Develop fee-for-outcome guidelines.
- Solicit vendor from R.D.P. Group, Project Network, P.W.I., State Certified Facility Programs, State Certified Injured Worker Programs.
- Develop self placement model, not requiring provider.
- Set up initial referral mechanism.
- Develop agreements with providers.
- Develop tracking system/M.I.S.
- Develop necessary regulations.
- Begin development of applicant screening tool.
- Orient SSA staff.
- Develop National Public Relation Campaign Strategy and initiate.

Service Enrollment Levels

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	N/A		
CDR	N/A		
General Caseload	N/A		
Youth	N/A		
Total Return-To-Work (SGA) Off Rolls			

Overview
Phase I - (continued)
Totals - Financial Summary

Net Cost Trust Fund Current Phase (500 Public Relations, 300,000 SSA)	800,000
Public Relations Costs	NA
Trust Fund Savings Reinvested Annually in RTW	NA
Savings to Federal Budget (Over 10 years - Cumulative Program)	NA
Benefit/Cost Ratio (Federal Budget - Over 10 years)	NA
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Inremental Cost)	10.17 for every $1 invested

Overview
Phase II - Objective
Initiate Program - Develop nationwide service delivery capacity with emphasis on getting people back to work who are medically stable and need support the least ("creaming") and deals with malingerers. Provide opportunity for youth to seek employment and avoid disability syndrome. Begin changing public expectation away from disability equals unemployability, toward everyone can participate in some level of gainful activity. Minimize need for incremental funding increase to initiate program.

Timeline - 2 years
Total elapsed time - 3 years

Key Activities

- Presidential Congressional Announcement of new direction.
- Initiate public relations campaign within agency and with local communities.
- Notify prospective participants.
- Initiate referral system.
- Test referral system with Project Network providers, R.D.P. and P.W.I.'s - first year.
- Expand referrals second year to facilities, state certified providers, individuals.
- Focus outreach to C.D.R., Youth.
- Implement provider payment system.
- Implement monitoring system.
- Develop automated applicant referral and screening system.
- Beta Site implementation of applicant RTW Referral System.
- Coordinated national public relations campaign.

Service Provided To

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	0	0	0
CDR	178,200	356,400	356,400
General Caseload	15,000	30,000	30,000
Youth	0	0	0
	193,200	386,400	386,400
Total Return-To-Work (SGA) Off Rolls		132,241	132,241

Totals - Financial Summary

Net Cost Trust Fund Current Phase	883 million
Public Relations Costs	2.4 million total
Trust Fund Savings Reinvested Annually in RTW	0
Savings to Federal Budget (Over 10 years-Cumulative Program Nominal $'s)	11.4 billion
Benefit/Cost Ratio (Federal Budget - Over 10 years)	$12.88 saved for every $1 invested
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Incremental Cost)	10.17 for every $1 invested

Overview

Phase III-Objective

Expansion/Refinement - Expand number of providers, refine processes, serve more difficult to serve, extend services to select applicants, increase service capacity to full operating, steady state level. Continue to reinforce with the Public the expectation of employability of our disabled citizens. Operate RTW services exclusively out of savings to trust fund from prior year's efforts.

Timeline - 2 years
Elapsed time - 5 years

Activities

- Implement
- Focus on refinement of referral, follow-up, evaluation components.
- Disseminate outcome and follow-up reports on all participating providers to clients and public from prior years.
- Full National Implementation of applicant RTW referral system.
- Presidential/Congressional progress report to the Nation.
- Bring on more specialized services and services to small community providers.
- Maintain public relation campaign.

Service Available To

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	6,250	12,500	12,500
CDR	178,200	356,400	712,800
General Caseload	30,000	60,000	90,000
Youth	0	0	0
	214,450	428,900	815.300
Total Return-To-Work (SGA) Off Rolls		146,787	273,518

Totals - Financial Summary

Net Cost Trust Fund Current Phase	0
Public Relations Costs -	2 million total
Trust Fund Savings Reinvested Annually in RTW	624 million
Savings to Federal Budget (Over 10 years - Cumulative Program)	24.1 billion
Benefit/Cost Ratio (Federal Budget - Over 10 years)	12.88 for every $1 invested
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Incremental Cost)	10.17 for every $1 invested

Overview

Phase IV-Objective

Full-Scale Operation - Service level optimized to return maximum number of people to gainful activity, continue system refinement. Public attitude focuses on ability not disability. Benefits considered temporary assistance for most people with disabilities, not a form of retirement.

Timeline - 2 years
Elapsed time - 7 years

Activities

- Easier cases have been placed, providers seek out more difficult cases.
- Continue to refine referral system.
- Report on provider success for all prior periods.
- Poor providers drop out.
- More highly specialized providers develop niches.
- More difficult people being placed.
- Provider increase effectiveness.
- Rate of malinger applicant should drop.
- RTW services become more efficient and effective, standards of performance evolve.

Overview
Phase IV- (continued)
Service Available To

	Per Year	Phase Total	Cumulative Total All Phases
Applicants	10,000	20,000	32,500
CDR	198,000	396,000	1,108,800
General Caseload	120,000	240,000	330,000
Youth	0	0	0
	328,000	656,000	1,471,300
Total Return-To-Work (SGA) Off Rolls		224,509	486,401

Totals - Financial Summary

Net Cost Trust Fund Current Phase	0
Public Relations Costs	1.0 million
Trust Fund Savings Reinvested Annually in RTW	1,170 million
Savings to Federal Budget (Over 10 years - Cumulative Program)	43.5 billion
Benefit/Cost Ratio (Federal Budget - Over 10 years)	12.88 for every $1 invested
Benefit/Cost Ratio (Excluding FICA & FUTA) (Total Savings/Incremental Cost)	10.17 for every $1 invested

CONCLUSIONS SECTION

The key components to bring together an effective working partnership between people with disabilities, Return-To-Work providers, employers, and the Federal Government are known and available. Methodology to return individuals to employment have been in practice for over 20 years and have demonstrated repeatedly that individuals with severe disabilities can be returned to gainful employment. Many individuals currently on the rolls are highly motivated to return to work and many employers are ready, willing, and able to provide jobs especially if reasonable incentives are provided to offset extra costs. The Social Security Administration has acknowledged the need for a Return-To-Work program and has expressed interest in pursuing a more aggressive approach. The key ingredient that is needed to bring together these essential stakeholders is a clear and decisive directive from Congress and the Executive Branch to proceed expeditiously with such a program. Private sector providers with substantial levels of experience are also ready, willing, and able to assist other partners in completing the design and implementing an effective program.

We request that you give us and our other stakeholders the directive to move forward so that we may begin immediately to assist hundreds of thousands of individuals return to self sufficiency and initiate an effort to stop the economic hemorrhage that is currently being experienced by the Trust Fund. We will assist you in whatever way possible to achieve these outcomes. Thank you for your attention to this issue and for requesting our input.

Chairman. BUNNING. Thank you, Mr. Start.

I would like to start the questioning with Ms. Johnson. In your testimony, you recommend that the CDR review process should include a consideration of all advances in the field of rehabilitation technology. Would you discuss this concept further and provide a few examples of what you mean and how it might work?

Ms. JOHNSON. It has been my observation through the years, being both a rehabilitation counselor and coming through the system to become State director of the Georgia vocational rehabilitation agency, that many times over the last number of years, the advances in the field of rehabilitation, and particularly in the field of rehabilitation technology, have made a significant difference in the capacity for individuals to be employed.

Taking that into consideration, I have experienced examples of individuals who, 10 or 15 years ago, it was unreasonable to think that in Camilla, Ga., where I spent a number of years, that an individual who needed family support could engage in employment. With the advent of technology, there are individuals in that community today who a number of years ago could not have worked, stayed at home, and participated in their communities. Today, they are working. There are things such as computers that can be accessed by individuals who are visually impaired or blind, computers that assist those with severe physical limitations to be able to participate in the work force, either from a remote site or directly onsite in the particular job.

There have been advances in this field that I think need to be considered in making a determination as to whether someone can work or not. I do say that these have to be available, and that is a premise that has to be in place before it can be a part of that system, is that people have the proper supports to be able to engage in employment.

Chairman BUNNING. Right now, State vocational rehabilitation agencies receive 100 percent of all referrals from the State disability determining agencies. What are your views concerning the possibility for creating a level playingfield where State and private rehabilitation providers would be able to compete to provide services for SSA beneficiaries?

Ms. JOHNSON. I will make an observation. I think there are things in place before we even address the issue of who is going to be providing it. The same disincentives are in place for populations, regardless of what provider they go to to receive their rehabilitation services. The same disincentives are there.

I am the director of a State vocational rehabilitation program. In our State agency, we serve 1 in 11 people who are technically eligible for vocational rehabilitation in our State today. We have entered into an order of selection to give priority to those with the most severe disabilities. Resources and the ability for agencies in the State are extremely pulled. We do not have the resources to address everybody. To open the market and give people choices I think is an issue we need to consider. However, at the same time, I think we need to be very careful to make sure that States have a comprehensive system, and in communities where there are no other options other than State vocational rehabilitation and those agencies, I think those need to remain in place and be viable.

So I am not saying exclusively one system or the other. I do think that there is a ball game for a wide variety of providers.

Chairman BUNNING. If the subcommittee were to write legislation that allows you to continue your program in Georgia as it is, and also that allows private sector participation in rehabilitation programs so we can get a good mix with the best of both private and public sector rehabilitation programs going, can we get people back to work quicker?

Ms. JOHNSON. I think options need to be there for both systems.

Chairman BUNNING. Mr. Young, you mentioned a risk/reward system which would pay rehabilitation providers based on savings to the trust fund. Payments would be made when an individual goes off the rolls and continue so long as the beneficiary does not return to receiving benefits. This payment would be based on a percentage of savings to the trust fund. You point out the higher the percentage and the longer the duration of the payments, the greater the incentives for the provider to accept the risk of providing services.

While such a system seems like it would work for larger providers, capable of absorbing the risk, wouldn't smaller organizations be unable to participate, as they would be unable to absorb the risk? Do you see any way to remedy such a situation as this?

Mr. YOUNG. Clearly, a pure risk/reward system is geared toward large providers who have deep pockets. That is why we agree with the return-to-work group that a milestone system would be able to bring in many, many more private providers, even the very, very small private providers, because the risk that they accept is small, because it is limited to the milestone that the provider and the consumer have agreed to meet on the way to employment.

The important thing is that we do not just pay for service delivery, that we pay for the milestones connected to that ultimate employment outcome, and then enable the providers to follow along with the individuals to keep them at work.

The problem with our system right now is there is no way for a provider to stay in touch with a person once he gets a job. It can take just a phone call, a piece of equipment, a negotiation with an employer, to keep a person in a job instead of having him cycle out of the job, fall all the way back into dependency, and then have to climb back out of that well again.

Chairman BUNNING. You would like a followup system so that a provider can trace what he or she has successfully done with the employer, to see if there is reinforcement needed to follow up with that person in the job?

Mr. YOUNG. Yes, exactly.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. Mr. Chairman, I have a gift for the subcommittee and the next panel—I pass.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Johnson, I liked your analysis of the three-pole tent. It kind of reminds me of this town, where we have a three-ring circus, that is, the House, the Senate, and the White House.

I think No. 5 on your list of objectives is really the one that we are looking at most, and that is to ensure that the disability pro-

gram does exist. It bothers me to know that over the next few years, we are going to move about $1/2 trillion out of the old age pension over into disability. I will tell the chairman the same thing I told the President back in April: Social Security is my old age pension. I will say it again: Social Security is my old age pension, because I do not have the congressional pension, and my business does not have a pension. I have an IRA, and Social Security is my old age pension.

Well, we want to make sure that they are there, and that is the purpose of these hearings.

My question, though, to each of you who would like to answer this—I want to go back to the employer, because I think the employer plays a major role in any type of disability employment. We have got to have an employer to hire these folks who need a job. What are the stumbling blocks for an employer in the current system?

Mr. Watters.

Mr. WATTERS. Mr. Collins, I share your view that the primary relationship here is not a bunch of rehabilitation providers with people with disabilities; it is an employer-employee relationship. There are some fundamental issues now that are of great concern regarding the basis of an employer-employee relationship agreement as it relates to a combination of entitlement benefit disincentives and the Americans With Disabilities Act.

Employers have an immense cost of disability as it is now. Between Workman's Comp. costs, the cost of long-term disability, the cost of health insurance, the cost of accommodation under the Americans With Disabilities Act, there are estimates that range as high as 8 percent or more of the payroll cost of an employer that are related to disability issues. That actually constitutes a de facto structure in which people who are considering hiring people with disabilities may shy away from them when they know that that particular type of population has a high incidence of additional costs to them.

Mr. COLLINS. We do not have a whole lot of time. What about the ADA? How does it impede an employer from wanting to hire someone who is disabled?

Mr. WATTERS. It impedes because of the potential threat of the cost of the accommodation. We suggest that——

Mr. COLLINS. How about the threat of litigation based on termination, should there not be a performance of productivity?

Mr. WATTERS. That is another thought.

Mr. START. Mr. Collins, in our Projects With Industries, where we work in partnership with industry, we have found that by being there and developing a relationship as kind of a quasi provider with the employer, we can mitigate some of their fears over the ADA and retaliation.

They are also concerned about getting people with a bad attitude, that kind of thing. That is one thing that frightens them a lot. We can help with that and counsel people. If they run into problems, we help people get a different job with a different employer. That reduces much of the stress that employers feel in terms of hiring people with disabilities.

Also, people with disabilities by and large are pretty poor at knowing how to look for jobs and present themselves. That is a major barrier to them. So the front that they present is often not the one the employer is looking for.

In our model, we looked at providing OJT of $1,500 per employer, $500 per person placed, for working on barriers, and a 3-year offset for FICA, a 50-percent offset, and with those kinds of incentives in place to bring in employers, it is still an incredibly cost-beneficial program to operate.

Mr. YOUNG. Mr. Collins, although there is some extraordinarily limited anecdotal evidence about cost of disability, brought on by the ADA, there is no empirical evidence that anybody has ever gone broke doing an accommodation or hiring a person with a disability.

Indeed, the ADA is set up so that you do not have to hire a person if the accommodation is an extraordinary expense.

The only situation in which the ADA is any kind of factor in a negative sense is when a very, very small employer wants to hire someone with a very significant disability. In our written testimony, we request that the Congress consider some tax incentives for very small employers to enable them to hire people with disabilities and to absorb that expense.

But all in all, the ADA is the positive force behind Americans with disabilities going back into the work force.

Mr. COLLINS. Anyone else? My time is running out; the yellow light is on.

Ms. JOHNSON. In Georgia, we have the Subsequent Injury Trust Fund in our State, and I serve on that trust fund board. We found that that has served as an incentive in our State for people to hire people with disabilities, which does limit the exposure that you have to your Workman's Comp. arena. Having served on that, I know that the fund has increased our options to get people with disabilities employed.

Mr. COLLINS. Is it not true, too, that for a lot of people who become disabled due to a work accident, oftentimes there is a settlement reached, and they are shifted to the government disability insurance?

Ms. JOHNSON. Part of the offset clause in our State's subsequent injury fund is that if the individual receives a settlement through Workman's Comp., through the subsequent injury fund, that reduces the amount of SSDI that is actually paid out to the individual. That is a part of the settlement agreement.

Mr. COLLINS. But it has shifted people——

Ms. JOHNSON. To the subsequent injury fund.

Mr. COLLINS. Thank you.

Chairman BUNNING. Mr. Laughlin.

Mr. LAUGHLIN. Thank you, Mr. Chairman.

Mr. Tenney, you talked about the success of the Projects With Industries and Project Network efforts that your company was involved with, and I noted in your testimony that in Project Network, 160 people were placed in employment. How long ago were these people placed, and are they still employed; and also, did the project call for any followup with the clients to see if they believed they could or would continue in the job you helped to place them in?

Mr. TENNEY. The people were placed approximately 1 year ago, maybe 16 months ago, up to probably 24–36 months ago. More specifically to your question, there was no provision under the contract that we had to do followup services to the folks that we did place, so we have no way of knowing whether or not they are still employed, other than the fact that the policy of my company is that if indeed one of the people we do place is unsuccessful, we will welcome him back into our program and replace him at no charge.

Mr. LAUGHLIN. Well wouldn't followup tell you whether your program was successful or not, because if they are all employed, or most of them, that would tell you it was a great success, and if they are all unemployed, that would tell you it is not working.

Mr. TENNEY. Absolutely, it would.

Mr. LAUGHLIN. So you do not have any idea whether it is working or not, because there is no followup.

Mr. TENNEY. Well, there was no provision for that in the contract. In order to follow up, you have to have some resources to provide that service, and within the contract with Social Security, they did not provide us with the resources to do followup—only to do the placement.

Mr. LAUGHLIN. Well, to find out whether these people are still working, wouldn't it just take a phone call, or is it more complicated than that?

Mr. TENNEY. That is pretty much what it would take, would be a phone call. We would usually follow up at 30, 60, and 90 days.

Mr. LAUGHLIN. Well, then, it would not take a lot of resources from the Social Security Administration to do a followup call. I think your statistics are good about getting people to work, but I think it would be important for us to know whether it is actually working or not.

Mr. TENNEY. I think it would be very simple to find that out, and that would be just to find out if they are still on the rolls.

Mr. LAUGHLIN. Yes. If they are still on the rolls 16 months later, that would probably tell you they were doing a good job and your program was working.

I would like to know that, Mr. Chairman.

Chairman BUNNING. I would, too, and Mr. Johnson also brought that to my attention. The followup, if people are put back to work through any contracted-out program with SSA, is not there.

Mr. LAUGHLIN. That is the point Mr. Young was making.

Chairman BUNNING. Yes. The followup is not there, and it does not take very much effort to trace whether someone who has been rehabilitated is now working, or if he is working 30 days, 60, or 90 days later. When the subcommittee writes legislation, there will be something addressing that.

Mr. LAUGHLIN. Mr. Start.

Mr. START. On that issue, there is limited data available nationally in terms of long-term followup. As a provider, you cannot even provide services to many people after a 60-day closure.

We did do a long-term followup study, however, about 10 years ago with Projects With Industries. One year out, we found that only 62 percent of the people were working at the original employer, and that caused me to be really concerned. So I had my placement staff run them down, make the phone calls, and look all

over until we found them. What we found was that 93 percent of those individuals were actually employed.

Now, that is a limited study and gives only a small snapshot, but by and large, most people, once they get jobs and start enjoying that standard of living, tend to stay working if at all possible.

Chairman BUNNING. The biggest problem—if you will yield——

Mr. LAUGHLIN. Yes.

Chairman BUNNING. The problem is that we do not have enough database, because we do not follow up. We do not have enough people getting off the rolls and going back to work to really make a complete study of what is going on.

Out of the 500,000 people who were supposed to have had CDRs last year, only 117,000 had them, and only 17,000 went back to work. So you can see that SSA does not follow up on rehabilitation very well. We are going to make changes to ensure that they do because that is unacceptable to this subcommittee.

Mr. START. One of the problems you run into is that because nobody has done followup, the data you will look at will not have return-to-work rates that will be nearly as high as a milestone system like we have basically all suggested, which encourages providers to do long-term followup.

Also, the system that we designed, from a financial risk point of view, for the trust fund, is almost foolproof, in that if people discontinue employment and go back on the rolls, providers do not get paid. We have designed models so that there is very limited financial risk to the trust fund, and they are only paying for performance and outcomes to deal with that problem. If you wait to get that data, you will wait 10 years, and you will lose literally over $100 billion, I am afraid, while you are researching it.

Mr. LAUGHLIN. Mr. Tenney, I do not want to give you the wrong impression. I want to compliment your program, but it would be very helpful to us to know how well it is working.

I just want to conclude by asking if you work with any previous employers to return your clients to jobs they had before they went on the disability.

Mr. TENNEY. Yes. That is usually the first place we go is the previous employer, to find out if indeed there is a way we can work out some kind of arrangement with him to return the employee back to the original employer for the comfort level that both would have.

Mr. LAUGHLIN. Thank you very much.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Neal.

Mr. NEAL. Thank you, Mr. Chairman, and thanks to the panelists. These moments are useful as we determine policy.

Let me, if I can, focus on the availability and the extension of services for just a couple of moments, and perhaps Mr. Young, Mr. Shaw, or Mr. Start could speak to this question.

In 1992, then-Secretary of Health and Human Services Louis Sullivan wrote to then-Chairman Rostenkowski, saying that the Bush administration could not implement a provision of law requiring a demonstration project to allow people to use private rehabilitation agencies. The Dallas area was surveyed in this case, and the Bush administration concluded that there were not enough provid-

ers of rehabilitation services available for people to be able to have the choice between private and State-provided rehabilitation services.

What has changed now that would make this proposal possible, and are there enough providers of private rehabilitation services to make it feasible to consider this type of care as an option?

I come to this, I want to tell you, with an open mind. I would like to hear what the witnesses have to say.

Mr. YOUNG. Well, I am not entirely sure where the Secretary got his information, but in our network, there are over 5,000 private providers of vocational rehabilitation services across the country, and that is just private not-for-profit providers; that does not count the for-profits, and probably a few dozen or so that I am not aware of. But there is an extensive network of private providers in this country who could step up to the plate, who are now providing vocational rehabilitation services through other programs, such as the DD program and the mental illness program and others, who would be glad to take on this opportunity.

Mr. SHAW. I remember when the study was done, the issue was not whether or not there were a sufficient number of providers, but would the providers participate. Due to the reimbursement policies that were in place at that time, a not-for-profit organization had no resources to provide the services to a large pool of people for whom they might get reimbursement, after an extended period of time.

Given that set of circumstances, you would find the providers not willing or able to participate in the projects. So it was not an issue of availability; it was an issue of would people do it.

Mr. NEAL. OK.

Mr. START. Beyond the members that Mr. Young mentioned, the National Association of Private Practitioners in Rehabilitation has an additional 4,000 members that I am aware of that provide rehabilitation services. The Projects With Industries, there are about 120 of those projects around the country that are well networked. In fact, Projects With Industries placed 2,500 of roughly 5,000 people who came off the rolls through the vocational rehabilitation process last year, just through their relatively small effort. So I think small providers could impact it immediately.

Mr. NEAL. The light is still green if the other members of the panel wish to address the issue.

Ms. JOHNSON. I think we need to be careful that we do not have an either/or kind of scenario, because as we look at the partnerships that have developed over the years—and my exposure, obviously, is to my State—but as I look at the partnerships that have developed, the State and the private nonprofit sector are working hand in glove with others in this arena. It is not an either/or process. So I hope we are very cognizant of the fact that we do not create a scenario that is totally one or the other kind of situation. Many individuals who are served in private nonprofit programs actually come through the door of the vocational rehabilitation system and receive portions of their rehabilitation services through the private nonprofit; other parts of their rehabilitation, they may receive from a private physician, from a private physical therapy firm, or others that may or may not be available in the small rural communities in my State.

Mr. NEAL. Thank you.

Sir.

Mr. TENNEY. I find that we have probably been one of the best kept secrets in the rehabilitation return-to-work movement, evidently. Certainly, if you were to take just the Projects With Industries model that is in place now, there are immediately probably in excess of 100 vendors who have proven to be successful in the return-to-work environment and could be jump started immediately with a return-to-work effort.

Also, the Social Security Administration contracted for about 150 different projects in the return-to-work arena, and they had no shortage of people who were willing to participate in that project. Certainly, at least 50 percent of those projects were successful. So I found it shocking when you said that there is just no one out there to provide it.

Mr. NEAL. No, I did not say that; Mr. Sullivan said that. We should qualify that.

Mr. TENNEY. Well, then, Mr. Sullivan said that. I think I understand.

Mr. NEAL. Mr. Watters.

Mr. WATTERS. I think the response of Mr. Shaw is really appropriate. There is a balance between two major factors that needs to be maintained in drawing the market of service providers to work with people with disabilities.

One factor is competition. We have to have enough incentive for competition for those providers, and the after-the-fact reimbursement model just simply did not provide it.

The other factor is that we want to pay for outcomes, not process, and that is the balance that needs to be maintained in this mechanism.

Mr. NEAL. Thank you, Mr. Chairman, and thanks to the panelists.

Chairman BUNNING. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Start, you say in here:

> The current proposed method of paying for rehabilitation costs after placement, plus a percentage of profit, ignores the substantial cost of those that fail in the rehabilitation process. It places all the risk on the providers and fails to level the playingfield because State vocational agencies are fully funded for both successful and unsuccessful.

I want to talk about that, because as you know, before 1981 State agencies got reimbursed for unlimited services, but few people returned to work; and since 1981, they have used trust fund moneys only after a person has gone back to work, but the results are still the same. It seems that nothing has improved.

What is happening here, and is the State just in the business of getting reimbursement?

Mr. START. Well, I think first of all, you are looking at a State model that is severely overworked, for starters. One of the witnesses talked about 11 percent of the people whom they are able to serve right now; so they are under a tremendous workload, as one piece of it.

In terms of the incentive—I have lost track of a piece of the question——

Mr. JOHNSON. Well, since 1981 we have only begun payments after 9 months' work.

Mr. START. Yes. One of the things that really has not changed is the fact that the State agencies are reimbursed for all their costs by the Rehabilitation Services Administration. So from our perspective as a private provider, all of the costs have already been paid for all the risk that the government is taking by an alternative funding source, and then, when and if the agency gets a successful return to work and gets somebody off the rolls, the payment they are getting is essentially a bonus.

Bonus payments do not mean much to State agencies. There is no profit motive there. They are already overworked. So frankly, I would not predict in that model, in an overworked system, that it would impact performance.

On the other hand, with private providers, we would love to work with a system like that, where you pay for everything up front and then reward us for that kind of an outcome.

Mr. JOHNSON. Would you advocate going to a private operation? Do you think that would be helpful?

Mr. START. Yes, definitely—but not quite like the setup of the State rehabilitation organization. Frankly, I think that that puts too much risk on the government. The model we have talked about pays a small incremental payment, similar to the Goodwill model, for completing a plan that the individual has signed and committed to, so the person is in charge of his plan and has made an active commitment to get a job.

Then we have another incremental payment after the person has retained the job for 60 days. That means the job is stabilized, the person likes it, and there is a low probability of failure. Then we have talked about another payment at 1 year, and then a percentage of the trust fund out over time. We have run that model by a number of providers, and there is significant interest of many to participate.

Actually, I designed the model to be foolproof. We loaded the funds such that you could not make money for failing, you cannot make money for providing process, and the only way a provider could really be successful is to satisfy the individual, get the job he wants, and keep him in it. The only way that the taxpayer risks money is—well, they do not risk much money past paying for an evaluation, frankly. It is all calculated into the model that we have developed.

Mr. JOHNSON. Thank you.

Ms. Johnson, do you agree with what he just said, and can you tell me what part of your reimbursement comes out of the trust fund, if any?

Ms. JOHNSON. Yes. We in Georgia get a reimbursement for those individuals who are receiving SSDI and have returned to work and have met the SGA level.

Mr. JOHNSON. You mean after 9 months?

Ms. JOHNSON. After 9 months, yes.

Chairman BUNNING. Will you yield?

Mr. JOHNSON. Yes, of course.

Chairman BUNNING. They also get paid up front for the rehabilitation.

Ms. JOHNSON. No.

Chairman BUNNING. Not from SSA, but from someone else.

Ms. JOHNSON. From someone else. The issue for us is dealing with managing an organization, as I stated, that technically serves 1 in 11. There are many pressures on the State agency not only to serve those with Social Security who are on SSDI, but also to serve a large base of population. So I have many pressures that he is talking about; in the public sector, it is not all security and safety there when you are dealing with a program that only serves 1 in 11 who are technically eligible. So it becomes the choice of whom do you serve. There are a lot of risks for us as well. If we invest a great deal of those RSA resources into a population that, for whatever reason, does not go back to work, then we are also not serving somebody else, because we have used those resources in another arena.

So I get a lot of pressure from a lot of fronts. It is not just a profit or loss, or when the money comes back. I am under the same standards to perform that a private sector provider would be.

Mr. JOHNSON. OK. Let me ask you two more questions. You've talked about taking care of those who are disabled and have bad attitudes. If you get them with a bad attitude, you counsel them; is that true?

Ms. JOHNSON. No, I did not make that statement.

Mr. JOHNSON. OK. Do you take care of those people?

Ms. JOHNSON. Well, there are people who come in, and I——

Mr. JOHNSON. I believe you have to help them all. How do you get them into the system?

Ms. JOHNSON. One of the things we look at is why people have an attitude on not returning to work, and it is my contention that our system is the problem, and not necessarily the individuals, and that if we can change that system so there is an incentive instead of a disincentive to go to work, I think we have dealt with a lot of the "attitude problems" that people have.

I really believe in the value of work and that people want to work. I have a problem with the phrase "bad attitude."

Mr. JOHNSON. I agree with you on that. Mr. Start alluded to it and so did the chairman. Are you getting paid double for what you do out of the rehabilitation fund and the trust fund?

Ms. JOHNSON. That money that comes back into the rehabilitation system allows us to serve other individuals with disabilities who may or may not be a part of SSDI. Believe me, when I am funded to serve 1 in 11, when that money comes back into the system, it goes to serve someone else.

Mr. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman, and I thank all of you for being here.

We are looking at a broad range of issues—management issues, due process issues—as represented on the chart over there—but nothing is more important than what you are telling us about today. I for one am learning a lot, and I think the panel is, too.

My first question really goes to Mr. Young's comments on providing incentives for employers. You talked about the targeted jobs tax

credit idea. What you have spelled out in your testimony is essentially what we have now. I think your figures show $444 more per employer as a maximum credit than we allow now, but otherwise, it reflects the current system.

If you will indulge me for 1 minute here—and I know it is not directly related to SSI, Mr. Chairman, but the subcommittee is looking at this issue right now of TJTC, the targeted jobs tax credit, and whether it works or not. Pizza Hut and other private sector entities claim that they have done effective outreach in the disabilities community and that it has been a good program. I wonder if you have any comments on the current targeted jobs tax credit, not just limited to small businesses, and if any others would have any comments on that program.

Mr. YOUNG. It has been an effective program over the years. We have a lot of evidence from our job coaches and job developers in the field who have used it as a tool to get entre into employers and to open up job markets and job opportunities for people that they had not been able to open up before.

Mr. PORTMAN. Any other comments on the TJTC?

Mr. START. Yes. Our placement counselors have considered it to be a real positive tool over the years in opening up jobs that would not otherwise be available.

One of the problems we have run into with it, though, is that its political future is swinging from a pendulum every, single year. I talked about relationships earlier in my testimony, and jobs come from relationships that we have with employers, and so our counselors get real nervous about talking an employer into a targeted jobs tax credit if he thinks the rug is going to be jerked out from under the employer.

So watching that pendulum swing from year to year has decreased the effectiveness of an otherwise quite effective tool, actually.

Mr. PORTMAN. That is an excellent thought, and I think most of us on this panel probably agree that permanence makes more sense, even if the program has to be slimmed down some, because of the lack of planning and certainty on the part of employers.

Mr. Tenney, do you have a comment on the targeted jobs tax credit?

Mr. TENNEY. Yes. One of the issues with targeted jobs tax credit is that—it seems like you are exactly right—Pizza Hut, McDonald's, McDonnell Douglas, America West Airlines—many of the large organizations are very much tuned into targeted job tax credits. But the little "mom and pop" operations where we do most of our job placement do not have access to that, they are not aware of it, they do not have the technical assistance to access it, they do not understand it, and they frankly have been given a bum rap, I think. They are out there, ready to go ahead and hire someone, and these other things are certainly tools for this population, but the small businessmen just do not have the wherewithal to access this tax benefit.

Mr. PORTMAN. One of the issues is the amount of redtape, paperwork, and so on involved in it, particularly after the employment certification that is in existence now, and a lot of us would like to simplify that and make it a precertification process. But it is inter-

esting to know that it is having some effect in the disability community.

More generally speaking, Mr. Start got into some of his model ideas, including a reduction in the employer payroll tax over a period of time, and other tax incentives that are much more aggressive, really, than the targeted jobs tax credit. I suppose your experience would indicate that that is an effective tool to get the private sector more involved in your relationship with them—or what has your experience been on some of these tax incentives?

Mr. START. Well, I have to agree with what Mr. Tenney said, in a way, in that for the smaller employers, it is not the best incentive. Actually, a simple OJT works well with a small employer. It makes sense. You just go in and ask what are you going to teach the person, how much is it going to cost, how long is it going to take, and do a quick little plan.

No incentive is going to work for every, single employer, and I would encourage you not to evaluate it that way. Tax incentives work really well for the big guys, for the big, growing companies and those that are in an incredible growth mode or are very, very profitable.

In our model, what I did there was pick a number that we thought would work, and actually, it is fairly high, because we wanted to demonstrate to you that even with a very significant, substantial tax incentive, that the return-to-work effort still works. I think there is a danger in trying to isolate one of these individual variables and ask, OK, should we put in the tax incentive? Let us do a 10-year study and see if it works. Where is your data? Well, then you have just lost another $100 billion. Does OJT work. So we try to take a holistic approach and say, look, if you throw all this stuff in there that everybody says works, and it costs this much, it still pays.

Mr. PORTMAN. It still pays off in the end.

Mr. START. It still pays off—and that is with the existing assumptions, the actual kind of performance that Mr. Tenney and other research projects got using some of these same kinds of tools. So it is not speculation; it is based on actual results from the field.

Mr. PORTMAN. My bias on this is probably on the competition side, on outcome based rather than process based. I come at it with an open mind, but I am more focused on the private sector side. You are outnumbered this morning, unfortunately, on the panel, Ms. Johnson, although you have done an excellent job presenting your point of view.

But I guess what I would like to hear from Mr. Start, Mr. Watters, and others—and perhaps this is in the written testimony and you could provide it to us later—as to what the parameters should be when privatizing to make certain all geographic areas are served. In other words, let us say rural areas, underserved, other areas where there might not be the private sector groups—I know Mr. Young talked about 5,000-plus groups—what do we do in those areas? In terms of your regulation and parameters, you talked about the theory that less regulation will have more results, which is my bias as well, but what should those parameters be? What kinds of certifying regulations should be in place to keep less

credible organizations from taking advantage of a private sector program getting Federal funds and taking off with them?

My time is up, but if you have a quick comment, I would like to hear it.

Mr. START. On the rural side, one of the things that we have proposed is that we utilize what we call the network manager, who would have to service a fairly large geographic area and be kind of an umbrella organization to work with the smaller providers and handle the funds and do the administrative stuff, and they would share in the performance payments. They would only get paid like the direct provider, for performance, primarily.

So that would create kind of a community of effort in that regard. That deals with a piece of it.

Mr. PORTMAN. Thank you.

Chairman BUNNING. Your time is up, Mr. Portman.

Mr. PORTMAN. Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Christensen.

Mr. CHRISTENSEN. No questions, Mr. Chairman. Thank you.

Chairman BUNNING. Mr. English.

Mr. ENGLISH. Mr. Chairman, I will yield my time to Mr. Portman to continue his line of questioning.

Mr. PORTMAN. Any thoughts on the rural areas, Mr. Watters? [Laughter.]

Chairman BUNNING. Well, since he is going to have to wait, I am going to question before him.

Mr. PORTMAN. All right.

Chairman BUNNING. I want to question Mr. Shaw on behalf of a good friend of mine who was a member of this committee, who is now representing your organization, Mr. Fred Grandy. You mentioned in your testimony that of the 34,000 referred to Goodwill Industries for job placement, 23,000 were placed in competitive jobs.

Mr. SHAW. That is correct.

Chairman BUNNING. That is a 70-percent success rate.

Mr. SHAW. That is correct.

Chairman BUNNING. Would you like to be appointed to be Commissioner of Social Security and DI? [Laughter.]

You are going to have to share with this panel and with this subcommittee how you do it, and how you do it successfully—and do you trace the people after they go to work?

Mr. SHAW. We do as has been indicated by many of the other panel members—we trace, either by requirement, by a funding authority, or by philosophy. We do not have the ability to track for the 12 or 18 months that I think is required to demonstrate success, particularly for this program.

We track traditionally between 90 days and 6 months for our programs to demonstrate——

Chairman BUNNING. Well, wouldn't you find some of those people coming back to you if they fell out of the work force?

Mr. SHAW. Yes, yes, we would.

Chairman BUNNING. So therefore, you can find those people. But the ones that do not come back——

Mr. SHAW. We can find them. The issue is not whether or not you can find people. You can do that if you invest resources in going out to the community and locating them.

Our success rate is measured, as I think is traditional in the field of rehabilitation, somewhere between 60 and 90 days counts as a success. I believe it has been the assumption in our industry that if you bond a person to the job, and that occurs during something like 60 or 90 days, then the likelihood of success is there. I think other research has indicated that that is not necessarily true, and I think the problem you have here in dealing with the Social Security program is that it is probably not true, that we do not have a lot of people achieving SGA.

Our contention is and has always been that there has to be points of intervention if you are going to ensure long-term success. Points of intervention require resources, and without any system that says we will resource what we think will work toward achieving that long-term outcome, it is not going to happen.

Chairman BUNNING. Do the persons who come to you generally have health care, or are they in a void of health care, or are they under Medicare, or Medicaid?

Mr. SHAW. Medicaid or Medicare. The preponderance of people we serve are still covered in some way, shape, or form by health care.

Chairman BUNNING. Is that a disincentive to go to work?

Mr. SHAW. Yes, it is a disincentive. It is a disincentive not only to individuals, but you must remember that disincentives also can occur to significant others—family, the people who would be care givers otherwise. They put a lot of pressure on the individual, so that even if the individual says, "I do not care; I am willing to take my risk," he can have a group of significant others who say, "We do not want to take the risk with you." So yes, the medical system is a problem.

Chairman BUNNING. That would be a disincentive, also.

Mr. SHAW. Exactly.

Chairman BUNNING. I think we can design a plan that would take away that disincentive, and I do not think it is that complicated.

Mr. SHAW. I think so, too.

Chairman BUNNING. Is there anybody else on the panel who has questions?

[No response.]

Chairman BUNNING. Thank you all very much for your testimony.

Would the last panel please come forward—Glenn Fait, Fred Arner, and Louis Enoff. Would the panelists please give their names and identify their positions as they testify, and Mr. Fait, would you please start us off?

STATEMENT OF GLENN A. FAIT, ASSOCIATE DEAN, SPECIAL COUNSEL AND DIRECTOR, INSTITUTE FOR ADMINISTRATIVE JUSTICE, MCGEORGE SCHOOL OF LAW, SACRAMENTO, CALIF.

Mr. FAIT. Yes, thank you, Mr. Chairman and members of the subcommittee. My name is Glenn Fait, and I am associate dean and special counsel at McGeorge School of Law in Sacramento, Calif., and director of the Institute for Administrative Justice there.

I would like to mention that the Institute for Administrative Justice is a unique organization in the country that for the last 23 years has specialized in the field of administrative hearings and appeals processes for a variety of Federal, State, and local agencies.

For the past 12 years, we have had a series of contracts with the Social Security Administration, primarily in the area of their reconsideration hearings that are required after continuing disability reviews. Congress, about 12 years ago, required that when a person was discontinued after CDR, they receive a face-to-face hearing at the DDS level.

I do want to mention that I am not speaking for SSA even though I have had contracts with them for years. I am speaking basically from my own experience, and my opinions are my own.

I do agree very strongly with many people who have said that there are too many levels of review and levels of appeal in the Social Security disability appeals system, and I do believe that they result in an inflation of allowance rates, and probably an inappropriate inflation.

I think it is very logical if you look at the system, the only people who are able to appeal are people who are denied at the lower level. Nobody is appealing inaccurate allowances. Therefore, if you were to add perhaps another three levels to that review process, an applicant would probably have a 100-percent chance of being allowed if he stuck in there for the 5 years it would take to be reviewed at every level.

There have been a number of reasons given for this allowance rate variance as it goes up the ladder—different law, different standards being applied, new evidence being submitted—and all of those are important. There is one that I would like to mention that I have not heard talked about, that I think is very important, and that is that many of these cases, if not most of them, that come to these hearings are very, very subjective issues.

The objective cases are usually taken care of early on, and when you get to these hearings, the impairment is usually not the issue. The issue is how that impairment affects a person's ability to work, and that very often becomes a very subjective issue, based upon the statements of the claimants themselves. Mr. Jacobs pointed out a very good example of that. It is basically the testimony of the person himself and how he is able to function.

Therefore, I think people tend to compare cases when they are very subjectively based, and you have a tendency when you conduct the hearing to say, well, this person seems worse off than the one I had last week, and I granted him, so I will grant this person. There is somewhat of a basis for comparison that you develop which becomes quite subjective and not very objectively based.

My proposal is that the Social Security Administration eliminate three levels of review that are currently in the system—the reconsideration level, the administrative law judge level, and the right to appeal to the Appeals Council. I believe that substituted for those should be a single, simple hearing of record at the local DDS level, and I think these hearings should be conducted by people who are specialists in disability evaluation and have experience with the Social Security program. My experience over 23 years has been that when you have a very special substantive decision to

make, you are better off to take a specialist in making that substantive decision and train him in how to conduct these informal hearings than you are to try to take a lawyer and make him into a specialist in that substantive area. After all, these are not O.J. Simpson trials. They are hearings that last perhaps 45 minutes; only one side is represented, and it is actually more like an interview by an investigator than it is a trial. People are easily trained to conduct those kinds of hearings.

We have trained many hundreds of those people to conduct CDR discontinuances under the current system, although there are not many CDRs being done, so they are not being used, but there are hundreds of them who have been trained for this purpose.

I think the hearings need to comply with the standards of due process established by the Supreme Court in the case of *Goldberg* v. *Kelly*. I do not believe these hearings should be subject to the Administrative Procedure Act, and I think Congress should specifically exempt them. In my opinion, the Administrative Procedure Act was intended for a traditional trial-type hearing and was not intended for a mass hearing process of which Social Security disability is the most massive, and we need to develop special rules for that kind of hearing.

I also believe in the disability court that Mr. Arner will talk about, and I think we should take the resources that we save on this very costly appeals process and move them to the front end of the system so that the initial determination and the investigation relating to it can assure that the first decision is correct so that appeals will not be necessary.

Thank you very much, and I would be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF GLENN A. FAIT
DIRECTOR, INSTITUTE FOR ADMINISTRATIVE JUSTICE
MCGEORGE SCHOOL OF LAW, UNIVERSITY OF THE PACIFIC
Before the
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
Regarding the
SOCIAL SECURITY DISABILITY PROGRAM
AUGUST 3, 1995

SUMMARY

The current SSA multi-level disability appeals system should be replaced by a single hearing of right and a special disability court to hear appeals.

Savings from the simplification of the appeals system should be reallocated to the initial determination process, and the initial decision maker should be given more flexibility to use those resources as appropriate for each individual case.

Only a single hearing is required by law, and the multiple levels of appeal within the current system result in an inflated overall allowance rate. This inflated rate is caused by four factors:

1. Adjudicators at different levels of review are using different standards to evaluate the claims.
2. New evidence is allowed at each level of review.
3. Some adjudicators do not understand their appropriate role in the institutional decision making process.
4. Many decisions are based on subjective factors which cause adjudicators to make judgements based upon comparisons of cases rather than objective evidence.

A single hearing will ensure that all evidence is put on the table at the earliest time. If the adjudicator understands his or her appropriate role, he or she will apply the same law and policy in making the decision as the initial decision maker. And, with only one hearing level, the adjudicator will have a broad base of cases to compare when subjective factors are present.

Hearing adjudicators should be chosen based upon their knowledge and experience in the field of disability evaluation and Social Security program.

The single hearing should be informal and should comply with all of the elements of due process required by the Constitution. The adjudicator should take an active role in developing evidence and should not have any responsibilities that conflict with the role of impartial adjudicator.

SSA should, on its own motion, be able to review and modify decisions that it determines are incorrect.

A special disability court should be established to review all appeals of disability decisions from SSA.

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to appear here today. My name is Glenn Fait. I am the Associate Dean-Special Counsel of McGeorge School of Law, University of the Pacific, in Sacramento, California. I have been the Director of the Institute for Administrative Justice at McGeorge for nearly 23 years. The Institute is a unique organization that specializes in the field of administrative adjudication. We have provided services in this field to a variety of federal state and local government agencies. We train administrative adjudicators, act as consultants to agencies in developing administrative hearings and appeals systems, and conduct hearings by contract for a variety of government agencies.

For the past twelve years, The Institute for Administrative Justice has worked under contract to the Social Security Administration. This work has been related primarily to the reconsideration hearings that are required by Congress to be conducted for continuing disability review cases (CDR's). We have trained hundreds of hearing officers and have provided advice and consultation to Social Security with respect to its appeals system. Let me make it clear, however, that I do not appear here today to speak on behalf of the Social Security Administration or to intentionally promote the views of any particular individuals employed by Social Security. Rather, I am here to offer my own opinions, opinions based on twenty-three years of experience in the field of administrative hearings and appeals.

I appear today in the spirit of President Clinton's initiative to put aside vested interests and take a fresh look at the best way to serve beneficiaries as though they were valued customers deserving of fair and prompt handling of their requests. I also would like to echo the views expressed by Social Security Commissioner Shirley Chater, who stated to this committee on May 23, 1995, that the current system is not working and that "tinkering at the edges" will not give the American people "the service they deserve." Unfortunately, no matter how dedicated Social Security is to these goals, real change cannot take place unless Congress and the President provide the clear direction needed for such change.

I will try to confine my remarks to my field of expertise, that is, administrative hearings and appeals.

Surely, few will argue with my general recommendation, that Congress establish a fair, more efficient and cost effective appeals system which will ensure that those eligible for benefits under the law receive them promptly, that those not eligible are denied promptly, and that those who have received benefits and are no longer eligible are promptly removed from the rolls. I believe that such a system can be achieved by strengthening the initial determination process, providing a right to a single hearing of record, and establishing a specialized disability court. I shall discuss each of the elements in more detail.

Initial Determination

I agree with many of the current reengineering initiatives that the initial determination process should be more user friendly and that applicants should not be made to feel that they are being bounced between various offices and decision makers. How this is best accomplished is not necessarily in my field of expertise.

However, an area that interests me greatly concerns the use of resources at the initial level. I believe that greater resources should be expended at this initial level of eligibility determination. Rather than spending vast sums on appeals that sometimes occur years after the initial determination, more of

those resources should be shifted to the front end of the system to provide the initial decision maker with the means to ensure a correct decison the first time.

With respect to the relationship between accuracy and resources, I believe that the initial decision maker should be given flexibility in developing the evidence necessary to make the correct decision. It is inappropriate to require that the same exact process be used in all cases. If the disability examiner believes that talking to the claimant by telephone or in person will help, the examiner should be able to do so. If additional medical evidence is necessary, the examiner should be able to obtain it. Many claims can be disposed of easily and accurately by a review of the records. Those claims that clearly are denials or allowances should not be encumbered by the costs associated with face-to-face interviews. Claims based primarily on subjective elements such as symptoms of pain described by the claimant may well require further investigation into how well the person is able to perform his or her daily activities. The initial decision maker should be provided the means to conduct such an investigation.

If the single-hearing system that I propose were to be adopted, the cost at the administrative appeals level should be significantly reduced. Much of the savings could then be reallocated to the initial level so that accuracy at that level could be further increased.

Why the right to only a single hearing?

The Supreme Court in the landmark decision of Goldberg v. Kelly, 397 U.S. 254 (1970) concluded that the Due Process Clause of the Constitution required an evidentiary hearing before the State of New York could discontinue public benefits. Although the law in the State of New York provided for a post-termination fair hearing, the Court ruled that an evidentiary hearing must be held prior to the termination of benefits. The Court commented that "due process does not, of course, require two hearings. If, for example, a State simply wishes to continue benefits until after a 'fair' hearing there will be no need for a preliminary hearing." The court did not require any other administrative proceedings or levels of appeal.

Many agencies have developed multiple levels of administrative appeal for a variety of reasons, but not because those levels of review are required by the Constitution or by statute.

The past practice in Social Security has been to provide a claimant the right to a number of levels of administrative appeal: the reconsideration stage after the initial decision in the DDS, the Administrative Law Judge hearing, the appeals council and, eventually, an appeal to court. At each level, there have been significant allowance rates. It is my opinion that the more levels of review within the system the greater the overall number of allowances that will result. After all, the only one with the right to appeal is the person who has been denied or discontinued. No mechanism exists for appealing erroneous allowances, with the exception of a few "own motion" reviews. And if there is an erroneous allowance, the improvement standard makes it all the more difficult to later cease that person's benefits.

There are a number of reasons for the significant allowance rates at the various levels of appeal.

1. Not everyone is applying the same standards.

The initial decision maker in the DDS is guided primarily by policies (POMS) of the Commissioner. Traditionally, when an applicant has appealed a denial of an initial applications, the first level of appeal has been to another DDS employee. That person has usually also applied the POMS. At the reconsideration

level for continuing disability review, the hearing officers are instructed to refer primarily to the regulations and Rulings. Most Administrative Law Judges (ALJ's) do not feel bound by the POMS, and many do not believe they have to comply with the Rulings. The Appeals Council uses the regulations and Rulings, but the Federal Court is not bound by the Rulings. Is it any wonder that there is little consistency among the various levels of appeal?

2. New Evidence is being admitted at each level of appeal.

I have often said that Social Security does not truly have an appeals system, but rather multiple levels of initial determination. One cannot fault the lower decision maker when the higher decision maker comes to a different conclusion because of new and different evidence. It is important to get as much of the evidence on the table as early as possible. Currently, claimant representatives have great incentive to hold back evidence until the ALJ hearing. If there were only one administrative hearing of right, the evidence would have to be produced early in the process, resulting in a more efficient process and a more prompt and accurate decision.

3. Many Administrative Law Judges do not have an appropriate view of their role in the appeals system.

Administrative hearings are designed primarily to provide a chance for an agency to correct its own mistakes. By taking a fresh look at the evidence in a hearing setting, another agent of the agency can determine whether the initial decision was correct. This process is referred to as "institutional decision making." The decision is the decision of the agency, not the decision of an individual judge.

The role of the adjudicator in such a system is to make fndings of fact based on all the evidence in the record and then to apply the regulations, rules and policy of the department in making the ultimate decision regarding disability. The only person given the power to make the ultimate decision is the Commissioner of the Social Security Administration. The hearing adjudicator should act as a trusted assistant to the Commissioner in formulating the appropriate decision. The Commissioner should always have the right to change the decision of the adjudicator if the Commissioner believes the decision is inconsistent with Social Security policy.

The Social Security Administration today is at war with itself. Instead of working to carry out the policies of the Commissioner, many ALJ's claim total independence from the agency. Many ignore agency policy in determining individual cases.

In recent years, many ALJ's have contended that to be impartial they must be given the same independence as a judicial judge. This contention totally misconstrues the role of an administrative adjudicator. In Goldberg v. Kelly, the court concluded that an adjudicator can be impartial even though he or she is an official of the public agency that made the initial decision, and can even have been involved in aspects of a case as long as he or she did not participate in making the determination under review.

The doctrine of "separation of functions" has been the central tenet of impartial administrative decision making under both the Due Process Clauses of the Constitution and the Administrative Procedure Act. While the decision maker must be performing a function distinct and separate from the initial decision making function, the decision maker need not be separate from the agency for which is he or she performs that function.

The failure of many ALJ's to understand the appropriate role of the administrative adjudicator may help explain why a DDS may be told by SSA that it has a 93% accuracy rate in making disability

decisions and then have seventy to eighty percent of its cases reversed by ALJ's.

4. When making subjective decisions, comparison of cases becomes a primary influence on individual decision making.

There is much talk about requiring that decisions be based upon objective evidence. The Social Security Administration has developed a comprehensive set of regulations, rulings, and policies to provide consistency of decisions based upon objective evidence. But the reality is that many decisions made by disability adjudicators are quite subjective.

The principal issue in most hearings is not whether there is an impairment, but rather, how that impairment affects a person's ability to work. Often there is little objective evidence for making such a decision. The doctor and the hearing adjudicator are forced to base their opinions on the statements of the claimants themselves. This is especially true in cases involving cardiovascular, musculoskeletal and psychological impairments.

I believe that when an adjudicator is required to make decisions based on very subjective evidence, the adjudicator will often rely on his or her experience with previous cases. In other words, the adjudicator will compare past claimants to the case before him or her. The thinking goes like this: "This person appears to be worse off than a similar case I had last month. I allowed that case; therefore, I should allow this case." In the process of making such comparisons, the adjudicator develops a kind of grading curve. This may account for the fact that many adjudicators have very predictable allowance rates that do not seem to be affected by a change in lower-level allowance rates.

A number of years ago, a state DDS administrator informed me that he was quite pleased that he had managed to double the allowance rate at his DDS initial decision level but was disturbed that the allowance rate at the ALJ level had not changed. He assumed that since the DDS was allowing twice as many cases, the ALJ allowance rate would decrease proportionately. It did not.

I am not aware of any study that has been conducted to prove or disprove this theory, but, if I am right, one proposal being considered in the reengineering effort may result in a higher level of allowances. One of the reengineering proposals is to have an adjudication officer (AO) review the file, gather the evidence together, and hold a conference with the claimant's representative prior to the ALJ hearing. The AO would then allow the cases that would likely be allowed by the ALJ. The ALJ would hear only those cases not allowed by the AO. The assumption is that the program will result in a lower allowance rate by ALJ's because fewer cases that should be allowed will be heard by the ALJ. If my theory is correct, the use of the AO will only further skew the cases that the ALJ will be comparing, and the allowance rate of the ALJ will not change significantly.

Taken to its extreme, this approach would assume that if there is an 80% allowance rate at the ALJ level, and we can identify those cases and allow all 80% before the ALJ level, the ALJ will have a 0% allowance rate. Can we really believe that this will happen? I believe that of the 20% of cases going to the ALJ, a significant percentage will still be allowed.

For the reasons stated above, I believe that the administrative appeal process should provide for a single hearing with all of the required due process protections, and that the hearing should be conducted by a person with experience in disability determination who applies the same law and policy as the initial decision maker.

Who Should Conduct the Hearing?

My twenty-three years of experience with administrative adjudication have convinced me that when the substantive decision to be made involves a high degree of special expertise, that decison is best made by a specialist in that substantive field. Social Security disability determinations require a high degree of special expertise in the area of disability evaluation.

It is easier to train a disability specialist to conduct the informal, one-party disability hearing than to train an attorney to be a disability evaluation specialist. Currently, ALJ's are often recruited based on their experience as trial attorneys. In my opinion, experience as a trial attorney can greatly interfere with an attorney's ability to assume the role of disability hearing adjudicator. The role of a disability adjudicator is that of a truth seeker, not an advocate. The procedures used in a court trial have little similarity to those in a Social Security disability hearing. In actuality, there is little in law school that prepares an attorney for the role of disability adjudicator. Law school curriculum is directed primarily to the adversary process used by courts. Little is offered with respect to administrative procedure and social legislation, and nothing with respect to disability determination. Certainly, law schools do attempt to teach their graduates how to think analytically. However, we do not have a corner on that market. There are many other professionals who learn to think analytically. Although attorneys should not be precluded from being disability hearing adjudicators, their selection should be based on their experience and knowledge of disability evaluation.

It is also important for the adjudicator to have experience with and knowledge of the Social Security disability program. Program knowledge is important to ensure that the adjudicator's decision is consistent with SSA policy. To ensure accuracy in decision making, it would also be helpful to have disability adjudicators with experience in reviewing a wide range of claims so that their basis of comparison is broad. This will be especially true as long as subjective factors continue to play a key role in the adjudication of disability claims.

Some people fear that nonattorneys will be unable to conduct fair hearings. However, for the past 12 years, a large number of trained nonattorney hearing officers have been conducting reconsideration disability hearings. Claimants in these hearings have often been represented by attorneys. By all reports, the hearing officers have performed well, guaranteeing the claimant a fair hearing while at the same time using their disability evaluation and program knowledge and experience to arrive at the correct decision.

To summarize, the criteria for selecting disability hearing adjudicators should emphasize expertise in disability evaluation and knowledge of the SSA disability program.

What Kind of Hearing Should be Provided?

The hearing provided as a matter of right to the disability claimant should continue to be an informal hearing in which the adjudicator has an affirmative obligation to develop the evidence in order to make the correct decision.

The hearing should provide the basic due process rights set forth in the Goldberg v. Kelly decision. These include the right to timely and adequate notice; the right to be heard, present evidence and witnesses; the right to be represented; the right to disclosure of evidence; and the right to confront and cross-examine adverse witnesses. The hearing should be conducted by an impartial

adjudicator whose functions are separate from those who make the initial determinations being reviewed. Adequate rules should be included to prevent inappropriate ex parte communications, and there should be a written decision that sets forth the findings of fact and the evidence relied upon, and that makes clear application of Social Security law, regulation and policy to the facts supporting the ultimate finding concerning disability.

I also believe that each adjudicator should handle his or her own cases from start to finish. The adjudicator should review the evidence, prepare for the hearing, conduct the hearing, and write the decision. The use of a decision writer allows the adjudicator to avoid engaging in the systematic evaluation required under the sequential evaluation process. The decision maker should be the decision writer.

All of the procedures mentioned above are currently a part of the continuing disability reconsideration hearings process.

Should the Hearing Decision be Subject to Review?

While there should be no further administrative appeal of right after the single hearing of record described above, the Social Security Administration should have the ability to review individual decisions on its own motion. The hearing adjudicator's decision should be an initial decision that would become the decision of SSA unless SSA decides to review the decision on its own motion. This procedure is consistent with the provisions of the Administrative Procedure Act and the concept of institutional decision making.

I do believe that any review of decisions should be based upon neutral criteria, such as the selection of a certain percentage of decisions from all regions, states, or individual adjudicators. Individual hearing officers should not be targeted, and allowances and denials should be reviewed with equal thoroughness.

I would also recommend establishing a procedure that would encourage hearing adjudicators to prepare proposed decisions in difficult cases and request the agency to review the decision prior to adoption.

Special Social Security Disability Court

I agree with the many people who have proposed the establishment of a special court to handle appeals of disability cases. Fred Arner will speak in more detail concerning this proposal. I do believe that such a court should be limited to determining whether there was an error of law, an error in applying the law to the facts, a procedural error, or a lack of substantial evidence supporting the findings of fact. The court should be precluded from allowing new evidence and should base its decision solely on the record of the administrative hearing.

Thank you for your time and I look forward to answering any questions you may have.

Chairman BUNNING. Thank you, Mr. Fait.

Mr. Arner, you had a long association with a former colleague of ours, Mr. Pickle. I only wish he were still here—believe me, I do. Please proceed, Mr. Arner.

STATEMENT OF FREDERICK B. ARNER, KENSINGTON, MD., FORMER CHIEF, EDUCATION AND PUBLIC WELFARE DIVISION, CONGRESSIONAL RESEARCH SERVICE

Mr. ARNER. Mr. Burke before Mr. Pickle, too.

Mr. JACOBS. You are probably disabled yourself.

Mr. ARNER. Well, I am unattached. I did work in the Congressional Research Service, on this subcommittee, and in the Social Security Administration in the disability area.

I will talk primarily about the Social Security court. We have a number of bills. We have Mr. Jacobs' bill that he has introduced in this Congress, which you, Mr. Chairman, and Mr. Jacobs introduced in the last Congress. That was a Social Security circuit court bill. I think this would go a very long way in making more uniform the treatment of claimants, elimination of the acquiescence problem, and the development of more uniform case law. It would also bring a much more rational way of approaching policy issues. The Social Security Administration would have one body of law to focus on; they could appeal cases; they could write new regulations, or they could come to the Congress, rather than the situation we have where law varies all over the United States. We really cannot come to grips with these variations, and the Social Security Administration has struggled with this to a great degree in recent years.

One amendment I would suggest to that bill is to allow the Social Security circuit court to handle the class action suits, that they all would come to the circuit court, and the circuit court would be allowed to send them out to the appropriate district court. The court could consolidate all the class actions throughout the United States.

We have had situations where we have had 10 or 12 class actions on the same subject, because attorneys go out and file them in different jurisdictions where they think they can get the best action. So I think that that would be a very commendable function to add to the courts jurisdiction.

Now, if you really want to bite the bullet—that was what Mr. Burke used to say, as Mr. Jacobs will remember——

Mr. JACOBS. Oh, he used to do it. [Laughter.]

Mr. ARNER. You go all the way, and you go to the Archer bill, or preceding that, it was the Pickle bill, and before that, it was the Burke bill. This is a specialized court that was really designed on the structure of the Tax Court, and it would replace the district court jurisdiction. Under the circuit court bill, you would still retain the existing district court structure, but under this Archer bill, you would replace the district court with a specialized court that would cover the United States and would have the ability, as one court, to try to develop a more coherent body of law. You could have this with the proposed circuit court review under your bill. I think under the Archer court bill, appeal would go to the Federal circuit, but if you wanted to have a Social Security circuit, that would make even more sense for the appeal.

One benefit here is that you would have specialized judges and you would have the ability to have uniform procedures at the district court level. Now, the district courts are governed by a multitude of rules and regulations and procedures at their level, but this approach would provide one standard set rules and procedures.

One example is the use of magistrates. Some district courts use them extensively; others do not use them at all. There is a provision in the Archer bill for the appointment of commissioners, which would be equivalent to magistrates, and they would have the ability to help with heavy workloads.

I will just mention briefly a couple of the other problems here. Uniform policy standards. The administration in their latest initiative is renewing the idea of reading from "one book." and I would like to call your attention to a rather productive period back in 1983 and 1984 where there was a plethora of rulings that came out at that time defining policy in a more coherent manner. The rulings are supposed to be applicable both to the DDS and the ALJs. Now, some ALJs do not think they are bound by rulings, and that causes a little problem. But it is a good thing that SSA is again working on this, because a lot of work needs to be done here. The class actions have diverted them from a normal policy evaluation to more of a reactive approach where they are putting out rulings and regulations, primarily to counteract or acquiesce to court rulings.

On the lack of uniformity between State agencies and ALJs, I will just say that there are two different standards of review that you might want to look at. The ALJs are reviewed on the substantial evidence standard.

I see the red light is on, so I will cease.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Testimony before Social Security Subcommittee
on the Disability Insurance Program
Frederick B. Arner
August 3, 1995

Mr. Chairman,

It is a pleasure to be back before the Social Security Subcommittee this morning. As Andy Jacobs knows, I served the Congress for over 30 years, and have devoted most of my career to disability issues.

From 1975 to 1983, I served on the Subcommittee staff, and had chief responsibility for disability issues. Prior to that, I spent many years with the Congressional Research Service, in the American Law Division, the Government Division, and finally, as Chief of the Education and Public Welfare Division. I attended Harvard Law School and have a law degree from George Washington University.

From 1983 until 1987, I worked at the Social Security Administration in disability policy and at the Office of Hearings and Appeals. In 1989, using a grant from the Sloan Foundation, I conducted an extensive study of the disability program, and wrote a book recommending a model structure for the program.

Of the subjects which were highlighted in your press release, I will deal primarily with the problems of litigation and the establishment of some type of Social Security Court. I will also discuss the related problems in providing and implementing uniform policy, and desirability of modifying a system which allows evidence on a case to dribble in for years.

Social Security courts

I am aware this is not the first time you have heard me on this subject so will try to be brief. This subject has been looked at many times by commissions, advisory councils, and study groups over the last twenty years, the latest of which is the Federal Courts Study Committee. The latter had been established by Congress and reported back in 1990. Mr. Chairman, you and Mr. Jacobs introduced a bill last Congress on the subject, as have past Chairmen and Ranking Members of this Subcommittee, including Mr. Archer, Mr. Pickle, Mr. Jacobs, and Mr. Burke.

I will summarize the pros and cons of the different approaches. The old Burke, Pickle, and Archer bills would have established a Social Security Court which would have jurisdiction over all Title II and XVI determinations. It would have taken away jurisdiction from the U.S District Courts and placed it in judges of the specialized court. Appeal from the Social Security Court would go to the Court of Appeals for the Federal Circuit. On the other hand, the bill you and Mr. Jacobs introduced, H.R. 3265, in the 103rd Congress (which Mr. Jacobs has introduced in this Congress - H.R. 1587) would keep the district courts but have all appeals of Social Security and SSI cases go to one circuit court, a new U.S. Court of Appeals for the Social Security Circuit.

Your previous bill would be a major step forward in providing uniformity in the interpretation of the disability provisions of the law. It would probably be more acceptable to the advocate community than the Archer bill from the 103rd Congress and could by implemented more quickly. In fact, it could be a transitional step toward a more comprehensive Social Security Court structure.

I would suggest that the Social Security Circuit Court should be given the authority to receive and assign all class action suits to the district courts. This was included in Mr. Archer's bill of last Congress. These cases -- though often legitimate in nature -- have been a major disruptive force in the administration of the disability program in the last fifteen years. Such a provision would allow the consolidation of cases on the same issue and greatly curtail "forum shopping" by advocates who wish to obtain the maximum sympathetic consideration of their concerns.

There are, however, a number of things you will not get out of the Social Security Circuit Court approach. You will not have judges at the district court level who are specialists in disability process and law. In this you will find support in the advocate community who have argued that a "generalist" district court judge is a better protector of claimant's right than a "specialized" court judge. They argue that a Social Security Court would be "dominated" by the administering agency. Ironically, in the past SSA has argued that such court would interfere with its policy setting functions. Although I believe both these arguments are not substantial, they apparently have been effective ones in preventing remedial action. The lack of uniformity of treatment of claimants because of judicial intervention has continued unabated under the present system.

Also, under your previous bill, Mr. Chairman, the rules of courts will continue to be determined differently -- by district and circuit -- throughout the United States. These rules of practice can by quite significant and would probably be beyond the control of the Social Security Circuit Courts unless it was stated otherwise in the legislation. Moreover, to have one set of rules for social security cases in the district courts and another for all others would add confusion to a scene already chaotic enough. One quite important difference in district courts throughout the United States is their use of magistrates. Some district courts use them extensively and magistrates in some jurisdictions become de facto disability specialists. The degree of supervision and review by the district judge vary by court and circuit.

If a uniform judicial approach is considered the highest priority, or as Mr. Jim Burke used to say "you want to bite the bullet", the Archer bill is the preferred approach. It would establish uniform rules of practice and procedure and it would provide a chief judge with authority to deal effectively with disability court workload and processing times. Under the existing district court structure you lack such flexibility. Moreover, a Social Security Court would provide you with a mechanism to deal in a uniform manner with remands and enforcement of the "substantial evidence rule". In the past these have been the subject of abuse by district court judges even though Congress has tried to curtail such activity a number of times.

Finally, if you go the Social Security Court route you appear to be setting up a court which is more of an Article I (legislative) court than an Article III (judicial) court. Constitutional experts struggle to explain the difference but the tenure of the judges seems to be the most crucial element. The Archer bill would have provided a tenure of ten years for such judges. To be a Article III, court life tenure is required. Either approach could be utilized. The argument for life tenure is the increases appearance of independence. Judicial independence is a mixed blessing in the views of some.

In addition, the law requires an appeal by the Government within 60 days of the district court decision and the Justice Department requires that SSA make their appeals recommendation within 30 days. The numbers and layers of lawyers, technicians, and bureaucrats who must input into the appeals process in the 30-day period is mind-boggling, and an effective review from both a policy and legal standpoint within this time period is very difficult if not impossible. I suggest a lengthening of the appeal time frame to at least 90 days. The Congress in passing the Social Security independent agency bill with Social Security having its own attorneys has helped. But SSA should have authority to appeal cases to the circuit court level without Justice Department participation. Presumably, appeals from the circuit court to the Supreme Court would still go through the Solicitor General.

Uniform Policy Standards

As part of its reengineering of the disability programs, SSA is continuing the struggle to implement the concept that all adjudicators read from "One Book" on policy and procedures. Over ten years ago Congress called for this and in the period 1983-1984 there was an unusually productive period went the Office of Disability and Office of Hearings and Appeals collaborated in the promulgation of a great number of Rulings which clarified the policy in many crucial areas. Since then, however, the lack of Rulings has been marked and the slowness in getting out Regulations has returned. Regulatory reform for SSA, in contrast to some other agencies, is the promulgation of more policy direction rather than its curtailment. The latest SSA efforts should be applauded and encouraged.

One of the primary reasons for a Social Security Court or appeals court is the elimination of conflicting court established disability standards in different regions of the country. Moreover, the "non acquiescence" problem will disappear under either type of legislation and coherent and relatively uniform body of case law will gradually be formed. Where SSA disagrees with a finding it will be able to appeal a court decision which it believes violates desirable and lawful policy or go to Congress for legislative clarification.

Administrative standards of review

A related concern is lack of uniformity in standards for disability or in their application at the administrative level. The constantly increasing ALJ reversal rate of State agency decisions continues to foster the belief that something is amiss in the process. The traditional explanation by SSA that the ALJs are really looking at different cases because of the passage of time and an "Open" record does not completely explain the difference in result.

A recent SSA study shows a substantial variation in how SSA quality assurance (QA) personnel look at State agency decisions as contrasted with Appeals Council review of ALJ decisions. For instance, in a study of ALJ decisions the QA personnel found 80% lacking documentation to support the decision while peer review by ALJs reviewers found only 20% had insufficient documentation. This is not altogether surprising in that the decisions are being reviewed on different standards. The ALJs use the Appeals Council standard of substantial evidence while the QA reviewers utilize a "preponderance of evidence" standard.

One obvious step in achieving more uniformity in decision-making would be the use of the same standard. I question whether it is appropriate to use the "substantial evidence" standard in reviewing cases at the administrative level. This is a standard used almost exclusively in courts review of administrative action. Use of "substantial evidence" at the administration introduces a looseness in review of both allowances and denial which does not support what might be considered a "best decision" philosophy. At the court level such a standard of reviews may be sustainable because deference is more appropriate to the "expert" agency making the determination. The committee may wish to consider whether legislatively it should provide a uniform standard for reviewing decisions and that the appropriate standard should be "preponderance of the evidence".

Closing the record

For almost fifteen years the Congress has attempted to reform the system so that documentation for determinations of disability be introduced early in the process. SSA reengineering endorses this concept in its emphasis on increased development at the initial level.

In the 1980 amendments the Congress attempted to put a modest restriction on the "open record" which would prevent new evidence to come in at the fourth level, the Appeals Council. The law and the legislative history stated rather clearly that the record would be closed after the decision of the ALJ. However, many years thereafter a regulation was promulgated which allowed "new and material" evidence to be introduced at the Appeals Council level as long as it related to the "period" before the Appeals Council level. This was a clear violation of Congressional intent.

In 1982 this Subcommittee reported out a bill that went further and required a "closing of the record", with some notable exceptions, after the reconsideration. The rationale was to expedite the process and to prevent the practice of some attorneys in holding back evidence for submittal to what they considered a more sympathetic forum, namely the ALJs. The legislation died in the Rules Committee. Perhaps this is an appropriate time for the Committee to once again explore this issue. At the very minimum it should demand that SSA revoke its misinterpretation of the 1980 amendment.

I thank the Subcommittee for the opportunity to present my views.

Chairman BUNNING. Mr. Enoff, please proceed.

STATEMENT OF LOUIS D. ENOFF, PRINCIPAL, ENOFF ASSOCIATES, LTD., SYKESVILLE, MD., FORMER ACTING COMMISSIONER OF SOCIAL SECURITY

Mr. ENOFF. Thank you, Mr. Chairman and members of the subcommittee. I have been here many times before, but this is the first time that I have been here as a private citizen, and I appreciate this opportunity to be here. I commend you for holding these hearings on this subject that is very important, and it appears that there is some consensus forming about some of the needs for change.

Let me say that the current Social Security disability program is, I believe, basically a sound program. It is very valuable to the workers and families that contribute to the Social Security Trust Fund.

However, the program has substantial lingering administrative problems, and I believe these problems do threaten to undermine the public's confidence in the program.

These problems include long delays in the decisionmaking process at the hearing and appeals level, an inadequate number of continuing disability reviews being performed, and perhaps most importantly, the lack of a viable rehabilitation component.

Suggestions for improving the process over the years have included shortening steps in the appeals process, as my colleagues have said, the closed record in appeals, creating a disability court, and creating a new category of temporary disability.

Now, my experience of over 30 years in Social Security, in this area primarily, convinces me that there are two overriding principles which you should employ when making change to the SSA disability program. First, the various segments of the program, as displayed on the chart that Ms. Ross used, the various portions are not independent. They interact with each other, and making changes to one process can have a tremendous effect on another process. So you have to consider the effects of changes to every one of those pieces when making changes.

More importantly, I believe, any substantial changes to the disability process must—and I repeat, must—be accompanied by safeguards to protect the rights of applicants and beneficiaries.

Now, with these principles in mind, I believe that a package that includes eliminating the reconsideration step, including a predenial interview, replacing the ALJ hearing with a hearing by a State disability hearing officer, closing the record, examination of the appeals council review, creation of a disability court, a strengthened SSA review process, the introduction of a temporary disability category, an improved and increased CDR effort, and an improved and increased emphasis on rehabilitation at all levels of the process, would be a package that would go a long way toward solving the current problems that plague this program.

This package should be accompanied by the safeguard of an introduction of an ombudsman concept in the State DDS to protect the rights of beneficiaries and applicants.

None of these recommendations should be taken as condemnation or even criticism of the persons who are serving as claims rep-

resentatives, disability examiners, or ALJs in the current process. I believe the overwhelming majority of these persons are competent, caring individuals who are attempting to carry out their duties in a professional manner.

These proposals recognize the need to streamline a process which threatens the viability of a basically sound program.

Since the orange light has not even come on, I would add two points. One thing that has not been talked about a great deal this morning, but that concerns me greatly, is the increase in the need for representation, or the belief by citizens that they need a representative to get what they are paying for in their FICA taxes. I believe Ms. Ross said it is now 70 percent of persons who hire a person to represent them. They pay for that out of their own funds to get a benefit which they have been paying FICA taxes to be entitled to. That troubles me and concerns me. I do not have a specific solution, but I think this package would go a long way toward eliminating what people conceive as a need to have someone represent them with their government or against their government.

The second point that I would make—and I was reminded when Mr. Jacobs told his story that Senator Long lectured me many times about what the disability program was intended to do and not to do, and about people who visited him who did various and sundry activities that they perhaps were not supposed to be able to do. But he said that when the program was created—and I was not there, despite what some people might say, in the fifties—the projection then was that one-half of 1 percent of payroll would cover the program. It is more than that. When someone asks, well, how much should it cost, I give you an answer in my testimony; I think it should cost what it takes to pay a reasonable benefit to persons who become disabled and to care for their families. They have paid for that right. I think the benefits now are reasonable, not excessive. So I do not think that the benefits are out of sync, but the administrative costs could certainly use some attention.

I thank you again, and I would be happy to try to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF LOUIS D. ENOFF, PRINCIPAL
ENOFF ASSOCIATES LIMITED
SYKESVILLE, MD.

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be here and to testify before you today. Although I have testified before this subcommittee many times, this is my first opportunity to come before you as a private citizen rather than a representative of the Executive Branch. I appreciate your invitation and will be pleased to assist you in any way I can.

Someone has said that a society may be judged by the manner in which it treats the most vulnerable of its members. The Social Security Disability Program often deals with those members of our society who are most vulnerable. I want to make this point up front. While my testimony will focus on problems with this program, I want to state forthrightly and unequivocally that there is much about the Social Security Disability Program this is right and honorable. There are literally millions of men, women, and children in this country who testify to the value and fairness of this program, as well as the need for it. Workers who during a period of disability were able to have the dignity of counting on the disability insurance program to which they had contributed during their employment as well as families who were able to get by and maintain a decent standard of living while a breadwinner was incapacitated, testify to the need for and value of this program.

The need for the program is certain and the basic concepts and principles of the program are right. Using medical and vocational standards to determine a person's ability to work and periodically reexamining those who are not permanently disabled is right. I also believe the placement of the responsibility for administering the program with the Social Security Administration and the use of state agencies as partners is correct. There may be a need to adjust these responsibilities from time to time, and to encourage more participation by the private sector, but the basic design is correct. The basic program design and the federal state partnership should be maintained.

On the other hand, there are problems, big problems and lingering problems, but not insurmountable problems. The program is worth saving and should not be scrapped because of these problems. The major problems as they have been correctly identified in your statements announcing this hearing are: Long delays in processing, lack of an effective CDR process, failure of the rehabilitation portion of the program, and the escalating costs in both program and administrative costs.

Before I discuss some solutions to these problems, let me first state two principles about changes to the disability process which I learned in my 30 years with the SSA. This experience has been confirmed from my experience working with and studying disability programs in dozens of countries throughout the world.

First, you cannot change any one segment of the disability process without having an effect on the other segments. Like the proverbial marshmallow, if you push in one side, there will be an extension on some other side. The initial application process, the disability determination process, the appeals process, the rehabilitation process, and the CDR process are interactive. Any change to one of the processes should carefully consider the likely effects on the other processes.

Secondly, and more importantly, introduction of sudden or major changes in any of the processes should not be made without adequate safeguards. I lived through the dark days of the early 1980's and the lingering after effects of the changed CDR process. We should learn from these and other experiences, where sudden or massive changes to the process were tried without adequate safeguard. The results can be lasting and even permanent for some of those affected.

With these principles in mind, I would like to discuss some of the suggestions for improving the current process.

Long Delays In Processing I would add to the long-delayed decision process another very disturbing problem that should be addressed. The continuing growth in the number of claimants who feel they need to hire a representative to have their claims properly decided. While I certainly believe that every citizen should have the right to have a representative, and that the SSA should recognize and cooperate with that representative, it is disheartening to think that a citizen should need to hire a representative in order to receive what is properly due them. FICA contributions are make by workers to endure fair and proper treatment of claims, and the growing dependence on paid representatives is to me a symptom of the current elongated disjointed appeals process that should be considered along with the other noted problems.

Based on the latest statistics I have seen, the delays in processing are concentrated in the appeals and court levels. The state DDS and SSA field office processing times and accuracy rates are at very good levels despite unprecedented workloads. Long term efforts to strengthen the partnership between SSA field offices and the DDS seem to have paid off and there needs to be continued effort to provide incentive for a total quality process that is more user friendly.

There have been several suggestions for improving the appeals process while ensuring fair treatment of applicants and lessening the need for a hired representative. My colleagues on the panel have offered some positive approaches and I would like to offer comments on those and others under

consideration.

Elimination of the Reconsideration Step This seems like a relatively easy way to shorten a lengthy appeals process. However, this action by itself would be a mistake. If you look at the various steps in the appeals process and their affect you will note that the reconsideration process accounts for almost 10% of allowances while consuming a short portion of overall processing time and at a cost well below the ALJ hearing. The reconsideration process serves to complete the appeals process for about half of those who appeal the initial decision. As a process by itself it is more efficient and effective than any of the following steps.

While I would not recommend elimination of reconsideration as a stand alone improvement, I have previously referred to the interaction of the various steps. Considering the interactions, I believe that elimination of the reconsideration step could be effective if it is combined with the introduction of a pre-denial interview by a decision maker trained to elicit relevant information from the applicant and a revised hearing process. Currently no information is collected about persons who are denied at the initial stage but do not appeal that decision Over half of those denied at the initial application stage do not appeal that decision. Not until the ALJ hearing does the applicant receive a face-to-face meeting with a decision maker.

Two aspects of that process are especially troubling. First, those persons who are denied and never get to a hearing are not tracked by anyone. SSA has no funds to track these persons or to refer them to rehabilitation or other services. I believe we should be concerned about those persons and that the pre-denial interview would be a helpful step in determining what type of help is needed for those persons. I agree that many of these applicants were applying only because of requirements from their welfare office or private insurance company. However, I am concerned that many of these persons may not appeal because they lack the stamina or ability to pursue what they view as an overwhelming bureaucratic process. I hope that the introduction of a pre-denial interview will help to elicit information about these persons and help to refer them to rehabilitation or other forms of assistance.

The second disturbing point about statistics from the appeal process is the allowance rate at the ALJ level which is over 70%. You may note that I did not call it a reversal rate, but an allowance rate. I do not call it a reversal rate because the ALJ decision is not a new decision based on the same record. The long passage of time and the introduction of new evidence often means that the ALJ is considering a new claim. ALJ allowances are sometimes based on impairments that were not even alleged at the initial application. In order to deal with these problems I suggest a combination of two solutions: A disability hearing by a state disability hearing officer, and a closed record. While these proposals have been put forth separately in the past, they are related.

First, the disability hearing. I have come to believe that a disability hearing by a state disability hearing officer could be an effective replacement for that ALJ hearing if two conditions are met: (1) The introduction of some safeguard at least in the early stages; and (2) The introduction of a more effective review process by SSA to replace the Appeals Council and current quality reviews.

Before elaborating on the idea of replacing the ALJ hearing, I want to make one thing very clear for the record. My experience with persons at all levels of the disability process from initial application at the SSA field office, through the initial disability decision and reconsideration at the DDS, through the ALJ hearings process and the Appeals Council, convinces me that the vast majority of these persons are competent, considerate, intelligent persons trying to fairly and accurately do their jobs. The process and other pressures often hinder claims representatives (CRs) from taking the time they would like. Time and lack of personal face to face contact impede the disability examiner from sometime performing the job they would like. The convoluted process, the passage of time, and disparate court rulings all serve to frustrate the ALJs' work.

I have said in the past and will say again for the record, in my opinion over 90% of the ALJs, disability examiners, and claims representative are competent, caring civil servants trying to do their jobs correctly. My recommendation to make significant changes to these processes should in no way be taken as criticism of the individuals. We all know that there are exceptions, where incompetence or poor conduct or even fraud is uncovered. In these circumstances administrative processes should be used to correct abuses. Program changes should not be made to overcome poor performance.

As for the disability hearing, I believe that there is merit in placing responsibility for the initial decision through the hearing decision within one component of the organizations involved. That should give better control for consistency and timeliness but a safeguard for the applicant is needed. This safeguard is especially needed when we recognize the three hat role of the ALJ which would be eliminated. I would interject, at least for the first few years, the use of an ombudsman for each state agency that conducts disability hearings. This would be federally financed position with specific duties, but some discretion should be left to the state in how and where to locate these positions.

Ombudsman staff should be kept small in size but have considerable visibility and independence in order to hear and resolve complaints in an impartial manner. I recognize that this is a new concept, but I have given considerable thought to the possible fall-out from the replacement of the ALJ process and believe that this safeguard is essential. I believe that no state should have more that 10 or less than 1 ombudsman to perform this role. I would encourage a dialogue between SSA and the DDSs to arrive at viable arrangements and support for this concept.

The ombudsman should provide protection for the applicant. On the other hand, there needs to be some protection of equal treatment between the state hearings offices and for the disability trust fund. There is no political incentive for states to deny applicants for disability benefits since it is 100% federally funded, and in the past the DDSs have not been prone to act outside the regulations of the program. However, with this newly proposed process, it is advisable for SSA to "beef up" the review process to combine the goals of the current quality assurance (QA) and Appeals Council reviews.

In terms of the closed record, I believe that the elimination of various steps in the process should provide enough of a time saving to allow the record to be closed after the pre-denial interview. In that way, any appeals to the courts would be for the purpose of clarifying policy.

Legislation has repeatedly been introduced regarding a Social Security Court. Once again the Social Security court by itself could be problematic, but when combined with the previously discussed proposals, I believe that such a court could be very effective. The courts have exerted a great deal of pressure on the disability program over the past 20 years. Some of these pressures have been real and some imagined, some justified and some unjustified, some good and some bad in my opinion.

The current system that allows the 13 circuits to make differing decisions about this highly technical program needs improvement. While closing the record would reduce the number of claimants who file for appeal, I am concerned that some increased Judicial Branch workload could result. Perhaps if there is a method to recruit large number of the highly qualified ALJs as principals in this process, a smooth transition could be effected.

A court system that provides consistent decisions and faster resolution of legal question should help reduce time delays and pressures throughout the process. Careful consideration needs to be given to how the SSA will carry out its representation actions with this court.

Another proposal that has been offered in the past is the idea of temporary disability. I think the idea of temporary disability should be given further consideration. Turning to our current statistics we see that about 20% of allowances occur at the ALJ level and above. Fully 80% of allowances occur through the sate DDS processes and accuracy rates at these levels hover around 97%.

If you talk to disability examiners and others familiar with the process, you would find consensus that about 80% or more of the applications for disability could be rather easily determined to be allowance or denials. It is the remaining 20% where much less certainty lies. Let's assume that we can divide the 20% of allowances that are made at the ALJ level into five categories: (1)New Evidence, (2) Worsening of condition because of the passage of time, (3) Court ruled differing from adjudication guideline, (4) Affect of the personal appearance and/or representative, and (5) Difference of opinion about allowance or denial between the disability examiner and the ALJ. My previous recommendations should alleviate all but the last of these categories, (5) the difference of opinion between the examiner and the ALJ. I believe we are talking at most about between 5% and 10% of the allowances.

Many disability examiners have told me over the years that they could predict which denials would be overturned by the ALJ with 90% accuracy. I believe that this is true and for this small percentage of cases, I believe temporary disability should be explored. I would limit temporary disability to this small group initially because I believe the system is not prepared for the idea of temporary disability. In order to be prepared to handle temporary disability, massive changes in the CDR and the rehabilitation processes must occur.

The CDR process is currently not able to keep up with current mandated reviews and does not really do anything to assist the disabled beneficiary in returning to work. The CDR process must be strengthened not only with staff and technology but by linking it to rehabilitative services. Currently less than 1% of disability beneficiaries leave the disability rolls in order to return to work. This is despite the fact that surveys show that 30% to 60% of disabled persons would like to return to work.

I believe that there are several basic reasons for the dismal failure of rehabilitation in the past. The first reason is somewhat historic. The original disability program was designed as a disability retirement program. The eligibility age was set at 50 and the criteria was to be a disability expected to be long term or to end in death. Although the definition of disability has been changed a couple of times the concept was never changed to emphasize the goal of rehabilitation. A second reason for the lack of success has been the lack of commitment or coordination among the agencies responsible

for administering the programs necessary for achieving success; HHS (now SSA), Education, and Labor. Also, there has been a lack of incentives for states to take innovative approaches and to involve the private sector. Until we create an atmosphere where rehabilitation and return to work are expected, we will not succeed.

Today's process causes the applicant to jump through hoops to prove inability to work, and then discusses the possibility of returning to work. I believe that there should be a definite link between the CDR process and rehabilitation. National attention and commitment to this effort by all three agencies are necessary. While the cost of this effort seems high, the cost of not investing in rehabilitation is phenomenal in human as well as monetary terms. With the right attitude and commitment it can be done. There are proven techniques and the results not only improve a person's self-esteem and attitude but result in a positive economic return. The private sector needs to be more involved and the rehabilitation budget needs to be raised and better utilized. In some countries they handle employment of persons with disabilities by requiring that every employer employ one person with a disability for every 25 or 30 persons in their work force. I hope we would not go that route, but the results are better than our current process.

Finally, let me address the issue of the cost of the disability program. When asked how much the disability program should cost in program dollars, I am tempted to quote Abraham Lincoln. When Lincoln was asked how long a persons legs should be in proportion to the rest of their body, his answer was, "Long enough to reach the ground." The Social Security disability program should cost as much as is necessary to pay and adequate benefit to those persons who are truly unable to work and have contributed for a sufficient period of time to be insured. Today's benefits are adequate, not generous, and any effort to reduce costs should be invested in improving eligibility determinations and the CDR process as well as investing in more and better rehabilitation efforts. This means that the focus should be on the administrative side. However, I would suggest that the Subcommittee begin to look at the potential effect on the disability program of the present law increase in the retirement age that will begin in about five years and result in an eventual full retirement age of 67 years.

In the administrative area there appears to be some room for cost savings and the proposals discussed earlier should be helpful. Opening more of the disability processes to the private sector could provide some positive economic results. Private sector assistance could be particularly helpful in alleviating peak workloads. One again I would urge safeguards if there is to be any sudden shift of responsibilities. Perhaps some kind of oversight activity could be employed to ensure that citizens rights are being protected.

In summary then, I would say that a comprehensive, coordinated approach that includes keeping the basics, continuing to improve the initial process, eliminating the reconsideration, adding a pre-denial interview, replacing the ALJ hearing with a hearing by a state disability hearing officer, closing the record, eliminating the Appeals Council, creating a Social Security Court, strengthening the SSA review process, improving and increasing the CDR effort, and improving and emphasizing rehabilitation, would go a long way to correct the current problems in the disability program. This coordinated approach should include the safeguard of an ombudsman in the state disability process to ensure the claimants' rights at least during transition.

Thank you again for the opportunity to appear hear today. I would be happy to respond to any questions.

Chairman. BUNNING. Thank you, Lou, for your testimony.

Let me start with Mr. Fait. In your testimony, you stress the importance of strengthening the initial determination the first time we visit someone who has applied for disability.

Mr. FAIT. Right.

Chairman BUNNING. What are your views regarding the addition of a predenial interview, conducted by the State DDS disability examiners?

Mr. FAIT. I have been in favor of that. However, in terms of the cost, it is important that it only be used when it can be of benefit.

I also take issue a little bit with how it is presented. I do not like the idea of a predenial interview because it makes it sound like you are going to deny them, and we are calling you in to try to talk us out of it. That bothers me a little bit. I think it should be presented as that we cannot grant benefits based merely upon the documents, and therefore, we would like to interview you before we make the decision. I think that that would be a very good idea.

I also think that the initial examiner should have the flexibility to conduct the kind of investigation that might be necessary for the specific claim.

Chairman BUNNING. If we are going to shorten the process and if we have a predecision interview, couldn't that interviewer say to the applicant, You lack *x*, *y*, and *z* to get a court decision. In other words, you do not have all your ducks in order, and therefore, if you do not want to have a problem, you need to make sure that you get this paper, this document, this examination, or you are not going to get a correct decision.

There has got to be someone who lets the applicant know if we close the process, that they must have everything in order before a decision can be rendered.

Mr. FAIT. Well, I would like to say that I do not believe in closing the record at that stage. I do not think it would be legal to do so. I think the record can only be closed after the hearing.

Chairman BUNNING. That should be considered.

Mr. FAIT. Right. I think you could do one thing, though. People talk about closing the record in a couple of different contexts. One is the context of appealing from a court, where you have a transcript of the hearing and all of the evidence, and no new evidence is allowed.

What really causes a lot of problems in the current system is when we are not talking about new evidence; we are talking about new medical reports, which are brought in at the time of the ALJ hearing. The ALJ hopes to get prepared for that hearing by reviewing all the evidence so that he can ask intelligent questions and then get some new report dropped on him when they come in.

I think any system we set up prior to that hearing or perhaps as part of this interview, you could say that by so much time before the hearing, you have to get all of your medical reports in, so that we are able to review them prior to the hearing and prepare for it.

Chairman BUNNING. We cannot succeed in speeding up the process if the ALJs are going to reverse 70 percent of the DDS decisions.

Mr. FAIT. Correct.

Chairman BUNNING. It is never going to work.

Mr. FAIT. Right.

Chairman BUNNING. We are never going to relieve the backlog.

Mr. FAIT. I agree.

Chairman BUNNING. OK. Lou, with at least 30 years of experience with SSA, you have done a lot of thinking about this and the problems with the disability program. Would you explain a little more what leads you to believe in the approach that you have in your testimony?

Mr. ENOFF. I think rehabilitation has never gotten the attention it needed or the money it needed in the process, so that is a linchpin to it. The other pieces kind of come together when you look at all of the proposals and you ask, What is not working here. As I said, I think all of the people involved are trying to do their jobs well, but the process kind of makes it impossible.

We tried many pilots during my days in Social Security, and as someone has said, it takes 5 to 10 years to get results. I think that if you look at this, it has been a problem, the difference of opinion—we say 70 percent are reversed. They are not really reversed, because a lot of it is new evidence—I think Ms. Ross said 25 percent—so it is a new case. Time has passed. The person's ailment may have gotten worse. So you must shorten that process.

So I come to the conclusion that shortening the process means taking out some steps, but then putting in some guarantees so the person does not lose his or her rights. Also, I would hope——

Chairman BUNNING. If we shorten the process, we will get those who need disability on the rolls.

Mr. ENOFF. Sooner, yes.

Chairman BUNNING. That is the whole idea. What is happening now is we have people dying before they ever get to the rolls, and I think that that is completely unjustified.

Mr. ENOFF. I agree.

Chairman BUNNING. We must make sure they get a fair, equitable due process hearing so that they can become eligible for what they have already paid for. It is not an adversarial relationship with the hearing officers. It should not be. It was never intended to be. Now, if you play the system, you know you have a good chance of having a denial reversed. If you appeal at every level, you have a heck of a lot better chance of getting on the rolls than you did when you started through the process. That is bad, really bad.

Let me ask you—and you do not have to answer this if you do not want to——

Mr. ENOFF. I do not have anybody looking over my shoulder now, Mr. Bunning. I would be glad to answer you. [Laughter.]

Chairman BUNNING. You used to answer even though you did. Is the disability program currently in the worst shape that you have ever seen it?

Mr. ENOFF. Well, I think certainly the appeals process part of it in terms of the lengthening of the process and the backing up piece is. The backlog of CDRs on a percentage basis is probably——

Chairman BUNNING. It is 1.7 million.

Mr. ENOFF. On a percentage basis, in 1980, when the legislation passed, it was probably that bad.

Chairman BUNNING. Percentagewise?

Mr. ENOFF. Percentagewise, I think, of cases.

Chairman BUNNING. That says we have done nothing to improve it.

Mr. ENOFF. Well, I will say that that is true; we have not improved. Part of the reason is that in all honesty, when we looked at the available funds, when I was there, the decision was to put the money on processing the initial claims for people who were trying to get on the rolls, given that choice. You may disagree with that choice, but that was the only fair choice.

Chairman BUNNING. Now that process has bogged down also.

Mr. ENOFF. It is at the appeals level. The initial seems to be doing well, from the data I have seen.

Chairman BUNNING. But the process to get them onto the rolls has bogged down. Whether you say it is at step one, two, three, or four, it is still bogged down.

Mr. ENOFF. Yes. I would like to make one other point if I could, and we have not talked about this at all this morning, and that is those people who do not appeal. I worry some about those people who do not appeal, because I believe that even though people who work in the area will tell you that a lot of people who apply initially apply because their insurance company or the welfare office says they have to apply, and that is probably true for a percentage. But there are other people who, because of mental impairments or just a lack of stamina to jump into the process——

Chairman BUNNING. Go through the system.

Mr. ENOFF. Yes, because it is an awesome process to the average person, do not appeal. Over one-half of the people who are denied at the initial stage do not appeal.

Chairman BUNNING. Do you realize that each of the Members of Congress sitting here has about 100 SSI or SSA cases, whether it be disability or whether it be benefits, monthly? Multiply that by 435. I believe that is the No. 1 issue in each congressional office—at least it is in mine—we deal with about 100 cases of SSA, whether it is initial claim, whether it is going through the process, or whether it is just getting information on how many dollars will be available when I become 65 or 68. One hundred out of two hundred cases are SSA related.

So we have got to do something about this situation because one-half of the administrative cost of SSA is being spent on it. So we are going to do something, and we are open to suggestions. We hope that if you have some, you will bring them forward. SSA may not like what we do, but we have to do it anyway.

Mr. ENOFF. Well, I would certainly be pleased to do anything I can to help the process, and I understand what you are saying. I did get involved in some cases during the years that I was there, and I will tell you that I still have claimants who call me, and I try to assist them, because it is an overwhelming process, and we do have to make it simpler to the extent we can.

I realize that it is not as easy as it looks, because I have been there, but I think these ideas ought to be looked at.

Chairman BUNNING. Would you agree that the two main problems in disability are shortening the time for the initial claims to get on, and also shortening the time that those who are eligible to leave the rolls leave, if they are no longer disabled?

Mr. ENOFF. Those are two main problems. I guess I would say the underlying problem—someone touched on it earlier—is that the process is geared to getting on disability and not getting back to work. I think that is the underlying problem, and it takes a real change of philosophy, and it will probably take some time, but you are going in the right direction.

Chairman BUNNING. Mr. Jacobs.

Mr. JACOBS. Let me see, Lou, you are the last witness of the day, so I suppose it might be said that when we get to you, we have "Enoff." [Laughter.]

I thought that over before I said it, and I thought I had the will power to resist it, but I guess I did not.

Mo Udall once told Hubert Humphrey, when Hubert Humphrey made his only speech, I guess the only one in history a Senator has made to the U.S. House—he reminded him before he spoke that in order for a speech to be immortal, it need not be eternal. That is the problem that I think we all agree about in this sort of Rube Goldberg process that has evolved since the fifties.

I will say parenthetically that I believe this panel, in terms of ABC logic and crisp expression of it, is about the best I have ever heard since I came on the Ways and Means Committee.

Lou, what about temporary disability—are you talking about the Scandinavian idea, or are you talking about limited benefits? That term is a little ambiguous to me.

Mr. ENOFF. It is not spelled out clearly in the testimony. What I said about time-limited benefits is that I believe the process is not ready to go to large-scale time-limited benefits because people do not get reviewed and they do not get the rehabilitation and vocational help they need. If we truly put people into a vocational pattern where they expect short-term benefits, and the process is ready, that might be different.

But what I said I thought was worth looking at further was that small percentage—although it looks large, the 70-percent allowance by the ALJs amounts to 20 percent or less of the people who are on the rolls. It is still a large number, and I do not want to minimize it, but it is about 20 percent of the people who get on the rolls. Within that 20 percent group, the reason that the ALJ allowance varies is for several reasons. We talked about new evidence in some cases, or worsening of the person's condition. I think there is only a true disagreement between the ALJ and the disability examiner in the State, I am going to say in 5 to 10 percent of the cases. In those—someone referred to subjectivity—if it is really a close call and you cannot agree, temporary disability might be the place to start. You can say let us put that person on for 3 years, and let us give him rehabilitation, and let us presume he is going to be able to come off the rolls.

Mr. JACOBS. Well, I assume you would agree that we want to avoid what President Bush would call the "deep doo-doo" we got into in the early eighties when the excommunication was rather ar-

bitrary and plenary, and where there were suicides reported, as I recall.

Mr. ENOFF. Yes. I certainly would want to avoid that and would build in safeguards in any way I could to avoid that.

Mr. JACOBS. Yes. I am in fact disabled. I have a 10-percent combat infantry disability from the VA—and I have a pretty good job—if you do not mind being slandered every 2 years, it is really not so bad, and working until 3 o'clock in the morning stimulates the imagination somewhat. [Laughter.]

Well, that is enough of that.

Fred—and Mr. Chairman, with your indulgence—and believe me, it is going to require a lot of it—I cannot help remembering that Jimmy Burke and Jake Pickle had a bone of contention, did they not, on Jimmy Burke's one-third/one-third/one-third plan. Jimmy Burke wanted the employer to pay one-third, the employee to pay one-third, and the general Treasury of the United States to pay the other one-third. Jake Pickle found that hard to gargle, and every time Jimmy brought it up, Jake gave it one of those faces, which some people may remember, and I heard it for years when I served on this subcommittee, and they successively chaired it, and it finally brought out the poet in me, and I think the record needs to be refreshed on that, Mr. Chairman.

"A man named Burke could amaze, when speaking of tax and who pays; a Caesar from Boston, he showed Jake from Austin the gall to divide it three ways." [Laughter.]

Sir, I just wish I could have had 10 percent and taken those two guys on the road for entertainment. [Laughter.]

Chairman BUNNING. Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Fait, I wanted to ask you how do you separate the subjective from the objective at the initial determination. You pretty much said let us get rid of reconsideration of ALJ, appeals court, district court, and I agree with you, for the most part. The problem we have in the initial determination, in my opinion, is that the people making the initial determination, even though you said they are doing a pretty good job at that level, there are subjective feelings. People are people, and the emotion and the compassion of the individual often comes out rather than the objective.

How can we help the initial determination be less subjective and move to more of an objective standard so that they treat the taxpayers' money like their own money, and that we do not pay out so much in that initial determination?

Mr. FAIT. That is a problem that I do not have an easy answer for, needless to say, especially when you consider that a huge percentage of the increase in applicants has been in the field of psychological problems. Let me tell you, there is nothing more subjective or difficult than the conflicting psychological reports that you often see in cases like this.

Actually, you are talking about two elements of subjectivity. One is the subjectivity of the initial claims examiner. I think there is a lot less of that than there is in other places, because right now, they do not see the person and they do not talk to the person. They have a file of written documents, and they review that, and they use what they consider to be a more objective standard. Bringing

in the people for interviews will allow a little bit more exposure to the symptoms and the statement of symptoms and whether those symptoms are believable. How you evaluate that is very difficult, as Mr. Jacobs pointed out beautifully. I just had a disability decision for the county that I submitted last week before I flew to Washington, and in that case I had exactly what Mr. Jacobs was talking about—a very convincing claimant until the videotape ran and showed her moving couches into the house and doing a variety of other things. That is the problem you run into. It is a matter of do you believe the person or don't you, and how do you determine that.

I teach a course for the hearing officers I train for about one-half of 1 day, trying to give them things that they can do to help them determine that. Science is now attempting to develop AFC scientific tests which will better evaluate the credibility of people when they come in and tell their doctors, because what happens is the doctors in their reports are saying this person cannot work, based on the fact that the claimant told them he cannot work—the same thing that we get when we are in a hearing. It is a very, very difficult thing.

On the other hand, if we made it purely objective, we know that some disabilities cannot really be shown with objective tests or x rays or whatever, and therefore there is some need to make these decisions.

I do not have an easy answer. I am sorry.

Mr. CHRISTENSEN. I think Mr. Enoff really put his finger on the problem when he said that the process of getting on Social Security is where most of people's time is spent, rather than figuring out how to get back into the job. I will tell you, you could not see the crowd in back of you, but a lot of heads were nodding yes, that is the problem.

But what do you think the public reaction will be to the proposals you have outlined this morning?

Mr. ENOFF. Well, it depends—I suppose some of the interest groups, if they take a narrow view, would oppose it because it jumps on some of the areas that are sacred to them. But I think if you look at it as a whole and hopefully study it and spell it out more carefully than I have in this short period of time, that the end result would be not only savings to the trust fund, but the human savings of people being able to enjoy full participation in work and being taxpayers rather than being on the disability rolls.

The long-term result I believe would be more people working and fewer people on disability, but they would have been served, hopefully, by the process.

Mr. CHRISTENSEN. Well, I want to thank you for your testimony, and I would echo the comments of my colleague from Indianapolis. You have been very candid and very straightforward, and I really appreciate that.

I would just say that I have been really disappointed with the current Social Security Commissioner. I just do not see any leadership there at all, and it is unfortunate that there was not someone here from her office—or maybe there was.

Chairman BUNNING. There is someone here—two people.

Mr. CHRISTENSEN. Good to have the opportunity to hear this testimony today.

Thank you, Mr. Chairman, for holding this hearing.

Chairman BUNNING. Mr. English.

Mr. ENGLISH. No questions, Mr. Chairman.

Chairman BUNNING. Mr. Christensen, there are some members of the staff of the Social Security Administration present, and I would suspect they were taking notes and that the Commissioner will hear from them.

I would like to thank this panel very much for their excellent testimony. It has been a pleasure seeing you all.

We are adjourned.

[Whereupon, at 11:48 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

Date: May 18, 1995

To: Phillip D. Moseley
Chief of Staff, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

COMMENTS ON PROPOSED RULEMAKING TO TITLE 20 CODE OF FEDERAL REGULATIONS (CFR) PARTS 404 AND 416

The undersigned Administrative Law Judges of the Sacramento, California, Office of Hearings and Appeals (OHA) submit the following comments on the Social Security Administration's (SSA) proposal to amend 20 CFR Parts 404 and 416 by adding new sections 404.942 and 416.1442. Unfortunately, after reviewing these new sections and SSA's stated policy for these (temporary) regulatory changes, we cannot endorse these proposals because we believe that they are legally and substantively defective and could not withstand a challenge in Federal Court. Moreover, the plain facts are that these regulatory changes are ill-conceived and offer no realistic solution towards meeting SSA's stated objective of reducing the backlog at OHA. To the contrary, we believe based upon our considerable experience in the field office, that, if implemented, the proposed regulatory changes will simply add yet another, needless bureaucratic layer to the adjudicatory process; an undesirable consequence, which is in direct opposition to SSA's Reengineering Policy. Because of the short comment period, we have not reviewed all of the legal ramifications posed by the proposed regulatory changes; however, we think the following points are significant.

1. The new sections violate the Administrative Procedure Act (APA) by creating two separate classes of claimants

after they have filed a request for hearing before an ALJ. The new rules propose to treat all claimants at this level, even though they are similarly situated, in a disparate fashion by creating an artificial class of claimants, i.e., Profile III, and then allowing them to have their cases further reviewed by SSA attorneys who will have a monetary incentive to assist the Profile III claimants toward ultimately receiving a favorable decision. By contrast, claimants not selected as Profile III candidates as well as those Profile III claimants who were unable even with the assistance of SSA attorneys to receive a favorable decision, will face ALJs at the de novo hearing level after being, in effect, denied three times. Needless to say, this result and the procedures set out in the proposed rules clearly violate fundamental notions of due process and equal protection by treating claimants similarly situated in an unequal manner. Further, under the APA an ALJ's jurisdiction attaches once a claimant files a request for hearing. Therefore, after filing a request for hearing under the APA, the claimant is legally entitled to a de novo hearing before an ALJ.

2. With these proposed rules, SSA is illegally attempting to substitute its judgement for the statutory authority vested in the Office of Personnel Management (OPM). Under 5 USC 3105 only OPM can appoint ALJs to hold the type of evidentiary proceedings required by the Social Security Act.

3. Absent any evidence that its cadre of GS-12, 905, Attorney Advisors have any experience in adjudicating appeals, SSA's proposed regulations assume that its attorneys have the requisite experience when all the evidence is to the contrary. Further, our experience in

this office has conclusively shown that when selected Attorney Advisors were assigned profile cases where all the claimants were 55 and over--and asked to review these files to determine if an on the record decision could be made--an overwhelming majority of our attorneys complained that the process was too difficult and time consuming and were unable to do both the OTR screening and their normal duties.

4. Temporarily promoting GS-12, Attorney Advisors to GS-13, for the sole purpose of adjudicating cases to reduce the backlog will invariably encourage those individuals to "pay" or "reverse" as many reconsideration decisions as possible since the SSA's corps of attorneys will have a vested interest in making the temporary proposals work and become permanent in order to maintain their temporary promotions. During a period when claims are being filed in record numbers, and where there is heightened public scrutiny of government operations, SSA should not be in the business of appointing, even temporarily, quasi-adjudicators who have a financial stake in the venture.

Due to the dubious and impracticable nature of the proposed rules over 30 states have flatly refused to accept or recognize revised reconsideration decisions drafted by SSA attorneys. We believe that this places SSA clearly on notice, and provides the most probative evidence, that the proposed rules will be ineffective in either the short or long term toward reducing OHA's backlog.

In summary, the proposed rules are presumptively illegal, violative of due process and equal protection and will serve as an inducement to squander federal resources. For the foregoing reasons, we suggest that any amendment of the rules to envision a greater role for OHA attorneys must be conducted, if at all, under the exclusive supervision of a duly appointed ALJ. No cases should be directly

assigned to an SSA attorney. It is common knowledge that SSA managers do not have an adequate performance plan in place sufficient to address attorney job performance issues that currently exist. For SSA to grant blanket authority and increased responsibility to its attorneys, given the vacuum that currently exists, would be painfully imprudent from a labor/management relations standpoint. By any measure, the ALJ corps has shown that productivity can be significantly improved by simply working within the system.

Antonio Acevedo-Torres
Administrative Law Judge

John M. Bodley
Administrative Law Judge

Arthur S. Cahn
Hearing Office Chief
Administrative Law Judge

Joseph F. DePietro
Administrative Law Judge

Cheri L. Filion
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F. Lamont Liggett
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August 15, 1995

Honorable Jim Bunning, Chairman
U.S. House of Representatives
Ways and Means Subcommittee
On Social Security
B-316 Rayburn HOB
Washington, DC 20515

Mr. Chairman, Members of the Committee, thank you for the opportunity to offer this statement on behalf of Allsup Inc., Work Recovery, Inc. and the National Rehabilitation Network--the three participants in the SSA demonstration proposal entitled Project Administration, Assessment and Reemployment (PAAR).

I will confine my comments to the written testimony submitted by the American Federation of Government Employees (AFGE) in conjunction with the August 3, 1995 hearing; specifically that section entitled "the Allsup Proposal" (PAAR).

The AFGE testimony regarding PAAR can be responded to quickly and simply. The Social Security Administration does not have the resources, private sector coordination expertise, rehabilitation performance or employee incentives to solve its current problems by itself. If it did, the current dilemma would not exist. Program administration and its 40 year isolation must be reformed. The AFGE testimony introduces no such reform--the PAAR proposal's reforms are evident. SSA disability administrative services can be efficiently and effectively provided by private third-parties -- evidenced by the existence of Allsup Inc. and the rapidly growing industry we created in 1984.

Regarding the unwarranted attack on Allsup Inc. and its financial and systems credibility, the allegations are totally without merit. We will be more than happy to share with SSA details of our financial condition and systems/claim processing capabilities.

I thank the Chairman and the Committee for the opportunity to comment.

Sincerely,

Jim Allsup

James F. Allsup
President and
Chief Executive Officer

JFA:pah

STATEMENT OF JOHN GAGE, PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

PROGRESS OF DISABILITY REENGINEERING

One of SSA's largest partnership efforts, SSA's Disability Process Redesign consists of management and employee representatives from virtually every SSA component involved in the disability process. AFGE has participated in this effort by asking our members to serve on redesign core and task teams. I believe that the success of this redesign can be attributed to the work of the agencies employees on these teams. They bring working expertise from every part of the process.

AFGE union officials have worked with SSA's top management, through partnership meetings, to craft strategies which we believe will help implement the redesign beginning this fiscal year. Partnership is a new challenge for us and we accept it enthusiastically. We don't always agree with management on everything--but by working in partnership--we believe that the transition to the new process can be a lot smoother.

In announcing the redesign effort in September 1994, Commissioner Chater stated that she was "absolutely committed" to turning the following redesign needs into realities:

- enabling information technology,
- ensuring the safety of employees,
- continuously delivering effective training,
- retaining the existing Federal/State relationship, and
- developing a simpler methodology for making disability decisions.

The Commissioner also stated that **"...all will take time and money..."** but that **"...all will need to be addressed if we are to achieve the successful outcome of the redesign."** The implementation team is charged with taking the 50,000 foot view envisioned in the redesign plan down to ground zero. This requires resources for **staffing, training and technology.**

To date, thirteen task team products have been completed to date. They include:

- **EARLY ADJUDICATION** which would allow claims representatives to make disability decisions on certain impairments.

  We support expanding the list of impairments even further to support adjudication in field offices.

- **DISABILITY CLAIM MANAGER** who would be the primary contact point for people filing for disability benefits. The DCM would make all initial disability decisions for the agency.

- **ADJUDICATION OFFICER** who would be the contact point for people who were denied disability benefits and who wish to appeal the decision. The AO will prepare the case for appeal, meet with the person and his attorney to explain the process, and will be able to make fully favorable allowances in certain cases.

  We believe that positions arising from the redesign should be filled by employees currently possessing the necessary

experience, but that where necessary, training should be available to allow employees to move into these positions.

We have some concern that the issue of **EMPLOYEE SAFETY** is not being adequately addressed.

We support the original redesign recommendation that the testing and pilots for these new processes should include a wide variety of scenarios so that the process can be broadly evaluated.

- **THIRD PARTY CLAIMSTAKING** would expand the use of these parties in obtaining medical evidence.

  While we understand the value of having these parties in the development of medical evidence we caution that more experience is needed about the use of them.

  We believe that shifting claimstaking to employers, third parties and other agencies will not result in World Class Service. Our employees have reported that the quality of the work done by third parties is significantly lower than that done by SSA employees who are trained professionals. These non-SSA entities have interests which are not necessarily related to the SSA goal of processing work fairly, accurately and expeditiously. Because other agencies don't have sufficient resources, or a stake in SSA work, our claims will be viewed by them as a last priority and quality can be anticipated to be poor.

  Our employees have also reported problems with regard to confidentiality and privacy of SSA records associated with third party claimstaking. And we are concerned that allowing systems access to these parties has the potential for fraud, abuse and/or misuse.

  Until there is a process which ensures both the integrity of the claims being taken and a system for tracking these cases, we believe that further expansion should be curtailed. For those third parties currently being used we suggest that SSA limit third party involvement to collecting medical evidence and assisting claimants only when the field office determines this is necessary.

- **QUALITY ASSURANCE** which will provide a means for evaluating the processes and positions created by the redesign.

  A quality assurance process should measure the entire process and not be geared to "finding errors" or used in individual performance appraisals. We support a centralized inline and end-of-line review for all operational components (including the hearings and appeals level).

- **PROCESS UNIFICATION** which will determine the short and long term statutory, regulatory,

and methodology changes that will be needed to implement the redesign.

We support the passage of HR 1587 which was introduced by Andy Jacobs on May 9, 1995, to establish a Social Security Court. Passage of this bill would help unify the current process by eliminating the variation in decision-making that results from each circuit's interpretation and application of social security law.

Finally, we believe that the evaluation of the redesign should include an assessment of the administrative and program costs to the program. Implementing the Early Decision List process will lower administrative costs because it will provide for earlier decision-making. Program costs can be decreased if we begin to process CDR's the way Congress intended. By making these changes, resource savings can be used to support redesign efforts such as this one. The following information concerns the state of SSA's workloads and resulting costs to the program.

A key reason that SSA is unable to provide adequate public service regarding Disability claims and postentitlement work is due to inadequate resources available to process these workloads. Staff has been cut in excess of 20% Agency wide.

OMB is requiring SSA to reduce 4700 FTE's by FY'99. This is SSA's share of government wide 272,000 FTE cut. This artificial ceiling does not reflect growth in SSA programs.

Staffing cuts have directly resulted in Disability backlogs since insufficient staff to handle the exploding workload.

In FY'96 disability claims are expected to total 2.7 million. This is 56% more than in FY'90.

Hearing requests are projected to total 609,000 in FY'96. This is double the hearing filed in FY'90.

SSA has projected a need for 29,000 more WY's by 2000 to process projected workloads. This does not even take account increased resources for the 800# and processing CDR's at the appropriate level required by Congress.

Initiatives that SSA has undertaken such as short term disability initiatives and redeployment are short term stop gap measures. These may assist in reducing backlogs. However, personnel shifting will adversely affect other SSA workloads.

Other SSA long-term plans (IWS/LAN, reengineering) may offer relief but despite SSA projections, the level of WY savings is unknown. Also, these initiatives won't be fully implemented until the end of the century. SSA has consistently overestimated WY savings from previous automation efforts. SSA should not be trusted today to arrive at accurate projections for WY savings.

One area where SSA has been deficient is in the workload of continuing Disability Reviews (CDR's):

- FY'94 SSA completed 86,000 Medical CDR's,
- FY'95 SSA projects completion of 194,000 work CDR's,
- In FY'80 Congress mandated 500,000 medical CDR's per year,

- SSA has never come close to completing this level of congressional mandated CDR's,
- SSA's entire projected workload of medical CDR's is through mailers,
- Mailers are a flawed process which will not result in the total purging of beneficiaries who are medical recovered,
- For ever $1.00 of trust expenditure on CDR's, SSA receives 46.00 return,
- Cost for a CDR per GAO is $1000 per case,
- Per GAO (GAO/T-HRD 93-9, 3/9/93) SSA's failure to do required CDR's for FY'90 to FY'93 will result in trust fund loss of $1.4 billion by end of 1997,
- Title XVI (SSI) is even worse. SSA projects doing only 10,000 medical Title XVI CDR's in FY'95,
- SSA's failure to do CDR's has resulted in significant trust fund loss, public criticism, and harmed the integrity of the disability program.

Congressional mandates such as Drug Addiction and Alcoholism Provisions (DA&A) have caused even more workload impact. SSA projects that this program will require 490 WY in FY'96.

- SSA cannot be asked to consistently take on more work and more programs when staffing is cut.
- Overtime is not the answer. Workforce morale is low and overtime by overworked, overstressed workers has diminishing returns.

SOLUTIONS

1. Immediately pass off-budget legislation which will remove the administrative funds from the normal budget process.
2. Exempt SSA from the government-wide effort to reduce staff ceilings.
3. Provide sufficient budgetary funds so that SSA can reduce its Disability backlogs, process ongoing workloads and do CDR's at levels mandated by Congress.
4. Need minimum of FTE increase of 4000 in FY'96 to accomplish above.
5. Justification (especially for CDR's) is that if administrative expenses are properly budgeted, SSA will recoup more money than is spent. This FTE increase would, therefore, be cost effective.
6. Review future efforts in reengineering and automation. If these result in a reduction in staff needs, cuts should be made at that time.
7. When Congress/President add workloads to SSA (i.e. 800#, PEBES, DA&A) adequate staff should be provided to do the job.

STATEMENT OF STEVE KOFAHL, SOCIAL SECURITY ADMINISTRATION ON BEHALF OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES (AFL-CIO)

Mr. Chairman, Members of the Committee, thank you for the opportunity to offer this statement on behalf of the American Federation of Government Employees, AFL-CIO.

BACKGROUND

The Social Security Administration has been increasingly unable to properly fulfill its public service mission and stewardship responsibilities over the past 10 years. These problems have been well-documented in testimony by AFGE and others concerned about SSA. The Agency cut its workforce by 17,000 positions in the late 1980's, and made unrealistic forecasts that future systems improvements would make up for it. Automation could not make up for the losses, and the situation has worsened as disability workloads and other responsibilities have grown much faster than predicted. We are now faced with the prospect of another round of cuts, and more promises about the efficiencies to be realized from automation. The crisis has been exacerbated by a lack of strong, stable, responsible leadership and by the continued politicization of the Agency and its programs. Things would be far worse if not for the efforts of the dedicated, experienced employees who remain.

We wonder when SSA will start acting like an independent agency by asking Congress and the Administration for what is so desperately needed, authority to hire and train more direct public service workers. Social Security is too important to the public to be further crippled by the meat axe approach to cutting the Federal workforce. By refusing to invest in hiring and training, SSA is being "penny-wise" and "pound-foolish".

Disabled individuals wait far too long for medical decisions. On the other hand, we are entitling people who should not receive benefits, and keeping others on the rolls after they have recovered. We save "pennies" in administrative costs by keeping staffing too low, and waste "pounds" by net payout of excess benefits.

Quality and integrity reviews, already inadequate, are being further reduced. Investigation and prosecution of fraud and abuse gets little attention and almost no resources. This depletes the Disability Trust Fund for Title II, and the General Fund for Title XVI, and causes further loss of public confidence in these programs and in Government at large.

PRIVATIZATION IS NOT THE ANSWER

Unwilling to champion the clear need for substantial increases in staff, SSA leadership has turned to others who wish to do the Agency's work, and intends to expand this collaboration. SSA claims that 6%-7% of disability claims are currently taken by "third parties".

State and local government agencies, non-profit organizations, and for-profit businesses are involved. Most operate with little or no oversight from SSA, and their employees/volunteers typically have little or no training. None are as qualified as SSA's own employees, and they do not receive similar ongoing training and access to instructions needed to properly take applications for our complex and constantly-changing programs. All are motivated to get their clients transferred from other income support and/or medical insurance programs to Social Security and/or SSI benefit rolls and Medicare and/or Medicaid.

For-profit businesses are paid well if they generate awards, little or nothing for taking claims which end up as denials. For instance, one of them receives $700 for an award and nothing for a disallowance, another a $125 filing fee only if the claim is denied but $1500 if allowed! These natural conflicts of interest distinguishes them from Federal employees whose duty it is to ensure that only eligible individuals become entitled, and then only to the amount in benefits due them under the Social Security Act.

It is also a conflict of interest for authorized representatives to "assist" SSA in taking initial claims, then represent the claimant against the Agency for a fee at a later hearing.

We know that allowing non-Federal employees to become involved in critical claims-related functions which are inherently governmental in nature can harm program administration, applicants, and taxpayers. The Agency has refused to code these "third party" claims for quality and integrity review purposes, to review the claims, or to conduct any cost-benefit analysis, despite the recommendations we have been making as this activity increased over the last 5 years.

Fortunately, we do know about the independent evaluation of the SSI Outreach Demonstration Program by Sociometrics Corporation, the expanding investigation of interpreter fraud in the SSI program, systems security risks identified by computer experts, Privacy Act issues, and the experiences of our own employees. On the basis of our knowledge and experience, we can evaluate the Allsup Inc. proposal and the Statement of Representative Tom Davis presented on May 24 to the Committee.

THE SSI OUTREACH DEMONSTRATION PROGRAM

Since 1990, Congress has appropriated at least $27 million in grants for the SSI Outreach Demonstration Program. Additional costs have been borne by local SSA field offices who train grantee personnel, correct obvious mistakes on forms received from them, and process the referrals or claims. SSA pays up to 95% of the administrative costs of agencies which are awarded contracts. Grantees once only screened and referred potential applicants; but have become increasingly involved in taking, developing, and documenting both SSI and Social Security Disability Insurance benefit applications. Non-profit, for-profit, and state or local government agencies are eligible to apply for grants under the latest version of the Program.

The Sociometrics Corporation's August 1994 Report revealed that after the first 4 years only 4,544 applicants had been awarded benefits through this Program! AFGE assures the Committee that SSA workers are far more productive, and is convinced that private sector efficiency would be worse yet due to the need to make a profit and the absence of any unpaid volunteer claim-takers. High turnover of grantee volunteers and employees, poor management, and underestimation of the difficulty of the work, were cited as problems in a number of the 31 projects which were evaluated. Large numbers of applicants were incorrectly "screened-in" as eligible by the grantees, causing a lot of unnecessary processing work for SSA's employees. Most alarming was the discovery that some applicants were incorrectly "screened-out" as ineligible, but later applied with SSA anyway and were determined to be eligible.

SSI INTERPRETER FRAUD

SSI fraud perpetrated by applicants, "middleman" interpreters (including state and non-profit agency employees), and physicians is currently being investigated by SSA employees serving on national and regional multi-component taskforces. Middlemen complete the medical questionnaire part of the disability claim, arrange for the manufacture of medical and non-medical allegations and evidence, charge fees to applicants illegally, and accompany them to Social Security offices and medical exams. Applicants do not know that SSA will provide service directly without charging a fee, and many who are in fact disabled and eligible are taken advantage of by these third parties. Hundreds of individuals have been implicated in the Tacoma and Vancouver areas in Washington state alone, and millions of dollars paid out erroneously. The problem in Seattle appears to be bigger, but has not yet been fully investigated. Significant activity has been uncovered in Texas and California, and probably is occurring in many other states.

This scandal was the subject of a hearing of the House Ways & Means Committee Subcommittees on Oversight and Human Resources in February 1994. Commissioner Chater announced that one of SSA's administrative initiatives would be to establish a database identifying available, reliable interpreters and translators for our employees to use. We are still waiting for the interpreter database, and we do not even have national directories of SSA employee interpreters and translators for our interviewers to use.

We have learned the following, and must not forget these lessons when considering other initiatives to privatize or collaborate with other organizations:

1. Given the opportunity, some people will steal from the most vulnerable individuals as well as the taxpayers at large.

2. SSA loses control of the claims process when others are involved in completing applications, recording information and documentation, and gathering evidence.

3. We cannot afford not to review cases. It took years for this scandal to be exposed. If we were doing timely continuing disability reviews and SSI Redeterminations in person, and comprehensive quality and integrity reviews, millions of taxpayer dollars would have been saved. Staff and resources, and a strong commitment from Management, is needed.

RISKS TO SYSTEMS SECURITY AND PRIVACY

SSA had planned to allow electronic filing by 3 Outreach Demonstration Project grantees beginning in April, and to other third party claim-takers as part of Disability Redesign beginning in August. These plans were put on hold due to concerns raised by AFGE and by a March 18 article in the Baltimore Sun. H&R Block, Allsup Inc., and other private sector entities have been lobbying for electronic access to file disability claims. SSA's REGO II initiatives call for electronic filing of retirement claims by businesses on behalf of their employees.

Computer experts insist that no "fire wall" can be built which would exclude skilled hackers from SSA's vast databases if electronic filing of applications by third parties is allowed.
Numerous intrusions into supposedly secure systems have been documented in the media. There must be no tolerance for any initiative which compromises systems security and the privacy of individual Americans in any way.

Funds could be stolen electronically by setting up phony claim records in SSA systems, money diverted from existing records to "representative payees" and through direct deposit to bank accounts, data could be changed on existing records to change payments, and earnings records could be altered.

In violation of the Privacy Act, the Agency currently permits volunteers and non-SSA employees in SSA field offices to have direct access to many kinds of records. It has also given some state employees direct access to Social Security Number records and other electronic systems of records, and expects to open these private files to other states. These non-Federal employees are not subject to the Privacy Act, and could not be sanctioned for violating it. SSA intends to allow the public direct access to its earnings files next year via kiosks and the INTERNET. Long-range plans would allow everyone direct access to databases to file claims, and to change addresses and other information.

Agency leaders have shown irresponsible disregard for their duty to protect the privacy and financial security of Americans. Congress and the public must insist that records be secured and not compromised by SSA's reliance on third parties, or on individual self service, where there is any possibility that an individual could access records on others.

It was reported that former Commissioner Dorcas Hardy lost her job in 1989, in part, because of an arrangement by which SSA verified Social Security Numbers for a credit agency. It seems that Agency leaders still do not take seriously their responsibilities to protect the extensive private information held in our files on virtually every American.

SSA EMPLOYEE EXPERIENCE WITH THIRD PARTY CLAIMS "ASSISTANCE"

The Agency has not been interested in determining how many people have lost benefits, been paid incorrect amounts, or received money not due, as a result of third party involvement. Claims are taken by people who have little or no training, and natural conflicts of interest. They are then submitted to our employees to be processed. Quality and integrity are traded off for the expediency of having someone else take applications, which is supposed to offer relief to our decimated workforce. In reality it often delays the process for the applicant, and creates more work for SSA employees.

Third parties frequently take weeks to get applications for benefits to SSA for processing, which delays initiation of development and the decision. The delay can cost the individual benefits if a filing date is not property protected by the third party. Few of them know enough about Social Security child, spouse, and survivor benefits to identify potential entitlement; again causing potential loss of benefits.

Claims Representatives must load paper applications from third parties into automated systems, but normally take claims directly on the system themselves. Paper claim questions and format are different than those for automated claims, so do not translate perfectly. SSA employees must make another contact or guess at the answers, which is either inefficient or puts quality at risk.

Recontact with applicants is often necessary to complete the claim file and resolve obvious errors and inconsistencies. Our Claims Representatives recognize when supplemental forms are needed and have them available, and the need to ask necessary follow-up questions not on the forms. Cleaning up third party errors and omissions becomes especially difficult and delays case processing when we are required to deal with a third party serving as authorized representative. We are then required to go through them rather than deal direct with the claimant. An SSA employee may have to call Kansas to request information about an individual who lives in the employee's own small community in Washington state, for instance. This causes more delays.

Third party authorized representatives demand that SSA employees photocopy files for them, send copies of notices and computer screens, etc. This creates additional work for Claims Representatives, since we have virtually no clerical support in field offices, and takes us away from claims processing work.

A Social Security employee typically has no direct contact with the claimant, which raises concerns about identity and possible fraud. We are concerned that widespread program integrity problems similar to those being identified in the interpreter fraud investigations are occurring in other kinds of third party situations. It also means that claimants are not receiving proper and complete reporting instructions, and our employees increasingly report that this is causing more overpayments which cannot be recovered. Allegations of "without fault" by beneficiaries who were not advised of their responsibilities to report changes lead to decisions to waive overpayments rather than collect them.

Some specific problems reported to us regarding actions particular for-profit third parties involved in the claims process include:

1. intentionally failing to list all income on applications.

2. altering applications by changing answers without the applicant initialling the change.

3. persuading claimants to waive the right to an oral hearing, to save administrative (travel) costs for the authorized representative.

4. withholding medical evidence in early stages so that claims go through the entire appeals process before being allowed, thus increasing the fee that SSA authorizes as a percentage of back pay to the claimant representative.

5. overcharging claimants by assessing fees both within and outside the fee petition process.

6. selective medical documentation to ensure allowance of claims, because a contract claim-taker is paid by an insurance company only if allowed.

7. claimant representatives tape-recording initial claim interviews with SSA employees and creating a hostile, adversarial relationship between the claimant and SSA.

8. abuses in preparing, and charging fees for development of, Plan for Achieving Self Support (PASS) plans.

THE ALLSUP PROPOSAL

Allsup Inc., with Work Recovery Inc. and the National Rehabilitation Network, submitted a proposal to SSA on May 24 for a Demonstration Project. The proposal was incorporated into testimony before the House Ways & Means Committee, Social Security Subcommittee on that same date.

The National Council of Social Security Management Associations, Inc. responded to the proposal in a June 30 letter to Congressman Bunning. AFGE strongly agrees with the position of NCSSMA, so we will not cover the same ground in this statement. Please give every consideration to the views which that organization expressed. They are thoughtful, accurate, and consistent with our experience. We ask that you also give careful consideration to the additional information which we present here, based on contacts with SSA employees and others knowledgeable about Allsup, Inc.

Allsup Inc. properly identifies 1985 as the beginning of the disability crisis. Not coincidentally, that year also marked the beginning of the Agency's 5-year 17,000 staffing reduction. Most positions lost were direct service positions, and this is the principle cause of the crisis. Restoring direct service positions is the only solution that would significantly improve service while protecting taxpayers. SSA knows it, Congress knows, and we must do the right thing for these important programs.

The proposal calls for authorized representatives to intercept individuals before they get to SSA, screen, then only take claims when appropriate and legitimate. The SSI Outreach Demonstration Program does that, and screens-out potentially eligible people. We do not need more of that.

The demonstration would "utilize specially trained authorized claimant representatives well versed in all major benefit plans...SSA claims representatives employed by SSA do not receive such training." This is just one of several demeaning, false statements about SSA workers. Virtually anyone can be an "authorized claimant representative", and SSA does not have any procedures for qualification or certification. Who will train them regarding Social Security program benefits? Our Claims Representatives receive 12-13 weeks of intensive classroom training, typically followed by a year working with an experienced journeyman. Changes in policies, procedures, laws, and regulations are communicated to them immediately as they occur. The private sector can provide no initial and ongoing training that in any way compares. It has been many years since Jim

Allsup was a Social Security employee, and the same is true for the few former SSA employees who work in his business. He has forgotten that SSA Claims Representatives are trained in all major benefit plans, including many he does not cite. It is an integral part of the job to compute worker's compensation offset and to make referrals for other benefits, including rehabilitation services.

The proposal for early intervention in providing rehabilitation services is presented as something with which SSA has no experience. In fact, SSA recently concluded the operational phase of a demonstration project to test four models. Project Network used a Case Manager Model, a Contractor Model, an Outstationing Model, and a Referral Manager Model. While Allsup's experience is with the best rehabilitation candidates, this project offered services to new applicants and current beneficiaries without prejudice regarding their prospects for successful rehabilitation, and largely represents the other end of the spectrum. It is being subjected to rigorous independent evaluation, and I am sure that Committee interest could expedite that process. That is a far better option than starting all over with a demonstration project which, even if a success, cannot be replicated in the real world.

The continuing disability review plan adds lots of bureaucracy, additional costs, and unnecessary extra steps. The current system is simple and worked well before 1985, when there were enough SSA and DDS employees to conduct reviews. There is no need to abandon a good process when the only problem is lack of resources (people). The Chairman has every right to be angry about SSA not spending dedicated CDR money on CDRs. Congress could order SSA to stop wasting money and manpower reprofiling cases already diaried and categorized, and spend it on doing real reviews rather than on sending out questionnaires and doing paper reviews. Why don't we just concentrate on working the medical improvement expected (MIE) cases first? How many of the CDRs SSA claims to have done were really cases that were just screened, then counted as CDR completions?

Turning third parties into SSA–paid fraud and abuse bounty hunters is a truly bizarre idea, fraught with all kinds of legal questions. It ought to be discarded on practical grounds, as authorized representatives who take claims do not, based on our experience, always provide proper reporting instructions. They therefore create, rather than prevent, overpayments. This would even inject a perverse incentive for representatives not to fully explain responsibilities to applicants. It is the beneficiary's responsibility to report; but we do take reports from family members, friends, neighbors, and organizations. We act on them at no charge to the taxpayer because it is our job and we take it seriously. Congress and the public ought to be very suspicious of anyone who wishes to provide a government service of this kind on a commission basis.

One of their former employees tells us that Allsup Inc. is in dire financial straits and, in order to cut costs, has had to let a number of key people go this year who have been important to their operations. We also understand that they have just one experienced "systems person" and one new one, and have almost no employees left with SSA technical experience. What is the financial arrangement between Allsup and other parties to this unsolicited proposal? Before the Committee promotes the proposal further, it may be prudent to determine precisely what their current capabilities are, and what they would gain financially from adoption and Federal funding of the proposal. They may not have the financial or technical capacity to do what they claim they can do.

THE STATEMENT BY REPRESENTATIVE TOM DAVIS

The Statement presented by Representative Davis at the earlier hearing proposes contracting–out of initial applications, continuing disability reviews, and other work. It is imperative that the Committee examine the inherent risks, and that the public be fully informed and have some say about this plan. Some of the most serious problems AFGE sees are noted below.

Services would be "transparent" to the customer, because private contractors would be "agents of the government subject to all the standards of service required of SSA's employees".
Does this mean the public would be deceived; thinking they are dealing with trained, experienced, SSA employees when they are not? We have discussed the level of training needed for Claims Representatives to do this difficult and demanding work, and problems with existing third parties. It is inconceivable that contract employees will meet SSA standards. The public should not accept substandard service.

Budget savings and new revenues would be targeted into the program, and the Trust Funds would realize net savings. The idea of targeting SSA personnel to invest in CDRs makes sense, yielding a $4 return for every $1 invested, according to GAO. The Agency only needs authority to hire, and a mandate from Congress to dedicate personnel to this task. Private sector start-up costs, training, and the need to generate profits; plus SSA's contract administration expenses, would greatly reduce Trust Fund savings.

Contractors would do eligibility screening. As noted in connection with the SSI Outreach Demonstration Program, and in our concerns about the Allsup proposal, we do not believe Congress should be part of any plan which would again discourage eligible individuals from filing claims and/or flood SSA with unproductive claims. Only SSA employees know enough to properly screen.

Contractors would have "secure" connections with SSA data centers, and safeguards would be established to assure privacy and confidentiality of information and records. As noted earlier, computer experts warn us that any intrusion risks the security of systems because no firewall is fool-proof. Furthermore, Americans should not allow their personal records to be accessed in violation of the Privacy Act.

Since the contractor(s) who Congressman Davis may have in mind is not named, and specifics of the proposal not detailed, we would appreciate another opportunity to comment when more is known about his proposal and others before the Congress.

THE MYTH OF THE SIMPLE CLAIM

Many people inside an outside of the Social Security Administration who do not themselves take, adjudicate, or review claims operate under false impression that certain kinds of claims are "simple". Retirement applications are often characterized this way. The implication is that these can be taken, developed, and documented properly by interviewers who have little training and experience. In reality there is no way to tell if any claim, no mater what kind it is or appears to be, will be "simple". Few turn out to be.

Social Security benefit applications are legal documents, and until each on is adjudicated, it is an application for all benefits which may be payable. Only careful interviewing by a fully-qualified SSA employee will ensure that entitlement to each type of benefit that exists is considered. A qualified interviewer must be knowledgeable about dozens of little-known benefits addition to the better-known retirement, disability, spouse, and survivor benefits. For example, entitlement may be available to a divorced individual on the record of living or deceased worker. We pay totalization benefits under a growing number of international agreements which credit workers for their coverage under social security systems of other countries.

Benefits can be lost when potential entitlement is not recognized and a claim not taken during what appears to be an early contact, because we cannot ordinarily pay benefits for months before the month of filing. Benefits based on age can begin before age 62, as early as age 60 or even 50 for certain benefits. Full-time employees, even those with high earnings who intend to stop or interrupt work later in a year, may need to file while still employed in order to receive correct payments.

In order to entitle people to the proper check, our interviewers must know which benefits from other sources result in an offset, which types of payments from employers or from self-employment require withholding of benefits, and be trained to identify and correct earnings record posting problem. Earnings record problems create significant risk of payment error, particularly because of the need to credit military service and due to especially significant earnings posting problem for years before 1951 and after 1977.

CONCLUSION

Americans pay more and get less when the most sensitive, critical, complex responsibilities of the Social Security Administration are turned over to others.

Their charitable contributions must increase to support non-profit organizations who take, document, and develop benefit applications. Their state and local taxes fund such activities by state and local government employees. Their fees to authorized representatives cost them up to $4,000 in retroactive benefits which they would otherwise receive. They pay more for goods,services, and insurance premiums when businesses' insurance companies pass along the cost of hiring private sector claim-takers to do SSA work. Federal taxes are increased to pay for demonstration projects and contracts which are far more expensive than increasing the number of SSA employee service providers.

Handling by third parties can add delays at various stages of the claim process, increase SSA administrative costs, and result in loss of benefits to individuals.

Fraud by "middlemen" has already cost all of us many millions of dollars in Washington state alone. This no doubt represents just the tip of the iceberg. SSA must finally take responsibility for evaluating and monitoring quality, integrity, and cost of third-party claims.

We have seen plenty of evidence in other agencies of the terrible risks involved when we rely too much on the private sector: those spendy Defense Department hammers were from a contractor, the U.S. mail was dumped in Chicago by contractors, the Space Shuttle "O" ring was from a contractor, and the $5 billion/year in fraudulent earned income tax credit refunds were obtained primarily through electronic filings via H&R Block and others in the private sector. We cannot afford a similar disaster at SSA. We are at a crossroads, and absent responsible Agency leadership it is incumbent on Congress to lead us down the good government path.

There must be no tolerance for compromising systems security and privacy. Current violations must be dealt with immediately, and future initiatives planned very carefully to ensure that laws are adhered to, and individual rights protected.

I thank the Chairman and the Committee for considering this testimony, and welcome any requests for more information and documentation.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFFILIATED WITH THE AFL-CIO
SSA GENERAL COMMITTEE

May 22, 1995

TO: Mr. Phillip D. Moseley, Chief of Staff
Committeee on Ways and Means

FROM: Earl Tucker, President
AFGE Council 224

Subject: SSA's QUALITY ASSURANCE WORKERS SAVE TAXPAYERS BILLIONS

Through internal reviews, controls, and audits in SSA, we as workers save the taxpayers billions of dollars on the program side. It's a shame that some of the savings are never transferred to the administrative side for continuous improvement in these programs that save big bucks. In many of these money-saving areas there is very little staff to process these workloads, if they are processed at all. In spite of our staffing, we will continue to help SSA deliver world class service to the public and its internal customers. These activities are performed by the quality assurance component of SSA which consists of three branches.

Disability Quality Branch

The quality assurance function for Disability Insurance (DI Program) is carried out by the Disability Quality Branches ("DQB") of the Office of Program and Integrity Reviews (OPIR). We save the taxpayer almost $10 for every $1 it costs us to review a title II disability case in the Preeffectuation Review (PER) sample. There is no similar review for title XVI disability cases. PER cases are actually reviewed by DBQ before payments can be effectuated. At the present time we are only reviewing approximately 50% of the Title II cases, but we have saved more than $2 billion in unnecessary trust fund expenditures since 1980. If this effort were continued and more cases were reviewed, including title XVI, we would save the taxpayers even more money.

We should also be saving dollars by doing more continuing disability reviews (CDR). These are follow-up reviews that should be done after a claimant has received disability benefits for a certain period of time to see if they are still disabled and unable to work. SSA is currently doing relatively few of these reviews.

We report our findings when great quantities of dollars have been misspent and mistakes have been made in the programs. We have been called the "inspector general" for independently determining and reporting the health of the SSA programs (SSI, DI and RSI). Our component acts as the "cop" because OPIR (Field) is independent of any regional authority and reports directly to Baltimore. With this autonomy, we are allowed to accurately report wastes of money or major problems in the programs.

There is a move afoot to place us under the Regional Commissioners in the field. If this happens, It will change our ability to accurately report our findings, especially if they are embarrassing to the Regional Commissioners. In addition, we perform many reviews and studies unbeknownst to the SSA Regional Commissioners. These too will stop if we are placed under the 10 Regional Commissioners. We are opposed to the "fox guarding the hen house". We are opposed to any reorganization that would put us under the Regional Commissioners. We should continue to report accurately and independently the health of all of SSA programs including a full-scale implementation of the PER and CDR reviews that will save taxpayers' dollars.

The Regional Offices of Program and Integrity Reviews (ROPIR) are crucial to SSA efforts to save money by maintaining and increasing quality. They are a set of offices with over 20 years of experience in recording and reporting statistically-valid data on a timely basis to interested parties both inside and outside SSA. In the process, they have maintained good relations with a variety of other offices: field offices, regional offices,headquarters, disability determination services, etc. They have a long history of participation in onsite reviews of other offices in order to help improve their operations. They have shown flexibility in adapting to new types of studies (such as IDA in the late '80's), new court cases (such as Zebley in the early '90's), and new types of workloads (such as screening OHA backlogs now). In short, if the ROPIRs did not exist, they would have to be invented.

Insurance Program Quality Branch

The quality assurance function for the Retirement and Survivor's Insurance Program ("RSI Program") is carried out by the Insurance Program Quality Branches ("IPQB") of the Office of Program and Integrity Reviews ("OPIR").

This function is conducted by means of the Index of Dollar Accuracy ("IDA") study of recently adjudicated initial claims, the IDA study of recently processed post entitlement transactions and special studies designed to assess areas of potential vulnerability.

The two IDA studies analyze cases that meet the criteria for: perspective of payment accuracy, adherence to correct procedures and the relationship thereof. In addition, IPQB's contact beneficiaries to determine customer satisfaction with the RSI programs.

As part of the regular post-entitlement IDA study, a group of cases that did not credit lag wages to beneficiaries' account were identified. This category of cases resulted in underpayments totaling $144,000,000.00. IPQB staff members not only identified the underpayments, but devised a means of processing these automatically. Prior to this innovation, processing such cases was expensive, labor-intensive, and time-consuming.

The following are examples of special studies conducted in the IPQB, the result of which were either financial savings or improved service to the public:

- At the request of GAO, the IPQB conducted a study of the Social Security Administration's representative payee program. Recommendations stemming from the data gathered in this study resulted in changes in policy and procedure.

- The IPQB conduct ongoing monitoring of the 1-800 number service in order to assess the quality of service to the public in terms of courtesy and the accuracy of information given to callers. In addition, IPQB make follow-up calls to the public to gauge customer satisfaction.

- The IPQB has monitored the quality of phone service to the public in District Offices.

- The IPQB has been involved in testing the quality of phone service to non-English speaking members of the public.

The efforts of the IPQB result in annual dollar savings to the taxpayers as well as ensuring that the public is satisfied with our service.

Assistance Program Quality Branch

The quality assurance function for the Supplemental Security Income Program ("SSI Program") is carried out by the Assistance Program Quality Branches ("APQB") of the Office of Program and Integrity Reviews ("OPIR").

This function is conducted by means of the Index of Dollar Accuracy ("IDA") study of recently adjudicated initial claims, the IDA study of recently processed post entitlement transactions and special studies designed to assess areas of potential vulnerability or concern.

The two IDA reviews analyze cases that meet the criteria for inclusion from the perspective of payment accuracy, adherence to correct procedures and the relationship thereof. In addition, APQB contacts beneficiaries to determine customer satisfaction with our the SSI program.

As part of the regular post-entitlement IDA study, we are now doing field assistance initiatives (FAI). The FAIs are to find out where the problems are in fielf offices ask what we can do to eliminate them. Referrals and handoff problems were causing claimants up to 16 days delay before any actions would be taken on their case. We developed a gating program in which one person completes most actions immediately without referral or handoffs. This "one stop shopping" program will save taxpayers time and money by routing inquiries immediately to the subject matter expert for action.

APQB trained Program Service Center employees to do title T2 offset computations. The manual offset computations are time consuming and labor intensive. Now that the PSCs are performing these difficult computations, the district offices will have more time available to services to the public in other areas.

In the IRS wage reporting study, the SSI monthly wage reports come directly to APQB for processing. This too will allow the district offices to do other work now that we are processing most of this workload.

APQB helped with the DYNACOMM/Testing. DYNACOMM is a specially tailored script that allows data to be downloaded directly onto the computer screen without employees having to re-key information into the system. This system was used recently to process over 87,000 one time payments (OTP) in a court order class action case-the Jones case, Ninth Circuit. This system will save SSA considerable time and money. Other Dynacomm scripts have been created to obtain batchers of queries for FO's (rather than prior manual querying) save inputs to memory (so that rejected actions don't need to be completely retyped), to automatically transfer data from computations screens to input screens (saving typing time and preventing human error). This is by no means an inclusive list. The efforts of the APQB result in annual savings to the taxpayers as well as ensuring that the public is satisfied with our service.

In recent years, OPIR's overall goal has changed from what can we find wrong in every SSA program to how can we improve the process in all programs and save money for the taxpayers. I believe we have done an outstanding job in improving processes and saving money to date. We are continuing to conduct studies with these goals in mind and to find other locations or employees to process backlogged work. Some findings have been to eliminate some processing steps and/or eliminate manual processing. Some other examples are title II offset processing, monthly wage reporting, interface diary resolution, continuing disability reviews based on earnings, and manual notice processing. Future iniatives include analysis of recipient self-supporting of charge and automated wage follow-ups. There studies are being conducted to try to provide more timely payments updates to prevent beneficiary mispayments, without causing more strain on over worked SSA employees.

In conclusion, OPIR (field) consist of SSA workers who perform quality review functions in three quality assurance branches: Disability Insurance, Retirement and Survivors Insurance and Supplemental Security Income. In addition to end-of-line quality reviews, Pre-effectuation reviews should be done by OPIR employees in all SSA programs especiality title XVI disability similar to what we currently do with title II disability cases. Of course this would require changes in Social Security Laws. These workers are skilled technicians with the necessary autonomy to perform accurate diagnosis and cure for many problems in all the programs in SSA. As a result, taxpayer dollars are saved annually by these dedicated workers through suggestions to streamline and reorganize field processing. At the same time, we are helping SSA provide the public with world class service. Therefore, OPIR (field) should retain its functions and report its findings independently of any regional authority.

If you have any questions do not hesitate to contact me. I can be contacted at: P. O. Box 1954, Chicago, Illinois 60690. My telephone number is 312/886-6574 or by fax at 312/353-8830.

Statement

for the Hearing Record

of the

American Medical Association

to the

Subcommittee on Social Security
Committee on Ways and Means

U.S. House of Representatives

RE: Social Security Disability Insurance Program

May 23, 1995

The American Medical Association (AMA) is pleased to submit this statement for the hearing record of the May 23, 1995, hearing on the Social Security Disability Insurance Program of the U.S. House of Representative Ways and Means Committee's Subcommittee on Social Security.

The AMA, like many other individuals and organizations in this country, is extremely concerned about the current operation and administration of the Social Security Disability Insurance Program. We are cognizant of the fact that during the ten years spanning from 1984 to 1994, while the U.S. population grew by 11 percent, the number of individuals on Social Security Disability increased 40 percent, to over 5.5 million. We are aware that over $42 billion in disability benefits will be paid this year. In addition, we know that of the four million disabled workers in this country currently receiving benefits, roughly half are long overdue for a continuing disability review, and this backlog is growing by 500,000 a year. We are cognizant of all these facts, and we strongly commend Subcommittee Chairman Bunning for holding this hearing.

While many issues are necessarily involved in the efficient and proper administration of the Social Security Disability Program -- such as the backlog of initial claims and claims for reconsideration, the backlog of continuing disability reviews, the high rate of reversals of decisions by administrative law judges upon review, the proposal for a unified Federal Court of Appeals to adjudicate all cases arising out of Social Security Administration claims -- the AMA's main focus of concern as the nation's preeminent physician professional association is the proposed reduction of the role of the medical consultant in Social Security disability cases.

The Social Security Administration's proposed disability program redesign would eliminate the current statutory requirement for an M.D. cosignature and review in signing off on claims in Social Security disability cases. It also proposes to have a single decision-maker responsible for both medical assessment and direct payment authorization in disability cases. The AMA believes that eliminating or reducing the role of the medical consultant will severely undermine the integrity of the program.

The process involved in making the initial medical determination of a claimant applying for Social Security disability benefits entails reviewing available medical records, determining if there exists sufficient evidence upon which to make a determination, making a diagnosis, and then determining the functional capacity of the claimant. The medical consultant is an integral and essential part of the process. Under the proposed disability program redesign, a non-physician known as a "disability claims manager" would serve to make this determination, and a physician would be involved only when deemed necessary by such disability claims manager.

The Social Security Act requires that those individuals entitled to receive disability benefits must have an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrated by medically acceptable clinical and laboratory techniques. Medical consultants are uniquely qualified by their medical education, training and experience to ensure that these medical evidential requirements of the law are met. Currently, every claimant applying for Social Security disability payments receives the benefit of participation of a medical consultant in his or her disability determination. The AMA believes that the medical wisdom and expertise of the medical consultant is a critical element in the operation of the process, and we strongly suggest that maintaining such medical consultant's role, without diminishing it in any respect, would be the most appropriate and cost-effective course of action to take, safeguarding the process from potential fraud and leading to the "right decision the first time" as often as possible.

The AMA thanks you for the opportunity to have our comments considered and included in the hearing record. Again, we commend the Subcommittee for holding the hearing.

STATEMENT OF RUSS NEWMAN, PH.D., J.D.
EXECUTIVE DIRECTOR FOR PROFESSIONAL PRACTICE
AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA) is pleased to have this opportunity to provide testimony to the House Ways and Means Subcommittee on Social Security concerning the management of the Social Security disability programs. APA is the professional organization representing over 134,000 members and affiliates engaged in the practice, research, and teaching of psychology.

On April 28, 1994, APA submitted testimony to the Committee regarding the Social Security Administration's (SSA) Reengineering Proposal. In our testimony today, we would like to elaborate on one theme that was raised at that time. It concerns the critical need for accuracy and efficiency in the disability decision-making process. We are concerned that SSA's contemplation of an expanded role for the disability claims manager, coupled with a minimized role for psychological and medical consultants, will seriously compromise the quality of the disability determination process, to the detriment of claimants and the public alike.

Although a final decision has not been rendered, SSA is actively considering an expanded role for the disability claims manager, the individual who, pursuant to SSA's ReDesign Initiative, will make the initial decision regarding disability. Currently, initial determinations of disability involve a team approach; a joint decision is rendered by a State agency medical or psychological consultant and a State agency disability examiner.[1] The expanded role of the disability claims manager that is currently being contemplated includes the possibility that this individual will be solely responsible for making the initial decision of disability, with the discretion to solicit technical support from medical and psychological consultants for expert advice and opinion if deemed necessary. This constitutes a significant departure from current practice. It is also inconsistent with current law and would require a statutory amendment to the Social Security Act.[2]

We believe that the disability claims manager should never have the discretion to independently decide a claim for disability benefits, and we have encouraged SSA to retain the current system in this regard. Determinations of disability are frequently quite complex, especially in cases alleging mental impairment. Moreover, the SSA disability programs are medically based, reflecting disability criteria that involve medical impairments. Determinations of disability typically require the evaluation and resolution of highly technical and conflicting medical evidence. We believe that the professional expertise of appropriate in-house medical and psychological consultants is critical if accuracy in the disability determination process is to be maintained and enhanced. Despite assurances from SSA that the disability claims manager will be "highly trained", no level of in-house training can possibly compare to the education and expertise possessed by professionally educated medical and psychological consultants.[3]

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[1] 20 C.F.R. Sections 404.1615(c)(1), 416.1015(c)(1).

[2] In making Title XVI disability determinations in cases where there is evidence which indicates the existence of a mental impairment, and in making such determinations with respect to the disability of a child under 18, the Act mandates that "reasonable efforts" be made to ensure that such cases are evaluated by medical or psychological consultants. Sections 1614(a)(3)(G) and (H), 221(h).

[3] Medical consultants must be physicians. Psychological consultants, whose expertise is utilized in cases where there is evidence of a mental impairment, must be licensed or certified as psychologists at the independent practice level of psychology by the State in which they practice. 20 C.F.R. Sections 404.1616, 416.1017.

We are concerned that SSA's possible endorsement of an expanded role for the disability claims manager would detract significantly from the efficacy of the disability determination process.[4] We also believe that in-house medical and psychological consultants represent an irreplaceable source of objective, unbiased professional expertise that should be utilized in the review of all but the most clearcut of cases.[5] Any attempt to dilute the role of these valuable professionals will seriously compromise the accuracy as well as the efficiency of the disability determination process.[6]

In his opening statement before the Social Security Subcommittee hearing on August 3, 1995, Subcommittee Chairman Jim Bunning emphasized that one of his main objectives is to ensure that people who are truly disabled receive benefits quickly and easily. If the expanded role of the disability claims manager currently being contemplated by SSA is ultimately adopted, we believe that serious errors will be made during the decision-making process as a direct result of the absence of professional input and analysis of claims by medical and psychological consultants. We are concerned that truly disabled claimants may be denied benefits, while others who are not disabled may be erroneously added to the disability rolls. In light of the many problems which currently plague the system, this is clearly not the time to decrease professional involvement in the decision-making process.

We are pleased to have had the opportunity to submit this testimony to the House Ways and Means Subcommittee on Social Security. We are hopeful that the Subcommittee will take an active role in encouraging SSA to incorporate our recommendations in its redesign initiative.

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[4] We are also concerned that SSA's future decision regarding the proper role for the disability claims manager may entail an expanded role during the Continuing Disability Review. The first step in the Continuing Disability Review involves determining whether or not "medical improvement" has occurred. We believe that it is equally critical that a medical or psychological consultant be part of the review team during this process.

[5] Cases involving insufficient medical evidence constitute clearcut denials that can be handled independently by a disability claims manager without input and/or oversight by a medical or psychological consultant. However, other cases that may at first appear to be "clearcut" allowances or disallowances are quite frequently determined to be far from clearcut upon further review by a medical or psychological consultant. For this reason, we favor continuation of the team approach to disability determinations.

[6] Experience at many state DDS' has shown that the team approach to the disability determination process can be extremely efficient, and does not impede the timely resolution of claims. Indeed, there are currently many state DDS agencies that are not burdened by a backlog of cases.

STATEMENT OF FRANK ARIA

Quality Assurance Specialist, New Jersey DDS

Mr. Chairman and Members of the Subcommittee:

The following items represent serious threats to the fundamental integrity and solvency of the disability program.

Ineffective Medical Improvement Review Standard (MIRS)

Virtually every state agency CDR examiner has conducted reviews where the beneficiary has not "improved" but is not currently disabled either. Under the MIRS, such individuals must almost always be kept on the rolls, even though they do not now meet the program's primary definition of being "disabled." In other words, they must continue to be issued disability checks even though they can work.

Why not research this point further? A study could be conducted to determine what percentage of continuances in "medical improvement expected" and "medical improvement possible" CDRs would currently be denied were they to be processed as initial level claims.

Even a small percentage of continuance awards made to those now able to work would represent a substantial future loss to the trust fund. Such a finding would argue in favor of displacing "medical improvement" by returning to the former "current severity" standard.

Flawed Redesign of the Disability Claims Process

To many of those experienced in claims adjudication, key elements of the Redesigned Process are poorly conceived, extremely impractical, and patently unworkable. Two of its critical provisions are particularly relevant to the discussion of program integrity and solvency.

The proposal envisions "early, ongoing dialogue" with nearly all claimants. But past personal interview studies, demonstration projects, and pilots conducted over 30 years have shown that face-to-face disability interviews are unusually difficult to control, are often adversarial, and, above all, are extremely subjective. Just now, the last thing the adjudicative process would seem to need would be more subjectivity.

A second critical flaw in the Redesigned Process is the shift from hard medical evidence to reliance on far more speculative "functional assessment certifications" supplied to claimants by their own treating sources. Decades of experience in documenting disability cases have shown that such statements standing alone would play havoc with decisional reliability.

In a nutshell, the Process Redesign is a costly blueprint for speedily placing even greater percentages of applicants on the disability rolls without reasonable assurances that they are actually unable to work. (And MIRS would keep them there.)

Questionable Quality Assurance Practices

Two key documents serve to illuminate the critical political and procedural issues which color the overall disability quality assurance process.

On February 19, 1987, the Auditor General of the State of California presented a report on "Investigation I-5008," which,

among other things, accurately described the political climate affecting accuracy data in the disability program.

Briefly stated, a competitive environment exists among the ten federal regions, as well as the 50 states, creating pressure to inflate accuracy ratings to obtain a better rank compared to your federal or state rivals. As performance rates and comparative ranks are published each month, officials from those federal or state jurisdictions landing on the bottom are embarrassed and concerned lest they lose resources and/or opportunities for personal advancement. In such an atmosphere, placing ethical considerations aside, there is every incentive to conceal improper practices that exaggerate accuracy rates.

A second report, "Social Security Disability: SSA Quality Assurance Improvements Can Produce More Accurate Payments" (U.S. General Accounting Office, June 1994), details the weak, neglected, and lenient procedures employed by SSA over the last 14 years to compile and assess the quality assurance accuracy rates. The conclusion is drawn that SSA has knowingly failed to evaluate the effectiveness of QA procedures, including the application of subjective procedural rules, leaving reason to believe that some deficient cases are not returned for correction, thereby inflating accuracy rates for the states and federal regions involved.

The GAO report notes that no state had failed the regulatory six-month 90.6% performance accuracy test since 1988. New Jersey ended that streak immediately after the report was released.

The national accuracy data published 4/12/95 shows final (i.e., recalculated) results for the six-month period ending December 1994. New Jersey registered 88.3% and 87.3% for consecutive calendar quarters, the first state to fail to meet federal accuracy requirements (90.6%) in six years. During the next quarter in this sequence, March 1995, New Jersey cleared the 90.6% mark, scoring 91.7%, ahead of Florida (89.5%) and Kentucky (91.2%).

New Jersey's March 1995 uptick represents the successful manipulation of the federal quality assurance review, particularly for the month of January 1995. The state agency internal QA review was temporarily altered to influence the federal figures, while federal QA physicians were substituted for state agency doctors in the adjudication process to a degree sufficient to skew the quarterly performance results.

Throughout 1995, program administrators from both SSA's New York Regional Office and the state Department of Labor have had the same agenda regarding New Jersey's accuracy crisis: lift the state, and, by extension, the New York federal region, out of last place in the nation by any means necessary. The two investigative reports cited above, while predating these recent events in New Jersey, go a long way toward explaining what was done there, why it was done, and how.

Unless and until a centralized federal QA review (with an independent monitoring mechanism) becomes a reality, competitive "regionalized" FQA statistics will serve to mask accuracy problems rather than expose them.

North Arlington, NJ
May 29, 1995

ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, INC.

Henery Reuss Federal Plaza, Suite 880
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August 2, 1995

Honorable Jim Bunning
Chairman, Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
Rayburn House Office Building, Rm B-316
Washington, D.C. 20515

RE: H.R. 1587

Dear Chairman Bunning:

I am writing this letter on behalf of the Association of Administrative Law Judges, Inc. in support of H.R. 1587. This legislation grants exclusive jurisdiction to a United States Court of Appeals for the Social Security Circuit over specified interlocutory orders or decrees and over appeals from final decisions of a U.S. district court.

The Association supports this legislation because it creates a uniform legal process for adjudicating Social Security disability claims. This change will create a system of law that is national in scope and will provide finality, consistency and predictability for the legal process. This legislation will develop a uniform body of Social Security disability law which treats all claimants equally and will provide all claimants with notice of the legal standard which controls the adjudication of disability claims. This legislation will also correct the troubled and long-standing Social Security Administration policy of non-acquiescence to Federal circuit courts of appeals decisions.

During the last Congress, the President of our Association appeared before this subcommittee and testified in support of this legislation. We now renew our support because this reform provides necessary change for the Social Security disability adjudication process.

Sincerely,

Ron Bernoski
Vice President

STATEMENT OF RONALD G. BERNOSKI
VICE PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, INC.

My name is Ronald G. Bernoski. I am an administrative law judge who for the last fifteen years has been assigned to the Office of Hearings and Appeals of the Social Security Administration in Milwaukee, Wisconsin.

This statement is presented in my capacity as the Vice President of the Association of Administrative Law Judges, Inc., (Association) which is a professional organization having the stated purpose of promoting full due process hearings to those individuals seeking adjudication of controversies within the Social Security Administration (SSA) and the Department of Health and Human Services.

This statement is in response to the issues raised in the written testimony of the GAO, Mr. Lou Enoff and Mr. Glenn A. Fait that was presented to the Subcommittee on Social Security on August 3, 1995. The written statements of Mr. Enoff and Mr. Fait contained recommendations that the administrative law judge hearing for Social Security disability claims be abolished and be replaced by a hearing conducted by a state disability hearing officer.

It is our understanding that the Subcommittee requested additional information at the August 3rd hearing on reasons for the difference between the claims allowance rate for first level claims consideration by state disability examiners and that for Federal Social Security Administration law judges. The stated public purpose of the Subcommittee at the hearing is to reduce the backlog of disability claims at the Federal Social Security Administration administrative law judge level by adjudicating more claims favorably in the process at the state level. The Subcommittee Chairman has expressed frustration with the high level of claims allowed at the administrative law judge hearing level that were denied at the state level.

The testimony on the differences in the claims allowance rate regrettably did not directly address the reasons for the claims rate difference or solutions which are legally sustainable. Mr. Fait appropriately identified that state determinations are based on the agency's POMs, the Social Security Administration Policy Operations Manual. For various reasons the POMs do not always follow the decisions set out by the Federal circuit courts in the 13 Federal circuits, which the administrative law judges are bound to follow since such relief would eventually be obtained by the claimant in a Federal district court. The administrative law judges are aware of their reversal rate by the Federal courts and that the Social Security Administration Appeals Council often uses the same standard. The Subcommittee Chairman's and Mr. Jacobs' bill on establishing a Social Security Federal Circuit Court would do much to establish uniform policy by the agency by developing legal issues brought forward by the Social Security Administration. Testimony by Mr. Fait and Mr. Enoff did not address the consequences of the two standards currently used by the state and Federal levels in disability claim determinations. In fact, they ignore the demands of the Federal courts, which under their proposals would be the site of a newly created backlog of disability claims denied by the POMs standard and currently addressed by administrative law judges.

One possible legally sustainable solution is to allow state agencies to use the legal standard and not the POMs standard. This would dramatically reduce the demand on the administrative law judges and reduce the backlog of cases. It would truly put more people on disability earlier in the process. A proposal similar to this was suggested in past legislation by Mr. Jacobs that would have employed a "face-to-face" evidentiary hearing before making an initial decision at the state agency. The General Accounting Office did a cost analysis of the legislation which indicated that such a change would have a dramatic impact on the Social Security Trust Fund by paying more disability claimants.

We doubt that the appropriate solution to the current crisis in the disability program is to employ the current court mandated standards for disability earlier in the process. There is a public perception and within the Congress that the current decision process for Social Security disability does not adequately identify those individuals who cannot perform gainful employment. On an ad hoc basis the Federal courts, over the past twenty years, have developed the definition of disability under the Social Security insurance program in the absence of Federal statutory definitions of disability by the Congress. The Social

Security disability insurance program has historically been defined by the courts and not the Congress in areas such as mental impairments, medical improvement and the treating physician rule.

The current public consensus that the disability program does not accurately identify the long-term disabled gives the Congress an opportunity to enact statutory changes in the SSDI program that the public supports. The Association has communicated its suggestions in this matter to the Subcommittee.

The testimony of Mr. Enoff and Mr. Fait, which recommends tne abolishing of the fair hearing at the federal level for the claimants, does not address the substantive issues of the standards used for disability determinations. Tinkering with the adjudication process is no substitute for statutory reform of the system. Procedural fixes as suggested to the Subcommittee will either deplete the trust fund or create a backlog of cases at the Federal courts.

In addition to the recommendation of Mr. Enoff and Mr. Fait for a procedural solution to a statutory problem, the witnesses also raise concerns with the public's sense of fairness relating to their proper degree of objectivity and impartiality for various reasons. In his testimony, Mr. Enoff stated that he had "lived through the dark days of the early 1980's and the lingering aftereffects of the changed CDR process." He failed to mention that he was part of the system that planned and executed the programs and policies of those dreadful years.[1] He failed to state that he did not take any overt action to relieve the claimants of the anguish of those policies. This Association had to obligate itself to a substantial attorney fee to break the yoke from the backs of the claimants. This effort resulted in the case of Association of Administrative Law Judges vs. Heckler, 594 F. Supp. 1132 (D.D.C. 1984), where the court found that the "unremitting focus on allowance rates....created an untenable atmosphere of tension and unfairness which violated the spirit of the APA, if no specific provision thereof." He also failed to mention that he had prohibited the Chief Administrative Law Judge of the Social Security Administration from accepting an award that was presented to the judges of the Social Security Administration by the American Bar Association. This award was given to recognize the public service provided by the judges when they stepped forward to protect the due process rights of the claimants during the 1980's. The citation provided as follows:

> Be It Resolved, that the American Bar Association hereby commends the Social Security Administrative Law Judge Corps for its outstanding efforts during the period from 1982-1984 to protect the integrity of administrative adjudication within their agency, to preserve the public's confidence in the fairness of governmental institutions, and to uphold the rule of law.

This award was then accepted by the President of this Association at a dinner that was attended by U.S. Supreme Court Justices. During that era, Mr. Enoff also appeared before the Subcommittee on Administrative Law and Governmental Relations of the House Judiciary Committee and denied that the Agency was maintaining case allowance rate records for judges. At a later hearing when he was confronted with records which had been obtained from the Agency, he then denied knowledge of their existence. It is inconceivable that he could now be brought forward as a credible authority on the Social Security hearing process and to further base a radical reform of the system upon his recommendation. The other witness, Mr. Fait, is a Director of the Institute for Administrative Justice at McGeorge School of Law. This organization has been under contract with the Social Security Administration for the last 12 years for the purpose of providing training for state agency CDR hearing officers together with providing other advice and consultation with respect to the Social Security appeals system. This places him in direct line for pecuniary benefit from the Social Security Administration if his

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[1] Mr. Lou Enoff was Deputy Commissioner for Programs for the Social Security Administration during much of the 1980's.

recommendation is accepted. Testimony offered by a witness with the potential of pecuniary gain evidences the lack of objectivity and impartiality in the manner.[2]

The history of the hearing system in the Social Security Administration has been a story of a struggle to strike a balance between quality justice and speedy justice in face of explosive growth. The Social Security Administration had no formal appeals process prior to 1940. The formal right to a hearing was created as the result of a study conducted by a work group headed by Mr. Ralph F. Fuchs, Professor of Law, Washington University, St. Louis, Missouri. The system started with 12 referees and has grown to what may be the largest institution for the administration of justice in the western world.[3] The title of the fact finder has changed over the years. It started with the title of referee, it was changed to that of hearing examiner and finally to administrative law judge.

In 1972 Congress passed the Supplemental Security Income Legislation which went into effect on January 1, 1974. The Civil Service Commission took the position that these cases were not covered by the Administrative Procedure Act. This issue was not resolved until Congress settled the issue with legislation in 1976.[4]

Since 1940, administrative law judges and their predecessors have heard millions of claims that have arisen under the Social Security Act. These cases have been heard with dignity pursuant to the constitution and laws of this nation. Due process has been protected and the rule of law has been respected and followed. In a few instances certiorari has been granted in these cases by the U.S. Supreme Court.

Mr. Enoff states that under his proposal "the three hat role of the ALJ .....would be eliminated." He doe not state how this will be accomplished. He appears to completely ignore the existing law which controls this aspect of adjudication of Social Security disability claims. The statute clearly provides that the Commissioner, in making any determination, shall make every reasonable effort to obtain from the individual's treating physician all medical evidence, including diagnostic tests, necessary in order to properly make such determination, prior to obtaining evidence from another source.[5] Many courts have also spoken on this issue and the overwhelming case law places an affirmative obligation upon the Commissioner to fully and fairly develop the record upon which the determination is made. The case of Sears vs. Bowen, 840 F.2d 394 (7th Cir. 1988) is typical of the holding of these courts. In that case the court stated that "there was no dispute that the Secretary has a duty to fully and fairly develop the record". This authority establishes that the Commissioner has a clear duty to develop the medical record on behalf of the claimant. The proposal of Mr. Enoff does not effect this responsibility in any regard. The courts will continue to enforce this rule of law. Mr. Enoff is also critical of the presence of attorneys at Social Security hearings to represent the interests of the claimants. These two concepts are completely inconsistent. If the Commissioner does not protect the interests of the claimant at the hearing and the claimant is not represented by an attorney, who will protect the interests of the claimant at the hearing?

Mr. Fait made several assertive statements regarding the hearing process and the administrative law judge which are not supported by any authority. It seems reasonable to require that a statement which proposes to replace a government process that has been in existence for nearly 60 years to be supported by more than opinion and innuendo. He stated that more than one level of review will result in a greater allowance rate for claims, that many judges claim total independence from the agency and ignore agency policy in deciding cases and that many judges fail to understand the appropriate role of the administrative adjudicator. These statements are not correct. In fact, a GAO analysis of legislation to abolish the DDS reconsideration review, introduced in several prior Congresses, reached the opposite conclusion. The administrative law judges in the Social

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[2] Charles T. McCormick, Evidence, page 62, 1954.
[3] A Quest For Quality, Speedy Justice, a history of the first fifty years of the administrative law judges of the Office of Hearings and Appeals, Social Security Administration, Department of Health and Human Services, Social Security Administration.
[4] Public Law 94-202-Jan. 2, 1976.
[5] Social Security Act Sec. 223 (d)(5)(B).

Security Administration completely understand that they are adjudicating claims on behalf of the Commissioner pursuant to the rules, regulations, case law, statutes and Constitution of the United States. Mr. Fait does not understand the basis of the difference between the state agency standard and court standard for adjudicating cases. He does not recognize that removal of the adjudication level to the state agency level will not change the law and that the courts will still review the cases under their legal standard. He has fallen into an old trap or laid it himself. He is asserting that substantive changes can be achieved by procedural means. If a change in the substantive law is the objective, it can only be achieved by a change in the basic law through act of Congress and not by procedural or policy means.

Mr. Fait stated that past trial court experience is not valuable training for being an administrative law judge. Anyone who has ever tried a case in a court of law knows this statement is false. Trial experience trains an attorney to produce and evaluate evidence and determine the credibility of a witness which is the primary responsibility of an administrative law judge. Since Social Security hearings are not adversary proceedings, they are more difficult to conduct than adversary hearings because the judge has the unusual "three hat role" which requires the judge both to develop and evaluate the evidence in the case and to assess the credibility of the witnesses.

Mr. Fait Stated that "administrative hearings are designed primarily to provide a chance for an agency to correct its own mistakes" (no authority is provided for this statement). This is a very simplistic description of the administrative hearing process. It fails to consider the fact the Administrative Procedure Act was adopted in 1946 after many years of careful deliberation by both the Congress and the Department of Justice. In 1938 the Attorney General suggested to the President that the Department of Justice be authorized to conduct a full inquiry into the administrative process which had been the subject of some criticism. The President requested the Attorney General to appoint a committee to make a thorough study of existing administrative procedures and to submit whatever recommendations that were deemed advisable. The committee, known as the Attorney General's Committee on Administrative Procedure, devoted two years to the study and then issued a final report to the President and the Congress. This report is considered a landmark in the field of administrative law and contained the main origins of the present Administrative Procedure Act. Extensive hearings were then conducted before both the House and Senate Judiciary Committees. A bill was subsequently adopted by both Houses of Congress without a dissenting vote. The Administrative Procedure Act was signed by the President on June 11, 1946.[6] The responsibility of the Commissioner to conduct a hearing in disability cases is provided for in the Social Security Act. The Act directs the Commissioner to make a findings of fact and decision as to the rights of any individual applying for a payment which involves a determination of disability. The decision shall contain a statement of the case, a discussion of the evidence and the reason upon which the determination is based.[7] This requirement is far more complex than giving the agency a chance to "correct its own mistakes."

Mr. Fait cites the case of Goldberg vs. Kelly, 397 U.S. 564(1970), for the principle that an adjudicator can be impartial even though he or she is an official of the public agency that made the initial decision. That particular question is not at issue here. It should also be noted, that the Goldberg case related to a state welfare claim and not a Federal Social Security claim. The question before this Subcommittee, instead relates to the nature of the hearing that is to be provided for the claimant and the inherent due process protections which guarantee that both the claimant and the agency will receive a full and fair hearing with the decision being made upon the evidence of record. The Social Security Administration has been providing an Administrative Procedure Act protected hearing for its claimants.[8] This issue was reviewed in the 1970's when the Administrative Procedure

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[6] Attorney General's Manual, on the Administrative Procedure Act, United States Department of Justice, 1947.

[7] Social Security Act, Sec. 205(b)(1).

[8] Social Security Administration administrative law judges are appointed under Sec. 3105 of title 5, United States Code. Section 3 of Pub. L. 95-251 provides that; "Any reference in any law, regulation, or order to a hearing examiner appointed under section 3105 of title 5, United States Code shall be deemed to be a reference to an administrative law judge."

Act hearing was also provided for Supplement Security Income claimants by legislation. In the case of Richardson vs. Perales, 402 U.S. 389 (1971), the United States Supreme Court was requested to determine if the Administrative Procedure Act rather than the Social Security Act governed the hearing of Social Security claims. The court did not directly decide the issue but instead stated that:

> We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act.

This finding by the court is an enormous compliment to the Social Security hearing system, and establishes that the reform act for all administrative hearings was modeled upon its principles. It further shows that the basic provisions for the Social Security Act and the Administrative Procedure Act are identical.

In the case of Caswell vs. Califano, 583 F.2d 9, 15, footnote 13 (1978), the court stated that "The Secretary's claim that the Administrative Procedure Act is not applicable to actions of the Social Security Administration is contrary to both the language of the statute and the case law of this and other circuits."

The courts have continued to recognize the due process protections provided to Social Security hearing claimants by the Administrative Procedure Act and the Social Security Act. An example of the holdings of these courts is set forth in the case of Salling vs. Bowen, 641 F. Supp. 1046 (1986), where the court stated that:

> We have seen that the administrative procedures in making Social Security disability determinations are a cumbersome 'Rube Goldberg' process at best, which have been further encumbered by a threat to the independence of the ALJ's who are the only people in the entire system who are oriented towards the main goal which should be the seeking of truth and the ultimate triumph of justice.

In 1983 the Subcommittee on Oversight of Government Management of the Committee on Governmental Affairs in the United States Senate conducted a hearing which inquired into the role of the administrative law judge in the Title II Social Security Disability Insurance Program (S. PRT. 98-111). The Committee issued its conclusions on September 16, 1983, which provided in part as follows:

> The APA mandates that the ALJ be an independent, impartial adjudicator in the administrative process and in so doing separates the adjudicative and prosecutorial functions of an agency. The ALJ is the only impartial, independent adjudicator available to the claimant in the administrative process and the only person who stands between the claimant and the whim of agency bias and policy. If the ALJ is subordinated to the role of a mere employee, an instrument and mouthpiece for the SSA, then we will have returned to the days when the agency was both prosecutor and judge.

The Social Security Administration recognizes the value of an independent adjudicator for its hearings. This principle is reaffirmed in its redesign plan.[9] This concept is stated as follows:

> ALJs are independent triers of fact who perform their evidentiary factfinding function free from agency influence. At the same time, the Administrative Procedure Act ensures that an ALJ's decision is subject to later review by the agency, thus giving the agency full authority over policy.

These materials clearly establish that the Administrative Procedure Act was adopted after careful study and deliberation by both the Department of Justice and the Congress. The Social Security Act provided for a hearing process which predated the Administrative

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[9] Plan For A New Disability Claim Process, Social Security Administration, 1994.

Procedure Act and the Administrative Procedure Act was modeled after its concept. The provisions of both of these Acts now control the Social Security hearing process with about 75% of the current administrative law judges assigned to the Social Security Administration. The proposal to transfer the current Social Security hearing function to the state agency would savage the existing Federal administrative law program. Any such action should not be taken without the deliberation that accompanied the passage of the original Act and it should include a study by the Department of Justice and hearings before the Judiciary Committees of both the House and Senate. The proposed action will also come at considerable expense to the working people of this nation. These citizens who have worked hard and paid FICA taxes for their entire working years will be denied a hearing that is protected by the Administrative Procedure Act. The first time the law will be impartially applied in their case will be at the Federal district court level. Unlike a pork belly or security instrument, which will continue to have a protected hearing, these citizens will be forced to go without this vital protection. It is similar to denying our citizens the right of a trial by jury. It is the Administrative Procedure Act which provides the basic dignity to the administrative law system and provides basic protection to the interests of both the claimant and the government. The Social Security system is the most revered program in the U.S. Government and effects the lives of all Americans. This program deserves the very best administrative law system. There is no substitute for the protections and due process guaranteed by the Administrative Procedure Act. Without the protection of the Administrative Procedure Act the administrative law judges of the Social Security Administration could not have protected the rights of the claimants during the 1980's. It is the Administrative Procedure Act that provides a shield for the individual, with the rule of law, that protects against the abuses of government. Any attempt to restrict the scope of these protections would amount to a stripping away of basic constitutional safeguards.

The splitting of the hearing system into 50 separate state agency units will have the direct effect of creating 50 distinct adjudication standards that will destroy any unified standard that now exists. It has the further potential of creating a constitutional problem of equal protection because a claimant's chance for recovery of benefits in this Federal program will depend on the geographical location where the claim is decided. This proposed system also will create a Federal Social Security Trust Fund that is resourced by the Federal FICA tax. The adjudicators at the state level will be spending the trust funds by paying claims while the Federal officials will be supplying the money with its taxing power. This appeals to be a plan for disaster.

The proposal also raises a potential constitutional question. The Social Security Act specifically designates the Commissioner as the official responsible for the hearing process. Can this Federal function be delegated to the states under our system of federalism? A second and more important issue relates to a separation of powers question. Can the Congress mandate, by legislation, that an Executive branch responsibility be executed by an agency which is not within the Executive branch? Proposed changes of this magnitude require a comprehensive study by the Department of Justice and hearings before the Judiciary Committees of the House and Senate.

The recommendations of these two witnesses would remove the current Social Security disability hearing to the state agency level. However, neither of these witnesses provides any system for insuring the due process rights of the claimants or insuring the fairness of the hearing. State hearing systems have the potential for becoming corrupted by denying the claimant a fair hearing. An example of this occurrence is the findings from a New York study that was conducted by a Task Force of the New York State Bar Association which provided as follows:[10]

> We found that all to often the substantive findings and decisions of agency administrative law judges in this State are influenced by executive officials within the agency. Often the influence of executive agency officials upon those within the agency who have adjudicative responsibilities is so pervasive as to prevent hearings

[10] Report of the New York Task Force on Administrative Adjudication, New york State Bar Association, 1988.

from being fair and impartial. The goal of any adjudication system--including a system provided administratively--must be to dispense justice. Any system in which executive personnel can manipulate what transpires in the hearing room is a system which falls short of its goal and which needs to be reformed.

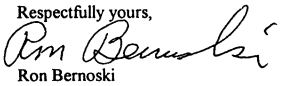
Under the present Federal system, an administrative law judge takes an oath upon appointment to uphold the Constitution and the laws of the United States. The judge is also subject to the standards of professional conduct of the agency, the standards of the Office of Government Ethics and the standards of the bar association in which membership is held. How will the proposed system be regulated for professional conduct? Will there be a Federal standard, or will there be 50 standards controlling the system? Who will have standing to file an allegation of unfairness or unprofessional conduct? Will the agency have standing? Will there be a cause of action for civil damages for the breach of the constitutional tort of interfering with a claimant's right to a due process hearing? Will there be a criminal violation for obstruction of this due process right? If any of these remedies are available, will jurisdiction lie in the state or Federal court, or both? Will state law control any aspect of the hearing; if so, will there be 50 separate legal systems controlling the hearing process?. Currently administrative law judges are selected pursuant to one of the most rigorous selection processes in the Federal government. The proposal would eliminate the professional requirements and is silent as to the selection process. How can this be an improvement?

Mr. Enoff recommends the creation of a Social Security Court. There are many questions that are not answered in his statement. Will the court be an Article I or Article III court? Will this court be part of the agency appeal process or will it be a Federal Social Security Court of Appeals? Who will have the appointment authority for the judges (Many experts contend that agency appointment authority will subject the court to undue agency influence resulting in an unfair process)? What jurisdiction will the court have, will the court hold a de novo hearing or will the appeal be on the record? Who will have standing before the court? This Association supports the U.S. Court of Appeals for the Social Security Circuit provided for in H.R. 1587.

The process recommended by these witnesses will place the Federal Social Security Disability Trust Fund under the control of 50 separate states. The Social Security and Supplemental Security Income systems have already experienced frequent state practices of attempting to shift state benefit recipients to the Federal programs. What will happen when we have another economic decline? How will this cost shifting be controlled with the states in charge of adjudicating claims for this Federal program? During the 1980's several state Governors ordered their state agencies not to enforce the rules and policies of the Federal Social Security program. What if this happens again? How will this conduct be regulated? How will it be possible to manage and implement a Federal program with uniform standards under these conditions? The recommendations of these two witnesses do not shed any light on to the solution to any of these potential problems.

The Association agrees that some changes are required in the Social Security disability system. We offer our expertise in working with the Subcommittee in making needed reforms in the Social Security disability insurance program.

Respectfully yours,



Ron Bernoski
Vice President

August 17, 1995

Subcommittee on Social Security
c/o Phillip D. Mosely
Chief of Staff, Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Re: August 3, 1995 Hearing

Re: Social Security Disability Determination

Dear Committee Members:

The Association for Attorney-Advisors is a professional association of attorneys employed by the Social Security Administration (SSA) Office of Hearings and Appeals (OHA). The Association provides a forum for communication with other OHA attorneys and components. As we previously stated in our June 5, 1995 statement to the Subcommittee, we have grave concerns regarding the future of SSA.

The "product" of the disability determination process is intended to be accurate decisions, providing due process, that comply with the applicable law at all levels of determination (See, 42 U.S.C. 421(k), 20 CFR 404.1615 and 20 CFR 416.1015). Disability determinations are subject to federal court review, 42 U.S.C. 405(g), and must be legally defensible in order to withstand judicial scrutiny. The Social Security Administration (SSA) has not assured compliance with the law at all levels of review in the past. The 1984 Disability Benefits Reform Act was directed, in part, at compelling SSA to assure compliance with the law, including applicable Circuit Court decisions, at all levels of adjudication.

In spite of this legislation, SSA has maintained a disability determination system in which different standards are used at different levels of determination. Rather than charging the state Disability Determination Services (DDS) with directly applying the Act, Regulations and applicable case law in making their determinations, the personnel performing initial and reconsideration level determinations are compelled by SSA to make their decisions in compliance with the SSA Program Operations Manual Systems (POMS). Ostensibly, POMS is based on the law, but time and time again the courts, as well as the legal community at the Office of Hearings and Appeals (OHA), have pointed out how compliance with POMS is NOT equivalent to compliance with the law.

Our experience as Attorney-Advisors has shown in multiple instances that the Social Security Act and implementing Regulations, as well as the applicable caselaw were not followed at the initial and reconsideration levels. These cases, when appealed, form the body of cases awaiting processing at OHA and are the source of the markedly increased backlog at the OHA level. Failure to use and follow the Social Security Act, implementing Regulations, and applicable caselaw forces OHA to process thousands of cases that should have been resolved in the claimant's favor at the initial or reconsideration levels; and in thousands of potentially unfavorable cases, OHA must perform the mandated development that should have been done at the earlier steps.[1]

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[1] Many corporations have components that are given high grades for producing large numbers of their "parts" only to find out that the next group must rework the parts extensively in order to generate the final product. This is just the type of problem that reengineering is directed at solving. See, Chapter 1 of Hammer, Michael and Champy, James, Reengineering the

SSA has stated that "The development of extensive medical evidence in every case impedes timely and efficient decisionmaking." This statement, as well as the current proposal to eliminate obtaining evidence in favor of a certification procedure (See "Plan For A New Disability Claim Process" and Task Team Report "Streamlining Medical Evidence") is cause for alarm and indicates a disregard for the statutes enacted by Congress. Evidentiary development is required under the law. 42 U.S.C. Sec. 423(d)(5)(B), 20 CFR 404.1512-404.1519, and 20 CFR 416.912-416.919. Due process is ignored and the emphasis placed on "moving the cases" at the expense of accuracy. Such a policy encourages erroneous decisions, both favorable and unfavorable, as it results in determinations based on insufficient evidence.

The current system also adds to the backlog indirectly, since the American public has learned that appeal to the OHA level insures proper application of the law and affords a better chance of being awarded benefits. As a result of this knowledge, fewer claimants drop their claim after initial or reconsideration denial. Indeed, the current appeal rate of reconsideration denials to OHA exceeds 75%. The current disability system was not designed to handle the percentage of appeals that this phenomenon has generated.

Recently, the National Council of Disability Determination Directors wrote the Commissioner of Social Security with their objections to this situation, requesting that DDS be allowed to apply the adjudication standard employed by OHA. The problem apparently lies in SSA's inordinate reliance on "policy" rather than the law and a lack of understanding of the legal requirements under the Act or the refusal at SSA to comply with these requirements.

Further compounding the situation is the decision to essentially abandon the performance of continuing disability reviews. The Agency now asserts that it has once again put resources into continuing disability reviews. While this effort may be laudable, we ask that Congress carefully monitor the implementation of that process, in light of the events that lead to the passage of the 1984 Disability Benefits Reform Act. Legally indefensible determinations such as those issued on a wholesale basis in the early 1980's will only add to the appellate backlog.

SSA's current reengineering and short term disability project initiatives do not appropriately address the problems regarding disability standards. SSA has refused to admit that the current system operates under different standards.[2] The "process unification" initiatives seem directed at developing a new "POMS". The result will be an even more complex layer of policy provisions rather than assuring that all adjudicators are applying the Act, regulations and applicable case law. Newly proposed regulations regarding Adjudication Officer qualifications fail even to refer to applicable caselaw as part of the legal standard (see, FR 30484).

Corporation: a Manifesto for Business Revolution. 1993 HarperBusiness. SSA has acknowledged the existence of this type of problem in the agency. "SSA measures the process from the perspective of the component organizations involved, rather than from the perspective of the claimant." Plan for a New Disability Claim Process, September 1994. SSA Pub. No. 01-005 at p. 11.

[2] Plan for a New Disability Claim Process, September 1994. SSA Pub. No. 01-005 at p. 10.

SSA makes it more likely that different standards will continue to exist by encouraging the selection of "adjudicators" who have no legal education. SSA undervalues legal education in selecting adjudicators and decision writers. No one at SSA with any significant legal education reviews a claim until it has reached the Administrative Law Judge hearing level.

Rather than acting to increase the education level of adjudicators, many current policies of SSA actually appear directed at reducing if not eliminating legally trained staff. The minimum qualifications for the Case Manager and Adjudication Officer positions do not even require a bachelor's degree. The Adjudication Officer position is scheduled to be filled at the GS 13 level. Current Adjudication Officer pilot proposals indicate that over two thirds of the pilot Adjudication Officers will be non-attorneys. They will assume their duties with only a very brief training period of three weeks. Upon full implementation, the Adjudication Officers are expected to replace the current Senior Attorney-Advisors, who are performing prehearing screening and decisionmaking under the Short Term Disability Plan, as temporary GS 13. Once the Adjudication Officers assume the duties now performed by the Senior Attorneys, the Senior Attorneys are to be returned to their previous GS 12 status.

The Short Term and Reengineering initiatives leave Administrative Law Judges, Attorney-Advisors and Paralegal Analysts with a much more difficult workload than they currently face. More cases are being paid prehearing through screening processes. The most difficult cases remain and eventually must be prepared, reviewed and drafted by the shrinking numbers of Attorney-Advisors and Paralegal Analysts. Expecting the Administrative Law Judges to alleviate this burden by writing more of their own decisions is not a viable option. This simply means that the ALJs have less time available to hold hearings. Detailing various other components to decision writing is also an inadequate long term option as the caseload at the hearing level will expand greatly under reengineering before it ever begins to decline. SSA asserts that the caseload at the hearing level will decline with full implementation of reengineering, but it is easy to see that the public will continue to appeal to at least the hearing level for years before they are convinced that SSA has actually improved true (legal) accuracy at the lower levels and that the likelihood of success on appeal has diminished.

In spite of these clear indications that the decision writing workload is steadily increasing in size **and legal complexity**, SSA has continued its trend of undervaluing legal education. SSA has hired less than one hundred temporary attorney advisors during the last three years and during the last year has converted the status of a few of those to permanent status. At the same time it has been hiring "Paralegal-Specialists," most of whom have not received any legal education and/or formal paralegal courses, who have only undergone a three week training course on the legal aspects of their job as a decisionwriter. SSA has argued for years that the work of OHA is not really related to legal issues and so this hiring pattern is continuing in spite of the fact that in-house studies confirmed that legal issues are critical to the work at OHA.

SSA also blames some of its problems on conflicts between the various Circuit Courts. There certainly are conflicts between the Circuits in resolving Social Security issues. However, this problem is no different than that experienced by any other agency. Differences between the Circuits are to be expected. These differences are a natural product of our system. They help the law develop and avoid stagnation and ossification.

The simplest answer is for the agency to consult with counsel and assure that appropriate personnel are apprised of the applicable law in their jurisdiction! This is what is done by all other

agencies, federal or state. Unfortunately, SSA's response appears to be to eliminate attorneys and ignore the courts. This should not be countenanced.

We know that Congress is reluctant to "micromanage" this agency. However, SSA's misguided policies have been followed for years at great cost to morale in the system and greater cost to the public due to resultant errors and inefficiencies. It must be compelled to make real changes.

The first of these long overdue changes is to assure that compliance with the law at all stages of the adjudication process is given its proper emphasis. Forcefully remind SSA that the "one book" to follow in making disability determinations, is the Act, the Regulations and applicable case law. Putting the emphasis on more policy in a vain attempt to make the process "simpler" or less "legalistic" is repeating our past mistakes.

Compliance with the law at all stages of the adjudication process will act to reduce the backlog in itself.

1) The number of requests for hearing will be reduced as more deserving claimants will be paid at an earlier level. At the same time, the overall reversal rate will not be appreciably altered.

2) The number of hearing requests will be further reduced as the public gains the perception that they are "getting a fair shake" at the earlier levels of decisionmaking and that their likelihood of success on appeal is greatly reduced from current levels.

3) The number of class actions in Federal Court should be reduced, since decisions will be more likely to be in compliance with the applicable law.

4) Processing time at the hearings level will be decreased, since necessary development will have already been performed.

5) Continuing disability reviews will be performed in a way that will avoid the debacle of the early 1980's. Public confidence will be restored. Claimants who no longer are disabled will be removed from the rolls, without the wholesale cessations of the past that withdrew benefits from an embarrassing number of people who actually remained disabled.

Failure to put the emphasis on compliance from the start, rather than on making decisions as fast as possible, is likely to result in improper awards and improper denials on a wholesale basis.

The second action should be to make a law degree the minimum requirement for all Social Security Administration adjudicators, at **every** level, and for all personnel charged with writing or drafting the written decisions of the agency. "Reengineering" is directed at developing a better educated workforce that is capable of independent action to produce a "product" as efficiently and effectively as possible. SSA's current policies will result in an adjudicative workforce with a lower level of education than is in the current unit and will cost more since they will be adding a large number of Adjudicative Officers at the GS 13 level.

Attorneys are the best qualified personnel for adjudicative positions and hiring them is cost effective. SSA is currently planning to hire employees at the same or a higher grade level who have less education and little or no post graduate legal training. The growing demands placed on SSA adjudicators require individuals with extensive knowledge of the complete process

including an understanding of the caselaw requirements placed by federal courts, strict ethical standards, canons of professionalism, and education. While no employee at SSA is precluded from possessing these attributes, a licensed attorney has been examined, investigated, and is bound by state and federal law for purposes of adherence to these principles. Attorney's are officers of the court and may lose their license to practice if found in violation of any ethical or professional canon. Making a legal education a prerequisite to such positions is a major change and goes against much SSA history, however that history clearly shows that such a change is absolutely necessary and long overdue. Improved quality will effectively increase productivity by reducing duplication of effort. Higher education translates into greater adaptability and the ability to handle more complex tasks. It lessens if not eliminates the need for large amounts of expensive training. This step clearly would be cost effective.

Finally, close Congressional oversight must be continued. The Social Security Administration has a long history of failing to comply with the Act and regulations. Unfortunately, it appears that strong Congressional oversight is needed to assure that SSA follows through with appropriate reforms.

Thank you again for your time and consideration.

Sincerely,

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STATEMENT OF
JOYCE KRUTICK BARLOW
U.S. ADMINISTRATIVE LAW JUDGE
Submitted as a personal statement on her own behalf

This statement is respectfully submitted in connection with this Committee's consideration of the Social Security Administration's proposals for the reorganization of the Office of Hearings and Appeals and whether the Administrative Law Judge Position should be reclassified to a hearing officer position.

I. SSA Hearings are "on-the-record-hearings" under the APA

In order to fully understand the issues before this Committee it is important to review the history of the Administrative Law Judge in the Social Security Administration and the hearings these judges conduct. A claimant's right (in a disability claim) to a due process hearing flows both from statute and U.S. Supreme Court case law. The relevant statute is 42 U.S.C. 421. This section specifically provides that any person not satisfied with the determination of a state agency has a right to a hearing to the same extent as is provided in 42 U.S.C. 405(b). Over the years, the Social Security Administration has contended that hearings under the Administrative Procedures Act are not "required", notwithstanding the fact that for years SSA has acquiesced in the use of APA appointed judges and APA notice and hearing requirements for all hearings under the act. As will be seen in the following discussion, APA hearings are mandatory, and thus may be held only by those appointed pursuant to the APA; to wit - Administrative Law Judges.

In 1936, prior to the passage of the APA, the U.S. Supreme Court defined a due process hearing administrative hearing as:

> A proceeding ... requiring the taking and weighing of evidence, determinations of fact based upon the consideration of the evidence, and the making of an order supported by such findings, has a quality resembling that of a judicial proceeding. Hence it is frequently described as a proceeding of a quasi judicial character. The requirement of a "full hearing" has obvious reference to the tradition of judicial proceedings in which evidence is received and weighed by the trier of the facts. The "hearing" is designed to afford the safeguard that the one who decides shall be bound in good conscience to consider the evidence, to be guided by that alone, and to reach his conclusion uninfluenced by extraneous considerations which in other fields might have play in determining purely executive action. The "hearing" is the hearing of evidence and argument. If the one who determines the facts which underlie the order has not considered evidence or argument, it is manifest that the hearing has not been given. ...
>
> For the weight ascribed by the law to the findings-their conclusiveness when made within the sphere of the authority conferred-rests upon the assumption that the officer who makes the findings has addressed himself to the evidence, and upon that evidence has conscientiously reached the conclusions which he deems it to justify. That duty cannot be performed by one who has not considered evidence or argument. It is not an impersonal obligation. **It is a duty akin to that of a judge.** Morgan et. al. v. U.S. , 298 U.S. 468, at pgs 480-418, (1936).

With respect to the Social Security Act, the first mention of a due process hearing appears in the original act and concerns state plans for dependent children. Section 402(a)(4) provided that "An individual whose claim is denied (for instance by a county board) must be given the right to a fair hearing before the State Agency" [see Senate Rept. 628 on H.R. 7260, 74th Cong., 1st session.]. Thereafter, the 1939 amendments provided for hearings with respect to the determination of rights to benefits. Section 205 of the act created the framework for a hearing process which remains with us today. The language of the statute provided that:

> The Board shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this title, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder. [Sec. 205(a)].

> The Board is directed to make findings of fact, and decisions as to the rights of any individual applying for payment under this title. ... In the course of any hearing, ... it may administer oaths and affirmations, examine witnesses, and receive evidence. Evidence may be received at any hearing before the Board even though inadmissible under rules of evidence applicable to court procedure. [Sec. 205(b)].

The same section of the act under these amendments provides for review of Board decisions by the district court of the United States, issuance of subpoenas, proof of service, fees and mileage for witnesses, penalties for failure to comply with subpoenas, immunity from self-incrimination, penalties for perjury, the substantial evidence standard of review by the court, remand orders by the court, and other housekeeping details [Sec. 205 (c)-(m)]. Section 206 provided for representation of claimants before the Board, rules for suspension of attorneys, and setting of maximum fees payable to attorneys with concomitant criminal penalties for fees in excess of the maximum [see 53 Stat.1368-1372, Pub. Laws, Ch. 666, Aug 10, 1939].

The language of these amendments fits squarely within the framework of the type of hearing described by the Supreme Court to be "quasi-judicial", imposing upon the one who makes findings of fact and conclusions of law "a duty akin to that of a judge" [Morgan et. al. v. U.S. et. al., supra, at p. 481].

In 1946 Congress enacted the **Administrative Procedure Act**[60 Stat. at p. 237, 79th Cong., 2nd Sess. Ch 324, June 10, 11, 1946]. The act defined an "agency" as "each authority of the Government of the United States other than Congress, the courts, or the governments of the possessions, Territories or the District of Columbia [Sect. 2(a)]. An "adjudication" is defined as the "agency process for the formulation of an order" [Sect. 2(d)]. Section 5, entitled **ADJUDICATION** provides the procedures to be applied, and defines those situations where the act applies:

> In every case of adjudication required by statute to be determined on the record after opportunity for an agency hearing, except to thee extent that there is involved (1) any matter subject to a subsequent trial of the law and the facts de novo in any court; (2) the selection or tenure of an officer or employee of the United States other than examiners appointed pursuant to section 11; (3) proceedings in which decisions rest solely on inspections, tests, or elections: (4) the conduct of military, naval, or foreign affairs functions; (5) cases in which an agency is acting as an agent for a court; and (6) the certification of employee representatives-[emphasis added]

parties must be informed of the time, place and nature of the agency hearing, the jurisdictional authority, matters of law and fact to be heard [Sec. 5(a)]; they must be afforded an opportunity for submission and consideration of facts, arguments and offers of settlement, and where the parties cannot reach a consent agreement, a hearing and decision upon proper notice and conforming to sections 7 and 8 must be held [Sec. 5(b)]. The balance of the act provides the procedure to apply to hearings held under the act, and appointment of hearing examiners (now administrative law judges). There can be no doubt that this act applies to hearings held with respect to all issues arising under the Social Security Act. Taking the exceptions one by one, Social Security hearings are not subject to de novo trial by a court. Both by statute, and case law, the substantial evidence rule applies to hearings under the Social Security Act. Thus, exception (1) does not apply. These hearings do not relate to the selection or tenure of an officer of the U.S., and thus, exception (2) does not apply. Social Security matters do not involve decisions resting solely on inspections, tests, or elections, precluding the applicability of exception (3), nor do they involve the conduct of military or foreign affairs, thus exception (4) does not apply. In such matters, the agency does not act as an agent for a court. Certification of employee representatives is not involved in these matters. Clearly, neither exceptions (5) nor (6) apply. **Thus, Social Security hearings are subject to the provisions of the APA** [NOTE: the current applicable section is 5 U.S.C. 554, and is substantially the same as the original Sec. 5].

Not long after the passage of the APA, the Supreme Court had occasion in two cases to discuss the reason for the passage of the APA. First, in Federal Trial Examiners Conference v. Ramspeck, 345 U.S. 128, 144 (1953) the court held that:

> The Administrative Procedure Act was designed to give trial examiners in the various administrative agencies a new status of freedom from agency control. Henceforth they were to be very nearly the equivalent to judges even though operating within the Federal system of administrative justice.

In the second case, Universal Camera Corp. v. National Labor Relations Board, 340 U.S. 474 (1954) the court expanded on the nature of the hearing (trial) examiner position:

> ... the indications in the legislative history that enhancement of the status and functions of the trial examiner was one of the important purposes of the movement for administrative reform. ... Section 11 of the Administrative Procedure Act contains detailed provisions designed to maintain high standards of independence and competence in examiners (at p. 494-5).

In 1960, the Supreme Court held that "The interest of a covered employee under the" Social Security Act "is of sufficient substance to fall within the protection from arbitrary governmental action afforded by the Due Process Clause [Fleming v. Nestor, 363 U.S. 613, 80 S.Ct. 1367 at 1373 (1960)]. In 1971, the court had the opportunity to review the social security disability hearing process, in connection with the question of admissibility of hearsay evidence. In declining to rule on whether the APA applies to social security disability claims, the court held:

> We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA. **Indeed the later is modeled upon the Social Security Act.**
> (emphasis this author's)[Richardson v. Perales, 402 U.S. at 409 (1971)].

Shortly thereafter, congress, again faced with a crushing backlog of disability claims decided that SSI hearing examiners would be temporarily assigned to hear these claims. In Senate Report No. 94-550, it was noted that "**The programs administered by the Social Security Administration presently have a huge backlog of some 103,000 cases awaiting hearing.** At that time Congress suggested that by reassigning the SSI judges, the backlog could be eliminated. Congress also suggested that a study be performed to ascertain what changes could be made in the hearing process to improve both "speed and quality of social security adjudications." It is interesting that Congress, then recognizing that the APA applied to these hearings, believed it necessary to make specific provision for the APA to apply to these SSI judges. Thus Section 3 of the bill [H.R. 10727, P.L. 94-202. 1975], provided that the temporary hearing officers authorized to conduct these hearings would be subject to the provisions of the APA. In doing so, the Senate Report noted that:

> To avoid any possible misinterpretation, the bill specifically provides that the temporary hearing officers authorized to conduct hearings under the bill would be subject to all the provisions of the Administrative Procedure Act that assure independence from agency control. These procedures include: Subchapter II of chapter 5 of title t of the United States Code (the substantive provisions relating to

APA adjudications); the second sentence of section 3105,of title 5 U.S.C. (assignment of cases in rotation and the prohibition of assignment to duties inconsistent with their responsibilities as hearing officers; and the deeming of them as hearing examiners appointed under section 3105 so that among other things, they would be exempt from agency performance rating requirements (5 U.S.C. 5362), and agency determination of performance acceptability for in-grade increases (5 U.S.C. 5335(a)(3)(B)), and making Civil Service responsible for determining their pay levels (5 U.S.C. 5362), removal for cause (5 U.S.C. 7521), and general administration (5 U.S.C. 1305). ... Moreover, the specific enumeration of these provisions of the APA should not be interpreted to make these adversary proceedings ... The enumeration of these provisions also should in no way suggest that they are not applicable to the regular Social Security ALJs. The committee and the Department of HEW consistently over the years have declared that the language in title II (and under the provisions of this bill, title XVI) of the Social Security Act call for "on-the-record" hearings which invoke the provisions of the Administrative Procedure Act.[S.R. 94-550 at p.6] (emphasis added) [Legislative History, P.L. 94-202, at pg. 6,]

In 1977, Section 1631(d)(3) of the Social Security Act was amended to permanently assign the SSI judges to hear all cases arising out of the Social Security act, "notwithstanding the fact that their appointments were made without meeting the requirements for hearing examiners appointed under such section 3106 and subject as such to subchapter II of Chapter 5 of title 5, United States Code. ..." In a report accompanying the bill (H.R. 5723) the Committee on Post Office and Civil Service reviews the history of the SSA hearing process and its status as on-the-record APA hearings. In very forthright and clear language, the committee noted:

It is hoped that these requirements and procedures will be applied in a manner to effectively serve the needs of the Social Security Act programs. The Committee is not convinced that these needs have been adequately served in the past by the Office of Administrative Law Judges, Civil Service Commission. The performance of this office in overruling the administering agency (HEW) in its legal opinion that SSI was under the APA and in downgrading title II social security adjudications as bearing "little resemblance to full-blown adversarial proceedings conducted by Administrative Law Judges, under the Administrative Procedure Act, in regulatory agencies" does not reflect the will of Congress [H.R. 95-617 part 2, pg 5, 1977, emphasis added].

In 1978, an amendment to 5 U.S.C. 3105 changed the name of the hearing examiner to Administrative Law Judge (although the Civil Service Commission had made the change in 1972, it was not made statutory until 1978). In a report from the Committee on Post Office and Civil Service, the following statement was made:

Hearing examiners [now, pursuant to Civil Service Commission regulation designated as Administrative Law Judges (ALJ's)] are an integral part of the rule making and adjudicatory procedures required by the Administrative Procedure Act (APA) of 1946 (codified as 5 U.S.C. 551 et seq.). Section 556 of title 5 requires ALJ's to serve as presiding officers with respect to rule making or adjudicatory hearings. The purpose for requiring ALJs to preside over such proceedings (unless the agency itself presides or one or more members of the body which comprises the agency preside) is to provide for independent individuals as presiding officers, thereby insuring the impartiality of the administrative process.[emphasis added]

To insure this independence and impartiality, the APA provides certain statutory protections of ALJs to preclude the possibility of agency pressure or influence. For example, although each agency appoints its own ALJs (5 U.S.C. 4301) it may appoint only those individuals which the Civil Service Commission has certified as qualified. In addition ALJs are exempt from performance evaluations by their agencies (5 U.S.C. 4301); can be removed only for cause established by the Commission, not their employing agency (5 U.S.C. 7521); and receive periodic step increases in pay without certification by their employing agency that they are performing at an acceptable level of competence (5 U.S.C. 5335). In essence, individuals appointed as ALJs hold a position with tenure very similar to that provided for Federal judges under the Constitution (H.Rpt 95-321, 95th Cong. 1st Session, May 16, 1977).

On April 28, 1995, Mr. Charles A. Jones, the director of the Disability Process Redesign Team circulated a concept paper for the reorganization of OHA. In that paper, he stated that "neither the agency nor the Supreme Court ... has ever conceded that SSA adjudication is strictly under the APA ... . While preserving that approach, SSA could undertake to clarify and refine APA procedures and mandates to fit its unique mass adjudication context." Apparently accepting this reasoning, a staff member of this subcomittee, Ms. Valerie Nixon, sent a memorandum on May 9, 1995 in which she stated that the committee wanted SSA/OHA reaction to "changing the Administrative Law Judge position to a Hearings Officer Position." **It is this writer's opinion that it is time once and for all, for Congress to put an end to the annual attempt of SSA to remove the disability hearings from APA coverage. The history set forth in this paper documents that from the inception of the Social Security Act, due process "on-the-record" hearings were mandated by Congress.** The Supreme Court has indeed recognized that these hearings are covered by the APA, and Congress, each time it makes changes in the Social Security Act reiterates its intention to maintain these hearings as "on-the-record" APA hearings. Thus, the hearings must be conducted under Title 5 of the U.S. Code, and the judges who preside over these hearings must be selected and assigned pursuant to Title 5 (the Administrative Procedures Act). It does not serve the public interest to have SSA raise this question almost yearly before Congress, necessitating time spent on rehashing something that is well established in statute and case law. While SSA would much prefer not to be subject to the APA, this is just not the case, and we can only succeed in making a dent in the backlog if we move forward, not backward.

II. The Administrative Law Judge is the only one who stands between the excesses of the Agency and the Public

It has long been the position of the administrative law judges that services to the public cannot be maintained at a level which provides procedural and substantive due process given the nature of the pressures placed upon both the ALJ and the support staff.

Historically, beginning in January 1981, hiring freezes accompanied by significant increases in the Social Security work load, created substantial problems in the appeals process. By 1982 both the Courts and Congress became concerned that the public was being deprived of due process as a result of the combination of these two factors and the shortcuts utilized in order to accommodate for the lack of personnel. Significant pressures were placed upon the adjudicative branch of the agency (the Administrative Law Judges) to increase productivity in order to keep pace with the ever increasing backlog.

In June 1983, Senators Levin and Cohen became so concerned with the increasing pressure for productivity that hearings were held by the Senate Subcommittee on Oversight of Government Management of the Committee on Governmental Affairs. Their report, issued September 16, 1983 found that:

> SSA is pressuring its ALJ's to reduce the rate at which they allow disabled persons to participate in or continue to participate in the Social Security disability program...,
> The Subcommittee also finds that the SSA is imposing this pressure through several means including the inequitable and unjustified targeting of only allowance decisions and high allowance judges for review pursuant to an amendment sponsored by Senator Henry Bellmon and passed in 1980 (Bellmon Review), **and the use of minimum production quotas and productivity goals.** (emphasis added)

The committee recommended that the Bellmon Review be immediately discontinued, that SSA immediately stop all managerial, administrative, and policy related activity directly or indirectly aimed at influencing the ALJ's allowance rates. It further recommended that the Judiciary Committees of both the House and Senate review the propriety and legality of the SSA's actions regarding ALJ productivity.

In September 1982,the Associate Commissioner introduced a program which was designed to work with the Bellmon review. It was known as a feedback program. As one Judge described it in his testimony in a Joint Hearing of the House Subcommittee on Social Security and the Senate Special Committee on Aging held on March 24, 1984 in Hot Springs Arkansas, "It would be a system whereby individual ALJ's would be advised of their 'decisional weaknesses,' and provided with a 'mechanism for long-term improvement.' [The] memorandum provided for a timetable for improvement, failing improvement within certain steps and after certain training and counseling, the memo promised that 'other action would be taken." As early as 1980, the Administration began discussing with Judges in Ft. Smith, Arkansas the fact that they had significantly higher allowance rates than other offices in their area. At a trial in the United States District Court for the District of Columbia, (in the winter of 1984) two Judges in the Fort Smith hearing office testified that the Deputy Director of the Office of Appeals Operations informed them that the only way to be free of the agency's continual peering over their shoulder was to lower their reversal rates (then in the 90% range) to the national average of 45-55% [all in violation of the APA 5 U.S.C. 4301 and 4302]. Litigation initiated by the Association of Administrative Law Judges Inc. to protect the rights of the public [paid for by donations from individual administrative law judges and ultimately fees awarded under the Equal Access to Justice Act] resulted in a decision written by the Hon. Joyce Hens Green, which is perhaps one of the most significant documents in support of the need for an independent corps of administrative law judges. In her words:

> ...the evidence as a whole, persuasively demonstrated that **defendants retained an unjustifiable preoccupation with allowance rates, to the extent that ALJs could reasonably feel pressure to issue fewer allowance decisions in the name of accuracy.** While there was no evidence that an ALJ consciously succumbed to such pressure, in close, cases, and, in particular, where the determination of disability may have been based largely on subjective factors, as a matter of common sense, that pressure may have influenced some outcomes. Association of Administrative Law Judges v. Heckler, 594 F. Supp 1132 (D.D.C., 1989)[emphasis added]

Interestingly, while Judge Green dismissed the claim of the Association upon the ex parte representation of the government that the so called "Bellmon Review" would no longer be utilized to rank and evaluate judges, we find that **Bellmon Review** remained "alive and well and living at OHA" in the form of a "quality review" predicated upon **Bellmon.** This "quality review" compiled region by region, gave a percentage rating for the quality of a judge's work, and gave each hearing office a percentage rating. Each judge in the Social Security Administration had his or her work evaluated and percentage ratings on a scale of 100 assigned to a) appealed affirmations; b) allowances; c) unappealed affirmations; and d) **a total composite accuracy rating.** A copy of such a report, bearing a June 1986 date was submitted as an exhibit to this writer's written and oral statement before this Committee's subcomittee on Administrative Law and Governmental Each individual judge was named, and a percentage as to accuracy in certain areas was assigned. This was clearly beyond the scope of Congressional intent, and in violation of the **Administrative Procedure Act.** 5 U.S.C. 4301 and 5 U.S.C. 4302, when read together provides that while each government agency is required to develop performance appraisal systems which would be utilized to assist in training, retraining, and possible merit increases, administrative law judges are specifically **excluded.** (see 5 U.S.C. 4301 (2)(D). Thankfully, the current quality review process, which this writer had the privilege of taking part in protects the identity of individual judges and is neutral in the manner in which it tracks accuracy. Moreover, cases are selected without regard to which judge heard the case, and solely on the basis of social security number [there still remains, however, some question as to whether even this procedure violates the APA provisions on rating and evaluating ALJ's].

There can be no doubt that the original intent of Congress was to create an administrative judiciary which while employed by the agencies it serves, was expected to maintain its decisional independence.

As a result of these pressures on administrative law judges, in 1981, the Judicial Administration Division of the ABA published a report entitled **THE IMPROVEMENT OF THE ADMINISTRATION OF JUSTICE**. In discussing the independence of the administrative law judge, one portion of the report stated:

> ... It is not too much to say that due process would require, if the independence of the trier of facts is tainted, that no weight or effect whatever be given to his decisions. A decision by a judge who is under the influence of one of the disputants would lack the most elementary basis of actual or apparent fairness.

Thereafter, the **American Bar Association** in response to the recommendation of John H. Pickering, Chairman of the Commission on Legal Problems of the Elderly issued an unprecedented award to the Administrative Law Judges of the Social Security Administration. Mr. Pickering's report stated in pertinent part

> "The Commission on Legal Problems of the Elderly hereby requests the American Bar Association Board of Governors to approve a one-time special recognition for the Administrative Law Judge Corps of the Social Security Administration (SSA) in recognition of their efforts to maintain the judicial independence expected of such functionaries in the face of various pressures to compromise objectivity and join in reducing the number of disability benefit allowances of the agency during the period from 1982-1984.
>
> The action of these ALJs during the period in question enabled many claimants to receive full and fair consideration of their eligibility for benefits and provided needed relief from policies and practices of the Social Security Administration which would have resulted in unjustifiable denials of benefits to thousands of disabled citizens who lack adequate means of financial support. The objectionable SSA policies attracted national concern. The Congress, the courts, and the Social Security Administration itself have addressed many of the problems which arose during the period and significant improvements have been made.
>
> In maintaining appropriate judicial objectivity, the 800 members of the Social Security ALJ corps evidenced a respect for the rule of law, protected the integrity of administrative adjudication within their agency, and preserved the public's confidence in the fairness of governmental institutions on a scale that has rarely been equaled in American adjudication. In so doing, they provided an extraordinary demonstration of the wisdom and viability of the 1946 Administrative Procedure Act and its protection of the administrative process which one past president of the ABA has described as 'literally our administrative bill of rights.'
>
> ...
>
> Despite the pressure felt by many ALJs to increase the rate at which they affirmed SSA benefit denials it is a matter of history that they largely maintained their traditional affirmance/reversal rates and, presumably, the objectivity of administrative adjudication within the SSA disability program.
>
> ...
>
> It is a tribute to the profession and its fidelity to the rule of law that the Social Security ALJs, during a period of great systemic strain, continued to insure that the processes they used to hear cases and render decisions were not compromised by pressures to stress 'quantity' or to respond to extra- judicial budgetary concerns of SSA in individual case adjudication (however legitimate these considerations might have been as matters of general agency policy.) This was in the best tradition American judicial officers discharging sworn obligations in times of public clamor and governmental flux. ...

These words alone are justification for retention of the present hearing system. It is worthwhile to note, that the Agency's present focus has changed from denial decisions to encouraging reversal decisions granting benefits, as these can be completed more quickly and according to the Agency, without the need for the use of an administrative law judge. Unfortunately this approach fails to take into account the economic considerations. It is important to note that over the course of the last several years, the Office of Hearings and Appeals has experienced little if any pressure with respect to the way in which claims are decided. In fact, professionalism has increased substantially. This writer believes that this is due in large measure to the stewardship of OHA by Daniel L. Skolar, Associate Comissioner, who as a former judge, understands the concept of due process and the need to separate prosecutorial and decisional functions of the agency.

III. Both the Short Term Project for Staff Attorneys and the Administrative Officer Concept violate the APA and should not be effectuated

Mr. Jones' April 28, 1995 memorandum outlines a plan for the reorganization of OHA that tramples upon the principles of the APA. When coupled with the AO concept, those individuals applying for disability benefits will be deprived of their ability to have a full and fair record before the administrative law judge. Moreover, the AO concept combines both the prosecutorial and adjudicative functions of the agency in one individual, violating the APA. It is very doubtful that even if this system were to be put into effect, it would reduce the backlog of cases reaching hearing level. One need not be an actuary or a mathematician to see that 1500 AO's nationwide cannot replace the current reconsideration determination and reduce the OHA case load. There are, at the present time, significantly more people handling the caseload at the state agency level, yet the case load increases. Assuming that the statutory standard for benefits remains the same, less people cannot do more.

Looking to the legality of the scheme, as was previously noted, A claimant's right (in a disability claim) to a due process hearing flows both from statute and U.S. Supreme Court case law. The relevant statute is 42 U.S.C. 421. This section specifically provides that any person not satisfied with the determination of a state agency has a right to a hearing to the same extent as is provided in 42 U.S.C. 405(b).

In order to properly understand the problems inherent in Mr. Jones suggestions for the new type of ALJ hearing, one must understand that it is a fundamental concept of administrative law that the administrative law judge has a duty to develop the record. In 1946, a Senate Committee report made it abundantly clear that it is the duty of the administrative law judge to develop the record, noting that presiding officers have "the authority and duty-as a court does-to make sure that all necessary evidence is adduced and to keep the hearing orderly and efficient."[Sen.Doc.No.248, 79th Cong., 2d Sess., 207 (1946)] The Supreme Court has recognized this special duty and stated that the Social Security ALJ "acts as an examiner charged with developing the facts." [Richardson v. Perales, supra.,] In another landmark case, Justice Brennan wrote

> There is a 'basic obligation' on the ALJ in these nonadversarial proceedings to develop a full and fair record, which obligation rises to a 'special duty ... to scrupulously and conscientiously explore for all the relevant facts' [Heckler v. Campbell, 461 U.S. 458, 103 S.Ct. 1952, (1982)].

Interestingly, this rule has been extended as far as the district court. While the district court judge does not have authority to develop the record, he or she also has the duty to assure that a complete record is before the Secretary. Thus, the judge has a duty to direct the Secretary to secure additional evidence where there is a showing that there is "new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding ... ". ... "Thus, while the district/courts have no factfinding role in Social Security review cases, the statute contemplates that matters not included in the administrative record may be presented to those courts for the purpose of establishing the need for an order directing the taking of additional evidence." [Hummel v. Heckler, 376 F. 2d 91, at 93 (3rd. Cir., 1984)].

Bearing this in mind, a scheme which contemplates closing the record before the matter reaches the ALJ is clearly illegal. Thus, Mr. Jones' plan for "a regulatory framework that discourages or precludes ALJ development activity once "certified" cases are handed to them for adjudication "[see Jones memo to the Disability Process Redesign Team Advisory Counsel, Apr. 28, 1995 with attachments] flies in the face of the language of the Supreme Court, and demonstrates a lack of understanding as to the law. The scheme provides for an Administrative Officer, not necessarily a lawyer, who is responsible for developing the record. He or she is to be co-located with other SSA components. The AO would have authority to decide whether to issue a favorable decision or an unfavorable decision which would result in the right to a hearing before an administrative law judge. The proposal indicates that this scheme does not violate the APA. This is a blatantly false statement. Section 5(c) of the original act provided that "no officer, employee, or agent engaged in the performance of investigative or prosecuting functions for any agency in any case shall, in that or a factually related case, participate or advise in the decision, recommended decision, or agency review pursuant to section 8 except as a witness or counsel in public 99 L:proceedings." [P.L. Ch 324, June 11, 1946]. The statute remains the same today. According to the plan, the AO will do just that. He or she will gather evidence, decide whether to proceed further with agency proceedings (hearing) or not (a prosecutorial function) and make a decision which would become the final decision of the agency if not appealed. All of this would be done without the protections of a due process hearing pursuant to the APA provisions. It is hard to fathom how anyone could believe this is not violative of the letter and the spirit of the act. In the 1950's the Post Office conceived of a plan substantially similar to the current AO proposal. The Post Office contended that the Postmaster General's authority could be delegated to any of his subordinates and contended that the APA did not preclude the delegation of his authority to make decisions to whomever he chose. The court, however viewed it differently, finding that "The provisions for the appointment of impartial, independent Hearing Examiners are the very heart and soul of the Administrative Procedure Act and variations therefrom should not be countenanced except where a statute expressly provides for a Hearing Examiner appointed in another manner." [see Borg-Johnson Electronics, Inc. v. Christenberry, 169 F. Supp. 746 at 753, (S.D.N.Y., 19590] The court noted that under the plan, the "corps of independent Hearing Examiners provided for in the act would be permitted to hear only such cases as the agency wanted them to hear" and that "The Administrative Procedure Act is to be viewed without antagonism by the courts and such a virtual nullification of one of its most important provisions is not to be countenanced in the absence of express congressional mandate CF. Shaughnessy v. Pedreiro, 1955, 349 U.S. 48, 75 S.Ct. 591, 99 L. Ed. 868."[Ibid., at p. 754. This decision was followed in a New Jersey case involving the same plan [Greene v. Kern, 178 F. Supp. 201 (D.N.J., 19590] and has never been overruled by a highter court.

The proposal to co-locate the Administrative Officer with other SSA components, even to the extent of a shared waiting room poses another significant problem. With the APA requiring a separation of the prosecutorial functions of the agency from the adjudicatory functions of the agency, the existence of a conflict is clear. The AO serving as both a prosecutor and decision maker violates the APA, and the violation is compounded with co-location. The same holds true for the plan to co-locate the Office of Hearings and Appeals with other components of the agency. Even under the present system, with ALJ's employed by the agency whose cases they decide, litigants in the system often believe they cannot receive a fair and independent judgment. As an example, in 1983, a businessman named Henry Stanko was charged with violating provisions of the Department of Agriculture's meat inspection regulations. When faced with a hearing before an Administrative Law Judge in the Department, he told a reporter from the Denver Post "I think it was because he does work for the Department of Agriculture. He felt a lot of pressure. He was on the Department of Agriculture team. You always vote with your team, don't you.?"[see Denver Post, Sat. Aug 25, 1984, p.1 Sect. C] So too, Winston Borden, President of the Minnesota Association of Commerce and Industry noted in a speech at Hamline Law school that "There is a need in that area (of administrative hearings) for independence and neutrality **both in appearance and in fact.** Business simply does not believe that those hearings are independent and objective today." [Address by Winston Borden, President,

Minnesota Association of Commerce and Industry, at Hamline Law School (Sept. 30, 1983)]. Imagine if you will, how can disability claimants, most of whom are not well educated (often illiterate), will perceive the new process for disability applicants. There can be no doubt that they will believe the agency is prosecutor, judge and jury. Nothing anyone tells them can change such an impression when they wait in the same room to see the Adjudicative Officer who denied their claim, and the Administrative Law Judge. One need not be a lawyer to understand the impropriety in co-location.

The proposal for short term solution to the backlog, the regulatory scheme advanced in the **Federal Register**, Vo. 60, No. 72, Fri. April 14, 1995 entitled Administrative Review Process, Prehearing Proceedings and Decisions by Attorney Advisors also creates serious problems in terms of the APA, and the substantive law.

As previously noted, a claimant's right to a due process hearing is statutory, and accrues under 42 U.S.C. 421. This section specifically provides that any person not satisfied with the determination of a state agency has a right to a hearing to the same extent as is provided in 42 U.S. C. 405(b). Thus, the jurisdiction of the administrative law judge attaches the moment the notice of hearing is filed. Although the Secretary is authorized to conduct own motion reviews under subsection (c), a reading of this subsection makes it clear that such reviews are for purposes of quality review and the Secretary is directed to review "to the extent feasible, ... those determinations which the Secretary identifies as being the most likely to be incorrect." [42 U.S.C. (c)(3)(B)]. The proposed regulations permit a broad based review by staff attorneys, including cases in which claimant's submit material which is new and material, and thus was not before the state agency. This goes far beyond the own motion authority put forth under the statute.

Interestingly, on August 8, 1978, in a letter to a Mr. Dale Buchanan, then Chief Judge Philip T. Brown voiced the opinion of the agency that a similar proposal would likely result in serious legal problems, and expose the agency to law suits. Moreover, he noted that "we have reservations about using the prehearing interview in highly judgmental factual situations; e.g., determinations of disability.".

While the proposed regulations state that staff attorney review of cases "will not delay the scheduling of a hearing" this is not correct. Most hearing offices assign a case to an administrative law judge from master docket. Current regulations provide that the ALJ sets the time and place of the hearing (20 C.F.R. 404.936 and 20 C.F.R. 1436). The proposed regulation provides "if the prehearing proceedings are not completed before the date of the hearing, the case will be sent to the administrative law judge unless a wholly favorable decision is in process ..." The implication is that the staff attorney will review the case **before** it is assigned to an administrative law judge. Thus, since it is the ALJ who sets the time and place of a hearing, no hearing date can be set until the case is sent to the judge. Thus the language of the proposed regulation creates an additional level of determination between that of the State Agency's reconsideration determination and the ALJ hearing. As such it creates delay rather than saving time, for a substantial number of cases.

It is interesting to note that the proposed regulation fails to state who will make a determination that a case should be reviewed by a staff attorney under this proceeding. I presume that it would be the supervisory staff attorney. Thus you interpose yet another level of screening to further delay the case reaching a judge.

In addition to this, each staff attorney who reviews reconsideration determinations for potential on the record fully favorable decisions, is one less staff attorney to draft decisions for those going to hearing. Although a proposal has been circulated that will establish writing centers to take up the slack, this again generates delay. When a case is written in a hearing office, it is usually no more than a matter of days before it is presented to the judge for review and final draft. If cases are to be sent to a writing center, we must add to processing time the time for logging the case in and out, as well as outbound shipping and return shipping. Furthermore, the ability of the writer and judge to communicate is severely limited, thus compromising the quality of the decision produced. Lastly, in this context, past experience has shown that when files are sent out of the hearing office there is a significantly higher chance of loss of the file.

This proposal further violates the APA in that attorney advisors are employees who are indeed rated, ranked and evaluated by the agency, yet they will be making final determinations of disability. Moreover, since they may only make final determinations if they are favorable to the claimant, it is to be expected that there will be a higher number of favorable determinations, in order for these attorneys to be favorably rated by the agency. Imagine what this emphasis on favorable decisions will do to the Trust Fund. Just as the Agency's press for denial decisions in the 1980's violated the APA, so too does its current push for favorable decisions violate the provisions of the Act. It is inconceivable that non APA covered employees will be permitted to make final determinations of disability without the appropriate guarantees of independence that the APA provides.

IV. Identifying the Problem and Proposed Solutions

Having worked in the Office of Hearings and Appeals for almost fourteen years, this writer has come to the conclusion that the problem lies not with the process itself, but rather with the way it is administered. OHA, as well as other components of the agency have, for years functioned without adequate staff and equipment. Given the current number of ALJ's, if staffing and equipment were significantly improved, the backlog could be eliminated without too great a strain on the system.

In 1987, and in 1989, the Committee on the Judiciary of the House of Representatives, Subcommittee on Administrative Law and Governmental Relations held hearings on the issue of the effect of staff reductions in SSA on the processing of disability appeals. In each instance the conclusion was drawn that such reductions were in large measure responsible for the difficulties. In the last issue of the **Social Security Forum**,[the monthly journal of the National Organization of Social Security Claimants' Representatives] a lawyer recently wrote the editor concerning the OHA backlog:

> Enclosed is the cover sheet and first decisional page of one of my client's ALJ decision, which I received today, April 26, 1995. Please note from the decisional page that the claimant's hearing was held February 9, 1994, and that the ALJ made his decision within 48 hours. However, it took more than 14 months to have his decision written and typed!
>
> Six months ago, November 28, 1994, I wrote the Administrative Law Judge asking for a critical need expedite on this case because the claimant informed us that she was homeless. I also wrote to the Hearing Office Manager February 8, 1995, in an effort to have the decision issued. I ultimately wrote to the Regional Chief Judge on March 22, 1995, and informed him of the situation. I believe that it was through his intervention that I ultimately received the decision. ...
>
> The reason I am sending this to you is that I think it points out quite succinctly that the terrible delay at OHA is not due to a deficiency in the number of the Administrative Law Judges or their own work product. Rather, it clearly lies in a deficiency in the ALJ's staff. OHA has continued to hire a number of new ALJ's but without the necessary support staff. The backlog will never go away as long as the ALJ's do not have sufficient staff to pull cases and write, type and mail decisions. [see Letter from John V. Hogan, Esq., Social Security Forum, Vol. 17, No. 3/4, Mar/Apr. 1995, at pg. 5]

OHA staff, what little we have is working in the dark ages. Our hearing assistants,[professionals who assemble the evidence, request medical information, and schedule hearings] are using IBM selectric typewriters, some of which are 30 years old. They do not have computers at their desks! There is insufficient staff so that staff attorneys have begun typing decisions to reduce the need for clerical employees! Hearings are held by the judge without anyone else present to run the tape recording equipment or to monitor for security problems [the hearing rooms do not have panic buttons]. This often poses a danger to the judge as many of the claimants suffer from mental illness with a history of violence. Photocopy machines in the hearing office are outdated, and not designed for the huge number of copies per day produced in order to put out decisions, send out for consultative examinations, and allow the public to copy their files. Only one postage meter is allocated per office. Recently, in the Newark Office of Hearings and Appeals [where this writer is assigned] all of our 3 copy machines were out of service for the better part of a week, as was the postage meter. Thus, no work could be sent out. On average, only one of our three copy machines is working at a given time. There is no doubt that if these problems were cured, while there would be a substantial initial cost for new equipment, in the long run, we would save huge amounts of lost time and money. As to the staff problem, in the early 1980's then Commissioner Louis B. Hayes increased staff to a ratio of 4.33 per ALJ. At that time, there were was only one manager in the office, the hearings office manager. The corps of ALJ's coped well with the large number of requests for hearing because staff was directly assigned to the judge and there was, for the most part, sufficient staffing. Today, while the agency may claim that the staff ratio is about the same, each office now generally has two supervisory hearing assistants, and two supervisory hearing clerks who supervise the few staff we have. These middle management people are counted in the ALJ to staff ratio, but have no direct impact on the processing of cases, except in the rare instance (as in the Newark hearing office) where these managers on their own pitch in to do the gut work. By reducing the number of managers and increasing the number of staff an immediate impact could be had. There was a time when this writer was assigned a hearing assistant, and two clerks and decision writer, who handled the work for her docket. Today, the assignment consists only of a hearing assistant and decision writer. One does not need to be a statistician to see that with the significantly increased workload, and the decreased staff, there will be a huge backlog.

First and foremost, we must bring OHA into the 20th century before the 21st arrives. Our hearing assistants need computers with word processors, now [they have been promised to be delivered "soon" since at least 1984]! We need increased staffing to do the typing, and monitor hearings both to protect the integrity of the taped record, and for safety! And we need high volume copy machines of sufficient number in each office, to allow for continuous availability even taking into account down time for repair!

Next, reduce the paper work both at the hearings level and the district office level. At present, the claimant fills out forms at the initial level which include an application, a disability report, and a vocational report, all of which in some measure duplicate each other. When they reach the reconsideration level, they must again supply the same information, and again at hearing level, yet another set of forms is sent out requesting the same information. There is no reason why one document, the application, cannot be used to secure this information. At the reconsideration level, the request for reconsideration should provide a space for any additional medical information not previously supplied, and the same could be done with the request for hearing. The time saving just with respect to photocopying at each level, each time the file changes hands would be huge, freeing up clerical employees to perform other tasks.

At the initial level the claims representative, already a highly skilled employee should have the responsibility to better develop the medical evidence. Often files are received at OHA with the claimant stating that he or she was hospitalized and saw various doctors, listing them on the many forms they fill out, yet these reports have never been secured. It should be the CR's responsibility to request this information and to follow up **before the case proceedes to adjudication.** Also at the initial level, the file should be kept in chronological order with non evidentiary material (i.e. special computer quierries) kept in another file, separate from the documents which will become exhibits at the hearing. This should hold true at the reconsideration level as well, so that all new medical received should be placed chronologically in the exhibit folder and letters requesting information, and other non evidentiary material should be kept in the second folder. Thus, when the case reaches hearing level with both folders forwarded, the hearing assistant will not have to spend hours on each case separating and organizing evidentiary material from the so called "junk" not bearing on the substantive matters at hand. This would enable the hearing assistant to process more cases, more quickly.

For years this writer has utilized bench decisions on cases with favorable outcomes to ease the stress on claimants. There is no reason why this cannot be extended to eliminate a paper decision in favorable cases. The judge would state the rationale for the decision, utilizing the required sequential evaluation process, at the end of the hearing. A notice of favorable determination would be sent to the effectuating component as well as the claimant and counsel. No other paper work would be required thus allowing staff to perform other duties. Commissioner Skolar and this writer have, on many occasions, discussed this reform, and the Commissioner is investigating the feasibility of such bench decisions.

With respect to the staff attorneys at OHA, utilize them much as the district courts utilize magistrates. Because ALJ jurisdiction attaches the moment a request for hearing is filed [42 U.S.C. 421 (d)], if any action is required, a scheme which contemplates the judge receiving a case directly from master docket, and referring it to a staff attorney for potential fully favorable decision, to be signed by the judge would be fully consistent with the act. Indeed, this type of plan would be an excellent means to guarantee that agency policy is applied evenly and properly. Moreover, this plan is consistent with both the Social Security Act and the APA. Such a project is in fact in place and working effectively. Attorneys selected for this position should be senior staff attorneys with at least one or two years experience in decision writing. Additional attorneys if needed could be supplied by instituting a law clerk type position of limited duration for new attorney graduates, and the hiring of additional attorneys. We might also consider selecting law clerks from second year law school students, in a joint effort with law schools. Such a project might include students working for OHA in exchange for law school credit.

Much has also been said about the problem of attorneys fees both from the standpoint of the fee petition and the current fee agreement process. It is imperative that SSA not abrogate its duty to assure quality representation for claimants. The 1939 amendments to the act make it clear that Congress believed this to be essential to a fair hearing process. Several years ago, when Congress reconsidered these provisions, it again made clear its intent to retain SSA as the "policeman" assuring quality representatives for claimants. SSA now contends that the administration of this program is too costly and needs to be abandoned. To follow the agency's recommendation to eliminate the withholding of attorneys fees would be to effectively preclude claimants from securing representation, as few attorneys would accept these cases without substantial retainers. If any change is to be made at all, retain the current option for fee petition or fee agreement, and in all cases with a fee agreement which has been approved, issue a two party check to the claimant and attorney jointly, without withholding of benefits. Thus we protect the claimants who would otherwise be without the financial means to secure counsel.

These suggestions are by no means the only changes needed. But, what is important to bear in mind is that the system is not broken, it is merely sick. It can be cured without amputating the diseased part. As we humans add vitamins and minerals to aid our health, we need to add staff and equipment to the existing framework to improve the health of SSA.

5417 West Oakdale Drive
Oak Lawn, IL 60453

May 18, 1995

Hon. Jim Bunning, M.C.
Chairman, Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman and Members of the Subcommittee:

My name is Russell S. Barone. I write this letter in personal capacity and do not purport to represent the Social Security Administration (SSA) or anyone else.

I write to address concerns surrounding SSA's proposed and in-process initiatives to deal with the large case backlog that now jams the dockets of its Administrative Law Judges (ALJs). I am one of those ALJs and I have been so engaged since my appointment in 1980.

The following letter, signed by myself and seven other Judges in the Chicago South Office of SSA's Office of Hearings and Appeals was sent in March of this year to each of the 24 United States Senators and 19 members of the U.S. House of Representatives listed on Exhibit A. Last month, April, it was sent to your staff person, Ms. Kim Hildred, in anticipation of your hearings set for May 23 and 24, 1995. Though logistics and time factors precluded an invitation to testify in person which another judge and myself had hoped to receive, Ms. Hildred urged that I nonetheless send a written statement for your consideration and for printing in the Congressional Record.

THE MARCH, 1995 LETTER TO CONGRESS

"You need to know that the Social Security Administration (SSA), in one of its first acts as a newly made agency, is now implementing a billion-dollar disability give-away program. A key part of the scheme takes away the right of SSA's duly appointed Administrative Law Judges (ALJs) to perform their sworn duty and, when appropriate, deny disability benefits in some of the hundreds of thousands of cases where a request for a hearing before an ALJ has been duly made and filed.

"This is how the 'plan' works. Having grossly mismanaged the disability claims process and literally created a backlog of nearly 500,000 cases for the ALJs to hear, SSA is about to hire and misdirect a whole new fleet of bureaucrats whose sole purpose will be to pay as many of those cases awaiting hearing as they can, without having any hearing at all. These people will have no authority whatsoever to deny a case. They are being employed for one purpose only -- reduce the backlog by paying the cases, and get rid of them all by the fall of 1996.

"An ALJ who would otherwise hear these cases and either pay or deny benefits as the evidence warrants, will no longer even see such cases. What's worse, what SSA is ostensibly hiring the new bureaucrats to do (merely review the paper record of a case and decide whether it can be paid without further ado), has already been done, not once, but twice before the case even got to the ALJ hearing level -- i.e., by other SSA employees at both the initial and reconsideration levels of the claims review process. While it is true that some cases are presently paid by the ALJ without a hearing after he or she reviews the paper record, this is a far cry from hiring a person for the sole purpose of paying off a backlog.

"There are far reaching ramifications of this scheme. It not only increases the initial benefit payout by billions of dollars, but it will also add thousands upon thousands of persons to the federal disability rolls permanently. More, as word gets out, it will certainly encourage an enormous increase in new applications for benefits, and the need for more bureaucrats to manage the increase.

"Thus the 500,000 case backlog will grow -- and this at a time when Congress is trying to cut costs by removing drug addicts and alcoholics from entitlement to direct money benefits. ALJs have suggested ways to more properly address the backlog -- but SSA is not listening.

"**CONGRESSIONAL HEARINGS ARE NEEDED**. SSA's plan is going ahead without public notice or comment. ALJs cannot be fired for paying or denying 'bureaucratically incorrect' numbers of cases, but the proposed new hires will be without a job if they don't do what they were hired to do -- pay off that backlog, and fast."

With the assistance of input from other colleague ALJ's I would like to now expand on the above letter. Characterizing SSA's short-term solution for the case backlog, I believe it is fair to ask the following question:

SSA PROPOSED NINE BILLION DOLLAR BLUNDER OR A GIVE-AWAY, WILL IT MARK THE END OF ADMINISTRATIVE PROCEDURE ACT (APA) HEARINGS AT SSA?

Understanding the causes for the backlog and something about SSA's respect for Acts of Congress such as the APA provides a pretty good answer to this question.

A MAIN CAUSE FOR THE BACKLOG

To begin with, the Secretary must file a written report with the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by April 1 of each year. The report is an analysis of the accuracy of the determinations made by the State agencies during the preceding fiscal year. Social Security Act ("The Act") Section 221(c)(3)(C). These determinations result in payments or denials of claims made for disability benefits under the Act. The denials can then be appealed with a request for hearing before an ALJ.

Section 221(k)(1) mandates the Secretary to establish by regulation "**uniform standards which shall be applied at all levels of determining whether individuals are under disabilities as defined in Section 216(i) or 223(d).**" (Emphasis Added) This includes the initial determination and reconsidered determinations at the State agency level, as well as the next level, at which an ALJ may later decide a case on appeal.

Should a State agency fail to comply with the uniform standards to be applied at all levels of review and if it is established that the State agency is "substantially failing to make disability determinations in a manner consistent with h(er) regulations and other written guidelines", the Secretary is mandated to make the disability determinations. See Section 221(b)(1). Under Section 221(b)(1), the Secretary replaces the State agency in the same manner as if the State decides it no longer wishes to make disability determinations. See Section 221(b)(2).

Under Section 221(c) the Secretary has discretionary power to conduct a case by case review in addition to the mandatory obligation required by Sections 221(b)(1) and 221(b)(2). When the Secretary exercises her discretionary power to review a State agency determination after a hearing is requested, 20 CFR Sec. 404.941 and 416.941 are cited as the authority. Unless the Secretary personally conducts the review, once a request for a hearing before an administrative law judge is filed, her power to delegate this function is restricted to an administrative law judge and to no one else.

When a request for a hearing before an administrative law judge is filed, the Office of Hearings and Appeals (OHA) is the next step in the process after the State agency denial determinations. On October 1, 1994, the number of State agency denials awaiting hearings at the OHA level was 488,000.[1] The significance of the number of appeals as of October 1 is that it represents the figures at the close of the preceding fiscal year which must be reported to the House Committee on Ways and Means and the Senate Committee on Finance on or before April 1, 1995 under Section 221(c)(3)(C) of the Act.

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[1] Source: "Disability Process Redesign: Next Step in Implementation" page 35 (November, 1994)

In order to deal with this backlog SSA has proposed its Short-Term Disability Project Plan. It is designed to review cases that fall within very general, grossly described masses or categories called "profiles." Known as "Action Item Number 7," it would divert staff from OHA to cull through the appeals and it is projected that this procedure will result in allowing approximately 100,000[2] of them with no Administrative Law Judge input, review or oversight. The 100,000 cases projected to be allowed in this process will have a minimum price tag of Nine Billion ($9,000,000,000.00) Dollars added to the Social Security Disability Trust Account and to the Supplemental Security Income annual appropriation. This amount considers that each case has an actuarial value of $90,000. See: Hon C. Moore, "SSA Disability Adjudication in Crises," Judges Journal, Vol 33, Number 3 at page 2 (Summer, 1994). In her article, Judge Moore indicated that the reason for the number of appeals at the OHA level is the failure to enforce the uniform standards to be applied at all levels of determination as mandated by Section 221(k)(1). Though extant for nine years, this statutory mandate -- promulgation and enforcement of uniform standards -- has never been complied with by SSA.

PRACTICAL, BUDGETARY AND LEGAL CONSEQUENCES TO SSA'S PROPOSAL

Staff attorneys and non-attorney paralegals would be empowered for the first time[3] to issue modified and revised reconsideration determinations which will have the desired effect of allowing the claims for disability and dismissing the appeal before the case is examined by an administrative law judge.[4]

As proposed this constitutes obvious violations of 5 U.S.C. 3105, the agency's position description for the administrative law judges and the relevant sections of the federal Administrative Procedure Act ("APA") as set forth in 5 U.S.C. 553 et seq. It will subvert the mandatory rotation of cases among judges as required by the APA and it will usurp many of the powers of the administrative law judges essential to their protection of the interests of not only the claimants, but also the Trust Fund. Additionally, such proposals will put into the hands of non-ALJ's powers heretofore reserved to ALJ's whose decisional independence is protected by the APA and therefore be violative of the APA.

Also, the effect of diverting the attorney advisors and paralegals to perform the modified and revised reconsideration determinations under Action Item Number 7 will be that the administrative law judges will lose the most experienced decision writers, which the agency has heretofore required to be used and who are crucial to the ALJ's being able to handle the enormous case load at this level. With the assistance of these decision writers as of February, 1995, the per judge monthly output of dispositions was at a record level of 44[5]. In some OHA Regions of the country, the agency has announced an increased goal of 50 dispositions per judge per month. Even with present staff available, a 14% increase in dispositions to 50 would be ambitious.

Without a writing staff, even maintaining current levels of production would be impossible. It is obvious that if implemented, Action Item Number 7 will seriously diminish the ability of administrative law judges to reach the production level which the agency feels is necessary to deal with the backlog. Most significantly, the greater harm will be to the people seeking and waiting for disability benefits as a greater

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[2] It is by no means clear how this figure is projected.

[3] The agency has heretofore rejected the notion of granting any decision making powers to non-ALJ's. On August 3, 1978, then Chief Administrative Law Judge Philip T. Brown rejected the suggestion to give staff attorneys a temporary assignment to decide cases as being "inconsistent with decisional independence." He wrote that "(t)he appointees could conceivably be under pressure to conform their decisions to the views of the employing agency."

[4] The agency will argue that each modified reconsideration dismissal will be signed by an administrative law judge and 20 CFR 904.957(a) and 416.1457(a) will be cited as authority; however under the proposed HALLEX only an objection to the receipt of benefits by a claimant would prevent the dismissal from issuing. Accordingly, the signature of the administrative law judge who will be a member of management as either a regional chief or hearing office chief judge will be an automatic rubber stamp. No administrative law judge will exercise any meaningful input in these modified or revised reconsideration. Further, an examination of 20 CFR 904.957(a) and 916.1457(a) does not allow for the "reasonable inference" drawn by the agency. The agency needed a regulatory basis to allow for the wholesale dismissal of appeals as part of this scheme to modify the state agency reconsideration determinations at the OHA level. Simply put, there is no regulatory basis. 904.957(a) and 916.1457(a) are the only sections which provide for a discretionary dismissal by an administrative law judge if prior to the mailing of the decision, the claimant or his representative requests a dismissal in writing. The 30 day requirement set for in the Draft HALLEX is a fabrication apparently inserted to give the appearance of a due process protection timeframe. In fact, what claimant would assert the right to a hearing within 30 days if he has been notified that a fully favorable determination will be granted in his case?

[5] Source: OHA Associate Commissioner Daniel Skoler at the American Bar Association, Mid Year Meeting in Miami, Florida, February 11, 1995.

backlog of cases at the ALJ level is logical to predict. The inevitable reduction in production will be at a point where the harm to claimants would be unprecedented.[6]

On March 31, 1994 Rhoda M. Greenberg Davis, the Director of the Process Re-engineering Program wrote to the Commissioner of Social Security that the Re-engineering Team "...took the approach of fundamentally rethinking the entire process..." And thus the Re-engineering Process Redesign was born. In the original Proposal issued in March, 1994, a series of "recurring suggestions for change" were identified by the Re-engineering Team. One of the "recurring suggestions" was that "...there is no need for an Administrative Procedure Act-protected administrative law judge (at SSA)."[7]

A valid question could be posed as to why at this time the resources crucial to fulfillment of the mission of administrative law judges are being diverted to correct the problem created at the previous State agency level?

Another obvious question is why does the SSA fail to adhere to its mandated obligation to force the State agencies to follow the "uniform standard which shall be applied at all levels of determination?"

By diverting staff from the OHA level, the agency will seriously damage its ability to function and its effectiveness. OHA is by these proposals planning to mop up the flood of improperly denied reconsideration determinations from the State agencies rather than fixing the leak at the State agency. Why not fix the leak? Why not correct the problem at the State agency level? After all, if SSA believes 100,000 decisions at the State agency are wrong (it expects to pay at least that many State agency denials in its short-term "Action Item Number 7"), something must be wrong at the State agency level.

Congress must act to require SSA to step in at the State agency level. Fix the problem where it really exists and the number of appeals will be manageable at the OHA level. It may be time consuming for administrative law judges to review each appeal; but is not each $90,000 obligation of the trust fund worth the effort and time to assure unwarranted raids do not occur?

Will this nine billion ($9,000,000,000.00) dollar give away[8] have an impact on the solvency of the Trust Fund? Will it render the pledge to provide world class service moot? There may be 488,000 "customers" at OHA; but there are 240 million U.S. shareholders in the Country who do not want to see this company bankrupt.

If there is an objection to characterizing this as a nine billion ($9,000,000,000.00) dollar give-away, then in the alternative, it constitutes the best evidence of a nine billion ($9,000,000,000.00) dollar blunder on the part of the State agencies.[9] What further evidence does the SSA need to establish that the State agencies are "substantially failing" to follow the "uniform standards" to be applied? SSA's failure to remedy the defects at the State agency level is compounded by SSA's appointment of a former director of a State agency to serve as the Director of Implementation of the Redesign Process at SSA.

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[6] The agency often cites the percentage of allowances when referring to the dispositions of administrative law judges. The number of denials and dismissals by administrative law judges exceed 100,000 per year. These are the claimants who would suffer the most under the implementation of Action Item Number 7 and these are the claimants for whom procedural and substantive due process protections have been created. It is the person denied benefits who deserves the expedited process so that if he so chooses, he can take his case to the next level of appeal. If staff presently drafting the denial decisions is diverted, the issuance of denial decisions would be substantially delayed. This delay may erroneously be interpreted to be due to the inefficiency of the ALJ when in fact, it is the inescapable result of the procedures the agency has implemented over which the ALJ's have no control.

[7] "Disability Process Redesign, The Proposal and Background Report from the SSA Disability Process Re-engineering Team," page 129 (March, 1994).

[8] It is characterized as a "give away" because there are no oversight procedures in place to ensure the trust fund interests are being protected at the OHA level. Congress intended that the administrative law judge would exercise this oversight function and the ALJ is absent from this process. These 100,000 favorable determinations are to be decided by non-ALJ's and in some cases non-attorneys who have been promised a grade increase as a questionable incentive to allow these claims.

[9] It may be characterized as a "blunder" when the Draft HALLEX envisions that non-attorney "paralegal specialists" may "issue a fully favorable modified reconsideration determination based solely upon the documents in the file" or "after completion of minimal development." (Emphasis Added). The Draft HALLEX constitutes recognition that the State agencies fail to apply the "uniform standards" at their level.

Congress must recognize this danger. If implemented as proposed it will also ultimately remove ALJ's from the hearing and appeal process. It must be remembered that the administrative law judge is the only truly independent employee making decisions on behalf of the agency. That judicial independence is the cornerstone of all of the protections envisioned under the Administrative Procedure Act. If the plan is implemented the effectiveness of the ALJ will be undermined and those in the agency who have long complained about the independence of ALJ will seek to replace them with employees who are not independent employees[10] and who can be controlled by the Agency to issue the decisions it wants depending on the political climate of the time.

The "suggestion" mentioned by the Re-engineering Team to remove the APA protected Administrative Law Judges will become a reality by default if Action Item Number 7 in the Short-Term Disability Project Plan is allowed to be implemented.

CONCLUSION

If implemented, SSA's proposals to deal with the administrative backlog (created by its own failure to address problems at the State agency level) will surely lead to both a financial and legal disaster.

In a very short term it will cost U.S. taxpayers at least nine billion dollars and it will begin to take away their right to a fair hearing by an independent judge in the Social Security disability claims process.

Remember, SSA's focus here is not directed toward finding deserving claims and paying them quickly. Rather, its only focus is to make a quick and mass reduction in the backlog. Its own recently proposed regulations to permit attorney advisors to pay claims directly at the ALJ level state as much.

Moreover, "Action Item Number 7" shows that SSA intends to reduce the backlog by simply paying cases that fall within the gross parameters of a statistical "profile." Yet, each disability claim is distinct and stands upon its own peculiar facts. In the final analysis, it cannot be decided en masse along with a statistical batch of close relatives. After all, the overall ALJ allowance rate while high, is not 100%; and many ALJ denials made after a hearing involve those cases which attorney advisors, even under present case processing systems, have suggested be paid on the paper record by the judge (ALJ) before hearing. Now, if these same attorney advisors are no longer required to make mere suggestions, but instead can pay a case without the judge's approval, it seems that the obvious will happen. SSA's short-term proposal is going to result in nothing more than an unwarranted mass payment of benefits. Even more so is this the case when one considers that the persons who will be hired to reduce the backlog in this way are empowered to effectuate the reduction in one way only -- pay cases and nothing more. This is what they will be paid to do, and I believe this is what they most certainly will do.

What about fair hearings and due process of law in the long run? If SSA is permitted to "re-engineer" the hearing process as it now proposes, forget it. SSA plans to virtually gut Administrative Procedure Act (APA) protections currently in place for Social Security hearings -- protections that have been built up and garnered by the law for over 50 years.

The hearing process for Social Security claims will be exposed to a real danger -- the danger of an almost arbitrary disregard for the facts of given case (i.e., SSA now wants to pay cases en masse; in 1983 -- the infamous cessation era -- SSA tried to deny hundreds of thousands of cases en masse, though then rejected in its efforts by the ALJs and the federal courts).

As the 21 Hearing Office Chief Administrative Law Judges (her own managers) recently warned Commission Chater in their lengthy May 9, 1995 letter (Exhibit B attached):

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[10] Previously known as "hearing examiners" "Referees" and "hearing officers" and soon to be known as "adjudication officers" and "senior attorneys."

"If the proposed framework for adjudication is now adopted, nearly 50 years of improvement, as established by congress, the federal courts and the administration in the delivery of administrative adjudication, will be completely set aside." (Page 5, Exhibit B)

In the last analysis, SSA wants U.S. taxpayers to pay at least nine billion dollars for the "privilege" of surrendering their right to a fair hearing under the Social Security Act -- a hearing which the largest independent administrative judiciary in the world can now provide and which SSA now seems bent upon destroying.

Sincerely,

Russell S. Barone

Enclosures

Senators

Hon. Bob Packwood
Hon. Arlen Specter
Hon. Pell Claiborne
Hon. John Chafee
Hon. Ernest Hollings
Hon. Strom Thurmond
Hon. Tom Daschle
Hon. Jim Sasser
Hon. Phil Gramm
Hon. Orrin Hatch
Hon. Patrick Leahy
Hon. Robert Byrd
Hon. Alan Simpson
Hon. John Glenn
Hon. Alphonse D'Amato
Hon. Jeff Bingaman
Hon. Pete Domenici
Hon. Daniel Moynihan
Hon. Jesse Helms
Hon. Bob Dole
Hon. Nancy Kassebaum
Hon. Richard Lugar
Hon. Paul Simon
Hon. Howell Heflin

Congresspersons

Hon. Dick Armey
Hon. Bill Archer
Hon. J. J. Pickle
Hon. John Kasich
Hon. Gerald Solomon
Hon. George GeKas
Hon. Susan Molinari
Hon. Gary Ackerman
Hon. Benjamin Gilman
Hon. Richard Gephardt
Hon. G. V. Montgomery
Hon. John LaFalce
Hon. Sander Levin
Hon. Dan Glickman
Hon. Jim Leach
Hon. Harris Fawell
Hon. Henry Hyde
Hon. Newt. Gingrich
Hon. William Lipinski

EXHIBIT A

SOCIAL SECURITY ADMINISTRATION

MEMORANDUM

Office of Hearings & Appeals

Date : May 9, 1995

To : Hon. Shirley Chater,
Commissioner of Social Security

From : Jerome Berkowitz, Hearing Office Chief Administrative Law Judge (HOCALJ) Minneapolis, MN; Tom Capshaw, HOCALJ, Evansville, IN; Stephen Davis, HOCALJ, Indianapolis, IN; William Decker, HOCALJ, Grand Rapids, MI; Patricia Kelly, Acting HOCALJ, Milwaukee, WI; James Lanter, HOCALJ, Chicago (South) IL; Anthony Leanza, HOCALJ, Cleveland, OH; Paul Lillios, Acting HOCALJ, Chicago (Downtown), IL; Martin Magid, HOCALJ, Detroit, MI; John Mondi, HOCALJ, Oakbrook Terrace, IL; Francis O'Byrne, HOCALJ at Large, Chicago (South), IL; Edward Pappert, Acting HOCALJ, Evanston, IL; Allan Ramsay, Jr., HOCALJ, Columbus, OH; David Redmond, HOCALJ, Dayton, OH; Robert Stalker, HOCALJ, Flint, MI; Phillip Waisblum, HOCALJ, Cincinnati, OH; Alan Wienman, HOCALJ, Peoria, IL; Michael Wilenkin, HOCALJ, Oak Park, MI; William Wilkin, HOCALJ, Fort Wayne, IN; Paula Zera, HOCALJ, Lansing, MI

Subject : **Comments to Proposed Rule Change, 20 CFR Parts 404 and 416**

We again want to take this opportunity to commend the strong leadership shown by yourself and the Administration in addressing the current backlog of cases at the Office of Hearings and Appeals (OHA). As you know, due to the unprecedented number of new applications for benefits, along with the relative breadth and liberality of the Supplemental Security Income program itself, the number of cases pending nation-wide has increased at an almost geometric rate. While the number of cases pending has greatly increased, OHA nonetheless has likewise responded. Indeed, over the past year, despite being inundated by overwhelming numbers, OHA case disposition increased at a record rate, fulfilling the goals set by the Administration.

EXHIBIT B

Over the past several months, we have reviewed in somewhat a piecemeal fashion a wide array of suggestions, proposals and counter-proposals forwarded by many Administration employees, task forces and study groups, related to reformation of the disability process. We recently communicated to you by memorandum dated March 27, 1995, regarding the Short Term Disability Project plan (STDP) and the draft Hallex Temporary Instructions implementing STDP Number 7. In this regard, we ask that the comments contained within that memorandum be incorporated herein since our strong concern voiced in that memorandum is fully applicable here as well. While we continue to maintain our complete support for the Administration's effort to fairly and competently address the backlog of cases, we again deem it vital that we communicate our response to the proposed changes to 20 CFR Parts 404 and 416.

The proposed changes to 20 CFR Parts 404 and 416 contemplate that attorney-advisors within OHA be now granted independent authority to conduct prehearing conferences and other proceedings, receive and develop evidence and issue decisions[1] which are fully favorable to the parties. The proposed rules now also grant the attorney-advisors the ability to call medical experts (presumably in a hearing-type forum, see 404.1520a (d)(1)(ii) and 416.920a (d)(1)(ii)), remand cases to the state agency for further development if a mental impairment becomes evident, and complete a psychiatric review technique form. In issuing their decisions, attorney-advisors under the proposed rules have also been granted the authority to assess and determine the residual functional capacity of the claimant. STDP proposals also provide that senior attorney-advisors be granted the authority to call vocational experts and take vocational expert "evidence" in addition to the above.

In order to place our comments into the appropriate context, it is instructive to review the position description designated for senior attorney-advisors under the current STDP proposal now implemented and presumably now under the above proposed rule changes. There it is stated by the Administration that:

> . . . the [attorney-advisor] is delegated the authority to issue a fully favorable action and effectuate payment of the case. The incumbent exercises independent judgment and discretion at the individual reviewing and making the final determination in the

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[1] *It is critical to note that unlike STDP Number 7 and the implementing temporary Hallex instruction, wherein paralegals and attorneys were granted the authority to issue modified and revised reconsiderations e.g., determinations, similar to those issued by the state agencies, attorney-advisors under this proposed rule are granted authority to issue decisions, exactly as would be issued by a judge appointed under the APA. This distinction is important since even under STDP Number 7, an argument could be made that the judge retained some type of oversight over even fully favorable modified or revised determinations, pursuant to 20 CFR 404.946 (a) and 416.1446 (a). However, this possibility appears to be foreclosed by allowing the attorney-advisors to issue decisions rather than determinations as defined by 20 CFR 404.901 and 416.1401. Nonetheless, there remains significant uncertainty under the proposed rules as to the nature of these decisions since even under the proposed rule it is the judge and not the attorney-advisor who will issue the dismissal of the notice of hearing.*

> case. The incumbent prepares and signs the fully favorable action as the final authorizing official.
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> * * * *
>
> In the performance of the duties delegated to the Senior Attorney Adviser position; i.e., issuing fully favorable actions revising prior reconsideration determinations and independently effectuating payment, the incumbent's decisions are issued without review and the incumbent has final adjudicative authority on the subject cases.
>
> * * * *
>
> . . . [I]t is necessary [for the attorney-advisor] to rely on past personal experience to evaluate the applicability of [the entire body of law, rules and regulations which relate to SSA] on issues where conflicting decisions have not been resolved or where factual situations vary so widely that it is highly questionable as to which precedents can be adapted to specific situations.
>
> * * * *
>
> The [attorney-advisor] has quasi-judicial powers in deciding issues based on the record he/she develops. The issues are frequently obscure and, by nature of their being decided at this level, represent those which are the most difficult to resolve. The [attorney-advisor] is responsible for conducting prehearing conferences including obtaining evidence from medical and vocational sources.

The position description also sets forth the nature of the "prehearing conference" which is in fact characterized as a "proceeding" by the position description. This "prehearing conference" or "proceeding" envisions participation by the claimant, the claimant's attorney or representative, vocational and medical experts, and any other source, e.g., fact witnesses, the attorney-advisor deems necessary or appropriate to call.

There can be no doubt but that the proposed rules (especially when read in conjunction with the above position description for the attorney-advisors and when compared to the position description for administrative law judges) intend to create a separate tier of judges within OHA, with duties that largely parallel and supplant those exercised by judges appointed pursuant to the Administrative Procedures Act (APA). Attorney-advisors within OHA will now be able to issue decisions that are dispositive of the entire claim. Except for the final denial of a claim, and perhaps the administration of oaths, the functions performed and actual duties allocated between attorney-advisors and judges are in reality, virtually identical. It is significant to note that now for the first time in OHA history, with this proposed rule, no APA-appointed judge would have any oversight authority or responsibility over the nature or quality of decisions emanating from any

OHA office. This function, with respect to the review of case dispositive decisions, would only be exercised by the Appeals Council. Needless to say, this proposed change is monumental.

At the threshold we must note that while the proposed rules and position description seem to indicate to Congress, the bar, and to the public that attorney-advisors will be independent "quasi-judicial" officers, exercising apparent unfettered decisional authority except for Appeals Council review, this simply cannot be under this proposed regulatory framework. Indeed, the sine qua non of any independent judicial officer, as recognized repeatedly by the Supreme Court, the lower federal courts and the Congress itself, is the true and actual ability to render decisions free of any control or bias. Here, the decision-maker proposed by the rule changes is neither free of control, since the attorney-advisor still can be rated upon overall performance issues, see, 5 USC 4302, nor free of bias, since the attorney-advisor is channeled by the regulations into making only one type of decision, i.e., favorable. By virtue of the retainment of the ability to rate job performance, it can easily be argued that the number and frequency of almost all favorable decisions issued by OHA can now be controlled with little difficulty, depending upon the prevailing climate or circumstances at hand, since the attorney-advisor would now have final dispositional authority over every case within OHA (except those scheduled for hearing) apparently notwithstanding whether or not a case has been assigned to a judge.

Moreover, unlike state agency adjudicators who normally can only assess the residual functional capacity of a claimant with the concurrence of medical or psychological consultants and also are closely supervised in the decisions rendered, or APA-appointed judges who cannot be rated in performance and are granted immediate tenure with removal only for cause, the grant of decisional authority to OHA attorney-advisors with no oversight by APA-appointed judges or APA protection, potentially exposes the majority of the cases which are pending to be disposed of, or influenced by, improper external factors that may be based upon political, financial or other similar considerations.

Thus, this situation is untenable for a number of reasons, both from a legal standpoint and from an institutional standpoint. We respectfully suggest that the proposed rules, as well as STDP Action Number 7 and the implementing Hallex Temporary Instruction may well irreparably impugn and impair the independence of every OHA hearing office. From a historical perspective, this is particularly problematic since OHA, having always been properly seen and considered as a neutral and unbiased entity fairly adjudicating claims, may no longer validly claim this distinction. As it is now proposed, these "quasi-judicial" officers, who clearly are not truly independent and free from decisional control are inexplicably at the same time, completely free of all effective oversight by the only independent officers of OHA hearing offices, APA-protected judges. This dichotomy is unprecedented, and carries with it the potential for complete disruption of the normal decisional processes of every OHA hearing office. This condition surely will allow the public, the bar, the federal courts and the Congress, to call into question the true independence or even the appearance of independence, of each and every OHA hearing office. If this occurs, the inevitable net effect will be to subject the Commissioner of Social Security to the charge that the fact-finding and decision-making process within the Administration, with respect to the majority of decisions rendered, is unfair and not truly free of bias or control.

Our concern also stems from a reading of pertinent Congressional statutes. It cannot now be seriously argued that the Administration (to its credit) has not over the years in good faith adopted and embraced the imposition of APA standards for adjudication of claims, or that decisional precedent does not now require this to be done. Given this condition, the

Administration thus appears to be bound to follow the requirements of the APA. In this case, the proposed rules run contrary to almost all applicable guidance given by Congress and the Office of Personnel Management in this regard. Title 5 USC 3105 requires the appointment of "as many" administrative law judges as necessary to conduct proceedings under 5 USC 556 and 557. Proceedings under section 556 include the taking of all relevant evidence, conducting conferences for the settlement of actions or simplification of the issues, disposing of procedural requests, and making or recommending dispositive decisions. As noted above, under the proposed changes to Part 404 and Part 416 and pursuant to the attorney-advisor position description, the newly created non APA-appointed "judge", i.e. attorney-advisor, would possess the complete authority to conduct section 556 proceedings as delineated above.

If the above is the case, then section 3105 requires that these proceedings be conducted by duly appointed administrative law judges rather than by any other agency employee. This point is also repeated and illustrated in 5 CFR 930.202, wherein it is stated that an administrative law judge position means a position in which any portion of the duties include those which require the appointment of a judge pursuant to 5 USC 3105, and in 5 CFR 930.209, wherein it is stated that an agency may not detail an employee who is not an administrative law judge to an administrative law judge position.

Congress and the Office of Personnel Management, since the time of the passage of the APA, have recognized the strong utility of requiring that administrative hearings and proceedings be conducted by APA-appointed judges. Not only are baseline due process concerns recognized and preserved, but also other appropriate safeguards, necessary for the fair and efficacious conduct of hearings, are maintained as well. For example, 5 CFR 930.203 requires that APA-appointed judges who are entrusted to conduct section 556 proceedings be judges who (1) are selected pursuant to open competition, (2) possess specific minimum qualifications, (3) are appointed only upon examination and (4) are given a final rating prior to appointment. Further, no APA-appointed judge can be rated in performance, 5 USC 4301(2)(D), 5 CFR 930.211, nor, pursuant to 5 USC 4503, can any APA-appointed judge receive any monetary or honorary awards for the performance of adjudicatory functions. Of course, the attorney-advisor "judges" who will now conduct section 556 proceedings under the proposed rules are not selected pursuant to the rigorous competition established by OPM for all agencies, will be continued to be rated on performance, and can be awarded monetary incentives for the exercise of adjudicatory functions. If the proposed framework for adjudication is now adopted, nearly fifty years of improvement, as established by Congress, the federal courts and the Administration in the delivery of administrative adjudication, will be completely set aside.[2]

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[2] *There are other legal concerns that have been voiced regarding the proposed rule as well. As a general proposition, an agency cannot promulgate any rule which is arbitrary or capricious. One aspect of the rule that must be considered is whether or not the granting of an additional level of administrative review, i.e., possible favorable consideration by attorney-advisors, prior to hearing by an APA-appointed judge, denies equal protection of the law to those individuals who failed, or were counseled against by the agency, to file a notice of appeal at the administrative level. Simply stated, those aggrieved individuals who file a notice of appeal automatically are accorded another level of review while those who do not file the notice of appeal are deprived of this possibility. In addition, disparate treatment, i.e., review by an attorney-advisor, is formally granted to "Profile III" claimants, at the same stage of the administrative process, but not to non "Profile III" claimants. Indeed, the denial itself of "Profile III" status to any particular claimant could conceivably be seen as an appealable issue.*

In making the above observations, it bears repeating that we do not in any way conceivable, question the Administration's authority to decide cases in any manner deemed appropriate by the Commissioner, prior to the time a request for hearing is filed and the matter is placed into controversy. Additionally, even after a request for hearing is filed, if the Administration decides at the field level to agree to the grant of benefits, this too may be appropriate under the proper circumstances. If this occurs, the Administration need only communicate the agreement of the agency and the claimant to OHA and the request for hearing may be dismissed by a judge. However, utilization of non-independent hearing office personnel (indeed the same attorneys utilized by the judges within our "chambers") to conduct evidentiary-type proceedings and make case-dispositive decisions, while at the same time purposely isolating these "decision-makers" from independent APA-protected judges, disrupts this process and appears contrary to long-established norms of jurisprudential standards recognized by virtually every federal court in the country.

In attempting to address the backlog of cases, hearing offices have on their own initiative implemented a wide number of measures to expedite the hearing process and decisionmaking in response to the concerns voiced by the Administration. Offices have begun, for example, to issue prehearing orders and conduct prehearing conferences to expedite the admission of evidence and to narrow the issues prior to hearing; have designed expedited hearing processes to deal with the high volume of cases, especially where the claimant is unrepresented in drug addiction and alcoholism SSI cases; have expanded the prehearing conferencing program to give decision-writers greater latitude in drafting and submitting decisions for judges' signatures; have implemented computer training for all employees of hearing offices; have standardized and placed on the computer routine notices, etc.; and have made computers available for judges so that they can draft fully favorable decisions and correct decisions directly off the computer network, thereby relieving typing resources. In short, the process to streamline our work operation is well underway, and will reflect in continued increased decisional performance. Accordingly, we are in agreement with almost all of the proposals forwarded by the Administration and with many of the preliminary reengineering proposals we have seen.

In assessing the efficiency of allowing paralegals and attorney-advisors to conduct proceedings and issue dispositive decisions, however, several early warning signals have emerged that should give pause to the Administration prior to implementation of the proposed rules. We have already seen a significant increase in the backlog of cases which have been decided by a judge but which are waiting to be drafted by a decision-writer. This, of course, is due to the shift in emphasis by paralegals and attorneys from decision-writing already decided cases, to screening, reviewing, developing and then writing their own cases. There has been no correlative increase in clerical support for this additional effort. Accordingly, since we are only shifting emphasis and not increasing real production capacity, the number of cases decided by attorney-advisors will be significantly offset by the removal of decision-writers from the judges. In addition, anecdotal experience in several offices has already shown that the vast number of cases reviewed for possible favorable disposition are not amenable to on the record treatment, since a formal hearing is required to truly gauge and determine variable issues such as credibility of the claimant and other witnesses. Therefore, in reality, the amount of time spent on any one case prior to final decision will often literally double given the fact that two judicial officers have handled the case rather than just one as is now the case. Finally, from a logistical standpoint, no consideration has been given to just where in the hearing office attorney-advisors will conduct their proceedings and how they will be staffed in terms of monitoring and security, what budget considerations are implicated by the probable increase in monies expended for medical and

vocational experts, and how will the possible conflicts in obtaining adequate numbers of expert witnesses where the attorney-advisor has already utilized a particular expert in prehearing proceedings and the case is subsequently forwarded for a formal hearing be resolved sufficient to satisfy due process concerns and other relevant concerns such as maintaining an adequate availability of different types of experts.[3]

In order to recognize and address the well-founded concern over the backlog of cases reflected in the proposed changes to Part 404 and Part 416, there is a readily workable solution that will vitiate nearly all of the concerns voiced above and, at the same time, will go dramatically further in reducing the backlog of cases. The proposed rules should be amended to provide that the attorney-advisors be allowed to issue recommended decisions in a magistrate judge-type of arrangement. This configuration is appropriate since it allows the attorney advisors to fully participate in conducting prehearing conferences, developing the record and moving the case towards ultimate disposition, while at the same time, maintaining the prerequisite of some degree of final judicial approval over decisions emanating from OHA by an Administrative Procedures Act (APA) appointed judge. With a magistrate judge system in place, the work of all judicial officers, both attorney-advisors and administrative law judges would be complementary and synchronized rather than separate, distinct and counter-productive.

A magistrate judge arrangement is a concept that has been universally adopted by state and federal courts across the country. In this case, the magistrate judge proposal can be effectively modeled after the magistrate - district judge relationship seen in the United States District Courts. In the federal district court, the magistrate judge (as well as the bankruptcy judge) operate as an adjunct to the district court. Title 28 USC 636 confers specific jurisdiction upon a United States magistrate judge, including the ability to administer oaths, conduct pretrial proceedings, conduct evidentiary hearings when designated by the district judge and to issue reports and recommendations for the district judge. Significantly, magistrate judges do not have the authority, except where all parties consent, to issue case dispositive orders in any civil or criminal matter.

Attorney-advisors can be utilized in much the same way as magistrate judges with beneficial results. Under this scenario, attorney-advisors can conduct proceedings as previously contemplated, and submit recommended decisions, both favorable or unfavorable depending upon the circumstances shown. The would be no question of partiality if the attorney-advisor has the ability to recommend either result. Further, under this system, there would be no duplication of effort. The case would be resolved simply at the appropriate stage of judicial scrutiny. Given the fact the Administration, through its well regarded recruitment and hiring practices, has developed a world class administrative judiciary which is on par with any judicial system in the country, it makes better sense to augment and support the decision-makers in place rather than create a entirely separate class of judges who compete for the same limited resources and who have not been duly qualified by OPM or have been accorded APA tenure.

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[3] *It should be remembered that with several types of experts, particularly specialized medical experts, in some areas there are not a sufficient number of experts currently on contract with the Administration. Thus, if the attorney-advisor has utilized the only available expert in an area and the case stills goes to hearing, a significant conflict will arise if the administrative law judge is unable to obtain an expert for the formal hearing. As the situation now stands, it appears that attorney-advisors under the proposed rules have the complete discretion and authority to call any medical, vocational, or other witness, without any substantive guidance, oversight or management by any APA-appointed judge or by the hearing office.*

We respectfully hope that these comments are helpful in resolving these complicated issues. As always, if the Administration needs any further information or clarification in this regard, we stand ready to assist. Thank you for your consideration.

cc:

Hon. Daniel Skoler, Associate Commissioner, OHA
Hon. James Rucker, Acting Chief Administrative Law Judge
Hon. Stephen Ahlgren, Regional Chief Administrative Law Judge

FROM DISABILITY ROLLS TO PAYROLLS: A PROPOSAL FOR SOCIAL SECURITY PROGRAM REFORM

Andrew I. Batavia and Susan B. Parker

The Social Security Disability Insurance (SSDI) Program, title II of the Social Security Act, offers cash benefits to people who are blind or disabled and have paid into the Social Security System through employment for a requisite number of quarters. It is a social insurance program, and serves as a basis for Medicare eligibility. As of December 1993, there were about 4.5 million SSDI beneficiaries (including 3.72 million disabled workers) for a total annual expenditure of $34.6 billion for the cash benefit alone (DHHS, 1994, page 158). In 1992, there were 3.57 million individuals with disabilities enrolled in Medicare, for a cost of $14.3 billion (DHHS, 1994, Table 8.B2).

The Supplemental Security Income (SSI) Program, title XVI of the Act, offers cash benefits to people who are aged, blind or disabled and have very limited incomes or resources. It is a welfare program, and serves as a basis for Medicaid eligibility. At the end of 1993, there were about 5.98 million SSI recipients (including 4.5 million SSI blind and disabled recipients) for a total annual federal expenditure of $24.6 billion for the cash benefit (DHHS, 1994, Table 7.A1). In 1993, there were 4.9 million individuals with "permanent and total disabilities" receiving Medicaid, for a cost of $38 billion (DHHS, 1994, Table 8.E2).

In response to a general consensus that these disability programs impose substantial disincentives to work, several laws were enacted by Congress in the 1980s to encourage SSI and SSDI beneficiaries to seek gainful employment and leave the disability rolls (NARF, 1988). Yet, despite this legislation and strong indications that many disability beneficiaries wish to work, very few ever leave the programs voluntarily (Muller, 1989). In December 1993, only 35,299 of the 5.98 million disabled SSI recipients participated in the Section 1619 work incentive program (DHHS, 1994, Tables 7.F5 and 7.A3).

In recent years, applications for both programs have increased dramatically due largely to increasing disability among the aging baby boom population. The number of SSDI beneficiaries alone increased 27% from 1989 to 1993, as compared with a 7% increase in retired-worker beneficiaries (DHHS, 1994, page 158). Disability benefit payments increased 51% over that period. The unabated growth of the programs, and the failure of the work incentive provisions to curtail such growth, has made it apparent that incremental changes are not sufficient. Substantial structural reform is needed to ensure the long-term viability of the programs. This article outlines a proposal for such program reform.

Medical Model of Disability

Both the SSDI and the SSI programs use eligibility criteria that deter beneficiaries from becoming employed. Under both programs, the determination that a claimant has a work disability for purposes of determining program eligibility is currently based largely on a claimant's diagnosed medical condition. The definition of disability requires that a person have a "medically determinable impairment that lasts for a period of 12 consecutive months or can be expected to result in death."[2] The definition also requires that the individual not be able to earn above the "substantial gainful activity" (SGA) level -- currently $500 per month.

SSA maintains a "Listing of Impairments" that assists the decisionmaker (i.e., disability examiner, physician) in determining whether a specific

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[2] 42 U.S.C. 416 (i) (1), 20 C.F.R. 404.1505.

impairment is sufficiently severe to constitute a disability. Further, SSA maintains a limited list of impairments (e.g., blindness, mental retardation) for which a presumptive disability decision can be made. This "medical model" assumes a causal relationship between the existence of a severe impairment and a permanent inability to work. While this assumption may have had some validity at one time, prior to efforts to make our society more accessible, nowadays even people with major functional limitations are able to work if provided the needed supports.

However, such individuals who actually achieve gainful employment and leave the disability programs continue to be the exception. They tend to be those with the strongest social support networks; individuals with families, friends and resources available. Many people with disabilities do not have these personal advantages and are provided little support to become productive. In fact, the medical model's underlying assumption equating impairment with disability tends to create a self-fulfilling prophesy, convincing people with certain conditions that they are "too disabled" ever to work.

Functional Model of Disability

This proposal is based on a "functional model" of work disability, as opposed to the medical model. Using this approach, few inferences are drawn about ability to work based strictly on impairment or medical condition. Currently, many individuals are on SSA's disability rolls who, with appropriate supports, could and would work despite severe impairments. However, once on the rolls, they are extremely likely to remain on. Recognizing this, SSA has incorporated aspects of a functional approach into the SSI and SSDI programs in recent years.

For example, SSA applies a functional approach to certain conditions (e.g., mental illness) that do not have presumptive disability status under the Listing of Impairments. These individuals are subjected to a "residual functional capacity" work evaluation to determine whether they have a disability. If they have the capacity to earn income at the SGA level, they are not eligible. Yet, if eligibility is established, the claimant's prospects for remaining on the disability rolls are determined largely based on the medical model.

Thus, the programs continue to be primarily medically-oriented with a focus on impairments rather than functional capacity. Currently, the claimant found to have a work disability is classified in one of three medically-oriented categories which are reviewed according to the expected improvement in the impairment:

(1) Medical Improvement Expected (reviewed in intervals from 6 to 18 months)

(2) Medical Improvement Possible (reviewed every 3 years)

(3) Medical Improvement Not Expected (reviewed between 5 to 7 years).[3]

Thus, a person who is permanently paralyzed or legally blind will typically be considered "presumptively disabled" with "medical improvement not expected," and will continue to receive cash benefits indefinitely because his or her medical status will not change. Of course, individuals could remove themselves from the programs by obtaining employment through their own initiative. However, this does not occur frequently, largely because the system allows such individuals to continue to receive benefits indefinitely by defining themselves as permanently disabled.

In fact, an individual's ability to work depends much less on medical status than on functional status and motivation, which may be affected by many

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[3] 20 C.F.R. 404.1590.

factors such as medical rehabilitation, vocational training, formal education, assistive devices, worksite accommodations, and personal assistance services. Consistent with the Americans with Disabilities Act of 1990 (ADA), public policy should reflect this reality by enhancing the functional capacity of disability beneficiaries through appropriate interventions, and by offering incentives for them to work (DeJong and Batavia, 1990).

The Proposal

The premises of this proposal are that:

- an individual's "ability to function" in the workplace should serve as the primary basis for disability determinations, and ability to function is affected by many factors in addition to medical condition;
- while medical impairments are often permanent, inability to function in a workplace is typically temporary, and therefore most determinations of work disability should be time-limited;
- people who recently sustained an impairment need a period of time to adjust to their situations, and if necessary, to gain new work skills, and the period of eligibility should reflect these needs;
- people with work disabilities often need certain services, such as attendant care, and devices, such as special computers, to assist them to function in the workplace, and such needs remain even after they become employed and lose their cash benefits; and
- it is often efficient to allow older persons with work disabilities (e.g., ages 55+), and particularly those who would require extensive retraining, to retire early with a permanent disability pension.

This proposal has ten elements. In conjunction with these, it would be useful to modify SSA's medically-oriented definition of disability consistently. Many commentors have pointed out that the current definition, which focuses primarily on one's impairment and insufficiently on one's ability to overcome handicap with environmental modifications, is obsolete. However, while modification of the definition using more functionally-oriented criteria would enhance its philosophical consistency with this proposal, it is not essential to achieving the proposal's objectives.

1. Create New Categories of Benefits

Currently, there is basically one category of benefits under the SSI/SSDI programs. If a claimant is eligible, he or she is entitled to receive a monthly amount prorated according to that year's rate. Claimants continue to receive benefits until they are no longer considered to be disabled under Social Security's definition. Under this proposal, there would be four categories of benefits. They are:

I. Permanent Disability Pension

These pensions would apply only to those claimants whose impairment inherently, totally, and permanently prevents functioning in the workplace. However, these pensions would not necessarily apply to all people with even the most severe impairments (e.g., those currently in SSA's classification "Medical Improvement Not Expected") unless there was a clear demonstration of total and permanent inability to function in the workplace.

II. Temporary Disability Benefit

These cash benefits would provide claimants with income while they are participating in various mandated interventions designed to habilitate or rehabilitate. Most beneficiaries initially would be classified in this category, and would receive benefits for a potentially expandable three-year period. The eligibility period could be expanded if the claimant can demonstrate that he or she cannot function in a workplace at the end of the

period despite substantial efforts to obtain gainful employment.[4]

A longer period of eligibility would apply to accommodate an approved vocational plan (e.g., approved technical program, four year college, graduate school). The criterion for a temporary disability benefit would be the existence of a determinable physical or mental impairment that prevents a claimant from continuing to do his or her current work or entering a chosen vocation for the first time without either a prolonged recuperative period or appropriate intervention strategies. The assumption is that, with "provision benefits" and other needed interventions (see section IV below), someone with an impairment would be able to make the transition to work.

The objective of the temporary disability benefit is to create a strong presumption of employability once the eligibility period has expired. This presumption, in conjunction with the advance understanding that program eligibility will expire at a set date and that funds are available for education, training, provision benefits, and other interventions, will create a strong incentive for the claimant to become employable. As a safety net, there could be a conversion path from the Temporary Disability Benefit to the Permanent Disability Pension if the individual fails to obtain or maintain gainful employment after several attempts.

III. Early Retirement Disability Pension

These pensions would be available to claimants over age 55 who qualify for temporary disability benefits. It would be strictly optional, and would allow such older disabled workers to choose not to reenter the work force. The amount of the pension would be the same as the temporary disability benefit to which the claimant would be entitled, but would not be terminated after three years and would not require retraining or other participation in intervention strategies. The rationale for this early retirement disability pension is that, for many older workers, the cost of retraining is not justified by the relatively few years that they will remain in the workforce.

IV. Provision Benefits and Other Interventions

These benefits comprise a wide variety of services and devices that enable a person with a disability to function as fully as possible in the workplace. Provisions include, but are not limited to, computers, voice synthesizers, adapted vehicles, transportation costs, and personal assistants (Seelman, 1993; Batavia, DeJong and McKnew, 1992; National Council on Disability, 1993). Other interventions include education, retraining, and case management services.

Provision benefits can be one-time, occasional, or ongoing, depending on the needs of the individual and his or her employment-related circumstances. Initial eligibility for these benefits would be triggered by eligibility for temporary disability benefits. Once eligible, entitlement to these provisions would be continued even after eligibility for temporary disability benefits is lost (though the employed disabled individual may have to pay for some of the cost on a sliding scale based on his or her income, and at some relatively high income level the individual would be required to pay the entire cost).

2. Eliminate Waiting Period for Eligibility

Consistent with SSI's current policy of no waiting period to apply for benefits, SSDI's requirement that applicants be out of work as a result of the impairment for a five-month waiting period would be eliminated. This would allow appropriate interventions to take place much sooner than they are currently. Claimants would need to provide documentation of their impairment

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[4] As an alternative to an across-the-board three-year eligibility period, there could be different eligibility periods for different impairments or levels of function.

from their treating physician and proof that they have been out of work as a result of the impairment. The goal is to identify appropriate intervention strategies early, before the impairment becomes permanently disabling and before the employment connection is irrevocably severed.

3. Expedite the Paperwork

Claimants would be required to facilitate the process by having their physicians submit, or by bringing with them, all relevant documentation of their claim (i.e., any medical evidence, clinical tests, laboratory findings, etc., from the treating physician). The physician who treats the claimant for the impairment would send a letter to SSA, certifying that the impairment prevents the claimant from working at the job he or she had prior to the onset of the impairment (or any job if the applicant was previously unemployed) and providing specific objective evidence documenting why. The physician would be held accountable for the accuracy of the assessment.

Alternatively, other health care or disability professionals (rather than, or in addition to, physicians) could be authorized to be gatekeepers to the system. Although the following discussion is based on the assumption that the physician will continue to be the sole gatekeeper, it should not be inferred that this is necessarily the best or most cost-effective approach. The determination of the most appropriate gatekeeper should be based on who can most efficiently provide accurate and reliable information in an accountable manner.

4. Reduce the Use of Consultative Exams

The treating physician's certification would typically serve as adequate documentation of the impairment, thereby reducing the need for many consultative exams (CEs). CEs are supplemental medical evaluations, currently used to corroborate the treating physician's certification or provided as the primary source of objective medical evidence if the person does not have a treating physician. Assuming the claimant has a treating physician with a medical specialty qualified to treat the specific type of impairment (e.g., a cardiologist for someone with a heart problem), SSA would take that physician's recommendations without any CEs. However, the current requirement that decisions be made using objective information describing the impairment and/or functional capacity would not be relaxed.

5. Determine the Prognosis and Appropriate Course of Action

Treating physicians would be asked to complete a check sheet providing documentation on (1) whether the individual has an impairment resulting in a functional deficit that affects employment; (2) how long the impairment could reasonably be expected to continue; (3) how long the functional deficit could reasonably be expected to continue; (4) whether specific interventions would help the claimant's ability to function in the workplace and if so, (5) which interventions. It might be necessary and desirable to provide training for physicians on intervention strategies that promote work or return to work, though the cost of such training will be an important consideration.

6. Categorize Claims By Expected Functional Outcomes

SSA's current categories concerning expected medical improvement would be abolished and replaced with the new functionally-oriented categories. Depending in part on the treating physician's prognosis, claims would be categorized by DDS examiners into 1 of 4 categories: (1) Allowance for a Permanent Disability Pension; (2) Allowance for a Temporary Disability Benefit; (3) Allowance for an Early Retirement Disability Pension; and (4) Ineligibility for a Disability Benefit.

7. Use Case Management Techniques

After a preliminary assessment of each case, the files of all temporary disability beneficiaries would be referred to rehabilitation case managers. The case manager would meet with the beneficiary to establish a habilitation or rehabilitation plan. Case management techniques would be used to capitalize on the beneficiary's existing functional capacity, to provide needed provisions and interventions to build that capacity, and to try, if possible, to maintain linkages with the former employer.

The initial step would usually be to determine whether the beneficiary could return to the former job or another job if worksite accommodations were made. The exact strategy would be determined by the beneficiary and the case manager, after consultation with the treating physician, the employer and the family. Intervention strategies might include use of public or private rehabilitation services, retraining, and provision of assistive devices.

8. Establish Ground Rules Between the Beneficiary and SSA

The beneficiary and SSA would sign a contract in which SSA would agree to develop and implement a habilitation or rehabilitation plan appropriate for the individual, and the beneficiary would agree to cooperate in the plan and attempt to return to work as soon as feasible. Unsuccessful efforts by the beneficiary would not be penalized and extensions in the eligibility period would be granted when necessary. However, extensions would have to be justified in writing by the beneficiary and his or her case manager.

9. Paying for Provision Benefits and Other Interventions

Essential to this proposal is adequate funding for the provision of retraining, assistive devices and other assistance needed by the individual to become gainfully employed. There are several potential financing mechanisms for such benefits and interventions.

a. Establishment of a Special Provisions Fund

Congress could authorize that a certain percentage of savings to the Disability Trust Funds be used to establish and finance an ongoing Provisions Fund. Ongoing studies could be conducted to establish actual savings, considering both money saved in expenditures for disability payments under the old system, as well as credit for FICA taxes paid by workers with disabilities who remain in or return to the labor force.

b. Use of the Income Tax System

There are a variety of ways in which individuals with disabilities who work might be credited with the cost of their disability-related work expenses using the income tax system. The system should acknowledge that a person who works despite having a disability incurs greater costs than his or her nondisabled colleagues and should be compensated for these additional costs. People with disabilities whose earnings are below a certain level (who might therefore not be able to pay for necessary provisions out of pocket) could be eligible for reimbursement from the Income Tax system or from another governmental source.

One approach would be to use a tax credit (possibly refundable for those with no tax liability) for disability-related expenditures. The individual would have to produce proof of the expenditures and show a primary, but not necessarily exclusive, relationship to work. Another approach would be to provide additional tax benefits to employers that incur disability-related work expenses. The precedent of using the tax system to encourage employers to hire persons with disabilities is already well established. For example, P.L. 101-508, The Omnibus Budget Reconciliation Act of 1990 (OBRA '90), contained a tax incentive to reduce the burden of small businesses to comply with the Americans with Disabilities Act.

c. Use of Social Security System

Furthermore, SSA and state Vocational Rehabilitation agencies already pay for some provision expenses, and funding for such benefits could be expanded. For example, the Plan to Achieve Self-Sufficiency (PASS), which is currently used by some SSI recipients to accumulate resources for independent living without compromising their eligibility, could be further encouraged and expanded.

10. Eliminate Remaining Work Disincentives

As suggested above, ever since the initial implementation of the SSDI and SSI programs, there have been claims that beneficiaries are deterred by the benefit structure from seeking gainful employment. Specifically, by earning a dollar of wages, beneficiaries had to sacrifice a dollar of benefits, thereby making them no better off by working. Moreover, by earning over the SGA level, beneficiaries could lose program eligibility altogether, subjecting themselves to potentially having to resubmit to the arduous eligibility process. In the 1980s, Congress has passed several amendments to the Social Security Act that allow beneficiaries to earn money without compromising their benefits (NARF, 1988). However, certain work disincentives still exist for disability beneficiaries (Muller, 1989).

The most important disincentive relates to access to adequate health insurance and personal assistance services. People with disabilities tend to have greater health problems, and consequently higher health care costs than other Americans, and many require personal assistance services to live independently (DeJong, Batavia, and Griss, 1989). If they are not adequately covered, they risk financial catastrophe in the event of a medical episode. When leaving the programs, disabled people risk losing their Medicare and/or Medicaid benefits and may not be able to obtain similar coverage with their employer.

Again, Congress attempted to address this problem, primarily by offering extended Medicare and Medicaid benefits even after cash benefits have expired. However, such extensions are not permanent, and many disability beneficiaries do not wish to risk the security of their health insurance coverage. Moreover, the work incentive provisions did not adequately address the issue of ensuring access to affordable personal assistance services, except to the extent that it expanded Medicaid eligibility in States that covered such services (Batavia, DeJong, and McKnew, 1992).

Unless the health insurance available to people with disabilities outside the programs is at least as secure and comprehensive as that within the programs, disabled people will continue to be deterred from seeking gainful employment. Many people with disabilities currently are effectively precluded from becoming employed, changing jobs, or starting their own businesses due to poor access to adequate health insurance. The best way to eliminate this work disincentive is to ensure that affordable, adequate insurance is available permanently to all disabled people who leave the disability programs; policy options range from insurance market reform to national health insurance (Batavia, 1993).

Conclusions

This proposal, if fully implemented and communicated to beneficiaries, could revolutionize the federal disability programs by fundamentally altering the expectations of all parties. There would be a new, more cooperative relationship based on the expectation that eligibility would generally be granted, but would be of limited duration. The job of SSA would shift to developing productive joint plans ensuring that beneficiaries will be able to leave the program when their disability benefits have expired. People with

disabilities would receive the support they need for the period of time they need it without being caught in the cycle of permanent dependence that the disability programs, and other social welfare programs, have traditionally imposed on their beneficiaries. If offered the necessary incentives and opportunities, people with disabilities will gladly leave the disability rolls to become working taxpaying citizens.

References

Batavia, A.I. 1993. "Health Care Reform and People With Disabilities," Health Affairs 12(1): 40-57, Spring 1993.

Batavia, A.I., G. DeJong, and L. McKnew. 1992. "Toward a National Personal Assistance Program: The Independent Living Model of Long-Term Care for Persons with Disabilities," Journal of Health Politics, Policy and Law 16(3): 525-547.

Department of Health and Human Services. 1994. Social Security Bulletin: Annual Statistical Supplement -- 1994. Washington, D.C.: U.S. Government Printing Press.

DeJong, G., and A.I. Batavia. 1990. "The Americans With Disabilities Act and the Current State of Disability Policy," Journal of Disability Policy Studies, 1(3): 65-75, Fall 1990.

DeJong, G., A.I. Batavia, and R. Griss. 1989. "America's Neglected Health Minority: Working-Age Persons with Disabilities." The Milbank Quarterly, 67 (Supplement 2, Part 2): 311-351.

Muller, L.S. 1989. "Disability Beneficiaries Who Work and Their Experience Under Program Work Incentives." Social Security Bulletin 55(2): 2-19.

National Association of Rehabilitation Facilities (NARF). 1988. Incentives to Work for SSI and SSDI Recipients. Washington, DC: National Association of Rehabilitation Facilities.

National Council on Disability. 1993. Study on the Financing of Assistive Technology and Services for Individuals with Disabilities -- A Report to the President and the Congress, Washington, DC: NCD, March 4, 1993.

Seelman, K.D. 1993. "Assistive Technology Policy: A Road to Independence for Individuals with Disabilities," Journal of Social Issues 49(2): 115-36.

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5/9/95

The Honorable Jim Bunning
The Honorable Andy Jacobs
Honorable Members of Congress
Sub-Committee on Social Security Disability

Dear Sub-Committee Members,

By way of introduction I have been a Medical Consultant for California's Social Security Disability system for eleven years and am very proud of the work I do here.

This is the second letter I've written on the Disability Redesign plan. The first was one of about six thousand letters sent in response to the initial redesign proposal back in 1994. Those six thousand letters represented individuals like myself and groups such as the AARP, AFSCME, AMA, and the UAPD. There were essentially no changes made in the redesign plan in response to those letters. The redesign team and the Social Security Administration chose to ignore the vast majority of those letters and the millions of Americans they represent.

But, at least one letter was not ignored. It was written by the National Council of Disability Determination Directors (NCDDD). I have provided a copy of the letter to Ms. Kim Hildred of the Sub-Committee staff. A primary goal of this organization is to diminish the role of the professional Medical Consultants that review medical records provided in support of disability claims and then adjudicate those claims. Page eight of their July 25th letter of last year state:

> "First, implement the team's proposal for redefination of the role of the DDS medical and psychological consultants. The consultants would become advisors rather than decision makers. Their expertise would be available to Disability Examiners, but their signatures would not be required on any folder documents other than those that contained their advice. The change will immediately remove a case load bottleneck in every DDS. It will send out a message to every adjudicator that he or she is empowered to perform the work without medical review and approval..."

It comes as no surprise that the view of the NCDDD won out over the other six thousand views that were

expressed because the Charles Jones who was the past president of the NCDDD is the Charles Jones who directs the redesign team.

Although my experience is limited to California, a few points need to be made to Congress so it can protect the American people from this sort of thinking. First, the implication that Medical Consultants cause backlogs in every DDS is fallacious at best. At worst this implication is either a deliberate attempt to deceive the SSA Commissioner or it reflects a staggering ignorance about how claims are being processed. Medical consultants have never been the cause of significant delays. It has never been true where I work. It was not true in 1994 when the NCDDD wrote this letter and it is not true now. Second, the Medical Consultant review protects the integrity of the system by weeding out claims that appear to be fraudulent or not based in medical fact. Finally, truly disabled Americans whose records my be incomplete or, like the vast majority of claims, far to complex for a lay person to understand have their earliest chance to qualify for the program if a doctor reads their medical records.

Contrast the NCDDD/redesign team's approach with that of Gov. William Weld of Massachusetts. Gov. Weld is quoted on Massachusetts' State Disability program in a Time magazine column dated 12/19/94. He says "We finally got smart Before...all people had to do was come in with a note asserting disability. Now claims are reviewed by a panel of doctors. We modeled our program on the one used by the feds; it works." (Emphasis added.) While Massachusetts is getting "smart" and saving millions, the NCDDD/redesign team has chosen a different road to travel.

The redesign team is on a fast track to fraud. Without physician review of Social Security Disability claims America will move closer and closer to the disability system found in the Netherlands. Years ago, " Sixty Minutes" called it the "Dutch Treat". Half the people in the country work, and the other half collect disability benefits.

If Congress does not jerk the chain of this runaway redesign committee more than money will be lost. The mechanism which keeps Social Security both medically current and compassionate will be lost if the NCDDD/redesign team has its way. High on their hit list is Medical Equivalency. Currently Medical Consultants can declare a claimant's impairment to be of "equivalent" severity to the published Listings of Impairments. The redesign committee hopes to do away with this tool quickly. Unfortunately for many disabled Americans the just review of their claims will vanish with the tool of medical equivalency. Americans were disabled and dying from A.I.D.S. for years before SSA got around to publishing listings pertaining to this disease. In the mean time Medical Consultants throughout the United States

recognized the disease as equivalent in severity to the Listings Of Impairments, and granted the claims.

It does not take a case as extreme as A.I.D.S. to justify the tool of medical equivalence. It takes years for SSA to respond to the diagnostic and therapeutic changes that occur in medicine. It took about a decade before we were allowed to officially use computerized treadmill tracings or radionuclear cardiac studies. The ability of Professional Medical Consultants to understand and use the rapid changes that occur in medicine is vital to the compassion and justice of the Social Security Disability system.

On April 14, 1994, Mr. Bunning said of the redesign plan, "Some might even call it grandiose....The Disability claims process redesign sounds wonderful and will make a lot of people feel good. But we need to see the real facts that go along with it...." The facts are becoming clear. By diminishing the role of Medical Consultant as reviewer of evidence and adjudicator of claims the redesign team is moving from the grandiose to the malignant. It will cost the United States taxpayers billions of dollars and bust the Social Security Disability budget, it will irreparably damage the integrity and compassion currently built into the system, and it will guarantee SSA's inability to keep up with medical science.

Governor Weld must be shaking his head in dismay. While Massachusetts gets smarter, SSA is on the way to dumb and dumber.

Thank you,

Paul E. Boetcher, M.D.

Distribution:

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STATEMENT OF CHARLES N. BONO
KANSAS CITY, MO.

Before the

SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

Regarding the

SOCIAL SECURITY DISABILITY PROGRAM

AUGUST 18, 1995

On August 3, 1995, the subcommittee held hearings on management of the Social Security Disability Insurance Program. There were two panels of witnesses invited to attend. One panel addressed "Return to Work" issues, and the other panel addressed recommendations for process improvement.

After careful reading of the testimony presented by the panel addressing process improvements, I felt the following information would be of use to the Sub-committee and offer it for inclusion in the records of the hearing. It should be understood that the comments and opinions expressed herein are not made in any official capacity and do not necessarily represent the policies or opinions of the agency in which I am employed as an administrative law judge, or that of any other organization.

Rather, they are my own personal opinions and observations based on 23 years of government service as an administrative law judge, former president of the Association of Administrative Law Judges for three consecutive terms, former chairman of the National Conference of Administrative Law Judges in the American Bar Association.

I was distressed to see that three of the panelists appeared to favor replacement of the Administrative Procedure Act (APA) hearings and appeals process in the Office of Hearings and Appeals, with hearings before non-judge, non- APA agency employees. The premise of their recommendations seem to be in part that applicants for disability under the provisions of the Social Security Act, are not as a matter of right entitled to an APA hearing before an impartial administrative law judge appointed under the provisions of section 3105 of Title 5.

They are, in my opinion, dead wrong for very important reasons. To begin with the Social Security Administration has employed and empowered APA administrative law judges to conduct the disability hearings. It has clearly been an important policy of the agency for many years. Thus, by its own policy the agency has provided for APA hearings since the passage of the APA in 1946. Indeed, SSA agency hearings were the model for fair hearings upon which the APA was based. Recommendations to abandon APA proceedings would have serious consequences, if implemented, as the panelists recommend.

On August 9, 1995, the American Bar Association House of Delegates passed, without opposition, Resolution No. 115 which specifically calls for continuation of the APA hearings and appeals process in SSA presided over by administrative law judges appointed under the provisions of the act.

After all of these years of providing a hearings and appeals process presided over by judges appointed on the basis of impartiality and independence for SSA to replace them with non-lawyer, non-APA appointed employees of the agency would return the system to the accusations of unfairness that existed before the passage of the APA. Will this increase the confidence of the citizenry in the fairness of an agency, which is already under great criticism, for its failure to be fair and efficient?

approval rating meant something in the 60s, because the review was 100%, but *most importantly, that review enabled policy makers and a cadre of career physicians to maintain the link between medical expertise and the RFC assessment.* Program administration was more effective in the 60s than at any time since.

This all changed beginning with the 70s. First, the 71-72 Administration cut funding, and the review was pared to 5%. *It was assumed that the review could be pared without the loss of realistic functional assessments. This would prove to be a bad assumption.* The ostensible reasons for paring the review were to 1) save cost and 2) decrease processing time. Second, SSA took over administration of what became the SSI program. The SA examiner staff doubled in size to handle the projected workload. Many newly recruited examiners came to their new jobs from universities inspired by the contemporary vision of eradicating poverty. Third, the *pre*-adjudicative review was changed to a *post*-adjudicative review; few corrections of unrealistic decisions were made. Fourth, SSA headquarter's control was weakened by diffusing the review to the Regional Offices and was weakened further when diffused to the SAs. In combination, these factors eviscerated the review process which led to the compromise of the reality factor of the RFCs.

In the 70s medical expertise was too often displaced by examiners following the social vision to eradicate poverty. Myriads of claimants were placed on the rolls erroneously. Paring the review decreased overall processing time (in the short run). In the 60s the tension between processing time and quality was more often resolved in favor of realistic RFCs (quality), but since the 70s, the tension has been persistently resolved in favor of processing time:

> Back in 1975, Social Security gave lip service to quality, worrying primarily about processing time and case backlog...
> Beginning in 1978, the Subcommittee examined in some depth two State agencies...which were expediting cases at the expense of quality with the tacit consent of SSA's Regional Office...Their operations still have not fully recovered. A recent (September 1979-January 1980) 100 percent review of ... and ... cases showed an error rate of 29 percent and 23.5 percent respectively.[2]

The tension between processing time and realistic RFCs is still being resolved in favor of processing time. A Memorandum from former Commissioner King to all Deputy and Regional Commissioners, *Plan for Disability Program Initiatives—ACTION,* Jan., 31, 1992 instructed Federal quality assurance units to:

> ...secure additional documentation only in cases when it is likely that such documentation will change the [State agency's] claims decision, [and Federal quality reviewers were told that they] *must* avoid substituting their judgment for the judgment of the adjudicating component physicians and examiners.[3] (Emphasis is in the original)

Back to the 70s, unwarranted allowances did not cause a public relations furor, but actuaries and

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[2] WMPC: 97-3, "Status of the Disability Insurance Program," p. 12.

[3] Cited by Koitz, Kollmann and Neisner, "Status of the Disability Programs of the Social Security Administration, September 8, 1992, p. CRS-8.

others signaled a serious problem. *Millions* in administrative costs were saved by the pared review, but *billions* were being lost through *unwarranted entitlements.*

> The Staff Report dealing with the DI program has indicated quite a number of elements which could have caused a loosening up of the disability claims process within the Social Security Administration and the state agencies, and also as a result of external sources such as court decisions. It seems that one very important element was the discontinuance by the SSA of a 100% review of state determinations of disability even though the law would seem to require this. Instead, the SSA adopted a scientific-sample approach, varying the size of the sample inversely with the number of claims for each state [Robert Myers, SSA Chief Actuary, 1974].
>
> During this period (1971-1974), administrative expenses remained almost level, while practically every other measure of the size of the DI program was increasing rapidly. Furthermore, a similar decline did not occur during this period in the ratio of administrative expense to benefit payments for the OASI program, to which the same benefit increases applied. In our opinion, the sharp decline in the ratio for the DI program was due to ill-advised budgetary decisions which kept administrative costs and personnel levels down but which resulted in a concomitant explosion in the number of benefits awarded during the period (Actuarial Note No. 101, Nov. 1980, p. 8).[4]

The last quote is of interest. Although many blame the downfall of the disability program on SSA's taking on the SSI program, the 1971 date substantiates that program deterioration was beginning *before* SSA took it over in January 1974 (Rollback cases in July 1973).

Congress requested the Secretary to make recommendations to achieve a proper balance between processing time and quality and also asked SSA to anticipate the budget and program ramifications of various alternative emphases.

> The 2½-page HHS report submitted over 4 months late gives some bottom line figures but included a number of exemptions which made these figures rather meaningless. Moreover, little rationale or alternatives were presented.
>
> The Committee was given almost no information which would help it legislate in this area, and the inadequacy of the report raised a question of whether the Social Security Administration was just being cavalier in answering legally imposed report requests or *whether it lacked the ability to define and assess its capabilities to carry out its mission in the disability area*[5] (Emphasis added).

SSA was not being cavalier. *Absent a viable quality review program, two things happen: 1) Most importantly, medical expertise cannot be brought to bear consistently, so the reality factor of RFCs suffers. Any agenda can fill the vacuum left by the diminution of the use of medical expertise, e.g., liberal-social agenda, fiscal-conservative, public relations, legal, etc. 2) SSA has no tool to administer the program effectively. If things go badly, no way exists to ascertain what is generating the problems, and if SSA cannot know, Congress cannot know either.* We now move to the 80s.

The 80s saw the rise of adjudication by formula. Congress wanted SSA to bring unwarranted SA

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[4] WMPC: 97-3, pp. 5-6.

[5] Ibid., pp. 13-14

allowances under control and to address the discrepancy between SA and ALJ decisions.[6] To do so, SSA created formulae for both SAs and ALJs to follow, i.e., "the same book." Here are two samples:

> Previous congestive heart failure because of "chronic" heart disease, currently compensated and with electrocardiographic and X-ray abnormalities not currently meeting requirements of Listing 4.02. Heavy work activity would be precluded. The distinction between the capacity to perform medium and light work activity requires consideration of the underlying heart disease and the residual impairment (SSR-82-51, B, 4).
> [Example of a non-severe impairment] Excision of lumbar disc has been performed and there are no ongoing significant motor abnormalities or significant objective abnormal physical findings (SSR 82-55, 1, c.).

These formulae and others proscribed the limits of RFC assessments *in advance of all the findings.* For example, many claimants who do not meet listing 4.02 should not perform more than sedentary work, but the formula excluded a sedentary assessment by limiting the choice to a light or medium RFC. In the second example many claimants without significant physical abnormalities should not be returned to heavy work, but the formula said they could. Decision making became unrealistically stringent. Although the formulae were rescinded a few years ago, their influence, though muted, continues through inertia.

PL 96-265 added to the stringency of decisions in the 80s by concentrating the Federal review on allowances. Now, the Feds are reviewing 50% of Title II allowances, but in the larger SAs only 1 out of about 400 denials is reviewed. One has to wonder about the validity of a 97% approval rating when less than 1% of denials is being reviewed, although denials account for 61% of the cases (FY 94). The review remains *institutionally* biased toward denials.

Taking this a step further, out of 1,000 cases about 600 will be denied. Of the 400 allowances about 200 will be reviewed. Of those about 70% will meet the listings; allowances on the basis of meeting the listings are seldom in error. That leaves roughly 60 claims out of 1,000 that were allowed with an RFC assessment. These claims have been allowed in spite of a "climate of denial" which means the allowance is probably solid. This virtually guarantees a high approval rating which mutes any questions. *The irony is a deteriorating program in the face of high approval ratings.*

The liberal, social agenda of the 70s gave way to the conservative fiscal agenda of the 80s. The media reacted–particularly to the purging of the rolls and to the denials of mental claims. This sparked a public relations need, and a different set of formulae emerged to counter those of the Administration, *but these also attenuated medical expertise as the basis of RFC assessment.*

Congress' formula was the medical improvement review standard (MIRS, PL 98-460, October 1984). The MIRS stopped the unwarranted cessations of those who were truly disabled. The problem, however, is that the MIRS also retains beneficiaries on the rolls who are not disabled. *The MIRS formula truncates the application of medical expertise to the RFC assessment* and is a major factor underlying the alarming growth rate of the rolls.

PL 98-460 also imposed an unfortunate degree of micromanagement on the SAs which lengthened

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[6] PL 96-265. Actually, the late 70s saw a drop in the number of unwarranted allowances. The listings were updated in March 1978, and the review had returned to a *pre*-adjudicative one in late 1978. PL 96-265 was "behind the curve" and contributed to an over correction.

processing time without helping SAs make more realistic decisions. PL 98-460 did not require SSA to reestablish the link between medical expertise and the RFC assessment.

The Courts also intervened with their formulae. The Courts have impacted SAs heavily by remanding over a million claims for readjudication and piling on procedures that increased processing time but not the reality quotient of RFC assessments. The micromanagement, i.e., added procedural requirements from both Congress and the Courts, is the primary reason for the SA increase in processing time. SA processing time was much better through the early 80s than it is now.

The breakdown in the reality factor of the decision caused the procedural buildup which caused the dramatic increase in processing time. Whenever the need for more quality review is mentioned, the immediate objection is, "That will increase processing time!" This can now be seen as a short sighted objection. As noted, SSA has pushed processing time over quality since the 70s. We have now reached the point that processing time takes longer *absent an effective review* than it used to take *with an effective review.* The quickest way to decrease processing time would be to jettison such procedures as the 12 month rule for development (PL 98-460) and others too numerous to mention.

Some will object that the procedures protect due process rights. Attending to the details of due process means little if the decision is unrealistic. The procedures since 1981 contribute little to that end; few of them were binding on SAs in the mid 70s *when we had the highest allowance rates in the program's history.* How the *pertinent* evidence is assessed is much more important to realistic RFC assessments than the number of procedures with which the examiner has to contend.

Summary observations:

1) The program goes as the decision goes. Loss of decisional integrity is loss of program integrity.
2) Decisional integrity is present only if the RFC assessments are realistic.
3) The *sine qua non* of realistic RFC assessments is medical expertise.
4) Only a viable quality appraisal program can ensure the consistent application of medical expertise to the RFC assessment. A 100% review is unnecessary; however, the scientific sample has been clearly inadequate. The sample size has to be sufficient enough to deter sloppy work. All review should be done by SSA headquarters–not by Regional Offices or the SAs. It should be *pre*-adjudicative covering an equal percentage of both allowances and denials. *Most importantly, reviews must be guided by medical specialists with the kind of expertise mentioned at the outset of the testimony.*
5) If quality appraisal cannot maintain medical expertise as the basis of the RFC assessment, other agendas will fill the vacuum. *That is what happened, and it explains SA decisional volatility since 1971.*
6) When a formula/agenda, other than medical expertise, becomes the basis for RFC assessment, SSA substitutes "accuracy" for quality, but accuracy is the measure of conformity to the standard of the moment–*even if the standard is distorted.* That is how SAs could show a 98% "accuracy" rate at the height of the CDR moratorium in spite of myriads of unrealistic cessations.
7) A formulaic approach to RFC assessment compromises medical expertise regardless of who sponsors the formula. Formulae do not *assess* but *determine* RFCs in advance of all the facts by identifying which evidence is probative and the weight it gets. *A formulaic approach creates arbitrary, unrealistic assessments. Consequently, the "one book" approach is not the way to*

standardize SA and ALJ decisions.

8) The relationship between processing time and quality must be rethought. Quality review does increase processing time in the short run. In the long run, however, processing time has increased tremendously due to failure to maintain the link between medical expertise and RFC. Experience now shows that the time taken to ensure realistic decisions is time well spent.
9) The two watershed events in the program were the paring of the review and the '81 Administration's desire to tighten the program which led to overly stringent RFC assessments. Both strategies to save administrative costs have cost far more in unwarranted entitlements. Effective program administration requires adequate funding.
10) SSA seems to place the onus on SA physicians for "driving the SA denial rate." They are stringent, but if they were like this by nature, how does one account for the 70s when they signed myriads of unwarranted allowances? SA physicians are doing what they believe SSA wants. An effective quality review would quickly reclaim them from excessive stringency.

II. THE APPEALS PROCESS

In 1973 ALJs received only 72,202 appeals, but in the early 80s they were "discovered." Now over 500,000 claimants per year appeal to ALJs. Had the Plan for a New Disability Claims Process been in effect in FY 94, that number would have gone over 800,000. The ALJ reversal rate is 75%. The OPIR study mentioned above[7] revealed an ALJ error rate of 59%. Some evidence suggests that is an underestimate. Under the Plan ALJs would have placed over 300,000 on the rolls erroneously in a single year. Over a ten year period 3,000,000 who do not belong will be carried on the roll, protected by the MIRS until retirement or death.

The received wisdom offers many explanations for the difference between SA and ALJ decisions. Most of them are accepted as axiomatic but turn out to be insupportable when subjected to an evidentiary investigation. The explanations that do account for the difference leave unsettled the question of whether ALJ or SA decisions are more realistic.[8]

The main reasons for the high reversal rate are just two: First, the law, i.e., the definition of disability requires medical expertise. ALJs lack the medical training to assess medical evidence on its merits. They depend on questioning and observations, i.e., claimant demeanor. ALJ subjectivity is uncontrolled by a working medical knowledge. A legal expert assessing medical evidence on its merits is like a medical expert writing contracts; the training is not apropos to the job.

Second, ALJs follow the formulae of the Courts. One formulae requires that controlling weight be given to the attending physician *"...even if contradicted by substantial evidence"* (Schisler v. Bowen, Sec. Cir., 1988). Other precedents, for all practical purposes, place the burden of proof on the Secretary to disprove excess pain claims (cf., Hyatt v. Shalala, District Court, Fourth Cir, 1988).

ALJs, following their subjective instincts and Court formulae, may be placing as many as a quarter of a million claimants on the rolls each year with unrealistically restrictive RFC assessments. Combined

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[7] See note 1 above

[8] The National Association of Disability Examiners has analyzed this problem and a report can be obtained on request.

with the MIRS formula, the future promises that more than the projected $499 billion will be needed from the OASI trust fund to keep the DI fund solvent through 2016—especially if the Plan for a New Disability Claims Process is implemented as currently conceived.

The bottom line: The unrealistic decisions of both SAs and ALJs stem from the same cause, viz., failure to bring unbiased, knowledgeable medical expertise to bear on the RFC assessment. *ALJs are not equipped to do so by training, and SAs are prevented from doing so by a biased review system. But if SAs and ALJs cannot agree on medical methodology as the basis of more consistently realistic RFCs, the prospects of ever building program unity is bleak absent radical changes.*

III. THE "PLAN FOR A NEW DISABILITY CLAIMS PROCESS"

Space forbids a full discussion of the Plan. It suffers from institutional amnesia because it repeats almost every serious mistake of the past. For example, it was considered safe to pare the 100% review because it was assumed examiners would continue to have a 97% approval rating. Disability examiners never had greater national cohesion in program understanding, never had better training, and were as professional as examiners today. Shortly after the paring of the review decisional integrity plummeted. If the system could function without a viable quality review under the best of circumstances, how will it do so now that the program has become so fragmented? Both the allowance rate and decisional fragmentation will increase exponentially.

The PLAN reduces medical expertise to an "on-call" role which is exercised only at the discretion of the Disability Case Manager.

The end-line, centralized quality review system will be as ineffective as the 70s because it will be *post*-adjudicative. The in-line peer review will be controlled by the same manager who controls production. Production demands will win out, and actuarial issues will continue to recur even as the quality rating is remains high.

The PLAN makes ALJs the back seat drivers without controlling their decisions. All of their reversals will go to the same Disability Case Managers who denied them at the beginning. The case managers' allowance rate will rise uncontrollably.

The PLAN's positive factors are overmatched by the drawbacks because they do nothing to restore realistic RFCs. It is a high stakes gamble built on a host of untested assumptions.

IV. ON VOCATIONAL REHABILITATION

Beneficiaries may be follow a VR plan but drop out when they get their first disability check. Many receive as much in monthly payments as they did when they worked, and some receive more.

It also works the other way. Disability recipients may be in a training program and dependent on SSA/SSI checks in order to continue. When their benefits are ceased, they cannot pursue the training.

SSA is not continuing benefits under Section 301 of PL 98-460 unless the claimant is being trained for sedentary work. These are deterrents for VR counselors to pick up disability caseloads.

This is a sizeable investment in time and effort for VR counselors, who are dedicated professionals, only to find their plans fall through.

Thank you for the opportunity to testify.

WRITTEN TESTIMONY OF
INDIVIDUALS CONCERNED WITH THE DISABILITY CLAIMS PROCESS AND CLAIMS BACKLOGS

SUBMITTED TO
THE SUBCOMMITTEE OF SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES

MAY 23, 1995

WE ARE A GROUP OF DISABILITY PROFESSIONALS WHO HAVE WORKED IN THE SOCIAL SECURITY DISABILITY PROGRAM IN POSITIONS OF EXAMINERS, SUPERVISORS AND HEARINGS OFFICERS. OUR EXPERIENCE RANGES FROM 2-24 YEARS. AS FRONT-LINE PROFESSIONALS WHO INTERFACE DAILY WITH DISABILITY APPLICANTS AND CONTEND CONTINUALLY WITH THE MEDICAL AND LEGAL NUANCES OF THE DISABILITY PROGRAM, WE HAVE A UNIQUE PERSPECTIVE ON THE DISABILITY ISSUES OVERWHELMING OUR PROFESSION.

AFTER A YEAR OF DIGESTING REDESIGN PROPOSALS AND IMPLEMENTATION PLANS, WE HAVE CONCLUDED THAT WHILE THERE CLEARLY ARE VERY SERIOUS PROBLEMS WITH THE DISABILITY PROGRAM, REDESIGN ONLY ATTACKS SOME OF THE SYMPTOMS OF THIS AILING PROGRAM. IN FACT, WE BELIEVE THAT IF REDESIGN IS IMPLEMENTED WITHOUT A BASIC PUBLIC POLICY CHANGE TOWARD DISABILITY ITSELF, THE ENTIRE CONSTRUCT OF THE PROGRAM WILL COLLAPSE UNDER THE WEIGHT OF INCREASED APPLICATIONS AND INCREASED ALLOWANCES OF BENEFITS.

THE SOCIAL SECURITY DISABILITY PROGRAM WAS CREATED BY CONGRESS TO FINANCIALLY PROTECT CITIZENS WHO CLEARLY COULD NOT PERFORM ANY SUBSTANTIAL WORK DUE TO A MEDICALLY DETERMINABLE IMPAIRMENT. AS SUCH, IT WAS BASED ON A MEDICAL MODEL OF DISABILITY WITH A VARIETY OF MEDICAL GUIDELINES TO ASSURE THAT ALL CITIZENS' IMPAIRMENTS WERE EVALUATED ON AN EQUAL BASIS. AS THE DISABILITY PROGRAM HAS EVOLVED OVER THE DECADES, THE MEDICAL MODEL HAS BECOME A LEGAL MODEL BECAUSE THE SOCIAL SECURITY ADMINISTRATION'S INTERPRETATION OF THE LAW HAS BEEN CHALLENGED IN THE COURT. FOR THE MOST PART, SSA HAS LOST THESE COURT CHALLENGES AND, AS A RESULT, THE SPECTRUM OF THOSE WHO HAVE BEEN FOUND TO BE DISABLED HAS GRADUALLY BROADENED. NO ONE EVER CHALLENGES SSA IN COURT ON THE BASIS THAT THEY HAVE BEEN FOUND DISABLED AND AWARDED BENEFITS. THE RESULT HAS BEEN THAT THE MEDICAL MODEL HAS SIGNIFICANTLY ERODED AND EVOLVED INTO A LEGAL MODEL, WHEREIN INDIVIDUALS CAN BE PLACED ON THE DISABILITY ROLES, NOT BECAUSE OF THEIR MEDICAL CONDITIONS, BUT BECAUSE OF DECISIONS AT THE DISTRICT AND SUPREME COURT LEVELS.

TODAY THE SOCIAL SECURITY ADMINISTRATION AND ALL OF THOSE WHO WORK IN THE DISABILITY PROGRAM ARE FACED WITH A TREMENDOUS CHALLENGE, AS OUTLINED IN THE ANNOUNCEMENT OF THESE HEARINGS. BECAUSE OF THE CHANGE IN THE DISABILITY PROGRAM, THE NUMBERS OF THOSE WHO RECEIVE BENEFITS HAVE GREATLY INCREASED. AS A WIDE VARIETY OF AGENCIES AND ADVOCATES ARE AWARE THAT IT IS NOW LEGALLY EASIER TO QUALIFY FOR DISABILITY, THE NUMBER OF APPLICANTS HAS BURGEONED OVER THE PAST SEVERAL YEARS. AT THE SAME TIME, OTHER ECONOMIC AND SOCIAL FACTORS HAVE COMBINED TO INCREASE THE OVERALL LEVEL OF APPLICATIONS. AS A RESULT, DISABILITY WORKLOADS AND THE DISABILITY ROLES HAVE SWOLLEN WELL BEYOND SSA'S RESOURCES.

AS SSA HAS PUT MORE RESOURCES INTO THE PROCESS OF MAKING DETERMINATIONS ON NEW CLAIMS, FEWER RESOURCES HAVE GONE INTO RE-EVALUATING CLAIMS OF THOSE WHO WERE EXPECTED TO HAVE SIGNIFICANT MEDICAL IMPROVEMENT. THIS HAS CREATED A VICIOUS CYCLE IN WHICH INDIVIDUALS BELIEVE THEY WILL RECEIVE BENEFITS FOR LIFE. THIS ENCOURAGES MORE APPLICATIONS. THESE LEGAL, SOCIAL AND ECONOMIC ELEMENTS WORKING TOGETHER, HAVE CREATED A TREMENDOUS DRAIN ON THE TRUST FUNDS AND BROUGHT THE WHOLE DISABILITY PROGRAM TO A QUESTIONABLE LEVEL OF INTEGRITY.

OUR RECOMMENDED SOLUTION TO THIS FINANCIAL DILEMMA, AS WELL AS THE LEGAL AND MEDICAL QUANDARY OF DEFINING WHO IS OR ISN'T DISABLED, IS TO RETURN TO A STRICTLY MEDICAL MODEL OF DISABILITY. THE SOCIAL SECURITY ADMINISTRATION HAS SPECIFIC LISTINGS OF IMPAIRMENTS WHEREBY AN INDIVIDUAL WHO HAS THE DESCRIBED MEDICAL CONDITION, OR A CONDITION EQUALLY SEVERE, IS ALLOWED DISABILITY BENEFITS. FOR THE MOST PART, THESE LISTINGS ARE MEDICALLY SOUND AND THE SOCIAL SECURITY ADMINISTRATION HAS KEPT THEM UP TO DATE TO BE CONSISTENT WITH MEDICAL PRACTICE AND TECHNOLOGY. WE PROPOSE THAT CONGRESS RE-WRITE THE DISABILITY LAW SO THAT INDIVIDUALS WILL BE DISABLED ONLY IF THEY MEET OR EQUAL A LISTED IMPAIRMENT. THIS WILL ASSURE THAT THOSE CITIZENS WHO TRULY ARE DISABLED WILL RECEIVE A TIMELY DISABILITY DECISION AND WILL ASSURE THE INTEGRITY OF THE TRUST FUNDS.

Kathleen Calabria

Kathryn Miller

Rebecca Dougherty

Ione Klima

Judy Evans

Debra Olson

Nancy Fox

Mark Pratt

Anne Haley

Deborah Sasada

CALIFORNIA STATE DEPARTMENT OF SOCIAL SERVICES
TESTIMONY FOR THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY
HEARING ON SOCIAL SECURITY REFORM

My name is Eloise Anderson and I am the Director of the California Department of Social Services (CDSS). The CDSS wishes to express its appreciation for the level of Congressional interest being shown for problems and issues in the administration of the Social Security Disability Insurance (DI) program. Given the growing number of recipients of Social Security disability benefits in California, your interest and concern are welcome and shared by the CDSS.

We believe that there are several reasons why the percentage of Social Security DI and Supplemental Security Income (SSI) disability recipients has far outgrown the general population over the past decade. The primary reason that the number of disability awards has increased so dramatically is simply that more people are now applying for disability benefits than ten years ago. Economic and social changes have induced many able-bodied workers to seek government assistance. In addition, the Social Security Administration (SSA) has engaged in aggressive outreach programs to educate the public about available services. As a result both select populations likely to meet the disability criteria, and the general population are now much more aware that financial assistance is available through the SSA and, hence, are more apt to file. Vulnerability of the disability program to abuses, has also adversely impacted workload. For example, the subjective criteria for some mental impairments, invite malingering and fraud. Likewise, the SSI childhood disability program does not have controls to assure benefits are expended on disability related needs of the child. Moreover, long-term program benefits have been provided to individuals for whom the program was not intended, such as drug and alcohol addicts who suffer disability due to their own correctable behavior. Another reason for increased number of applicants is that many government and private agencies now require their clients to first seek alternate funding through federal agencies such as the SSA. Finally, the courts have repeatedly rendered legal decisions which have eased the requirements for obtaining and continuing to receive disability benefits. Class action court decisions such as *Zebley v. Sullivan, Lopez v. Heckler,* and *Smith v. Sullivan* have mandated the readjudication of denied SSA disability determinations using less stringent criteria. The end result is that more applicants receive disability benefits, while fewer have their awards terminated.

Because of this extraordinary growth in the disability rolls, it is particularly critical that changes be made to assure that only those who meet the disability criteria continue to receive benefits, and to assure that highly subjective criteria be made more objective. To this end, I am pleased to present the following suggestions for legislation and other reforms which would place time limits on eligibility for benefits, provide more realistic continuing disability review criteria, and reduce the number of DI/SSI disability awards. We are advocating these changes in federal law and administrative practices to improve the integrity of the program.

IMPLEMENT TIME LIMITATIONS ON PAYMENT OF
SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

Current federal law provides medical improvement as the test for determining whether a disability recipient is still disabled. There is no time limit placed on the period that an individual may receive benefits. At the time of initial adjudication, a decision is made as to whether the individual's medical condition is expected to improve, may possibly improve, or is not expected to improve. Federal law requires that a continuing disability review (CDR) be done at least every three years for nonpermanent impairments. However, unless a timely CDR is performed, the recipient can continue to receive DI/SSI benefits indefinitely despite having an impairment that may have improved sufficiently to allow a resumption of substantial work activity.

Currently, over one-third of all allowed disability claims are based on medical impairments that are expected to improve. Yet, because of high workloads as a result of an escalating number of initial applications and limited funding for staffing, SSA has been unable to process CDRs in a timely manner. In 1989, recognizing that state Disability Determination Services did not have adequate staff to handle the CDR workload, SSA allocated its limited resources to servicing initial disability applicants, and placed a moratorium on CDRs. Since that time, as you are

aware, only a very limited number of CDRs have been reviewed. Unless an individual reported medical improvement or returned to work activity with reported income, disability payments would continue to be provided. Although SSA has recently resumed CDRs on a limited basis, there is a significant backlog of overdue medical reviews. Hence, many individuals continue to receive benefits long after their medical conditions have improved sufficiently enough to resume work activity.

California recommends that time-limited benefits be imposed on individuals who have impairments that are expected to improve. Time-limited benefits would provide for an automatic termination of benefits after a specific time. The duration of entitlement would depend on the nature of the impairment. SSA already has the structure in place to make such determinations as it has developed a list of impairments where medical improvement is expected. These are known as "MIE" cases. This measure would significantly decrease the number of beneficiaries who continue to receive federal and state monies inappropriately. Also, time-limited benefits would allow states such as California to redirect staff from conducting these CDRs to processing initial applications. For those beneficiaries who remain impaired after their expected date of medical improvement, we recommend that they be given the opportunity to re-file for benefits or submit new medical information that confirms their disability is continuing.

We believe that time-limited benefits will result in better service to the DI/SSI disability population by reducing the number of CDRs which must be processed. In addition, individuals with temporary rather than life-long impairments will know exactly how long their benefits will be available, and will be able to plan for an eventual return to work.

IMPLEMENT MORE STRINGENT CRITERIA FOR EVALUATING SOCIAL SECURITY DI/SSI RECIPIENTS' CONTINUING DISABILITY

In 1984, federal law substituted "medical improvement" for "current severity" as the test for determining whether a recipient is still disabled at the time a continuing disability review (CDR) is done on his/her case. Under the previous rules, benefits could be ceased if the CDR established that the recipient was not currently disabled using the same standards as applied to initial applications. Under the 1984 implementing regulations, even if it is established that the initial disability decision was questionable, we cannot terminate an individual's Social Security disability benefits unless there has been medical improvement in the recipient's condition. Thus, a person who may have been inappropriately granted eligibility on the basis of a questionable or minor impairment, or on the subjective decision of an administrative law judge, can continue to receive benefits if that impairment still exists at the time of the CDR. The medical improvement review standard (MIRS) has resulted in an inequitable disability standard in which a recipient may continue to receive monthly payments for the same impairment that an initial applicant would have been denied benefits.

Before the implementation of the MIRS, about 35% of CDRs resulted in termination of DI/SSI benefits, while currently less than 10% of those who initially qualify are ever removed from the disability rolls. Once receiving benefits, there is little incentive for recipients to attempt to return to substantial work because few are ever terminated. This has placed an inordinate burden on both the state and federal funding programs. Hence, California strongly urges Congress to establish a modified "current severity" criteria for the evaluation of continuing disability. While the MIRS should remain the main criteria for evaluating CDRs, an additional step should be included in the review process. We recommend that DI/SSI benefits be terminated if the adjudicative team determines that the initial decision was not supported by objective findings and the impairment is not currently severe.

IMPLEMENT MORE STRINGENT CRITERIA FOR DISABILITY BASED ON MENTAL IMPAIRMENT

In August 1985, the mental impairment criteria in the federal disability regulations were liberalized. The intent of the revised regulations was to more realistically reflect the effect of functional limitations caused by a mental impairment. Unfortunately, the implementation of the law has resulted in a subtle shift in reliance from objective to subjective evidence. Since that time, there has been a significant increase in the number of approved DI/SSI claims involving a

mental impairment. In 1993, approximately 50 percent of all approved claims had a mental impairment as the primary diagnosis. The more liberalized mental impairment criteria has allowed many individuals with mild anxiety or slight behavioral or maladjustment problems to become eligible for benefits. There has also been a substantial increase in the incidence of individuals faking a psychiatric impairment in order to obtain benefits. As previously indicated, it is difficult to remove such individuals from the disability rolls unless clear medical improvement can be documented.

California recommends that consideration be given to initiating more stringent criteria for affective disorders, anxiety-related disorders, and personality disorders. Many individuals with such impairments do retain the ability to work, but are not motivated to seek employment when disability benefits can be so easily obtained. It has also been our experience that these type of mental conditions can often be faked or exaggerated, and that more objective medical information is needed to adequately document their severity. Given the large number of disability applicants who allege mental impairments, we believe that a more strict standard will significantly reduce the number of questionable allowances.

SUMMARY

California urges Congress to support the proposals detailed in this statement of testimony. In summary, we are proposing the following:

- Implement time limits on payments of Social Security DI/SSI disability benefits, when medical improvement is expected.

- Implement more stringent criteria for reevaluating Social Security DI/SSI recipient's continuing disability, by allowing for consideration of current severity when the original determination is not supported by objective findings.

- Implement more stringent criteria for disability based on mental impairment.

STATEMENT OF PAUL S. CARTER
BOSTON, MA.

Before the
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

Regarding the

SOCIAL SECURITY DISABILITY PROGRAM

August 18, 1995

By way of introduction and disclaimer, I have been an Administrative Law Judge with the Office of Hearings and Appeals since my appointment in 1990. This letter is sent in my individual capacity. The following are my personal beliefs borne of more than fifteen years as an attorney devoted to protecting the Constitutional rights of countless clients and my experience as an administrative law judge appointed pursuant to 5 U.S.C. sec 3105. I do not represent the interests of any agency, body or association and through these remarks, no representation should be implied or inferred.

On May 24, 25 and on August 3, this Subcommittee held hearings to consider reforms to the process of determining disability under the Social Security Act. I believe that the following information would be of use to the Subcommittee and offer it for inclusion in the records of the hearing.

Many of the suggestions that have been advanced to reform the disability determination process are worthwhile and if integrated into the current framework of APA protected administrative law judge hearings would improve the Social Security Administration to the satisfaction of the taxpayers, the claimants and the Congress.

This Subcommittee has an established agenda--to find a solution to a disability determination process gone haywire. The selection of panelists for the portion of the August 3, 1995 hearings set aside to consider "Process Improvements" is most telling and most disturbing. Dr. Glen Fait advocated the removal of administrative law judges from the adjudication process and the removal of administrative law judges happened to have been the position of the other panelists Louis Enoff and Fred Amer. This panel of three spoke as private individuals and did not speak on behalf of SSA; yet, each had significant ties to SSA. Further, all who testified happened to share identical opinions on the subject matter and they were the only invited guests of the Subcommittee on this issue.

Where were the panels of jurists, academicians and renowned administrative law judges[1] from within and outside SSA who would have testified that the essence of our jurisprudence requires adherence to the Administrative Procedure Act? A short list of invited speakers should have included: Hon. Stephen Breyers, United States Supreme Court, Hon. John W. Hardwicke, Chief Administrative Law Judge, State of Maryland, Hon. Charles N. Bono, Administrative Law Judge, SSA/OHA, Kansas City, Kansas and Professor Victor Rosenblum, Northwestern University School of Law, Evanston, Illinois.

The fundamental problem in the disability process exists at the lower levels of determination, and not at the hearings and appeals level. It has been the avalanche of an unmanageable volume of hearing requests filed by claimants dissatisfied with the DDS determinations which has crippled this process. As set forth in the GAO report submitted to this Subcommittee on August 3, 1995, the results of an SSA study published in 1994 concluded that the **error rate at DDS was at 29 percent.** Simply by proper evaluation or by obtaining better evidence at the DDS level, the hearing requests for this fiscal year could have been reduced by more than 141,000[2].

Correct the problems at the lower levels and also incorporate the worthwhile suggestions of reengineering which will create a more streamlined and efficient disability process -- one which will utilize the same standard of disability required at the hearing level, and the number of hearing requests will be reduced to an appropriate level. Administrative law judges will continue to conduct APA proceedings in all cases where a request for hearing is filed by a claimant. This Subcommittee and the Country could expect significant improvements without sacrificing procedural due process protections.

Further, grant to administrative law judges the additional powers to order:

a closure of the record;

time limited benefits in certain cases;

a CDR that will be carried out as ordered;

vocational rehabilitation and mandate its compliance as a condition for continued benefits; and

vocational/medical rehabilitation vouchers in lieu of payments to claimants in certain cases.

Reallocate personnel in order to improve significantly the processing time of cases without sacrificing the proper processing of cases and issuing of decisions.

At the hearing level, it is essential to recognize an obvious fact lost on the advocates of the hearing officer position proposal; the work product at the hearing level is a *legal determination,* known as a decision. These legal determinations are subject to review not only in the United States District Courts, but also, on occasion, before the United States Supreme Court. The allocation of staff and resources must support the issuance of sound, legally defensible decisions. Those resources should enable an administrative law judge to concentrate on the oldest cases awaiting hearing and still allow the Office of Hearings and Appeals to manage the volume of appeals.

In time, with the expected rate of attrition in the administrative law judge corps which reduction would coincide with the anticipated reduction of hearing requests after reeingeering is fully implemented, a corps of administrative law judges of approximately 500, exclusive of supervisors would be needed. The point of this proposal is that this process will continue to ensure APA protections for the claimants and the interests of the trust fund. Further, this proposal provides for many of the advancements recommended by reeingeering and recognizes one of the accepted principals of the reengineering team--that APA administrative law judge hearings would be preserved.

After all, the underpinning of our system of justice, including administrative adjudication is the country's confidence in the judicial process.

Regardless of the end result of these hearings the bottom line to any proposal is whether or not it will undermine the appearance of fairness in administrative proceedings and the judicial acceptance of the results of these proceedings.

Does anyone seriously think that a claimant facing the massive bureaucracy and denied benefits will find comfort in the knowledge that an "ombudsman,"[3] controlled and directed by the agency, is looking after his/ her interests? Does anyone

seriously argue that the courts will accept the results of these proposed proceedings?

No matter how well intentioned the prior testimony and the narrow scope of these hearings, these are disturbing developments that suggest the rights of claimants to due process protections under the Administrative Procedure Act are in jeopardy. Now, proponents support the abandonment of hearings before APA protected administrative law judges in favor of an agency crafted process utilizing hearing officers who will be subject to the total control and direction of the agency. I am very concerned that this proposal will violate the rights of countless claimants and do irreparable harm to our system of administrative adjudication. I urge that the protections afforded to claimants through an APA protected administrative law judge hearing be preserved as inviolate.

To assist this Subcommittee, I would suggest that two additional days of hearings be set aside for the purpose of taking testimony in support of continuation of the claimants rights to hearings before APA protected administrative law judges at SSA.

Respectfully Submitted,

Paul S. Carter

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1. In May, 1995, this Committee heard testimony from an Officer of the Association of Administrative law Judges at SSA. It is estimated that dues paying membership in this Association accounts for less than one half of all SSA administrative law judges. After its initial reengineering position paper was filed in 1994, in my view, it has played no meaningful role on behalf of SSA judges with respect to the issues affecting their authority and ability to conduct APA protected hearings in the future. In short, the Association no longer represents the interests of this judge or the majority of judges with whom I am in contact. For these reasons, it is respectfully submitted that the inclusion of an Association judge on one panel does not satisfy the need to take testimony from the administrative judiciary.

2. based upon a pending workload of 488,000 requests for hearing as of October 1, 1994. See: *Disability Process Redesign: Next Steps in Implementation*, HHS/SSA, November, 1994, p. 35.

3. Testimony of Louis Enoff, August 3, 1995.

STATEMENT OF CONSORTIUM FOR CITIZENS WITH DISABILITIES SOCIAL SECURITY TASK FORCE

INTRODUCTION

The Consortium for Citizens with Disabilities (CCD) is a working coalition of approximately 100 national consumer, service provider, parent and professional organizations that advocate on behalf of people with disabilities and their families. The work of the Consortium is conducted by task forces in various policy areas such as health care, telecommunications, education, employment, technology, housing, civil rights, social security, taxes, transportation, and budget and appropriations.

In developing policy recommendations to assist the Congress and the executive and independent agencies, CCD is committed to the full inclusion, independence, empowerment and integration of individuals with disabilities in every area of our society. As a guiding element in development of national policy, attention to these principles means a better society for all. The following testimony is submitted on behalf of the CCD Task Force on Social Security.

Several issues have been raised at hearings throughout the first session of this Congress which are of grave concern to the Task Force. The substantial policy shifts surfacing through the proposals for time-limited benefits and changes to the adjudication process — especially closing the record — are of primary concern.

When Social Security is considered "off the table" in the budget cutting decisions, people generally consider all Title II programs to be included in that category. The disability programs are as much a part of the earned insurance benefit as the retirement program. Furthermore, beneficiaries with disabilities receive benefits based on various categories of eligibility: as insured workers based on their own work history and as dependents or survivors of insured workers are who retired, disabled, or deceased. (Many are adults who were disabled during childhood and are eligible based on their parents' work history.) Retired people and working people believe that they are protecting their family members as well as themselves through their payments into the FICA system. Reducing program costs by establishing time-limited benefits or eliminating access to redress for grievances substantially alters the basic insurance contract with the public.

Closing the record early in the adjudication process will have devastating long-term effects. Ensuring that claimants are protected from administrative errors in the determination process and continue to have the right to appeal an inappropriate decision is paramount to maintaining confidence that the system will work for them and not against them. Currently, many aspects of the evidence collection process are outside of the control of the applicant. For example, SSA does not always request the appropriate information necessary to process the claim correctly or in a timely manner. The current "re-engineering" process does not appear to eliminate this basic problem. Until all aspects of evidence collection in the determination process have been improved — and proven accurate and effective — closing the record will harm the applicant. One **immediate** result will be a substantial increase in the number of individuals appealing to Members of Congress for assistance in getting their claims approved or filing new applications. Such a change will benefit neither claimants nor the process.

Several Members have indicated concern about the small number of people with disabilities who leave the rolls to enter the workforce. Unemployment among working-age persons with disabilities is due to a combination of factors, not the least of which is the impact of the impairment on the individual's physical or mental capacity to work. Other factors include lack of health care coverage, lack of long-term supports for people with severe disabilities, the inability of some to work at a fully self-supporting level, and a continuing misconception that people with disabilities cannot work. The lack of easily accessible, reliable, and affordable housing and public transportation are also contributing factors. All of these factors must be addressed in constructing a system which would assist those people with disabilities who may be able to transition into the workforce and achieve a greater degree economic self-sufficiency. Some individuals with disabilities will never be able to make the transition to full economic self-sufficiency. Congress must be careful to ensure that these individuals are not punished by the system.

A variety of critical supports and work incentives must be created and maintained to enable persons who can transition to self-sufficiency to do so. Such a transition package requires extending health care coverage to working individuals with disabilities, establishing wage supports to raise net income, providing access to personal assistance services and assistive technology. Maintaining a reliable system to ensure that those individuals who make the attempt but do not attain self-sufficiency are not abandoned to the streets is critical for the success of the program. Overhauling the current Beneficiary Rehabilitation Program is also required to make such a transition feasible.

TIME-LIMITED BENEFITS

The implementation of time-limited benefits was discussed in the August 3rd hearing of the Committee of Ways and Means Subcommittee on Social Security. We strongly oppose the implementation of time-limited benefits which, as we understand they are currently being discussed, would only exacerbate existing problems in the system and have potentially serious consequences for many individuals with disabilities.

- **We believe that time-limited benefits will merely shift responsibility from the Congress and SSA onto the shoulders of the beneficiary or applicant for disability insurance.**

  Time-limited benefits are an inappropriate response to the failure of the Social Security Administration to properly conduct continuing disability reviews (CDRs) over the last several years. For years, we have urged the Administration to request and the Congress to appropriate adequate funds to address SSA's massive backlog in disability applications. The failure to conduct an adequate number of CDRs is one of the results of inadequate funding for administrative overhead. Neither SSA — through current or past Administrations — nor the Congress have placed enough priority on a proper and timely review of beneficiaries when improvement in their conditions was possible. To now shift the burden to beneficiaries through a time-limited approach is not only unfair, it is unconscionable. Essentially it boils down to beneficiaries bearing the burden re-proving their cases every so-many years in an atmosphere of continued staffing declines in an agency that cannot even meet its current workload. We predict that Congressional offices will be flooded again, as in the early 1980s, with constituent requests for help or calls of desperation. We believe that the costs of a properly administered CDR process would be far less than the costs of periodic recurring reapplications, both in actual dollars and in public perception of the program.

- **A time-limited benefits approach is likely to greatly increase administrative costs.**

  As mentioned above, when a significant proportion of the beneficiary population, through the need for on-going support and the inability to become self-supporting, is forced to reapply periodically for eligibility, the administrative workload will increase significantly. In addition, there is a risk that there will be an increased number of initial applications (not necessarily increased awards) due to a new public perception of "temporary disability benefits". While a new approach to "temporary disability" is not inherently undesirable, it should be understood that the creation of this new concept and the resulting number of applications to be developed and decided could adversely impact already strained administrative resources.

- **There is no known method for accurately predicting who, based solely on their underlying condition or impairment, will be capable of working at a self-supporting level.**

  Although extensive research has been conducted, it has not produced reliable predictors of the effects of various disabilities on an individual's ability to work at a self-supporting level. To institute a system of time-limited benefits on the basis of the underlying condition or impairment would, therefore, be arbitrary. Numerous questions and obstacles to this approach present themselves: what criteria would be used to establish

the time-limited conditions; who would develop such criteria; who would make the decision; would the decision be appealable; what impact would appeals have on the federal court system; how could individual variances be factored in; on what medical, vocational, and/or scientific basis would this whole system rest?

- **The negative effects of such an arbitrary approach would be further exacerbated by the disincentive to attempt work which we believe would be inherent in such an approach.**

  Although we believe that the current "work incentives" in Title II need extensive improvement, at least the 9-month trial work period and extended period of eligibility provide some opportunity for people who are severely impaired to attempt to work despite those impairments. Many find that, because of their impairments, they cannot manage self-support and continue to need the on-going support of the cash benefits of the disability insurance program and the medical coverage of Medicare. Those who do manage self-support can successfully leave the disability insurance (DI) rolls. In a time-limited benefits approach, those who have long-term or life-long disabilities will be further discouraged from attempting work because the consequences of failure in an attempt at self-support may be that much greater.

PROPOSED CHANGES IN THE APPEALS PROCESS

Several changes to the appeals process have been raised by these hearings — including closing the record and a new process for hearings and appeals.

CLOSING THE RECORD TO NEW EVIDENCE

We agree that claimants should be strongly encouraged to submit evidence as early in the process as possible. The benefit is obvious: the earlier a claim is adequately developed, the earlier it can be approved and the earlier payment can begin. Past efforts to close the record to new evidence have failed. Both Congress and SSA have recognized that such proposals are neither beneficial to claimants nor administratively efficient for the agency.

Despite the obvious benefit to claimants, the fact that early submission of evidence does not occur more frequently indicates that factors beyond the claimant's control contribute to this problem. In attempting to find a solution, Congress should be careful not to make the process less "user-friendly" or more problematic for SSA.

There are several reasons why closing the record is not beneficial to claimants.

1. CONDITIONS CHANGE

Most medical conditions change over time: they may worsen or improve, diagnoses may change, or the diagnosis may become more finely tuned after further testing or assessment. Individuals may undergo new treatment or procedures which affect their disability(ies). They may be hospitalized or referred to different specialists. Some conditions, such as multiple sclerosis, may take longer to diagnose. Some claimants may also mischaracterize their own impairments, either because they are in denial or lack judgment or understanding about their illness.

By their nature, these claims are not static and a finite set of medical evidence does not exist. If the record is closed, individuals will be forced to file new applications merely to have new evidence reviewed, such as reports from a recent hospitalization or a report which finally assesses and diagnoses a condition. Closing the record to such evidence does not serve either the claimant or the agency well.

2. ABILITY TO SUBMIT EVIDENCE NOT IN CLAIMANTS' CONTROL

Claimants always benefit by submitting evidence as soon as possible. However, there are

many reasons why they are unable to do so and for which they are not at fault. Closing the record punishes them for factors beyond their control, including:

- Disability Determination Service examiners fail to obtain necessary and relevant evidence.[1]
- Neither SSA nor DDS explain to the individual what evidence is important and necessary for adjudication of the claim.
- Claimants are unable to obtain medical records either due to cost or because state laws prevent them from directly obtaining their own medical records.
- Medical providers, especially treating sources, receive no explanation from SSA or DDS about the disability standard and are not asked for evidence relevant to the claim.
- Medical providers delay or refuse to submit evidence.

So that claimants are not wrongly penalized for events beyond their control, the current system provides a process to submit new evidence if certain conditions are met. This exception should not be eliminated in the name of streamlining the system.

3. THE PROCESS SHOULD REMAIN INFORMAL

For decades, Congress and the United States Supreme Court have recognized that the informality of SSA's process is a critical aspect of the program. Imposing a time limit to submit evidence and then closing the record is inconsistent with the legislative intent to keep the process informal and with the philosophy of the program.

The value of keeping the process informal should not be underestimated: it encourages individuals to supply information, often regarding the most private aspects of their lives. The emphasis on informality also has kept the process understandable to the lay person and not strict in tone or operation. SSA should be encouraged to work with claimants to obtain necessary evidence and more fully develop the claim at an earlier point.

Additionally, closing the record will not improve the process from an administrative perspective. As mentioned above, a claimant will be require to file a new application merely to have new evidence considered, even though it was relevant to the recent, prior claim. As a result, SSA can expect to handle more applications, unnecessarily clogging the front end of the process. Further, there will be more administrative costs for SSA since the cost of handling a new application is higher than reviewing new evidence in the context of a pending claim.

HEARINGS AND APPEALS

In addition to the issue of closing the record, the nature of the entire appeals process has been called into question by this hearing. While we agree that the appeals process should be shortened by eliminating certain levels of review, primarily reconsideration and modification review by the Appeals Council, two fundamental requirements for the hearing process must be retained:

I. There should be a hearing before an independent decision maker, i.e., an administrative law judge (ALJ).

In contrast to the GAO's statement in its written testimony (p. 12), the ALJ hearing is not

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[1]The GAO's written testimony for this hearing (p. 9) notes that a significant number of ALJ reversals are caused by **DDS** errors. According to a 1994 SSA study, about 29% of reconsideration denials appealed to ALJs either should have been decided differently or better evidence should have been obtained.

intended to be an appellate review. Rather, it provides the right to a full and fair hearing by an independent decision maker who provides impartial fact-finding and adjudication, free from agency coercion or influence. A fundamental principle of this right is the opportunity to present new evidence in person to the ALJ and to receive a decision from the ALJ based on all available evidence

II. Judicial review should remain in the regular federal court system.

As described below, both individual claimants and the system benefit from the regular federal courts hearing social security cases. Given the wide variety of cases they adjudicate, federal courts have a broad background against which to measure the reasonableness of SSA's practices.

Reasons given for establishing a Social Security Court include creating a uniform body of case law and guaranteeing that the claims of similarly situated claimants are treated without regional disparity. Creation of a Social Security Court is not the most effective, efficient, or fair manner in which to accomplish these goals.

Intervention by the federal courts has played and continues to play a vital role in protecting the rights of claimants. The courts have halted illegal practices by SSA and have provided standards and guidance in instances in which the Agency has failed to articulate clear policies. The current federal court system has contributed to national uniformity. The process of federal court review has not led to significant regional variation. In general, the courts have reached agreement on core issues concerning SSA programs. As a result, extensive circuit case law has provided guidance to SSA in developing uniform standards. Two examples in major areas include: 1) rules describing the weight to be given all medical evidence, including reports from treating physicians; and 2) rules to evaluate subjective symptoms, including pain.

The courts should be readily accessible to all citizens, and should allow everyone, including people who are poor, disabled, or elderly, an equal opportunity to be heard by judges of the high caliber we expect. A Social Security Court would relegate social security claimants to second-class citizenship in the federal system.

Further, a Social Security Court located in Washington, DC, would severely limit access to the court for those who most need it — people who are disabled or elderly and who have limited financial means. Currently, claimants and their lawyers have relatively easy access to the federal courts and unrepresented individuals are able to file appeals without the assistance of counsel. If Social Security courts were not located in as many locations as the federal district courts, many people would be unable to appear in court because of distance and the cost of travel. These individuals would likely feel that the system had utterly failed to provide a fair opportunity for review. In light of geographical distances and high caseloads, the court might be forced to forego oral argument altogether, as has been the case with the Appeals Council.

There are high financial and administrative costs in creating the court. The court would involve expenditures for judges, staff, courthouse space, etc. The financial cost of creating the court must be weighed against the questionable effectiveness of the court to achieve its stated objective, especially given the limited resources available.

NECESSARY WORK-RELATED IMPROVEMENTS

Enabling individuals to overcome the economic disincentives inherent in the current system requires the establishment of a floor for net income that enables those individuals to survive. The current structure punishes rather than rewards people with disabilities who attempt to leave entitlement programs for employment. The system, except for some critical — but underutilized — work incentives in the SSI program, essentially eliminates eligibility for both cash and non-cash benefits (health care) before the individual can earn a living wage. This total loss of support, well-known by people with disabilities as "the earnings cliff", is viewed as the greatest work disincentive.

This structure forces people to choose between taking employment that typically does not even

cover basic necessities (food, clothing, shelter) and does not provide health care coverage (much less disability-specific medical expenses) versus remaining on the disability insurance and related programs. Through SSDI, they receive some cash assistance and vitally needed medical coverage. Given the on-going need for such health care and income assistance, many people with disabilities are trapped in endless unemployment and poverty.

To eliminate the disincentives to work, there are several areas in which Title II could be amended to increase the number of people who achieve the transition from program benefits to self-sufficiency. These foundational elements (discussed further below) are:

- maintaining security in the system,
- extending health care coverage to working individuals with disabilities,
- establishing wage supports to raise net income,
- adjusting the Substantial Gainful Activity (SGA) level,
- providing tax assistance for personal assistance services and assistive technology, and
- providing tax incentives for employers of all sizes.

Additionally, delivering services to enable an increased number of individuals with disabilities to transition from program benefits to self-sufficiency requires the overhaul of the current Beneficiary Rehabilitation Program.

Overhauling the Beneficiary Rehabilitation Program

We propose two initiatives which may enable some individuals to enter the workforce: 1) allow direct contracting by SSA to any public or private provider of rehabilitation services selected by the consumer; and 2) modify the existing outcome-based system to provide two options: reimbursement based on milestones or reimbursement based on a risk/reward system.

1. Direct contracting with consumer selected rehabilitation providers.

People with disabilities who are SSDI beneficiaries and consumers of vocational rehabilitation and placement services have no choice in the providers of their services. SSA refers consumers to a state vocational rehabilitation (VR) agency which **may** provide or contract for the provision of rehabilitation services. Consumers who are not accepted for services or who determine that they are not receiving appropriate or quality services generally have no recourse other than to purchase services themselves from private vendors. Given the cost of private services and the limited financial resources of most consumers, this is an option few can afford.

Active participation in rehabilitation increases the chances of a successful outcome, in this instance a successful return to work that could end reliance on cash assistance. Enabling consumers to choose their rehabilitation providers gives the individual a sense of ownership in the process. Given the diversity of individuals with disabilities and their individual needs, it would be much more productive to utilize the vast capacity of the private rehabilitation service providers available throughout the nation to assist SSDI beneficiaries to return to work.

2. Reimbursement based on milestones or on a risk/reward system.

There is tremendous potential for reduction of dependency and cost savings that is not being realized, because so few SSDI beneficiaries receive effective vocational rehabilitation services.

The present authority for delivery of rehabilitation services under the Social Security Act is inadequate for two reasons. First, all services are provided through referrals from state DDSs to the vocational rehabilitation (VR) agencies (discussed above). Second, the state VR agency is reimbursed for services only when the SSDI beneficiary receiving such services is placed in a job, earns more than the SGA rate and does so for more than the trial work period.

We believe that in certain situations, the number of SSDI beneficiaries returning to work can be expanded with a net savings in cost. This can be accomplished through a combination of providing direct referral to rehabilitation providers and basing payment for services on milestones which may lead to employment and savings to the government. (If a beneficiary begins or returns to work and stops receiving cash assistance, there is a savings to the government.) Basing payment on savings to the government can be done in two ways: a milestone reimbursement system, or a pure risk/reward system. We recommend that Congress direct SSA to develop and implement both payment system options.

A milestone reimbursement system pays providers only upon achievement of milestones, or goals, in a written rehabilitation plan that is agreed to by the provider and the consumer. Although plans would be individualized to the consumer's skills, talents, interests, and needs, plans would contain at least four employment-related milestones. These milestones would include: 1) an initial assessment and plan development; 2) acquisition of job skills and related competencies; 3) job placement; and, 4) completion of nine months at SGA and departure from cash assistance. Providers would receive a partial payment at the successful completion of each milestone. Additionally, an incentive payment at completion of SGA of a percentage of savings to the government may be made to the provider as an incentive to assist the individual to remain employed. Although these programs may not furnish adequate reimbursement for all providers to supply training and develop the system of supports necessary to move the people with disabilities served into the workforce, they will be a significant step toward employment for some persons with disabilities.

A risk/reward system would operate by providing for direct referral of beneficiaries to rehabilitation providers. Payment to such providers would be based on savings to the trust fund, as such savings accrue. Providers would bear the risk for the effectiveness of services, and be compensated on savings to the trust fund, rather than cost of services. This can be achieved by providing payments for services when a beneficiary leaves the rolls which continue as long as the beneficiary is employed and does not return to the income support rolls. Payment should be based on a percentage of the cash assistance that would otherwise be paid to the individual. There would be an incentive to provide continuing assistance to beneficiaries, since payment to the provider would continue only as long as the beneficiary stayed off the income support rolls. This approach is a win-win-win situation — for the beneficiary, the rehabilitation provider, and certainly the taxpayer. Again, this approach will not work for all, but could be significant in serving some people with disabilities.

Other Critical Work Supports and Incentives

Maintain Security in the System

The disability insurance system should address the unique needs of workers with disabilities who, due to the nature of their disability or the effects of aging with a disability, are unable to work continuously. Further, individuals with disabilities occasionally experience acute episodes or the onset of secondary disabilities that require them to leave the workforce for the period of time necessary to alleviate or adjust to these conditions. Many others may work full-time to their maximum capacity and still not be capable of earning the minimum wage or supporting themselves. The creation of quick access for a return to benefits is imperative to the success of individuals attempting to make the transition who may need intermittent, or a reduced level of, on-going support.

Cash assistance and medical benefits should be continued for individuals with disabilities, who, due to the nature of their disabilities, can work only minimally, intermittently, or not at all. Modifying the standards of eligibility to take into account the nature of relapsing/remitting diseases such as multiple sclerosis (and other relapsing/remitting conditions such as some forms of mental illness) would enhance the ability of individuals with disabilities to take the risk of entering the workforce. All individuals should be encouraged to attempt to return to work,

regardless of disability, without the fear of losing financial and medical support if the attempt is unsuccessful due to a recurrence or worsening of their condition.

Health Care Coverage

Lack of health care coverage serves to create a substantial barrier to taxpayer status for individuals who have difficulty finding affordable health insurance. Numerous studies have documented the fear beneficiaries and recipients have about leaving SSDI because they either cannot afford or find health insurance or employment that offers adequate health insurance. Extending health care coverage, or allowing disabled workers to "buy-into" health care coverage by paying required premiums and deductibles on an income-based sliding scale, will ultimately save money by removing the risk of loss of health insurance and providing an incentive to reduce reliance on cash assistance, enabling these individuals to become taxpayers.

Individuals with disabilities should be allowed to buy into Medicare, Medicaid, or the Federal Employee Health Benefit Plan (FEHBP) on an income-based sliding scale. The current Medicare buy-in should be simplified and adjusted as necessary to provide greater access. The scale should adjust for the extraordinary expenses related to disability for the individual with a disability or for the household in which the individual with a disability resides. Deductibles and co-payments may be used to reduce costs and control utilization.

Wage Supports and Work Incentives

Individuals with disabilities may incur substantial expenses in the conduct of their everyday lives as they try to learn, work, recreate, and live in the community. The cost of personal assistance to enable individuals with severe disabilities to work can be a barrier to employment, as individuals with disabilities often do not earn enough in wages to afford to pay for personal assistance in addition to a rent or mortgage, utilities, food, and related life expenses. Other examples of extraordinary expenses include the cost of accessibility modifications such as a wheelchair lift for a van or hand controls for a car; a wheelchair ramp or alternative signaling device for an accessible home; or medications and medical supplies. There may be major expenses for assistive technology, including wheelchairs, hearing aids, animal companions, computers, augmentative communications devices and the training and maintenance costs of the equipment. Even if health care coverage is available, extraordinary health care expenses must be taken into account. Not the least of these extraordinary expenses is for health specialists and services above and beyond the typical health expenses incurred by the average person. All of these expenses conspire to trap individuals with disabilities in a cycle of poverty.

For some, tax relief to level the economic playing field would assist them in going to work and becoming self-supporting. The Earned Income Tax Credit should be extended so that it helps bridge the gap between the SGA level and a minimum income level for low-income workers with disabilities. The present SGA level for non-blind beneficiaries is $500 per month, or $6,000 per year — less than the Federal poverty level. It is impossible for an individual with a severe disability to live on this level of income, especially given the often extraordinary expenses of living with a disability.

Substantial Gainful Activity

If the SGA level is to remain an integral part of the disability determination process, it should at least reflect the inflation which has affected every other aspect of our society. We recommend that, as an interim step, the SGA level for non-blind people with disabilities be increased in fiscal year 1996 to a rate equivalent to the average monthly cash payment — $630 — received by SSDI beneficiaries. We further propose that the non-blind SGA level be increased incrementally over a five-year period to the level established by law for people who are blind. Further, it should be indexed to the cost-of-living annually.

We believe, if the present system is maintained, it should be modified. Work incentives should reward rather than punish people who attempt to work. There should be a **transitioning into self-support on a gradual slope of decreasing benefits**. We recommend the program be

hiring people with disabilities.

CONCLUSION

We appreciate this opportunity to submit testimony for the Subcommittee's consideration. These are very important issues for people with disabilities. We look forward to continuing working with Subcommittee Members and staff. If you have any questions, please contact one of the Social Security Task Force co-chairs: Marty Ford, The Arc, (202) 785-3388; Doris Lentz, Paralyzed Veterans of America, (202) 416-7707; or Tony Young, American Rehabilitation Association, (703) 716-4064.

On Behalf of the Listed Members of the CCD Task Force on Social Security:

American Association on Mental Retardation
American Council of the Blind
American Network of Community Options and Resources
American Rehabilitation Association
The Arc
Bazelon Center for Mental Health Law
Justice for All
National Association of Developmental Disabilities Councils
National Association of Medical Equipment Services
National Industries for the Blind
National Mental Health Association
National Easter Seal Society
National Multiple Sclerosis Society
Paralyzed Veterans of America
Spina Bifida Association of America
United Cerebral Palsy Associations, Inc.

Mr. Philip D. Mosely
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 10515

June 2, 1995

Re: Recent Hearings on Social Security Disability Issues

Dear Mr. Mosely;

I learned of the recent hearings (May 25) after the fact. I wish to raise an issue which was not directly, to my knowledge, addressed at the recent hearings.

I have been an Administrative Law Judge with the Social Security Administration for seven years. Before taking this position, I was for five years a Member (now called Administrative Appeals Judge) of the Social Security Administration's Appeals Council. Before that, I was a trial attorney for ten years in the Office of the General Counsel, Social Security Division, Department of Health and Human Services. Since 1972, I have been involved in the adjudication and litigation of claims for Social Security disability in both the administrative process and in litigation in the Federal District Courts and Courts of Appeals.

It appears to me that among the issues Congress should address is the issue of the redefinition of "disability" itself. I have enclosed a copy of an article in the American Bar Association's Judges' Journal which discusses this issue at length. I hope someone will take the time to examine the issues raised therein. Your attention is particularly drawn to the section on the evolution of disability law, beginning at page eight, and to the dismaying statistics at footnote 5, page 46. The disability rolls have increased ten-fold in 30 years. The reason for this is liberalization of the definition of disability, primarily by the federal courts.

The courts have taken what was once a system based on objective evidence, and, contrary to original Congressional intent, made the program essentially one of subjective perception of disability. The Social Security Administration has failed to maintain the integrity of Congress' original intent, by failing to litigate fallacious court decisions, and Congress, since the 1984 Amendments, has failed to address itself to this important issue. See Pub.L. No. 98-460, section 3(a)(3), 98 Stat. 1799-1800 (1984). The 1984 effort succumbed to inattention due to a "sunset" provision, and was turned completely on its head in judicial interpretation. See, Bunnell v. Sullivan, 947 F.2d 341 (9 Cir., 1991).

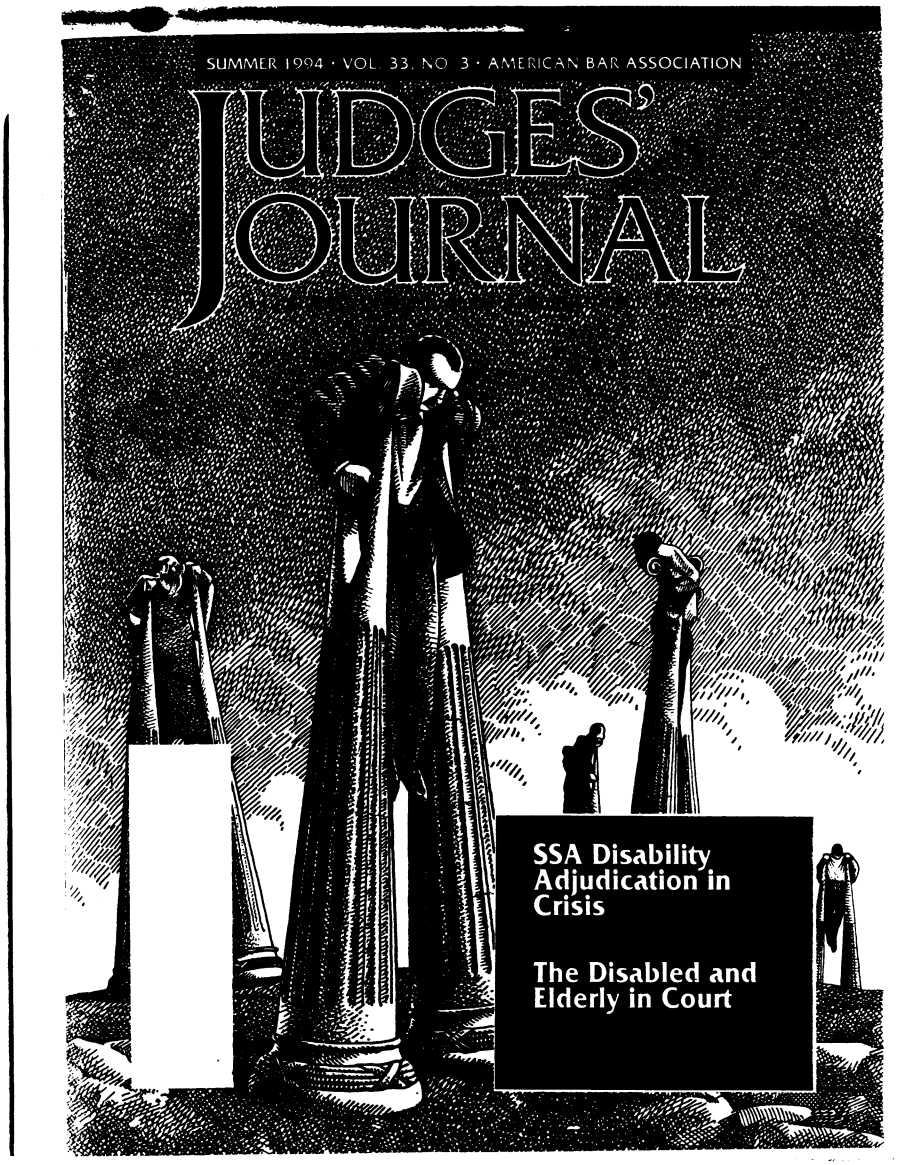
The practical effect of the courts' expansive interpretation of "disability" has been to place a burden of disproving disability on the government. Over time, because the courts have been so receptive to expansive interpretation of the "substantial evidence rule," and have constantly changed technical requirements for sustaining a denial, the federal court dockets have exploded, as have the processing burdens at all levels of the administrative process. Congress needs to reassess this issue and exercise more meaningful oversight.

Thank you for your consideration.

Sincerely yours,

Verrell L. Dethloff

Enclosure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The Disabled and Elderly in Court

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SSA Disability Adjudication in Crisis!

By Christine M. Moore

Since 1989, the number of Social Security disability claimants has jumped by 40 percent, from 2.5 million to 3.5 million each year. Over the next three years, the Social Security Administration's Office of Hearings and Appeals projects more than 500,000 additional requests for hearings per year. There is currently pending a several hundred thousand-case backlog,[1] with an average actuarial value of $90,000 per case. The total amount at issue before the judges amounts to $40 to 50 billion, with some sources now estimating that the Disability Trust Fund will be exhausted within five years. The problems are dire and immediate.

Many of the difficulties with the disability benefits adjudication system are self-made. For example, administrative law judges overturn 75 to 80 percent of the claims that are appealed because different standards are used at the initial level and at the appeals level, which makes no sense. To solve these problems, the JAD's National Conference of Administrative Law Judges is recommending a major overhaul of the SSA adjudication system and believes that the time is ripe for these recommendations to be implemented.

It is not the purpose of the following proposals to fix blame for the problems now facing the disability program. Though a historical review is essential to understanding how the system became what it is and to making recommendations for reform, we recognize that virtually everyone within the Social Security Administration, from judges to upper management to disability claims examiners to quality control personnel, is dismayed and frustrated by a system that seems to create obstacles to delivering the very service the system is charged to deliver. Our purpose is to suggest reform rather than assign responsibility.

What follows are the report and recommendations of the Health and Benefits Committee of the National Conference of Administrative Law Judges, which were adopted by the Conference at its midyear meeting in Kansas City, Missouri, February 5, 1994. These recommendation also have been approved by the board of directors of the Association of Administrative Law Judges, Inc.—a recognized professional association of Social Security administrative law judges—and were forwarded to SSA.[2] The report is currently under consideration by the ABA's Judicial Administration Division.

The committee's original mission was "revamping of disability adjudication from top to bottom." The committee was careful to maintain an appropriate neutral posture on matters beyond its purview and chose not to recommend changes in the substantive law—whether established by case law, statute, or regulation—because to do so would be inconsistent with our positions as neutral arbiters of the law.

NATURE OF THE PROBLEM

Social Security administrative law judges are part of a larger system caught up in a volume vortex that threatens to overwhelm

each public servant working in it. These cases are decided initially by the agency and, if denied, then appealed to administrative law judges. With the Office of Hearings and Appeals of the Social Security Administration projecting more than 500,000 additional requests for hearing per year for the next three years, the administrative appeals level will continue to fall further behind.

Although the most immediate visible problem is the backlog, there are numerous underlying systemic problems that have created the current impasse and contributed to that backlog:

First, the agency and its administrative law judges work toward different, though entirely legitimate, goals in attempting to serve the public. However, the *means* by which they seek to achieve those goals conflict, and the result is that the agency and judges often work at cross-purposes. The administrative law judges are currently adjudicating cases upon legal standards that have not been incorporated into the procedures used by the agency in deciding cases at the initial and reconsideration levels. The facts suggest that the agency is doing so in an effort to "protect" the disability trust fund from the developing law by two primary means: (1) largely ignoring or paying only lip service to select legal standards at the initial and reconsideration determinations; and (2) failing to fund the early determination levels so that adequate development and assessment of the evidence, and training of personnel, can be done.

The result is that many otherwise legitimate claims are denied at the agency level and "washed out" because many claimants are discouraged and confused and drop out of the system rather than appeal. This re-

Illustration by Tom Herzberg

Christine M. Moore
is an administrative law judge for the U.S. Department of Labor in Washington, D.C., and a former ALJ with SSA's Office of Hearings and Appeals*

sults, in turn, in something quite different from a true appellate system, where the same standards apply at all levels.

Cases that *are* appealed to the administrative law judge level are poorly developed, developed inconsistently throughout the nation, and "dumped" at the judge level, where the Office of Hearings and Appeals must sort them out. The primary responsibility of the administrative law judges is to apply legal requirements to each and every case to ensure due process to each and every claimant. Judges grant benefits to somewhere between 70 and 80 percent of the claimants whose applications have been denied by the agency previously. We are unaware of any other appellate system in the world in which there is such a discrepancy between determinations at the first decision-making level and the level at which an impartial fact finder becomes involved. The reasons for this disparity must be examined and remedied.

Second, the SSA judges are tasked with responsibilities that do not belong in a judicial function. Worse, they are tasked to do them without adequate resources or means to tap the resources of the agency. In addition, there is inadequate control over the timeliness and quality of the available information (which comes largely from claimants' attorneys). Judges throughout the country are frustrated with their inability to "get at" the evidence they need and to access resources (particularly personnel) so that the job gets done properly.

Third, the erosion of the "substantial evidence" rule, along with the open record approach and lack of finality in the system, means that cases are adjudicated time and time again. Many cases are remanded because an Appeals Council member or staff person disagrees with the judge's factual decision. This also happens at the federal court level.

Claimants may submit new information at any time in the administrative process, regardless of whether it was previously available at the hearing level.[3] As a result, an administrative law judge may issue a perfectly appro-

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priate denial decision, only to find that on appeal, the claimant has provided new evidence to the Appeals Council or district court, which then remands the case for further hearing. Because the administrative law judge has remand authority to the agency in only limited circumstances, all such cases are readjudicated at the hearing level. The lack of finality in the system creates a merry-go-round that falls most harshly on the administrative law judges, not to mention the cost to society.

The substantial case backlog results from the culmination of these problems and does not result from lack of diligence or production by the judges. The large majority of judges have continually risen to the challenge of the increased caseload and now produce an average of nearly 44 cases per month per judge, a tremendous output under the circumstances of an increasingly complex set of legal requirements. The number of incoming requests for hearings is so enormous, and the authority and resources for the judges so scant, that more production cannot be demanded of the judges without risking serious harm to individual claims. Revolutionary, fundamental changes are needed.

CURRENT ORGANIZATION

The current field organization of the Office of Hearings and Appeals (OHA) of the Social Security Administration (SSA) consists of approximately 800 administrative law judges (ALJs) who are located in 132 hearing offices throughout the nation. SSA administrative law judges are delegates of the Secretary of the Department of Health and Human Services appointed as independent adjudicators pursuant to the Administrative Procedure Act. The current head of OHA is an associate commissioner appointed by the commissioner of SSA.

Other important entities are (1) the disability determination services (DDS), which are SSA field offices[4] within each state that adjudicate the claims initially and on reconsideration, and (2) the Appeals Council, which is the Secretary's administrative appellate body. The Appeals Council reviews cases on appeal from administrative law judges' decisions and makes certain policy determinations.

DDS is charged with the initial development of the case. The claimant is usually not represented by counsel at this juncture. DDS has at its disposal teams of in-house physicians who review the medical records and make recommendations to disability examiners. Additionally, DDS may seek consultative examinations from outside physicians who actually examine the claimant and render a report. In deciding claims, the DDS offices are guided by the Program and Operation Manual System, (the POMS), a voluminous set of standards representing the SSA view of disability adjudication. Disability examiners at DDS virtually never see any claimant. Their assessment is based entirely on the medical record, applying the standards of the POMS. The POMS are updated periodically by the agency but frequently do not reflect current statutory, regulatory, and case law standards.

At the DDS level, a sampling of claims is review by the Disability Quality Branch (DQB). Data available to us indicate that DQB does not sample randomly: 95 percent of the claims it reviews are those *granted* by DDS; only 5 percent are the claims denied. Common sense suggests that if a reviewing entity second-guesses and scrutinizes most closely those granted, DDS examiners will quite naturally think twice about granting claims. There is no evidence whatsoever that any disability examiner at DDS has succumbed to these subtle pressures. Nevertheless, these pressures are a systemic reality and create an unhealthy climate for impartial adjudication at the DDS level.

THE NATURE OF THE WORK AND PROBLEMS

The majority of OHA's work concerns claims for disability benefits under the insured portion (Title II) of the Social Security Act or under the Supplemental Security Income (Title XVI) provisions of the Act (42 U.S.C., §§ 401 and 1301, *et seq.*). The ultimate issue in a disability matter is whether the individual claimant suffers from a medically determinable impairment that renders or will render him or her incapable of substantial gainful activity for a period of at least 12 months. To answer this question, a five-step sequential evaluation process has been promulgated for application at all levels of administrative adjudication (20 CFR 404.1520, *et seq.*).

Such a claim may undergo as many as four levels of administrative review: (1) an initial determination is made by disability examiners at DDS, who are guided by the POMS. If the claim is denied at this level and appealed, it undergoes (2) a reconsideration determination made by different disability examiners at the same DDS office, again applying the POMS standards. If the claim is denied at this level and appealed, it undergoes (3) a formal hearing before an administrative law judge, who issues a decision that may become the final decision of the Secretary. If the claim is denied at this level and appealed, it undergoes (4) review by the Appeals Council. A decision of the Appeals Council may be challenged by a complaint in the federal district court. As stated above, the claimant may submit new evidence at any point in the process.

Current data indicate that few claims that are denied by DDS at the initial review are changed on reconsideration by DDS. In contrast, approximately 75 to 80 percent of those claims appealed from the DDS reconsideration denial are granted by administrative law judges. The most glaring and obvious source of the discrepancy is that administrative law judges apply the statute, the regulations, and the case law, while DDS applies the

---

*Judge Moore is a member of the Executive Committee of the ABA/JAD's National Conference of Administrative Law Judges and has been chair of the Conference's Health and Benefits Committee for two years. This report presents the joint efforts of committee members Charles Bono, David Tennant, James Simpson, Charlotte Hallam, Marguerite Schellentrager, and Thomas Robinson, all of whom contributed significantly to both this article and the report.

The views expressed in this report are those of the author and the National Conference of Administrative Law Judges. Nothing expressed therein should be construed to represent the views of either the Department of Labor, the Department of Health and Human Services, or the Social Security Administration.

POMS. Most judges do not have access to the POMS and do not regard it as controlling in any event.

At the hearing level, although the judge is charged with *responsibility* for continuing to develop the file (a carryover from the days when most claimants were unrepresented), the administrative law judge has no meaningful development *authority*. If the judge believes a consultative examination is called for, he or she must request it from DDS, which is not required to respond as requested. Many disability examiners question the judges' requests, decline to carry them out, or simply carry them out as they think best. The judges' requests for further development are often ignored or delayed for extended periods of time.

Judges do not have the authority to either place time limits on the development or reach presumptive conclusions about failure to develop. Judges may call medical or vocational experts to testify at a hearing, although no funds have been allocated to train these experts. The judges may or may not have any input into the question of whether the doctors or vocational counselors are qualified to be placed on the experts roster. The judges can issue subpoenas for documents or testimony, although these are routinely ignored, particularly by doctors (both in and outside the government), and there is no independent sanction or enforcement power. In practical effect, because 80 to 90 percent of claimants are represented at the hearing level, judges depend on the claimant's attorney to supply information and must essentially rely on the ethical practice of the attorney to ensure that all relevant information has been supplied. No uniform, enforceable rules of procedure exist.

THE EVOLUTION OF DISABILITY LAW

Disability adjudication has changed dramatically over the years, resulting in tremendous demands at the administrative law judge level, particularly when viewed against a system of mass justice. In years past, disability examiners and administrative law judges confronted mostly physical, objectively verifiable impairments. Over the last two decades, the law in this area has evolved tremendously, probably reflecting medical and social recognition that other, more subtle, problems can impact a claimant's ability to be productive.

Currently, evidence in a disability case must be assessed under strict court-established standards. The greatest legal changes have come in three areas of the law: assessment of subjective complaints (both physical and nonexertional), assessment of opinion evidence, and assessment of drug and alcohol abuse.

Disability insurance benefits were established by the Social Security Amendments of 1956 (P.L. 90-248, 90th Cong., 1st Sess.). The original concept of disability adjudication was two-fold: first, entitlement to disability was impairment-driven and based on a fundamentally objective test; second, adjudication by an administrative law judge was contemplated to be an informal nonadversarial proceeding, something akin to a "chat" between judge and claimant, in which the judge was to ensure both the rights of the claimant and the interests of the Secretary. However, the federal courts began early on to add a gloss to the strict objective test. In *Underwood v. Ribicoff*, 298 F.2d 850, 854 (4th Cir. 1962), a germinative case in terms of disability "substantial evidence" review, the court declined to sustain the Secretary's decision, commenting that a finding of nondisability was possible on the record before it only if one adopted a highly technical and literal interpretation of the Act, which the court declined to do. By 1967 Congress was already concerned with the manner which the definition of disability was being interpreted in the courts. This concern was precipitated by cases such as *Ber v. Celebrezze*, 332 F.2d 293 (2nd Cir. 1964), reversing the Secretary in a case of questionable objective basis on the rationale that claimant's pain was "very real to her" and that pain "real to the sufferer" can constitute a disability regardless of the source. (*Id.* at 294-297.)

This congressional concern was manifested in the enactment of a new section 223(d)(3) of the Social Security Act: "For purposes of this subsection, a 'physical or mental impairment' is an impairment that results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." (42 U.S.C. 423 (d)(3).) The Senate Finance Committee noted: "The studies of the Committee on Ways and Means indicate that over the past few years the rising cost of the disability insurance program is related, along with other factors, to the way in which the definition of disability has been interpreted. The committee therefore includes in its bill more precise guidelines that are to be used in determining the degree of disability which must exist in order to qualify for disability insurance benefits." (Senate Rep. No. 744, 90th Cong., 1st Sess., reprinted in (1967) U.S. Code. Cong. and Adm. News 2834, 2881.[5]) To effectuate this legislative intent, the Secretary promulgated 20 C.F.R. 404.1529 (1983), which provided:

> If you have a physical or mental impairment you may have symptoms (like pain, shortness of breath, weakness or nervousness). We consider all your symptoms, including pain and the extent to which signs and laboratory findings confirm these symptoms. The effects of all symptoms, including severe and prolonged pain, must be evaluated on the basis of a medically determinable impairment which can be shown to be the cause of the symptom. We will never find that you are disabled based on your symptoms, including pain, unless medical signs and findings show that there is a medical condition that could be reasonably expected to produce those symptoms.

There are three notable things about the 1967 amendments beyond the issues discussed above. First, Congress was already concerned with the rising costs of the disability program. Second, Congress apparently expected that the majority of cases would be decided on the basis of medical considerations alone. Third, the courts' interpretations were resulting in an increasingly

subjective system of adjudication of disability and, in a practical sense, displaced the burden of proof on the ultimate issue of disability from the claimant to the administrative law judge. This was accomplished by interpreting "substantial evidence" to require that the judge show that a claimant's allegations of disabling pain or other symptoms were not credible, rather than requiring that the claimant prove on a medical basis that the allegations were supportable. Similar rules were posited and proliferated with respect to pronouncements of disability on the part of treating physicians. If a treating physician pronounced a claimant disabled, it became incumbent on the administrative law judge to provide clear and convincing reasons not to accept this opinion.

The expansion of case law affecting the disability adjudication process may be seen in the Ninth Circuit Court of Appeals, which in 1986 refined its position to the "excess pain" standard. In *Cotton v. Bowen*, 799 F.2d 1404, 1407 (9th Cir. 1986), the court stated "if the claimant submits objective medical findings that would normally produce a certain amount of pain, but testifies that she experiences pain at a higher level (hereinafter referred to as the claimant's "excess pain"), the Secretary is free to decide to disbelieve that testimony, . . . but must make specific findings justifying that decision" (citations omitted). That this requirement of "findings justifying that decision" amounts to a burden of proof has been recognized by the courts. The Ninth Circuit in a subsequent case, *Fair v. Bowen*, 885 F.2d 597, 603-605 (9th Cir. 1989), discussed how the administrative law judge may "rebut" claims of "excess pain," and further noted the development in the circuit of an "intricate assortment of judicially created rules" wherein the administrative law judge must "convincingly justify" his or her rejection of testimony, while the circuit rules on a piecemeal basis that the reasons offered in given decisions are insufficient. Circuit Judge Sneed, concurring in *Stewart v. Sullivan*, 881 F.2d 740, 746 (9th Cir. 1989), notes his "belief that it is extremely difficult for the Secretary to refute successfully an excess pain claim." Both Judge Sneed, in *Stewart*, and the court in *Fair*, noted the changing nature of the mark that an administrative law judge must hit in rationalizing his or her cases. The crux of the difficulty with this approach to disability case adjudication, and the effect of this approach on both the disability rolls (in terms of allowance rate) and the administrative process, is presaged by footnote 3 in the *Fair* decision, 885 F.2d, at 602:

> The growth in the number of excess pain cases may be a self-perpetuating phenomenon. As we decide more cases involving pain, the law regarding pain acquires more and finer refinements. The time lag between an ALJ's decision in a particular case and the day that case comes before us is often two years or longer; ALJs are thus often making excess pain determinations according to law that has been superseded by the time the cases are judicially reviewed. By continually shifting the target at which we ask ALJs to aim, we no doubt make it harder for them to hit it. The likelihood that an excess pain claimant will win reversal on appeal because the ALJ applied the wrong law accordingly increases, causing a corresponding increase in the number of excess pain cases appealed. And so on.

The development of this line of cases and a similar line requiring the rebuttal of treating physicians' opinions of disability (*see, e.g., Day v. Weinberger*, 522 F.2d 1154, 1156 (9th Cir., 1975)) persisted and gathered steam after not only the 1967 amendments but the 1984 amendments as well, as discussed below.

Another area that the agency found (and continues to find) troublesome is a line of case law establishing that drug and alcohol addiction are legitimate, disabling impairments when they are of such severity that the claimant cannot control them, and they render the person so unreliable that he cannot be expected to sustain competitive employment.

In the early 1980s, the then-new administration sought to cope with the growing problem using drastic and ultimately untenable methods. To reduce the rolls, it instituted "paper" or medical file reviews by physicians at DDS, who, without seeing the claimant, made a decision on whether or not the claimant's impairment had improved to the point that he or she was no longer disabled. Benefits for thousands of claimants were ceased at the DDS level without a hearing. In so doing, the agency chose to largely ignore the case law regarding subjective complaints and treating physicians' opinions. Congress and the federal courts responded with vigor, as did the SSA administrative law judges, who reinstated many claims wrongfully ceased.

Contemporaneously, the agency instituted the "Bellmon review," a surveillance program of judges thought to be granting too many disability claims. The effect of the Bellmon review on judicial independence was chilling. The American Bar Association issued a commendation to the Social Security judges in recognition of their relentless work in ensuring the rights of the claimants in the face of agency pressure.

In 1984, Congress revisited the issue of the definition of disability and the role of the courts in interpreting the statute. A cornerstone of the 1984 amendments was Congress's insistence that the agency bring the four levels of adjudication into line, that is, that it ensure disability adjudication be based on one uniform standard at each level. While Congress took one track and the agency another, the federal courts continued as they had to develop the gloss on the disability system. In the face of this redefinition of fundamental aspects of the Social Security disability program, the agency embarked upon the highly questionable tactic of "nonacquiescence." Rather than appeal much of the troublesome precedent which flowed from the courts, the agency proceeded simply to ignore such precedent in deciding similar issues in subsequent cases.

Another, related agency technique was a failure to inform the DDS offices of the current case law. Because

(Please turn to page 39)

1. Its members were H. Rutherford Turnbull, professor, University of Kansas School of Law, and a member of the ABA Commission on Mental and Physical Disability Law, Lawrence, Kansas; Patricia Riley, executive director, National Academy for State Health Policy, Portland, Maine; Judge William Dressel; Fort Collins, Colorado; Judge Karl Grube, St. Petersburg, Florida; Ellen Marshall, director, Maryland Judicial Institute; Mary-Jane Owen, Disability Focus Inc., Washington, D.C.; and Erica Wood, associate director, ABA Commission on Legal Problems of the Elderly, Washington, D.C.

2. They are Judge Richard S. Brown, Wisconsin Court of Appeals; Professor Stanley Herr, University of Maryland School of Law; Associate Dean Rebecca Morgan, Stetson College of Law, St. Petersburg, Florida; Holly Riddle, executive director, North Carolina Council on Developmental Disabilities; Alexandria Bosna, legal services developer, New Jersey Division on Aging; and Bill Scott, president, Abilities Unlimited, a disabilities issues consulting firm, Phoenix, Arizona.

3. Leon, J. and Lair, T., *Functional Status of the Noninstitutionalized Elderly: Estimates of ADL and IADL Difficulties* (DHHS Publication No. (PHS) 9003462), 1990, National Medical Expenditure Survey Research Findings 4, Agency for Health Care Policy and Research, Rockville, MD: Public Health Service).

Figure 2

Action Plan

Present Situation _____

_____

Preferred Solution _____

Necessary Actions:	Responsibility	Timeline
1.		
2.		
3.		
4.		
5.		
6.		

Needed Resources:	Source
1.	
2.	
3.	
4.	

Opportunities for Interested Persons to Participate

1. _____
2. _____
3. _____
4. _____

Moore

(Continued from page 9)

disability examiners are guided by policies set forth in the POMS, they are unable to effectuate case law for which they have been given no guidance. This policy creates one level of justice for those claimants who can go on with their appeals and another for those who cannot or do not know how to pursue their claims. It was among other things the nonacquiescence policy that prompted Congress to issue the 1984 amendments to ensure uniform adjudication standards, an effort which has failed. The American Bar Association also has taken a stand against the nonacquiescence practice, and passed a resolution condemning it.

This in turn has been the cause of a considerable rift between agency administration on one side and the administrative law judges, who by oath of office and professional tradition recognize and honor the controlling nature of judicial appellate decisions. The ALJs have been caught in the middle of the face-off between the agency and the courts. *The Office of Hearings and Appeals Handbook*, published in 1976, stated: "[W]here a district or circuit court[']s decision contains interpretations of law, regulations, or rulings [that] are inconsistent with the Secretary's interpretations, the [administra-

tive law judges] should not consider such decisions binding on future cases simply because the case is not appealed." (*Id.*, section 1-161, quoted in *Steiberger v. Heckler*, 615 F. Supp. 1315, 1351 (S.D.N.Y., 1985), *vacated on other grounds*, 801 F.2d 29 (2d Cir., 1986).)

In 1985 SSA revised its approach and indicated it would henceforth issue Notices of Acquiescence. Under this procedure the agency now issues Acquiescence Rulings "identifying circuit court decisions which are at variance with established SSA policy" and "explaining how SSA will apply the decision within the circuit." The result of the agency's failure to adhere to circuit court precedent has been an explosive growth in the number of disability cases filed in the federal courts, as well as a patchwork of case law varying from circuit to circuit.[6]

The SSA administrative law judges find themselves in this legal and political maelstrom. With respect to acquiescence, the agency plays tug-of-war with the courts, interpreting holdings narrowly, ignoring them altogether, or to all appearances not educating the DDS on judicial developments in the law. For example, DDS offices virtually always refuse to pay substance abuse cases, despite the well-developed case law providing that addiction can be disabling. The onslaught of such cases is thus simply passed through by the agency to the administrative law judge level, which must shoulder the responsibility of authorizing these often unpalatable awards. We conclude that the agency finds this law distasteful (as do many judges) and has either not instructed the DDS to pay in accordance with the law or has simply failed to update the POMS.

Another example also illustrates the problem. In 1990, the Ninth Circuit held in *Gonzalez v. Sullivan*, 914 F.2d 1197 (9th Cir. 1990), that when the agency denies a disability claim by issuing a defective notice, that claim must be reopened as a matter of law. Consequently, administrative law judges throughout the Ninth Circuit have, since 1990, been routinely reopening prior claims with defective notices, although this is not provided for by regulation.

However, the agency recently issued Acquiescence Ruling 92-7(9), holding that *Gonzalez* may be applied only to initial denial notices that are defective, not to reconsideration notices that are defective. Most judges agree that this interpretation is incorrect, but they are nevertheless bound by the agency ruling. We emphasize that *Gonzalez* is a constitutional interpretation by the Ninth Circuit, and we are unaware of any authority within the executive branch to "reinterpret" such a holding. More important, although *Gonzalez* is now three years old, the local DDS offices advise that they have never been told how to handle the millions of cases sitting in archives that have defective notices.[7] To our knowledge, the only stage at which *Gonzalez* is being applied to correct defective notices is at the administrative law judge level. This means that the judges must often adjudicate prior claims that the DDS has never bothered to resurrect, despite the Ninth Circuit ruling.

As a result, DDS disability examiners make determinations that are by and large medical, with agency standards that do not incorporate an accurate picture of legal standards. In contrast, administrative law judges are charged by their oath of office to apply the law, regardless of whether they agree with it. The judges make a legal decision based on medical facts and lay, medical, and vocational testimony. Judges, then, adjudicate a case that is different from the case as perceived by DDS. This, we submit, is the discrepancy that is the cause of the enormous "reversal" rate at the hearing level. For good or for ill, the disability program is and will remain a matter of statute, regulation, and case law. The agency simply chose to disregard this fact, at the initial and reconsideration levels, by following policy rather than law. The judges are literally at the center of the storm in disability adjudication.

For the administrative law judge, as we see from the foregoing discussion, the adjudication of objective medical information must be accompanied by assessment of subjective allegations, including pain, fatigue, emotional complaints, and the like. This latter adjudication is left to the administrative law judges, as the courts have established it, essentially as a rebuttable presumption created by allegations.

However, such a system necessarily requires resources to investigate the viability of such allegations. No adequate resources are available to the administrative law judge. This situation exists against a backdrop of ever changing judicially created rules. In such a context, there is little reason to wonder at the multiplying number of claims and allowances and the expanded roll of disability recipients currently exhausting the Disability Trust Fund. Litigation at all levels continues to grow as the subjectivity of the system and the changeability of the applicable rules encourages the pursuit of appeals.[8] One must be mindful that this system continues to be nonadversarial and the Secretary unrepresented, despite the changing nature of the law and practice at the administrative law judge level. Only claimants are represented, and this is the case at all levels of administrative adjudication. Where a claimant is represented, the practical effect is that primarily only information favorable to the claimant is presented because of the difficulty of accessing other information. This, coupled with the necessity of rebutting subjective allegations and the opinion of the treating physician,[9] results in a situation where the judges see a need for evidentiary development of the Secretary's case, but are powerless to direct that development.

CURRENT MANAGEMENT AND ALLOCATION OF RESOURCES

Management practices and allocation of resources do not permit the administrative law judges to do their jobs. The current organizational structure, both centrally and in the field, does not allow the judges to develop their cases because they have no authority over staff in the hearing office or the field. This lack of authority leads to many other problems, resulting in a compounding of inefficiency. While many offices, particularly small

hearing offices, manage to work well, they do so in spite of the current structure. In contrast, many other offices do not work well. The reality of the system in the field is that there is little consistency in terms of staff responsiveness, and many staff personnel respond erratically, if at all.

Because the agency holds the purse strings, it can and does dole out funds rather stingily to the hearings level. The Central Office of OHA, in turn, has historically punished offices that it thinks are not doing well by depriving them of needed resources—rather than instituting management techniques to help revive them. Moreover, the lack of authority is multitiered: Whereas judges lack the authority to direct hearing office staff, the hearing office staff have no ability to ensure that the agency field offices respond to the requests that are made. This leads to much frustration among the hearing office staff as well as the judges.

The fundamental problem in the Office of Hearings and Appeals, as currently constituted, is that the responsibility and accountability for the entire hearing and decisional process is placed upon the individual administrative law judge, yet the judge has been given no authority or resources to carry out this mandate. Administrative law judges are said to wear "three hats," an ironic euphemism that is now undermining the hearing process itself. The judge is charged with representing the interests of the claimant *and* the Secretary (regardless of whether the claimant is represented), and to be a fact-finder—yet with no independent investigative authority or resources other than astute questioning at hearing. The judge has two theoretical sources of support: DDS and the hearing office staff. As to DDS, when judges deem a case needing additional development and request documents or a consultative examination, they must request the same through DDS. Often the DDS will not cooperate, citing lack of funds, or questioning the decision; often the DDS itself is simply overwhelmed and cannot cooperate. Indeed, judges have on occasion asked that agency witnesses appear to explain the agency's actions and rationale, only to find that the agency refuses. This is particularly frustrating in overpayment cases, which often involve computer entries, calculations, and inconsistent notices that are inexplicable.

As to the hearing office staff, some years ago a "managerial" decision was made to take away from administrative law judges all supervisory authority over hearing office support personnel, including staff attorneys, decision writers, clerical support staff, and typists. In 1981, confronted by a concerned Congress about increasing volumes and delays in adjudication, the agency committed to increase the ratio of support staff to judges by five to one. While statistics from the agency appear to show such a ratio, they do not reflect reality.

In 1976, when data were first compiled regarding support staffs, the staff was directly assigned to the individual judge, who directed and supervised them on a daily basis in managing the cases. This system was known as the "unit system." Each judge was assigned a unit of support staff members. This system was perceived by agency management officials as "insulating the judge from agency control," resulting in the agency's wholesale removal of staff from judges.

In connection with this reconfiguration scheme, the agency has delegated supervisory and directive authority to "manager judges," known as hearing office chief administrative law judges or "HOCALJs," who operate with inconsistent, unclear, and unspoken guidelines concerning their authority. In practice they have no meaningful authority over actual resources. Some "manager judges" misuse the authority they believe they have. While the official position description of administrative law judges provides that they shall not be subject to agency direction and control, and may be subject to supervision only in general office management matters, the agency's policies have gone far beyond general office management matters.

"Manager judges" perceive and are instructed to believe that they, in fact, are the supervisors of the judges and may dictate to them the manner and method by which a case should be processed, even to the point of insisting that drafts of decisions be edited little, if at all, so that the typing function will not be delayed. Cases are routinely reassigned in some offices after judges have made significant discretionary decisions and spent considerable time preparing the case. Such direction and control by a person not assigned to the case and who is a "management official" of the agency is unauthorized and should be discontinued.

The result of this office configuration is that administrative law judges have no power to expedite the work or ensure that it is done correctly. Managerial decisions are often made for the purpose of facilitating management itself (allocating resources for report writing and data gathering, for example, rather than for hearing and issuing decisions). In addition, cases are often not assigned on a strict rotational basis, as required by the Administrative Procedure Act; rather, a member of the support staff, under supervision of management, makes a decision about which judge is assigned to which case. There is often an imbalance in terms of type, number, and age of cases assigned.

With respect to the current parallel rather than cooperative system of management, judges are dependent on staff who are not supervised by judges, but by others who assess their performance. Thus, many times judges make requests only to find that they have been countermanded or ignored by midlevel supervisory staff. Judges in some offices also find that staff attorneys are ignoring their instructions in drafting decisions, resulting in much lost time while the judges make the appropriate corrections. Because of their frustration in trying to ensure that their work is done appropriately, the judges have become demoralized, especially with the added pressure to issue a large volume of decisions.

Thus it is no longer meaningful—and this has been the case for over a decade—to speak of support staff ratio to judges. The staff do not exist to support the judges' work, but that of management. The true support staff ratio of office members to individual judges is now

zero to one, as a result of pooling the staff. With the inception of the "reconfiguration" system the judge became isolated, with needless adverse affect.

In addition, OHA has been impaired by inconsistent policies of other branches within SSA which have impacted upon its ability to perform efficiently. As an example, the recently instituted Quality Assurance Program has created an elaborate 22-page checklist to review ALJ decisions, which are frequently much less than 22 pages in length. Twenty-five judges have been taken from their judicial duties to perform quality assurance review, another inroad on the corps's ability to adjudicate the backlog of claims pending. At the same time, the SSA workgroup on OHA workload issues has suggested that, in view of the caseload crunch, judges issue short-form decisions and "limit editorial changes to initial draft decisions." The Office of Human Resources of SSA is simultaneously implementing a program to replace OHA attorney decision writers with non-attorney writers. Thus, while appearing to demand a high-quality legal product, the agency denies its judges the resources to meet the demand. Inconsistent policies of this type, by other branches within SSA, impact upon OHA in an adverse manner which is wasteful and inefficient. These practices result in a poor-quality work product, a waste of resources, and delay in claims adjudication.

In short, while responsibility for development of the evidence and protection of the interests of all parties clearly rests on the administrative law judge, in practice the judge's independence and authority have been roundly undercut by management practices largely directed to controlling the judge, which appear to have stemmed from a long-standing agency intolerance of judicial independence. Ironically, these limitations on judicial authority severely undercut the judge's ability to develop evidence favorable to the agency, and place the claimant's counsel in control of evidentiary development.

In addition, the original notion of the hearing—an informal "chat" with an unrepresented claimant—is a thing of the past. Over 80 percent of the claimants are represented, and the substantive law has become increasingly complex. Moreover, there are no rules of procedure such as those by which other judges throughout the United States manage their dockets. There is no provision for prehearing motions, dispositive motions, settlement or discovery procedure, or control over attorney conduct (for example, no sanctions are available for failure to provide evidence timely, or failure to disclose all evidence). Judges currently are expected to issue 37 or more decisions per month; by 1996 they will be expected to issue 42 or more decisions per month; to meet the increase in receipts.[10] This currently translates into 1.6 written decisions per day, in addition to the duties to review, develop, and hear cases, and to travel to remote sites. The amalgam of these factors—that only evidence in favor of the claimant is readily available, that the judge must bear the burden of rebutting the presumption that subjective allegations and treating physicians' conclusions are supportable, and that 1.6 decisions must be issued daily—creates an inevitable pressure on the system, and results in a 70 to 80 percent allowance rate by the judges.

RECOMMENDATIONS: THE PROCESS AT DDS

1. Institute one standard for determining disability. SSA has never complied with Congress's 1984 directive to institute a single standard to be applied at every level of disability adjudication. The substantive law governing disability has been largely defined by standards established in judicial settings, but disregarded at the DDS level. We recommend that evaluation at DDS be brought into compliance with those standards by requiring the agency to establish guidelines reflecting the case law, and to advise DDS regularly of those standards. As discussed above, DDS disability examiners are currently kept in the dark about the case law or else ill-advised by the agency, which chooses either to ignore or interpret holdings in an indefensibly narrow manner. This reform can be accomplished by one or a combination of the following:

a. **Require a complete revision of the POMS** to reflect current law, with ongoing advice to the DDS concerning implementation of the law.

b. **Require the agency to establish legal development teams at the DDS level,** consisting of an attorney and paralegal charged with developing the evidence, assembling the file, and reviewing the disability examiner's decision to determine if it is supportable under applicable law. We anticipate that if the legal team is doing its job, 30 percent or more of the caseload now presently appealed to the administrative law judge level will be resolved below, resulting in earlier payment for worthy cases, better preparation of the cases for hearing, and reduction of the caseload on appeal with concomitant freeing of time and resources to devote to those cases genuinely in dispute. In addition, the legal development team should ensure that the file is assembled identically to the way in which it would be assembled for appeal, thus eliminating the current, very costly practice of completely disassembling and reassembling the file at the appeal level. Once assigned to a legal development team, the claim should remain with that team throughout all levels of adjudication.

2. Authorize face-to-face interviews at the initial determination stage at the request of either the claimant, the disability examiner, or the legal development team. Disability cases are not always clear-cut, which makes it very important to have a clear visual picture of the claimant, his or her impairment, and its effect on the claimant's functioning. The availability of face-to-face interviews enhances the ability of the claimant to understand the issues and present favorable evidence, as well as the ability of the agency to assess his or her case.

3. Abolish the reconsideration decision. As it now stands, DDS makes an initial determination under the POMS which, if appealed, is simply reviewed once again on reconsideration (by a different person), but

again under the POMS. Given that the POMS do not accurately reflect the standards applicable to disability adjudication, one can fairly conclude that under the current system, DDS is simply doing half the job, but doing it twice. Instead, we suggest that the initial determination itself be a two-part decision: one medical, the other legal. Thus, DDS will be doing the entire job, which, if done correctly, need be done only once. One can reasonably project that with the revision of the POMS, implementation of the legal development team, and institution of face-to-face interviews, the number of cases correctly decided at the agency level will increase and, more importantly, result in paying deserving claimants earlier. To the extent that the agency has relied on the reconsideration level to act as a "sifter" of cases, reconsideration should no longer be necessary.

4. Enhance the quality of the evidence by instituting training for consultative examiners. The consultative examination should be, but unfortunately is not, a valuable tool for disability examiners or judges. The evidentiary value of consultative medical examinations is actually quite low, largely due to lack of training and in part due to inadequate funds. Currently reports of such examinations are virtually meaningless in terms of determining functional limitations; often the physicians—who are practicing doctors trained to take a history and place credence in subjective complaints—merely report what the claimants have told them instead of making an objective evaluation. The investment in forensic and report-writing training would yield vastly superior decisions at both the DDS and administrative law judge level. This will require adequate funding.

5. Reform the DQB review process. Currently "quality control" at the DDS level involves reviewing only the decisions granting benefits. Even assuming that this one-sided review does not actually skew the system, it certainly has the appearance of doing so. We recommend that quality control include an equal random sampling of both grant and denial decisions, in conformity with acceptable statistical practices designed to ensure integrity of the sample, to ensure that all decisions are carefully made.

THE PROCESS AT THE HEARING LEVEL

6. Require the agency to establish an adversarial system of adjudication at the hearing level. The time has come to acknowledge that the disability system, at the hearing level, has not only changed fundamentally since its inception, but also that the matters at stake to both the claimant and the public are of utmost importance, not the least of which is the average actuarial value of $90,000 per case. While the vast majority of claimants make genuine or at least defensible claims, a disturbing number file bogus claims. An adversarial system is the classic American way of ensuring balance in truth-seeking process.[11] The public merits having its interests protected to the same extent afforded claimants, who regularly avail themselves of needed, helpful, legal representation. To ensure high-quality representation, we recommend that only licensed attorneys be admitted to practice in these hearings.

Providing representation for the Secretary is integral to the involvement of the agency throughout the process, as set forth in Recommendation 7. However, some claimants may not be represented by an attorney, and where claimants appear *pro se*, procedures must be adapted accordingly. Nevertheless, the legal team for the Secretary should be charged with responsibility for developing and presenting the evidence, to ensure that all appropriate evidence is available to the fact finder. When the claimant is represented, such a system will result in the type of adversarial hearings that are typical under the Administrative Procedure Act.

7. Restore the entire responsibility for development of the evidence to the agency, and remove that responsibility from the administrative law judge. As mentioned, the current system retains the fiction that the administrative law judge should and can successfully wear three hats, representing the interests of the Secretary and the claimant, while acting as a neutral fact finder. This fiction ill serves all parties, for two primary reasons. The first, and most practical, reason is that while judges are given that responsibility in theory, in practice they are provided no useful tools for carrying it out. Indeed, they are more often thwarted in their efforts to fulfill this responsibility, depending on DDS personnel who may or may not respond to requests, depending on claimants' attorneys who may or may not supply all relevant evidence, and without meaningful recourse to personnel in their own hearing offices or field offices.

The second, and most compelling, reason is that conflict of interest is simply unavoidable. An impartial fact finder must not be in the business of developing evidence and questioning witnesses; he or she should be evaluating the evidence, not generating it. Moreover, the interests of the two litigants are so obviously adverse that a judge wearing three hats cannot do justice to one without doing injustice to the other. Instituting a legal development team at the DDS level will go far toward accomplishing the placement of this responsibility where it belongs—with the agency—where it should remain at all phases of adjudication.

If, despite the foregoing recommendation, the development responsibility were maintained with the judge at the hearing level, then five other key reforms would be necessary to offset the burden this responsibility imposes. First, the regulations must be amended to grant authority to administrative law judges to issue orders of remand to the DDS, requiring the DDS to carry out the particulars of those orders. Second, judges must have access to adequately trained court experts. The current situation allows experts to enter a hearing room with virtually no training in the disability system and no notion of their appropriate forensic function. Many of the medical experts believe, mistakenly, that their duty is to solve a puzzle for the administrative law judge, somehow discovering the proper diagnosis that explains the claimant's subjective complaints. Thus, rather than examining the record from an objective point of view and some background in forensics, medical experts in many

cases arrive at conclusions supporting the claim for disability. Third, judges must be given enforceable subpoena power, and the agency must be required to supply agency witnesses for hearing when requested. Fourth, adequate funds must be allocated to pay for high-quality expert testimony, subpoenaed documents, and the like. Fifth, outside investigative resources, such as *sub rosa* investigations, similar to those used in workers' compensation schemes, must be provided.

8. Reaffirm ABA support for an independent Federal Administrative Law Judge Corps. The ABA has long supported an independent administrative judiciary, and the need for this independence is especially important now. If the words of the Administrative Procedure Act granting judicial independence are to have any meaning, that independence must be structural so that judges' obligations to apply the law are not thwarted. Judges cannot long survive in an agency whose public and private agenda is in direct conflict with the very integrity of the judicial process, from the administrative law judge to the federal courts. Equally important is the current public perception that administrative law judges are simply tools for the agencies that employ them and that litigants will not get a fair shake on appeal. A bill before the Senate, S. 486, which would establish an independent corps of administrative law judges, was passed on November 19, 1993, and is now proceeding through the House in H.R. 2586. Senator Arlen Specter spoke eloquently about the need for the bill:

> . . . as we have seen the progress of the administrative agencies in carrying out the complex laws of the federal bureaucracy, which is too massive, these administrative law judges have been created as part of the executive branch. Whereas they ought to be independent, and ought to function in the traditional role of judges, as impartial, they have, regrettably, been subjected to pressures from within their own agencies. (Cong. Rec. November 19, 1993, at S. 16555.)

The separation of the judges from a dependent position and employee status with the agencies, and establishment of a truly independent judicial position, will do much to ensure the protection of the claimants' rights and to assure the public that appeals before administrative law judges are fair and impartial.

The independent corps itself must be structured to ensure the independence guaranteed by the Administrative Procedure Act. Lessons from OHA dictate that, at a minimum, the corps must:

a. restore supervisory control of support personnel to the judge
b. eliminate unnecessary layers of management, including the ten regional offices, whose function is simply to micromanage the hearing offices, and convert the position allotments to meaningful support staff in the hearing office to work on the case backlog.
c. eliminate unnecessary supervisory, and multiple existing supervisory, positions in the hearing office and allocate those employees to work on the case backlog.
d. remove actual and apparent policies which permit "manager judges" to supervise and direct individual judges in the performance of their judicial functions.
e. restore case assignment on a strictly rotational basis as required by the Administrative Procedures Act.
f. prohibit removal and reassignment of cases from one judge to another, except with consent of the judge from whom the case is removed, except where ordered on remand or where the judge is unable to serve.

Indeed, such reforms are necessary regardless of whether an independent corps is established.

9. Early dispute resolution or other disposition. Passage of the independent corps bill will not, however, solve all of the problems at the hearing level. There must be means of resolving cases short of full-blown hearings. These means include:

a. **Prehearing motion procedures addressing jurisdictional, procedural, and substantive defenses.** Currently there is only a narrow band of resolutions for disposing of a claim: on-the-record decisions which must be decided favorably to the claimant, or a hearing. A means of summary judgment should be instituted for cases which involve only matters of law, which happens quite often in overpayment cases. Jurisdictional motions (for example, concerning timeliness of filling) should be available for the agency. Both claimants and the agency should have the authority to bring such motions.
b. **Institution of settlement procedures between the claimant and his attorney and the legal development team.** Currently the only prehearing disposition procedure in place involves a system euphemistically known as the prehearing conference. In practice, the system involves the master docket clerk assessing the case against a set of criteria (advanced age and adverse vocational factors). The case is then assigned to a staff attorney at OHA who reviews it and makes a recommendation either to issue an on-the-record favorable decision or to proceed to hearing. We propose that, instead, the agency's legal development team, which is much more familiar with the claim, should have responsibility to negotiate meaningfully with the claimant, investigate leads, and obtain all other outstanding evidence, as well as enter into a proposed settlement, subject to the approval of the judge to whom it is assigned.

10. Narrowing and presenting the issues for hearing. If the case cannot be resolved by settlement, the agency (through its legal development team) and claimant should attempt to limit the issues remaining in dispute to be resolved by the judge at hearing. The legal development team would then have the opportunity, if it or the judge chose, to present the issues and the evidence at the hearing, as the claimant does now and would continue to do, along with the power to call and cross-examine both lay and expert witnesses at the hearing. In addition, we recommend that the judge have authority to order the agency to be represented to ensure full airing of the facts and issues. As indicated previ-

ously, this is particularly important in program issues such as overpayments which often involve computer entries and calculations that are not comprehensible based on the documentary evidence alone.

11. Realignment of personnel to reflect the reassignment of the developmental, investigatory, and representative functions. The agency's claim of a five-to-one staff/judge ratio, as mentioned earlier, really translates to the judges having no staff. Judges need staff but do not need five support personnel each. We believe a judge's chambers are well served by a law clerk, a clerk/typist, and a centralized docketing office, much as the federal courts now employ. Currently, hearing offices house career staff attorneys and hearing assistants. The hearing assistants put in order the file received from DDS, and are responsible for independent development as well as carrying out the judges' requests for development: All of their work is prehearing. These positions can be eliminated at the hearing level because they would be transferred to the legal development team. The legal research and drafting functions at the hearing level should be performed by law clerks assigned to and supervised by the judges, with perhaps a two- or three-year tenure, rather than by career attorneys whose talents are best used elsewhere, such as the legal development teams. The net result of this would, of course, be a reduction of staff at the hearing level, with a concomitant increase at the agency level, under direct control of the agency.

12. Institution of uniform rules of administrative procedure. Currently no rules exist to manage the caseload or ensure that claimants and their attorneys comply with even the most rudimentary of expectations in a judicial setting. A poignant example of this need is a recent case in which an ALJ was chastised by management for attempting to require, in prehearing orders, that the claimants' attorneys submit their evidence in a timely fashion. Such rules are necessary for the anticipated independent corps, and will be needed even if the corps legislation is not passed. In addition to the establishment of prehearing motions by such rules, the procedural scheme must address discovery procedures, timeliness and submission of evidence, and closing of the evidence. The current system requires the administrative law judge to develop the case and resort to uncertain, balky staff within the agency who may or may not respond. With a legal development team and rules of administrative procedure, these functions will be carried out where it appropriately belongs—by the parties. The committee recommends immediate implementation of Uniform Rules of Procedure.

THE POSTHEARING PROCESS

13. Close the record at the hearing level and reinstate the substantial evidence test on appeal. As indicated previously, the current regulations allow introduction of evidence at virtually every level of adjudication, even so far as the U.S. district courts. One must keep in mind that a claimant has six potential levels of adjudication available to him or her: initial, reconsideration, administrative hearing, administrative appeal, appeal to district court, and appeal to circuit court. Yet the evidence of record is a moving target and subject to change at every level except the last. As a result, claimants and their attorneys are able to keep a case spinning for any number of years, up and down the ladder. No appellate system can function under such circumstances; nor does due process require such an open-ended opportunity to make one's case. Rules of finality are required to get and keep the backlog under control. Therefore, the record must close at the hearing level, the only exception being for good cause such as newly discovered evidence.

The issues on appeal should be narrowed. Currently, claimants can raise issues for the first time before the Appeals Council and the district court, which, rather than deal with them on the merits, simply remand for yet another hearing. This is an untenable state of affairs, particularly where 80 percent of the claimants are represented. A true appellate system should be instituted where the issues reviewed are those raised below, where findings of fact are sustained when supported by substantial evidence, and where the focus is on appropriate standards and conclusions of law.

14. Institution of a Social Security Court of Appeals under Article III. The patchwork of circuit law must be integrated into a single court whose authority cannot be challenged by the agency. We submit that a federal circuit court whose function is to establish a nationwide set of standards will obviate the lawless practice of nonacquiescence. In this regard, the rulings of the court must be applicable at all levels of adjudication, and the DDS in particular advised of the import of those rulings. This recommendation does not disturb the claimant's right of appeal to the federal district court.

INTERIM EMERGENCY PROCEDURES

We recommend that the process for implementing the foregoing recommendations begin now and proceed apace. In the meanwhile, as we wait for new systems to be put in place, the agency continues to face a nightmare backlog. The agency should explore immediately a system whereby retired judges and soon-to-retire judges can be retained on an interim or part-time basis after retirement, with a provision for adequately funding contract support staff. The agency is now considering part-time or contract judges to be hired from the newly opened register. We disapprove of this proposal, given the lack of training, experience, and uncertain qualifications that can be expected when hiring from the register outside the normal process.

* * *

The impact of the disability system is widespread. It affects not only the public servants and claimants involved in it, but the public at large simply in terms of its budgetary impact. It is the Conference's hope that the foregoing report and recommendations will serve as the starting point for ABA involvement in reform of that system.

1. The backlog situation is as follows:

	Receipts	*Production*	*Backlog*
1994	522,000	421,000	459,000
1995	542,000	502,000	499,000
1996	626,000	562,000	563,000

The production and backlog figures assume an increment of 210 judges (with appropriate support staff) for FY 1994; 150 in FY 1995 and 60 in FY 1996 (with a small attrition in 1996) and productivity increases above 1993 levels. To achieve the match between receipts and dispositions, the required productivity levels are:

1994: 972 judges @36 cases per judge per month X 12 mos. = 420,000

1995: 1,072 judges @39 cases per judge per month X 12 mos. = 501,700

1996: 1,102 judges @42 cases per judge per month X 12 mos. = 555,400

The foregoing figures are even more sobering if one factors in retirements in greater numbers than now anticipated. OHA anticipates only small attrition in 1996. However, currently over 50 percent of the ALJ corps within Social Security is eligible for retirement, and one can safely assume that once those judges have achieved their "high three years" for calculating maximum retirement benefits, many will leave the corps. This should be happening within three to six years after the 1990 pay raise.

2. At the behest of Vice-President Al Gore, in connection with his National Performance Review, SSA has formed an 18-member task force to reengineer the disability process. This report and its recommendations have been forwarded to that task force which issued its initial proposals for comment on April 1, 1994.

3. During FY 1993, the Appeals Council remanded 26 percent of the cases appealed to that level. The federal court remand rate was 42 Gpercent.

8374. DDS is actually composed of state offices that contract with the agency to perform disability evaluations.

5. The Finance Committee's concern with rising costs was voiced at a time when the number of disability recipients had risen from 455,371 in 1960 to 1.193 million in 1966. The failure of congressional efforts in 1967, and in 1984 (see discussion, below), to limit the increase is reflected in the fact that by 1992 the disability recipient roll had risen to 4.9 million. *See* Social Security Bulletin, Annual Statistical Supplement 1993. The cost in dollars rose apace, from $568 million in 1960, to $1.78 billion in 1966, to $31.1 billion in 1992. *Id.* The foregoing figures are for Title II beneficiaries only, whose benefits are paid through the disability trust fund. In addition, in 1992 some 5.6 million people received an average monthly SSI disability payment of approximately $361, a cost of $21.7 billion from the U.S. General Fund.

6. *See* CFR 404.985 and 422.406.

7. OHA has recently advised that there are *Gonzalez* instructions in the POMS. (GNO 03109.100-.150 and DI 32717.001-.030.) However, the actual claims seen at OHA do not reflect that the agency DDS offices are in fact reopening prior defective claims. Indeed, the agency is now destroying all Title II claim files that have had not claim activity for five or more years to free up storage space, rendering it impossible to determine whether *Gonzalez* might apply to them.

8. This, along with virtually no finality in the system, results in claimants' attorneys doggedly pursuing claims through every stage, knowing that the chance of some degree of success on appeal is substantial. The process is commonly known among the claimants' attorneys as "going back to the well."

9. See in this latter regard, Novack et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, Journal of the American Medical Association, May 26, 1989, indicating statistically a willingness of physicians to deceive insurers for the global well-being of their patients.

10. See Footnote 1. OHA bases production expectations not on factors such as feasibility and quality, but simply by dividing the pending caseload by the number of available judges.

11. Other benefits programs, such as Black Lung Benefits Act and the Longshore and Harborworkers Compensation Act, provide for adversarial hearings at the administrative level.

SSA Disability Resolution Adopted by the National Conference of Administrative Law Judges

February 1994

Whereas the National Conference of Administrative Law Judges has long been aware of serious problems existing at the administrative hearing level in Social Security disability cases; and

those problems appearing to have resulted in a backlog that threatens the ability of Social Security administrative law judges to ensure due process; and

the Health and Benefits Committee having reported on the source and nature of those problems; now therefore

Be It Resolved that the National Conference of Administrative Law Judges recommends reforms as follows:

Prehearing:

1. That the Social Security Administration be required to institute, at all levels of decision-making, one standard for deciding disability based on the current law as determined by the Congress and the federal courts, by implementing a complete revision of the Program Operations Manual System and establishing legal development teams at the agency/pre-hearing level.
2. That the Social Security Administration authorize face-to-face interviews with claimants at the initial determination of disability claims.
3. That upon implementation of the foregoing, the Social Security Administration abolish the reconsideration level of decision making.
4. That the Social Security Administration be required to enhance the quality of independent medical assessments by training and increased funding for consultative examiners.
5. That the Social Security Administration require its Disability Quality Branch to review equal numbers of allowance and disallowance decisions in conformity with statistical procedures designed to ensure the integrity of the process.

Hearing:

6. That Social Security hearings be adversarial in nature and representation of all parties be by duly qualified attorneys.
7. That responsibility for development of evidence

be removed from the administrative law judge and placed upon the parties; or, in the alternative, that the administrative law judge be given direct control over and access to investigative resources primarily by way of remand authority to the agency.

8. That the American Bar Association reaffirm its position supporting an independent corps of administrative law judges.
9. That early dispute resolution measures be undertaken by way of prehearing motion and settlement procedures between the claimant and the agency legal development team.
10. That the parties be required to narrow the issues for hearing.
11. That personnel be realigned to reflect the reassignment of the development, investigative and representation functions, such that all prehearing work remains with the agency.
12. That uniform rules of administrative procedure be developed for immediate implementation.
13. That the record be closed at the hearing level.
14. That a Social Security Court of Appeals be established pursuant to Article III of the U.S. Constitution, to ensure a uniform, nationwide standard for deciding disability matters.
15. That interim emergency procedures be implemented, consisting of a system for employing retired judges on a part-time basis, with full funding for adequate contract support staff. ■

Special

(Continued from page 20)

office. All panelists will then discuss how to design and implement an effective security system.

Disasters: Natural and Unnatural. What Happens Next? This program will focus on emergency procedures for jurisdictions experiencing or recovering from disasters (e.g., hurricanes, earthquakes, riots, or firestorms).

Families of Judges: What is Their Burden? How Do Their Problems Affect Judicial Functioning? A panel of distinguished judges will discuss the following questions: How does the stress of judging affect the family? Do the tensions of judges cause excessive discord in the family?

Sex Abuse Inside the Family: A Treatment Model. The Montgomery County, Maryland, intrafamily sex abuse program will be presented.

These are just a few of the exciting educational and social programs that will be presented during the 1994 Annual Meeting.

Finally, it has been an honor to have served as chair of this dynamic Conference at a time when there is so much activity in the area of the administration of justice. This Conference is a powerful force because of the talent, energy, and commitment of its officers, directors, committee chairs, and sustaining members. I thank each of you for your efforts during this past year. While those who have made significant contributions are too numerous to mention, I must especially acknowledge and thank Judge Resa Harris and the 25th Anniversary Committee; Judge Salvador Mulé, the social host, for planning the Louisiana Supreme Court reception and assisting in various social events; Judge Robin Smith for the newsletter; Judge Beth Keever for membership activities; Judges Roger LaRose and Ben Aranda for redesigning the membership brochure and designing the 25th anniversary pen; Judge Bob Pirraglia for chairing the special committee on enhancing opportunities for NCSCJ and drafting a document to help the Conference position itself for enhanced leadership roles in the ABA; Judge Bill Kelly for being NCSCJ's Rock of Gibraltar and for his unselfish assistance in so many things; and for all those judges who are putting together programs for the Annual Meeting—Judge Resa Harris, Judge Bob Pirraglia, Judge Clint Deveaux, Judge Roger LaRose, Judge Sandra Thompson, Judge Frank Moran and the Flaschner Award Ceremony committee, Judge F. A. Gosset and the Education Award Committee, and our staff director, Kristin Taylor. ■

JAD

(Continued from page 17)

> liberty or property to the judgment of a court, the judge of which has a direct, personal, substantial pecuniary interest in reaching a conclusion against him in his case. . . .
>
> We have been referred to no cases at common law in England, prior to the separation of colonies from the mother country, showing a practice that inferior judicial officers were dependent upon the conviction of the defendant for receiving their compensation. Indeed, in analogous cases it is very clear that the slightest pecuniary interst of any officer . . . in the resolving of the subject-matter he which was to decide, rendered the decision voidable. [Citations omitted]

And, citing *Hawkins, 2 Pleas of the Crown*, Bk. 2, ch 8, §§ 68, 69, the opinion continues:

> There was at the common law the greatest sensitiveness over the existence of any pecuniary interest however small or infinitesimal in the justices of the peace. [47 S. Ct. 442]. ■

1. Clifford J. Levy, *Tempest in Town Court: A Judge Ousted for Not Enough Fines*, N.Y. Times, May 8, 1994, at B1, B5. Personal communication between Judge Smith and Judge James B. Kerr, June 17, 1994.
2. *Id.*
3. Personal knowledge of the chair, who was born and raised not that far from Metuchen.

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May 15, 1995

Phillip D. Moseley, Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Hearings on Social Security Disability System

Dear Mr. Moseley:

This is in response to your advisory of May 3, 1995, informing that the Social Security Subcommittee will hold hearings on ways to improve the disability system.

I have been an attorney for 26 years. My practice is devoted primarily to Social Security disability cases. I am a sustaining member of the National Organization of Social Security Claims Representatives (NOSSCR). I've also served as Social Security Section Chairman for the South Carolina Trial Lawyers Association. I have been active in lobbying before Congress and the Subcommittee with regard to various measures impacting the Social Security disability system.

In my opinion, the major problem facing the disability system at the present time is the Agency's persistence in attempting to implement various aspects of "reengineering." It is my understanding that, when reengineering was proposed, a couple years ago, there was overwhelming opposition. One has to ask why the Agency continues to pursue reengineering when very few people seem to think it's a good idea.

One aspect of reengineering particularly concerns attorneys, and that is the proposal to create "adjudication officers," who, apparently, would be non-lawyers, something less than administrative law judges, and apparently the equivalent of Solomon when it comes to dispensing wisdom.

I have yet to see an estimate of what any of the aspects of reengineering would cost. I suspect the cost is prohibitive. However, with regard to reengineering proposals, one is compelled to inquire, why are we trying to fix something that's not broken?

Phillip D. Moseley, Chief of Staff
May 15, 1995

I am quite familiar with problems faced by the disability system with regard to the Office of Hearings and Appeals in Greenville, South Carolina. That office, for example, is in dire need of additional support personnel -- secretaries and administrative people. Instead, the Agency hires approximately 200 additional administrative law judges, and sends three of them to Greenville. We were glad to get the new judges; however, sending three judges to Greenville was like sending three more chiefs and no more Indians. I'm advised the Greenville OHA is still seriously short-handed on secretaries, etc.

Most Social Security disability lawyers, and I happen to be one of them, are convinced the purpose behind most of the so-called reengineering proposals is to eliminate lawyers from the system.

If the Agency's purpose is <u>not</u> to eliminate lawyers, why, then, would Commissioner Chater propose to stop withholding funds to pay attorneys? In my own practice, if attorney's fees were not withheld, I would probably not realize a fee in at least 20% of the cases I handle.

If the Agency stopped assisting us in receiving fees, I would have to carefully screen every case, and decline to represent a lot of disabled people, simply because I did not feel they were good credit risks.

I realize there is not a lot of sympathy toward lawyers in this country, or in Congress at the present time, however, with regard to the attorney-fee issue, I suggest you consider two things: 1) it is clear the majority of people are not going to be awarded disability benefits unless they can get the assistance of competent attorneys; and 2) attorneys are not going to take these cases unless they can be assured of payment if and when they are successful. In other words, with regard to the attorney-fee issue, in Social Security disability claims, what benefits the attorneys also benefits the claimants.

In summary, I would like to see 1) the Agency hire more secretaries and support personnel to assist the administrative law judges in working the cases up for hearings and in getting decisions to claimants in a timely fashion; 2) an end to efforts

to implement reengineering and a focus on the system we have in place; and 3) a strong rebuke from Congress to Commissioner Chater for suggesting the Agency does not need to assist attorneys in receiving fees.

With regard to attorneys' fees in Social Security disability claims, it should also be pointed out that these fees, i.e., 25% of retroactive benefits, are the lowest contingent fees charged by attorneys for any sort of representation. Also, it should be emphasized that attorneys such as myself, who handle a great many of these cases, do not get paid 25% across the board. We don't get a fee in cases we lose. Even in the cases we win, we rarely get 25%. First, the Agency refuses to approve any fee in excess of $5000, and secondly, there is no provision under the present system for recouping expenses advanced by attorneys in order to win these cases.

If Congress is serious about improving the system, I would like to see an attitude toward attorneys' fees that guarantees attorneys can be reimbursed for costs and expenses that are advanced in the successful handling of disability claims.

I hope these comments prove useful to you in your inquiry. Thank you for your attention.

Yours truly,

Will T. Dunn, Jr.

WTDjr/nrg

cc: Nancy Shor
Executive Director, NOSSCR

Clara W. Dworsky
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Houston, Texas 77098
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WRITTEN STATEMENT FOR INCLUSION IN THE PRINTED RECORD OF THE SOCIAL SECURITY DISABILITY HEARINGS

As an attorney engaged solely in the practice of Social Security law, I am deeply concerned with particular aspects of the current disability insurance program, which I am not certain the new "reforms" may be adequately addressing. I am especially concerned about the current program's effect on the rights of many social security claimants as well as on the representation of these claimants by their attorneys.

First, my experience has been that there is a general unawareness in the community of the existence of the disability insurance program. I have seen too often individuals applying for and receiving early retirement because they are no longer able to hold a job due to declining health. They may have been unable to work for several years and finally, out of desperation, seek early retirement, perhaps not understanding completely that the benefits will be permanently reduced, that they will not receive Medicare until age 65, and that they may be eligible for disability benefits at the full rate and with Medicare. In fact, many of my clients have stated to me that they wish they would have known about the disability program sooner.

I would like to urge allocation of a budget to establish an effective "outreach" program to keep the public apprised of the various benefit programs available, including the disability program. Perhaps the Social Security Administration could distribute brochures at key locations, such as hospitals, or publicize through the media on an ongoing basis. The outreach program should be directed so that all individuals, and not necessarily "high" target groups, can be informed. Although the Administration currently has an "800" number individuals can call for information, many are unaware of this. The program should "come to the citizens" rather than have individuals, many of whom are gravely ill and perhaps with a limited education, search for assistance.
Second, having worked extensively with the statute, I have noticed that the listing of impairments, 20 C.F.R. Pt. 404, Subpt. P, App.1, is outdated in several areas. For example, there is no section pertaining to women's health issues. While the section on cancer addresses some women's issues, there are many areas not covered that certainly should be recognized. I understand there is a study that shows that women, particularly housewives, tend to fare worse in their disability claims than men. I would urge this be examined and corrected.

Further, there are ailments that are addressed but are not based on current medical standards, such as sickle cell anemia. One of the standards under the listing is "chronic, severe anemia with persistence of hematocrit of 26% or less." It is my understanding, per the testimony, at a disability hearing, of a physician with extensive background in hematology, that the hematocrit level is relative because it has no direct correlation to the frequency of crises. Rather, it is the reticulocyte count that is significant because it reflects a constant state of hemolysis. I submit the statute (effective through December 6, 1995) should so reflect the standards of the medical community. Similarly, connective tissue diseases such as fibromyalgia, and illnesses such as chronic fatigue syndrome, should certainly be more clearly addressed and defined and standards should be promulgated to qualify these as impairments. With all the "reforms" in the disability program, many of which could result in fewer awards of benefits, I submit it is most imperative that the listing of impairments be an accurate reflection of the ailments and revised to include "newer" ailments.

Third, I submit the section regarding worker's compensation payments, providing for an offset where a claimant is entitled to both Social Security benefits and worker's compensation payments, should be revisited. I have seen too often claimants' benefits reduced to such small amounts ($ 50.00 a month, for example) and for such great lengths of time (one case 15 years!) because they

were injured on the job and received a "settlement" that they are in essence in no better position than they were prior to receiving disability benefits. I think it is a great injustice to claimants to penalize them, in the form of lower disability benefits, for receiving a "settlement", which, to oversimplify, is but compensation for an injury to the body suffered while employed. Such appears to be in direct contravention to the purpose of the social security disability program to assist individuals who are unable to work. Further, the two programs are funded separately and should have no bearing on one another. I would suggest it is an inequity to maintain the current provision.

Finally, I believe the proposed plan to eliminate withholding for attorney's fees in Title II cases should be carefully reexamined. While I understand the need to make the Administration more efficient, eliminating the withholding for attorney's fees would essentially eliminate the ability of claimants to obtain representation from private counsel, as attorneys would exercise caution in undertaking such cases due to the risk of not being able to collect their fee. From handling supplemental security income cases, where there is no withholding of attorney's fees, I know of many instances in which claimants, for whatever reason, literally absconded with the fee. It would be quite foolish, frankly, for attorneys to undertake representation in such cases with such uncertainty as to whether they will be paid. I am all for pro bono work, as I am sure most attorneys are, but, realistically, I do not know of many who can devote their entire careers to providing free legal services. This of course, would have a severe impact on claimants, who without representation, cannot effectively pursue their claims. This is particularly so now, when there are movements afoot to have funding for legal aid programs severely curtailed.

I would suggest, if a change is needed at all, to have the "lump sum" check, addressed to the claimant but mailed to the representative of record, so that the attorney would be assured of getting his or her fee. This would indeed eliminate several steps involving a great of paperwork in the system and at the same time would enable the attorneys to receive their fees on a timely basis - which is not the situation at this time.

I trust that serious consideration will be given to the above and urge that the rights of the claimants be kept in mind when reviewing, and proposing changes to, the disability program.

Respectfully submitted,

Clara W. Dworsky
Attorney-at-Law

Shepherd's Elder Law article retained in Committee files.

FORMAN &
CRANE, L.C.

Attorneys at Law

Roger D. Forman*
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*Also licensed in New York and Iowa.

June 5, 1995

Philip D. Moseley, Chief of Staff
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

RE: House Social Security Subcommittee
Hearing on Disability Programs

Dear Mr. Moseley:

We understand the House Social Security Subcommittee convened a hearing May 23, 1995, to assess the status of SSA's administration of the disability program. We further understand that the Subcommittee has a deadline of June 7, 1995 for receipt of written testimony for inclusion in the printed record of the hearing. With that in mind, please consider this letter as our formal commentary for inclusion into the printed record.

As a former legal services attorney and paralegal with a combined total of over thirty years experience in representing Social Security and SSI claimants, it is absolutely appalling to witness the continuing attack by the government upon the poor people of our country. We strenuously resist and object to your proposal to discontinue withholding of attorney fees from Title II recipient's past-due benefits. If this proposal is adopted, individuals seeking disability benefits will lose the pitifully small access to justice which now remains in existence after the tremendous cuts in legal services to the poor so rampant during the lean Reagan years. The majority of West Virginians who apply for disability benefits have become unable to work through no fault of their own usually the result of some traumatic accident or catastrophic illness. These "newest of the poor" are then cast aside by society thus becoming candidates to join the ranks of America's homeless thousands. If it were not for public legal service agencies and law firms such as ours with staff comprised of "former Legal Aid-ers," these individuals would not have access to our justice system. America's poor people must be served -- we cannot deprive them of equal access to justice. Many small law firms throughout this country now are operating only on a shoestring. If Congress takes away the automatic withholding of attorney's fees from Title II benefits, many of these lawyers will

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Philip D. Moseley, Chief of Staff
Committee on Ways & Means
U.S. House of Representatives
June 5, 1995

no longer be able to afford to represent Social Security claimants. When people are down and out, having only a small amount of money at their disposal, the last people who get paid are the doctor and the lawyer. We do not mean to insinuate that these people are dishonest but by the time their past-due benefits are received, they simply are so far in debt to their creditors, friends and relatives, by the time they get their debts paid, they just don't have enough left to pay their legal fees.

We provide criminals with court-appointed lawyers. How **dare** Congress attempt to deny America's poor equal access to justice! How much more can we take? In the name of common decency, we beg you not to deprive Social Security applicants the right to counsel and the right to have their claim adjudicated based upon the totality of the law handed down not only by agency regulations but by the Courts as set forth by the checks and balance system established by the United States Constitution.

Very truly yours,

Roger D. Forman
Attorney at Law

Mary F. Peterson
Paralegal

RDF/mfp
cc: Sen. Jay Rockefeller
Sen. Robert C. Byrd
Rep. Bob Wise
Rep. Nick Jo Rahall
Rep. Allen Mollohan

May 30, 1995

Dear Mr. Moseley:

There are immigrants from Russia and other countries who are now receiving Social Security funds under SSI, as a financial grant to assist them in their adjustment to life in America. These individuals have no right to the funds that americans have put aside from their wages and intended as a retirement or disability supplement. The use of Social Security monies for any purpose other than to assist americans (who have paid into the fund) in their old age or disablement is outright theft and shows contemptible actions toward the citizens of the U.S.

Let!s put and end to this disgraceful practice as soon as possible.

Sincerely,

Raymond Harvey

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June 2, 1995

Philip D. Mosely, Chief of Staff
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Social Security Subcomittee Hearing on Disability Program

Dear Mr. Mosely:

I wish to submit this letter as written testimony for in clusion in the printed record of the hearing on the above subject held May 23, 1995.

Over the past five years I have represented approximately forty-five clients in claims for social security disability and five clients in claims for supplemental security income.

During the period in which the Social Security Administration has been "streamlining" its procedures, the average wait for a hearing has doubled from approximately six months to about a year.

If the proposal of the Social Security Administration to eliminate the Attorney Fee Program were implemented, none of my clients in claims for supplemental security income would have been able to deposit in an escrow account the amount of money necessary to make sure I was paid in the event of victory in their case; no more than one in ten of my clients in claims for social security would have been able to make such a deposit. The result would have been that none of them would have been able to afford this lawyer, and in all likelihood they would have had no lawyer to represent them.

It is shocking that a Democratic administration would engage in an attack of this sort on the deserving poor. The proposal to do away with the Attorney Fee Program is a sneaky, underhanded way of depriving them of representation when they need it most.

Very truly yours,

John E. Horn

P.S. I have warned that one of the ladies I represent has gone to cleveland to appear before the Social Security Administration.

Statement for the Record
Inter-National Association of Business Industry and Rehabilitation
PO Box 15242
Washington, DC 20003
202-543-6353

submitted by
Charles Wm. Harles
Executive Director

Social Security Subcommittee
Ways and Means Committee
US House of Representatives
in conjunction with hearing held August 3, 1995

The Inter-National Association of Business, Industry and Rehabilitation (I-NABIR) represents more than 110 organizations. Our membership includes major international corporations, local rehabilitation service organizations, state and regional programs, national and local labor organizations, state rehabilitation agencies, national trade associations, school transition programs, disability specific organizations, mental health centers, and organizations created just to provide Projects With Industries (PWI) services. It is a group of organizations that run the gamut of organizations providing employment related services to persons with disabilities, but the business and labor communities are active members as well. Most major metropolitan areas are well represented and there are regional and statewide programs covering all states, including many rural areas.

Projects with Industry (PWIs) are training and placement programs for persons with disabilities. They differ from other vocational rehabilitation programs in several respects. Business is an active partner in the program and most PWIs use a business marketing approach. All PWIs have a business advisory council which plays a much more active role than does the typical advisory board. They actually help determine local market needs, training programs and content, and assist in the placement process.

Projects With Industry (PWI) is the only program in the Rehabilitation Act that has developed standards and indicators to measure success of the program and to make decisions as to whether a program should be continued or terminated. These standards and indicators were mandated by Congress in 1986 and they have been in use for more than five years now. These standards include serving a certain percentage of persons with severe disabilities , a specific level of placement, and a maximum cost per placement. If a project cannot meet the standards, their funding is discontinued.

We are providing this testimony because we feel strongly that many, if not most, people receiving disability benefits through Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) would like to return to work if given adequate opportunities and supports. We also feel strongly that there are services providers, including our members, who have developed training and placement models that have already proven successful in helping SSDI and SSI beneficiaries and recipients to go to work or to return to work.

The Problem

The problem is that current efforts to return this population to work have been too little and not effective. As the General Accounting Office recently reported:

> Helping people with disabilities return to work has been a low priority of SSA and the Congress for both the SSI and DI programs, and, in fact, SSI and DI return virtually no one to work. This low priority is especially evident in vocational rehabilitation (VR), to which relatively few resources are allocated. For example, for every $100 SSA spends on cash benefits, it spends little more than 10¢ on VR, and few recipients are referred for VR services. As we reported in 1993, VR beneficiaries receive, on average, only modest services and show limited long-term improvement. [1] In 1993, compared with $52 billion in combined SSI and DI benefit payments, $63 million

was spent for VR. Of over 7 million SSI and DI disabled recipients, only 300,000 were referred for VR, and 6,000 were successfully rehabilitated.

[13]Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed (GAO/PEMD-93-19, Aug. 27 1993).

(from GAO Report GAO/HEHS-95-137, ***Supplemental Security Income - Growth and Changes in Recipient Population Call For Reexamining Program***, July 1995)

We would like to make it clear that the problem is not necessarily with the state vocational rehabilitation agencies who are currently providing rehabilitation services. Rather it is the constraint imposed by the current authority and the lack of almost any incentive for a state agency or any other service provider to want to provide services under the current system. We support changes in the current statutory authority that would:

- provide a level playing field for a wide range of service providers including private non-profit and for-profit rehabilitation service , as well as the state VR agencies who are currently eligible to provide services
- provide a reasonable reimbursement for services leading to successful return to work and removal from SSI or SSDI rolls.
- provide incentive payments for successful placements based on long term placement and long term removal from rolls

Are there Solutions?

You heard from several excellent witnesses who testified before the Subcommittee on August 3, 1995. We support the testimony given by Tony Young, Kenneth Shaw, George Watters, Steve Start and Fred Tenny as their testimony related to possible improvements to the rehabilitation program for SSDI and SSI recipients. We are all in general agreement - reduce the SSDI and SSI rolls by getting people back to work by fully utilizing the private rehabilitation sector.

There are several possible solutions that this subcommittee must address if there is to be a reasonable degree of success in addressing the growth of the number of people on SSI and SSDI. They all must be addressed. At a minimum they include:

- better and quicker disability determinations
- improved continuing disability reviews (CDR)
- timely access to quality rehabilitation services
- assurance of ongoing access to medical assistance

We will restrict our comments to the need to revamp and improve the provision of rehabilitation services to SSDI and SSI recipients. There are four key elements in providing rehabilitation services to this population:

- **reduce the number of people on the rolls**

  The GAO reported only about 6000 persons being removed from the rolls due to rehabilitation services in 1993. It is our understanding that last year the number was even smaller. The 45 PWIs who kept the statistic last year reported that 25% of the persons they placed had been receiving SSI or SSDI payments prior to PWI services and placement. It is estimated that all PWIs placed approximately 2500 persons who had been receiving SSI or SSDI payments.

  The RTW Group has estimated that a fully implemented return to work program could put over 900,000 to work

- **be cost effective**

  PWIs can show that a substantial amount can be saved by the federal government for every dollar spent on PWI in one year (see statistics attached). Approximately 30% of the savings are coming from reduced SSI and SSDI payments. The RTW Group has projected very impressive savings for a fully implemented program.

  It must be realized that a federal level program is needed to meet federal needs. The state oriented job training programs will not meet the needs since the states will be most concerned with serving those people who have been

displaced or who are receiving unemployment compensation. In fact there may be an incentive for the state to assume that the federal government will take care of persons with disabilities through SSI or SSDI payments. (federal program needed to meet federal needs - states have different priorities)

- **be accountable**
  Any new reimbursement system for rehabilitation services should pay for results - not process. PWI already has a system of standards and indicators that could be modified to be used in serving SSI and SSDI.

- **long term benefits for both the individual and the federal government**
  Cost savings need to be long term to ensure that the federal government is getting real savings and not just projected savings. The individual who is leaving cash benefits needs long term assurance that they can be reinstated if and when necessary and that medical benefits will be available as long as needed. This can best be done by required follow-up. Service providers will have to make sure the person maintains their work status or at least stay off the rolls to get any incentive payments.

How Should the Program be Administered

SSA should use existing organizations who are:

- already certified by a state to provide rehabilitation services, or
- accredited by a nationally recognized accrediting body, or
- already providing rehabilitation services with recognized federal standards and indicators

SSA should use existing organizations, such as I-NABIR, the RTW Group, American Rehabilitation Association, United Cerebral Palsy Associations, and Goodwill Industries International to be the linkages to the private provider networks.

We will be glad to work with subcommittee staff and our allied organizations to quickly develop a method of implementing services under a new program. We think that the methods of referrals and cost reimbursement developed by the RTW Group have been well thought out and can serve as a basis to develop such a system.

We want to acknowledge the outstanding efforts of the subcommittee staff; Valerie Nixon, Kim Hildred and Mary Ann Gee. They have spent countless hours seeking out the input of organizations and individuals on this complex issues.

We look forward to working with you and your staff as we proceed on this issue.

Cost Effectiveness of 90 Projects With Industry

(this data represents 70% of funded projects in 1994)

- 10,901 persons were placed into community jobs
- average annual earnings were $12,311
- average federal income tax assuming the people were single was $894
- average FICA tax paid by employer and employee was $1921

Assuming one year of employment for the 10,901 persons employed:

- $7,910,454 in federal income taxes
- $17,346,774 in FICA payments
- $15,305,340 in support payments for the 2551 persons estimated on SSI or SSDI

total savings: $40,562,568
total PWI Grant: $15,612,785

net savings to federal government: $24,949,783

PWIs generate $2.56 in direct savings for each federal dollar spent on PWI in one year.

source: Report on indicators and standards reported by the project to the US Department of Education. Data is for FY 1994. 81% of those placed had severe disabilities and 71% had been unemployed for more than six months.

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IRWIN M. PORTNOY
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August 16, 1995

Phillip D. Mosely, Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Dear Mr. Mosely:

I received a copy of an Advisory regarding hearings with respect to the Social Security decision making process and wish to submit a written statement for the printed record of the hearing. I am a former Administrative Law Judge with the Social Security Administration (SSA). I was appointed in April, 1980, and retired on September 30, 1989 after thirty years of service to the U.S. Government with that Agency and the National Labor Relations Board. Since then I have practiced before SSA.

Those who have administered the disability insurance program have not been fair to the public, nor to Congress in the past. The whole shabby story is laid out for all to see, if they will, in a recent decision by the Second Circuit in *Dixon v. Shalala*, 54 F. 3d 1019 (2d Cir. 1995). Beginning in 1976, the Social Security Administration persistently and systematically misapplied the severity regulations promulgated secret policies to its decisionmakers, destroyed files, and would not adjudicate claims on the basis of combined impairments until forced to do so by a United States District Court Judge. When the court attempted to fashion a remedy in order to make whole the many persons who had been caused untold hardship, the Agency asked the court to excuse it from making whole the persons who had been damaged thereby because it would cause an undue strain on the Agency's resources. The Court of Appeals found this argument to lack merit. They refrained from saying that this is like a person accused of murder asking the court for mercy because he was an orphan.

The Commissioner has, according to the Advisory I received, made the claim that there are discrepancies caused by differing standards in the disability decision-making process. I would view this claim with a great deal of scepticism. In viewing the differing opinions of the courts as to issues of law, I am more impressed by the degree of consistency in the opinions of the various courts around the country. This can be readily seen for example in the decision of the court in *Robinson v. Shalala, (1994, SDNY* 1994 US Dist *LEXIS 3988, 92 Civ. 8289 (SS).* The decision adopted the opinion of the 9th Circuit in *Gonzalez v. Secretary* regarding the issue as to whether or not notices issued by the Agency in denying claims at the initial and reconsideration level afforded individuals due process when they failed to inform them that they might lose valuable benefits if they failed to appeal the denial which had been issued to them. The Agency again had little regard for the rights of the public.

Insofar as decisions at the administrative level are concerned, decisions based on facts as to severity of medical conditions are bound to vary according to the evidence and the individual who is viewing the evidence. If the Commissioner is seeking uniformity, this is an objective, which, by the very nature of the task involved, cannot be attained. As you know, there are 50 State Agencies all of whom review the applications that are filed. There are approximately 800 or more Administrative Law Judges whose independence is, and should remain protected by the Administrative Procedure Act. Attempts by the Agency to achieve "consistency" in the past have failed, and, I submit, should fail. There is no reason why the independence of the Administrative Law Judges should by compromised or bypassed, otherwise they will become totally subservient to the Agency. The independence of Administrative Law Judges was attempted to be compromised by "Bellmon review". The Agency was sued, and rightfully so, by the Administrative Law Judge Corps of the Agency. The Agency finally settled the case before it proceeded very far. The decision issued by the court in that case reflected a scathing indictment of the Agency's conduct.

When the Commissioner complains that differing court interpretations have hobbled administration of the system, I, for one, would conclude that she really wants to limit the scope of review of their decisions. The Agency, at one point had 48 class actions pending against it. Congress had to enact reforms in 1984.

The Agency before 1984 provided little by way of guidance to Adjudicators regarding the evaluation of reports by treating physicians, and delayed in promulgating regulations thereafter. The Agency did not promulgate a "treating physicians' rule in its regulations until 1991 when it promulgated 20 CFR 404.1527, and then did so in response to court decisions in various circuits. The Agency thus has only had about five years experience in adjudicating cases on a uniform basis. Before then, the Agency had, by inaction, created the very situation of which it now complains, i.e. differing court interpretations.

The Agency has been more than lax in conducting continuing disability reviews. It simply has not done them. It has yet to review the bulk of the cases in *Stieberger v. Sullivan*, 792 F. Supp. 1376 (S.D.N.Y. 1992). In my experience, borne out of my practice before the Social Security Administration since my retirement from federal service, a number of my clients have rehabilitated themselves, gone back to work, and completed a trial work period, or have gone into business and become self-employed (in the proce employing others). In our office, it is our practice to inform our clients about the services provided by the State of New York's Office for Vocational and Educational Services for Individuals with Disabilities (VESID) and encourage them to take advantage of their services. At one point the Agency was distributing information to claimants about their services, but lately has not done so. I believe that a system of incentives for vocational rehabilitation can be worked out. As a concept, this is not susceptible to a "one size fits all" approach. The essence of vocational rehabilitation is to work with individuals on an individual basis, find out what their aptitudes and limitations are, and provide training or other means to get them back to work.

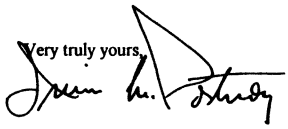
So far as the speed of the disability process is concerned, the quickest and simplest way to improve the procedural difficulties which claimants face is to eliminate the reconsideration step which the system presently has, and proceed directly to the hearing stage when claimants are initially denied.

Another proposal which would speed processing is to eliminate the "two standards for finding a person disabled" now presently in effect, and require the state agencies to apply the same standards used at the Administrative Law Judge level. This would encourage attorneys to participate in the process early on, particularly if the Agency utilized a two party check system for payment of their fee (which should remain at 25% of the retroactive amount under the fee agreement and fee petition process).

In view of the tawdry, and indeed shameful, behavior of the Agency in dealing with the public in the past, I am far from convinced that the Agency has any expertise in this field which would commend itself to Congress or the public insofar as substantive changes in the definition of disability is concerned. The definition of disabiiity contained in the law as presently constituted is fair. It is ascertainable by lay adjudicators if they use the medical and vocational resources open to them. That definition is based on the analysis of a combination of medical and vocational factors which are capable of review by the Agency itself or by a court of law. Similarly, the Agency's past behavior with regard to the administration of the process itself does not inspire any confidence that it has expertise in framing meaningful suggestions as to how to do so in the future.

The Agency's actions in determining disability have to remain open to challenge by the public in the future, as it presently is. The key to the courthouse door is to encourage the public to have access to a vigilant bar. The maintenance of the present contingent fee system, modified only by the issuance of a two party check would make this possible.

Very truly yours,



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cc: Benjamin Gilman, Member
U.S. Congress
National Organization of Social Security Claimant's Representatives

COMMENTS FOR THE SOCIAL SECURITY
SUBCOMMITTEE HEARING

I. I make these comments for consideration by Congress as an individual who has not worked since May 1992 as a weaver in the textile industry. I filed a Title II disability application in May 1994. The claim was denied initially and on reconsideration. I have a request for hearing pending with the Office of Hearings and Appeals. Therefore, my comments are based on my experience as a disability applicant.

II. The local Social Security office should have business hours that are convenient for the public. They currently close at 3:30 in the afternoon. Local Social Security offices should be open at least one evening per week or should be open on Saturday from 8:30 am until 3:30 pm.

III. The local Social Security office could have its work load reduced by transferring a lot of the disability paperwork to the state agency immediately. No one in the local Social Security office makes any medical or vocational decision that relates to my claim. Therefore, the people who are responsible for interviewing me at the local Social Security office have nothing to do with the decision made at the state agency which is 35 miles away. It makes sense to have those interviews conducted by the people who are making the decision rather than clerical people at the local district office.

IV. There is a tremendous duplication in information requested from Social Security claimants. The local Social Security interviewer at this district office does not make a decision based on the information received in the interview. Therefore, move this responsibility from the district office to the state agency. This would eliminate my need to provide the same information repeatedly.

V. The reconsideration process needs to be improved. The number of hearings held by administrative law judges would be reduced if more claims were paid on reconsideration. A claimant for disability benefits should have the right to request reconsideration directly with the state agency rather than returning to the local Social Security office for another series of reconsideration interviews by people who are not involved in making decision.

VI. Nothing should be done to interfere with the attorney/client relationship. The Social Security disability process is a complicated process. People should have the right to hire attorneys. Nothing should be done to interfere with my right to retain an attorney to assist me with my Social Security claim. I understand that Social Security is trying to change the arrangements for withholding 25% of the retroactive benefits if a favorable result is achieved by my attorney. I know that many people will never be able to hire an attorney to help them with their Social Security claim if Social Security makes that type of change. Social Security should not be permitted to make changes in the law that would make it more difficult for Social Security applicants to hire attorneys. The system is so complicated that no one can get through the system without legal counsel.

VII. My hearing is pending at the Office of Hearings and Appeals in Greenville, S. C. I have offered evidence from my attending physician who has documented that I am disabled. Recent contacts at the Office of Hearings and Appeals suggest that an additional 6 or 8 months may pass before a

hearing is held or a decision is issued. I understand that routine delays of 3 to 6 months exist for hearing decisions to be issued after the hearings are held. I understand that the problem with the issuance of decisions is primarily clerical in nature. New judges have been added but sufficient clerical staff has not been added. The decisions are being delayed because of insufficient clerical staff to get the decisions typed. Solve that problem and the Office of Hearings and Appeals will improve.

Very truly yours,

Christine J Johnson

Christine J. Johnson
P. O. Box 8122
Spartanburg, S. C. 29305

Testimony before the Committee on Ways and Means, May 25, 1995.

"The Future of Social Security

by Raphael G. Kazmann
231 Duplantier Blvd
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Let us agree that the intent of the program is noble and the objective worthwhile. Nonetheless good intentions have no influence on the workings of natural law. And it is a law of societal life that stealing cannot be countenanced lest it destroy the society. And this law applies whether the individual is acting for himself or for a private organization like the Mafia or a labor union or for a public organization like the U.S. Government. It is instructive to examine the results of the Social Security program in the light of actual experience.

Briefly, the argument is this: when an individual saves for his old age he reduces his immediate consumption of goods and services and, effectively, invests in the purchase of capital goods, tools for the production of commodities and services. He may do this by direct investment in corporate stocks or bonds, by purchasing insurance, by putting money into mutual funds, by purchasing his home so that he will have shelter without the making of current payments except for operation and maintenance, or by directly lending the money to others who are in business. The key point is that his consumption has been reduced, he has "saved" money and this reduced consumption has resulted in an increase in the capital stock of the country.

The United States Supreme Court, in an opinion handed down on June 20, 1960, described the Social Security program in the following manner:

"The program is financed through a payroll tax levied on employees in covered employment, and on their employers ... The tax proceeds are paid into the Treasury as internal revenue collections ... and each year an amount equal to the proceeds is appropriated to a Trust Fund, from which the benefits and expenses of the program are paid...

Persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents. Plainly the expectation is that many members of the present productive force will in turn become beneficiaries rather than supporters of the program. But each worker's benefits, though flowing from the contributions he made to the national economy while actively employed, are not dependent on the degree to which he was called upon to support the system by taxation."

It should be noted that the employer's share of the tax is simply an added labor cost which must, of necessity, be included in the cost of the product as if it had been paid to the employee as an increase in wages.

The Social Security program, insofar as it provides for benefit payments to workers upon retirement, differs fundamentally from the retirement program of an individual or groups of individuals. In each program, the current consumption by the individual is reduced.

In the private programs the reduction in consumption is translated into the increased production of capital goods. This results, fundamentally, in an increase in the capital stock of the country and thence into an increase in production. Moreover, the individual retains title to his investments and if he should die before reaching the age of retirement, his savings become part of his estate and go to his heirs.

The money extracted by the Government from the individual in the form of taxes for "social security," and particularly that fraction to be devoted to payments upon retirement, is not invested in the creation of capital stock. Instead it is immediately distributed to those who have reached the arbitrary age of retirement, so that they may consume it as any other current income. True, the level of payment depends on the number of quarters of "covered" employment and the taxes paid during that period. But this is merely a subterfuge in that the Congress decides the level of benefits, decides on "cost of living adjustments" (COLA), the fraction of the population included in the system, and other matters.

Thus the system has the outward trappings of a legitimate retirement system, but actually the costs and benefits are not related, and the system merely transfers funds from the younger, and more productive, fraction of the population to the older fraction. For purposes of this discussion, two items are of interest: the government takes money from a fraction of the population by force (or threat of force) and bestows it on another fraction without receiving services in return. By definition, this is the stealing of money and is a violation of the natural law that is summarized as, "Don't steal". The potential capital stock of the nation is less than it would otherwise have been. Is this actually happening? Table 1 lists the rates used and taxes exacted by the program:

TABLE 1
SECURITY TAX RATES AND MAXIMUM TAX

Year	Maximum Taxable Base	Combined Employer and Employee Tax Rate	Combined Employer and Employee Maximum Tax
1960	$ 4800	6 percent	$288
1970	7800	9.60	748
1980	25900	12.26	3174
1990	51300	15.30	7849

Future rates and limits will be adjusted by Congressional action.

It should be noted that since 1962, the combined maximum tax has increased at the rate of approximately 3 percent per year and the rate shows no signs of decrease. The tax rate, itself, has increased by an average of 0.3 percent per year since 1966 and it is, of course, a tax on gross income which applies to the first dollar earned. At this time more than one seventh of the gross income earned by the working population is taken from them (stolen) and transferred to the beneficiaries of this program.

Only a relatively few economists have had the courage to analyze the impact of the social security program on the economy of the nation. In the summer of 1975, Martin Feldstein (later to be Chairman of President Reagan's Council of Economic Advisors) published a landmark article in the Summer issue of **THE PUBLIC INTEREST**. His empirical study provided a first look at the results of violating one of the natural laws that lead to a stable society: impoverishment. Said Dr. Feldstein:

> The most important impact is a substantial reduction in the nation's rate of savings. This reduction in savings makes our capital stock much lower than it otherwise would be. With less capital, our national income is reduced and wage rates are lower. Moreover, the specific form of the reduction in saving greatly increases the unequal concentration of the ownership of wealth ..social security is bankrupt by the conventional standards used to determine the actuarial soundness of private pension programs... A private pension program must have sufficient assets to meet all prior commitments because it cannot be certain that any future contributions will be made. In contrast, the social security program can continue to compel future generations of workers to pay social security taxes.

The forced transfer of funds will continue as long as the voters (some of whom are beneficiaries) approve. This is a clear instance of organized theft and the action strikes at the very basis of democratic organization.

What have been the actual results of this chicanery on the standard of living of the population? Dr. Feldstein documented it, based on the available data from 1971 (there is every reason to believe that at present the negative impact is even greater):

> In a recent study, I estimated the 1971 value of this social security "wealth" at $2 trillion. Since the total private wealth of households in that year was about $3 trillion, the calculation suggests that social security may have reduced the stock of private wealth by about 40% — i.e., from $5 trillion of wealth that would exist without social security to the $3 trillion that currently exists. The 40 percent reduction is remarkably close to the estimate obtained by looking at the reduction in personal savings that would occur if households viewed social security taxes as an alternative to savings." [[Footnote by Dr. Feldstein: This social security "wealth" is not real wealth but only an implicit promise that the next generation will tax itself to pay the annuities currently specified in the law. Although there are no tangible assets corresponding to this "wealth", it is perfectly rational (? RGK) for households to regard the value of their future social security benefits as part of their personal wealth.

Dr. Feldstein noted a distinct tendency for people to retire earlier and for a greater percent of the population to retire than formerly retired. In 1929, 45 percent of men over 65 years of age were retired; by 1971, the retirement rate had increased to 75 percent. This result could have been anticipated. In the Spring of 1977, Dr. Feldstein's additional thoughts on the social security system were published by **THE PUBLIC INTEREST:**

> ...the social-security "tax" [is] a very important source of work disincentive. For most families, the social-security tax is more than the personal income tax. This 12 percent tax on top of federal and state income taxes moves the marginal tax rate from one fifth of additional earnings to one third. And when taxes take one third of extra earnings, there is bound to be an effect on such things as work effort, job choice, and the willingness to get extra training or to relocate...(it also) creates a sense of unfairness that can undermine the support of the entire program.

What was the effect of the social security program on the standard of living of the population? Dr. Feldstein computed that the gross national product was, in 1974, approximately $200 billion *less* than it would have been had the social security program not been in operation. In that year consumer spending was approximately $800 billion. Said Dr. Feldstein: **"Let me emphasize that this lower level of GNP reflects the pay-as-you-go nature of our social security system."** There is the distinct implication that the available capital per worker is less than it would have been in absence of the program. Thus wage rates were lower and, owing to the scarcity of capital, the rate of return on the available capital was higher than it would otherwise have been. Recent discussion on the need to "re-industrialize America" has pointed out the scarcity of capital and the aging and obsolete manufacturing plant that has made whole industries uncompetitive in the world market.

In **THE PUBLIC INTEREST** of the winter of 1980, Nathan Keyfitz, a demographer and sociologist took a look at the social security system and found still another fraud:

> American social security payments by wage earners and their employers reached $95 billion. This compares with $140 billion of all personal savings plus undistributed corporation profits. The first figure can be looked at as the savings of working people against the contingencies of old age and sickness; the second, as mainly the voluntary savings of the more affluent for whatever purposes more affluent people save ... The remarkable fact is that, under present arrange ments, virtually no interest is paid on the first quantity, the compulsory savings of working people, while the voluntary savings draw as interest all that the economy provides in the way of return to capital...

If we disregard the fact that the Supreme Court does not consider social security taxes as savings (and Dr. Keyfitz was undoubtedly aware of this fact), the misapprehension of this fact by the working population is the key to the entire fraud. But natural laws operate whether or not we understand them, and the writer submits that the case has been proven: whether or not

robbery has been made legal matters not an iota. The results are the same: less incentive to work and a lower standard of living are the first and most obvious results.

Other social consequences of the Social Security fraud are inevitable and must not be ignored. Since one part of society is living from the proceeds of the robbery of another part of the same society, the victims may be expected, some day, to finally understand this and to band together as a voting group to oppose it. This point in time has almost arrived and we will have the unappetizing spectacle of the young, those under 50, actively working to reduce their tax payments while the old (those over 62) try to maintain or increase the level of taxes so that their rate of take (benefits) will increase. There will be a middle group that will be torn in both directions. No matter how it works out, the social structure will be damaged. The probable outcome will be that the younger generation will prevail. In the final analysis, the welfare of the children and grandchildren must take precedence over the needs of the older generation. The problem we must solve is how to set matters right with minimum disruption of the society, a society that has been lied to concerning Social Security by its political leaders at every level from the days of Franklin D. Roosevelt to the present time.

Much thought has been devoted to extricating the country from the intolerable position that its violation of moral law has placed it in. Peter J. Ferrara, in a book, **SOCIAL SECURITY: AVERTING THE CRISIS**, has suggested changing from a governmental social "security" system to an individual retirement system that has been properly funded. He would increase the retirement age from 65 to 68, index the benefits to the rise in wages rather than prices, relate the benefits strictly to the amount paid into the fund, and remove the additional benefits that retired and disabled workers receive for spouses and dependents. Then each worker would establish an Individual Retirement Account (IRA) for himself and, over the course of a decade or two, an increasing percentage of the taxes that he and his employer paid to SS would go into the individual account. Finally the worker would terminate his connection with the SS system. In addition Dr. Ferrera discusses the insurance phase of the SS system and how this could be replaced by purchasing insurance by the individual. The annual cost to the taxpayer would be as much as 57 billion dollars (in 1996) and would fluctuate widely. The proposal does furnish a basis for discussion, but the operation is so drawn out that possibly it could be done more quickly; even with some temporary disruptions, speed would be desirable.

Retired persons who had reached age 72, could reenter the labor market and would make no deposits to their IRA's unless they wanted to. Retired persons between ages 62 and 72 could purchase annuities based on the bonds received for their contributions to the social security system and would probably return to the labor force, perhaps with some retraining at public expense. The entire problem of transition is complex and needs serious study. The shorter the transition period, the less might be the damage to the body

politic: a five-year transition period would be more desirable than a 20- year period. Probably the smallest feasible time period would be five years, considering the great amount of paperwork and the need to accomodate the large amount of investment capital that would be made available.

The Chilean government encountered the same results of violating natural law as the experience in the United States is producing. It decided to replace its social security system with a compulsory private pension plan: each employee must turn over 17 percent of his wage to a private social security fund (10 percent for old age benefits, 3 percent for life insurance, and 4 percent for health care.) The money of the worker must be placed with a private corporation that, in turn, would invest in high grade securities of one type or another. The employee is able to withdraw the money from one private corporation and place it with another if he is dissatisfied with the rate of return. Upon retirement he may either buy an annuity or make monthly withdrawals from the fund. He would receive exactly what he put into the fund plus all of the money earned by his investment, tax free. There are other provisions, but since the former tax was 28.7 percent of the labor cost and the companies were required to increase the wages of the employees by 18 percent, there was a net reduction of labor costs of some 10 percent. Most important, the money received upon retirement has been placed under the control of the employee and is not based on funds extracted from the younger generation. In addition the worker receives his actual contribution to the old system plus 4% interest and an inflation adjustment as a lump sum from the government upon his retirement. This, combined with his private fund, is used to purchase an annuity. The Wall Street Journal (3/31/82) published an article by E. G. Martin on the subject. Manifestly this is a vast improvement over Chile's former system, which was much like ours still is. Chile's new system is also far more in accord with the underlying laws of human society than is our own social security system.

Any system that seeks to protect the individual against the weaknesses and infirmities of advanced age must do so in accord with natural law. This means that there shall be no robbery and no misrepresentation, as far as this is humanly possible. Thus, in the United States, for future participants, all payments must be made on the basis of money actually saved plus the returns on investment less necessary operating expense. All payments should be made, tax free, by the employee, possibly by payroll deduction. Over a transition period, each employee might receive a bond equal, in face value, to all the money he had contributed in social security tax plus the appropriate interest. This bond would draw the current rate of interest paid by any other federal obligation. The bond would be deposited in an investment house and would be in the IRA account of the bondholder. The investment house would utilize the bond just as it does its other investments, changing its investments as the market dictated. Of course the IRA could be withdrawn for use after retirement,

although its owner could specify where his money should be invested and would bear any risks. However, the citizen could change investment houses if he became dissatisfied with the rate of return on his contributions.

In summary: the Social Security system must be abolished, the sooner the better. Why? Because it is based on stealing from the younger generation for the benefit of the old and stealing must be stopped or it will inevitably destroy a society from within. Evidence? Since the money is not saved (invested) but is used by the beneficiaries immediately, the capital stock of the country is less than it would have been if the money had been saved - and the standard of living is substantially reduced. At the inceasing rate that funds are being stolen from the younger, productive, sector of the population, the entire enterprise will be bankrupt in about 30 years. Long before that, if taxes are perennially raised to pay the beneficiaries, there will be a tax revolt and civil disorder. At the same time we are seeing the beginnings of political efforts by the young to organize to protect their interests and the the future of their children. This will divide the country along generational lines and will destroy the internal cohesion of our society.

Conclusion? The Congress should go full speed ahead to figure out how to terminate the Social Security system as soon as possible. I believe that it must be done in 5 years or less."

1709 Bayside Drive
Chester, Md. 21619
June 5, 1995

Phillip D. Moseley
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

RE: Hearings on the Social Security disability insurance (DI) program.

In the early 1970's the Social Security Administration's Office of Disability and International Operation (ODIO) stopped doing a centralized one hundred per cent (100%) review of all the disability cases adjudicated by the various state disability determination sections (DDS). Afterwards a very limited (approx. 5-10%) review process was implemented. The disability rolls grew but the growth was kept within reasonable bounds because cases with impairments that were expected to improve were routinely reviewed for continuing eligibility. Individuals were still removed from the disability rolls when it was determined by the continuing disability review (CDR) process that their impairments were not disabling.

Around 1980 the CDR process was expanded. Medical reviews were conducted on all disability cases regardless of what the expectation was for medical recovery. Significant numbers of disability recipients were terminated but these terminations resulted in a public outcry for a reform in the continuing disability adjudication process. Because of this public outcry the number of disability cases which were subjected to CDR's was reduced in 1983.

All medical CDR's were subsequently stopped in 1984 when a moratorium was declared. Numerous class action lawsuits had been filed and those that had been decided placed the entire medical CDR process into disarray. Congress then passed PL98-460 (The Social Security Disability Reform Act of 1984) which established new adjudicative criteria to be used in the CDR process. PL98-460 created a medical improvement (M.I.) standard that had to be met before a determination could be made that an individual was no longer disabled and no longer entitled to disability benefits.

Since the implementation of this M.I. standard in 1984 fewer and fewer persons have been removed from he disability rolls. This reduction in the number of medical terminations has been largely due to the M.I. criteria established by PL98-460 but it could also be attributed to the fact that fewer disability cases have been getting complete medical CDR's. This diminution in the medical CDR's even

reached the point that for an extended period of time various DDS's would not accept the medical cases assigned to them for CDR's. Virtually no medical CDR's were being done for a period of time (attachment A).

Currently the number of disability cases getting a complete medical CDR is less than the congressionally mandated 500,000 annually. However, this situation is being further compounded by the fact that experienced disability examining personnel in ODIO are now being restricted from initiating medical CDR's when they discover cases which were not properly and timely alerted for CDR review by the computer's selection process. This restriction applies even to those cases with medical conditions previously designated as the ones most likely to show medical improvement (see the attachment B - note that "MIE" diary cases represent those cases previously diaried because medical improvement was expected).

It is agreed that an additional review of cases will be helpful in reducing the number of future disability recipients but my feeling is that the bulk of the efforts should be directed at preventing persons who are truly not disabled from wrongly getting these benefits. The integrity of the Administrative Law Judges (ALJ) and DDS's original decisions of allowance/denial must be validated as a first priority. Given the restrictions placed on CDR adjudicators by the M.I. concept, implemented by the Disability Reform Act of 1984, it is very difficult, if not almost impossible, to remove someone from the disability rolls once they have rightly or wrongly been entitled. If someone is wrongly entitled with little or no impairment it is virtually impossible to find any significant improvement in work related terms that would justify a medical termination under the M.I. criteria unless the person had an impairment that was expected to improve. If the M.I. concept is not changed or eliminated than it is very important that the integrity of the initial ALJ and DDS decision process must be validated.

All of the problems with the disability program can't be cured simply by passing laws that require more reviews. There are additional concerns which must be simultaneously addressed. One of these concerns is the fact that the reviews must be conducted by an organization that is trained and dedicated to its mission. Unfortunately, the environment in the Social Security Administration review components still needs to be addressed (See attachment C).

If you wish to discuss these issues further I can be reached at home (410) 643-2377 or work (410) 966-1651.

Bob Lanasa

Bob Lanasa
Disability Examiner Consultant
Office of Disability and
International Opr.

ATTACHMENT A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Social Security Administration
REGION X

Refer to: S2DXB4:DPP1 June 7, 1989

Memorandum

Date JUN 7 1989

DI-28000

From Regional Commissioner
Seattle Region

Subject Washington CDR Moratorium - ACTION

To Assistant Regional Commissioner, Field Operations
Area Directors I, II, III
All Field Office Managers Serving Washington State

Effective immediately, a moratorium is in effect on field office processing of medical CDRs involving Washington residents. No new medical CDRs should be initiated until further notice. Medical CDRs in which contact has already been made with the beneficiary should be completed as soon as possible and sent to the DDS.

This moratorium is necessary due to the court ordered Morrison - Doe - Decker case reviews which will begin in July. The Washington DDS will receive approximately 1,000 review cases per month and lacks the resources to adjudicate initial and reconsideration claims, carry out the court ordered review, and do medical CDRs.

Work issue CDRs which require DDS review are not included in this moratorium.

If your staff have questions about the moratorium, they may contact the Disability Programs Branch, FTS 399-4459, COM 206-442-4459.

for Peggy Foertschbeck

cc: Administrator, Washington DDS
Washington DPA

SOCIAL SECURITY ADMINISTRATION
REGIONAL OFFICE, ORC
75 HAWTHORNE STREET
SAN FRANCISCO, CALIFORNIA 94105

Regional Memorandum No. 91 - 58

TO : All Region IX Managers

FROM : Regional Commissioner

DATE: MAR 11 1991

Refer to: S2D9B4

File Code: DI-13-4

SUBJECT: California CDR Moratorium Update--INFORMATION

This memorandum serves as an update to the ongoing moratorium on sending CDRs to the California DDSs.

The moratorium continues on routinely scheduled MIE, MIP, and MINE cases. In addition, the California DDSs are not processing most work issue CDRs, including 1619 cases.

The CDRs which the California DDSs will process are as follows:

- o Voluntary report of improvement;
- o Third party report of improvement;
- o Evidence received in conjunction with a new or existing claim raises a CDR issue;
- o New initial claim is filed, and there is a matured MIE diary on another Title or on another type of claim on the same Title (e.g., DIB/DWB);
- o Certain DA/A cases. The FO should contact the Regional Office on each DA/A case for a determination on whether the CDR issue should be addressed despite the moratorium.

If you have any questions about this memorandum or wish to discuss a possible exception to the moratorium, please contact Priscilla Royal, Disability Programs Branch, at (415) 744-4505 or FTS 484-4505.

for Linda S. McMahon

CONFERENCE AND CALL RECORD

ATTACHMENT - B

CONFERENCE OR CALL INITIATOR			
John Bryan, Program Analyst	OAS, ODIO, DCO	9:15 a.m.	8/4/94

RECORD OF

☐ OFFICE CALL ☐ CONFERENCE ☒ PHONE CALL ☐ PHONE CONFERENCE

FILE REFERENCE NO. DI-12

LOCATION 7060 Security West Tower

SUBJECT -

Past Due MIE Diaries--INFORMATION

ROUTE TO:	INITI
Ms.Burgan Mr. Lanasa Ms. Myers Div I-IV PAs Div I-IV DECs Div I-IV DEs Ms. Cohen	

PARTICIPANTS

NAME	ORGANIZATION	PHONE N
Mr. Robert Lanasa, Disability Consultant	MOD-10, ODO, ODIO	61650
Ms. Georgia Myers, Program Analyst	DDPP, OD	59212

SUMMARY OF DISCUSSION

Mr. Lanasa requested clarification as to whether POMS DI 40505.140(A) remains in effect. This section of POMS directs that a medical CDR should be initiated for past due MIE diaries that are discovered during the course of non-CDR processing. Ms. Myers was contacted and indicated that DI 40505.140 was to be changed, or deleted, in a future revision. Until the section is changed, DEs should disregard DI 40505.140(A). Past due MIE diaries should no longer be routinely referred to the field for CDR action. However, MIE diaries will continue to be referred when a work issue raises the question of possible medical improvement.

ACTION TAKEN OR REQUIRED

Distribute copies of this CCR to all DE PAs, DEs and DECs.

NAME OF PERSON PREPARING THIS REPORT		DATE
	cc John Bryan	8/9/94

HHS-508 (Rev. 11/90)

NOTE: a "MIE" diary is established when an individual's medical condition is likely to improve (MIE = Medical Improvement Expected)

ATTACHMENT - C

DATE: MAR 1 3 1991

TO: MR. TORNER

FROM: CONCERNED DISABILITY EXAMINING PERSONNEL

SUBJECT: ODO'S INDIFFERENCE TO THE DISABILITY REVIEW PROCESS

THE ATTACHED IS A SYNOPSIS OF THE ISSUES DISCUSSED WITH YOU ON FEBRUARY 19, 1991.

NOTE

MR. TORNER WAS AN ombudsman FOR SSA's FORMER COMMISSIONER, Gwendolyn King.

LITTLE has changed IN ODIO SINCE 1991 WHEN THIS SYNOPSIS WAS PREPARED. (bf)

In accordance with your request during our meeting on Feb. 19,1991, we have prepared a list of the issues that are of primary concern to us as disability examiner (DE) personnel in the Office of Disability Operations.

I. ODO'S Module Structure

The organizational structure of ODO is askew and does not promote a quality review of disability claims. ODO's GS-11 DE s with their GS-12 Disability Examiner Consultants (DECs) are divided into thirty six (36) separate modules. This arrangement hinders the fulfillment of the uniform, consistent quality review that Congress mandated.

All other components in the Social Security Administration (SSA) which review disability decisions (e.g., the PSCs, OPIR, the R/Os and even ODO's Division of Appealed Claims) have consolidated their DE personnel. ODO does localize its personnel for special projects such as the 1619 Workgroup, the California Workgroup, the Alternate Decision Review (ADR) Project and the Morrison, Doe and Decker Project. But it remains a mystery why ODO centralizes only for special projects yet keeps the DE personnel separated to work their regular case loads. Many DEs believe that the quality of the disability review suffers by our being in so many separate distinct groups. It appears to us as if the primary purpose for such an arrangement is not to encourage a uniform, consistent quality review but rather to support the higher grade levels of the module managers.

Concentration of DE personnel would make it easier to monitor the application of SSA policies and help insure that the often judgmental procedures are correctly and uniformly interpreted. Perhaps ODO could avoid a fiasco similar to that caused by the implementation of the 1980 Amendments. Because DE personnel have been so dispersed, procedures concerning the 1980 Amendments were variously interpreted. Even today those procedures and subsequent ones are still not applied with conformity. Uniform consistent quality review would be encouraged by consolidating DE personnel. We suggest that the initial and reconsideration DE personnel be merged into functional units within ODO or at least within each division.

II. Management Responsibility

ODO's management personnel should be accountable for monitoring and managing the disability review performed in ODO. Less than fifteen (15) percent of the GS-13

and GS-12 module managers and assistant module managers have had any significant experience in the preparation and/or review of disability decisions. The vast majority of the managers who directly manage the DE personnel in ODO have had little or no experience actually performing a substantive review of disability decisions. The few who do have this experience are usually at most only minimally involved with monitoring the disability review process.

The proper management of this congressionally-mandated review warrants a sufficient number of managers who have currently relevant disability adjudication experience; i.e.; they were actively involved on a daily basis in verifying that disability cases were being uniformly adjudicated according to the various disability laws and regulations. Our experience in the modules for more than ten (10) years has shown that the module managers and their assistants lack sufficient experience, inclination or the responsibility to properly monitor, coordinate or direct the disability examiners and the disability review process.

III. Adjudicative Atmosphere

The creation of a quality environment that is equally mindful of accuracy, efficiency and service which is compassionate and considerate was Commissioner King's goal in March 1990 when she suspended numeric goals for both supervisory and non-supervisory employees. While superficially ODO has removed numeric goals the numeric atmosphere still exerts an undue influence on the disability adjudicators in ODO. Both prior to and since March 1990 employees have been repeatedly confronted with their module's relative position on the Management Information System (MIS) reports and constantly encouraged to see if they could work one or more additional cases to improve the module's standing on the MIS report. ODO has replaced individual numeric assessment with an obsession for numerically comparing the various units' MIS status. Put in proper perspective an awareness and discussion of production and numbers is appropriate in an operating component, but unfortunately it continues to dominate and almost totally preoccupies the scene in ODO.

In ODO the first-line supervisors' thoughts and time are still almost totally absorbed with numeric statistics because of upper management's daily use of

the MIS report as a managing tool. This concern and preoccupation with numbers is very easily transmitted to the non-supervisory employees who know that they can keep their supervisors happy by moving more cases. This situation is then further complicated by the fact that production (workloads and MIS statistics) is addressed and discussed in most meetings while accuracy and good service are hardly ever mentioned by the supervisors.

Until upper management starts using the MIS report appropriately and stops overusing and abusing it, the prevailing environment is going to remain one that overemphasizes numbers. More than occasional lip service is required to change the environment to one that encourages accuracy and provides service that is compassionate and considerate.

A first step in this direction could be made if ODO's management would relax its emphasis on the daily MIS statistics so that the lower level supervisors would have the time needed to concentrate on the responsibilities of their positions other than those related to their units' statistical standing on the daily MIS report. Perhaps supervisors would have a chance to become significantly involved with the disability program and process, if upper management would restrict the use of the MIS report to a weekly or monthly basis rather than a daily one.

Proper disability adjudication requires a climate that encourages quality service, proficiency and production on an equal basis. Periodically saying that quality and proficiency are equally as important as production is not the same as performing daily actions that show this to be true. Currently we are occasionally told that these things are equally important but management's daily activities convey an entirely different message to the employees. Actions do speak louder than words.

IV. Vocational Specialist

ODO's DE personnel are responsible for determining who is and isn't still disabled. A decision of whether a beneficiary with a severe medical impairment is realistically capable of returning to the world of work often involves the assessment of how the beneficiary's medical condition interacts with his/her age, education and vocational history. Sometimes the decisions are very judgmental and require special guidance.

In the past ODO had specially trained vocational consultants to assist its examiners in their evaluation of the more judgmental decisions. Currently ODO does not have any of its own specially trained vocational consultants to assist in vocational assessment. If we need the service of a vocational specialist, we refer the case to such a person in OPIR. (NOTE: OPIR performs a consistency review of ODO's cases. Can they review themselves?)

ODO's reestablishment of the vocational consultant position would demonstrate its sincerity about making quality disability reviews. The individual in these position could be available for face to face discussions of the more complicated situations. They could also keep themselves and ODO's examiners abreast of any advances in medical and/or vocational technology that impacted on vocational assessment. Additionally they could review all of ODO's vocationally related returns to the various DDS's.

V. Opportunities for the GS-12 Disability Examiner Personnel

Although the GS-12 DECs and Reconsideration Examiners have been repeatedly advised that they have promotional and advancement opportunities, no more than one GS-12 who was actively adjudicating and reviewing disability claims in ODO has been promoted directly to a GS-13 since 1979. This record is an obvious affront to the GS-12 disability examining personnel and raises a question about the philosophy of an organization that purports itself to be more than a payment center.

A responsible management attitude would seem to dictate that the individuals knowledgeable in disability adjudication be given promotional opportunity in SSA's disability operational component. Unceasingly ODO's management has advised its disability personnel that they were eligible for promotional opportunity but they have not followed up their rhetoric with supportive actions. When will they stop promising promotional opportunity and start giving it? Why have they discriminated against these GS-12s during the past decade?

VI. Opportunities for the GS-11 Disability Examiner Personnel

The GS-11s in ODO who have been actively adjudicating disability claims have been given less than equal consideration for promotion into ODO's GS-12 management and reconsideration disability examiner positions. In the last seven (7) years there has been no promotion into the GS-12 reconsideration disability examiner position because every vacancy has been filled with former GS-12s and GS-13s who were being reassigned, mostly from ODO management positions. Likewise, no more than one GS-11 who was actively adjudicating and reviewing disability claims in ODO has been promoted directly to a GS-12 management position in ODO since at least 1980.

Equal opportunities for advancement and promotions should be available to all ODO's GS-11 employees. The employees performing the valuable job of preparing and reviewing disability decisions should no longer be disadvantaged and deprived of these opportunities

LEGAL ASSISTANCE FOUNDATION OF CHICAGO

● 1661 S. Blue Island Avenue ● Chicago, IL 60608 ●
● 312-633-9890 ● FAX 312-421-4643 ● TDD 312-421-6574 ●

STATEMENT OF THOMAS YATES OF THE LEGAL ASSISTANCE FOUNDATION OF CHICAGO TO THE SOCIAL SECURITY SUBCOMMITTEE OF THE COMMITTEE ON WAYS AND MEANS, UNITED STATES HOUSE OF REPRESENTATIVES, CONCERNING THE SOCIAL SECURITY DISABILITY INSURANCE PROGRAM

On behalf of Social Security and Supplemental Security Income applicants and recipients living in Chicago who are eligible for legal representation from the Legal Assistance Foundation of Chicago ("LAFC"), I write concerning problems in the Social Security Disability Insurance program.

LAFC provides legal representation to the poor in Chicago on most civil legal matters, and represents thousands of persons on Title II and XVI issues each year. This representation is provided free to eligible clients.

In this testimony, I address four issues:

- the difference in allowance rates between state disability determination services and Administrative Law Judges ("ALJs");
- creation of a Social Security Court of Appeals;
- the backlog of claims at the Social Security Administration ("SSA"); and
- the need for continuing disability reviews to maintain integrity in the Social Security disability programs.

A. The Reasons For Differences In Allowance Rates Between State Disability Determination Services and Administrative Law Judges

Much has been made of the disparity in allowance rates between state agencies making initial and reconsideration decisions on one hand, and ALJs making hearing decisions on the other. To a large extent, the discussion appears to rest on the assumption that ALJs are making wrong decisions when they allow benefits on claims that were denied at the initial and reconsideration levels.

I believe that the differences in allowance rates between state disability determination services ("state DDSs") and ALJs are caused by three factors in combination:

1) Many claimants at the hearing level are represented by legal counsel; few are represented by legal counsel at

the initial and reconsideration levels;

2) Initial and reconsideration decisionmakers have no personal contact with the claimant while ALJs usually take testimony from the claimant at hearing; and

3) Initial and reconsideration decisionmakers rely on the POMS, which are inapplicable at the hearing level.

First, legal representation makes a major difference in allowance rates. In Illinois, few claimants are represented before the Illinois DDS at the initial and reconsideration levels, although a majority of claimants are represented at the hearing level. However, statistics show that legal representation, when present at the state DDS level, makes a huge difference in allowance rates.

LAFC provides representation to SSI applicants at the initial and reconsideration levels. Based on our experience, represented claimants have a far better chance of being found disabled at the initial and reconsideration levels than do unrepresented claimants, as the data for adult disability claimants below demonstrates.

Allowance Rates Based On Legal Representation

	All Cases[1]	Represented By LAFC
Initial	32.8%	60.6%
Reconsideration	15.9%	71.4%

Source of Data: Legal Assistance Foundation of Chicago SSI Advocacy Project, "Annual Report for FY 1994," Table H (data covers period of July 1993 through June 1994).

The allowance rates for persons represented by legal counsel at the initial and reconsideration levels are largely the same as the average ALJ allowance rate of 66%.

Second, there is no substitute to seeing and personally questioning a disability claimant. ALJs are provided a unique opportunity to question and assess the credibility of disability applicants. This is particularly relevant when pain or mental illness is part of the alleged disability. Initial and reconsideration decisionmakers do not have this opportunity.

---

[1] I am assuming that very few other claimants had legal representation at the initial and reconsideration levels in Illinois. I am aware of no other legal services organizations or private attorneys that routinely provide legal representation at the initial and reconsideration levels.

Indeed, it is telling that when SSA's Office of Program and Integrity Reviews studied the difference between state DDSs and ALJs, they did not have the state agency decisionmakers who reviewed ALJ decisions listen to tapes of the hearings. See SSA Office of Program and Integrity Reviews, "Findings of the Disability Hearings Quality Review Process: An Assessment of the Quality of Hearings Decisions And Appealed Reconsideration Denial Determinations," September 1994.

Third, some of the disparity is caused because the state DDSs are bound by the POMS while ALJs are not. I believe that the POMS mandate a more standardized assessment that fails to properly factor in limitations in functioning in some cases, particularly those involving pain, mental impairments, and assessment of residual functional capacity. To eliminate this as an issue, SSA should establish one standard for disability adjudication at all levels.

B. Creation Of A Social Security Court of Appeals Will Not Aid In Adjudication Of Social Security And SSI Cases

Advocates of creation of a single court of appeals to handle appeals of Social Security decisions rendered by federal district courts stress the need to create a uniform body of case law and to guarantee that the claims of similarly situated claimants are treated without regional disparity. I take no issue with these goals. However, as I set forth below, I believe that creation of such a court will hamper, rather than advance these goals.

First, the case law of different circuits has been, in significant part, uniform. The various courts of appeals have taken similar, if not identical, positions on application of the severity step, the treating physician rule, and jurisdiction over class actions under 42 U.S.C. § 405(g), to name a few examples. The difference in interpretation has arisen between the courts of appeals and the Social Security Administration ("SSA"), which has pursued a policy of non-acquiescence in appellate decisions.

Moreover, some differences are beneficial to the Social Security system. The process of "percolation," in which more than one court passes on issues, often arising from slightly different factual backgrounds, has contributed to a fuller development of the law. Limiting all appellate inquiry to one court would negate this.

In addition, creating one appellate court will not guarantee that one uniform standard will be applied to all social security claimants. The disparity in standards has largely resulted from SSA's nonacquiescence policy which led to two sets of standards, those applied to claimants in the administrative appeal process, and those applied to the few who exercised their right to judicial review. Creation of one appellate court does not guarantee that SSA will follow all of that court's decisions.

Finally, I question whether a specialized court, limited to hearing social security claims, would be as capable as the regional courts of appeals in objectively judging SSA. Social Security law does not exist in a vacuum. I believe that regional courts of appeals, precisely because they address other issues, are better suited for judging the actions of SSA.

Moving the courthouse door to Washington, DC (or some other central location) will make it more difficult for claimants and their advocates in Chicago to pursue their claims to the appellate level. Many Social Security claimants and all SSI claimants are indigent or near-indigent; neither they nor their attorneys, often federally funded legal services programs such as LAFC, have the resources to go to Washington for oral argument. And, the alternative, foregoing oral argument will lead to less than full development of issues at the appellate level.

For these reasons, I oppose replacing regional courts of appeals with a single appellate court of appeals to hear and judge Social Security claims.

C. The Backlog Of Claims At The Social Security Administration Has Been Caused By The Agency's Failure To Provide Adequate Staffing To Handle Caseloads.

The backlog of claims at the Social Security Administration is a major problem. In Chicago, disability claimants whose claims are allowed by ALJs routinely wait two to two and one half years to receive favorable disability decisions. Indeed, the average length of time from the date of filing a request for a hearing to the date a hearing decision is rendered is more than 12 months a year at Chicago Offices of Hearings and Appeals. I have seen cases in which claimants waited over two years from the date of request for hearing to receive a hearing decision, in addition to the time the claimants waited to receive initial and reconsideration denials before requesting the hearing before an ALJ.

In addition, claimants and recipients routinely face long delays in receiving service at local Social Security offices. It is not uncommon for persons to wait for several hours up to most of the day to be seen by claims representatives at some Social Security offices in Chicago. Staff at LAFC instruct clients who must go to local Social Security offices to take with them food and their daily medications because of the long waits.

The backlogs are largely the result of SSA's decision to automate its system so that employees could be eliminated. Automation has not successfully replaced human staff. Moreover, the reduced number of staff do not have the time to adequately assist claimants and recipients and make eligibility determinations. Unless the Administration is able to add staff, it will not be able to successfully deal with the backlog of claims.

D. SSA Must Do Continuing Disability Reviews To Maintain Integrity In The Social Security Disability Programs.

SSA's failure to do timely and effective continuing disability reviews ("CDRs") has contributed most to the perception that the disability program is out of control. Persons who no longer meet the disability standard, as defined in 20 C.F.R. §§ 404.1594, 416.994, and 416.994a, should have their disability benefits terminated.

The problem is forcing SSA to actually do the CDRs. As an advocate, I rarely see CDR cases, and I assume that SSA is not regularly reviewing claims to see if disability has continued. SSA should be required to do the following:

1) set dates for CDRs in all cases in which a disability finding is made;

2) inform disabled persons of the scheduled CDR date, and advise them that they should receive all medical care necessary to treat or control the disability;

3) require SSA to do the CDRs in a timely fashion;

4) set up special funding to cover SSA's costs of doing these CDRs; and

5) require SSA to report yearly to Congress concerning the number of CDRs scheduled to be done, the number of CDRs actually performed, and the cessation rates.

DAVID B. LOWRY
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10300 S.W. Greenburg Road
Portland, Oregon 97223
(503) 245-7281

May 31, 1995

Philip D. Moseley
Chief of Staff - Ways & Means Comm.
US House of Representatives
1102 Longworth House Office Bldg.
Washington, DC 20515

RE: Social Security Disability

Dear Mr. Moseley,

I am writing to submit written testimony regarding your recent hearings on this subject. I have practiced Social Security Disability law since 12/91.

1) The DDS standard for evaluating disability is an incomplete standard. For example, people go to SSA and report that they are disabled for reasons that are objectively measurable: e.g., "I am four feet tall and I weigh 600 pounds." In such a case, DDS tends to grant benefits because they can objectively measure the impairment. Or, people may go to SSA and report that because of one or more health problems, they suffer from subjective symptoms, such as pain or fatigue. Since there is no objective way to measure this, these claims are routinely denied by DDS for want of adequate means to evaluate severity. These cases are won, if at all, at a hearing where an ALJ can assess the nature and extent of all factors, objective and subjective. In the Re-engineering program, SSA is pursuing a mirage of being able to "objectively" determine the severity of these symptoms. They cannot. Subjective symptoms require a whole person analysis. Any "objective" measurements would be further complicated by the good days and bad days aspect as well. Any physical capacities evaluation will be but a snapshot in time which ignores this fact of live. In my practice, 80-90% of my clients report good days and bad days and physical activity (like work) is the most common cause of bad days. (I.e., becoming physically active today makes for a miserable day tomorrow.) Most such clients need to lie down intermittently during the day in order to relieve pain. Pain is subjective and hard to measure, but very real. The same is true for fatigue. These two symptoms

University of Arizona, B.A. 1966; J.D. 1969; admitted to practice in Arizona 1969; in Oregon 1973
Who's Who in American Law

usually go hand-in-hand. These in turn tend to negatively impact memory, attention span and concentration. People hurt, and it interferes with their ability to think straight.

2) Continuing disability reviews can be made <u>if</u> Congress segregates funding <u>solely for this</u>. This problem could be further helped if the original disability decision maker would indicate if time and treatment are likely to result in improvement, with cases coded for review accordingly.

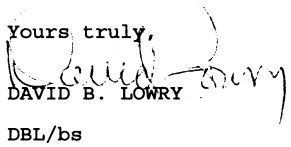
3) Cost growth could be contained by re-defining the Cost of Living, which impacts COLA. Even Alan Greenspan likes this idea.

The whole idea for the existence of Social Security is to provide a <u>safety net</u> for people who, because of age or disability, cannot maintain employment, or by virtue of old age, should not have to do so. In this light, the disability aspect of Social Security is not a "drain" on the retirement program. Between the two, those who are disabled ought to have the greater claim to the government's help. Those who are not of retirement age, but are disabled, cannot save for their retirement. Or work beyond normal retirement age.

4) The cost of paying Social Security benefits could be reduced if benefits were <u>means tested</u>. This idea has been kicked around a long time and will likely command public acceptance (albeit reluctantly). If everyone who claims SS benefits with an income over "X" times the Federal poverty level saw their SSA benefits reduced until their income was at "Y" times the Federal poverty level when no further eligibility for benefits existed, a cap on budget problems could occur. This is a more worthwhile approach than picking on disabled citizens when they are at their most vulnerable and if 60% or so of us still qualified for some amount of SS benefits, the "welfare" stigma for SS could be minimized.

I realize there must be a lot of frustration over the dollars involved, but disabled citizens should not have our budget balanced on their backs. Our budget frustration should be re-directed to other areas.

Yours truly,



DAVID B. LOWRY

DBL/bs

c: Nancy Shor, NOSSCR

March 2 1995

STATEMENT ON SOCIAL SECURITY DISABILITY

PROGRAM PROBLEMS

FOR THE SENATE SPECIAL COMMITTEE ON AGING

BY ANN DEWITT

DIRECTOR MAINE DISABILITY DETERMINATION SERVICES

Mr. Chairman and Members of the Committee:

My name is Ann DeWitt. I am the Director of the Maine Disability Determination Services agency. I have worked with Social Security Disability claims for 25 years. I wish to thank this committee for the opportunity to speak about the current problems in the Social Security Disability Program.

This past year has brought specific program problems into public view with press and television accounts of unsupervised disability payments to addicts, disability payments to children with behavior problems and disability payments to immigrants who came to this country with sponsors. The current national controversy has caused problems locally. When our agency allows childhood claims with attention deficit disorder as directed by current Social Security rules we are brought into conflict with special education teachers who believe we undermine their efforts to help the children be capable, productive citizens. Some of these teachers believe parents who contribute to the child's problems are rewarded with checks.

These media accounts while alarming do <u>NOT</u> address a serious underlying

malfunction of the disability system viewed as a whole. The fact is that state decision-makers (such as examiners and physicians in the Maine State agency) use medical, objective standards when deciding individual disability claims at the initial and reconsideration levels. In the states, doctors decide what effect a medically determined impairment has on a claimant's remaining functional abilities. These state decisions are subjected to rigorous federal quality review. Most states make the correct decision 96% of the time according to federal reports. Cases found to be in error are sent back to states for correction.

When a claim is appealed to a federal Administrative Law Judge subjective, legalistic standards are used to determine individual disability claims. Judges or staff attorneys (not doctors) make the critical judgement regarding what effect a medically determined impairment has on a claimant's remaining ability to function. Administrative Law Judge decisions are NOT subjected to quality review. The result of the more liberal review on appeal is that about 1,300 beneficiaries who would not receive benefits under state standards are added to the Maine disability rolls each year. This number may seem unimportant when compared to the 47,000 beneficiaries currently receiving monthly checks. The trend, however, is upward. Maine experienced a 55% increase in SSI disability claims between 1991 - 1994. With more claimants applying and more subjective standards in use, the trend will be for more people to be on the disability rolls nationwide. Another result of the increased volume of applications is that states are unable to undertake continuing disability reviews and

to stop benefits to people who have improved. Thousands of claims are awaiting review because states are too busy with initial claims.

Administrative Law Judges overturn about 70% of claims denied at the state reconsideration level. These reversal rates are seen by most onlookers as evidence of problems with state decision-making. The truth is that states have always acted as unwilling screens.

Our disability programs lack a goal. Both the program for those who earned coverage under Social Security and the program for those of low income and resources suffer from the same systemic problem. As claims go to higher levels of appeal more liberal standards are applied. Each level should have the same standards. If congress wants more citizens on the disability rolls then states should be given the ability to have state workers decide what effect a medically determined impairment has on functional ability and state decisions should have much less quality review. If on the other hand congress wants fewer citizens on the disability rolls, then Administrative Law Judges should be required to use physicians to make medical judgements about functional abilities and Administrative Law Judge decisions should have quality review.

The national redesign of the disability program that is now underway does not adequately address the forementioned problems. A troubling aspect of the current federal redesign project from a state perspective is that the memberships of the redesign task teams include few state decision-makers. The people whose jobs are most heavily affected by redesign are proportionally the least involved.

My greatest concern is for the future. If the systemic Social Security disability program problems are not addressed there may well be no money left for even the most disabled citizens in the 21st century.

Again, thank you for allowing me to appear and speak on this very important public issue.

AD/SS/ds

STATEMENT OF LAURA LEE HALL, DIRECTOR OF RESEARCH NATIONAL ALLIANCE FOR THE MENTALLY ILL

On behalf of the National Alliance for the Mentally Ill (NAMI) and its 140,000 members who are families of people with severe mental illness as well as people with these diseases themselves, I am pleased to submit the following written testimony on the Social Security Disability Insurance program (SSDI).

Chairman Bunning has made clear his desire to restore "fairness to the disability program by enabling those who are truly disabled to receive benefits quickly, and by stopping payments to those who have recovered," and to improve links to vocational rehabilitation services. NAMI shares the Chairman's desire for an efficient SSDI program that places a high value on work. Work is extremely important to many people with severe mental illnesses and their families (Uttaro and Mechanic, 1994; Estroff et al., in preparation; VMHCA, 1992). Yet the supports necessary to achieve employment are simply not in place for most individuals with these illnesses. Furthermore, it is essential to not lose sight of the fact that the severe and long-lasting disability associated with schizophrenia, manic-depressive illness and other such brain diseases curtail work capacity. SSDI, as well as the Supplemental Security Income program (SSI), are absolutely essential for many people with severe mental illnesses. Without this bare minimum of resources, severe mental illnesses would result in increased homelessness or institutionalization for many hundreds of thousands of people with these diseases.

The need for SSDI (and SSI) by people with severe and persistent mental illnesses has its roots in the policy of deinstitutionalization. Deinstitutionalization resulted in an influx into the community of hundreds of thousands of people with these diseases (Grob, 1983). Although the original vision was to integrate people with severe mental illness into their home communities, unfortunately deinstitutionalization occurred without the needed treatments, supports, and resources that put people in the mental hospital in the first place. Afterall, these were individuals who were considered, historically, so ill that the only option was long-term residence in a mental institution.

SSDI and SSI are critical components of community-based treatment and support. SSDI provides these gravely ill individuals with $641 a month for rent, food, transportation, and clothing (NASI, 1994). SSDI and SSI assure access to treatment, by making individuals eligible for Medicare and Medicaid. This link to treatment is critical, as most private health insurance policies do not cover severe mental illness treatment and state mental health programs historically have inadequately funded treatment that did not occur behind the institution walls.

What captures the attention of many policy analysts is the high percentage of people receiving SSDI and SSI on the basis of mental illness. Psychiatric disorders have been the largest diagnostic category among adult disabled SSI recipients since the inception of the program (Kochhar, 1979); since 1987 the same ranking applied to SSDI. Kennedy Manderscheid (1992) report that in 1991 the number of individuals with mental disorders exclusive of mental retardation who received SSI and SSDI was 1,154,754. Individuals with severe mental illnesses now represent the largest single diagnostic group of disabled adult recipients in both the SSI and SSDI programs, constituting 28.2 percent of SSI recipients and 24.5% of SSDI recipients, or

about 1 in 4 adult recipients under the age of 65 (Kennedy and Manderscheid, 1992; NASI, 1994). They tend to be younger than recipients with other impairments (Kennedy and Manderscheid, 1992) and have the longest tenure as SSDI recipients, a mean of 15.6 years, when compared to persons with all other disabling conditions (Hennesey and Dykacz, 1989). Furthermore, the number of beneficiaries with severe mental illnesses is increasing, as is the total number of persons with disabilities, but at a somewhat higher rate than total program growth.

What is lost in the discussion of these numbers is the fact that less than 50 % of American adults with serious mental illnesses--approximately 5 million American adults--receives SSDI or SSI. Furthermore, studies have shown that many of those individuals who may be eligible for these income programs by virtue of a severe mental illness *do not* apply (Estroff et al, in press; Steinwachs et al., 91, 92). Furthermore, all who apply do not receive the benefits--a recent study found that only 75% of those who applied were found eligible (Estroff et al., in press)--even though studies suggest that many who apply and are rejected are indeed severely disabled and do not work (see GAO, 1989 and Estroff et al., in press).

Some analysts recently have suggested that people with severe mental illnesses receiving SSDI and SSI do not have real disabilities, but rather have psychological or social problems, and thus are not appropriate candidates for this disability program. The fact of the matter is that schizophrenia, manic-depressive illness, recurrent and severe depression, and other mental disorders are real diseases with real, severe, and long-lasting functional consequences. Modern science has pinpointed the brain mechanisms involved in these brain-based disorders (OTA, 1992). In schizophrenia, for example, abnormal brain structures and functions underpin the symptoms of psychosis--imaginary voices that won't be quieted or ignored, paranoid ideas that hound waking life, the untrue belief that an individual is Jesus Christ or Abraham Lincoln, and frightened disorientation and sometimes rage. Other regions of the brain malfunction in ways that impair the ability to pay attention, to concentrate, to sort through facts and other mental and cognitive functions. For most people with severe mental illness, disease onset is early, during adolescence or young adulthood. The course of illness is ongoing, with acute and severe episodes of symptoms crashing forth repeatedly and unpredictably.

Unsurprisingly, these brain diseases have severe functional consequences. Inability to handle stress, concentrate, and interact with others means that people with severe mental illnesses cannot take care of themselves without assistance (OTA, 1994; Barker et al., 1992). They may not be able to get out of bed in the morning, do their shopping and banking, go to work, or even maintain the semblance of human contact. Most individuals with severe mental illness do not work--85 percent of more (Anthony and Jansen, 1984; Noble, 1984) . Hundreds of thousands are homeless and in jails, simply for the crime of being "mentally ill" (NAMI, 1992; DHHS, 1992). Ten to fifteen percent commit suicide (OTA, 1992).

It's not just these brain illnesses that are so disabling. The stigma and discrimination that surrounds mental illness in our society mean that people with these diseases are shunned and avoided (OTA, 92, 94; Link, 1987; Estroff et al., in press). They are denied access to employment and other aspects of public life that most of us take for granted. They are dismissed

as fakers, slackers, crooks, or worse. They are demoralized and handicapped by the strangulating hold of ignorance and stigma on our society.

Perhaps the greatest tragedy in this grim picture of severe and persistent mental illness is that people do not have access to the growing retinue of treatment and supports shown scientifically to be effective in controlling symptoms and improving functional status. Discrimination is so deep-rooted and pervasive that private insurance will not pay for the care that people with severe mental illness need (OTA, 1992).

Data concerning the employment and rehabilitative potential of individuals with severe and persistent mental illnesses are especially germane to your committee's deliberations. A variety of studies are now showing that with training and ongoing support, many people with these brain diseases can achieve better levels of employment than previously thought or now seen (Bond and McDonel, 1991; Drake et al., in press; NAMI, in preparation). Data from one of the most recent and comprehensive study done to date show both the promise for improved employment outcomes and the limits of what may be achieved. In a 7 year study involving people with severe schizophrenia, individuals received what is undoubtedly the most comprehensive and intensive forms of community-based treatment possible, well known as Assertive Community Treatment. The researchers added to this treatment supported employment services, services available as needed to the individuals with schizophrenia throughout their job-tenure (Test, personal communication). The good news is that 50 percent of the individuals receiving these interventions, versus 30 percent among the control group, were able to work in the competitive employment market. The sobering reality is that even with this intensive array of services, to which most individuals with severe mental illness in the U.S. do not have access, only 50 percent achieved the goal of work. And this goal was defined as 400 hours of work a year, approximately 8 hours each week or more. Furthermore, the pattern of work was typically interrupted, and not consistently maintained over time.

It is important to note that different treatment and employment service programs can achieve different rates of success, indeed measure success differently. In addition, factors other than the brain disease itself impact on employment outcomes, including discrimination and employment opportunity (Estroff et al., in press; Yelin, 1992). The bottomline is clear, however: people with severe mental illnesses want to work; want meaningful and productive activity in their lives. However, their illness, the availability of treatment and services, and the opportunities that they have forestall full-time, uninterrupted competitive employment. In your efforts to redesign SSDI policy, we urge you to eliminate barriers to employment that exist for people with severe and persistent mental illnesses--barriers to effective treatment and vocational rehabilitation services, and discrimination--while maintaining the essential safety net that SSDI provides to people with these diseases. These goals can be achieved by the following policies:

Do not change the SSDI eligibility criteria for adults with severe mental illness. The current eligibility criteria, including the *Listing of Impairments,* for mental illnesses reflect modern diagnostic terminology and consider functional domains known to be impaired by these diseases and to be relevant to work ability. The criteria were devised with the input of experts and have

been shown to be reliable by scientific studies (Pincus et al., 1991; Okpaku et al., 1994). The criteria take into consideration the medical status of an individual (their diagnosis), the functional results of the impairment (Barker et al., 1992), and the fact that highly structured supports can give the illusion of little disability. Improvements can be made, however, in the criteria, namely by improving the way in which difficult cases are decided and further educating mental health care professionals on how to provide relevant information for the disability determination.

Do not impose a short time-limit on the receipt of benefits for people with severe and persistent mental illnesses. As noted above, these brain diseases are long-term, unpredictably episodic, and severely disabling. The scientific data, concerning the nature of these diseases and the best possible employment outcomes, absolutely contradict the use of an arbitrary time limit on benefits. Furthermore, it would be a bureaucratic nightmare for people with severe mental illnesses (not to mention the government) to have to constantly reapply for benefits, a prolonged and complicated process that leaves individuals in dire straits as they wait for the process to move forward. A short-term SSDI benefit is a recipe for disaster, which would undoubtedly leave more people with severe and persistent mental illnesses homeless, in jails and prisons, or in institutions such as nursing homes. All of these alternatives are much more costly--to society and individuals with these diseases and their families--than SSDI.

Strive to eliminate barriers to achievable work levels by people with severe mental illnesses. As the research literature demonstrates, and NAMI firmly advocates, productive activity is critically important to people with severe mental illnesses. A variety of public policies stand in the way of achieving this goal. Work disincentives in the SSDI program itself hamper the pursuit of gainful employment (Koyanagi and Goldman, 1991). The fact that the SSDI benefit is an all-or-nothing entitlement flies in the face of the reality of these illnesses, as unpredictably episodic in symptoms and levels of disability, and discourages employment. We would like to work with the committee in developing a mechanism for titrating SSDI benefits, as needed, to people with severe mental illnesses.

Among the largest barriers to employment is limited access to treatment. As noted, people with severe and persistent mental illnesses generally cannot get private insurance that will cover their health care needs. They have no choice but to turn to the public health care financing mechanisms, Medicare and Medicaid. And access to Medicare and Medicaid is generally achieved by going on SSDI and SSI. An individual with a severe mental illness is forced to go on SSDI and SSI to get treatment. ***The committee can work to overcome this perverse system by turning its attention to discrimination in private insurance against people with severe mental illnesses. Furthermore, it can change policy so that once people become eligible for SSDI and SSI, access to Medicare and Medicaid become permanent.***

Finally, ***improve access to effective vocational rehabilitation services for people with severe and persistent mental illnesses***. People with these diseases can achieve better levels of employment and productive activity, if only those interventions shown to be effective were made available to them. Certainly, shunting people to the Federal-State vocational rehabilitation (VR) system is *not* the answer. The VR system has by-and-large failed people with severe mental

References

Anderson, J.R., "Social Security and SSI Benefits for the Mentally Disabled," *Hospital and Community Psychiatry* 33: 295-298, 1982.

Andrews, H., Barker, J., Pittman, J., et al., "National Trends in Vocational Rehabilitation: A Comparison of Individuals with Physical Disabilities and Individuals with Psychiatric Disabilities," *Journal of Rehabilitation* January-March: 7-16, 1992.

Anthony, W., and Jansen, M., "Predicting the Vocational Capacity of the Chronically Mentally Ill: Research and Policy Implications," *American Psychologist* 39: 537-544, 1984.

Barker, P.R., Manderscheid, G.E., Hendershot, et al., "Serious Mental Illness and Disability in the Adult Household Population: United States, 1989," *Advance Data From Vital and Health Statistics of the Center for Disease Control/National Center for Health Statistics,* Sept. 16, 1992.

Bond, G.R., and McDonel, E.C., "Vocational Rehabilitation Outcomes for Persons with Psychiatric Disabilities," *Journal of Vocational Rehabilitation* 1(3):9-20, 1991.

Drake, R.E., McHugo, G.J., Becker, D.R., et al., (submitted). The New Hampshire study of supported employment for people with severe mental illness: I. Vocational Outcomes.

Estroff, S.E., Zimmer, C., Lachiocotte, W.S., et al., "'No Other Way to Go': Pathways to Disability Income Application Among Persons with Severe Persistent Mental Illness," forthcoming in: R. Bonnie and J. Monahan, eds. *Mental Disorder, Work Disability, and the Law* Chicago: University of Chicago Press.

General Accounting Office. Social Security Disability: Denied Applicants' Health and Financial Status Compared with Beneficiaries. Report No. B-229289: Human Resources Division, November, 1989.

Goldman, H., and Manderscheid, "Chronic Mental Disorder in the United State," In, R.W. Manderscheid and S.A. Barrett, eds. *Mental Helath U.S., 1987* DHHS Pub. No. (ADM)87-1518. Washington, DC: U.S. Govt., Printing Office, pp. 1-12.

Grob, G.N., *Mental Illness and American Society: 1875-1940.* Princeton, NJ: Princeton U. Press, 1983.

Hennessey, J.C., and Dykacz, J.M., "Projected Outcomes and Length of Time in the Disability Insurance Program," *Social Security Bulletin,* 52: 2-38, 1989.

Kennedy, C., and Manderscheid, R.W., "SSDI and SSI Disability Beneficiaries with Mental Disorders," In *Mental Health, United States, 1992.* DHHS. Washington, DC: U.S. Govt. Printing Office, 1992.

Kochar, S. "Blind and Disabled Persons Awarded Federally Administered SSI Payments, 1975," *Social Security Bulletin* 42:13-23, 1979.

Koyanagi, C., and Goldman, H., *Inching Forward: A Report on Progress Made in Federal Mental Health Policy in the 1980s* (National Mental Health Association, 1991).

Link, B.G., "Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection," *American Sociological Review* 52:96-112, 1987.

National Alliance for the Mentally Ill, *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals,* 1992.

National Alliance for the Mentally Ill, *Vocational Rehabilitation and the Seriously Mentally Ill: A Failed System,* in preparation.

National Alliance for the Mentally Ill, *The Efficacy of Schizophrenia Treatment,* in preparation.

Noble, J.H., Rehabilitating the SSI Recipient: Overcoming Disincentives to Employment of Severely Disabled Persons. The Supplemental Security Income Program: A Ten Year Overview, Washington, DC: U.S. Govt. Printing Office. 1984.

Okpaku, S.O., Silbulkin, A.E., and Schenzler, C., "Disability Determinations for Adults with Mental Disorders: Social Security Administration vs Independent Judgments," *American Journal of Public Health,* 84: 1791-1795, 1994.

Pincus, H.A., Kennedy, Simmens, S.J., et al., "Determining Disability Due to Mental Impairment: APA's Evaluation of Social Security Administration Guidelines," *American Journal of Psychiatry* 148: 1037-1043, 1991.

Steinwachs, D.M., Kasper, J., and Skinner, E.A., "Family Perspectives on Meeting the Needs for Care of Severely Mentally Ill Relatives: Final Report" 1992.

illnesses, as shown by a NAMI study soon to be released and other previous reports (NAMI, in preparation; Andrews et al., 1992; Tashjian et al., 1989). We advocate that money in the VR system that is now spent for people with severe mental illnesses be stripped from that agency and be given directly to consumers and family members themselves or effective vocational rehabilitation programs. The chairman's idea to provide SSA funds for such services also be distributed directly to people with disabilities and effective service providers. Finally, we urge you to work to make rehabilitation services mandatory covered services in Medicaid and the Federal mental health block grant.

In summary, we applaud the committee's attention to the importance of an efficient and work-focused SSDI program. We are eager to work with you in designing a humane and pro-work policy for people with severe and persistent mental illness. And we urge you to abide by the facts of severe mental illness--as disabling and long-term illnesses that leave many people with a need for income replacement--as shown by volumes of scientific data and the experiences of people with these diseases and their family members.

Once again, NAMI appreciates the opportunity to provide written testimony to the committee.

Tashjian, M.D.., Hayward, B.J., Stoddard, S., et al., *Best Practice Study of Vocational Rehabilitation Services to Severely Mentally Ill Persons, Volum I: Study Findings* (Washington, DC: Policy Study Associates, 1989).

Test, M.A., personal communication, 1995.

U.S. Congress, Office of Technology Assessment, *Psychiatric Disabilities, Employment, and the Americans With Disabilities Act,* OTA-BP-BBS-124 (Washington, DC: U.S. Government Printing Office, March 1994).

U.S. Congress, Office of Technology Assessment, *The Biology of Mental Disorders,* OTA-BA-538 (Washington, DC: U.S. Government Printing Office, September, 1992).

United States Department of Health and Human Services, *Outcasts on Main Street, Report of the Federal Task Force on Homelessness and Severe Mental Illness* 1992.

Uttaro, T., and Mechani, D., "The NAMI Consumer Survey Analysis of Unmet Needs," *Hospital and Community Psychiatry* 45: 372-374, 1994.

Virginia Mental Health Consumers Association, *Commissioners Guidance Questionnaire Survey Results,* 1992.

Yelin, E., *Disability and the Displaced Worker* New Brunswick, NJ: Rutgers Univ. Press, 1992.

STATEMENT OF LINDA HILL LANGELE, PRESIDENT
NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

The National Association of Disability Examiners (NADE) appreciates this opportunity to comment on the discrepancies caused by differing standards in the disability decision making process, the variations in disability standards across the country caused by the impact of the Federal Courts and issues impacting vocational rehabilitation of Social Security and SSI disability recipients.

NADE believes that the only way to restore uniformity to the disability program is to return to an unbiased, objective, knowledgeable medical foundation. Regretfully, it does not appear that the Disability Process Redesign Plan recognizes or will accomplish that goal.

The "one book" philosophy envisioned by Disability Redesign is not sufficient to resolve the vast discrepancy between ALJ and DDS decisions.* That concept has been tried in the past without success. As long as DDSs continue to administer a medical program and ALJs continue to view this as a legal program these differences will remain. If both the DDSs and the ALJs administer this as a legal program DDS decisions will become increasing subjective. Currently the legal methodology is loading the rolls each year with thousands of claimants who do not meet the unbiased, objective medical definition of disability. To extend this subjectivity to initial decisions will only increase those numbers at tremendous cost to the tax payers and uncounted personal loss to the beneficiaries?

What Needs To Be Done?
1. A Social Security Court is Needed Now More Than Ever.

ALJS are now following the courts' reinterpretation of the Social Security Law. Many DDS are following Circuit Court mandates. National uniformity is lost when the disability decision is affected not by the claimant's medical condition but rather by his or her state of residence.

2. The Administrative Procedure Act Must Be Rewritten to Enable SSA to Review ALJ Decisions.

These reviews should be pre-adjudicative, centralized and include a sufficient number of an equal percentage of allowances and denials to return integrity to the decision.

3. Funding should be set aside to Train ALJs in Medical Evaluation.

The legal/procedural methodology places the program in serious doubt. Perhaps medical training would help. That would depend in large measure on whether ALJs would admit to the need for such training and receive it enthusiastically.

4. The DDSs Must Be Provided Sufficient Resources (Including Staff) To Handle The Rising Number of Applications and Continuing Disability Reviews (CDRS).

The ratio of administrative costs to benefits paid in FY'60 was 6.1%: in FY'97 that is expected to drop to 2.6%. If all mandated CDRS were initiated this could amount to 4-500,000 cases annually. At the same time, applications can be expected to rise steadily as the baby boomers age.

*Bob Burgress, NADE Past President, has prepared a detailed analysis of why ALJ and DDS decisions vary so widely. A synopsis is included as an addendum to this testimony. Copies of the full report are available on request.

Every large cut of expenditures in the past had ended up costing in unwarranted entitlements or severely compromised service. Administrative costs must not be allowed to fall below what is necessary for efficient administration of the program.

5. An Increased Number of Continuing Disability Reviews Must Be Done.

To maintain fiscal accountability in the program and reduce the drain on the Trust Fund, more CDRs need to be initiated. Federal legislation mandates that all disability recipients have their disability status reviewed every three or seven years, depending on whether the condition is permanent. SSA has not fulfilled that mandate. Although some CDRs are now being conducted hundreds of thousands are still awaiting review. In order to achieve the maximum impact on the Trust Fund, Congress needs to revisit the Medical Improvement Standards that has been used since the 1984 amendments. Under current law it is almost impossible to remove recipients from the rolls, even if they were allowed capriciously or erroneously.

Although not actively involved with the rehabilitation process. NADE strongly supports initiatives designed to provide services necessary to enable beneficiaries to return to work. Our experience and contact with vocational rehabilitation (VR) agencies has show that Social Security and DDS disability recipients are among the most difficult to successfully rehabilitate. In order for a VR agency to receive reimbursement from the Trust Fund a disabled beneficiary must be earning SGA (substantial gainful activity, generally $500/month) for nine out of 12 months post closure. Most Social Security and SSI recipients referred to VR have long term chronic illness and require a high degree of ongoing continuous support in order to meet this requirement. VR agencies are understandably reluctant to accept older individuals who are traditionally more difficult to place. Younger beneficiaries, who would otherwise be better prospects, are usually more severely impaired and thus are poor candidates for successful rehabilitation. Additionally, a large percentage are receiving benefits due to mental impairments. VR experience has shown that these individuals can be very difficult to rehabilitate. These conditions are often subject to exacerbations and remissions which mitigate against the ability to work for nine consecutive months or nine out of 12 months post closure. In addition, there are significant disincentives for a beneficiary returning to work. Aside from losing case benefits, more meaningful to many disability recipients is the loss of medicare or medicaid coverage if they are no longer on the rolls. These disincentives must be removed to give rehabilitation a better chance to work and VR agencies must be compensated for appropriate expenses incurred in rehabilitating severely disabled beneficiaries even if such efforts ultimately prove unsuccessful.

Thank you for giving us the opportunity to comment on these important issues.

STATEMENT OF JOAN GREENE
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES & PRACTITIONERS
CHERRY HILL, N.J.

The National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) is grateful for the opportunity to submit testimony on the issue of the Social Security Disability Insurance and Supplemental Security Income programs. NAPNAP represents over 4,400 nurse practitioners dedicated to pediatric care. We strive to enhance the quality of health care for infants, children and adolescents, and we serve many children with disabilities.

We recognize the need for improvements in the federal policy relating to aid for people with disabilities, and we commend the subcommittee for taking on this task. As you work to reform the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs, we would like to make you aware of our concern with the programs. Of primary concern to us is the current restriction on the ability of nurse practitioners to submit medical evaluations to the Social Security Administration (SSA). Under SSA regulations, "the existence of a disabling condition must be supported by medical evidence such as a report signed by a duly licensed physician or psychologist." While other health professionals may be used as sources of insight into a child's functioning, nurse practitioners who routinely provide direct patient care to children and their families, are not permitted to authorize a medical report for SSA. We believe this policy is excessively narrow and complex, and should be simplified to allow qualified health professionals such as nurse practitioners (NPs) to submit evaluations.

Pediatric nurse practitioners are qualified health professionals, serving children independently under the guidance of state and federal regulation. Although children with disabilities and their families receive direct patient care from NPs, they must get a physician to sign medical evaluation forms for the SSI program. An evaluation may sit for days or weeks waiting for a physician's signature, creating an added burden of paperwork on the already-burdened physician. It is oftentimes the nurse practitioner, and not the physician, who spends the time needed with the child and family to assess the disability and intervene with a treatment strategy. The policy of requiring a physician's signature creates an additional level of bureaucracy and red tape, undue hardship on the children and families treated by nurse practitioners, on the nurse practitioners themselves, and on the clinics and offices where they work.

For example, a child was seen at a Minneapolis children's health clinic by a certified pediatric nurse practitioner and a masters prepared psychologist. Both diagnosed the child as suffering from Attention Deficit Hyperactivity Disorder (ADHD). However, SSA would not accept the evaluation because it did not come from a licensed physician or Ph.D. level psychologist. The child had to be re-evaluated by a private Ph.D. level psychologist at the family's added expense. The private psychologist came to same conclusion as the clinic's health professionals. This process of added expenses, red tape, frustration and complexity happens regularly -- not just in Minnesota, but all over the country. It is a particular concern in rural and underserved areas, where nurse practitioners may be the only health professionals serving local communities.

Certified pediatric nurse practitioners are recognized and reimbursed by private insurance carriers and public insurance programs such as Medicaid. Nurse practitioners routinely work with children and their families to help them through various stages of disability. NPs conduct physical, developmental, and neurologic examinations, assess the psychological and emotional status of children, and evaluate their speech, language and motor skills. After diagnosing a disability, NPs coordinate treatment for affected children. NPs then act as liaisons between medical clinics, homes and schools to coordinate referrals and to promote evaluation and ongoing assessment on intervention strategies. (Lobar and Phillips, Journal of Pediatric Health Care, May-June 1995.)

We believe that these abilities should be recognized by the SSA. Recognizing the ability of nurse practitioners to conduct medical evaluations would allow nurse practitioners, physicians and all health professionals to do their jobs more effectively and efficiently. Such a change would also mean better and more efficient care for children and families. As you continue to consider SSDI and SSI reform, we recommend a change in federal policy to allow qualified health professionals to submit medical evaluations to the Social Security Administration.

NARPPS **National Association of Rehabilitation Professionals in the Private Sector**

May 23, 1995

The Subcommittee on Social Security
Committee on Ways and Means
B-316 Rayburn House Office Building
Washington, DC 20515

Dear Subcommittee Members:

I am writing the members of this Subcommittee to address concerns regarding possible reforms to the Social Security Disability Insurance (SSDI) program.

The National Association of Rehabilitation Professionals in the Private Sector (NARPPS) was established in 1977 and is the only association that exclusively represents the interests of rehabilitation professionals who work in the private sector. The NARPPS National Office is headquartered in Boston, Massachusetts, a city recognized as a leader in health-care related research, service, and industry. The NARPPS membership consists of nearly 3,000 members. These professionals provide a broad range of rehabilitation and employment services to people with disabilities in all 50 states and Canada.

The interdisciplinary nature of NARPPS' membership brings the strength of diversity to an association which includes Case Managers, Rehabilitation Nurses, Educators, Occupational Therapists, Vocational Counselors and Rehabilitation Managers/ Administrators. Also included are Forensic Specialists, Physical Therapists, Job Placement Specialists, Speech and Language Therapists, Vocational Evaluators, and all other professional disciplines united in providing rehabilitation services in the private sector. The one factor that unites all of our disciplines is knowledge regarding functional limitations and the skills of what it takes for individuals to obtain substantial, gainful employment. It is these same skills and knowledge that is used by other disability compensation systems to help individuals with disabilities become employed and save money.

I am the Executive Director of NARPPS and have been involved with the rehabilitation field since 1973. I am also owner of a small company in San Diego, California that has provided vocational rehabilitation services to over 2,000 people with disabilities in the past 15 years. Like many of the NARPPS' members, I have provided services to recipients of a number of disability compensation systems, including state and federal workers' compensation, long-term disability, and SSI/SSDI programs. I have also served as a vocational expert with the Social Security Administration, as well in state and federal civil court, assisting in a variety of disability adjudication proceedings.

Our organization has historically supported policies that expand consumer freedom of choice, competition, and the provision of quality rehabilitation services at a reasonable cost. Recent trends in vocational rehabilitation have focused on increasing client involvement, client empowerment, and the quality of services provided (Thomas & Strauser, 1995). Other researchers (Emener, 1991; Weaver, 1991; 1994) have pointed to the need for legislators to give rehabilitation systems the power to negotiate with private sector service providers so that efficient and effective services to people with disabilities can be delivered. Broadening the range of professionals and rehabilitation agencies involved in serving consumers will undoubtedly bring increased efficiency, accountability, and performance to the rehabilitation system in the United States. Testimony was provided by NARPPS on these very same points to this Committee in 1978. We are very pleased that the Social Security Administration is now ready to explore strategies that involve the private sector in the delivery of eligibility-determination, rehabilitation-planning, and case coordination services to SSDI recipients.

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It is the position of our organization through our own published research (Olsheski and Growick, 1993) that the performance of the current system in rehabilitating SSDI recipients is dismal, and that a number of administrative changes need to occur before rehabilitation can be truly effective.

First of all, the responsibility for identifying and referring claimants for rehabilitation should be shifted from state Bureau's of Disability Determination to SSA offices. The state-federal rehabilitation system, which has had responsibility for referring claimants through their BDD offices has been a failure (Department of Health & Human Services, 1988; Hester & Faimon, 1985). Secondly, as with any indemnity program, the use of case managers to oversee the planning and timely provision of services is crucial. In this regard, like with workers' compensation, both the private and public sector should have the opportunity to manage cases for appropriate outcome and cost savings. And lastly, the SSA needs to change the way in which it defines initial eligibility and evaluates short term disability and utilizes incentives so that beneficiaries are encouraged rather than discouraged from returning to the work place.

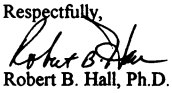
In summary, the social security disability system is a much needed support for individuals of working age who sustain a disability and cannot work. Rehabilitation can help many beneficiaries who have the potential for gainful employment if accessed and used properly. Unfortunately, rehabilitation has not been fully used, and probably will not be until the needed changes have occurred.

It is NARPPS position that private sector rehabilitation can play a significant role in helping achieve these goals. Introducing *competition* into the rehabilitation service delivery system will help accomplish the following needed positive changes:

- Consumers will have many more providers to choose from, increasing their motivation as a result of increased control and choice in their rehabilitation programs;
- Demand on the overloaded state-federal rehabilitation program will be relieved; allowing them to retain their focus on the most severely disabled;
- Increased provider innovation and creativity in re-employment efforts;
- Focus on rehabilitation, not disability compensation;
- Greater incentives will exist for providers to involve employers in training and re-employment efforts;
- Rehabilitation providers will be forced to produce favorable performance and outcomes to maintain their referrals and remain responsive to the needs of consumers and employers;
- Focused effort on those SSDI recipients most capable of working;
- Increased timeliness in service interventions will maximize the efficient use of available resources and reduce delays that prolong disability and increase costs;
- Increased emphasis on return to work efforts for younger SSDI recipients.

Private sector rehabilitation is ready and willing to work with the Social Security Administration and Congress to design, implement, and evaluate a new vocational rehabilitation system for SSDI recipients. A system that saves not only productive workers but also money. I thank you on behalf of NARPPS members for the opportunity to share this information with you, and I offer the resources of our membership and organization to assist you in your efforts.

Respectfully,



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References

Emener, W.G. (1991). An empowerment philosophy for rehabilitation in the 20th century. *Journal of Rehabilitation*, 57(4), 7-12.

Department of Health and Human Services. (1988). Report of the disability advisory council. Washington, DC: U.S. Government Printing Office.

Hester, E. and Faimon, G. (1985). Project report. The effectiveness of vocational rehabilitation with the SSDI recipient. Topeka, KS: The Menninger Foundation.

Olsheski and Growick. (1993). The Social Security Disability System and rehabilitation in review. NARPPS Journal, 8(4), 143-156.

Thomas, K., Strauser, D. (1995). Rehabilitating the rehabilitation delivery system: a commentary on the voucher system. *Journal of Rehabilitation*, 61(1), 18-22.

Weaver, C. (1991). The politics of empowerment: Vocational rehabilitation reform: Holding out a hand? *The American Enterprise*, 2(4), 20-23.

Weaver, C. (1994). Privatizing vocational rehabilitation: Options for increasing individual choice and enhancing competition. *Journal of Disability Policy Studies*, 5(1).

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BURTON D. FRETZ
EXECUTIVE DIRECTOR

STATEMENT OF ETHEL ZELENSKE, STAFF ATTORNEY
NATIONAL SENIOR CITIZENS LAW CENTER
BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY,
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON MANAGING THE SOCIAL SECURITY
DISABILITY PROGRAM

MAY 23, 1995

The National Senior Citizens Law Center (NSCLC) provides legal assistance and support to legal services advocates and other advocates for elderly and disabled clients. I work solely on Social Security and Supplemental Security Income (SSI) issues. Prior to my employment at NSCLC, I was an attorney for fourteen years at the Legal Aid Bureau, Inc. in Baltimore, Maryland, a statewide program providing free civil legal services to indigent residents of Maryland. While I worked at the Legal Aid Bureau, I specialized in social security law and represented hundreds of clients at every administrative and judicial level regarding their claims for Social Security and SSI disability benefits.

This statement addresses the testimony at the hearing on May 23, 1995, concerning the differences between decisionmaking at the state agency or disability determination services (DDS) level and at the hearing level by the administrative law judge (ALJ). The high reversal rate at the hearing level has several causes which must be considered before any measures are taken to change the process in a way that could be disadvantageous to claimants.

The causes, described in more detail below, include the DDSs' failure to: (1) obtain complete and updated documentation from all treating sources; (2) properly explain the disability standard to treating sources or ask questions relevant to the disability determination; (3) obtain functional assessments from treating sources; or (4) properly evaluate the evidence which is obtained. In addition, the face-to-face meeting between the claimant and decisionmaker for the first time at the hearing is also a significant factor.

1. **Failure to obtain documentation from treating sources.**

The key to a successful disability determination process **at all levels** is having an adequate documentation base and properly evaluating the documentation that is obtained. However, DDSs often fail to obtain documentation and thus do not have a complete medical and functional picture of the individual upon which to base an accurate decision. DDSs frequently miss treating sources altogether and all too often treat the case as static. However, the claim of an impaired claimant is not static and they are often hospitalized or experience deterioration in their conditions between the time the initial application is filed through the reconsideration level. This information is often not utilized or even obtained by the DDS.

It was suggested at the hearing that applicants be required to bring evidence with them when they apply. Claimants should always be encouraged to participate in the process **to the extent they are able.** However, there are valid reasons why they are unable to provide the evidence, requiring SSA's assistance:

- Many claimants suffer from severe mental disorders which make them poor historians and therefore unable to provide SSA with the necessary information regarding medical care.

- Many individuals are poorly educated and are simply not aware of the information required to file a complete application.

- It may be difficult for claimants to obtain evidence because of state laws limiting the individual's access to his or her own medical records.

- Many claimants may be unable to pay for records where there is a charge.

SSA should remain ultimately responsible at all levels to ensure the overall quality and integrity of the process and to oversee the completeness of the record.

2. **Failure to ask questions relevant to disability determination process.**

Even if the DDS sends a request to a treating source, their forms fail to ask questions relevant to the disability determination process. Doctors and other providers are not educated about the disability standard and evaluation process. The failure to ask for relevant information from treating sources leads to receipt of incomplete, general, or unresponsive medical evidence. This problem is frequently overcome at the hearing level where representatives use their own programmed letters and forms to obtain the relevant information, which was always readily available if only the rights questions had been asked.

3. Failure to obtain evidence of functional limitations.

The DDSs fail to obtain evidence of what the person can still do in light of functional limitations, i.e., residual functional capacity (RFC), from treating sources and consultative examinations. Obtaining evidence of RFC is critical since it analyzes the medical findings and provides a medical assessment of the ability to perform work-related activities.

4. Failure to properly evaluate evidence under uniform standard.

Even where DDSs obtain evidence, they fail to properly evaluate it by applying incorrect standards which are inconsistent with their own regulations and circuit case law. As a result, several rules which are particularly helpful in evaluating a case are not applied by the DDSs, but are applied at the hearing level. For instance, there is extensive case law in all federal circuits regarding the weight to be given to a treating physician's report and the evaluation of pain. Generally, there has not been significant regional variation.

Based on the guidance from the circuit case law, SSA has issued regulations in both areas providing a detailed framework for evaluating medical evidence,[1] including treating physicians' reports, and subjective evidence,[2] including pain. As regulations which have been promulgated under the Administrative Procedure Act (APA), providing for public notice and comment, these policies are legally binding on every SSA adjudicator, including ALJs, and provide a uniform standard at every level. Unfortunately, DDSs rely more on the SSA programs manual (the "POMS"), which is not published under the APA, for guidance in the decisionmaking process, even though they are not binding and have no legal force.[3] Use of a set of policies based on the regulations would provide the basis for a uniform process.

RECOMMENDATIONS

Despite the severity of the problems in the disability program, the system is not beyond repair and the following recommendations should be considered:

1. **Provide SSA with adequate staffing.** Staffing levels must be increased to adequate levels in order to provide quality service to the public. It seems that many of SSA's current problems can be traced back to the 20% cut in staffing levels during the mid-1980's.

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[1] 56 Fed. Reg. 36932 (Aug. 1, 1991).

[2] 56 Fed. Reg. 57928 (Nov. 14, 1991).

[3] *See Schweiker v. Hansen*, 450 U.S. 785, 789 (1981)("[T]he Claims Manual is not a regulation. It has no legal force, and it does not bind the SSA.").

2. **Improve gathering of medical evidence:**

   a. Obtain medical records from all treating sources and update them when necessary. When information is received, it should be reviewed to determine if further documentation is necessary to fill gaps or clarify inconsistencies.
   b. Treating sources should be educated about the disability process and sent letters and forms individualized to the specific case which ask questions relevant to the process.
   c. Opinions about functional capacity should be obtained from treating, as well as consultative, sources.

3. **SSA should develop a single set of policies.** These policies should be binding on all adjudicators and published according to the Administrative Procedure Act (APA) for public notice and comment. National uniformity has been and can be restored by the promulgation of uniform standards, eliminating the need for another entity, such as a Social Security Court of Appeals. Creation of such a court is not the most effective or efficient manner in which to accomplish these goals.

4. **Provide a face-to-face interview at the initial level.**

5. **Retain APA-protected ALJs as hearing officers.** The right to a full and fair hearing before an unbiased decisionmaker is a basic element of constitutional due process and is also at the core of the APA. Independent ALJs are free from agency coercion or influence and provide a guarantee to claimants against arbitrary or illegal agency practices.

6. **Increase the number of continuing disability reviews.** CDRs are a necessary feature of any disability program. The integrity of the program is affected when whey are not performed. We support reasonable attempts to help SSA get back on track, including creative legislation like H.R. 1586 which would create a CDR account in the disability trust fund.

State of Ohio
Rehabilitation Services Commission
Robert L. Rabe, Administrator

TESTIMONY
ERIC D. PARKS
OHIO REHABILITATION SERVICES COMMISSION
AUGUST 11. 1995

My name is Eric D. Parks. My business address is Ohio Rehabilitation Services Commission, 400 E. Campus View Blvd., Columbus Ohio 43235. I have been a Commissioner of the Ohio Rehabilitation Services Commission for four years. Presently, I serve as the Commission's Vice Chair and as chair of the Commission's Legislative Committee.

I appreciate the opportunity to provide testimony pertinent to the Ways and Means Subcommittee on Social Security's hearings on Thursday, August 3, 1995.

We applaud the Subcommittee's efforts to review the Social Security system and particularly its disability programs. We believe this to be an opportunity for positive change that will ensure critically needed supports are available while restoring a commitment to the value of work and individual responsibility.

The Ohio Rehabilitation Services Commission (RSC) is the state agency in Ohio that has responsibility for implementation of the Rehabilitation Act and for adjudication of social security disability claims(Social Security Disability Insurance - SSDI, Supplemental Security Income - SSI) for the Social Security Administration(SSA). In 1994, RSC made decisions on over 150,000 claims for SSDI and SSI benefits. In addition, we placed over 4000 persons with severe disabilities into competitive employment. In the past several years, Ohio has ranked 2nd or 3rd nationally in placing people in work who have a disability and receive SSDI or SSI benefits and for whom we have been reimbursed.

Our experience gives us a unique perspective about changes needed to improve the Social Security disability program. There are numerous "disincentives" for persons receiving benefits who are capable of going to work. We must find ways to aggressively change the disincentives into "incentives" to go to work. The State Vocational Rehabilitation system is the most effective manner to provide quality service to all persons in partnership with qualified local providers throughout the state. We must ensure that all persons have access to needed services so that they may go to work.

We have identified a preliminary list of factors which directly impact on a person's ability to go to work and which hinder the

State's ability to successfully work with these people. Some of those factors are:

1. **Medical Coverage**: Most individuals currently receiving SSDI or SSI benefits have medical coverage through Medicare (SSDI) or Medicaid (SSI). We believe that any revisions to the Social Security programs should assure persons of continued medical coverage if it is not provided by the employer. Medical coverage could be funded by a variety of means such as;

* a charge to the individual that would be income based
* the federal government paying the amount of an increase in premium for the employer or the employee
* providing continued medical coverage through Medicare/Medicaid for a time-limited period after full-time work begins(current legislation covers this in part but could be extended)

2. **Income Dependency**: There are substantial savings that could be realized if more people were able to reduce their dependency on the cash benefits provided under the Social Security program. For example in the first three quarters of Federal Fiscal Year 1995, RSC placed 501 SSDI beneficiaries into competitive employment at an average wage of $6.05 per hour. Since the average SSDI person receives $660 per month in benefits, this results in a Disability program savings of $3,967,920 per year or $79,358,400 over a 20 year period. The work income clearly replaces the income received from the benefit program. However, many beneficiaries believe that they will not be able to earn enough from a job to replace the benefit income they are currently receiving. To provide the appropriate incentive to go to work, several options could be considered;

* establish time limits on the receipt of all disability benefits, except those for medical conditions which are life threatening
* index the benefits against the earnings, reducing the benefits incrementally over time as earnings increase

In addition to dramatic Disability Program savings, reducing a person's dependency on Social Security benefits through work will also increase self sufficiency.

3. **Mandatory Referrals**: Every individual (over age 16) applying for SSDI and SSI should be required to participate in the state vocational rehabilitation program unless their medical condition is life threatening. The referral should be made at the time of application for benefits, not after a decision is made.

4. **Reimbursement Bureaucracy**: The Social Security Administration's current requirements and proposed rules create a malaise of bureaucratic "administrivia" before reimbursement to the State Vocational Rehabilitation agency takes place. It also can take over a year for claims to be approved by SSA for this program.

(For example in Ohio, RSC filed two claims in August 1993 which have not yet received a final decision. One claim is an initial request; the other, an appeal.) There should be extensive reduction in paperwork for this program as well as increased speed for payments. This process needs to follow the "KIS" principle - "Keep It Simple".

5. Unclear Figures: It is difficult to determine the true impact of VR services on SSDI and SSI beneficiaries since reports from SSA do not readily distinguish the number of persons who are over age 16 and who do not have a life threatening condition. After we have a good understanding of the number of people who could be served, we then need to determine the resources needed to serve all persons who could go to work. The GAO report you received clearly states that lack of sufficient resources negatively impacts on the States ability to rehabilitate persons.

6. Social Security Program Efficiency: As your committee has already identified, the administration of the Social Security disability program must be simplified. There would be significant savings in SSA Administrative dollars by establishing one set of "rules" for determining whether an applicant meets the definition of disability. Currently, Disability Examiners/Adjudicators follow one set of rules in making a disability determination and Administrative Law Judges follow another. This results in denial of some claims at the initial and reconsideration level and approval of these claims at the hearings level. Therefore, many applicants pursue their claims to the Hearings level when a similar decision could be made much earlier in the process if the Disability Examiner could apply different rules. If the decisions of ALJs are not considered programatically appropriate for all applicants, then their instructions should be changed. We must reduce overall case processing time and reduce the number of appeals beyond the initial determination. There are other changes which should be made in the Social Security disability process. We would welcome an opportunity to discuss these at a later point.

7. State Incentives: Individuals who have been awarded Social Security benefits have been required to prove their inability to work. Then they come to the Vocational Rehabilitation counselor who must persuade them of the opposite. This complication is compounded by serving individuals with more severe disabilities who require more time and expense to rehabilitate than individuals with less severe disabilities. Hence the state Vocational Rehabilitation system's reluctance to serve this population in an agressive manner. Therefore, an incentive for the states to serve and rehabilitate the social security beneficiary becomes important to that process if we are serious about moving people from tax users to tax payers.

In summary, the Subcommittee has taken on a formidable but most important task. We believe the recommendations shared above will move us in the direction of providing a hand up to our fellow citizens so they may realize the benefits of independence and self

sufficiency.

As you continue to work with this challenge to make changes, we stand ready to provide assistance, information, comment or ideas that might be of assistance to the Subcommittee. We appreciate the opportunity afforded to us to submit this testimony. You can reach me at the above address or by calling (614)438-1210.

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June 6, 1995

PHILIP D MOSELEY, CHIEF OF STAFF
COMMITTEE ON WAYS & MEANS
US HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON DC 20515

Re: Commentary on Social Security Disability Process

Dear Mr. Moseley:

In regards to the above-referenced matter, we would like to comment on the Social Security disability process and our suggestions on how to improve this process. As the current and former Chairpersons of the Orange County Social Security Disability Section of the Bar, we represent most of the attorneys who specialize in this area of law. Our attorney members deal with this process on a daily basis.

First and foremost, the purpose of the disability program is to provide financial benefits in a timely manner for those individuals who are deemed disabled. Unfortunately in an effort to weed out the unqualified applicants, the process has become unwieldy. Those who are qualified for benefits wait an inordinate amount of time to receive justly deserved benefits.

Elimination of the Reconsideration stage of the process has been proposed. We support this proposal. The process of Reconsideration is time consuming and resolves little. Truly deserving applicants are delayed in the receipt of benefits.

Another area of concern is the process by which medical evidence is obtained to determine disability. Many claimants are required to attend medical exams at high-volume medical clinics which have been established for the sole purpose of performing these evaluations. Disability "mills" have proliferated. These evaluations are often performed in unhygienic facilities. Examinees are herded through these "mills" by the droves. The perfunctory exams often contribute little to a determination regarding disability. The reports generated by these examinations are often given little weight at the administrative law judge hearing level due to their inadequacy and similarly are disregarded frequently in litigation in the U.S. District Court. Although the government spends a small amount for each exam, in aggregate, millions of dollars are wasted on this process.

As a major improvement in the disability process, we propose the

elimination of these disability evaluation "mills." Federal Regulations allow the use of the treating physician to perform this same evaluation. The elimination of this aspect of the disability process would save taxpayers thousands (albeit millions) of dollars which could be better spent on accessing claimants' medical records and paying for evaluations to a medical source familiar with the history of the claimants' medical conditions.

It has also been suggested that the Social Security Administration reconfigure the structure of the various departments within the Agency. While improvements are surely beneficial, caution must be exercised to preserve the rights of the disabled to a fair hearing of their claim. The disabled claimant deserves a well-educated and experienced adjudicator which the present system provides. In addition, recent attacks on the method of payment of attorneys can not have a positive effect on the ability of claimants to obtain a fair and adequate hearing. In fact, this proposal to revise the long-standing statutory recognition of the valuable contribution attorneys provide to the process will have a "chilling effect" on disabled individuals right to adequately present their claim for disability to the Social Security Administration. It should be noted that Social Security carefully studied the attorney fee program in 1988 and recommended the substitution of a two-party check for the present withholding system of the current statute. It did not suggest elimination of the attorney fee program . .

The right to representation and the right to a fair hearing is recognized under the present statutory system and should not be altered without due consideration to the above-referenced factors.

We would be happy to discuss any of these issues in greater detail should you wish to do so.

Very truly yours,

Tina L. Laine

Tina L. Laine, Chairperson
Orange Country Bar Association
Social Security Disability Section

Judith S. Leland, Former Chairperson
Orange County Bar Association
Social Security Disability Section

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

June 7, 1995

Mr. Phillip D. Moseley
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth HOB
Washington, DC 20515

Dear Mr. Moseley:

The Paralyzed Veterans of America (PVA) submits this letter for the record of the hearing on Social Security Disability Programs held May 23, 1995. In addition to our support of the testimony submitted by the Social Security Task Force of the Consortium for Citizens with Disabilities, PVA has a related issue of great concern to our members.

In 1994, a Lou Harris survey was conducted which indicated that 79% of working age people with disabilities want to work. Individuals with disabilities face significant disincentives in attempting to enter and remain in the workforce. Not least among these are disability related costs and the unavailability of adequate health insurance.

Currently, people with disabilities must face an earnings test to determine if they are engaged in Substantial Gainful Activity (SGA). The distinction made between blind and non-blind persons with disabilities results in significant financial disparity. The present SGA level of $500 per month -- $6000 annually -- is significantly below the poverty level of $7,470 for an individual. For blind or visually impaired individuals, the earnings level is $940 per month -- $11,280 annually -- nearly twice the income permitted for other individuals with disabilities. People with all types of disabilities experience difficulty in entering or re-entering the work force and experience unique costs.

In determining the level of income which constitutes SGA, the Social Security Agency fails to take into account minimum wage, the poverty level, cost of living, the consumer price index, or any other accepted available economic standard. It is an arbitrary figure with no basis in reality. Nor is it subject to annual review. Although SSA has the administrative ability to rectify this egregious situation, it has steadfastly refused to

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increase the SGA level to ensure there is no financial discrimination due to type of disability.

Should an individual with a disability attempt to supplement his or her income or to "test the waters" to determine if employment is a viable option, the risks inherent in making such a move discourage countless beneficiaries from even trying. If Social Security determines that SGA exists over a nine month period, a person with a disability loses monetary compensation as well as Medicare coverage. This represents a significant barrier to tax-payer status for individuals who want to work, and ignores the reality of the day-to-day costs of living with a disability.

PVA recommends that a program of tax-incentives and a gradual reduction in benefits be established along with the option to buy into Medicare. This would serve to eliminate much of the fear of losing financial and medical benefits. Increasing the number of people with disabilities who are working would reduce the out-flows of the SSDI Trust Fund and increase the revenues to both the General Fund and the SSDI Trust Fund.

As you know, the House approved legislation earlier this year that would raise the earnings level for individuals of retirement age from $940 to $2,500 per month by the year 2000. This would enable senior citizens to earn substantial wages -- $30,000 annually -- before having the amount received from Social Security reduced. Medicare coverage provided by SSA would remain intact. PVA is concerned about the great disparity which will result if the new earnings level is not applied more equitably to all people who receive monies and Medicare benefits under the Old Age, Survivors, and Disabled Insurance Program of the Social Security Act (OASDI). We see no basis for continuing to make a distinction between disability and age.

PVA recommends that the Committee carefully examine the distinction in the Substantial Gainful Activity level. Congress should make every effort to ensure that people with disabilities who desire to re-enter the workforce and become tax-payers are treated equally. The penalties associated with the effort to return to work should not be so severe and unrealistic that they discourage virtually any attempt.

Thank you for this opportunity to submit written testimony for the record. If you have any further questions, please contact me at 202) 416-7707.

Sincerely yours,

Doris F. Lentz
Associate Advocacy Director

STATEMENT BY LARRY JACKS OF
THE PUBLIC EMPLOYEES FEDERATION

As frontline workers in the Disability Program we welcome Chairman Bunning and Congress' continuing focus on the management and performance of the Disability Program.

It appears increasingly likely that without Congressional intervention, SSA's managers will refuse to heed the warnings from a majority of stakeholders. The SSA tightly controlled ongoing redesign will not correct critical program deficiencies.

- Can we as a nation afford to sustain a program viewed by many as a permanent disability/early retirement program?
- Can we afford to buy our way out of the backlogs by simply allowing more and more applications?
- Can we continue to underwrite SSA's grandiose and increasingly costly redesign plans?
- Can we continue to fail in helping individuals who need assistance in returning to work despite their disabilities?
- Can we afford not to streamline the appeals process?
- Can we ignore the reality that underlying much of the increasing application rate there is a real and growing problem of structural unemployment and underemployment?

Representative Bunning and other Congressional leaders have rightfully asked whether our current definition of disability is inadequate. The real threat to the solvency of the Disability Trust Fund stems from the unbridled growth in disability entitlement and related socioeconomic factors. We as a country must make difficult choices yet must continue to help the truly disabled. We must be honest with the public about the need for a strict and streamlined disability process. SSA's redesign is already drowning in its own ever growing bureaucracy.

We ask that this committee review carefully the following steps that are not without pain, but would begin to restore fairness, reduce entitlement abuse, and ensure trust fund solvency.

1. **Establish time limited benefits in appropriate impairment categories.**
2. **Process the long overdue Continuing Disability Reviews with earmarked funding.**
3. **Remove vocational considerations in disability decisions for applicants UNDER age 50.**

We look forward to discussing these ideas with you and appreciate the leadership this committee has shown in meeting head on the problems in our national disability program.

THE STATEMENT OF

JUDGE PAUL WINSTON SCHWARZ

OF

5336 SUGAR HILL DRIVE
HOUSTON, TEXAS 77056

BEFORE THE

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

DATE OF HEARING : AUGUST 3, 1995
TIME AND PLACE : 9 AM, ROOM B-318

INTRODUCTION

Mr. Chairman and distinguished members of the Subcommittee , I wish to thank you for inviting me to provide this testimony. I consider it a high honor and a privilege to be able to share my thoughts with you on how to improve the adjudicative process of Social Security cases arising under the Administrative Procedure Act. I am naturally providing this testimony in my private capacity and not as a representative of any organization or group whatsoever.

By way of background I should say that before being appointed from among the first of twenty nine applicants from among a field of four thousand who desired the same highly sought after position as a U.S. Administrative Law Judge, I served in a wide variety of other legal and professional positions for over twenty years. I believe that my experience as a Vice President and Secretary of a subsidiary of one of this countries largest and most successful computer software manufacturers, and earlier as the Chief, Classified Acquisition Department of the Army, Judge Advocate Generals Corps equips me with a unique insight into solving both legal and complex management problems. In my experience when a very large institution such as the Social Security Administration has backed itself into a corner the solutions for ways out seldom come from within the ranks of the same management that steered the Agency into the corner in the first place. In this regard I happily confess that I have been an Administrative Law Judge since only January 1994. Hopefully my perspective will be as insightful and constructive as it is fresh.

Entitlement to transfer payments, including Social Security benefits will shortly comprise one of the largest fiscal challenges in the U.S. government. To a great extent claims volume is predetermined by factors such as age of the population, health (variously effected on a large scale by increases in disease such as AIDS, and decreases in incidents of polio, rubella, and a variety of avoidable birth defects), and occupation. However, the large increase in disability claims, particularly those which do not result from medically determinable impairments, can be better controlled. Social Security administrators propose regulations which limit a claimant's right to a hearing and summarily determine disability claims. Lawyers, public interest groups, and claimants consider these proposals to be a denial of due process. All too often the U.S. Supreme Court agrees that due process is not being afforded. Only the Congress can ensure that the Social Security adjudication process affords each claimant and the government an impartial, individual and prompt decision which respects due process and represents the highest traditions of American justice.

BACKGROUND

At present neither Social Security claimants, nor the OASID Trust Funds are being treated efficiently. Since it was created by Congress, the Social Security Administration has been reluctant to accept judicial review of its program implementation. Therefore when a claimant successfully appeals to the federal courts, the Administration often refuses to give full effect to many landmark decisions interpreting the Act. This leads inevitably to the apprehension that the Administration is using the claims and adjudication process as a denial mechanism to "protect" the Trust Funds - an improper executive interference in the adjudicative process.

To rectify this predicament, I suggest that Congress should ensure that Social Security Administrative Law Judges are provided judicial independence from their agency so that they may conduct adversarial and therefore impartial hearings under the Administrative Procedure Act to guaranty due process. Administrative law Judges are the historical protectors of the Trust Funds and the claimants who appear before them. I respectfully suggest that their truly proper role is that of finder of fact and guardian of the law just as it is for any other federal trial judge. These problems can be easily remedied by either the creation of a Social Security trial court, or the enactment of the A.L.J. Corps bill H.R. 1802 and its companion S.486. Either of these approaches would go a long way in my opinion toward improving what is now the largest adjudicative tribunal in this country. A casual reading of either version of the Corps Bill makes it clear to me that the Congress is well aware of the problems and is now poised to do the right thing by cleaning up this process. Aside from these small but cost effective organizational changes, I suggest that the Social Security Act requires two immediate revisions of law to correct gross deficiencies in the present process: First, A.L.J.'s must be given authority to grant disability for a limited time period. At present judges may only put a claimant on disability for an undefined period - limited in practice only by longevity. I suggest that

First, A.L.J.'s must be given authority to grant disability for a limited time period. At present judges may only put a claimant on disability for an undefined period - limited in practice only by longevity. I suggest that Congress should give A.L.J.'s this express power. Second, Rules of Procedure and Evidence, akin to the normal federal rules need to be adopted which will promote efficiency and facilitate the conduct of the hearing in accordance with commonly recognized Constitutional requirements. Unfortunately the Social Security Administration has not proven up to this task. These uniform rules of administrative law and procedure might best be written by the proposed A.L.J. Corps and implemented only after express approval of the Congress just as are the F.R.C.P. and F.R.E. I am confident that these few initiatives will save substantial administrative costs such as are now incurred for such things as having to reschedule hearings and pay expert witness fees for claimants who have failed to appear for their hearing without good cause.

PRESENT PROCEDURES

The current Social Security disability program brews an illegitimate mixture of purely administrative functions delegated by Congress, with an adjudicative function, required to be implemented under U.S. Constitutional due process guaranties. This formula is improper because it commissions the Social Security Administration to determined disputes with claimants under its own ground rules without regard to traditional due process. I respectfully submit that separation of agency rule making from adjudication is critical because the line between these distinct forms of delegated power is not always a clear one. Rule making is naturally legislative in nature because of its general applicability and its concern for policy implementation. By contrast, adjudication is concerned with the determination of past and present rights and liabilities. The distinction narrows where agency advocates during adjudication a result in general concert with its policy as evidenced in rule making, and then employs its own employees to determine the justness of the rule when applied to the complainant.

THE PREDICAMENT

It has been estimated that the Social Security docket consists of over 500,000 cases with an average actuarial value of $90,000 per case. Consequently the total amount in controversy before Administrative Law Judges is in excess of $50 billion dollars. A daunting workload for the judges and an alarming fiscal challenge. The expected increases in claims for retirement and disability benefits will intensify this predicament. A more prudent and forthright strategy than that recently adopted by the Social Security Administration in its "re-engineering plan" is required to address these challenges. I suggest that although the administration should continue to make policy, and initial decisions on disability and other matters within its jurisdiction, when disputes between claimants and S.S.A. arise, the controversy should be determined by an independent adjudicative body. Unfortunately but predictably, S.S.A. administrators did not even consider the need for an impartial decision process in its re-engineering proposal. Today such disputes are

necessarily adversarial, and must be recognized as such. The S.S.A. concept of a friendly meeting between the claimant and a hearings examiner is outdated and disingenuous. The S.S.A. should be represented at these hearings by its own advocate. There are an adequate number of staff attorneys who are fully capable of being delegated this responsibility assuming the appropriate agreements and delegations are reached with the Justice Department. Claimants should continue to be able to represent themselves, assuming they are competent or to retain counsel. Administrative Law Judges ought to be given the authority to appoint counsel for claimants not capable of representing themselves . This could be done from a list of volunteer attorneys who are known to be competent. All advocates should present a fully developed case to an independent judge for decision. That judgment should only be appealable to an Article III Appellate Court by either party for a substantial error of law. But appeals should definitely not be taken to local U.S. District Courts as they lack the expertise and cohesion necessary to fabricate a uniform body of case law necessary to afford due process on a national basis. The American Bar Association has also identified the recognition of these hearings as adversarial as a minimal first step in the promotion of due process. They have also suggested and I agree with them that the burden of evidentiary development be lifted from the Judge and be placed as it would be in any other forum- principally on the party asserting the fact in dispute. In no circumstances should the judge have the Executive branch responsibility currently imposed by Agency regulation of preparing a case for trial before him or herself. This is inherently inconsistent with the judges statutory duty and Constitutional obligation to be an impartial trier of fact. As a practical matter this improvement would also reduce the caseload because it would require a more thorough review of the evidence by the agency before effectively abrogating its responsibility to an Administrative Law Judge as it does now.

REFORMS

There is an immediate need for both organizational reform and substantive changes to select aspects of Social Security disability law. Fortunately the orgazinational changes have already received a substantial head start in both Houses of Congress. Naturally I am referring to H.R. 1802 and to S. 486 - Reorganization of the Federal Administrative Judiciary Act. This bill passed in the last Senate unanimously but unfortunately the House adjourned before this body could consider it. The time to pass this bill is now. Disputes between citizens and agencies arising under the Administrative Procedure Act must be decided by an impartial Administrative Law Judge. Historically this has proven to be the most economical and expeditious way of meeting this obligation of government. To not make this small group of judges administratively independent from the Agency before whom citizens and businesses must plead their cases sends a wrong signal to those claimants for all the obvious reasons. Under this Bill the Judges would report to Congress rather than to the agency Secretary as they do now. This has the advantage of providing an unfiltered report on the impact of the laws which it passes on the adjudication of disputes. I might also add as an additional consideration that the O.M.B. has

Finally I believe this suggestion is fully consistent with the Long Range Federal Court Plan (March, 1995), which included a recommendation that Congress and the Administrative Agencies take measures to broaden and strengthen the administrative hearings and review process for disputes subject to adjudication without Article III court intervention.

There are several substantive changes to the adjudication of Social Security claims which as a judge I respectfully commend for your consideration . These ideas are presented seriatim as they do not lend themselves to any particular order of presentation.

If a claimant is found to be disabled, S.S.A. rules mandate that the A.L.J. enter a judgment placing him on the disability rolls for an indefinite period. Because the S.S.A. has never recognized that a person can be disabled, even enough to meet a listing of S.S.A., and then get better (unless the individual has already improved prior to the hearing and this can be proven). Consequently, A.L.J.'s must grant an unlimited period of disability even where they know within reasonable medical certainty that the individual should recover within a finite period. There is no recognition that medical expertise can predict recovery from certain injuries or disease with substantial accuracy. For example, broken legs and arms heal at a predictable rate at various ages, absent complications from infection or other disorders such as diabetes. A.L.J.'s should be given authority to enter a decision fixing a disability termination date in the future where medical evidence reasonably establishes that recovery should occur by a certain date. A.L.J.'s would retain jurisdiction during the period of projected disability and could order a consultative examination before termination of benefits on petition by a claimant for good cause shown as to why they had not recovered as expected. Where appropriate the period of disability could be extended where recovery has been slow. A supplemental hearing could also be made available to claimants on the single issue of whether they had recovered sufficiently to be removed from the disability rolls. As a corollary to this authority A.L.J.'s should be given the power at any time during a period of disability to issue an order to show cause why benefits should not be terminated where information has been received that would reasonably cause the judge to believe the the individual was no longer disabled. I have personally denied cases where tips received prior to the hearing from the claimants neighbors and friends about a claimants daily activities, including work for cash employment, that had I received later I would have been without the authority to remedy myself.
Expert testimony plays a crucial role in determination of severity of impairments and the realistic ability of the claimant to find work in light of his age, education, past work, and any transferable work skills which he may have acquired. Obviously when you add to this task the fact that A.L.J.'s often must decide claims of disability from obscure physiological and psychological conditions, eg. chronic fatigue syndrome, and other diseases and disorders which may or may not have a demonstrable basis in objective medical evidence or are diagnosed by elimination of other diseases and you should appreciate that the A.L.J. must be the finder of fact and needs to be supported in this regard. Unfortunately, under present S.S.A. practice, A.L.J.'s are not permitted to

be the sole decider of the weight to be given the evidence. An example of this is that treating physician statements of the claimants condition are to be accorded greater weight where not contradicted by the objective ie. diagnostic evidence. This sounds good until you understand something about physician - patient dynamics , to wit that by the time the patient arrives at a disability hearing the physician has typically made several unsuccessful attempts to treat the illness and this attesting to the patients hopeless condition is the last thing which the doctor can actually do to help the patient. Not that the doctors intentionally lie, but they have often by this time given up on being able to improve the patients condition and this is the last professional service which they can render. In point of fact, consultative experts, who may have far more expertise than the treating physician, are entitled to less weight under the S.S.A. scheme, because they did not treat the claimant but may instead have examined and tested him without any personal interest in the outcome. The solution to this and other weight of the evidence problems is simple. The A.L.J.'s are the trier of fact, consequently as judges they are in the best position to determine both the relevance and weight of the evidence.The overall hearing process is frustrated because of an erosion of the "substantial evidence" rule, along with a completely nonsensical approach to the record which is not only not closed prior to the hearing, but which remains open indefinitely so that an appeal,remand, and reversal may be and are often based on evidence which the A.L.J. and the consultative experts did not even see at the hearing on which the decision was based. This is both inefficient and wasteful of valuable resources and is a practice which has outlived whatever its paternalistic genesis may have been. I urge the Congress to reform this deficiency. I suggest that one way to do this would be to amend the A.P.A. to give the A.L.J. the authority to close the record. Another way would be to pass the Corps Bill and the Corps could promulgate this as one of the procedural rules by which it operates. Another way of reestablishing the "substantial evidence rule" is to amend the A.P.A. to expressly state that administrative and appellate review of the A.L.J. decision shall not be reversed unless clearly based on an erroneous finding of fact or error of law.

PROPOSED COST REDUCTION MECHANISMS

The Acting Chief Administrative Law Judge of S.S.A. in a memo dated August 7, 1995 just congratulated the "Field Employees" on awarding 41,731 disability cases in just 19 workdays by using the administrations scheme to bypass the A.L.J, known as "initiative #7". The cost to the taxpayers of this rush to judgment in no less than 19 days will be not less than $3,755,790,000.00. This will be paid from both the Trust Fund and the General Fund. The sum is arrived at by multiplying $90,000.00 (the GAO average case value of a favorable disability case). I opposed this initiative because I believed it would remove the protection to all parties of an impartial skilled A.L.J. from a highly complex process and would result in a wholesale giveaway of favorable decisions. You may judge for yourself if I was right, but more importantly I ask you to immediately suspend and to permanently prohibit this egregious violation of the Administrative Procedure Act. I would also note that

many Governors, including Governor Bush of Texas strongly opposed this practice but their objections along with the objections of numerous A.L.J.'s were steadfastly ignored. The Congress should mandate that every decision which was a product of "initiative 7" be reviewed by an A.L.J. at hearing to decide if the decision should stand as written. I am confident that such a review will cull many thousands of cases which are not meritorious.

Because disability adjudication involves a high degree of subjective judgment including the evaluation of the credibility of the claimants testimony regarding pain, and various doctors testimony and statements which are often at odds an experienced A.L.J. who is used to the vicissitude of litigation is the best final arbiter of the issues. Although it is tempting to sweep away the pending cases it is shortsighted to do so in the manner presently being pursued.

There are several relatively simple ways to greatly improve the process which will both speed it up and result in huge cost savings. What follows is a list of them:

>>> Define a person as disabled only : If by virtue of some medically determinable physical and or mental impairment you cannot reasonably be expected to hold any job which generates at least the mimimum wage for at least one year and which job exists in substantial numbers in the national economy taking into consideration your age, education, and work experience, if any.

This change alone should reduce the disability rolls by thirty five to fifty percent. Leaving only those who cannot hold a job at all off the rolls, which was probably the original intent of the Congress anyway. If this is too conservative, the present definition could be retained for insured Title II cases, and the proposed definition could be applied to uninsured Title XVI, S.S.I. cases.

>>> Define pain : Pain alone may be a disabling condition. Although pain is usually accompanied by objective evidence of injury or disease, its residual effect on individuals may vary greatly and will be carefully weighed. Due to the highly subjective nature of the functional limitations of pain, it is evaluated principally as an issue of credibility. The Administrative Law Judge will weigh testimony regarding pain in light of both the objective scientific and medical evidence which documents the probable basis and intensity thereof and will accord the subjective testimony such weight as is appropriate in light of all the evidence.

This change should reduce the disability rolls by at least five percent.

>>> Abolish the "Grid Rules" at Part 404 , Subpart P App. 2, of 20 C.F.R. by stating that they are not binding on or applicable to decisions made by an Administrative Law Judge.

This change should reduce the disability rolls by fifteen percent.

>>> Authorize A.L.J.'s to enter a decision for a period of disability to end on a date certain in the future where reasonable medical evidence can be adduced to project when recovery should be reached given the particular impairments and condition of the claimant. A brief supplemental hearing should be offered to those who wish to contest their recovery.

This should remove from the disability rolls about twenty five percent of those who now go on disability and never go off inspite of their recovery. These people are never caught by the Agency because they work for cash only in non-witholding jobs, or are content to receive disability as a supplement to other family income.

>>> Provide for closing the record. Amend 20 C.F.R. ss 404.935, Regulations No. 4 and 416.1435 as follows: Any evidence offered for consideration in your case must be received by the Administrative law Judge not less than ten (10) working days prior to the date of your scheduled hearing. The Administrative Law Judge may in his or her discretion accept later offered evidence if in his or her sole discretion it is determined to be essential to making a full and fair judgment in your case or to prevent a manifest injustice.

This change will probably eliminate thirty five to forty five percent of the cases now needsely remanded.

CLOSING

I hope that my thoughts and suggestions will be helpful as they come from someone who is convinced that vast improvements can be made to the Social Security disability process which will both respect the peoples Constitutional right to due process achieved through a uniform national policy and which nevertheless recognizes that the Social Security Trust Fund is a finite asset, and the General fund is not without fiscal limits. I appreciate having been afforded the privilege of offering my point of view to the Subcommittee and would be happy to answer any questions which you may have.

5310 Farm Pond Lane
Charlotte, N. C. 28212-2915
June 6, 1995

Mr. Phillip Mosely, Chief of Staff
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Mosely:

I am writing concerning Disability Insurance for the Blind. I did not know about the May 23 and 24 meetings, and I just read today in one of my Braille magazines that the deadline for receiving written statements is tomorrow. I am sure you will not receive this letter until after the 7th, but I hope you will please accept accept and consider it since I did not know in time to write sooner.

Social Security Disability Insurance for the Blind has for years been linked to that of senior retirees. However, in section 101B of the Contract with America, the Senior Citizens Equity Act, SSDI for the blind was eliminated. I understand that Mr. Gingrich has stated that this was an oversight and would be corrected. Has this been done, and, if not, can it still be done? The blind are the most severely handicapped of all disability groups. No matter how qualified we may be, everybody is skeptical aboit employing us. As a result the blind are 70 percent unemployed or underemployed. SSDI is really essential for our very survival. Please help us get it linked again to the senior retirees.

Very sincerely,

Ruth Hazel Staley

Ruth Hazel Staley

MAY 11 1995

May 8, 1995

Honorable Jim Bunning
United States House of Representatives
Washington, D. C. 20515-1704

Subject: Hearings on Social Security Disability Program

Dear Congressman Bunning:

I am an Administrative Law Judge in the Office of Hearings and Appeals of the Social Security Administration. I have been doing this work for the last four years. Previous to this I worked for five years as an Assistant Regional Counsel for the Department of Health and Human Services in the Atlanta Region. My job as Assistant Regional Counsel was to defend the unfavorable disability decisions made by Administrative Law Judges or the Appeals Council of the Social Security Administration in the federal district and circuit courts. Before this I worked for five years as an Attorney-Advisor in the Office of Hearings and Appeals of the Social Security Administration. My job as Attorney-Advisor was to write decisions for Administrative Law Judges primarily in Social Security disability cases. I give you this information so that you will understand my perspective.

The Subcommittee on Social Security, on which you serve, will soon hold hearings on the Social Security Disability Program. I offer these thoughts for your consideration in that regard.

We all recognize that the Social Security Disability Program is currently overwhelmed with applications. Traditionally, the applicant for disability benefits is faced with a five level system. The initial decision on disability is made by a state Agency based on a paper review. Figures for fiscal year 1992 (current figures would differ only by being larger) show that over two million applications were filed for various disability benefits under the Social Security Act. (See attached 1992 fiscal year statistics). Some 43% of these two million applicants (approximately 860,000) were granted benefits at the initial level. Of the 57% of the applicants (approximately 1,140,000) who were denied benefits at the initial stage, only 47% (535,800) requested reconsideration. At the reconsideration level the State Agency again makes a decision based primarily on a paper review. Some 17% of the applicants requesting reconsideration (approximately 91,086 are granted benefits. Of the 83% of applicants denied benefits at the reconsideration level (approximately 444,714), 80% (approximately 355,771) request a hearing before an Administrative Law Judge. At the hearing level 69% of the applicants were granted benefits (approximately 245,482). Of the 29% of the applicants denied benefits at the hearing level (approximately 78,269), 80% (approximately 62,615) request review of their unfavorable hearing decisions by the Appeals Council. The Appeals Council

granted benefits to 4% of the applicants (approximately 2,504). Of the 64% of the applicants denied benefits by the Appeals Council (approximately 40,073), 13% (approximately 5,209) appeal to the U.S. District Court. The U.S. District Courts granted benefits to 20% of the applicants they reviewed (approximately 1,041).

I am enclosing a chart detailing the above information for fiscal year 1992. My point in going through this lengthy analysis is that the decision making process for the Social Security Disability Program works like a pyramid shaped filter. We start with a huge number of applicants, and each stage of the process pays some claims and filters out others that are deemed not to meet the legal requirements for entitlement. At each succeeding stage of the process the number of applicants in the system is reduced, until at the end, all cases are resolved.

For fiscal year 1992, out of 2,278,733 applicants for disability benefits, 1,307,075 (57%) were granted benefits. Out of all the applicants who were ultimately paid benefits, more than 80% were paid either at the initial or reconsideration level. At the hearing level, although 69% of applicants were paid, this constitutes only 16% of all applicants granted benefits. It is obvious that this multi-level system was set up to discourage as many people as possible from pursuing their claims after the initial denial and as a cost control check on the system. It has functioned well in this manner for a number of years. In fiscal 1992 some 604,200 individuals did not pursue their claims after they were initially denied; another 88,943 did not pursue their claims past a reconsideration denial; another 15,654 did not pursue their claims past a hearing decision denial; another 34,864 did not pursue their claims past the denial by the Appeals Council. The lion's share of the funds paid to applicants from the Disability Trust Fund result from decisions made at the initial and reconsideration levels by the State Agencies, not from decisions made by Administrative Law Judges at the hearing level.

Those who propose a radical reorganization of the Office of Hearings and Appeals, generally point to the large backlog of pending claims and the high percentage of claims paid by Administrative Law Judges. The huge increase in the number of applications filed for disability benefits each year for the past ten years is the obvious cause of distress at all levels of this process. There are many contributing causes to the increase in the number of applications. Among these are economic recession, court mandated changes in the way disability claims for children under the SSI program are evaluated, court mandated changes in the way that disability claims for widows and widowers are evaluated, increased legal immigration, general displacement of many "blue collar" jobs in the economy, economic displacement caused by corporate downsizing, and general population growth and aging of the population.

In response to this overwhelming increase in the number of disability applicants the Social Security Administration has

downsized its workforce, taken many shortcuts in time-proven procedures, and has overemphasized the economies and efficiencies to be realized through computer technology. When staffing increases in some limited areas such as the disability program have been granted by Congress they have been poorly allocated to address the problems. To illustrate, in the Birmingham Hearing Office, when I was appointed an Administrative Law Judge in 1991, there were approximately 1800 cases pending for seven Administrative Law Judges and their support staff. I was in a group of three new Administrative Law Judges assigned to Birmingham in 1991, raising the total number of Administrative Law Judges to ten, but providing no additional support staff. For the first six or seven months the three new Administrative Law Judges had to fight to get cases scheduled. Today there are twelve Administrative Law Judges in the Birmingham Hearing Office. There has been some, but an inadequate increase in support staff. The pending caseload for the twelve Administrative Law Judges is now over 8,000 cases. As a group, the Administrative Law Judges and their support staff are hearing record numbers of cases and producing record numbers of dispositions. However, we are currently receiving an average of 150 to 200 more new cases each month than we are able to dispose of with current staff.

The Social Security Administration's response to his crisis has been two-fold. One, a short term plan for reduction of the current hearing office backlog. The gist of this plan is to shift finite resources from one place to another in the process, the end result desired being the payment of as many claims as possible before the cases get to a hearing, thus reducing the pending cases. No thought has been given to the fact that the payment of these claims may trigger an even higher volume of applications. Meanwhile, because of the shift in resources, Administrative Law Judges are left with even more inadequate resources to put out their written decisions, because the most experienced staff are being utilized for other tasks. Second, a long term "reengineering" plan, referred to in-house as simply THE PLAN. The gist of the long term plan is to do more work less well with fewer people. Neither plan addresses the source of the problem, namely the large increase in the number of disability applicants. The source of the problem can only be addressed by the Congress. It requires policy decisions about what kind of disability program we want for our citizens and what we can afford. Only Congress can examine how disability is defined, decide how much of a disability program we can afford and ultimately have an impact on the number of claims filed.

In the meantime, those of us in the system have a Constitutional, statutory, and moral duty to attempt to provide individual citizens who apply for benefits a full and fair hearing and a prompt and fair decision. I find personally offensive the widely disseminated and largely believed myth that Administrative Law Judges in the Social Security Administration are unique because they "wear three hats". As this fable goes,

we have to be advocates for the claimant, advocates for the federal fisc,and impartial adjudicators. As far as I am concerned I wear "one hat" as an Administrative Law Judge. It is my sworn duty to provide each individual applicant with a full and fair hearing resulting in a prompt and fair decision. I am not an advocate for the claimant. Our hearing process is by statute and Congressional intent a nonadversarial process. I am not an advocate for the federal fisc. Congress defines disability in the statute and the Disability Trust Fund is managed by Trustees responsible to the Congress. My job is to apply the statutory definition of disability to the particular facts of the case before me. I am, of course, supposed to be an impartial adjudicator under the Administrative Procedure Act.

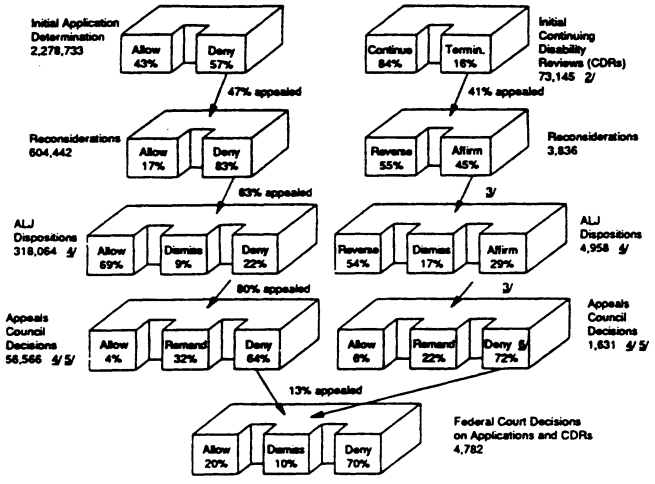
What makes the Social Security disability hearing unique is its nonadversarial character and the due process protections afforded to claimants by the Administrative Procedure Act. Congress must decide if they wish to reconsider how disability is defined and whether due process hearings with the safeguards provided under the Administrative Procedure Act are worth preserving for individual applicants. I believe that however the Congress chooses to refine the disability program, that preservation of due process hearings for individual applicants conducted by Administrative Law Judges protected by the Administrative Procedure Act should be preserved and strengthened. For these reasons I urge you to support passage of the House equivalent of Senate Bill 486 which would establish an independent Administrative Law Judge Corps managed by Administrative Law Judges and completely outside the agency whose case is being adjudicated. As things currently stand the citizens of this country are not being well served and they deserve better. When the witnesses from the management of the Social Security Administration appear before your subcommittee I hope that you will challenge their vision of a "mass adjudication" system and send them a clear message that Congress intends to preserve nonadversarial due process hearings.

Sincerely,

David L. Stephens
Administrative Law Judge
Office of Hearings and Appeals
Social Security Administration
117 Gemini Circle, Suite 407
Birmingham, Alabama 35209
Phone 205-290-7273

TABLE 6. DISABILITY DETERMINATIONS AND APPEALS, FISCAL YEAR 1992

TITLE II, TITLE XVI AND CONCURRENT TITLE II AND XVI DECISIONS FOR DISABILITY CLAIMS BY WORKERS, WIDOWS, WIDOWERS AND DISABLED ADULT CHILDREN 1/



% of Total Allowances	
Total	100.0
Initial Decisions 7/	75.9
Initial Applications	72.3
CDR	3.6
Reconsiderations	7.7
ALJs	16.2
Appeals Council	.2
Federal Court	.1

1/ The data relate to workloads processed at various levels in fiscal year 1992, but include some cases where the initial level decision was made in a prior period. The data include determinations on initial applications as well as continuing disability reviews (both periodic reviews and medical diary cases).
2/ Includes 15,300 CDRs where there was "no decision." The continuance and termination rates are computed without the "no decision" cases.
3/ Many ALJ dispositions and AC decisions are based on DDS determinations from a previous year. Therefore, a percent appealed is not provided.
4/ Preliminary data.
5/ Includes ALJ decisions not appealed further by the claimant but reviewed by the Appeals Council on its "own motion" authority.
6/ Includes affirmations, denials and dismissals of requests for review, own motion and reopening cases.
7/ Initial determinations plus CDRs.

Source: Social Security Administration

Source: Ways and Means Committee Print 103-18, July 7, 1993.

STATEMENT OF BILL D. STURM
PRESIDENT, HEALTH INFORMATION MANAGEMENT
UNISYS CORPORATION
for
THE SUBCOMMITTEE ON SOCIAL SECURITY
of
THE COMMITTEE ON WAYS & MEANS
U.S. HOUSE OF REPRESENTATIVES
AUGUST 3, 1995

THE SOCIAL SECURITY DISABILITY PROGRAM

Mr. Chairman and members of the subcommittee, let me begin by expressing my appreciation for the opportunity to contribute to the subcommittee's continuing deliberations on how to improve the administration of the program as it relates to the problems of disability claims backlogs. In addition to the issue of the backlogs, two of the most serious problems identified by the subcommittee from testimony at the previous hearings were discrepancies caused by differing standards in the disability decision making process and the variations in disability standards across the country. We would like to add some comments to address these issues.

Rep. Tom Davis submitted testimony for the May 24, 1995, hearing that suggested that SSA should again consider "outsourcing" some of the agency's work in order to reduce the DDS's backlogs and to produce models of efficiency and coordinated services which can be adopted throughout the delivery system. We concur.

Unisys believes industry could help SSA improve customer service and fiscal and quality outcomes by applying integrated business and systems solutions to these problems, including modern information technologies. We believe that the agency would reap positive results that would include not only faster and uniformly fairer processes for the eligible population but also improved Trust Fund Integrity.

While Unisys believes an industry focus in general is needed to offer significant improvements in the disability program, we are ourselves positioned as one of the leading providers of technology enabled services in the world. We specialize in providing business-critical solutions for organizations such as SSA that operate in transaction-intensive environments. These organizations include government agencies at both the Federal and State level, financial services companies, airlines, telecommunication companies and other commercial enterprises. Our solutions are used by more than 1600 government agencies worldwide, including multiple government agencies that have the responsibility for the administration and management of large scale, complex health and human service programs such as SSA.

Our services to public sector programs and government agencies are vital components to our business. We are the largest single information technology supplier to the U.S. Government, and we also supply products, services and a wide variety of solutions to all 50 state governments. Unisys supports critical federal program objectives in the Departments of Health & Human Services, Housing and Urban Development, Commerce, Interior, Agriculture, Treasury, Transportation, Defense and all branches of the armed forces. For decades, we have helped federal agencies manage day-to-day critical requirements.

On the State level, Unisys has been a recognized leader in delivering public assistance, child welfare, child support and Medicaid fiscal agent services and has earned one of the strongest track records in the industry. For instance, while each Medicaid contract varies in the scope of Unisys responsibility, we perform all major functions including claims management operations, medical review, electronic claims management, eligibility verification, provider and beneficiary relations, statistical, financial and management reporting, surveillance and utilization review. We are actively applying outcomes-based, managed care techniques to a large scale, medically based program with relationships with more than seven (7) million beneficiaries and several hundred thousand medical providers.

It is my understanding that SSA's disability claims process has been under study for some time and that the agency has not only acknowledged the need to improve the process but has taken steps toward positive change. I believe with Unisys' background in health and human services program management, we could assist SSA in reengineering itself to new process models, while at the same time providing some meaningful relief to its current workload. This could accomplish immediate direct improvements in 1996 potentially while helping the overall changes occur without major disruptions to the disability program. Even on an interim, contractual basis, (relative to the backlogs) reengineering SSA processes with revised workflows can provide lessons to improve the productivity of personnel in almost all areas.

SSA has indicated that their claims processing and reporting has historically been a slow, cumbersome, error prone, paper based process. As I indicated earlier, Unisys has combined integrated business and systems solutions to improve quality and create user friendly claims management environments. Applying new information technology to reengineer business processes can lead to improved performance, more accurate and faster response to inquiries, reduced operating costs and greater access to the data needed for efficient, fair claims management.

To streamline the paper intensive public assistance, child welfare, child support and medical environments, Unisys (and other industry participants) seek to build modern operations. For example, Unisys provides an innovative document imaging solution, converting claims into electronic data and images that can be processed more quickly and retrieved easily to support customer service inquiries. Information technologies are one of the most important reengineering tools enabling us to improve processing efficiencies and increase the service levels for our customer's clients.

Because the disability determination process includes a medical component, it is also important that any "Outsourced Contractor" have extensive background and experience in performing medical reviews. Experience in case management techniques and actual medical and social services responses to disability is also important in order to enhance the rehabilitation of SSDI and SSI recipients and improve the agency's "return to work" efforts.

As suggested earlier, Unisys offers mission-critical capabilities in high volume claims management and adjudication services, fee-for-service, and managed care programs, health information networks and point of service systems. Of particular application to SSA's current needs would be our ability to:

- Provide improving customer service support based on modern operations
- Direct the implementation and operation of procedures to ensure that disability claims are paid correctly and on a timely basis;

- Coordinate disability claim activities with other entities (both public and private) to ensure that both medical, rehabilitation and social services are appropriately authorized in order to enhance the "return to work" process, and,
- Ensure that the most effective processes are used to meet the overall needs of the agency's SSDI and SSI clients.

Unisys is experienced in and committed to a process-driven approach to requirements analyses, system design and development, implementation, project management, Total Quality Management (TQM), business process reengineering, and ongoing operations management. While technology is critical to the solution of client problems, the real value is created through professionals who have technical knowledge complemented by industry and domain specific expertise. Each of Unisys strategic business areas is supported by dedicated groups of professionals including program and policy experts, operations experts, application designers and developers, trainers, and support specialists. In fact, Unisys concentrates its talents and resources in areas where the company offers superior strengths, skills, and experience as an industry leader. You should be assured of our interest in contributing our strategic business areas to the success of the Social Security Disability Program.

Most importantly, however, is the fact that we have a reputation for being sensitive to the needs of our clients. We work with our clients in order to develop a focused approach to help them better serve their customers. For this effort, for instance, it is clear that SSA's initiative would be an interim contracting approach and the vendor would be an "agent of the government", subject to all the appropriate standards of service required of SSA's employees. The scope of work would include but not be limited to:

- initial applications,
- case management,
- medical review management
- coordination with other entities for necessary medical, rehabilitation, and social services in order to enhance to the "return-to-work" process
- continuing disability reviews (CDR's),
- fiscal agency
- outcomes analysis and reporting

We understand that this temporary outsourcing approach would supplement the agency's current structure not replace it. However, because of our experience in health and human services programs we have the capacity to gear-up quickly and provide additional capacity now. This is an important point for the agency and the Congress. The economies of scale needed to produce cost-effective operations will require the expertise of companies who can bring both the ability to ramp up quickly and to manage large numbers of events and transactions. We think that Unisys and industry offer competitive options for the agency.

In closing, I would like to emphasize that I firmly believe that were SSA to consider outsourcing on an interim basis Unisys would be the partner who could best help the agency. By deploying our large scale project and program management expertise with domain knowledge and modern information management techniques, we believe we could get up and running within an appropriate ramp-up period without major disruption to the current program. The additional capacity would not only serve to rapidly reduce the backlogs, but, by relieving some of the pressure on the current DDS workload, would also allow the agency to quickly and directly improve customer services and permit it to shift attention to other efforts including their reengineering efforts.

By helping the agency develop a fairer, more equitable and efficient disability determination process, eligible people would be served as soon as practicable and ineligible people would not receive payments in error. This builds trust not only in the integrity of the program but in the Trust Fund itself. Unisys would be honored to become a partner in such an important laudable undertaking.

"Transforming Persons With Disabilities on Public Assistance Into Taxpayers"

STATEMENT
OF
UNITED CEREBRAL PALSY ASSOCIATIONS
BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY
UNITED STATES HOUSE OF REPRESENTATIVES
FOR THE RECORD OF THE HEARING ON
SOCIAL SECURITY DISABILITY PROGRAMS

May 23, 1995

Mr. Chairman:

Thank you for this opportunity to present testimony for the record on the Social Security Disability Insurance (SSDI) program. United Cerebral Palsy Associations (UCPA) is the nation's largest disability service organization. Our organization's mission is to advance the independence of people with disabilities. To that end, we are pleased to provide this testimony. The statement focuses on a number of issues as it examines the SSDI program, and the problem that very few people receiving benefits due to disability return to work. Our statement focuses on how to remove work disincentives from the system and how to promote employment for individuals with severe disabilities without financial penalties and the loss of medical coverage.

According to the GAO Report, "Federal Disability Programs Face Major Issues" (GAO/T-HEHS-95-97, March, 1995), one of the primary reasons for the growth in enrollment of the SSDI program is the small numbers of beneficiaries and recipients who leave the disability roles to accept employment. The reasons why individuals with disabilities do not leave the disability roles for employment are complex and varied. Primary among them is the lack of timely access to appropriate medical and vocational rehabilitation services, and work disincentives that make accepting employment nearly impossible.

The major assumption behind Social Security's current definition of disability is that employment and disability are mutually exclusive. Many, although not all, individuals with disabilities are fully capable of working, if presented with an opportunity, appropriate supports, and the financial rewards which come with employment. What is needed is timely access to appropriate medical and individualized vocational rehabilitation and job placement services.

By the time many individuals have gone through the process of applying and being approved for SSDI benefits, the optimum opportunity for education or retraining has passed. Currently, SSA's processing takes an inordinate amount of time. In many cases, this results in the individual becoming convinced that he or she is incapable of working. Vocational Rehabilitation services should be offered at the time the individual is most receptive to them -- at the onset of disability -- rather than at the end of the disability determination process.

Social Security should change its thinking to a more individualized functional assessment in the determination of disability that recognizes the ability of some eligible individuals to return to the workforce. For many of those who have contributed to the SSDI system, disability payments from the onset of disability until age 65 is not the preferred goal. A "safety net" which assists the individual to transition from pre-disability employment to a new career that utilizes individual capabilities as well as assistive technology would better serve both the individual and the United States. SSA must recognize that medical and technological advances have extended the post-disability lifespan and expanded work opportunities for many individuals with even the most severe disabilities.

The current eligibility determination system forces an individual with a disability to prove that "no residual work capacity" remains in order to be eligible for SSDI benefits. The explicit message to successful SSDI benefit applicants is that they should give up all hope of ever being gainfully employed. This creates a nearly impenetrable barrier that few individuals can rationalize away in order to become mentally prepared for the rigors of undertaking a search for employment.

The SSDI eligibility determination system should be changed from a medical classification system that assumes a lack of any residual work capacity and retires an individual from the work force to a functional evaluation system which identifies work potential and then encourages the maximization of that work potential. ***UCPA urges a new system which would recognize the difference between individuals who have disabilities which truly do eliminate any work potential, such as a terminal illness, from individuals with disabilities who can work given appropriate supports.***

The concept of appropriate supports means the elimination of all financial, administrative and psychological disincentives to work. The current disability determination system first forces an individual to struggle to prove eligibility for benefits by establishing there is "no residual capacity" to work at all, then immediately refers the individual to vocational rehabilitation services. The individual must overcome the barrier created by convincing SSA that a disability exists before being able to fully utilize the vocational and placement opportunities available. If an individual's vocational rehabilitation efforts are successful, resulting in placement in a wage-earning position, SSA rewards him or her with a virtual total revocation of all benefits. Benefits are lost once the substantial gainful activity level reaches $500 per month -- $6000 annually -- in the case of an individual with a disability other than blindness; or $940 per month -- $11,280 annually -- for an individual who is blind or visually impaired. Not only is this well below the national poverty level, it ignores the day-to-day costs associated with living with a disability as well as the specialized medical needs of many individuals with disabilities. The fear endemic to losing medical and financial supports can be debilitating to those desiring to re-enter the workforce.

The current system does this by creating the fiction that, because the individual is working, the individual is no longer disabled! Of course, the disability does not magically disappear upon reentry into the work force; it continues indefinitely, along with the difficulties it engenders: the extraordinary, and ongoing, cost of equipment, supplies, and support services; and a tendency for disability impact to change over time, requiring comparable changes in lifestyle, work situation,

and support services.

This fiction thus becomes a work disincentive in its own right. Former SSDI beneficiaries who have reentered the work force once again must prove they have "no residual work capacity" in order to reestablish eligibility for benefits should the individual have a change in condition. This is true even if the individual merely needs to locate to a different type of job in order to accommodate a change in their disability (e.g., one utilizing telecommuting, "flex time").

A new system would eliminate this fiction by acknowledging that some disabilities are life-long in nature, and continue the individual's eligibility for SSDI in-kind benefits, such as Medicare, beyond the onset of work.

In order for a new program to be truly successful, all other disincentives to work must be eliminated, including the lack of access to medical insurance, paternalistic treatment of beneficiaries, and an abandonment of the "penny wise but pound foolish" philosophy that has underlaid the development of our Social Security disability policy in the past. In order for the United States to remain competitive in the future, and to enable individuals with disabilities who are SSDI beneficiaries to achieve productive independence in their own futures, we must begin viewing monies spent in the disability program as investments in human capital. Only through this fundamental change in the disability program will we ever be able to assist SSDI beneficiaries to return to work.

It is not that we cannot afford to spend the money to make these investments. The SSA Trust Fund paid out $50 billion in FY 1990 in SSDI, SSI, and Medicare to beneficiaries. This money was all spent as part of a retirement program, which provides benefits below the poverty level. There is every indication that this amount will continue to grow in the future. In contrast, during the same period, SSA spent only $60.2 million to provide vocational rehabilitation services to beneficiaries. This represents an investment in the future of only one-tenth of one percent (.1%) of all the resources spent on beneficiaries.

The fact is that we cannot afford **not** to invest in a new kind of future -- one of productive independence for individuals with disabilities, and of increased productivity for the entire nation.

We believe this new future can begin if the principles outlined below and policy recommendations are put in place.

1. Return to Work As the Goal: While expecting every person with a disability to work is unrealistic, not assisting those who could work is inequitable and unsound public policy. Because disability is a continuum, a disabled/nondisabled binary system is not effective. Return to work is accomplished through a commitment that begins at the onset of disability; therefore the return to work goal must underlie all parts of the system.

2. Early Intervention Is Critical to Success: Immediate assistance in establishing a return to work objective and mindset, tied to needed medical and vocational rehabilitation services and supports, and continuing contact and coordination, facilitates a successful return to work.

3. People vs. Case Management: Assisting individuals, rather than managing cases, should result in higher success rates in navigating a treacherously complex system of rehabilitation, employment opportunities, work incentives, and needed supports during the return to work effort.

4. Prevention: SSA should authorize interventions and rehabilitation services designed to maintain workers on the job who have no private insurance coverage, thereby preventing some individuals from being determined eligible for SSDI.

5. Incentives: Financial incentives to work for persons with disabilities, employers, insurers, and service providers alike will provide adequate support for those for whom return to work is a realistic goal.

UCPA believes these principles are represented in the following specific recommendations for a revised national disability policy.

UCPA recommends several strategies to solve the problem of growth in the SSDI and SSI roles:

> 1) enable newly eligible SSDI beneficiaries to have immediate access to medical and vocational rehabilitation; 2) revise the current Return to Work Program by allowing consumers to select their Vocational Rehabilitation providers from among private and public agencies; 3) provide direct income subsidies to disabled workers bridging off of public assistance through income tax credits and deductions; and, 4) allow disabled workers without private health insurance to participate in Medicare or Medicaid through purchase of this public health coverage.

1) Enable newly allowed SSDI beneficiaries immediate access to medical and vocational rehabilitation services.

Currently, there is a 24 month waiting period between the determination of eligibility for SSDI benefits and the beginning of Medicare eligibility. This waiting period often elapses without the beneficiary receiving any medical rehabilitation services. These services might mitigate the severity of the disability, prevent or postpone the onset of more severe disability, prevent or postpone the on set of a secondary disability. Such services would also promote a more rapid return to work. SSDI beneficiaries should be eligible to receive medical rehabilitation services available under Medicare immediately upon determination of eligibility. This may or may not be coupled with full medical coverage. That is, beneficiaries would benefit from full Medicare coverage, however if this is not feasible, then, at a minimum, beneficiaries should be covered for medical rehabilitation.

Similarly, referral and access to vocational rehabilitation services should be made available to beneficiaries immediately upon determination of eligibility. The current system of rehabilitating beneficiaries through State Vocational Rehabilitation Agencies is ineffective and unwieldy. Under this system, not more than one of every 1,000 SSDI and SSI beneficiaries returns to work (Vocational Rehabilitation: Evidence for Federal Program's Effectiveness Is Mixed, GAO/PEMD-93-19, August, 1993). ***UCPA recommends that it be replaced by a new system using private vocational rehabilitation providers.*** A system in which a fiscal intermediary in each

State facilitates referrals and timely reimbursements to private providers should be developed in cooperation with private vocational rehabilitation providers.

2) Revise the current Return to Work Program by allowing consumers to select their Vocational Rehabilitation providers from among private agencies.

There are many models of vocational rehabilitation service delivery used by Workers' Compensation programs in the various states and by rehabilitation providers in other countries which are worthy of trial by SSA. However, there is another source of proven techniques for vocational rehabilitation and placement of SSDI beneficiaries which has been virtually ignored by SSA: its own Research Demonstration Program.

SSA has spent over $30 million in demonstration programs involving over 100 primarily private rehabilitation providers during the last few years to investigate ways to increase placement of SSDI beneficiaries into jobs. Mandated by Congress in Section 505 of the Social Security Amendments of 1980, Congress directed SSA to conduct a series of demonstration projects designed to increase the number of beneficiaries who return to work and to produce savings to the Federal government. SSA has collected large amounts of invaluable information concerning the problem of placements, but SSA has done nothing to implement any of the proven techniques that could be used to increase the placements of SSDI beneficiaries into jobs.

UCPA proposes two initiatives: ***A) allow direct contracting by SSA to any public or private provider of rehabilitation services selected by the consumer, and, B) the establishment of a risk/reward system for reimbursing rehabilitation service providers.***

A. Direct contracting with consumer selected rehabilitation providers, including private providers.

People with disabilities who are SSDI beneficiaries and consumers of vocational rehabilitation and placement services have no choice in the providers of their services. Consumers are assigned to a service provider by SSA, which by law must be a state vocational rehabilitation agency, **usually by type of disability rather than type of services required**. Consumers who determine that they are not receiving appropriate or quality services generally have no recourse other than to purchase services themselves from private vendors. Given the cost of private services and the state of most consumers' finances, this is an option few can afford.

Active participation in rehabilitation increases the chances of a successful outcome, in this instance a successful return to work that ends reliance on cash assistance. Enabling consumers to choose their rehabilitation providers gives the individual a feeling of ownership in the process. This choice of service providers treats the beneficiary as an adult, capable of making significant life choices, thereby enhancing the individual's self-esteem and confidence. Choice eliminates the conflicting signals currently sent by the referral system, which tells beneficiaries they are capable enough to work, but they are not capable to select where to go for vocational services.

In order to enable consumers to select their own providers, SSA must be able to refer to and contract with providers of rehabilitation services in addition to State Vocational Rehabilitation Agencies, agencies which the General Accounting Office has found do not work well and are not

effective. By restricting referral and contracting only with state vocational rehabilitation agencies, SSA forces these agencies to be all things to all people. Given the diversity of individuals with disabilities and their individual needs, and the other extensive responsibilities these agencies have, this is truly a mission impossible. It would be much more productive to utilize the vast capacity of the private rehabilitation service providers available throughout the nation to assist SSDI beneficiaries to return to work.

B. Establishment of a Risk/Reward system.

There is tremendous potential for reduction of dependency and cost savings for the SSDI trust fund that is not being realized because so few SSDI beneficiaries receive effective rehabilitation services.

The present authority for delivery of rehabilitation services under the Social Security Act is inadequate for two reasons. First, all services are provided through referrals from state Disability Determination Service to the vocational rehabilitation agencies.

Second, the state VR agency is reimbursed for services only when the SSDI beneficiary receiving such services is placed in a job, earns more than the SGA rate and does so for more than the trial work period. The State VR must use money from other sources and programs up front for the SSDI beneficiary with the hope of being reimbursed by SSA. Hence, there is little incentive for state agencies to expend VR funds to help SSDI beneficiaries. At best, the cost can be recovered in successful cases. There is no payment for services when they do not result in SGA. Thus, the net effect is a loss for the state agency. The policy of reimbursing state agencies only for successful cases has been the law since 1981. The policy of making all referrals through state VR agencies dates from the origin of the Beneficiary Rehabilitation Program (BRP) in the 1960s.

UCPA believes that the volume of rehabilitation services and return to work of SSDI beneficiaries can be expanded with net savings in cost to the trust fund through a combination of direct referral of beneficiaries to rehabilitation providers and payment for services based on savings to the government, rather than the cost of services.

Consider this. If a beneficiary is returned to work and goes off cash assistance there is a savings to the trust fund. The value of the rehabilitation services should be determined by such savings. Apart from humanitarian considerations, if the cost of rehabilitation is less than the cost of maintaining benefits, then it makes sense to spend money for rehabilitation services. Various studies have addressed this cost/benefit relationship. UCPA believes that the relationship can be made explicit with benefits for all concerned.

This can be done by providing for direct referral of beneficiaries to rehabilitation providers and for payment to such providers based on savings to the trust fund, as such savings accrue. Providers would bear the risk for the effectiveness of services, **but be compensated not on cost, but on savings to the trust fund**. This can be achieved by providing for payments to be made for service when a beneficiary goes off the rolls and continues so long as the beneficiary is employed and does not return to the SSDI rolls. Payment should be based on a percentage of the cash assistance that would otherwise be paid to the individual. A reimbursement system that rewards

outcomes both during the rehabilitation process, at job attainment, and throughout the employee's tenure in the workforce and off the disability roles would benefit all parties.

Obviously, the higher the percentage and the longer the duration of payment the greater the incentive for providers to accept the risk of providing services under such a contingency arrangement. Providers would have to make very explicit judgements about the potential for rehabilitation and the costs of services. Furthermore, there would be an incentive to provide continuing assistance to beneficiaries since payment to the provider would continue only so long as the beneficiary stayed off the SSDI rolls. This approach is a win-win-win situation -- for the beneficiary, the rehabilitation provider, and certainly the SSDI Trust Fund.

However, as this and other work incentives evolve, UCPA believes that it is essential that the needs of young people in transition (e.g., beneficiaries 18 to 25 years of age) be fully and appropriately served. The federal disability rolls include thousands of young SSDI beneficiaries, who receive benefits on the basis of their own work history or as the disabled children of parents deceased, retired or themselves disabled. Data from SSA indicates beneficiaries aged 18-25 in those categories at the close of 1993 numbered more than 61,000 and 69,260, respectively. A disability determined in childhood need not and should not be presumed to be lifelong in nature. Rather, the full panoply of services -- including referral and access to vocational rehabilitation, assistive technology and other supports -- should be provided to these young adults in transition. This service is consistent with UCPA's vision of a system which encourages people with disabilities to become tax-payers rather than tax-takers, a system which reduces the out-flows of the SSDI Trust Fund and increases the revenues to both the General Fund and the SSDI Trust Fund.

3) ***Provide direct income subsidies to disabled workers through income tax credits and deductions.***

Individuals with disabilities incur substantial expenses in the conduct of their everyday lives as they try to learn, work, recreate, and live in the community. The cost of personal assistance to enable individuals with severe disabilities to work can be a barrier to employment, as individuals with disabilities often do not earn enough in wages to afford to pay for personal assistance in addition to a rent or mortgage, utilities, food, and related life expenses. Other examples of extraordinary expenses include the cost of accessibility modifications such as a wheelchair lift for a van or hand controls for a car; a wheelchair ramp or alternative signaling device for an accessible home; or medications and medical supplies. There are major expenses for assistive technology, including wheelchairs, hearing aids, animal companions, computers, augmentative communications devices and the training and maintenance costs of the equipment. Not the least of these extraordinary expenses is for health specialists above and beyond the typical health expenses incurred by the average person. All of these expenses conspire to trap individuals with disabilities in a cycle of poverty and total government dependency from which most cannot escape without tax assistance to level the economic playing field.

In order to promote the goal of employment and increased self sufficiency for individuals with disabilities, there must be financial incentives for beneficiaries and recipients to take the risk of leaving the disability roles for payrolls. This could be accomplished by modifying the current Earned Income Tax Credits for low-income workers to individuals with disabilities, and by

creating a Personal Assistance Services Tax Credit for working individuals with disabilities who have significant needs for personal and technological assistance in order to work.

The Earned Income Tax Credit should be extended to include persons with disabilities age 18 and older, structured to ensure that it helps bridge the gap between the Substantial Gainful Activity level and a minimum income level for low-income workers with disabilities. The present Substantial Gainful Activity level for non-blind beneficiaries is $500 per month, or $6,000 per year less than the Federal poverty level. It is impossible for an individual with a severe disability to live on this level of income, especially given their extraordinary expenses of living with a disability.

In addition, we recommend changes to address the cost of long-term services for working persons with the most significant disabilities. To do this, we propose a tax credit of one-half of all personal assistance services up to $15,000 for any individual with a disability who is working. Expenses for personal assistance services beyond $15,000 per year should be deductible as a medical expense.

The proposed modification of the EITC and changes in medical care deductions for Personal Assistance will help to offset the extraordinary expenses of living with a disability and assist people with severe disabilities to enter the workforce by giving them a measure of economic equity with those wage earners and tax payers who do not need to pay these extraordinary costs.

Personal assistance is defined as one or more persons or devices assisting a person with a disability with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

4) Allow disabled workers without private health insurance to participate in Medicare or Medicaid by purchasing this public health coverage.

Linking eligibility for in-kind services such as health insurance to the lack of employment is unnecessary and counterproductive. The lack of health coverage serves to create a substantial barrier to taxpayer status for individuals who have difficulty finding affordable health insurance. Numerous studies have documented the fear of beneficiaries and recipients in leaving SSDI or SSI because they cannot afford or cannot find health insurance. Allowing disabled workers to "buy-into" health coverage by paying the required premiums (based on a sliding scale linked to income) and deductibles will ultimately save money by removing the risk of loss of their health insurance and giving them an incentive to reduce their reliance on cash assistance and enable them to become tax payers instead of tax users. In lieu of reforms to the health insurance market that eliminate preexisting conditions, guarantee portability, and reduce the cost of coverage for individuals with disabilities, opening Medicaid or Medicare for disabled workers would eliminate a major disincentive to employment.

Before closing, UCPA must emphasize one point. Unemployment among working age persons with disabilities is due to a combination of factors, including lack of health coverage, lack of long term supports for severely disabled persons, a continuing misconception that people with disabilities can't work, the failure of our educational system to adequately prepare young persons with disabilities for a lifetime of work, and the difficulties in transitioning from dependence on disability related cash assistance and in-kind support programs to financial independence and self-reliance. Americans with disabilities are citizens who expect to participate fully in society with all the opportunities, privileges and responsibilities of every other citizen.

Thank you for this opportunity to submit this testimony for the record.

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May 31, 1995

Philip D. Moseley
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

RE: Hearings on Social Security Disability system

Dear Mr. Moseley:

I am an attorney in private practice in the Chicago suburbs in Illinois. I have been handling Social Security disability cases since 1979 and those cases now constitute half of my case load, with almost 100 hearings per year being handled by myself and one associate attorney. Overall I would estimate that my office has handled nearly 1000 disability and SSI cases over the past 16 years, with most of those going to a hearing or beyond.

Since your committee is looking at the disability system I would like to offer my observations and opinions of the entire process from my perspective as an advocate for disabled persons.

I think we should first bear in mind that those citizens who are applying for disability benefits under Title II of the Social Security Act are asking for the same thing as citizens who reach age 65, namely a return on the money that they have paid in over the years as workers and taxpayers. They are applying for disability because they are unable to continue working until they reach retirement age. This is part of the "contract" for which they have been paying taxes for many years.

In most cases these people come into my office only after they have been denied by at least one level of the Social Security system. Usually they have received what amounts to a form letter which informs them that they can either return to their former job or can do something else. In almost all cases, the decision as to the amount of work they can do seriously overestimates their actual abilities as determined by later appeals.

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The initial levels of the system will tell them, usually without a medical examination and contrary to the opinions of their treating physicians, that they can, for example be on their feet all day and lift up to 50 pounds. It will later be determined that they cannot do this level of work and are relegated to light or sedentary work, or no work at all.

I have won 88% of my cases over the last 18 months. In each and every case, the client had been turned down at one or more levels of the system. Even in the cases that were lost, the final determination was almost invariably a different, and less demanding, level of work than had been found in the previous determinations.

In other words, the first levels of the Social Security disability determination process are wrong about 99% of the time, at least insofar as those persons who proceed with further appeals are concerned. Moreover, it takes the applicants over a year, and sometimes up to two years, to receive the benefits they should have been granted in the first instance, had a proper evaluation been made. During this time, many of them have no other source of income and are reduced to poverty, losing their homes, cars, and everything they have spent a lifetime acquiring.

I might also mention that, being in the suburbs, the overwhelming majority of my clients are white, middle class people who have worked and paid taxes all of their lives. They all expected to be able to continue to work up to their retirement, only to find that cut short by some type of illness. They are not looking for a hand out from the Government, only a return on their investment when the need arises.

Under the present law governing disability, these applicants must prove that they are unable to perform not only every job they have had in the past 15 years, but also every other job that exists in America given their age, education and job skills. If they are under age 50, or if they are over 50 but have a high school diploma or better, they must prove that they cannot do any work, even as a security guard or receptionist.

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I think that the present definition of disability is overly harsh and should be relaxed at least for Title II applicants. As it now stands, the law under which Social Security operates for determining disability are stricter than comparable definitions of disability in the private sector or under state workers compensation laws.

The main problem that most of my clients have is that once they develop some type of serious impairment, whether it is a back problem, a heart condition, a breathing impairment, or a mental problem, they become essentially unemployable. No employer in his or her right mind is going to hire someone whose productivity will be impaired and/or who will pose an increased risk for a workers compensation claim, not to mention increased health insurance costs, the provisions of the ADA to the contrary notwithstanding.

Would you hire someone to work for you, for example, who couldn't effectively use their dominant hand, or had a back problem which prevented them from sitting or standing comfortably, or had trouble breathing and had to use an oxygen tank during the day, when you have your pick of completely healthy applicants?

Complicating this picture is the fact that, as our economy becomes increasingly technologically oriented, people who are thrown out of less skilled occupations due an impairment or impairments have great difficulty learning what they need to know to compete for the higher tech positions and the Government does nothing to help retrain them or provide financial support during the retraining process.

I would suggest the Federal Government adopt the standards used for private disability plans and most state workers compensation systems in providing disability payments for a limited period whenever a former worker is unable to perform his or her immediately prior job coupled with job retraining and job placement assistance.

After that period, which I would suggest should be two years as is provided by the major disability carriers, the individual would have to be unable to perform all work which exists in the national economy, regardless of age or education for benefits to continue.

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I would suggest that this only apply to those workers who are insured for coverage under the present Title II of the Social Security Act. The Supplemental Security Income applicants should have to prove inability to do all work to receive any benefits, as they have not made tax contributions for this coverage.

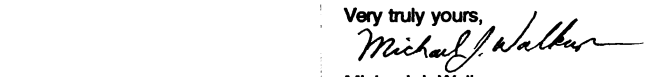
I think that although more money might initially be spent with this approach on Title II applicants, this would eventually be saved by fewer payments to Title XVI (SSI) claimants and in the cut off of many Title II beneficiaries after the two year period. Overall, there might be a long term cost savings. I would suggest that you solicit actuarial information from long term disability carriers who should be able to tell you what such a system would cost.

On the administrative level, there should be face to face hearings at the time the applicants first apply for benefits to reduce delays in receipt of benefits and the Reconsideration level should be eliminated.

I should point out that these proposals would probably reduce, rather than increase or maintain, my own income from representing disability claimants, but I think they are a better course from a policy standpoint. I can always make my living doing something else, but my clients cannot.

Thank you for your consideration.

Very truly yours,



Michael J. Walkup
Attorney At Law

cc: NOSSCR; U.S. Senators Paul Simon & Carol Mosely-Braun; U.S. Representatives Phil Crane, John Porter, Donald Manzullo, Dennis Hastert, & Henry Hyde.

From Congressman J.C. Watts, Jr.

The following statements are the results of our case workers working with real-life SSI cases. The examples that follow and the suggestions are the result of day to day workings and are offered as ways to improve the system.

1. Make it mandatory for a child with Attention Deficit Disorder to be under the care of a Medical Doctor to monitor the affects of their medication. Also keep in mind, an awful lot of these kids appear to "grow out" (so to speak) of this condition in that some of them, their brain begins to function in a more "normal" manner, or they learn life skills that cause many of them to have accomplishments far beyond what their peers accomplish. (A lot of very successful people have ADD).

2. EVERY PERSON WHO RECEIVES SSI OR SSD SHOULD BE REQUIRED TO SUBMIT MEDICAL EVIDENCE OF CONTINUED DISABILITY ANNUALLY. If necessary, contract with doctors through out the nation to do independent evaluations. Furthermore, the doctors need to be drawn at random throughout a district to prevent the impression of a hired gun. eg., select 3 doctors in every county and combine them in to districts (so many square miles per district) and schedule them in rotation so that there is a perception of fairness.

3. If someone spends years trying to "get on the system" and can not, beyond a reasonable doubt, prove disability, charge them for the costs incurred by the agency. For instance, say someone says they can not work because of a back injury and pursues the claim even though the doctors say they can work, make them pay the cost of processing his claim.

4. The use of a system of "parole officer types" is intriguing. But instead of the person reporting to the SSI officer, the SSI officer may randomly visit the recipient. Years ago, a company I worked for used Liberty Mutual for Workers Compensation. They had people who visited, at random, people drawing workers comp. On more than one occasion they "caught" someone and stopped their workers comp. Like the lady who said her back was hurt so badly she could never pick up her babies again, won 2 state barrel racing contests after she got a $50,000+ settlement. She had to pay it back or be prosecuted.

5. For any child drawing SSI or any benefits from the government, the money should go with the child. That is, if the child is in a shared custody, the parent who has the child in their possession for a period of more than one month, the money should go to the custodial parent for that month. There are a lot of fathers who have their children all summer long and receive nothing while their ex-wives take rather extravagant vacations with their new husbands. These fathers, who have to provide 2, 3 or more months of care, are concerned that the funds are not used for the child, but rather for the parents lifestyle.

6. Limit the number of family members that can draw SSI. You should not be able to have 8 or 10 kids with "ADD" drawing thousands of dollars. Also, there should be some form of proof that the money goes for the child, not the parent.

7. Require expenditures to be on an EBT system so the monies can

be tracked to insure it gets for the proper items. (ie, rent, medical bills, etc. paid, not new cars or trips and such). A photo ID would also be helpful to curb fraud on the Medicare side. I have been told that people give their cards to sisters or cousins to use at clinics.

8. There needs to be a separate division which handles chronic cases such as cancer, heart attacks, strokes, etc. There should be a specially trained staff to handle chronic cases who work directly with the claimant, physicians and hospitals to insure these people who are looking death in the face don't have to go through the endless processes which are currently taking in many cases years to decide. They should not have to "get in line" behind alcoholics and drug addicts. It is beyond comprehension that a 51 year old man with terminal cancer is put in the same "pool" with a 32 year old drug addict when it comes to determining need. Once they go through the same series of hoop jumps, odds are the cancer patient is dead while the drug addict just keeps on getting high. It is unbelievable that my government would do such a thing but you know what, it happens every day. I have a lady right now that was involved in a head on collision (driver of the other car was DOA), her legs were crushed, not just broken, CRUSHED, to the point that she can not stand on them and needs intense physical therapy and pain management. They denied her. But you get a kid whose counselor says he doesn't act like other kids his grade, and they can't get the check book out fast enough!!! Something is wrong.

9. As I mentioned before, I feel there needs to be more emphasis placed on efficiency and effectiveness in key areas. Modernization of system or more effective utilization of personnel perhaps.

10. While I realize there is going to be some changes in the requirements for alcoholics and drug addicts, I feel the new language may still be too lenient. Are we enabling these people by helping them out with money?

11. Make the ban on fraudulent draws for life, not 10 years.

12. Encourage reporting abuse. I get people every week who call and say their neighbor or cousin or someone is drawing SSI or SSD and is not as bad off as a lot of other people who can't qualify.

13. There should be a 1st priority "garnishment" for child support for anyone who receives SSI or SSD. Also, we should consider a requirement that government payments including income tax and social security payments are used to offset the care provided to those individuals in government funded mental or correctional facilities.

14. There needs to be a cross reference directory for name changes that will allow SSA to track possible fraudulent claims.

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STATEMENT OF MARK DAKOS, VICE PRESIDENT, WORK RECOVERY, INC.

Mr. Chairman, Members of the Subcommittee:

I would like to take this opportunity to commend you on the excellent series of hearings the Subcommittee is holding on issues related to the growth in costs and caseloads of the Social Security Disability insurance program and the possibility that a stronger and more effective rehabilitation and re-employment effort can have a positive effect on these issues.

As you may recall I had the privilege of appearing before your committee on May 24 to describe the ERGOS™ Work Simulator, a functional capacity evaluation system that was developed by Work Recovery, Inc and which is being used in Social Security Disability cases at both the initial determination level and the hearing level, as well as in workers' compensation cases, Americans with Disabilities Act compliance situations, long term disability insurance claims and courts of general jurisdiction.

In view of the range and diversity of ideas for improving the disability determination process and prospects for re-employment of disability applicants and beneficiaries that have been presented to the Subcommittee, I wanted to take this opportunity to provide a more generic statement for the record of the August 4 hearing. In this statement I have tried to draw more broadly on my experience in the vocational rehabilitation field as well as my work at Work Recovery, Inc. with the ERGOS™ Work Simulator, to try to identify some key elements that would need to be included in any successful program to assist persons to return to work and leave the disability rolls.

First, it may be useful to consider not only the urgent need for improvements in the Social Security disability process and in returning beneficiaries to productive employment ut also some of the philosophical and technical strides which have been made in recent years to facilitate progress in this area. For example, at Work Recovery, Inc. the development of the ERGOS™ Work Simulator for objective computerized measurement of an individual's physical and functional capacities as they relate to work performance provides a very valuable tool for evaluating work potential as well as "disability." Moreover, there seems to be some renewed national emphasis on what persons with disabilities can do, rather than what they cannot do. This also suggests that it may now be timely to take a fresh approach to the question of return to work on the part of persons with long-term and severe impairments, such as those receiving Social Security disability benefits.

Conflicting basic premises:

1. There is an unquestioned need for basic income support programs for persons who have such long-term and severe impairments that they cannot reasonably be expected to support themselves through current work.

2. There are obvious and enormous advantages -- in terms of national values, the appropriate use of tax dollars, the strength of the national economy, and the well-being of persons with disabilities -- if persons with disabilities can remain or become active members of the work force. Work is often the key to a sense of usefulness and self esteem and to the rewards that come from being a participating and contributing member of one's family and one's community.

Reconciliation:

While work must generally be the preferred option, a strong Social Security program must be available for those for whom there is no realistic "option." In balancing these concerns, it is critical to find ways to determine which persons with disabilities can be expected to work, to enable such persons to take advantage of their work potential, and yet to recognize that there will be those for whom work is not a reasonable alternative. Although it is true that some exceptional individuals with the very severest long-term disabilities do remain or become productive workers, such results are extraordinary; public policy cannot be premised on the assumption that they will become the rule.

Present Law Vacuum:

The job of identifying the remaining functional capacities among persons applying for and receiving Social Security Disability Insurance benefits and providing the requisite rehabilitation and related services is a crucial one and one that is not now being well done. This is not an area in which Social Security Administration has great experience or expertise. And despite the statutory structure which accords state agencies a major role in the disability determination process and which gives primary rehabilitation responsibilities to state agencies administering rehabilitation program, there has been a lack of leadership and coordination in this area.

Potential for Public-Private Partnership:

There is a growing body of experience in the private sector that suggests more can be done to return disability beneficiaries to productive employment and there is a growing body of experience of effective cooperation between SSA and private providers, through contracts and demonstration projects. The difficult, but doable, task is to craft a new working relationship between the private sector and the SSA, including the State Disability Determination Services and the applicant/beneficiaries that will take maximum advantage of the strengths of each partner and will not risk deterioration into the half-hearted and ineffective situation that now exists. A system based on the use of vouchers which beneficiaries could use to select the appropriate vocational rehabilitation counselor seems a most promising approach.

There are doubtless many forms such a partnership may take but some characteristics, some safeguards and accountability measures, seem essential to any successful effort in this direction. These include:

1. Maximum feasible reliance on effective and objective criteria for selection of return-to-work candidates.

2. Maximum feasible reliance on a return-to-work and employment monitoring process that is clearly defined, with measurable milestones and quantifiable results.

3. Payment to providers based on achievement of key milestones and, ultimately successful return to work and termination of disability benefits. Payment should relate to provider costs rather than be framed as an open draw on "trust fund savings." Providers who services were not found to be cost effective should be terminated from the program.

4. The program should be subject to ongoing review and programmatic audit by a special unit in the office of the SSA Inspector General.

Functional Assessments

It is possible today to do much more sophisticated, objective and informative assessments of an individual's functional capacities. The use of Functional Capacities Evaluations, Transferable Skills Analyses and Residual Functional Analyses can be of very great value both in the disability determination process and in the process of identifying individuals likely to be able to return to work as well as developing and implementing appropriate and effective return to work strategies. The earlier in the process, and the more universally such tools are used the more effective they can be.

However, even in the relatively late and limited circumstances in which "residual functional capacity" evaluations are now called for in the Social Security disability process -- in the initial determination where a person has severe impairments(s) but does not "meet or equal" the medical listings, and frequently (at ALJ discretion) at the administrative hearing stage -- the use of state-of-the-art technology and expertise in evaluating functional capacity could be of enormous value in improving the consistency and objectivity of the decision-making process and in providing clues as to potential for rehabilitation and return to work.

Obviously, more extensive use of state-of-the-art functional assessments early in the disability determination process, and general use in Continuing Disability Reviews (CDRs), would have additional advantages, especially if used in conjunction with a greatly strengthened "employment strategy" or return-to-work effort.

Under optimal conditions, virtually all disability applicants might undergo the functional capacity evaluations at the same time that medical evidence was being gathered and submitted in order that (a) those who did not meet the Social Security definition of disability and (b) those who might be candidates for return to work in the near future could move quickly into a return to work track.

Process Following Functional Evaluation

Whether or not SSA moves to broader use of computerized and objective evaluations of functional capacity, such modern evaluations of functional capacity must be a first step in the rehabilitation/return-to-work process. Such evaluations are uniquely valuable in providing the substantive, quantifiable data that are necessary to make a determination as to the feasibility of rehabilitation efforts. Where immediate vocational rehabilitation is not promising, the beneficiary and the provider alike can be spared unnecessary stress and frustration and the beneficiary may be referred for medical or rehabilitation or other appropriate services.

Further with the use of the transferable skills analysis and information on the individual's work and educational history, the re-employment effort can begin as close as possible to the job the person held prior to this disability.

Meeting with employer: In the effective provision of vocational rehabilitation services a counselor should always consider the transferable skills of the client prior to proceeding in directions that deviate from previous vocational history. In many cases an excellent employer-employee relationship existed prior to the onset of disability. Both parties may be looking for guidance in determining what type of work functions would be plausible without the risk of further injury. Also, the employer may be unaware of some of the transferable skills of the employee and the worker may be unaware of some of the types of positions the employer may be able to develop.

Thus, an important step in an effective and accountable return to work process is a requirement that the counselor meet with the employer and employee to explore the options which may exist. The decision as to whether return to modified or alternate work can be achieved should be fully documented.

Establish Decision Tree/Set and Meet Time Lines: Where return to work with the prior employer is not feasible, it will be necessary to move to further rehabilitative efforts such as rehabilitation directed at the use of transferable skills; vocational exploration using residual functional analysis; specific rehabilitation plans; a of ongoing monitoring of approved plans.

In order to have some assurance that vocational rehabilitation efforts will be effective and that there will be positive outcomes, it is essential to follow a logical process or "decision tree," and to establish and adhere to reasonable time frames to accomplish the steps in the process. Experience suggests that difficulties arise in the present system when VR counselors stray too far from an appropriate framework for the delivery of services.

Professional Status of Vocational Rehabilitation Counselors: Currently there is a great range in the competency and effectiveness of different vocational rehabilitation counselors: there are no minimum standards to practice as a VR counselor, and fees or salaries do not generally vary on the basis of professional education or proficiency.

With a greater emphasis by Social Security upon rehabilitation, and greater use of Federal dollars and private enterprise in this field, there will be a unique opportunity to establish minimum standards and to improve the quality of services throughout the system through provider competition and payments based on appropriate fees for top quality service.

Payment to Providers

In any voucher system it seems desirable to base payment to Vocational Rehabilitation providers on some measure of successful outcomes. Under the present system State VR agencies are generally reimbursed by SSA (for "reasonable and necessary costs") only in cases where the individual works at or above the SGA level (now $500 per month) for at least nine months. (In the absence of such "reimbursement" the rehabilitation is financed through the Federal-State VR program.)

Clearly, a different approach will be needed in the case of a voucher system which also utilizes private providers. An appropriate "milestone" payment approach will be necessary in order to encourage and enable a wide range of competent providers to participate.

The rate of payment would need to be high enough to cover provider costs, including a reasonable recognition of the professional credentials of the counselors and the levels of expertise required. It would also have to be low enough to assure that there would be no question as to the net value to the trust funds (in the case of Disability Insurance) or the net value to general revenues (in the case of SSI payments based on disability) without undue speculation as to how long the individual would have continued to receive benefits in the absence of vocational rehabilitation.

The concept of a payment to vocational rehabilitation counselors based upon a percentage of savings to the Trust Fund also raises serious concerns. An "award system" of this nature, coming directly from the diminishing resources of the Trust Fund will jeopardize the continued solvency of the Fund. Furthermore, determining the extent of savings is subject to several considerations that will produce a wide range of purported savings upon which an accurate payment cannot be based. The payment of fees predicated upon the documentation of a successful placement and based upon a negotiated capitation level is the most appropriate means to compensate a counselor for services.

In addition, it should probably be specified that SSA could enter into voucher agreements only with providers that met certain standards and could terminate agreements with providers that did not meet performance criteria or other requirements.

Conclusion

The development of a more effective rehabilitation process for Social Security disability applicants and beneficiaries is necessary. The basis for such reform should be focused upon outcomes and should include: a return-to-work approach; accountability of rehabilitation personnel; and a cost effective and fair compensation plan. The new system should also include an oversight mechanism in order to ensure value for services provided.

Such a system should be based upon an appropriate process which delivers quality service to the recipient and heightens their chances of successful return to suitable, gainful employment. Payments should be based upon the combination of the process associated with the new system and the outcome of vocational rehabilitation services. Such an approach would benefit both the participant as well as the solvency of the Social Security Trust Funds.

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July 31, 1995

The Honorable Lewis F. Payne, Jr.
U.S. House of Representatives
2412 Rayburn House Office Building
Washington, D.C. 20515

Re: Cost-Benefit Analysis of the ERGOS™ Work Simulator

Dear Congressman Payne:

During the May 24, 1995 Ways & Means Social Security Subcommittee hearing you voiced considerable interest in the use of technology to assist with Social Security disability determinations. In particular, you requested cost-benefit information which would document any savings to the Trust Funds based upon the use of functional assessment technology, especially ERGOS™.

I have enclosed a cost-benefit review which estimates that Trust Fund savings between 1996 and 2002 could total nearly $3 billion dollars, assuming that the ERGOS™ Work Simulator could improve the accuracy of disability decisions by only 1%. These estimates are based upon current regulations without regard to any change in the definition of disability for Social Security benefit purposes; we consider these estimates to be very conservative.

Though administrative savings are included in these estimates, other savings which could be generated through the use of ERGOS™ have been excluded because they would assume a significant change in the current management of disability processing. With the consistent processing of Continuing Disability Reviews by the Social Security Administration, the ERGOS™ Work Simulator could be used to determine improvement in a beneficiary's vocational capabilities and/or focus the vocational rehabilitation efforts needed to return that individual to the labor force.

My recent meeting with Ford Drummond of your staff presented an opportunity to further explain how the use of neutral technology can be of assistance to the adjudication process of workers' compensation programs throughout the federal sector, as well as entitlement programs such as Social Security and Veterans' Administration disability programs. I believe that similar savings can be generated in all of these programs through the use of functional assessment technology.

Should you have any questions about this review, I hope that you will not hesitate to let me know. I will be attending the August 3 hearing and look forward to seeing you again at that time.

Sincerely,

Mark S. Dakos
Vice-President
Intergovernmental Affairs

BRUCE D. SCHOBEL
5 OAKWOOD WAY
ROBBINSVILLE, NJ 08691-9583

July 27, 1995

Mr. Mark Dakos
Vice President, Intergovernmental Affairs
Work Recovery, Inc.
2341 South Friebus, Suite 14
Tucson, AZ 85713

Dear Mark:

I have reviewed the information on the ERGOS Work Simulator and developed illustrative estimates of the benefit savings that could accrue to the Social Security Disability Insurance (DI) program from using ERGOS equipment to make determinations of disability on new applicants for disabled-worker benefits. This letter describes the disability-determination process under present law and explains how the use of ERGOS equipment could improve that process.

If the use of ERGOS equipment could improve the accuracy of disability decisions enough to reduce the number of new awards by just 1 percent (or by 6-7 thousand per year), then benefit expenditures would decline by about $33 million in 1996, relative to expected costs using current procedures, and the savings would grow to about $343 million by 2000. An additional $100+ million in administrative expenses could be saved through eliminating most expenditures for "vocational experts" and reducing the number of hearings required at the administrative law judge (ALJ) level. The combined benefit and administrative savings over the critical budgetary period 1996-2002 could total nearly $3 billion. Such savings would greatly exceed the cost of procuring the ERGOS equipment. In other words, it would more than pay for itself. While these savings estimates should be regarded as illustrations, rather than projections, I believe that they are reasonable, as explained below.

Current Process

At the initial stage, disability determinations are performed by state agencies under contract to Social Security Administration (SSA). In recent years, the annual number of disabled-worker determinations has been around 1.2 million. Roughly 40 percent of these applicants are awarded benefits at the initial stage, and the other 60 percent are denied. These figures do not include either (1) additional determinations that are done with respect to disabled widow(er)s and children under the DI program or (2) determinations with respect to applicants under the Supplemental Security Income (SSI) program. The ERGOS Work Simulator has limited applicability in those situations, because the determinations are much less likely to involve vocational considerations (as described below).

An applicant who is denied at the initial (state agency) level can appeal that decision. The first level of appeal is called "reconsideration" and is handled at the same state agency that did the initial decision, although by different personnel. If the claim is still denied, the applicant can request, in order: (1) a hearing before an ALJ, (2) a review by SSA's Appeals Council, and (3) a hearing in a Federal District Court. Most awards on appeal are made by ALJs, who in the aggregate are responsible for about one-fourth of all disability benefit awards.

At all levels, disability determinations must follow a "sequential-evaluation process" prescribed by regulations. The first three stages take into consideration only current work activity and medical factors, and most decisions can be made at those stages. If the medical evidence is not sufficient to justify an allowance or denial, then the evaluation must continue to the last two stages.

The fourth stage of the process is a determination as to whether the applicant can still perform work that he or she did in the past. If so, then benefits are denied. The fifth stage considers whether the applicant can do "other work" that may exist in the national economy, taking into account the applicant's age, education, and work experience. If so, then benefits are denied; if not, then benefits are awarded.

The ERGOS Work Simulator is designed to provide information that can be used to evaluate vocational characteristics, which are relevant only at the fourth and fifth stages of the sequential-evaluation process. It is not particularly useful at the earlier, medical-based stages. Because disabled widow(er)s, children, and SSI applicants tend to have limited (or even nonexistent) work histories, vocational factors usually have little to do with determining whether or not these applicants are disabled. ERGOS, therefore, tends not to be useful in such cases.

Erroneous Decisions

SSA monitors the accuracy of decisions made by the state agencies that perform the initial disability determinations and reconsiderations. If an agency's accuracy is below a specified threshold, then SSA is required to take action to raise the accuracy. If the accuracy does not improve, then SSA may be required to take over the agency's determination function (although this has never occurred). SSA's Appeals Council monitors the accuracy of ALJ decisions, although to a more limited extent.

With respect to accuracy alone, only four types of decisions can be made: (1) disabled applicants can be awarded benefits, (2) non-disabled applicants can be denied benefits, (3) non-disabled applicants can be awarded benefits, or (4) disabled applicants can be denied benefits. Obviously, the first two types of decisions are correct, and the last two are incorrect. Of course, no action is necessary with respect to correct decisions, which are the great bulk of all decisions (well over 90 percent).

Incorrect *denials* tend to self-correct, because of the increasing willingness of applicants to avail themselves of the elaborate appeals process, as well as the presence of a large corps of lawyers and other "claimants' representatives" who are more than willing to help applicants to pursue their claims. These appeals are often successful; for example, the ALJs have reversed disability denials at a 70-percent rate for several years. Obviously, some deserving applicants who are denied benefits do not pursue appeals, for a variety of reasons, but most do so and are ultimately awarded benefits.

Incorrect awards present greater problems. The government has limited opportunities under the law to reopen incorrect award decisions and limited resources to bring to bear on the problem. Moreover, the applicant in such a situation has nothing to gain by cooperating with the review. Consequently, most incorrect awards do not get changed, and the applicant begins receiving benefits, which can continue until the person reaches normal retirement age (at which time the benefits are converted to retirement benefits, generally at the same monthly rate).

The government is required to review the eligibility status of disabled beneficiaries, usually once every 3 years, but these reviews have become so terribly backlogged today that they are often not done or are done in a perfunctory manner. In any case, the law requires SSA to abide by its earlier determination, unless it can demonstrate that the beneficiary has "medically improved" (with a few insignificant exceptions to that rule). The average new award results in annual benefit payments of about $10,000 today, and the average beneficiary remains on the rolls for about 10 years.

SSA's latest data with respect to error rates cover the period April-June 1995. During that calendar quarter, the "decisional return rate" on awards was 0.9 percent. The "documentation return rate" on awards was 2.7 percent. All of the decisional returns were, by definition, erroneous awards. Some of the documentation returns were actually correct decisions, but the correctness could not be demonstrated by examining the file. If we assume, for purposes of illustration, that 40 percent of the documentation returns were actually erroneous awards, then the overall error rate on awards is about 2 percent. Reducing this rate, even slightly, can save considerable program dollars.

Use of ERGOS Work Simulator

Some erroneous awards occur at the medical stages of the sequential-evaluation process. These stages are not especially error-prone, however, because much of the medical data used is objective, and the personnel making the medical evaluations always include trained doctors. The trickiest decisions, however, are the ones that cannot be made on the basis of medical evidence alone. These decisions occur in the fourth and fifth stages of the sequential-evaluation process, where vocational factors are considered for the first time and where ERGOS can make a great contribution.

Mr. Mark Dakos
July 27, 1995

Currently, vocational evaluations are done by vocational experts hired by the state agencies, ALJs, and claimants' representatives. The quality of the work varies from expert to expert, and the evaluations can be very subjective. The ERGOS equipment, on the other hand, has a record of producing consistent, reliable results. The use of ERGOS equipment clearly can reduce -- and experience in other programs suggests that it can virtually eliminate -- the number of errors that occur at stages four and five. For purposes of illustration, we may assume that the *overall* error rate on awards is reduced by half, from 2 percent to 1 percent. Other assumptions could be made, but the results would be directly proportional to those resulting from this 1-percentage-point reduction.

Benefit Savings from Reduced Awards

The illustrative benefit savings resulting from a 1-percentage-point reduction in the annual number of awards are shown in the enclosed chart. The savings start at $33 million in 1996 and rise gradually to $343 million in 2000 and to $535 million in 2002. Not surprisingly, these figures will ultimately approach 1 percent of the cost of the DI program, which is estimated to cost $74 billion annually in 2002 (according to the 1995 OASDI Trustees Report, intermediate assumptions).

Administrative Cost Savings

The use of ERGOS equipment would also reduce the administrative costs of the DI program, which now exceed $1 billion annually. The savings would occur two ways:

1. Elimination of most vocational experts. Currently, SSA spends millions of dollars each year for the services of vocational experts, who evaluate claimants for disability benefits and produce reports on their capabilities. Those reports become part of each applicant's file and are taken into account by the various decision-makers. The ERGOS equipment could replace these experts in most cases.

2. Reducing the number of ALJ hearings. To the extent that the use of ERGOS equipment reduces the number of erroneous *denials*, it will reduce the number of appeals as well. That will reduce the number of ALJ hearings, the average cost of which now exceeds $1,000.

In addition to producing reliable, objective evaluations, the ERGOS equipment also has the capability of transmitting its results electronically, thereby reducing delays in getting the necessary information to the evaluation team. Thus, administrative costs could decrease while the quality of service simultaneously increases.

Mr. Mark Dakos
July 27, 1995

Other Savings

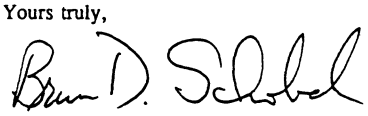
ERGOS could someday be used in the context of continuing disability reviews (CDRs) of disabled workers. As noted above, these reviews are often not done today, but they are still required by law and will resume at some point (unless the law is changed). When they resume, the ERGOS equipment could play a role, because it could demonstrate improvement in vocational capabilities. As noted above, SSA is ordinarily bound by its earlier determinations, unless it can demonstrate that the beneficiary has "medically improved." Increased vocational capabilities might be used as evidence of such medical improvement. This is an area for further study.

Conclusion

The Congress and SSA have recognized for years that substantial savings would result from reducing the error rate on disability awards. The error rate has already been brought down to a fairly low level, in historical terms, but it can still be reduced further. ERGOS equipment has already demonstrated its potential to improve decisional accuracy in other programs, and it could likely do the same for DI. At a minimum, I believe that SSA should run an experiment using ERGOS, to see its impact. If ERGOS can reduce the DI award error rate by only 1 percentage point, it would much more than pay for itself.

Please let me know if I can provide any additional information.

Yours truly,



Bruce D. Schobel, FSA, MAAA, FCA
Consulting Actuary

Enclosure

DI Program Projections* and Savings from ERGOS Proposal

Year	Number of disabled-worker benefit awards	Average monthly benefit amnt.	Annual cost rate of awards (millions)	Annual cost rate of awards, including auxiliaries** (millions)	Annual cost of DI program+ (millions)	Illustrative++ savings from ERGOS proposal: Benefits (millions)	Administration (millions)	Total savings (millions)
1994	631,870	$646	$4,898	$5,743	$38,879	--	--	--
1995	648,000	678	5,274	6,184	42,713	--	--	--
1996	664,000	712	5,675	6,654	46,361	$33	$122	$155
1997	681,000	748	6,111	7,165	50,087	102	125	227
1998	698,000	785	6,577	7,711	54,021	177	127	304
1999	715,000	824	7,074	8,294	58,493	257	133	390
2000	733,000	866	7,615	8,928	63,236	343	140	483
2001	751,000	909	8,192	9,605	68,300	436	149	585
2002	770,000	954	8,819	10,340	73,801	535	158	693
Total illustrative savings under ERGOS proposal, 1996-2002:						$1,883	$954	$2,837

* Data for 1994 are actual; data for other years are projected, based on the 1995 OASDI Trustees Report, intermediate assumptions.

** Scale-up ratio based on 1-percent sample of 1993 awards:

Category	Number	Average monthly benefit	Annual cost rate (thousands)
Disabled workers	6,297	$640	$48,346
Wives	665	162	1,291
Husbands	24	114	33
Children	3,633	161	7,015
Total			$56,685
Scale-up ratio			1.172480

\+ 1995 OASDI Trustees Report, intermediate assumptions.

++ Assumes that improved vocational evaluation reduces the number of new awards by 1 percent through reduction in erroneous awards. Also, assumed to reduce administrative costs by 10 percent through eliminating vocational experts and reducing the need for hearings. See accompanying report for additional details regarding these illustrative savings.