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OVERSIGHT OF THE DISABILITY APPEALS PROCESS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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OVERSIGHT OF THE DISABILITY APPEALS PROCESS

THURSDAY, APRIL 24, 1997

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

The Subcommittee met, pursuant to notice, at 9:04 a.m., in room 1100, Longworth House Office Building, Hon. Jim Bunning (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
April 17, 1997
No. SS–3

CONTACT: Ari Fleischer or
Scott Brenner (202) 225–8933

Bunning Announces Hearing on Oversight of the Disability Appeals Process

Congressman Jim Bunning (R–KY), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on oversight of the disability appeals process. The hearing will take place on Thursday, April 24, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:00 a.m.

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

BACKGROUND:

The Social Security Disability Insurance (DI) program provides cash benefits to insured, severely disabled workers. Applications for disability benefits are filed with one of the Social Security Administration's (SSA's) more than 1,300 field offices. Applications, along with supporting medical evidence, are then forwarded to State disability determination services (DDSs), which make the initial medical determination of disability according to SSA's policy and procedures. Applicants who are dissatisfied with an initial determination may request reconsideration by different staff at the DDS. Applicants who disagree with a reconsideration denial have the right to appeal the decision to the Office of Hearings and Appeals (OHA), where cases are heard by administrative law judges (ALJs).

A steadily increasing number of appeals has caused workload pressures and processing delays, particularly for OHA. In the decade ending in 1995, the number of disability cases appealed to OHA had increased by about 140 percent. Despite SSA's attempts to manage this workload, between 1985 and 1995, its inventory of appealed cases increased from about 107,000 to almost 548,000. The case inventory was reduced to 511,000 at the end of 1996. However, some individuals who appeal their disability claims report unsatisfactory public service after waiting over a year for their appeal to be processed.

In addition, decisional inconsistency between DDSs and ALJs continues to lower public confidence in the disability program. In 1996, approximately 75 percent of individuals who were denied benefits by DDSs appealed their decisions to an ALJ. On average, ALJs are reversing DDS decisions 67 percent of the time. Last year, Chairman Bunning asked the General Accounting Office (GAO) to report on factors that contribute to differences between DDS and ALJ decisions and what actions SSA is taking to obtain greater consistency between the decisions in initial and appealed cases.

Over the past few years, SSA has initiated both near-term and long-term initiatives to improve public service. These initiatives include the Short-Term Disability Plan (an initiative to reduce case inventories at OHA) and SSA's Plan for a New

Disability Claim Process, referred to as the "redesign plan," to address systemic problems contributing to inefficiencies in the disability program.

FOCUS OF THE HEARING:

During the hearing, the Subcommittee will: (1) review the current status of OHA workloads and their impact on service to the public; (2) examine the effects of SSA's short- and long-term initiatives to address those workloads, including what is working, what isn't working and what else needs to be done; and (3) consider the findings of the GAO regarding SSA's management of the timeliness and consistency of SSA's disability decisions.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

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 and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Thursday, May 8, 1997, to A.L. Singleton, 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 to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Social Security office, 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 including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

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. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

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 available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–225–1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman BUNNING. The Subcommittee will come to order.

This morning, the Subcommittee picks up where it left off the last Congress examining the management of the disability program at SSA, the Social Security Administration. Today, as before, we will focus on, number one, the action SSA is taking to address the tremendous backlog of cases, waiting for a decision at the appeals level; and, number two, learn more about why there is a decisional inconsistency between the examiner physician teams who make decisions at the State disability determination agencies and ALJs, the administrative law judges.

As I have stated before, my primary objective in looking into the disability program is to make sure that those who are truly disabled receive benefits quickly and relatively easily and that those who have recovered and are no longer eligible for benefits are removed from the rolls. Effective customer service and public confidence must be restored at SSA, especially in the disability program. It is still difficult for persons with disabilities to believe they are receiving adequate services when they are forced to wait 1 year or longer for a decision, and it is extremely disheartening to the American taxpayers to hear their hard-earned dollars are supporting disability benefits for people who are able to work.

It is clear from testimony we will hear today that SSA is trying to make progress. I am pleased to hear about these efforts and look forward to hearing the details.

During the 104th Congress, I asked GAO to investigate the reasons for the inconsistencies between the decisionmakers at different levels of the disability determination process at SSA. Today, they will share with us their findings.

We will conclude with testimony from a panel of witnesses who work in the disability process every day. I believe they will be able to give us valuable insight into what is working, what isn't working, and offer their suggestions for improvement.

In the interest of time, it is our practice to dispense with opening statements, except from the Ranking Democrat Member. All Members are welcome to submit statements for the record. I yield to Congresswoman Kennelly for any statement she wishes to make.

Mrs. KENNELLY. Thank you, Mr. Chairman.

I venture to say most Americans don't spend a great deal of time thinking about the disability appeals process. If they do think about it, they are hoping they will never have to use it, but if misfortune comes their way and they are forced to apply for disability benefits, there are probably two things they will expect from the process—let it be speedy and let it be fair.

They want to receive their benefits in a timely fashion. They want to be treated fairly by the Federal Government.

The backlog of cases at the Office of Hearings and Appeals is currently nearly half a million cases. Moreover, applicants who appeal their cases wait well over 1 year, on average, before they receive a decision. Such a lengthy wait can cause severe financial hardship for many disabled people who are unable to support themselves through work.

SSA has taken some positive steps to reduce these backlogs and has had some measures of success, but progress remains slow.

I look forward today to hearing more from SSA about the effectiveness of its activities in this area. In addition to a swift decision, the public has a right to expect a fair hearing. Most people would expect to receive a hearing before an individual with some independence from the agency. This is the agency, after all, that has rejected the applicant's claim for benefits. If the public does not believe that SSA provides a fair and impartial hearing, then more people will appeal their decisions to the Federal courts. The result will be to clog the Federal court system and further delay decisions. I don't believe that is a result anyone desires.

Clearly, a very high reversal rate for ALJs is in no one's best interest. It is slow, expensive, and undermines the integrity of the process. However, the public must be confident that when they have been inappropriately denied benefits, they will nevertheless receive a fair an impartial hearing on that denial.

It was not so long ago in the early eighties that the public concluded that applicants were being unjustly denied benefits, and ALJs were applauded for their independence and willingness to buck the agency by reversing DDS, disability determination services, denials. We must be careful the administration plan which we put in place to streamline the process and speed decisions does not have the potential to strangle the fair hearing process. No one would be the winner in that case.

Thank you, Mr. Chairman.

Chairman BUNNING. Thank you, Mrs. Kennelly.

Today, we will begin with testimony from—if the first panel will be seated—Carolyn Colvin. Is that correct?

Ms. COLVIN. Yes.

Chairman BUNNING. From the Social Security Administration, Ms. Colvin is the Deputy Commissioner for Programs and Policy. She is accompanied by Rita Geier, Associate Commissioner for Hearings and Appeals; and Arthur Fried, General Counsel.

Ms. Colvin, would you please begin.

STATEMENT OF CAROLYN W. COLVIN, DEPUTY COMMISSIONER, PROGRAMS AND POLICY, SOCIAL SECURITY ADMINISTRATION; ACCOMPANIED BY RITA GEIER, ASSOCIATE COMMISSIONER, HEARINGS AND APPEALS; AND ARTHUR FRIED, GENERAL COUNSEL

Ms. COLVIN. Good morning, Mr. Chairman, Members of the Subcommittee. I am very pleased to be here to discuss the Social Security disability appeals process today.

To my right is Rita Geier, who is the Associate Commissioner of the Office of Hearings and Appeals, and to my left is Arthur Fried, who is our General Counsel.

We appreciate the opportunity to submit a statement for the record. I will describe today many short-term and long-term initiatives designed to strengthen and streamline our appeals process.

It is important to note that more than 70 percent of the beneficiaries awarded disability benefits in 1996 were allowed by the DDS. Fewer than 30 percent were allowed at the ALJ hearing level or at a higher appellate level.

I also want to stress that there is one and only one standard for determining disability at all levels of the adjudicative process.

A fundamental goal of SSA's effort to redesign its disability process is to make the correct decision as early in the process as possible. When developing our redesign strategy, we recognized that, in order to achieve this goal, we needed to minimize those factors within our control which contribute to the variance in allowance rates between the DDSs and ALJs. Collectively, we are calling these initiatives Process Unification. Our goal is to achieve similar results on similar cases at all stages of the process, through consistent application of laws, regulations, and rulings with minimal or no impact on program costs.

I am proud to report that SSA has made significant strides toward this goal. One of the factors we have identified as contributing to the different allowance rates is the different approaches the DDSs and the ALJs take in evaluating claims which can lead to different conclusions in a particular case. These are areas which are highly complex.

Last year, we published eight new Social Security rulings clarifying policy in these complex areas designed to assist all decisionmakers in applying the policy in the same way. To assure consistent application of these rulings, we conducted for the first time joint training for SSA's 15,000 disability adjudicators. The hearings level allowance rate declined to 59 percent in fiscal year 1996, and data for the second quarter of fiscal year 1997 indicate an increase in the initial and reconsideration allowance rates at the DDS with an accompanying further decrease in the ALJ allowance rate.

Some of this likely can be attributed to the new rulings and the training. Another initiative designed to improve consistency is the development of a single presentation of policy that is binding on all decisionmakers. This will ensure that different presentations of policies do not result in different outcomes.

We are taking several other crucial steps, for instance, preparing revised regulations clarifying the ALJ's responsibility for considering the medical opinions of DDS physicians. It must be kept in mind, however, that because of the new information presented by the claimant as well as other factors, most ALJ allowances are based on a substantially different case than the case evaluated by the DDS. Therefore, as part of our Process Unification effort, we are trying to minimize this effect by permitting the ALJs to remand cases to the DDS for a review when new medical evidence is received prior to the hearing being scheduled. This will permit the DDS to change its denial to an allowance which will result in fewer cases going to hearing. For cases that the DDSs do not allow, the ALJ will benefit from the DDS' assessment of the new evidence.

Additionally, SSA recently published a ruling reemphasizing its acquiescence policy, and one of the initiatives in Process Unification is to streamline the process for issuing these rulings.

Under SSA's acquiescence policy, SSA issues a ruling in all cases where the final circuit court decision conflicts with SSA policy and SSA decides not to appeal the decision to the Supreme Court. Our adjudicators are not authorized to give precedential weight to the circuit court decision until these rulings are issued.

Another key initiative in Process Unification is implementation of preeffectuation quality review of OHA allowances. Under this initiative, the Office of Program Integrity Review will screen approximately 10,000 favorable hearing decisions each year and forward the case to the Appeals Council if a possible error is detected.

It is important to note, however, that the hearings process is different by design from the DDS process. Claims heard by the ALJ generally are the most complex and the toughest to evaluate. It is entirely appropriate for such cases to be heard in a more formal setting allowing presentation of testimony and questioning of witnesses.

At the same time, we want accurate decisions and more consistency in our decisionmaking process. To achieve this goal, SSA is developing a clear vision of what the future of a quality review should be, a more comprehensive review program that better defines its quality standards, communicates more effectively to employees, and continually provides the employees with a means to achieve them.

Mr. Chairman, I would like to very briefly address the increased disability workloads which have required us to evaluate ways to process cases more efficiently. SSA's short-term disability project successfully achieved a substantial near-term reduction in both initial and appeals backlogs. From the inception of the project through the end of fiscal year 1995, the number of initial claims pending in the DDS was reduced by more than 120,000. And, since its inception, SSA increased hearing dispositions by almost 100,000 cases.

In another effort to reduce OHA pendings, over 300 ALJs were hired during the course of fiscal years 1994 and 1995.

The plan for a new disability claim process represents a long-term initiative to provide world class service within available resource levels by redesigning SSA's disability process. The streamlined process is expected to significantly reduce the time and resources needed to process disability cases through the hearing stage.

In closing, Mr. Chairman, I want to thank the Subcommittee for the opportunity to address these important issues. With the assistance of Ms. Geier and Mr. Fried, we would be very happy to answer any questions you may have.

[The prepared statement follows:]

Statement of Carolyn W. Colvin, Deputy Commissioner, Programs and Policy, Social Security Administration

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the workloads at our Office of Hearings and Appeals (OHA), and the General Accounting Office's (GAO) findings on inconsistencies in disability decisionmaking at different levels of the adjudicatory process. As described below SSA is working on myriad initiatives designed to improve and streamline the appeals process. These include short-term initiatives designed to improve our processing time, as well as long range initiatives such as the implementation and testing of several elements of our disability process redesign.

DISABILITY CLAIMS PROCESS

Mr. Chairman, a brief overview of the disability process might help put this statement in context. The Social Security Act broadly defines disability as the inability to engage in any substantial gainful activity. The Act requires the Commissioner of Social Security to prescribe rules for obtaining and evaluating evidence and making

disability decisions. The law further requires that initial disability determinations be generally made by State Disability Determination Services (DDSs) following Federal rules and guidelines and financed by Federal funds.

State DDS Process

In the State DDS, a team composed of a disability examiner and a physician (or sometimes a psychologist) makes the disability determination based on an evidentiary record. The State DDS requests medical evidence from the treating physician(s) and other sources identified by the claimant. If that evidence is incomplete or conflicting, the disability examiner may request a consultative examination from the claimant's treating physician or a physician under contract to the DDS to perform these examinations. If necessary, the examiner will also obtain evidence from the claimant's family, friends, or other third parties which will help explain how the individual's impairment(s) affects his or her ability to work. The team then considers all medical and other evidence to make the disability determination; if the claimant is not disabled, the DDS releases a denial notice to the claimant.

Appeals Process

A person who is denied disability benefits may pursue an appeal through three administrative levels, one at the State DDS and two at SSA, and the Federal courts. The Act requires the Commissioner to provide a dissatisfied claimant the opportunity for a hearing before an SSA administrative law judge (ALJ), and allows for filing of a civil suit in Federal court after the Commissioner's final decision. SSA has also provided a reconsideration review at the State DDS prior to the hearing and a final review after the hearing by SSA's Appeals Council.

Reconsideration is the first administrative review for claimants and is a de novo (fresh) review of the claims file (including any new evidence) by a State DDS doctor/examiner team who did not participate in the original decision. The new team considers all of the evidence and issues a reconsideration decision.

The second level of administrative appeal is a de novo hearing before an administrative law judge (ALJ). The ALJ can call on medical and vocational experts to assist in evaluating the evidence. Usually the claimant will obtain legal representation at this point. Frequently new evidence is introduced by the claimant and his or her representative, often at the hearing itself. They are allowed to present testimony to the ALJ in person, to subpoena witnesses, and to obtain answers to interrogatory requests.

The final administrative appeal level is the Appeals Council (a group of 24 administrative appeals judges), which may grant, deny, or dismiss a request for review of the ALJ decision. It will grant review if the ALJ decision contains an error of law, is not supported by substantial evidence, involves a broad policy issue, or there appears to be an abuse of discretion by the ALJ. After an unfavorable Appeals Council decision or an Appeals Council dismissal, if the claimant is still dissatisfied, the next step is filing a civil action in Federal court.

Allowance Rates

Although there is one and only one standard for determining disability at all levels of the adjudicative process, there are some inconsistencies in disability decision-making at different levels of the adjudicatory process. Before I cite the statistics on the different allowance rates at the DDS and OHA levels, it is important to note that more than 70 percent of the beneficiaries awarded disability benefits in 1996 were allowed by the DDS. Fewer than 30 percent were allowed at the ALJ hearing level or higher levels of appeal.

From the late 1970s and throughout the 1980s while the DDS allowance rates remained fairly stable at about 35 percent, the hearing level allowance rate fluctuated between about 48 to 59 percent. From 1990 to 1992 both the DDS and hearing level allowance rates increased primarily because of the effects of the Zebley Supreme Court decision. Although the DDS allowance rate decreased in 1993, to about 39 percent, the hearing level allowance rate remained at 67 percent through 1995. In contrast the DDS allowance rates dropped to the low 30 percent range during those years. However, in FY 1996 the hearing level allowance rate decreased to about 59 percent and has declined even further in the second quarter of FY 1997. Additionally, the DDS allowance rate has risen slightly.

PROCESS UNIFICATION

A fundamental goal of SSA's effort to redesign our disability process is to make the correct decision as early in the process as possible. When developing our redesign strategy we recognized that in order to achieve this goal we needed to minimize

those factors, within our control, which contribute to the variance in allowance rates between the DDSs and the ALJs. To that end, we are implementing several initiatives designed to do just that. Collectively, we are calling these initiatives Process Unification. Our goal is to achieve similar results on similar cases at all stages of the process, through consistent application of laws, regulations, and rulings with minimal or no impact on program costs.

At the outset I want to stress that there is one and only one standard for determining disability at all levels of the adjudicative process. As I will explain below, the difference in the State DDSs and hearing level allowance rates is influenced by many different factors, including differences in the process, as described above. I am proud to report that through the Process Unification initiatives SSA is making significant strides toward minimizing these factors.

As an initial step, we have convened a group of Agency experts to identify policy issues that are critical to process unification. In addition, we have established a senior level group to oversee all aspects of process unification implementation.

Consistent Application of Policy at all Levels

A key element in process unification is consistent presentation of policy both in written instructions and in training. One of the factors we identified is the different approaches that the DDSs and ALJs take in evaluating claims which can lead to different conclusions in a particular case. These are areas which are highly complex, like how pain and related symptoms are evaluated, or what weight to give treating physician opinion, or deciding an individual's residual functional capacity.

Last year we published eight new Social Security rulings clarifying policy in several complex areas of disability evaluation, designed to assist all decisionmakers in applying the policy in the same way. To ensure consistent application of these rulings, we conducted—for the first time—joint training for SSA's 15,000 disability adjudicators. This training included DDS examiners, quality reviewers, senior attorneys, and ALJs as well as members of the Appeals Council and their staffs. Training commenced in July 1996 and was completed in February 1997. Each training class was comprised of representatives from all levels of our disability decisionmakers. The training allowed the participants to benefit from the experience of adjudicators at every level, to hear the same information from the same instructors, and to discuss and resolve any differences in interpretation.

Preliminary results are very favorable. Decisionmakers surveyed about the training generally praised the quality of the training and the substance of the new rulings. In fact, our internal stakeholders—DDS administrators, physicians, examiners and ALJs—think that process unification, besides being essential, is progressing positively.

Additionally, we have seen a recent shift in the pattern of allowances both by the DDSs and the ALJs. As mentioned above, the hearing level allowance rate declined to 59 percent in FY 1996, and data for the second quarter of FY 1997 indicate an increase in the initial and reconsideration allowance rates at the DDS with an accompanying further decrease in the hearing level allowance rate. Some of this likely reflects an impact from the process unification initiatives. The rulings published last summer and the joint training effort recently completed were expected to affect decision outcomes in these directions.

We plan to have similar joint training sessions on other complex policy areas in the future. Quality assurance efforts are in place to support and evaluate the training objectives.

Another initiative designed to improve consistency is the development of a single presentation of policy (the "one book") that is binding on all decisionmakers. This will ensure that different presentations of policies, although those differences may be slight, do not result in different outcomes.

Additionally, the process unification workgroups are continually looking at ways to improve our guidance in the areas of policy identified by an intercomponent panel, described below, as "problem areas" . For example, we are in the process of preparing revised regulations clarifying residual functional capacity (RFC) assessments for less than a full range of sedentary work, a particularly difficult area of assessment.

Expanded Rationales at the DDS

In the early 1990s, in response to workload pressures caused by the skyrocketing number of new applications for disability benefits, we allowed the DDSs to use simplified rationales to document their determinations. Since the DDS decision is considered evidence at the hearing level, the simplified rationale did not provide the ALJs with the information they needed to determine why the DDS denied a case.

Therefore, in some cases, the ALJ was unable to give proper weight to the DDS determination while evaluating the evidence in file.

We are now requiring that the DDSs fully rationalize all of their reconsideration denials so that this valuable expertise is fully utilized at the hearing level. We are also preparing revised regulations clarifying the ALJ's responsibility for considering the medical opinions of DDS physicians.

Remands of Cases to the DDS

In reality, most ALJ allowances are based on a substantially different case. Thus, an ALJ decision may "allow" benefits but it does not necessarily "reverse" the DDS determination. A substantial majority of ALJ decisions are based on additional and different evidence from that available to the DDSs.

Also, the ALJ hearing is the first step of the claims process in which the claimants may appear in person before the decisionmaker to explain their impairments and present witnesses who can attest to the effects of their impairments. DDSs do not meet the claimant. In addition, more than 80 percent of the claimants are represented by an attorney or other individual at the hearing. Because the representative assists the claimant in obtaining new evidence to support the case and explaining the effects of the impairments to the ALJ, representation can have a substantial impact on the hearing decision. There is also some anecdotal evidence that representatives wait until the hearing before submitting some of the evidence of disability.

Additionally, in some cases the person's condition has worsened, or the person alleges an additional impairment. Other cases, denied by the DDS based on expected improvement in the claimant's condition within 12 months of the onset of the condition, are allowed by the ALJ because improvement has not occurred since the DDS determination.

Therefore, as part of our Process Unification effort, the ALJ can remand to the DDS, for a new determination, those cases where new medical evidence is received prior to the hearing being scheduled. In many cases this will permit the DDS to change its denial to an allowance which will result in fewer cases going to hearing and decrease the time a claimant must wait for a favorable decision.

Additionally, for cases that the DDS cannot allow, the ALJ will be reviewing the same claims file as the DDS and benefiting from the DDS's assessment of the new evidence.

Precedential Value to Court Cases

Because ALJ decisions are reviewed directly by the district and appellate courts, ALJs are more inclined than DDSs to be sensitive to how the courts review disability law and policy. Under SSA's acquiescence policy, a ruling is issued in all cases where the final circuit court decision conflicts with SSA policy and SSA decides not to appeal the decision to the Supreme Court. Our adjudicators are not authorized to give precedential weight to the circuit court decision until these rulings are issued. SSA recently published a ruling reemphasizing our acquiescence policy, and one of the initiatives in Process Unification is to streamline the process for issuing these rulings.

Increased Review of ALJ Cases

Another key initiative in Process Unification is implementation of pre-effectuation (PER) quality review of OHA allowances by the Appeals Council under its authority to conduct "own motion" reviews. The Office of Program Integrity Review (OPIR) (which is not a part of OHA) will screen approximately 10,000 favorable hearings decisions each year, in addition to the ongoing quality review of ALJ allowance and denial decisions, and forward these cases to the Appeals Council if a potential error is detected.

While we are preparing a regulation describing this new process, we have begun a post-adjudicative "dry run" of OPIR's identification of cases for Appeals Council review. OPIR is providing feedback to the ALJs on cases when they detect a possible error and an intercomponent panel is being established to review a body of "tough policy cases" which can be used to identify problem areas between the DDSs and ALJs and then to develop policy solutions. We have put the staffing and processes in place so that the official reviews can begin immediately after the regulation is published.

Rewards of Success

The benefits of successful process unification will be enormous. Obtaining the correct decision as early as possible in the process will greatly improve administrative efficiency, often avoiding an expensive hearing. If fewer claimants seek appeal, OHA

workloads will decrease, and service to claimants will improve. Not the least benefit will be that DDS examiners and ALJs can work together more harmoniously, and each will be more effective in their roles as decisionmakers.

Having said all this, however, it is important to note that the hearing process is different by design from the DDS process. In a program as important to the American public as this one is, it is imperative that the process not only be fair but also be seen as fair to those applying for benefits. Disability evaluation is a complex task requiring sophisticated, professional expertise. Claims appealed to the ALJ generally are the toughest to evaluate, the most complex and the most subjective. It is entirely appropriate for such cases to be heard in a more formal setting allowing presentation of testimony and questioning of witnesses.

I want to emphasize that all of the SSA family (including the DDSs) is committed to Process Unification. We all recognize that the goals of process unification are important on their own, and they are essential for the success of our highest priority, a better and more efficient disability process.

QUALITY REVIEW

Current Process

At the same time that we want more consistency in our decisionmaking process, we also want accurate decisions. To achieve this goal, SSA's quality review activities comprise an integrated system designed to provide the Agency with a "report card" of management information (MI) about how different components within the disability decisionmaking process are doing in terms of well documented, policy-consistent correct decisions. At the State level, each DDS conducts inline quality reviews on samples of determinations before they are returned to SSA's field offices. Subsequently, SSA reviews, at the regional level, DDS determinations issued at the initial and reconsideration steps. When appropriate, determinations are returned to the DDS to either change the decision or obtain additional documentation. Some of the cases which are sampled at the DDS level and regionally also receive a review by a component at SSA Headquarters. Known as a consistency review, this assessment enables SSA to check on the consistency with which the regional review components are applying Agency policy. All of these reviews of DDS determinations are integrated in that there is a sharing of findings so that any adjustments in the reviews resulting from this data can be coordinated to achieve greater efficiency and an improved product through the planning and scheduling of DDS/SSA training initiatives.

At the hearing level, the history of quality review is more recent. Prior to 1993, there was no ongoing quality review of hearing decisions per se, and as a result, the Agency lacked a basic source of ongoing MI with respect to that level. To some extent, the Appeals Council was viewed as a quasi-quality review component because of its review of hearing decisions. However, its formal position as the last step in the administrative appeals process is separate and distinct from that of a quality review component.

In 1993, SSA began its first ongoing quality review of ALJ allowance and denial decisions. This sample is stratified 50 percent allowances and 50 percent denials. Valuable MI has been obtained which has resulted in both ALJ training and process unification initiatives. Moreover, this review also includes a review of the initial and reconsideration denial determinations which preceded each ALJ decision. This unique aspect of the review enables the Agency, for the first time, to obtain a multilevel longitudinal assessment of each case. In addition to identifying process unification issues arising between the DDS and the hearing level, this review enables SSA to ascertain whether hearing allowances were allowed at the earliest possible point in the adjudicative process, which is a fundamental goal of policy unification.

Transitioning to a New Quality Review Vision

With respect to the future of quality review within a redesigned process, SSA is developing a clear vision of what the future of quality review should be—a more comprehensive quality review program that better defines its quality standards, more effectively communicates them to employees in a consistent manner and continually provides employees with the means to achieve them.

SSA's existing quality review system has always demonstrated the flexibility necessary to adapt to the new concerns and many changes which have occurred in the disability program over the years. The enhancement of the hearing-level reviews is just one example of that flexibility. As SSA continues forward with its redesign activities, its quality review system will continue to be adaptable and meet the growing needs of the new processes which SSA introduces.

WORKLOAD ISSUES

The enormous demands confronting SSA in the form of increasing disability workloads required us to evaluate policies and procedures which might be streamlined or altered to process the workload more efficiently. Record numbers of disability applications were received in the early 1990s, leading to skyrocketing hearing requests and ever larger OHA pendings. Additionally, we expect more than 125,000 additional hearings from now through FY 1998 relating to the legislation passed last year affecting individuals disabled due to drug addiction and alcoholism and children and non-citizens receiving Supplemental Security Income payments. SSA has sought both short-term and long-term solutions to manage the unprecedented workload increases.

Short-Term Disability Project

SSA's Short-Term Disability Project was designed to achieve a substantial near-term reduction in both initial and appeals backlogs. From the inception of the Project in October 1994 through the end of FY 1995, the number of initial claims pending in the DDS was reduced by more than 120,000. Project initiatives designed for OHA had to await completion of hiring, redeployment, and training of staff, as well as approval of a new regulation. This initiative allowed us to increase hearings dispositions by almost 100,000 cases (and doubled the number of CDRs processed), while maintaining most of the progress made in basic DDS initial claims pendings.

Some of the more successful elements are being continued, including:

- expanding the prehearing conference procedures to ensure claimants' files are complete;
- granting temporary authority to experienced staff attorneys and paralegal specialists to make allowances in certain prehearing cases; and
- establishing screening units to identify appealed reconsideration decisions which can be allowed based solely on the record without additional development or a hearing.

In addition, SSA increased decision drafting capacity by detailing employees to decision drafting functions. Through September 1996, these employees produced nearly 58,000 decision drafts.

New ALJ Hires

In another effort to help reduce OHA pendings, over 300 ALJs were hired during the course of fiscal years 1994 and 1995, increasing the total number of ALJs on duty by over 25 percent to about 1050. New ALJ hires in FY 1996 essentially covered attrition, which is also the plan for FY 1997. In order to help with the new "welfare reform" legislation workloads, 60 ALJs are being hired this year in anticipation of FY 1998 attrition and will report in June.

Additionally, SSA is exploring ways to hire ALJs with subject matter-specific experience. These ALJs would be able to become proficient immediately and would help address the short-term need of "welfare reform" legislation.

Disability Redesign

The Plan for a New Disability Claim Process represents a long-term initiative to provide world-class service within available resource levels by redesigning SSA's disability process. It is expected to significantly reduce the time and resources needed to process disability cases, and is the Agency's highest priority. We are concentrating most of our redesign efforts on several key elements and have begun testing an integrated redesign process that incorporates many of these elements. While redesign's project life is expected to run over many years, SSA is moving to implement those aspects of the new process that can be implemented in the nearer-term.

Two of these projects are of particular pertinence to the appellate process. First is the Adjudication Officer (AO), currently being piloted in 25 sites nationwide. The AO will serve as the focal point for claimants who request a hearing and will have full authority to issue a favorable decision, if the evidence so warrants. Of the over 20,000 AO cases processed since testing began in November 1995, about 30 percent have been allowances, with the remainder being fully developed by the AO and forwarded to the ALJ for hearing. At slightly less than one case per day, productivity is lower than expected but improvements are anticipated. While quality review of allowances has found some problem areas that need work, the quality of the information being forwarded to ALJs is high.

Second is the Full Process Model, which tests several redesign features working together, including the AO, a pre-decision interview similar to the face-to-face interaction of a hearing, and elimination of the reconsideration step prior to the ALJ hearing. Testing began in eight states this month. Testing of an additional feature—

elimination of mandatory Appeals Council review prior to the filing of a civil suit in Federal court—will begin after publication of a revised testing regulation.

CONCLUSION

In closing Mr. Chairman, I would like to thank the subcommittee for the opportunity to address these important issues. We expect, based on the short-term efforts mentioned earlier and followed by improvements related to implementing the redesigned disability process, to increase hearings dispositions significantly.

While process unification has already accomplished a great deal, much still remains to be done. You may rest assured that SSA is fully committed to obtaining correct, similar results in similar cases at all stages of the disability claims process. Although all indicators suggest that our initial efforts are succeeding, SSA will continue to monitor carefully the results of all our initiatives.

Chairman BUNNING. Thank you.

First, let me say that I am pleased to see there has been some progress made and I commend the agency for its work. I know you would be disappointed if I didn't get to ask you some questions, so let me begin.

There is no question that these issues are complex and DDS and ALJ processes are different by design. Nevertheless, many of the reasons for differences between DDS and ALJ determinations have been around for a long time.

For example, let me quote, "The council believes that the lack of uniformity in application of eligibility standards stem from: One, a lack of specificity in the rules for determining disability; two, an inadequately controlled, Federal-State arrangement for administering DI and SSI Programs; and three, an appeals process which fails to encourage the development of complete and correct evidence early in the process." This quote is from the report of the Disability Advisory Council, March 11, 1988.

There is another statement, "The high reversal rates after the initial decisions have been attributed to: One, inadequate documentation of the initial claim; two, the progressive nature of an applicant's medical condition; three, the nature of disability; and four, different sets of rules governing different levels of disability decisionmaking processes." This quote is from the final report of the National Commission on Social Security, March 12, 1981.

These issues have been around for a long time, and certainly, the American people deserve better from its Federal Government. Clearly, you are trying to make a number of improvements in your disability process, but what about the legislative changes? Certainly, as a fully independent agency which operates two of the largest disability programs in the country, you must have some suggestions for improvements that could be made into law. None have been submitted since I have been Chairman of this Subcommittee, not one.

There are many positive comments in testimony received today about the benefits of training ALJs and DDS personnel together. Did this job training occur regarding the legislation ending eligibility for drug addicts and alcoholics or for the SSI children provision?

Ms. COLVIN. Let me address your last question first. The training we recently provided to the 15,000 adjudicators, which includes

both OHA staff as well as DDS staff, our quality review staff and our Appeals Council staff, was designed to review the eight new rulings that were recently developed to ensure consistency of application of the laws and regulations at all levels of the adjudicative process. This would certainly impact on all of the disability reviews, the childhood disability cases, or the noncitizen cases that we have processed will be coming forth, as well as, of course, the many DA&A, drug addicts and alcoholics, cases.

Chairman BUNNING. Will you answer my question? Did this job training occur because of the legislation ending eligibility for drug addicts and alcoholics or for the SSI children's provisions? Is that why you did it, or did you do it for some other reason?

Ms. COLVIN. We did it because it was recognized that we needed to unify the process for disability determinations to try to ensure that we would get the correct decision as early in the process as possible. Certainly, Mr. Chairman, this will impact implementation of the legislation on the DA&A and SSI children.

Chairman BUNNING. In other words, that wasn't the initial or main purpose for your joint training? You just decided to do it on your own?

Ms. COLVIN. We decided to do it as part of the Process Unification Initiative, which is a part of our overall disability redesign initiative.

Chairman BUNNING. The reason I push that is because SSA must pay attention to the Congress when it passes laws, so that as an independent agency, you can fully implement those laws. The American people and the Congress are interested in knowing that you are complying with the new laws that we pass.

Ms. COLVIN. Let me be clear, Mr. Chairman, that we are, in fact, complying with the new laws. The Process Unification training will enable us to comply more thoroughly with those laws because by unifying the process we can ensure that the decisions we have to make about the DA&A workload, under the new law, are adjudicated in a fair and accurate manner early in the process. So, clearly, the Process Unification training will allow us to comply with the DA&A law.

Chairman BUNNING. I will inquire later.

Barbara, would you like to question?

Mrs. KENNELLY. Thank you, Mr. Chairman.

Thank you for coming.

Ms. Colvin, are you aware of an article that was in the New York Times, Monday, April 21, 1997, the United States challenges courts on disability?

Ms. COLVIN. Yes, we are.

Mrs. KENNELLY. So I can ask you a few questions about it. For people who are interested, the New York Times asserted that SSA has told its administrative law judges that they could disregard Federal court decisions if these decisions are in conflict with agency policy. "An ALJ is bound to follow agency policy even if in the ALJ's opinion on that policy is contrary to law. The Federal courts seem to disagree with SSA's pronouncement that ALJs should ignore the law. In the *Hutchison* charter case, the court said, regardless of whether the Commissioner formally announces her acquisition, she is still bound by the law of this circuit and does not have

the discretion to decide whether to adhere to it. The Congressional Research arm also agreed saying whether SSA issues an acquisition ruling or not, the agency must follow the court's decision that is binding on SSA." Yet, from reading this article, I think there is a disagreement from SSA. It appears SSA is asking the ALJs to ignore the Federal courts. Is that correct?

Mr. FRIED. No, it is not correct. The SSA's policy is to follow circuit court decisions, and that has been the SSA's policy since the late eighties, and it is pursuant to regulations that were issued by Social Security on January 11, 1990.

The most recent issuance was on July 2, 1996, and it was a ruling that merely restated the policy reflected in the 1990 regulations.

Mrs. KENNELLY. Thank you, Mr. Fried.

Well, is SSA providing DDSs and ALJs with timely interpretations of these court decisions, of the Federal court decisions?

Mr. FRIED. Unfortunately, in the past, there have been some extensive delays in providing what are called acquiescence rulings. However, we have recently committed to issuing acquiescence rulings as fast as possible. The goal of the agency is to issue them within 120 days.

Mrs. KENNELLY. What is the backlog now?

Mr. FRIED. Currently, SSA has four circuit court decisions under serious consideration for publication of an acquiescence ruling.

Mrs. KENNELLY. OK. My problem is, as a Member of Congress, we get numerous constituents who don't have the decisions they are seeking, and then they come to us to see if we can help them, and sometimes we can, and obviously, as you well know, sometimes we can't. But another problem we are constantly dealing with is the clogged courts. If SSA ignores the Federal court decision, I am afraid the courts could get even more clogged, and here, we have got this huge agency that has everything set up to do what should be done, and then it ends up in a court situation at the highest level. So I will continue to follow this situation.

Let me ask you another question, Ms. Colvin. As one possible reason for differences in DDS and ALJ decisions, you have cited the type of cases we viewed at each level; that is, allowances are reviewed at the DDS level and denials are reviewed at the ALJ level. This would tend to make DDS—or I would think, maybe, this would tend to make DDS reluctant to award cases and ALJs reluctant to deny cases. So your solution is to review more allowances at the ALJ level.

DDS has immediate review of their allowances by quality assurance personnel, but there is no immediate review of denials. Doesn't it make sense, also, to review more denials at the DDS level?

Ms. COLVIN. Let me say, first, that there is review of denials at the DDS level. As part of our Quality Assurance Program, we review a sample of both denials and allowances from each DDS. In addition, by law, we are required to perform a preeffectuation review of 50 percent of all title II concurrent allowances by the DDSs.

Also, in 1993, we began reviewing a small percentage, about 1 percent, of all ALJ decisions split between approvals and denials.

Mrs. KENNELLY. Thank you.

I am new to this Subcommittee, and I am doing a great deal of reviewing and reading. Last night, reading about this situation and looking at, obviously, the problems. To a layperson, it just jumps out to you that the first step is dealing with paper, and there is a certain percentage of dissatisfaction. Then, you go to the second step, and you get medical opinions. You get a person. Is there any thought that maybe we should be looking at the person or getting a doctor who knows the case earlier in the process?

I am not going to try to do your business this morning. As I said, I am new to this, but it jumps out at me that we are dealing totally in a paper fashion. Denials are happening, and then, when we get to the level where you have individual and the medical opinions, then we see things change. Obviously, you have thought about this.

Ms. COLVIN. In fact, we have looked at those issues that you raise, and the full process model under our disability redesign plan will test a number of those issues, including an early opportunity for the claimant to actually appear before the decisionmaker.

We have recognized that some of the differences result from the fact that the first opportunity for the claimant to actually appear before the person making the decision is at the ALJ level. So one of the models we are testing is designed to see what difference would exist if the appearance were earlier.

Mrs. KENNELLY. Thank you.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Collins will inquire.

Mr. COLLINS. Thank you, Mr. Chairman.

Ms. Colvin, this is one of the areas in the district offices back in Georgia that we have more inquiries and complaints about, I think, than most any other area of constituent work. What is the procedure for a person to apply for disability, and what is the criteria?

Ms. COLVIN. The procedure to apply for disability would be to make application at one of our field offices where there is a nonmedical determination made, and then, the medical determination of disability is made at the State DDS level. Individuals would submit or SSA would obtain evidence that is used to evaluate their disability. A review would be made of that evidence, and a decision would be made by the DDS team composed of a disability examiner and a medical consultant.

Mr. COLLINS. It seems like it is just an automatic denial on the largest percentage of the applicants that submit application. Is this common across the country?

Ms. COLVIN. Your second question that you raised, Mr. Collins, is what is the definition of disability. The person has to demonstrate they are unable to perform substantial gainful activity for at least a 12-month period or which will result in death. If the evidence does not substantiate that, then, more than likely, the person is going to receive a denial.

Mr. COLLINS. OK.

Ms. COLVIN. We believe the application of the definition is consistent throughout the country, regardless of the region, and we do have quality reviews to take a look at the accuracy of the decisions that are made.

Mr. COLLINS. Like I say, though, it just seems like it is an automatic denial on the first go-around, and then, with the appeal for

reconsideration or ask for reconsideration by other staff, then it seems to be, again, a denial, and then, when you get to the administrative law judge step in the process, there are a lot of reversals. It looks like the first approach to this thing is what is bottlenecking the whole system. Why do we have such a large denial rate to begin with, denial again, and reversing the denials?

Ms. COLVIN. Let me——

Mr. COLLINS. Are we all working off the same page and the same criteria, the same requirements, or is this different somewhere?

Ms. COLVIN. You are describing many of the issues that we have identified and which resulted in our implementation of Process Unification.

Let me just say that we have a 30-percent award rate at the initial DDS level, so about 70 percent are initially denied.

By the time the case gets to the ALJ level, in many instances, it is not the same body of evidence. You will recall we mentioned additional evidence can be presented at the ALJ level. This is the first time the individual appears before the person making the decision. Substantial time has often passed, which may mean the medical problems have increased.

What Process Unification is designed to do is to identify those problems that prevent an early decision so that we will get the correct decision earlier in the process and fewer cases go to the ALJ level. About two-thirds of the cases that are heard at the ALJ level are not the same cases that were heard at the DDS level.

Mr. COLLINS. Well, we don't have a way of handling this without going to the ALJ level when this new evidence is submitted, this medical documentation?

Ms. COLVIN. I understand your question. You are asking do we have a way of handling new evidence——

Mr. COLLINS. This is a long, drawn-out process for the individual that has replied.

Ms. COLVIN. One of the things we are testing under the Process Unification Initiative is having cases where new evidence is presented at the hearing level, returned to the DDS level, so that the evidence can be reviewed and any revised decisions can be made at the DDS level and will not, in fact, be heard at the ALJ level.

Mr. COLLINS. OK.

Ms. COLVIN. So that is an area of concern we have identified and are attempting to address with the Process Unification Initiative.

Mr. COLLINS. We thank you, and with the long list of panelists we have today, we have to move on.

Thank you.

Chairman BUNNING. First of all, I am going to take the privilege of the Chair and say that, since 1981, these same problems have been around, as I reviewed for you. Only since 1991 have we made significant progress. At that time, 40 percent of the initial DDS claims were being allowed. That meant 60 percent were being denied in 1991.

The reversal rate at that time was 66 percent at the ALJ levels. So, of the 60 percent that had been denied and appealed, 66 percent were being allowed on appeal to ALJs.

Now, over 1991, 1992, 1993, 1994, 1995, and 1996, 30 percent of initial claims are allowed at the DDS level. So 70 percent are being

denied. Of those 70 percent, approximately 60 percent are now being reversed at the ALJ level.

Now, what Mr. Collins is getting at and what everybody up here wants to know, Why can't we do a better job on the initial claim and make sure there isn't a running evidence trail from the time the process begins until the time of the ALJ pronouncement? Wouldn't it be much easier for everyone, including the applicant, on overall program costs, if we did it right in one decision? I think that is what we are trying to get at here, because it is acceptable for applicants to wait for over 1 year.

In Kentucky, the waiting times are not that bad. It averages 4 or 5 months, but in other States, additional evidence often prolongs the disability application process to over 1 year. Considering the 30 percent DDS initial allowance rate in 1996, with ALJs overturning 60 percent of those 70 percent that are denied by the DDS who appeal, suggests there ought to be a better way of handling evidence.

Ms. COLVIN. I am going to ask Rita Geier to help me with this question, but I want to emphasize that we are looking at ways to improve. We are expecting through our Process Unification Initiatives to be able to address those problems you have just identified, the problem of getting all of the evidence earlier, so that the case can be decided correctly at the DDS level.

This is the problem I spoke about earlier; there is often additional information at the ALJ level, and there is a personal——

Chairman BUNNING. We are familiar with that. We are familiar. We don't think that is acceptable. We think all the information should be on the original application, and we are going to explore doing something about it legislatively because, obviously, it is not satisfactory if people have to wait over 1 year for their initial claim to be decided. They die. People actually die while waiting for the benefits, and that is not acceptable to me.

Mr. Hayworth will inquire.

Mr. HAYWORTH. I thank the Chairman, Ms. Colvin, and those with us on the panel. I thank you for joining us today.

Part of the frustration expressed by those of us in the Congress has already been outlined, I think, quite eloquently by the Chairman, and we are going to hear from a lot of different people today who will testify in support of SSA's initiative to develop one book where all decisionmakers are following the same set of instructions. To reasonable people, that makes immanently good sense.

So I am interested today, Ms. Colvin, in getting your assessment of just where SSA is on its development of the one book and when will it be made available to all decisionmakers.

Ms. COLVIN. We are making significant progress in that direction, Mr. Hayworth.

We have just recently, as I mentioned, trained the 15,000 disability adjudicators on the same rulings. This is the first time in our history we have actually had training together for all of those individuals who adjudicate disability cases on the same laws, regulations, and rulings.

The one book will pull that together even more. I am not prepared today to give you an exact date of when that one book will be available, but we will be very happy to provide that to you for the record.

Mr. HAYWORTH. That would be good.

It is my understanding that in the discussions with staff, we have been told the one book is still at least 2 years away, and that is very disturbing when you consider the fact that this notion was first put forth in October 1994.

Certainly, since we are dealing with such a critical need, even understanding the complexities, I am a bit miffed with the notion of waiting an additional 2 years.

Ms. COLVIN. I am not prepared to respond to that at this point. This is an area we recognize will have a significant impact on the process. This is a very high priority for us. It is very complex with the various rulings and regulations, but as I said before, I would be very happy to provide you more specific detail for the record.

Mr. HAYWORTH. Well, we appreciate that, and we look forward to getting your assessment of the timeline to complete this work, and we will wait with great interest on that.

[The following was subsequently received:]

Compilation of the "one book" is an iterative process. As an interim measure, we have been putting the exact text of regulations and Social Security rulings into the POMS so that decisionmakers at all levels will have the identical presentation of policy. Decisionmakers at the administrative appeals level already use the regulations and rulings directly.

As part of our strategy to build a single presentation of policy, which is what the "one book" is designed to be, we are also maximizing the use of Social Security rulings as a means of conveying policy clarification rather than providing such guidance in operating instructions that apply to only one level of the process. Rulings are binding on all levels of decisionmaking and review in our process and are thus ideally suited to enhancing uniformity of appilication of policy. As you know, regulations are also binding on all decisionmakers and reviewers.

SSA began this effort by placing the text of the regulations on symptoms including pain in the POMS in early 1995; eight rulings on the areas of symptoms, residual functional capacity, and weighing of evidence were put into the POMS in July 1996 and the recently published childhood regulations were put into the POMS in March of this year.

This process will continue with the ultimate goal being the presentation of all substantive disability policy identically at all decisionmaking through use of regulations and rulings.

Mr. HAYWORTH. Ms. Colvin, you mentioned training for folks involved in the adjudication process. How much medical training do the ALJs receive?

Ms. GEIER. I will answer that, Congressman Hayworth. When the ALJs come on board, they are initially involved in a 5-week training program. This involves medical training, as well as training on the conduct of a hearing and full training in the specifics of the disability statute, regulations, and rulings.

About 1 year after they are on board, we bring them back for supplementary medical training geared to reinforce the earlier training.

There are also ongoing means of medical training through seminars and participation of ALJs in CLE-type training.

Mr. HAYWORTH. So, Ms. Geier, you are saying the initial training process is about 5 weeks in duration, but if you had to isolate the

specific medical training, are we not, in fact, looking at about 1 week, initially?

Ms. GEIER. Well, it is difficult to say. In terms of only medical training, that may be accurate, but medical training involves casework, too. So, as we train through casework, we are also teaching the application of medical standards and evaluation.

Mr. HAYWORTH. And then, in the refresher course, for lack of a better term, you mention after people have been in the field when they come back, how long does that medical training run?

Ms. GEIER. That is about 1 week.

Mr. HAYWORTH. About 1 week. I thank you, ma'am.

Mr. Chairman, my time is up, so I yield back.

Chairman BUNNING. Mr. Portman.

Mr. PORTMAN. I have to do a little followup on that questioning. That is how much training the ALJs get. Clearly, we have an issue with the ALJs reversing these decisions from the earlier decisionmakers. How much training do the earlier decisionmakers get? What does the DDS get in terms of medical training as compared to the—roughly, it sounds like 1 week of medical training, initially, and then some refresher training throughout the year. Obviously, those folks aren't looking at these individual cases in the same way the initial decisionmakers are. How much medical training do the initial decisionmakers receive?

Ms. GEIER. It is my understanding that that is about 5 or 6 weeks for the initial level at DDS.

Mr. PORTMAN. But DDS only gets 5 or 6 weeks——

Ms. GEIER. Weeks.

Mr. PORTMAN [continuing]. Of training, 5 or 6 weeks of training? Is that initial training?

Ms. COLVIN. Yes, that is my understanding.

Mr. PORTMAN. Five or six weeks——

Ms. COLVIN. Yes.

Mr. PORTMAN [continuing]. Of medical training?

Ms. COLVIN. Yes.

Mr. PORTMAN. OK.

Mr. FRIED. That is just for the disability examiner. At the initial level, there are also medical advisers who participate in the decisionmaking process, and they are doctors with specialties in various areas.

Mr. PORTMAN. Well, in fact, every initial decision has to be signed off by a physician. Isn't that correct?

Mr. FRIED. Currently, that is correct. There are tests Ms. Colvin referred to before of what is called the single decisionmaker, and we are also looking at early decision lists which may, in appropriate cases, depart from that, but currently, the standard is for a doctor to sign off——

Mr. PORTMAN. To sign off.

Mr. FRIED [continuing]. The initial decision.

Mr. PORTMAN. So give me a generalized comment here, if you would. Where is the medical expertise located in the system? Is it more at the outset? Mr. Bunning told us that 70 percent of the initial applications are being denied at the initial level, and then, about 67 percent are being appealed later on in the process once you go through the two steps. Where is more of the medical exper-

tise, at the beginning of the process or at the ALJ part of the process?

Ms. COLVIN. I would——

Mr. FRIED. The——

Ms. COLVIN. Go ahead.

Mr. FRIED. The ALJs, if they determine it is necessary, can bring a medical adviser to testify at the hearing or can submit——

Mr. PORTMAN. That is not really answering my question, though. Do they do that on a typical——

Ms. COLVIN. It is really throughout.

Mr. PORTMAN. Do more than——

Mr. FRIED. The answer is it is throughout the process.

Mr. PORTMAN [continuing]. One-half of the ALJs do that, Mr. Fried?

Ms. COLVIN. They do——

Mr. PORTMAN. Do the majority of the ALJs do that?

Mr. FRIED. The ALJs have significant medical evidence in the file. They have the medical evidence that was developed at the——

Mr. PORTMAN. But answer my question. Do they bring in medical experts or a doctor?

Ms. GEIER. They do, Congressman Portman.

Mr. PORTMAN. They do in more than one-half of the cases?

Ms. GEIER. Yes, 40 percent or so have medical expert or consultative medical input.

Mr. PORTMAN. Forty percent or so?

So, in every instance at the outset—I am just trying to figure out. This is such a bizarre system we have, and one must wonder to the extent this is a medical determination, which it really is, where does that expertise lie, and you are telling me that in roughly 40 percent of the cases with regard to the ALJs, they actually bring in some medical professional to help them analyze the case, and in every case at the outset with the DDS examiner, there is a doctor that signs off on the initial decision?

Mr. FRIED. In every case, the ALJ has the expertise of medical professionals and evidence in the file.

Mr. PORTMAN. Has evidence in the file.

Mr. FRIED. In addition to 40 percent, they actually specifically get medical advice for——

Mr. PORTMAN. That evidence in the file comes from the applicant?

Ms. COLVIN. What was your question, the last one?

Mr. PORTMAN. Well, Mr. Fried is indicating there might be some objective medical expertise at the ALJ level, and my time is almost up, but it sounds as though that is more evidence that is in the file that clearly would be available to them in rendering their decision, but not something that they would be receiving independently.

My only point, because I have got—unfortunately, the Chairman is good at keeping these sessions going. So I am not going to go overtime. Otherwise, I will never get another question.

I think part of the issue Mr. Collins alluded to, and the Chairman alluded to it, is to determine how we can get more of that medical expertise at the front end of the process, or if it is already there, maybe rely more on that end of the process and have all that

information provided initially, to the extent it is possible. I know new information might arrive, conditions change, so that we don't have this kind of—as I said earlier, a bizarre situation where you have got all of these denials initially and then go through this long process and then have them reversed, two-thirds of them being reversed.

One other comment I need to make, and that is, I was very supportive of the independent agency. I think it is a great idea, and the reason I think it is such a good idea is, in large measure, because it allows you to have independent judgment with regard to tough issues like this.

You have got to give us your thinking on this, independent of HHS, independent of the administration, what really makes sense. Give us legislative recommendations. I don't think you have given us any in 3 or 4 years, and I would just encourage you to do that, look at it objectively, how you can do your job best, and tell us how we can help you do that.

Thank you, Mr. Chairman.

Chairman BUNNING. Thank you, Rob.

Let me ask—who hires the ALJs?

Ms. GEIER. Congressman, the——

Chairman BUNNING. Would you please bring your microphone a little closer. I am having an awful time hearing you.

Ms. GEIER. Is that better?

Chairman BUNNING. Go ahead.

Ms. GEIER. The process of selection——

Chairman BUNNING. That mike is not working. Would you try another one?

Ms. GEIER. The SSA actually hires the ALJs, but it hires the ALJs from a certificate of eligible candidates that is provided by OPM.

OPM maintains a register of eligibles, of persons who satisfy the basic threshold qualifications for ALJ positions throughout all of the government. The agencies request the number of ALJs they need to hire from that register, and OPM provides a certificate.

Chairman BUNNING. Who pays them?

Ms. GEIER. The agency pays.

Chairman BUNNING. The SSA?

Ms. GEIER. Yes, sir.

Chairman BUNNING. OK. Who hires the DDSs?

Ms. GEIER. That would be the States. They are State——

Chairman BUNNING. They are State-determined employees——

Ms. GEIER. That is correct.

Chairman BUNNING [continuing]. Hired by each individual State. Who pays them?

Ms. COLVIN. They receive Federal funding from SSA for their staff. So, we do. The SSA pays them.

Chairman BUNNING. Pays them. So you pay both the DDSs and the ALJs?

Ms. COLVIN. Yes.

Mr. FRIED. If I may just clarify to make sure it is accurate, we provide funds to the DDSs. The DDS employees receive State agency checks. They don't receive a Federal check, but the funds are

funds provided by SSA through a regulatory arrangement. We have no direct relationship with an employee of the State DDSs.

Chairman BUNNING. In other words, you don't hire the DDS personnel, they are hired by the State.

Ms. COLVIN. That is correct.

Chairman BUNNING. But you pay them.

Mr. FRIED. We pay the State.

Chairman BUNNING. Which pays them.

Mr. FRIED. We reimburse the State for its expenses in operating the DDS——

Chairman BUNNING. But what I am getting at is the decisionmaking process and who is paying for it and why people are losing confidence in the decisionmaking process. If SSA pays the ALJs and the DDSs, and people are coming to SSA for disability benefits, there is always the possibility of the applicants thinking the reason they are not getting satisfaction or the reason they are not getting a fair hearing, so to speak, is because the decisionmakers are employees of SSA.

There have been bills introduced to make the ALJs independent, and I am not really happy with that bill. I never liked that bill, but the fact of the matter is, unless we can solve this problem of credibility, particularly at the initial decisionmaking process, and then have a reasonable appellate or appeal process, we are not going to build the confidence we need in this program. People should not think we are trying to rip them off and keep them out of the program. We, on this Subcommittee, need your assistance in order to help you do your job better. We haven't had any assistance from the SSA in trying to solve this problem, other than efforts from within SSA, which you are doing on your own. We think we can assist you by writing a better disability law and making sure all the evidence is up front and that there can't be a different set of evidence for the DDSs and the ALJs. Then SSA can make the decision without 60 percent being reversed as in 1996.

Ms. COLVIN. Mr. Chairman, we appreciate that offer, and we are, in fact, continuing to evaluate what legislative proposals might be desirable under the Process Unification Initiatives.

[The questions of Chairman Bunning to Acting Commissioner John J. Callahan and Mr. Callahan's answers follow:]

Question. 1A. In their testimony, GAO discussed the fact that should an applicant be determined to have a functional capacity of less than the full range of sedentary work, this classification is likely to lead to an award. GAO reports that decisionmakers in the State DDSs make this classification in less than 6% of the allowed cases. ALJs, however, utilize this classification in 63% of allowed cases. How does this happen?

Answer. We are continuing to study functional capacity assessment at all levels of the process to determine the reasons for differences and have taken steps to address this issue, including recent issuance of Social Security Ruling 96–9p which explains SSA policy on assessing functional capacity for less than a full range of sedentary work. This ruling is part of a broad array of Process Unification activities, designed to reduce decisional inconsistencies between OHA and the DDSs. Much of our efforts at process unification are directed at the issue of assessing functional capacity, especially in the more difficult cases involving pain and other symptoms and evaluating treating physician opinion. As mentioned in our testimony, we have recently completed a large, national training effort in which we trained more than 15,000 individuals involved in assessing disability. This included disability examiners, State agency medical consultants, Administrative Law Judges (ALJs), agency attorneys, and quality review personnel from all levels. In that training, we specifi-

cally discussed the issue of use of a functional capacity for less than a full range of sedentary work.

*Question.*1B. ALJs may ask independent medical experts to testify, yet they do so in only 11% of the hearings. How are they, then, making what must be very difficult judgment calls regarding how long a person can stand or walk or how much a person can lift?

Answer. Although ALJs use the testimony of medical experts in 11% of the hearings, the ALJ has an extensive case record before a hearing is held. At the very least, there has been an initial determination by the State agency followed by a reconsideration determination by the State agency. At both levels, the DDS is expected to document all known alleged impairments and limitations. In addition, we have begun testing the use of an Adjudication Officer (AO) who serves as the focal point for all prehearing activities when a claimant requests a hearing before an ALJ. The AO has the responsibility for assisting the claimant and claimant's representative, as well as ensuring that the case record is ready for a hearing.

Therefore, the ALJ has, in most cases, extensive medical evidence which must be weighed according to SSA regulations and rulings in order to make a disability decision. The file includes evidence from the claimant's treating sources, as well as the assessment of that evidence by a State agency medical consultant.

Question. 1C. I understand that, in the long term, you are planning to develop a simplified decision-making process which will expand the role of functional capacity assessments. Since differences in functional assessments are the primary reason for inconsistent decisions, how do you justify expanding the use of these assessments?

Answer. The adjudicator's findings, based on his or her review of the medical and other evidence, are called a "residual functional capacity," or RFC assessment. Our plans do not call for expanding use of RFC assessments. Rather, they call for investigating alternative ways of assessing functioning.

As a part of its Disability Process Redesign, SSA is engaged in a long-term research project to develop a simpler, more efficient disability decisionmaking process. Conceptually, this new process is expected to be based, in part, on a more objective assessment of the functional consequences of an individual's impairment, i.e., by using standardized measures of functional ability. In the medical field, these standardized measures are called functional capacity assessments or functional capacity evaluations. We believe that reliance on more objective functional measures will have many advantages, including greater decisional consistency. However, we will not use any functional assessment tool until extensive research has been conducted and testing has been completed.

2. SSA's testimony states that the agency is also planning to implement quality review of 10,000 favorable ALJ decisions each year. Will these cases be reviewed by the same group of people who review State DDS decisions? How was this number determined and is it a valid sample?

At this time, we have not determined exactly how we will implement the quality review nor which group will be responsible for the review. We will advise you when the implementation strategy is finalized.

3. A number of witnesses testified in support of SSA's initiative to develop a "one book" approach, where all decisionmakers are following the same instructions. Exactly where is SSA on their development of "one book" and when will it be made available to all decisionmakers?

Compilation of the "one book" is an iterative process. As an interim measure, we have been putting the exact text of regulations and Social Security Rulings into the POMS so that decisionmakers at all levels will have the identical presentation of policy. (Decisionmakers at the administrative appeals level already use the regulations and rulings directly.) As part of our strategy to build a single presentation of policy, which is what the "one book" is designed to be, we are also maximizing the use of Social Security Rulings as a means of conveying policy clarification, rather than providing such guidance in operating instructions that apply to only one level of the process. Rulings are binding on all levels of decisionmaking and review in our process and are thus ideally suited to enhancing uniformity of application of policy.

SSA began this effort by placing the text of the regulations on symptoms, including pain, in the POMS in early 1995. Eight Rulings on the areas of symptoms, residual functional capacity, and weighing of evidence were put into the POMS in July 1996 and the recently published childhood regulations were put into the POMS in March, 1997.

This process will continue with the ultimate goal being the presentation of all substantive disability policy identically at all levels of decisionmaking through use of regulations and rulings.

4. In SSA's testimony, it mentioned that as part of the Process Unification, the ALJ can remand, or return a case of the State DDS, those cases where new medical evidence is received prior to the hearing. This permits the DDS to allow the case, if warranted, or to provide an explanation why the evidence doesn't change the decision. Is this an option for the ALJs? Isn't the public better served if the DDS can go ahead and allow the claim, rather than have the claimant wait well over a year for a hearing? How exactly does this process work?

Our regulations include the authority to have cases returned to the DDS by an ALJ after the claimant has requested a hearing and before it is held for the purpose of deciding whether the determination may be revised. However, the case review that is being established under process unification is not solely to identify favorable decisions that can be expedited (although the DDSs will have the opportunity to prepare favorable determinations, when appropriate.) Most of the cases that are being identified for this review are ones in which the claimant has provided new medical evidence since the reconsideration determination.

One purpose for sending the case to the DDS is to obtain a review and explanation of the new medical evidence by a State agency medical consultant. Of course, if the evidence supports a favorable determination, the DDS will revise its determination.

5. According to SSA testimony, the State DDSs are now being asked to fully rationalize all of their decisions so that the ALJ will give the DDS decision proper weight. ALJs have been described as wearing three hats; one representing the claimant, one representing SSA, and one as the independent decisionmaker. It was stated that more than 80% of claimants are represented by an attorney or other individual at the hearing, so the claimant and their representative provide evidence in support of their claim. How do the ALJs represent the Administration? Do they develop evidence from other medical sources? Do they order consultative examinations? Do you have objective data and have you studied cases to know the degree to which this is done?

It is the policy of the Social Security Administration that its ALJs will fairly and fully develop any claim for benefits which reaches the Office of Hearings and Appeals. Social Security hearings are non-adversarial and not all claimants are represented or capable of representing themselves. Therefore, the ALJs have the duty to assist these claimants in getting the evidence to perfect their claims.

There is case law in some Federal circuits holding that the ALJs are responsible for developing the record even if the claimant is represented. If the ALJ concludes that the evidence is insufficient to make a decision, the ALJ can order a consultative examination of the claimant. The ALJs may order these examinations on their own motion or on the recommendation of staff or medical advisors. The ALJs can also order the examination based on a request from the claimant or representative.

When the record is complete, the ALJs act as fact finders and decide the case. The role of the ALJs in securing evidence, both favorable and unfavorable to the claimant, and then deciding the case, has led to the three hat analogy. However, as the Supreme Court stated in Richardson v. Perales, 402 U.S. 389 (Supreme Court, 1971): "Neither are we persuaded by the advocate-judge-multiple-hat suggestion .... The social security hearing examiner, furthermore, does not act as counsel. He acts as an examiner charged with developing the facts."

ALJs must order the consultative examination through the State Disability Determination Services. The ALJs ordered consultative exams for 59,168 cases in FY 1996 and 26,494 cases for the first 6 months in 1997.

6. Do all of the ALJs write their own decisions? If not, how many do? Why aren't the ALJs asked to write their own decisions?

ALJs draft their own decisions when by doing so, the ALJ would be providing better service to the public. Such a situation would arise when the time required to draft the decision is the same or less than the time required for the ALJ to prepare decision draft instructions. However, when a particular decision draft may be more time consuming, the public is better served by having the draft prepared by an attorney advisor or paralegal specialist. This permits the ALJ to focus on those activities which are uniquely the province of the ALJ, i.e., hearing and deciding cases.

During FY 1996, ALJs drafted about 66,000 decisions. During the first half of FY 1997, ALJs have drafted about 30,000 decisions. Although some ALJs dictate or handwrite decision drafts, the majority of ALJs who prepare drafts do so on personal computers.

7. In his testimony, Judge Bernoski raised a series of questions regarding the relationship of any quality assurance system to the constitutional due process rights of claimants, as follows. Will the rights of the claimants be protected? Will the claimant have notice of review? Will the claimant have the right to appear and defend their interests? How do you plan to protect the rights of the claimants through-

out the quality review process you are establishing? Please respond to these questions.

SSA has always ensured that the due process rights of the claimants who file for benefits are protected. The quality assurance review of ALJ decisions is designed to ensure accurate and equal treatment in the decisionmaking process. This review will be conducted under the existing regulatory authority of the Appeals Council. Every claimant whose case is selected for review by the Appeals Council will be notified within the 60 day timeframe provided for by the regulation. Where the case is remanded and corrective action is taken by the presiding ALJ—including conducting another hearing where needed—the claimant and/or representative will have full access to the appropriate files, including the Appeals Council basis for remand; and the opportunity to raise objections or concerns. If the decision is reversed, we will provide proper notification and the claimants appeal rights will be further protected.

8. One of the witnesses, Senior Attorney Mr. Hill, recommends that subject matter expertise should be included in the ALJ selection criteria. Is it not part of the selection criteria now? What criteria are used and how are the judges selected?

The Office of Personnel Management (OPM) retains the responsibility for administering the merit selection and pay systems for ALJs government-wide. The basic qualifying experience for ALJs includes 7 years as a practicing attorney, preparing for, participating in, and/or reviewing formal hearings or trials, involving administrative law and/or litigation at the Federal, State or local level. The current process administered by OPM for the selection of ALJs involves OPM certifying candidates for appointment consideration from the top of the register (i.e., those with the highest score) without reference to a particular subject matter area or experience in the program of the agency that requested a list of eligibles. Under the current process, it has been OPM's policy that if agencies can justify by empirical data gathered through job analysis that agency-specific subject matter expertise enhances performance on the job, OPM will give special consideration to those applicants in certifying them to agencies.

SSA had requested OPM to enter into an agreement to conduct a pilot study to determine the effect that subject-matter-specific experience has on the productivity of recently hired ALJs at SSA. We requested that OPM consider subject-matter-specific experience in certifying ALJ applicants because our productivity data have shown that new ALJs with SSA disability program experience have significantly higher productivity during the first 9 months on the job than those ALJs without this experience. We also found that new ALJs with such experience can be trained more quickly and require less mentoring from experienced ALJs. OPM had agreed to participate in the pilot; however, we recently learned that OPM no longer agrees to conduct the pilot. SSA considers the pilot to be particularly important to SSA given our current disability workload and the additional workloads projected from Welfare Reform legislation.

The pilot study would not involve a permanent change in the hiring process for ALJs. At the conclusion of the study, which would last for 1 year, a determination will be made concerning the need for change to the policy and regulation, if any, for selection of ALJ candidates. In addition, as part of the study requirements, SSA would continue to hire some ALJs from regular ALJ certificates. On June 8, 1997, 31 new ALJs, who were hired from the regular ALJ certificate, reported for duty. We have made no selections thus far from a subject-matter-specific ALJ certificate.

SSA has legal authority to select candidates from certificates, including subject-matter-specific certificates, provided to it by OPM. Furthermore, OPM has determined its own legal authority to provide certificates to agencies requesting them. In addition, the subject-matter-specific certificate does not violate the intent of Congress with respect to merit selection.

9. The National Council of Disability Determination Directors recommends that SSA develop a shared vision of the program among all components: quality, policy, operations and budget. They seem to feel they are getting different messages from each component. What are your views?

SSA works very hard on communication. The State-Federal relationship, while very effective, provides additional challenges in communications. The disability program has many complex factors affecting day-to-day program administration. Over the last several years, program administration has been particularly complex for DDSs because of special one-time legislated workloads they have been asked to handle in tight timeframes, efforts to assist the Office of Hearings and Appeals, and the various disability redesign initiatives underway. Through all of this, DDSs have responded to the challenges, focusing on providing the best possible service.

It is understandable that DDSs may feel they are getting different messages from time to time as SSA strives to provide management direction that is responsive to

the workload pressures that we face, while we continue to make needed refinements to our processes. In addition to our ongoing daily contacts with DDSs, SSA executives make special efforts to communicate frequently and openly with the officers of the National Council of Disability Determination Directors during quarterly meetings of the National Disability Issues Group, and with all DDS administrators twice a year during DDS Management Forums. We will continue to do all that we can to provide coordinated, clear direction to DDSs as we balance all of the various facets of disability program administration.

10. Over the years, a number of questions have been raised regarding the scope of SSA's management authority over its ALJs. I understand that in January 1997, the Office of the General Counsel provided a memorandum to the Commissioner which provided clarification to this matter. Would you please comment on the primary contents of the memorandum?

The purpose of the memorandum (attached at Tab A) was to review the scope of management authority that SSA may exercise over its ALJs, considering the factors that led to the passage of the Administrative Procedure Act (APA), the protections afforded by the APA to both ALJs and to those utilizing the administrative process, and the often misunderstood concept of the ALJ's "decisional independence."

The memorandum's primary message is that the agency has the right and duty to ensure that its ALJs, like any other agency adjudicators, perform their jobs with appropriate demeanor and decorum and without bias, and that the decisions they issue on behalf of the Commissioner be made timely, be of the highest quality, supported by the evidence found in the record, and consistent with the agency's procedures and interpretations of law. The memorandum also states that, to achieve these goals, the agency can ask ALJs to follow reasonable administrative practices and programmatic policies as long as these do not interfere, either directly or indirectly, with the duty of impartiality that ALJs owe to claimants when hearing and deciding cases. Specifically, the memorandum discusses the agency's responsibility to ensure that its ALJs are well versed in its interpretations of the law, and reinforces the agency's ability to use a number of tools to guarantee that its hearing process is operated efficiently and effectively, including the use of reasonable production targets and quality assurance programs.

ATTACHMENT TO QUESTION 10

SOCIAL SECURITY

MEMORANDUM

Date: January 31, 1997 Refer To:

To: SSA Executive Staff

From: Shirley S. Chater
Commissioner of Social Security

Subject: The Duty of Impartiality in SSA Hearings and its Applicability to Administrative Law Judges (ALJ)--INFORMATION

There has been a growing awareness over the last several years of the need to clarify the scope of the Agency's management authority over its ALJs in view of the protections afforded to claimants under the Administrative Procedure Act. This has been underscored by internal and external studies of the Office of Hearings and Appeals (OHA), including a recent study of the General Accounting Office. Therefore, I requested the General Counsel to conduct a historical review of this issue, focusing, in particular, on any potential or perceived conflict between ALJ "decisional independence" and the Agency's management authority, and provide me a clear articulation of this relationship.

The attached memorandum, which was prepared with significant input and consultation from OHA, sets forth the General Counsel's review and analysis. Following a thorough review of history and case law, the memorandum concludes:

> "...the Agency may establish administrative practices and programmatic policies that ALJs must follow, as long as the Agency does not take actions which abridge, directly or indirectly, the duty of impartiality the Agency and ALJs owe the claimant when hearing and deciding claims. Examples of such practices include requiring ALJs to attend training on the Agency's policy interpretations, and to follow them, enforcing specific time and attendance requirements, and establishing performance goals, as well as quality assurance programs. Along with the authority to set these policies, of course, goes the authority to ensure that these policies are carried out...."

This statement confirms what I know to be the understanding of OHA officials and the majority of ALJs, and it in no way undermines SSA's full support for the ALJ hearing and the full due process rights of claimants. Rather, it should serve to reassure all in SSA that there is no conflict between protecting the duty of impartiality owed to claimants in our hearings and the exercise of appropriate management authority over ALJs.

I encourage you to read the memorandum and to distribute it to interested persons in your organization.

Attachment

SOCIAL SECURITY

Office of the General Counsel

Legal Foundations of the Duty of Impartiality in the Hearing Process and its Applicability to Administrative Law Judges

January 28, 1997

MEMORANDUM

Legal Foundations of the Duty of Impartiality in the Hearing Process and its Applicability to Administrative Law Judges

I. Introduction

The Social Security Administration (SSA or the Agency) has long recognized the need for consolidation and review of the issues surrounding what is commonly called the "decisional independence" of Administrative Law Judges (ALJs). As various commenters have suggested recently, SSA's and the claimants' ability to benefit from the highest quality and most efficient service of the ALJ corps is undermined by the differing and often contradictory understanding in various parts of the Agency of such "decisional independence." This confusion exists about both the meaning of "decisional independence," and the extent to which such independence limits the otherwise appropriate authority of the Agency to manage the performance of the ALJ corps. To address this situation, it was considered important to prepare and circulate this description of the protections for ALJ decisional independence that arise out of the Agency's duty of impartiality towards claimants, as well as the scope of the Agency's authority to supervise and oversee the performance of its ALJs. As discussed more fully below, SSA has significant authority in these management areas. This authority does have some limits, however, as the ALJ's status as an impartial adjudicator of claims presented to the Agency appropriately prevents SSA from infringing on the ALJ's responsibility to develop and evaluate the record, find the facts, apply to those facts the Agency's policies as prescribed by law and regulations, and issue a decision. These limits also are discussed below.

I. The Concept of ALJ "Independence"

It is perceived by some that the Agency's authority with respect to ALJs is limited due to the concept of "decisional independence," [1] a concept that protects adjudicators from actions that infringe on their ability to decide cases impartially. However, as explained below, the outer sphere of the Agency's authority more properly flows from a duty both the ALJ and the Agency owe to the claimant: the duty to decide claims in an impartial manner, consistent with Agency policy, and not from the ALJ's status as "judge."

Thus, to properly examine the scope of the Agency's authority to implement hearings practices and procedures, it is necessary to understand the concept of "decisional independence" in light of its origins in the duty of impartiality. Accordingly, Part I of this memorandum examines the evolution of the ALJ position, including the passage of the Administrative Procedure Act (APA), 5 U.S.C. §§ 551-559, and various explanations of the ALJs' unique status as Agency employees. In Part II, we extract some general principles of Agency authority from judicial and Merit Systems Protection Board (MSPB) decisions.

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[1] The term "decisional independence" has evaded a precise definition. One interpretation defines the term as not only the freedom to decide cases based on the facts according to Agency policy, but also includes the ALJ's freedom to find facts, and to render decisions without fear of retaliation or discrimination because of the decision. See Statement of the Forum of United States Administrative Law Judges in Opposition to the Administrative Law Judge Corps Act (H.R. 3910) at 3 (April 29, 1992). Another interpretation describes it as "the increased independence from Agency pressure to decide a particular case, or a particular percentage of cases, in a particular way." See Social Security Administration v. Anvel, 58 M.S.P.R. 261, 269 (1993). Other synonymous terms have been used to describe the concept, such as "qualified independence." See Social Security Administration v. Glover, 23 M.S.P.R. 57, 76 (1984).

A. Establishment of the ALJ Position

For many years, today's ALJs were known as "Hearing Examiners," a title descriptive of the role they served in the administrative review process, such as hearing testimony, reviewing evidence, and issuing decisions.[2] When Congress changed the statutory title to Administrative Law Judge in 1978, it applied the title administratively adopted in 1972 by the Civil Service Commission.[3]

Prior to passage of the APA, the impartiality of hearing examiners was called into serious question. As early as 1929, there was congressional "concern over administrative impartiality." Wong Yang Sung v. McGrath, 339 U.S. 33, 37-38 (1950).[4] With the passage of the APA, Congress sought to achieve two fundamental designs with regard to the hearing examiners' role: 1) to eliminate Agency control over the classification and compensation of hearing examiners; and 2) to separate the prosecutorial from the adjudicatory functions, which previously had resided in the same person. Id. at 41. See Ramspeck v. Federal Trial Examiners Conference, 345 U.S. 128, 130-133 (1953). At that time, proposals were also made to separate hearing examiners from the agencies, for example, by establishing a "pool" of examiners apart from any agency. Ramspeck, 345 U.S. at 132

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[2] See Friendly, Some Kind of Hearing, 123 U. Pa. L. Rev. 1267, 1269 n.8 (1975).

[3] In so doing, however, Congress did not intend either to alter the substance of the position or its relationship to the administrative agencies. S. Rep. No. 697, 95th Cong., 2d Sess. 4 (1978). See also Hearing on H.R. 865 Before the Subcommittee on Civil Service of the House Committee on Post Office and Civil Service, 95th Cong., 1st Sess. 8 (1977). The title change was incident to legislation increasing the number of supergrade positions for ALJs.

[4] This case reviews the legislative reform efforts leading to enactment of the APA. See Wong Yang Sung, 339 U.S. at 36-45.

n. 2; Wong Yang Sung, 339 U.S. at 42-45. Instead, Congress decided "to make hearing examiners a special class of semi-independent . . . employees by vesting control of their compensation, promotion and tenure in the Civil Service Commission [now the Office of Personnel Management (OPM)] to a much greater extent than in the case of other federal employees," Ramspeck, 345 U.S. at 132 (emphasis added)(internal quotation deleted), while retaining most aspects of employer/employee relationships with the agencies.[5] This decision sought to create a balance whereby the hearing examiners would have the independence necessary ensure impartial decisionmaking in the cases before them, while allowing the Agency heads the freedom to promulgate rules regarding the examiners' role as Federal employees, as well as the standards and procedures to apply in rendering such decisions.

B. The Modern View of the ALJ

This modern view of the ALJ has refined further the employee/employer relationship existing between the ALJs and their agencies. For example, ALJs must comply with the Agency's

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[5] See also See also Administrative Procedure Act: Legislative History, S. Doc. No. 248, 79th Cong., 2d Sess. 192 (1946) (hereinafter "APA Legislative History")(Senate Committee Report) (characterizing ALJs as "a special class of semi-independent . . . hearing officers"); id. at 213(Senate Committee Report); id. at 277 (House Committee Report); Attorney General's Manual on the Administrative Procedure Act 83-84 (Dept of Justice 1947) (hereinafter "Attorney General's APA Manual"). The Attorney General's APA Manual is entitled to some deference because of the Justice Department's involvement in drafting the APA. See Steadman v. Securities & Exchange Commission, 450 U.S. 91, 102 n.22 (1981). Accord, e.g., 2 K. Davis, Administrative Law Treatise, 35 (1958); J. Mashaw, C. Goetz, F. Goodman, W. Schwartz, P. Verkuil & M. Carrow, Social Security Hearings and Appeals 121 passim (1978); Scalia, The ALJ Fiasco - A Reprise, 47 U. Chi. L. Rev. 57 (1979); cf. L. Jaffe, Judicial Control of Administrative Action 613 (1965); see also, Butz v. Economou, 438 U.S. 478, 512-14 (1978).

substantive policies, i.e. its regulations and rulings. "It is, after all, the [Commissioner] who ultimately is authorized to make final decisions," Nash v. Bowen, 869 F.2d 675, 680 (2nd Cir. 1989)[hereinafter "Nash II"], and ALJs are authorized only to exercise those powers delegated by the Commissioner and in accordance with the Commissioner's interpretation of laws and policy. See id. (citing Mullen v. Bowen, 800 F.2d 535, 540-41 n. 5 (6th Cir. 1986); Association of Administrative Law Judges v. Heckler, 594 F. Supp. 1132, 1141 (D.D.C. 1984)). See also Stieberger v. Sullivan, 738 F.Supp. 716 (S.D.N.Y. 1990)("In the absence of an instruction to apply court of appeals holdings to cases before them, SSA adjudicators are obliged to apply agency policy and agency interpretations of the law").[6]

Thus, ALJs "are not policy independent." J. Mashaw, et al, supra note 5, at 121. This principle simply recognizes that the Agency has the responsibility for carrying out programs which Congress has assigned to it. 2 K. Davis, Administrative Law Treatise 35 (1958). In matters of law and policy, the Agency head has primacy.[7] An ALJ is bound to follow Agency policy even if, in the

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[6] The Office of the General Counsel has taken the position that the Agency's Program Operations Manual System (POMS) is not binding on ALJs, since the POMS are not subject to the APA's rulemaking requirements. See Memorandum from the Office of the General Counsel to the Office of Operational Policy and Procedures, dated June 2, 1981, on "Making POMS Binding on ALJs." However, this Memorandum also suggests that the Agency could amend its regulations to give the POMS the same binding effect on all components of the Agency, including ALJs, as the Agency's regulations and Social Security rulings. See 20 C.F.R. 422.406(b) (1996).

[7] See generally Attorney General's APA Manual, supra note 5, at 14-15, 55, 84; Attorney General's Committee on Administrative Procedure, Administrative Procedure in Government Agencies 51, 53, 57 (1941); APA Legislative History, supra note 5, at 210-11, 229, 262-63, 273 (1946); Administrative Procedure Act: Hearings on S. 1160, S. 1336, S. 1758, and S. 1879 Before the Subcommittee on Administrative Practice and Procedure of the Senate Committee on the

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ALJ's opinion, the policy is contrary to law. D'Amico, 698 F.2d 903.[8] Were this not the case, Agency policy could be subject to conflicting and varied interpretations and the coherence of the administrative program would be seriously impaired. Id.; see L. Jaffe, Judicial Control of Administrative Action 613 (1965). As a result, ALJs are bound to decide all cases in accordance with an Agency's policies and its interpretations of applicable law. M. Mullins, Administrative Conference of the United States, Manual for Administrative Law Judges 79 (3rd ed. 1993); D'Amico v. Schweiker, 698 F.2d 903 (7th Cir. 1983).[9]

Under the APA, an presiding employee's enumerated powers for the conduct of hearings (e.g., evidentiary rulings, regulating the hearing) are also "[s]ubject to published [procedural] rules of the Agency. . . ." 5 U.S.C. § 556(c); Section 205(a) of the Social Security Act. See Attorney General's APA Manual, supra note 5, at 75, which provides:

> The phrase "subject to the published rules of the Agency" is intended to make clear the authority of the Agency to lay down policies and procedural rules which will govern the exercise of such powers by presiding officers. . . . For example, if an Agency provides by rule that the fact of citizenship must be established in a prescribed manner, the hearing officer must conform to such rule in exercising his power to "rule upon offers of proof and

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Judiciary, 89th Cong., 1st Sess. 161-67 (1965)(testimony of Kenneth Culp Davis); D'Amico, 698 F.2d 903.

[8] See also J. Mashaw, supra note 5, at 121; Pederson, The Declaration of Separation of Functions in Regulatory Agencies, 64 Va. L. Rev. 991, 1004; Zwerdling, supra note 6, at 29; 1 B. Mezines, J. Stein & J. Graff, Administrative Law 6-8 (1980).

[9] Accord, 1 B. Mezines, J. Stein, & J. Graff, Administrative Law 6-8 (1980); Scalia, supra note 5, at 57, 62 (1980); Zwerdling, The Role and Functions of Federal Hearing Examiners, 400 Annals 27, 29 (1972).

receive relevant evidence."

These provisions permit an Agency to publish rules requiring how the hearing is to be conducted, what procedural rules are to apply, in what form a decision is to be written, and what process will be followed in reaching the decision. While the Supreme Court has never ruled on the applicability of the APA to hearings under the Social Security Act, the Court has recognized that the Agency's administrative proceedings provide procedures which meet or exceed Due Process or APA protections. See generally Richardson v. Perales, 402 U.S. 389, 400-1, 408-10 (1971). [10]

C. Statutory Protections of An ALJ's Impartiality

The current statutory scheme also includes provisions which are designed to protect the ALJ's previously-described impartiality. With regard to tenure and compensation, ALJs are exempt from the structured performance appraisal and rating system prescribed for other federal employees. See 5 U.S.C. §§ 4301 et seq.; see also 5 C.F.R. §§ 430.201-210; 930.211 (OPM regulations). An ALJ's compensation is set by OPM independently of Agency recommendations or ratings, see 5 U.S.C. § 5372, although an Agency is permitted to communicate its views to OPM concerning the

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[10] Section 205(a) of the Social Security Act gives the Commissioner authority "to adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of proofs and evidence and the metho d of taking and furnishing the same in order to establish the right to benefits hereunder." See also Santise v. Schweiker, 676 F.2d 925, 931 (3rd Cir. 1982) (Agency "has the authority, both under the [Social Security] Act and under previous judicial decisions, to pursue the goal of greater uniformity by issuing regulations that may result, at least to some extent, in a lesser degree of consideration of claimants' characteristics"), cert dismissed, 461 U.S. 911 (1983).

compensation and promotion of ALJs as a general matter.[11] OPM also has adopted extensive regulations governing the appointment, compensation, and removal of ALJs, see 5 C.F.R. §§ 930.201-216.

The Agency's authority to take a disciplinary action against an ALJ is limited by 5 U.S.C. § 7521, which permits an Agency to take specified types of disciplinary action only for "good cause established and determined" by the MSPB after an opportunity for a hearing before the MSPB. See infra, Part II. Under section 7521(b), the specified disciplinary actions are removal or suspension, reduction in grade or pay, and furlough of 30 days or less. Reprimands were intentionally omitted from the actions specified in § 7521,[12] and the Agency's supervisory or disciplinary authority is not constrained in any other way.[13] Indeed, certain disciplinary actions are explicitly excluded from the limitations of § 7521. A "good cause" determination by the MSPB need not be made when the Agency removes an ALJ as a result of a reduction in force, 5 U.S.C. §§ 3502, 7521(b)(B); 5 C.F.R. § 930.215(a) and (b); when the action is in the interests of national security, 5 U.S.C. § 7532; or

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[11] S. Rep. No. 752, 79th Cong., 1st Sess. 29 (1945); H.R. Rep. No. 1980, 79th Cong., 2d Sess. 47 (1946); see Scalia, supra note 5, at 67 & n. 49.

[12] The actions covered by section 7521(b) were codified by Congress in 1978. At the time, an organization of ALJs proposed the inclusion of written reprimands. Civil Service Reform: Hearings on H.R. 11280 Before the House Committee on Post Office and Civil Service, 95th Cong., 2d Sess. 605-13 (1978). The House version included reprimands relating to adjudicatory duties. Section 204 of S. 2640 as passed by the House of Representatives, 124 Cong. Rec. 29,228-29 (1978). The Senate version did not contain a corresponding provision, and the Conference Committee deleted any reference to reprimands. H.R. Conf. Rep. No. 1717, 95th Cong., 2d Sess. 29-30 (1978).

[13] Congress has not precluded the Agency from taking disciplinary actions in any particular category of cases. See Social Security Administration v. Goodman, 19 M.S.P.R. 321, 328 (1984).

when the action has been initiated by the MSPB's Special Counsel because the ALJ committed a prohibited personnel practice, or violated a law, rule or regulation as specified in 5 U.S.C. § 1215.

The ALJ's duty of impartiality, although not explicitly addressed in the Social Security Act, also is alluded to in the APA's prohibitions against specified ex parte communications and certain forms of Agency supervision. Section 556(b) governs employees who "preside at the taking of evidence," and mandates that "the functions of presiding employees . . . [and others] shall be conducted in an impartial manner." Section 554(d)(1) provides that an "employee who presides at the reception of evidence" may not have ex parte consultations with "a person or party on a fact in issue" without notice to all parties. (Emphasis added). Section 554(d)(2) provides that a presiding employee shall not be responsible to, or subject to the supervision of, an Agency's employee or agent engaged in prosecutorial or investigative functions for the Agency. These proscriptions are precisely drawn. Even in pending cases, they do not foreclose appropriate consultation between an ALJ and responsible Agency officials and personnel to ensure that decisions will be in accord with law and Agency policy.[14] In fact, such consultations promote the sound administrative review of

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[14] See Asimow, When The Curtain Falls: Separation of Functions in Federal Administrative Agencies, 81 Columbia L. Rev. 759, 764 (1981); J. Mashaw, supra note 5, at 121. A number of bills considered by Congress would have imposed absolute or nearly absolute prohibitions on such consultations. They were criticized as unnecessary to insure fair adjudication, and as inimical to sound results especially in cases involving complex technical issues or difficult questions of law or policy. Hearings on S. 674, S. 675 and S. 918 Before a Subcommittee of the Senate Committee on the Judiciary, 77th Cong., 1st Sess. 266, 464-65, 646-47, 662-63, 836, 1487-88 (1941); Hearings Before the House Committee on the Judiciary on the Subject of Federal Administrative Procedure and on H.R. 184, H.R. 339, H.R. 1117, H.R. 1203, H.R. 1206, and H.R. 2602, 79th Cong., 1st Sess. 55-56 (1945), reproduced in APA Legislative History, supra note 5 at 45, 101-2. Congress rejected these proposals and adopted the more limited restrictions on consultation that now appear in section

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claims and correct application of Agency policy.[15]

In sum, as far as the claims review role is concerned, the Agency has the paramount role in formulating substantive and procedural rules. ALJs have statutory protections to be independent of their employing agencies in regard to their compensation and tenure, Goodman v. Svahn, 614 F. Supp. 726, 728 (D.D.C. 1985), and there is a formidable statutory bulwark to protect these rights, with ample administrative recourse in cases of Agency abuse. Both the Agency and ALJ are bound by section 554(d) to a duty of impartiality--and while the ALJs' independence as impartial finders of fact is preserved, that duty is for the benefit of claimants. Thus, the general rule in this regard is that an ALJ's independence is "limited to the protections of . . . compensation and tenure found in the [APA]," and that any "larger right of decisional independence" would not rest with the ALJs, but with "the claimants whose rights are adjudicated by the ALJs."[16] Goodman v. Svahn, 614 F.Supp. at 728.

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[14](...continued)
554(d).

[15] "The availability to the hearing officer of appropriate assistance and advice will result normally in a more accurate initial or recommended decision and one that better reflects the views of the Agency on questions of law and policy. Thus, the parties are better advised on the real issues that must be met in the subsequent procedure before the final decision." Attorney General's APA Manual, supra note 5, at 55; accord, K. Davis, Administrative Law Treatise §§ 17.8, 17.9 (2d. ed. 1980); Asimow, supra note 14, at 763-64 (1981). Conversely, Agency heads are free to employ the hearing offices in a particular case to assist in formulating and drafting the Agency's final decision. Attorney General's APA Manual, supra note 5, at 87.

[16] Consequently, ALJs seeking to challenge an Agency policy allegedly infringing on the ALJ's "decisional independence" have had a difficult time establishing that they are the proper litigants. See D'Amico, 698 F.2d at 906-7; Goodman, 614 F.Supp. at 728 n.2.

Therefore, it comports more closely with the APA, and other applicable principles, that the concept of decisional independence actually denotes an ALJ's responsibility to exercise impartiality in each case according to Agency policy, free from Agency pressure to decide the case one way or the other.[17] Use of the term "decisional independence," even though qualified, without mentioning its foundation in the duty to be impartial, has on occasion been interpreted improperly by some to suggest more adjudicatory and administrative latitude than is warranted under the APA, or is required by the ALJs' responsibilities.

II Theory in Practice: A Distillation of The Case Law

Federal court and MSPB decisions have defined the manner in which ALJs are subject to the Agency's management, supervisory, and policy-making authority. While this authority has been challenged before the MSPB and through lawsuits, the Agency has consistently been found to possess broad authority to enforce substantive and procedural standards with respect to its ALJs, as long as the ALJ's ability to act as an impartial arbiter in a particular case, or a particular class of cases, is not compromised thereby.

As discussed previously, the provisions at 5 U.S.C. § 7521(a) require that an Agency have

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[17] See Nash v. Califano, 613 F.2d 10, 16 (2nd Cir. 1980) [hereinafter, Nash I], ("The independence granted to ALJs is designed to maintain public confidence in the essential fairness of the process through which Social Security benefits are allocated by ensuring impartial decisionmaking"). See also Butz, 438 U.S. at 513 ("[A]gency adjudication is currently structured to assure that the hearing examiner exercises his independent judgment on the evidence before him. . . .").

"good cause" before taking any of the disciplinary actions specified in the statute (removal, suspension, reduction in grade or pay; or furlough for 30 days or less).[18] Even before enactment of this specific statutory provision, the Supreme Court had held that the Civil Service Commission's reasons for removing examiners in a RIF (reduction in force) constituted "good cause." Ramspeck, 345 U.S. at 132-33, 142-43. "Good cause" is not limited to misfeasance, but may be found in many different contexts, including poor performance or unacceptably low productivity. The courts and the MSPB have interpreted this "good cause" standard to emphasize that ALJs are subject to "appropriate administrative supervision . . . required in the course of general office management," as long as such supervision does not interfere with the ALJ's performance of "review and . . . quasi-judicial functions,"[19] Brennan, 787 F.2d at 1562, that is, as long as the duty of impartiality is not compromised.

Accordingly, the Agency's authority to impose standards and procedures concerning the activities of ALJs has been upheld in a number of different areas. For example, the Agency was

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[18] "Good cause" is not defined in the statute. Commenting on this term when the APA was first adopted, Senator McCarran (Senate Floor Manager) stated: "The cause so specified must be interpreted by the context of the provision in which it is found, and the purpose of the entire section and bill." APA Legislative History, supra note 5, at 324, 326; see id. at 217. A "good cause" finding made by the MSPB is reviewable by the Court of Appeals for the Federal Circuit, 5 U.S.C. § 7703, and the MSPB and Federal Courts construe the statute on a case-by-case basis. See Brennan v. Department of Health and Human Services, 787 F.2d 1559, 1562-3 (Fed. Cir. 1986); Goodman, 19 M.S.P.R. at 324 (citing Administrative Procedure Act-Legislative History, S. Doc. No. 248, 79th Cong., 2d Sess. 324, 326 (1946)).

[19] Although the cases discussed in Part II of this opinion are instructive in evaluating the term "quasijudicial function," it is not defined with precision, and the MSPB will determine on a case-by-case basis whether it is infringed. See supra at 13-18.

permitted to suspend an ALJ for 30-days for refusing to schedule or hear cases because he disagreed with the manner in which the support staff was utilized and disagreed with the office travel policy. Social Security Administration v. Manion, 19 M.S.P.R. 298, 303 (1984), aff'd sub nom. Manion v. Department of Health and Human Services, 746 F.2d 1491 (Fed. Cir. 1984)(unpublished opinion). A 60-day suspension was found to be warranted because an ALJ insisted on receiving all mail relating to his cases without it being docketed, contrary to office policy, and refused to use an office worksheet to track the progress of his cases. Social Security Administration v. Brennan, 27 M.S.P.R. 242, 247-8 (1985), aff'd, Brennan, 787 F.2d 1562. An ALJ's 30-day suspension was deemed reasonable because she refused to travel to hear cases outside the ALJ's local area, as was required of all ALJs in that office. Social Security Administration v. Arterberry, 15 M.S.P.R. 320 (1983), aff'd sub nom. Arterberry v. Department of Health and Human Services, 732 F.2d 166 (Fed. Cir. 1984) (unpublished opinion). See also Social Security Administration v. Boham, 38 M.S.P.R. 540, 543 (1988), aff'd sub nom. Boham v. Social Security Administration, 883 F.2d 1026 (1989), where a 75-day suspension was upheld for an ALJ's refusal to schedule or hear any cases which required travel. A number of administrative and judicial decisions also have recognized the Agency's right to require that ALJs undergo training so that they correctly apply the Agency's policies correctly in their decisions. Cf. Stephens v. Merit Systems Protection Board, 986 F.2d 493, 496-97 (Fed. Cir. 1993). See also Association of Administrative Law Judges, 594 F. Supp. at 1141; Nash II, 869 F.2d at 680. This line of cases also makes it clear that the Agency "has the right to assign work and to determine how its operations will be conducted."[20] See Association of Administrative Law Judges,

[20] The Agency's authority to manage and oversee the work of its ALJs is not without limits. The (continued...)

594 F. Supp. at 1141; Boham, 38 M.S.P.R. at 543.

Thus the Agency must determine on a case-by-case basis whether a practice or procedure is based on the Agency's legitimate management interests and does not interfere with the duty of impartiality. If so, then the Agency will be able to apply such practice or procedure with respect to ALJs and will have good cause for their enforcement. Id. If the action is based upon an improper interference with the ALJ's impartiality, however, good cause will not be found. See Goodman, 19 M.S.P.R. at 328 ("If the Agency is basing its charge on reasons which constitute an improper interference with the performance by an ALJ of his or her judicial functions, the charge cannot constitute good cause. Whether it is, is a question of fact to be decided in the context of each specific case."). Where the disciplinary action is based on an ALJ's performance of an adjudicatory function, the MSPB has stated that the proposed charge will be "very carefully scrutinized for adequate bases in meeting the 'good cause' standard." Glover, 23 M.S.P.R. at 77 (quoting In re Chocallo, 1 M.S.P.R. 605, 611 (1980), aff'd mem. in pertinent part sub nom. Chocallo v. Prokop, 673 F.2d 551 (D.C.Cir. 1982), cert. denied, 459 U.S. 857 (1982)).

It is clear then, that an Agency may take reasonable actions to ensure that an ALJ carries out

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[20](...continued)
MSPB recognizes that agencies may not take actions which are the equivalent of actions specified in section 7521. The test for determining whether an Agency action is a "constructive" discharge is whether the Agency has so infringed on the "impartial exercise of [the ALJ's] judicial functions . . . [as to cause] a pernicious effect on the [ALJ's] qualified independence." See In re Doyle, 29 M.S.P.R. 170, 175 (1985). This cause of action remains a theoretical one, because to date, there have been no decisions where the MSPB has found that an agency so interfered with the impartial exercise of an ALJ's judicial functions as to have constructively discharged him or her.

his or her primary function of hearing and deciding cases, as long as these actions do not "affect the [ALJ's] ability to hold full and fair hearings or to render impartial and complete decisions," consistent with Agency policy and procedure. Manion, 19 M.S.P.R. at 303; Sannier, 931 F.2d at 858 (management's actions did not interfere with ALJ's decisionmaking ability); Boham, 38 M.S.P.R. at 543. SSA can enforce standards to minimize defects in decision-writing, ensure reasonable levels of productivity, and require appropriate behavior in the course of adjudicatory proceedings. Since these areas strike close to an ALJ's fact-finding functions, a closer look at cases involving them will be beneficial in determining the limits of an Agency's authority to supervise its ALJs.

For example, an Agency can establish and enforce productivity standards for ALJs as long as they are not intended to affect an ALJ's impartiality.[21] See Sannier, 931 F.2d at 858-9; Nash II, 869 F.2d at 680; Goodman v. Svahn, 614 F.Supp. at 730 In Goodman, 19 M.S.P.R. 321 (1984), the Agency attempted to have an ALJ removed because of his unacceptably low productivity level. In rejecting the ALJ's allegations that the APA prohibits disciplinary actions based on performance-based charges, the MSPB stated that the APA left to judicial discretion what good cause would suffice to take disciplinary action against an ALJ, and that Congress did not prohibit disciplinary

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[21] Any proposals made to establish production targets or to create quality assurance programs may have to be reviewed in light of the settlement agreement that resolved Bono v. Califano, No. 77-0819-CV-W-4 (W.D. Mo. filed July 26, 1979), to determine if the terms of that settlement apply to the proposals. The plaintiffs in Bono challenged the Agency's establishment of an ALJ case production quota and related OHA management policies, asserting that they violated the APA and the Fifth Amendment. See also Goodman v. Svahn, 614 F.Supp. at 731. As part of the Bono settlement, the Agency agreed to consult with "the ALJ Policy Council, the Association of ALJs in HEW, and the ALJ corps" prior to modifying or amending any of the terms of the settlement agreement, including whether the Agency may institute "quotas" or "goals" for deciding ALJ cases, and in what manner the Agency's then-functioning Quality Assurance Program would be operated.

action against an ALJ for low productivity. Id. at 325-330.[22]

A similar point has been discussed in a memorandum previously issued by the Office of the General Counsel.[23] That memo analyzed whether the Agency could establish a particular quality review system for ALJ decisions, and after a discussion of the case law in the area, concluded that legal authority supported the proposed system. Again, though, such goals or systems cannot go so far as to affect an ALJ's ability to decide a case or class of cases impartially. Accordingly, in Association of Administrative Law Judges, 594 F.Supp. at 1143, the court found that the Agency's Bellmon Review program targeted ALJs with high allowance rates for own motion review and thus "created an untenable atmosphere of tension and unfairness which violated the spirit of the APA, if no specific provision thereof." Id. Notwithstanding this finding, the district court stated that the Agency could "gather data and form an opinion of an ALJ's performance," and that nothing prohibited the Agency from calculating and maintaining such data. Id. at 1140-41.[24] Implicit in this

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[22] In Goodman, the comparative statistics used by the Agency as the basis of the adverse action were not validated and, as a result, the MSPB found that the Agency had insufficient evidence to prove the charge of low productivity. Id. at 331-2.

[23] See Memorandum from Donald A. Gonya, Chief Counsel for Social Security, to Louis D. Enoff, Principal Deputy Commissioner, dated May 4, 1992 on "Authority for the Social Security Administration (SSA) to Conduct Quality Assurance Reviews of Decisions Issued by Administrative Law Judges."

[24] Any specific program proposed for assessing productivity or for ensuring a "reasonable degree of uniformity among ALJ decisions," Nash II, 869 F.2d at 680, should be scrutinized, however, to ensure that it does not infringe on the Social Security Act, as amended, or any regulatory provisions, and does not conflict with the APA. Cf. Butterworth v. Bowen, 796 F.2d 1379, 1385-89 (11th Cir. 1986); McCuin v. Secretary of Health and Human Services, 817 F.2d 161, 171-5 (1st Cir. 1985)(cases interpreting the Agency's policies for reopening ALJ decisions).

analysis is the concept that while targeting only ALJs with high allowance rates might signify pressure on the ALJs to deny more cases, thus undermining ALJs' impartiality, an unbiased system of review that otherwise sought to identify cases in which Agency rules and standards had not been properly applied, would not be so tainted. It is thus incorrect to say, as some have, that the APA prevents an agency from setting performance standards for ALJs - only those requirements which impact an ALJ's ability to decide cases impartially are prohibited.

An ALJ also is accountable to an Agency for improper conduct during the hearing process, such as exhibiting bias or lack of judicial temperament. A high rate of significant adjudicatory errors in the decisions likewise can form a proper basis for disciplining an ALJ. See Glover, 23 M.S.P.R. at 76-77 (1984) and Anvel, 58 M.S.P.R. at 266-67 (1993); Chocallo, 1 M.S.P.R. at 652-4 (removal of ALJ supported by her "obvious and gross bias against claimant's attorney" as exhibited at the hearing, in the ALJ's decision, and "through her caustic, derisive and unjustified remarks" about the claimant). As stated previously, however, the MSPB will carefully scrutinize any adverse action that might encroach on the ALJ's freedom to hear and decide a case impartially. See Glover, 23 M.S.P.R. at 77.

III. Conclusion

In sum, the Agency has both the right and the duty to ensure that ALJs perform their jobs with appropriate demeanor and decorum, without exhibiting any prohibited bias, and that the

decisions rendered by ALJs be of the highest quality, consistent with the Agency's policies, procedures and interpretation of the law, supported by a sufficient evidentiary basis, and issued in a timely manner. These are, of course, important Agency objectives - and are essential to the delivery of "world class" service.

For the foregoing reasons, the Agency may establish reasonable administrative practices and programmatic policies that ALJs must follow, as long as the Agency does not take actions which abridge, directly or indirectly, the duty of impartiality an ALJ owes the claimant when hearing and deciding claims. Examples of such practices include requiring ALJs to attend training on the Agency's policy interpretations, and to follow them, enforcing specific time and attendance requirements, and establishing production targets and similar goals, as well as quality assurance programs. Along with the authority to set these policies, of course, goes the authority to ensure that these policies are carried out and, where appropriate, i.e. where a factual basis exists, to discipline ALJs for violations of such policies.

11. In his testimony, Judge Bernoski indicated that the Office of General Counsel memo appears to be an attempt to provide a legal basis to require ALJs to follow SSA policy that is not consistent with the law. What is your reaction?

SSA's policy is to acquiesce in final circuit court decisions which conflict with SSA's interpretation of the Social Security Act or regulations regardless of our disagreement with the holding. This policy has not changed since SSA's current regulations (20 C.F.R. § § 404.985 and 416.1485) on acquiescence were published on January 11, 1990 (55 Fed. Reg. 1012). (See May 21, 1997, letter to you from Acting Commissioner John J. Callahan, attached at Tab B). The Office of the General Counsel memorandum makes no changes to the acquiescence policy. It merely restates well-established law that an ALJ is not free to apply his or her own interpretation of the law, but, instead, is bound to apply the law as enacted by the Congress as set forth by the Commissioner through regulations and rulings.

As explained by the General Counsel in his testimony before the Subcommittee on Commercial and Administrative Law Committee on the Judiciary on May 22, 1997: "Circuit court decisions are written to decide individual cases, not to provide adjudicatory instructions to decisionmakers, and are therefore often subject to disparate interpretations, particularly when the myriad possible situations to which they may apply are considered. If each of SSA's thousands of decisionmakers were responsible for interpreting circuit court holdings, it could result in conflicting decisions by different decisionmakers, even within the same circuit. SSA would have no way to ensure uniform application of eligibility standards as required by law, leading to further litigation. Indeed, SSA would have no mechanism to ensure that agency rules are consistently applied, since under this approach, it would be the adjudicator's role to interpret circuit court decisions for him or herself. Instead, the interpretation of a circuit court's decision and its consistency with SSA policy is appropriately made with careful scrutiny by SSA officials who have a broad understanding of national policy and who work closely with Department of Justice attorneys in this effort. If an ALJ or other decisionmaker believes that a particular circuit court decision conflicts with SSA policy, the decisionmaker can provide input to the Office of General Counsel through the appropriate channels about either appealing the case or issuing an Acquiescence Ruling."

ATTACHMENT TO QUESTION 11

SOCIAL SECURITY
Office of the Commissioner

May 21, 1997

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

Dear Chairman Bunning:

This is in response to your April 29 letter concerning whether the Social Security Administration (SSA) adopts circuit court decisions with which it disagrees.

The April 21, 1997 New York Times article referred to in your letter incorrectly suggests that SSA reserves the right to not acquiesce in final circuit court holdings with which SSA disagrees. Our policy is to acquiesce in final circuit court decisions which conflict with SSA's interpretation of the Social Security Act or regulations regardless of our disagreement with the holding. This policy has not changed since SSA's current regulations (20 C.F.R. §§ 404.985 and 416.1485) on acquiescence were published on January 11, 1990 (55 Fed. Reg. 1012), and we have not proposed changing it.

The recent SSA policy statement referred to in the New York Times article is Social Security Ruling (SSR) 96-1p (copy enclosed) which was published July 2, 1996. The SSR simply reflects SSA's longstanding policy that SSA adjudicators are to follow SSA's nationwide policy until SSA determines that a circuit court holding is in conflict with its nationwide policy and issues an acquiescence ruling (AR) instructing adjudicators on how the decision is to be followed. The reasons for this policy were explained in the preamble to the 1990 acquiescence regulations. SSR 96-1p also describes SSA's longstanding procedures which permit claims adjudicated by SSA between the date of a circuit court decision and the issuance of an AR for that decision to be readjudicated in accordance with the AR. Moreover, the recent memorandum regarding the scope of SSA's management authority over

its administrative law judges (ALJs) referred to in the New York Times article makes no changes to the acquiescence policy. It merely restates well-established law that an ALJ is not free to apply his or her own interpretation of the law, but, instead, is bound to apply the law as enacted by the Congress as set forth by the Commissioner through regulations and rulings.

The following are our answers to your specific questions about SSA's acquiescence policy.

1. What is SSA's policy regarding acquiescence?

SSA's regulations on acquiescence provide that SSA will apply a holding in a circuit court decision which SSA determines is in conflict with SSA's interpretation of the Social Security Act or regulations unless the Government seeks further review of that decision or, under certain limited circumstances, SSA, in consultation with the Department of Justice (DOJ), relitigates the issue presented in the decision. SSA applies the holding by issuing an AR, which is published in the Federal Register. The AR explains how the court's holding differs from SSA policy and how SSA will apply the court's holding, instead of its nationwide policy, when deciding claims within the applicable circuit.

As discussed in the preamble to the 1990 acquiescence regulations, the Agency believes that the most effective and fair way to implement a policy of acquiescence with circuit court law is for decisionmakers to apply nationwide policy until such time as SSA issues an AR based on its determination that a circuit court decision conflicts with SSA policy. Court decisions resolve individual claims and neither address similar circumstances, nor are written in a way that necessarily instructs our decisionmakers, at all levels, how to consistently apply the courts' rulings to other cases. In addition, circuit court decisions are often subject to disparate interpretations and, if each of SSA's thousands of decisionmakers were permitted to apply his or her own interpretation of the decision, it could result in conflicting standards being used by different

decisionmakers, even within the same circuit. That could undermine uniformity in decisionmaking and lead to further litigation. Thus, the AR is the means by which SSA provides individual adjudicators with direction on how to uniformly apply a circuit court decision which conflicts with SSA's nationwide policy.

SSA's regulations also address the situation in which a claim is adjudicated according to national policy between the date of a circuit court decision and the date of issuance of an AR for that decision. Claims adjudicated by SSA, between the date of a court decision and issuance of an AR, can, upon request, be readjudicated in accordance with the AR.

Since the adoption of its acquiescence policy, SSA has reviewed every circuit court decision on a flow basis to determine whether the court's holdings are in conflict with SSA policy. If SSA determines that a holding of a circuit court decision is not in conflict with SSA policy, SSA does not need to issue an AR. If a decision is in conflict with SSA policy, an AR is prepared for that decision and published in the Federal Register. Publication of our current acquiescence regulations essentially ended the widespread criticism by the courts in the early 1980's of SSA's prior policy of only applying a circuit court decision to individuals who were parties to the lawsuit, but not to all others similarly situated residing within the applicable circuit. Furthermore, in recent years there has been virtually no criticism of SSA by circuit courts for failing to issue an AR for specific cases decided by the courts.

Finally, no AR has been found to be inadequate by the circuit court which issued the underlying adverse court decision.

2. Is SSA's policy on acquiescence consistent with that of the Department of Justice?

Yes. In 1988, DOJ reviewed and commented on SSA's proposed acquiescence regulations and expressed its general agreement with them. In addition, SSA works closely with DOJ attorneys in interpreting circuit court decisions and their consistency with SSA policy. DOJ reviews and approves every AR prepared by SSA prior to its issuance.

3. On average, how long does it take SSA to issue an AR once it decides not to ask DOJ to seek further judicial review?

Ordinarily, once SSA decides not to seek further judicial review of a circuit court decision that is in conflict with SSA policy, we begin to consider whether the court's holdings require publication of an AR. For the 16 ARs initiated and published after December 1991, the average processing time was 366 calendar days from the date we began to consider publishing an AR to its date of publication in the Federal Register.

Recognizing the need to more expeditiously publish ARs, SSA has begun streamlining the process by establishing a 120 calendar-day goal for publishing an AR. Under the new process, SSA begins to consider whether to publish an AR when the circuit court decision is received.

4. How many ARs are pending?

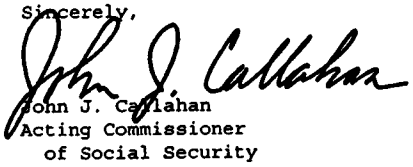
Currently, SSA has four circuit court decisions under consideration for publication of an AR.

5. In recent testimony before the Subcommittee, Deputy Commissioner Colvin mentioned that one of SSA's initiatives includes streamlining the process for issuing these rulings. What, specifically, are you planning to do?

On March 26, 1997, we issued a memorandum establishing a 120 calendar-day goal for publishing an AR. The time frame is calculated from the date of the circuit court decision. SSA recognized when it promulgated the acquiescence regulations that as a matter of operational necessity some time would always elapse between the date of a court decision and the time we could issue an AR because these circuit court decisions often involve complex and difficult issues and the court's holding may be unclear in its scope and susceptible to differing interpretations.

I hope this information is helpful. Please let me know if I can be of further assistance.

Sincerely,



John J. Callahan
Acting Commissioner
of Social Security

Enclosure

cc:
The Honorable Janet Reno

determinable impairment(s) that could reasonably be expected to produce the symptoms. If the adjudicator finds that such symptoms cause a limitation or restriction having more than a minimal effect on an individual's ability to do basic work activities, the adjudicator must find that the impairment(s) is severe and proceed to the next step in the process even if the objective medical evidence would not in itself establish that the impairment(s) is severe. In addition, if, after completing development and considering all of the evidence, the adjudicator is unable to determine clearly the effect of an impairment(s) on the individual's ability to do basic work activities, the adjudicator must continue to follow the sequential evaluation process until a determination or decision about disability can be reached.

Effective Date

This Ruling is effective on July 2, 1996.

Cross-References

SSR 85-28, "Titles II and XVI: Medical Impairments That are Not Severe," SSR 96-4p, "Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations," and SSR 96-7p, "Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements;" and Program Operations Manual System, sections DI 24505.001, DI 24505.005, DI 24515.061, DI 25215.005, DI 25225.001, DI 26515.005, DI 26515.015, and DI 26516.010.

[FR Doc. 96-16686 Filed 7-1-96; 8:45 am]

BILLING CODE 4190-29-P

[Social Security Ruling (SSR) 96-1p]

Application by the Social Security Administration (SSA) of Federal Circuit Court and District Court Decisions

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling.

SUMMARY: In accordance with 20 CFR 422.406(b)(1), the Commissioner of Social Security gives notice of Social Security Ruling 96-1p. This Ruling clarifies SSA's longstanding policies that (1) unless and until a Social Security Acquiescence Ruling is issued determining that a final circuit court holding conflicts with the Agency's interpretation of the Social Security Act or regulations and explaining how SSA will apply such a holding, SSA decisionmakers will continue to be bound by SSA's nationwide policy, rather than the court's holding, in adjudicating other claims within that circuit court's jurisdiction, and (2) despite a district court decision which may conflict with SSA's interpretation of the Social Security Act or regulations, SSA adjudicators will continue to apply SSA's nationwide policy when adjudicating other claims within that district court's jurisdiction unless the court directs otherwise.

This Ruling does not in any way modify SSA's acquiescence policy to which the Agency continues to remain firmly committed, but instead serves to emphasize consistent adjudication in the programs SSA administers.

EFFECTIVE DATE: July 2, 1996.

FOR FURTHER INFORMATION CONTACT: Joanne K. Castello, Division of Regulations and Rulings, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, (410) 965-1711.

SUPPLEMENTARY INFORMATION: Although we are not required to do so pursuant to 5 U.S.C. 552 (a)(1) and (a)(2), we are publishing this Social Security Ruling in accordance with 20 CFR 422.406(b)(1).

Social Security Rulings make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. Social Security Rulings may be based on case decisions made at all administrative levels of adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, and other policy interpretations of the law and regulations.

Although Social Security Rulings do not have the force and effect of the law or regulations, they are binding on all components of the Social Security Administration, in accordance with 20 CFR 422.406(b)(1), and are to be relied upon as precedents in adjudicating cases.

If this Social Security Ruling is later superseded, modified, or rescinded, we will publish a notice in the Federal Register to that effect.

(Catalog of Federal Domestic Assistance, Programs 96.001 Social Security—Disability Insurance; 96.002 Social Security—Retirement Insurance; 96.004 Social Security—Survivors Insurance; 96.005 Special Benefits for Disabled Coal Miners; 96.006 Supplemental Security Income)

Dated: June 7, 1996.

Shirley S. Chater,

Commissioner of Social Security.

Policy Interpretation Ruling

Application by the Social Security Administration (SSA) of Federal Circuit Court and District Court Decisions

Purpose: To clarify longstanding policy that, unless and until a Social Security Acquiescence Ruling (AR) is issued determining that a final circuit court holding conflicts with the Agency's interpretation of the Social Security Act or regulations and explaining how SSA will apply such a holding, SSA decisionmakers continue to be bound by SSA's nationwide policy, rather than the court's holding, in adjudicating other claims within that circuit court's jurisdiction. This Ruling does not in any way modify SSA's acquiescence policy to which the Agency continues to remain firmly committed, but instead serves to emphasize consistent adjudication in the programs SSA administers. This Ruling is also issued to clarify longstanding Agency policy that, despite a district court decision which may conflict with SSA's interpretation of the Social Security Act or regulations, SSA adjudicators will continue to apply SSA's nationwide policy when adjudicating other claims within that district court's jurisdiction unless the court directs otherwise.

Citations (Authority): Sections 205(a), 702(a)(5) and 1631(d) of the Social Security Act; Sections 413(b), 426(a) and 508 of the Black Lung Benefits Act; Regulations No. 4, section 404.985; Regulations No. 10, section 410.670c; Regulations No. 16, section 416.1485; Regulations No. 22, section 422.406.

Background: Final regulations on the application of circuit court law in the Social Security, Supplemental Security Income, and Black Lung programs were published in the Federal Register on January 11, 1990 (55 FR 1012). SSA first adopted the acquiescence policy set forth in these rules in 1985, with the details evolving over the next 5 years. These rules explain how SSA acquiesces in circuit court law which conflicts with Agency policy: it does so by issuing an AR for a final circuit court decision which SSA determines is in conflict with the Agency's interpretation of the Social Security Act or regulations. 20 CFR 404.985(b), 410.670c(b) and 416.1485(b). The AR, which is issued through publication in the Federal Register, describes the administrative case and the court decision, identifies the issue(s), explains how the court decision differs from SSA policy, and

explains how SSA will apply the court holding, instead of its nationwide policy, when deciding claims within the applicable circuit. ARs apply at all steps in the administrative process within the applicable circuit unless the court decision, by its nature, applies only at certain steps in this process. In the latter case, the AR may be so limited.

As of the effective date of this Ruling, SSA had issued a total of 62 ARs, averaging about 3–4 ARs per year in recent years; 47 of those ARs are still in effect. The majority of the ARs issued by SSA to date have dealt with nondisability issues, although a significant portion have dealt directly with the disability determination process. Decisions for which ARs are issued often involve complex and difficult issues. The court's holding may be unclear in its scope and susceptible to differing interpretations. Despite these difficulties, no AR has been found to be inadequate by the circuit court which issued the underlying decision.

Policy Interpretation: Unless and until an AR for a circuit court holding has been issued, SSA adjudicates other claims within that circuit by applying its nationwide policy. The preamble to the final acquiescence regulations published on January 11, 1990, explained the basis for this approach in responding to a public comment suggesting that administrative law judges (ALJs) and the Appeals Council should be allowed to apply circuit court holdings without the benefit of an Acquiescence Ruling:

> [W]e have not adopted this comment. First, under this final acquiescence policy, Acquiescence Rulings apply to all levels of adjudication, not only to the ALJ and Appeals Council levels, unless a holding by its nature applies only to certain levels of adjudication. Thus, the approach suggested in this comment would create different standards of adjudication at the different levels of administrative review. Second, interpreting and applying a circuit court holding is not always a simple matter, as we noted previously.[1] Finally, by statute, establishing policy is the Secretary's[2] responsibility; adjudicators are responsible for applying that policy to the facts in any given case. Therefore, we believe that to ensure the uniform and consistent adjudication necessary in the administration of a national program, the agency must analyze court decisions and provide adjudicators as specific a statement as possible explaining the agency's interpretation of a court of appeals holding, as well as providing direction on how to apply the holding in the course of adjudication.
>
> 55 FR 1013 (1990).

As explained in SSA's regulations at 20 CFR 404.985(b), 410.670c(b), and 416.1485(b), if SSA makes an administrative determination or decision on a claim between the date of a circuit court decision and the date of issuance of an AR for that decision, the claimant, upon request, is permitted to have the claim readjudicated by demonstrating that application of the AR could change the result. Thus, as explained in the preamble to the acquiescence regulations, a readjudication procedure is provided which allows a claimant, whose application was adjudicated during the interim period between a circuit court decision and the issuance of an AR for that decision, to seek immediate application of the AR once it is issued, without the necessity of appeal. 55 FR 1013 (1990).

Finally, in accordance with its regulations, SSA acquiesces only in decisions of the Federal circuit courts, and not in decisions of Federal district courts within a circuit. Thus, despite a district court decision which may conflict with SSA's interpretation of the Social Security Act or regulations, SSA adjudicators will continue to apply SSA's nationwide policy when adjudicating other claims within that district court's jurisdiction unless the court directs otherwise such as may occur in a class action.

Effective Date: This Ruling, which reflects longstanding procedures which SSA continues to believe represent the most effective and fair way to implement its acquiescence policy, is effective on July 2, 1996. This Ruling does not apply to the claims of New York disability claimants who are covered by the court-approved settlement in *Stieberger* v. *Sullivan*.

[FR Doc. 96–16684 Filed 7–1–96; 8:45 am]

BILLING CODE 4190–29–P

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[1] The preamble previously noted that, "Whether or not the holding of a particular circuit court decision 'conflicts' with our policy is not always clear . . ." 55 FR 1012 (1990).

[2] As a result of Pub. L. 103–296, the Social Security Independence and Program Improvements Act of 1994, which made SSA an independent agency separate from the Department of Health and Human Services effective March 31, 1995, the responsibility for establishing policy now resides with the Commissioner of Social Security, rather than the Secretary of Health and Human Services.

Social Security Ruling (SSR) 96–5p. Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling.

SUMMARY: In accordance with 20 CFR 422.406(b)(1), the Commissioner of Social Security gives notice of Social Security Ruling 96–5p. This Ruling clarifies Social Security Administration policy on how we consider medical source opinions on issues reserved to the Commissioner of Social Security, including whether an individual's impairment(s) meets or is equivalent in severity to the requirements of any impairment(s) in the Listing of Impairments in appendix 1, subpart P of 20 CFR part 404 of the Social Security Administration regulations; what an individual's residual functional capacity is; whether an individual's residual functional capacity prevents him or her from performing past relevant work; how the vocational factors of age, education, and work experience apply; and whether an individual is "disabled" under the Social Security Act.

EFFECTIVE DATE: July 2, 1996.

FOR FURTHER INFORMATION CONTACT: Joanne K. Castello, Division of Regulations and Rulings, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, (410) 965–1711.

SUPPLEMENTARY INFORMATION: Although we are not required to do so pursuant to 5 U.S.C. 552(a)(1) and (a)(2), we are publishing this Social Security Ruling in accordance with 20 CFR 422.406(b)(1).

Social Security Rulings make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. Social Security Rulings may be based on case decisions made at all administrative levels of adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, and other policy interpretations of the law and regulations.

Although Social Security Rulings do not have the force and effect of the law or regulations, they are binding on all components of the Social Security Administration, in accordance with 20 CFR 422.406(b)(1), and are to be relied upon as precedents in adjudicating cases.

If this Social Security Ruling is later superseded, modified, or rescinded, we will publish a notice in the Federal Register to that effect.

(Catalog of Federal Domestic Assistance, Programs 96.001 Social Security—Disability Insurance; 96.002 Social Security—Retirement Insurance; 96.004 Social Security—Survivors Insurance; 96.005 Special Benefits for Disabled Coal Miners; 96.006 Supplemental Security Income.)

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

April 29, 1997

The Honorable John J. Callahan
Acting Commissioner of Social Security
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Acting Commissioner Callahan:

Early last week, I saw an article in the *New York Times* regarding the Administration adopting Circuit Court decisions with which it disagrees. As you know, the Subcommittee on Social Security has focused a great deal of attention examining the disability appeals process and the public service impacts of mounting case backlogs, particularly at the appellate level. I, along with the Members of this Subcommittee, am particularly concerned about whether and when the Administration does not adopt Circuit Court decisions with which it disagrees.

For your information, attached is a letter I have sent to the Attorney General of the United States seeking clarification of this matter. I am also interested in hearing directly from you, regarding the following:

1. What is the Social Security Administration's (SSA's) policy regarding acquiescence?

2. Is SSA's policy on acquiescence consistent with that of the Department of Justice?

3. On average, how long does it take SSA to issue an Acquiescence Ruling once it decides not to ask Justice to seek further judicial review?

4. How many Acquiescence Rulings are pending?

5. In recent testimony before the Subcommittee, Deputy Commissioner Colvin mentioned that one of SSA's initiatives includes streamlining the process for issuing these rulings. What, specifically, are you planning to do?

I appreciate your sharing this information with me at your earliest convenience. If you or your staff have any questions concerning this request, please contact Kim Hildred, Subcommittee Staff Director at (202) 225-9263.

Best personal regards,

Jim Bunning

JIM BUNNING
Chairman

cc: The Honorable Barbara Kennelly

12. Judge Bernoski also asked the question "how does an agency 'manage' the administrative hearing process and not trample on the rights of the claimants?" How do you respond?

As the January 28, 1997, Office of the General Counsel memorandum makes clear, part of the agency's responsibility in managing the administrative hearing process is to ensure that the rights of the claimants are protected, and that the agency's adjudicators are conducting themselves appropriately through the hearing process, including issuing fair and legally sufficient decisions. If a claimant believes that the hearing process used to decide the case did not comport with legal requirements, he or she can appeal the decision through the administrative appeals process and seek review in federal court. It would be far more likely that the rights of individual claimants would be "trampled" if each ALJ were free to determine for himself or herself what the proper procedures and policy should be, than under the current system in which it is the agency which promulgates rules and regulations, in accordance with statute, to protect claimants' rights and can be held accountable for ensuring that such rules and regulations are properly administered.

13. In his testimony, Judge Bernoski indicated that the largest distinguishing factor for difference in results between DDSs and ALJs is the use of the legal standard at the appellate level which provides the claimant with the benefit of the full scope of the law for the adjudication of the claim. The DDS standard is set forth in instructions used only by DDS decisionmakers and not the judges (these are referred to as POMS). What are your views?

For the past two years, SSA has had a workgroup of senior SSA and DDS officials studying the disability process at both the DDS and ALJ levels. This included looking at the so-called "medical" versus "legal" model. We have concluded that disability is now, and always has been, a medical-legal issue, and we disagree with Judge Bernoski that the largest distinguishing factor for difference in results is "the use of the legal standard at the appellate level."

SSA has also looked extensively at the regulations, rulings, and POMS that provide instructional guidance to our adjudicators and concluded that there is no substantive difference between the regulations and rulings used by the ALJs and the POMS used by the DDSs. In other words, there is not a different substantive legal standard applied at the appellate level. However, we are aware that there is a perception by some (such as Judge Bernoski) that the different instructional materials result in differences. That is why we are preparing a single presentation of policy that will be used by all decisionmakers.

Finally, there are some differences between the DDS and ALJ levels that are intentional. The ALJ conducts a formal hearing in which the claimant can appear before an ALJ and has due process rights, such as the right to request subpoenas and to cross-examine witnesses. These procedural differences naturally have some affect on the ALJ decisions; however, the policies for determining disability are the same for all adjudicative levels.

Chairman BUNNING. Thank you. Thank you all for your testimony. We appreciate it very much.

If the next panel would come forward.

GAO, the General Accounting Office, at my request, has been investigating SSA's management of the disability program with particular focus on the reasons for differences in DDS and ALJ decisions. Presenting the GAO findings are Jane Ross, the Director, and Cynthia Bascetta, Assistant Director of Income Security Issues of the Health, Education, and Human Services Division.

Ms. Ross, would you please begin, once you get settled.

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 DIVISION

Ms. ROSS. Good morning, Mr. Chairman. Thank you for inviting me to testify on SSA's management of its disability programs.

My testimony is based on our reports and ongoing study which we are conducting for you. As you know and as you have just heard, SSA set out in 1994 to redesign disability decisionmaking to improve its timeliness, efficiency, and consistency. It undertook redesign because the lengthy and complicated decisionmaking process and the inconsistent decisions between adjudicative levels compromise the integrity of disability determinations and result in poor service for people applying for benefits.

SSA has an opportunity now if it follows through on its plans to finally address some of the longstanding problems with disability decisionmaking.

I want to talk briefly about the number of cases awaiting ALJ hearings. This backlog began to grow dramatically in 1987. By 1996 the backlog had reached 475,000 cases. The huge increases in the number of appeals contributed to a rise in averaging processing time which now exceeds 375 days.

SSA acted to try and reduce this backlog by developing their short-term disability project, and under this project, SSA staff review and attempt to resolve appealed cases before they are actually assigned to ALJs, but despite this short-term initiative, the agency wasn't able to reach its goal, so the current backlog is now about 491,000 cases.

The point we would like to make here is, even though the goal hasn't been reached, about 98,000 more cases would have been added to the backlog without this short-term initiative. So we urge SSA to continue its short-term effort while it is moving ahead to more fundamentally change their disability determination process.

Besides the backlog, high ALJ allowances have been a subject of concern for many years, as you have said. Because ALJs allow about two-thirds of all the cases they decide, there is a real incentive for claimants to appeal, and indeed, for several years, about three-quarters of everyone whose claim has been denied at the DDS reconsideration level has appealed their claims.

Under Process Unification, which is a part of SSA's redesign plan, several initiatives were developed specifically with the objective of achieving similar decisions on similar cases regardless of whether the case was decided at the DDS or ALJ level.

SSA expects that improving the consistency of decisions will result in a substantial reduction in the proportion of appealed cases and a reduction of ALJ allowance rates as well.

You can observe in table 1 of the written testimony you may have before you the current high rate of inconsistency between DDSs and ALJs. You can notice that DDS award rates vary by impairment type from 11 percent for back impairments to 54 percent for mental retardation.

In contrast, ALJ award rates are uniformly high, with much smaller amounts of variation. For physical impairments, as you can see on the table, ALJs award about 74 percent of their claims, and for mental impairments, about 87 percent.

We were able to determine three major reasons for these inconsistencies. Briefly, it has to do with the differences in approach between ALJs and DDSs, the difference in their procedures, and the difference in their quality assurance reviews.

Let me just summarize my conclusion. SSA is on the verge of implementing several initiatives to reduce these three sources of inconsistency and issued rulings last July to remind DDSs and ALJs of agency policies related to evaluating evidence and following the Commissioner's guidance.

They also plan to return to DDSs about 100,000 cases a year for further consideration when new evidence is introduced at the ALJ level and to review about 10,000 ALJ awards per year to assure the ALJ allowances are appropriate, but here is our major point we would like to emphasize.

There are other high priority issues that are causing workload pressures for SSA, for all of their adjudicators. For instance, SSA is required to conduct hundreds of thousands more continuing disability reviews to ensure that beneficiaries are still eligible for benefits. They are required to readjudicate over 300,000 childhood disability cases by February 1998. Our concern is how they are going to be able to manage all of these initiatives at the same time, along with keeping a high priority on Process Unification.

To follow through on its initiatives to address the longstanding problem of decisional inconsistency, we believe that SSA, in consultation with this Subcommittee and others, will need to sort through its many priorities and do a better job of holding itself accountable for meeting its deadlines. Otherwise, plans and target dates will remain elusive goals and may never yield the benefits of helping to restore public confidence in decisionmaking and improving service to the public.

Mr. Chairman, this concludes my prepared statement. I would be glad to answer your questions.

[The prepared statement follows:]

Statement of Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

SSA ACTIONS TO REDUCE BACKLOGS AND ACHIEVE MORE CONSISTENT DECISIONS DESERVE HIGH PRIORITY

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to testify on the Social Security Administration's (SSA) management of the Disability Insurance (DI) and Supplemental Security Income (SSI) programs. In 1995, these programs paid benefits approaching $60 billion a year and served nearly 7 million working-age adults. As you are aware, SSA's process has been overwhelmed with a large number of appealed cases, which grew from about 225,000 in fiscal year 1986 to about 498,000 in fiscal year 1996.

Today I will discuss actions that SSA undertook, beginning in 1994, to improve the timeliness, efficiency, and consistency of disability decisions. Its actions resulted from a realization that the lengthy and complicated decision-making process and the inconsistency of decisions between adjudicative levels compromise the integrity of disability determinations. More specifically, I will describe SSA's actions to reduce the current backlog of cases appealed to the agency's administrative law judges (ALJ). Then I will discuss how functional assessments, differences in procedures, and quality review contribute to inconsistent results between different

decisionmakers and describe SSA's strategy to obtain greater decisional consistency. My testimony is based on our reports and our ongoing studies of SSA's disability programs being conducted for the Chairman of the Subcommittee. (See the list of related GAO products.)

In summary, our work shows that while SSA has developed broad-based plans to improve the management of its disability programs, many initiatives are just beginning and their effectiveness can be assessed only after a period of full-scale implementation. For example, in the short term, SSA has taken action to try to deal with the backlog crisis, but it is still about 116,000 cases over its December 1996 goal of 375,000 cases. In the longer term, SSA needs to come to grips with the systemic factors causing inconsistent decisions, which underlie the current high level of appealed cases and, in turn, the backlog crisis. For example, we found that differences in assessments of functional capacity, different procedures, and weaknesses in quality reviews contribute to inconsistent decisions. Although SSA is on the verge of implementing initiatives to deal with these factors, we are concerned that other congressionally mandated workload pressures, such as significantly increasing the number of continuing disability reviews and readjudicating childhood cases, could jeopardize the agency's ability to move ahead with its initiatives to reduce inconsistent decisions.

BACKGROUND

SSA's disability programs provide cash benefits to people with long-term disabilities. The DI program provides monthly cash benefits and Medicare eligibility to severely disabled workers; SSI is an income assistance program for blind and disabled people. The law defines disability for both programs as the inability to engage in substantial gainful activity because of a severe physical or mental impairment that is expected to last at least 1 year or result in death.

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 at the DDSs, a disability examiner and a medical consultant (physician or psychologist) make the initial determination of whether the applicant meets the definition of disability. Denied claimants may ask the DDS to reconsider its finding and, if denied again, may appeal to an ALJ within SSA's Office of Hearings and Appeals (OHA). The ALJ usually conducts a hearing at which applicants and medical or vocational experts may testify and submit new evidence. Applicants whose appeals are denied may request review by SSA's Appeals Council and may further appeal the Council's decision in federal court.

Between fiscal years 1986 and 1996, the increasing number of appealed cases has caused workload pressures and processing delays. During that time, appealed cases increased more than 120 percent. In the last 3 years alone, average processing time for appealed cases rose from 305 days in fiscal year 1994 to 378 days in fiscal year 1996 and remained essentially the same for the first quarter of fiscal year 1997. In addition, "aged" cases (those taking 270 days or more for a decision) increased from 32 percent to almost 43 percent of the backlog.[1]

In addition to the backlog, high ALJ allowances (in effect, "reversals" of DDS decisions to deny benefits[2]) have been a subject of concern for many years. Although the current ALJ allowance rate has dropped from 75 percent in fiscal year 1994, ALJs still allow about two-thirds of all disability claims they decide. Because chances for award at the appeals level are so favorable, there is an incentive for claimants to appeal. For several years, about three-quarters of all claimants denied at the DDS reconsideration level have appealed their claims to the ALJ level.[3]

In 1994, SSA adopted a long-term plan to redesign the disability decision-making process to improve its efficiency and timeliness. As a key part of this plan, SSA developed initiatives to achieve similar decisions on similar cases regardless of whether the decisions are made at the DDS or the ALJ level. In July 1996, several of these initiatives, called "process unification," were approved for implementation by SSA's Commissioner. SSA expects that process unification will result in correct decisions being made at the earliest point possible, substantially reducing the proportion of appealed cases and ALJ allowance rates as well.

Because SSA expects that implementation of its redesigned disability decision-making process will not be completed until after the year 2000, SSA developed a Short Term Disability Project Plan (STDP) to reduce the existing backlog by intro-

[1] Processing time represents total OHA workloads, which include appealed Medicare cases.
[2] ALJ decisions are said to be de novo, or "afresh."
[3] About one-third of claimants denied at the initial DDS-level appeal, while the rest abandon their cases.

ducing new procedures and reallocating staff. STDP is designed to expedite processing of claims in a way that will support redesign and achieve some near-term results in reducing the backlog. SSA expects that STDP's major effect will come primarily from two initiatives—regional screening unit and prehearing conferencing activities. In the screening units, DDS staff and OHA attorneys work together to identify claims that could be allowed earlier in the appeals process. Prehearing conferencing shortens processing time for appealed cases by assigning OHA attorneys to perform limited case development and review cases to identify those that could potentially be allowed without a formal hearing. The plan called for reducing the backlog to 375,000 appealed cases by December 31, 1996.

DESPITE SSA'S EFFORTS, SSA STILL FACES A HIGH BACKLOG

Despite SSA attempts to reduce the backlog through its STDP initiatives, the agency did not reach its goal of reducing this backlog to 375,000 by December 1996.[4] SSA attributes its difficulties in meeting its backlog target to start-up delays, overly optimistic projections of the number of appealed cases that would be processed, and an unexpected increase in the number of appealed cases. The actual backlog in December was about 486,000 cases and has risen in the last few months to 491,000 cases, still about 116,000 over its goal. Although SSA did not reach its backlog goal, about 98,000 more cases may have been added to the backlog if STDP steps had not been undertaken. The contribution made by STDP underscores the need for SSA to continue its short-term effort while moving ahead to address the disability determination process in a more fundamental way in the long term.

DECISION-MAKING PROCESS YIELDS HIGH DEGREE OF INCONSISTENCY BETWEEN DDSS AND ALJS

In addition to the backlog problem, SSA's decision-making process has produced a high degree of inconsistency between DDS and ALJ awards, as shown in table 1. Although award rates representing DDS decision-making vary by impairment, ALJ award rates are high regardless of the type of impairment. For example, sample data showed that DDS award rates ranged from 11 percent for back impairments to 54 percent for mental retardation. In contrast, ALJ award rates averaged 77 percent for all impairment types with only a smaller amount of variation among impairment types.

Table 1: Award Rates at DDS and ALJ Levels by Impairment Type

	DDS award rates (percent)	ALJ award rates (percent)
Physical	29	74
Musculoskeletal	16	75
Back cases	11	75
Other musculoskeletal	23	76
Other physical	36	74
Mental	42	87
Illness	39	87
Retardation	54	84
All impairments	30	77

Note: ALJ data are from an ongoing SSA study. Data include ALJ cases decided from September 1, 1992, through April 30, 1995. Study samples excluded certain types of cases, such as children's cases. DDS data for the same period and types of cases were obtained from SSA's administrative database.

Disability Determinations Require Complex Judgment

SSA's process requires adjudicators to use a five-step sequential evaluation process in making their disability decisions (see table 2). Although this process provides a standard approach to decision-making, determining disability often requires that a number of complex judgments be made by adjudicators at both the DDS and ALJ levels.

[4] SSA's goal included Medicare claims, which ALJs also decide. However, the STDP initiatives focused only on disability claims, which represented about 94 percent of the backlog in fiscal year 1996.

Table 2: Five-Step Sequential Evaluation Process for Determining Disability

Step	Questions asked in the sequential process	Action or decision taken if answer to question is:	
		Yes	No
1	Is the claimant engaging in substantial gainful activity?.	Stop—claimant is not disabled.	Go to step 2
2	Does the claimant have an impairment that has more than a minimal effect on the claimant's ability to perform basic work tasks and is expected to last at least 12 months?.	Go to step 3	Stop—claimant is not disabled
3	Do the medical facts alone show that the claimant's impairment meets or equals the medical criteria for an impairment in SSA's Listing of Impairments?.	Stop—claimant is disabled.	Go to step 4
4	Comparing the claimant's residual functional capacity with the physical and mental demands of the claimant's past work, can the claimant perform his or her past work?.	Stop—claimant is not disabled.	Go to step 5
5	Based on the claimant's residual functional capacity and any limitations that may be imposed by the claimant's age, education, and skill level, can the claimant do work other than his or her past work?.	Claimant is not disabled.	Claimant is disabled

As the application proceeds through the five-step process, claimants may be denied benefits at any step, ending the process. Steps 1 and 2 ask questions about the claimant's work activity and the severity of the claimant's impairment. If the reported impairment is judged to be severe, adjudicators move to step 3. At this step, they compare the claimant's condition to a listing of medical impairments developed by SSA. Claimants whose conditions meet or are medically equivalent to the listings are presumed by SSA to be unable to work and are awarded benefits. Claimants whose conditions do not meet or equal the listings are then assessed at steps 4 and 5, where decisions must be made about the claimant's ability to perform prior work and any other work that exists in the national economy. To do this, adjudicators assess the claimant's capacity to function in the workplace.

DDS and ALJ adjudicators exercise considerable judgment when making these functional assessments. They must consider and weigh all available evidence, including physician opinions and reported symptoms, such as pain. Mental impairment assessments include judgments about the claimant's ability to understand, remember, and respond appropriately to supervision and normal work pressures. For physical impairments, adjudicators judge the claimant's ability to walk, sit, stand, and lift. To facilitate this, SSA has defined five levels of physical exertion ranging from very heavy to sedentary. However, for those claimants unable to perform even sedentary activities, adjudicators may determine that a claimant can perform "less than a full range of sedentary" activities, a classification that often results in a benefit award.

DDSs and ALJs Differ Primarily Over Claimant's Functional Abilities

Our analysis found that differing functional assessments by DDSs and ALJs are the primary reason for most ALJ awards. Since most DDS decisions use all five steps of the sequential evaluation process before denying a claim, almost all DDS denial decisions appealed to ALJs included such a functional assessment. On appeal, the ALJ also follows the same sequential evaluation process as the DDS and also assesses the claimant's functional abilities in most awards they make.

Data from SSA's ongoing ALJ study indicate that ALJs are much more likely than DDSs to find that claimants have severe limitations in functioning in the workplace (see table 3).

Table 3: DDS and ALJ Differences in Functional Assessment Classifications for Physical Impairment Awards

Level of physical exertion determined by functional assessment	Percentage of awards	
	Quality reviewers using DDS approach	Original awarding ALJs
Heavy work (or no limiting effect on physical effort)	0	0
Medium work	22	1
Light work	56	8
Sedentary work	15	25
Less than the full range of sedentary work	6	66

Note: Data are for ALJ awards made from September 1992 through April 1995.

Most notably, in the view of the awarding ALJs, 66 percent of the cases merited a functional capacity assessment of "less than the full range of sedentary" work—a classification that is likely to lead to an award. In contrast, reviewers, using the DDS approach, found that less than 6 percent of the cases merited this classification.

Functional assessment also played a key role in a 1982 SSA study, which controlled for differences in evidence. This study indicated that DDS and ALJ decision-makers reached different results even when presented with the same evidence.[5] As part of the study, selected cases were reviewed by two groups of reviewers—one group reviewing the cases as ALJs would and the other reviewing the cases as DDSs would. Reviewers using the ALJ approach concluded that 48 percent of the cases should have received awards, while reviewers using the DDS approach concluded that only 13 percent of those same cases should have received awards.

The use of medical expertise appears to influence the decisional differences at the DDS and ALJ levels. At the DDS level, medical consultants are responsible for making functional assessments. In contrast, ALJs have the sole authority to determine functional capacity and often rely on claimant testimony and the opinions of treating physicians. Although ALJs may call on independent medical experts to testify, our analysis shows that they do so in only 8 percent of the cases resulting in awards.

To help reduce inconsistency, SSA issued nine rulings on July 2, 1996, which were written to address pain and other subjective symptoms, treating source opinions, and assessing functional capacity.[6] SSA also plans to issue a regulation to provide additional guidance on assessing functional capacity at both the DDS and ALJ levels, specifically clarifying when a "less than sedentary" classification is appropriate.[7] In addition, based on the nine rulings, SSA completed nationwide process unification training of over 15,000 adjudicators and quality reviewers between July 10, 1996, and February 26, 1997. In the training, SSA emphasized that it expects the "less than sedentary" classification would be used rarely. In the longer term, SSA plans to develop a simplified decision-making process, which will expand the role of functional capacity assessments. Because differences in functional capacity assessments are the primary reason for inconsistent decisions, SSA should proceed cautiously with its plan to expand the use of such assessments.

Procedures Limit Use of DDS Decisions as a Foundation for ALJ Decisions

Procedures at the DDS and ALJ levels limit the usefulness of the DDS decision as a foundation for the ALJ decision. Often, ALJs are unable to rely on DDS decisions because they lack supporting evidence and explanations of the reasons for denial, laying a weak foundation for the ALJ decision if the case is appealed. Moreover, although SSA requires ALJs to consider the DDS medical consultant's assessment of functional capacity, procedures at the DDS level do not ensure that such assessments are clearly explained. In a 1994 study, SSA found that written explanations of critical issues at the DDS level were inadequate in about half of the ap-

[5] 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, SSA, Department of Health and Human Services (Jan. 1982). This report is commonly known as the "Bellmon Report."

[6] Federal Register, 61 F.R. 34466–34492 (July 2, 1996).

[7] SSA told us that the notice of proposed rulemaking on the "less than sedentary" regulations is ready for release but did not provide the date when it would be issued.

pealed cases that turned on complex issues.[8] Without a clear explanation of the DDS decision, the ALJ could neither effectively consider it nor give it much weight.

At the ALJ level, claimants are allowed to claim new impairments and submit new or additional evidence, which also affects consistency between the two levels. Moreover, in about 10 percent of cases appealed to the ALJ level, claimants switch their primary impairment from a physical claim to a mental claim. In addition, data from a 1994 SSA study show that claimants submit additional evidence to the ALJ in about three-quarters of the sampled cases, and that additional evidence was an important factor in 27 percent of ALJ allowances.

To address the documentation issues, SSA plans to take steps to ensure that DDS decisions are better explained and are based on a more complete record so that they are more useful if appealed. On the basis of feedback during the process unification training, SSA plans further instructions and training in May 1997 for the DDSs on how and where in the case files they should explain how they reached their decisions. SSA also plans to issue a regulation clarifying the weight given to the DDS medical consultants' opinions at the ALJ level.[9]

To deal with the potential effect of new evidence, SSA plans to return to the DDSs about 100,000 selected cases a year for further consideration when new evidence is introduced at the ALJ level. In cases where the DDS would award benefits, the need for a more time-consuming and costly ALJ decision would be avoided. SSA plans to implement this project in May 1997. Moreover, SSA's decision to limit such returns to about 100,000 cases may need to be reassessed in light of the potential benefits that could accrue from this initiative.

Quality Reviews do not Focus on Inconsistency Between DDSs and ALJs

Although SSA has several quality review systems to examine disability decisions, none is designed to identify and reconcile factors that contribute to differences between DDS and ALJ decisions. For example, although ALJs are required to consider the opinion of the DDS medical consultant when making their own assessment of a claimant's functional capacity, such written DDS opinions are often lacking in the case files. Quality reviews at the DDS level do not focus effectively on whether or how well these opinions are explained in the record, despite the potential importance of such medical opinion evidence at the ALJ level. Moreover, SSA reviews too few ALJ awards to ensure that ALJs give appropriate consideration to the medical consultants' opinions or to identify means to make them more useful to the ALJs. Feedback on these issues could help improve consistency by making the DDS decision a more useful part of the overall adjudication process.

To improve consistency, SSA is completing work on a notice of proposed rulemaking, with a target issue date of August 1997 for a final regulation, to establish the basis for reviewing ALJ awards, which would require ALJs to take corrective action on remand orders from the Appeals Council before benefits are paid. SSA has just started conducting preliminary reviews of ALJ awards, beginning with 200 cases a month. After the regulation is issued, they plan to increase the number of cases per month. SSA has set a first-year target of 10,000 cases to be reviewed, but this reflects only about 3 percent of approximately 350,000 award decisions made by ALJs in 1996. Ultimately, SSA plans to implement quality review measures to provide consistent feedback on the application of policy. By doing this, the agency hopes to ensure that the correct decision is made at the earliest point in the process.

Competing Workloads Could Jeopardize Initiatives to Improve Consistency of Decisions

At the same time that SSA is trying to begin implementation of its process unification initiatives, it faces significantly increasing workloads at all levels of adjudication. In particular, efforts to improve decisional consistency will compete with specific congressional mandates for time and resources. For example, the Social Security Independence and Program Improvements Act of 1994 and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 require hundreds of thousands of more continuing disability reviews (CDR) to ensure that beneficiaries are still eligible for benefits. By law, SSA will be required to conduct CDRs for at least 100,000 more SSI beneficiaries annually through fiscal year 1998. Last year, the Congress increased CDR requirements for children on SSI, requiring them at least every 3 years for children under age 18 who are likely to improve and for all

[8] Findings of the Disability Hearings Quality Review Process, Office of Program and Integrity Reviews, Social Security Administration (Sept. 1994).

[9] SSA told us that the notice of proposed rulemaking on the DDS medical consultants' opinions is in final clearance within SSA.

low-birthweight babies within the first year of life. In addition, SSA is required to redetermine, using adult criteria, the eligibility of all 18-year-olds on SSI beginning on their 18th birthdays and to readjudicate 332,000 childhood disability cases by August 1997. Finally, thousands of noncitizens and drug addicts and alcoholics could appeal their benefit terminations, further increasing workload pressures.

CONCLUDING OBSERVATIONS

Despite SSA's Short Term Disability Project Plan, the appealed case backlog is still high. Nevertheless, because the backlog would have been even higher without STDP, SSA will need to continue its effort to reduce the backlog to a manageable level until the agency, as a part of its long-term redesign effort, institutes a permanent process to ensure timely and expeditious disposition of appeals.

In addition, SSA is beginning to move ahead with more systemwide changes in its redesign of the disability claims process. In particular, it is on the verge of implementing initiatives to redesign the process, including ones for improving decisional consistency and the timeliness of overall claims processing. However, competing workload demands could jeopardize SSA's ability to make progress in reducing inconsistent decisions.

We urge the agency to follow through on its initiatives to address the long-standing problem of decisional inconsistency with the sustained attention required for this difficult task. To do so, SSA, in consultation with this Subcommittee and others, will need to sort through its many priorities and do a better job of holding itself accountable for meeting its deadlines. Otherwise, plans and target dates will remain elusive goals and may never yield the dual benefits of helping to restore public confidence in the decision-making process and contributing to permanent reductions in backlog.

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.

For more information on this testimony, please call Cynthia Bascetta, Assistant Director, at (202) 512–7207. Other major contributors are William Hutchinson, Senior Evaluator; Carol Dawn Petersen, Senior Economist; and David Fiske, Ellen Habenicht, and Carlos Evora, Senior Evaluators.

RELATED GAO PRODUCTS

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Social Security Disability: Management Action and Program Redesign Needed to Address Long-Standing Problems (GAO/T–HEHS–95–233, Aug. 3, 1995).

Disability Insurance: Broader Management Focus Needed to Better Control Caseload (GAO/T–HEHS–95–233, May 23, 1995).

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

Social Security Disability: SSA Quality Assurance Improvements Can Produce More Accurate Payments (GAO/HEHS–94–107, June 3, 1994).

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

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).

Social Security: Results of Required Reviews of Administrative Law Judge Decisions (GAO/HRD–89–48BR, June 13, 1989).

Chairman BUNNING. Thank you, Ms. Ross.

In reading your testimony, it is clear the ALJ association has a number of disagreements with many of your findings. Did GAO talk to the ALJs in conducting its work for this study?

Ms. ROSS. First of all, let me just say that our study hasn't been released yet. So I am not sure what it is the ALJ association is actually objecting to, except, perhaps, a one-page summary that went out with your hearing notice, but more specifically to the point of whom we talked to, we talked to the current acting president of the ALJ association, as well as the former president. In addition, we talked to 20 administrative law judges and some regional chief judges and hearing office judges. So we think we have done a very good job of making the ALJ context at the whole range of the ALJ level, but let me also say the major focus of the work we are doing for you is a data analysis. We are looking at the data on how these inconsistencies occur, where and why. We are using our interviews to confirm what we find, but the major thing is a solid analysis from data that SSA has shared with us.

Chairman BUNNING. In looking at that data, as you say GAO is doing, do you find the disability determination being done on a medical or legal basis?

Ms. ROSS. I think the appropriate answer is that disability determination is a mix of the two. On the medical dimension, both the DDSs and the ALJs are required to go through a fairly extensive sequential evaluation of a person's impairment. Is it severe? Does it meet medical listings? Does it allow people to continue to function in the workplace? So both the ALJ and the DDS examiner are supposed to use that same set of criteria.

The way in which they evaluate that is different, and that is part of the issue, but they both are supposed to have a medical dimension, and obviously, they are both supposed to do their evaluation within the law, the regulations, and the rulings of the SSA. So I think it is both legal and medical, and it ought to be consistent for both levels.

Chairman BUNNING. Would it help for a more consistent ruling if, when the applicant applies, nothing could be added to the record from that point forward? Do you think that that would help or hinder the ALJs and the DDSs in being more consistent in their determinations and reduce this high rate of overturning at the ALJ level?

Ms. ROSS. You have put your finger on something important because the ALJs say that in 27 percent of the cases they allow, new evidence has been an important factor. So we have to be aware that for over one-quarter of the cases, new evidence was not only added, but was quite relevant.

Under Process Unification, what Social Security is contemplating doing is taking 100,000 of those cases with new evidence and shipping them back for the DDSs to look at again. I think there, the idea behind that is, if people understand that they ought to get their evidence in earlier, perhaps they will.

Chairman BUNNING. But what if we just cut it off? In other words, what if a new law said that once you start the process, if you have significant new evidence, you have to go back to the starting line? In other words, you can't just add to the process as you move to the ALJ and the appellate level because, obviously, with different evidence, the ALJs are going to rule differently than the DDSs did at the beginning. That is the problem we are having, or at least a major portion of the problem.

Ms. ROSS. That is a piece of the problem.

Let me tell you what GAO's major concern is, and I alluded to it at the end of my testimony. From a management perspective, we are concerned about how many things SSA can take on all at the same time, and I would put this closing the record in that category. It may very well be a good idea.

When we testified before you a year and a half ago, we said it may well be a good idea, but I have some concerns about how many things SSA can undertake at the same time, and so I would just put it into that category of let's be cautious about how many more things we ask SSA to do.

Chairman BUNNING. This will be the last question because I had given myself 5 minutes and I am over 5 minutes, but the fact of the matter is, by law, SSA, as an independent agency, is supposed to do CDR reviews. They are supposed to do disability determinations. They are supposed to do all of these things you are concerned about.

You have yet to make a recommendation to us, if you want to, on how SSA might do things so that they can process all of the workloads they are expected to.

So, if you want to make some recommendations to this Subcommittee on how to alleviate SSA's problems in their workload processing that by law they are required to do, we are willing to listen to anything you might suggest because we want them to do their job more efficiently and effectively.

Ms. ROSS. I would suggest that that is SSA's business and SSA's responsibility.

As you suggested earlier on when you were speaking with them, you asked them for legislative proposals, and I think one of the things that might be appropriate to come forward with is some balancing of a set of things. If, in fact, they don't have the resources to do all of these requirements at the same time, I think it behooves them to come back to you and say, We want to do them all, we don't have the resources, or we need to make some adjustments.

GAO has the concern, but they have the expertise to tell you whether they can get these all done.

Chairman BUNNING. Ms. Ross, we did put an awful lot of money in CDR reviews, and when given good cause to do things like that, we have tried to cooperate with the SSA.

Ms. ROSS. Absolutely.

Chairman BUNNING. So, when they come with proposals, we will examine them, but yet, they didn't come to us with the CDR proposal. We did that on our own.

Ms. ROSS. I am urging that they think about coming because we have heard some concerns about their workload. So I think it behooves them to come and discuss it with you.

Chairman BUNNING. Thank you.

Mrs. Kennelly.

Mrs. KENNELLY. Thank you.

I would like to go back to the medical piece. The DDSs get a medical decision very often from a doctor who hasn't seen the patient. Then you get to the point where you appeal to the judge, and the judge has a physician there, often, the treating physician.

So I would, once again, assume that this is part of the problem, and I will take that a step further, asking your opinion. If the Chairman suggests no new information, God forbid we would start with the DDS and not be able to get the medical information from the doctor who understands the case.

I wonder if you would comment on this process of, first, having a doctor who doesn't know the patient personally, then when appeals come, the doctor who somewhat knows the patient gets more involved. Obviously, that is setting you up for somewhat of a different opinion.

Does it make sense to give weight to a medical finding when the physician has never seen the applicant, as the DDSs do?

Ms. ROSS. The DDSs have available to them the medical evidence from the treating physician. They have or can have available evidence from the treating physician and all of their medical records. That is the sort of thing that is supposed to be shipped to the DDS initially.

Mrs. KENNELLY. But I believe the figures that some of the information we have show that they very often don't ask for that doctor. I believe the Federal Government pays for it. Who pays for that? Does anybody know who pays? SSA pays the doctor if they require the doctor to come in at the DDS level?

Ms. ROSS. I don't know, but I would be glad to find out for you. I am talking about getting the medical records, the medical history, which is available at the DDS level, and then every case at the DDS level has an expert, a medical expert look at that paperwork.

You contrasted—so the treating physician has an opportunity to make their records available at the DDS level. That is the only point I am trying to make.

At the administrative law judge——

Mrs. KENNELLY. Well, I just want to put on the record that I will be asking for that breakdown, and I will have that put on the record because we should know that there is a difference of opinion even up here.

Ms. ROSS. At the administrative law judge level, I don't know, but I would be glad to find out what proportion of the treating physicians actually make appearances.

What information I do have is that in 8 percent of the cases, there is a medical person who testifies at the ALJ level. So I don't know how many of the 8 percent are treating physicians, but it is in only a small proportion of the cases there are physicians present to testify in ALJ hearings.

[The following was subsequently received:]

As to who pays a treating physician at the DDS if a personal appearance is requested, DDSs, like ALJs, are required to assure complete medical evidence development, including evidence from a claimant's treating physician. At both the DDS and ALJ levels, SSA pays for requested written medical evidence. DDS decisions are based almost exclusively on a paper review of the case file, and no provision exists to pay for the in-person appearance of the treating physician. For claimants who do not have a treating physician, SSA will send the applicant to a physician for a consultative examination and will pay for it.

As to what proportion of the treating physicians actually make appearances at the ALJ level, data on the proportion of treating physicians who made an appearance to testify at hearings is not readily available, although OHA officials told us it is a rare occurrence. In almost all appeals, ALJs rely on treating physicians' written medical reports rather than their testimony at a hearing. However, at the claimant's

request and with the agreement of the treating physician, the treating physician may be asked to testify. When this occurs, SSA does not pay for the treating physician's appearance. However, if the ALJ requests the treating physician to testify when it is believed that a more fully inquiry is needed, SSA will pay the treating physician. If the treating physician will not testify voluntarily, the ALJ may issue a subpoena.

Mrs. KENNELLY. Thank you, and I will pursue this, but before you finish—or I finish asking you questions, Ms. Ross, there are those that argue, one sitting right next to me, if his—well, I shouldn't say that because the Chairman has a suggestion I really haven't studied.

Mr. Chairman, you have a one-step type of——

Chairman BUNNING. Appeal. An appeal.

Mrs. KENNELLY. OK, with an appeal.

Chairman BUNNING. Surely.

Mrs. KENNELLY. OK, but I have heard people argue that there should be no ALJs at all. What do you think of the idea that it just be the SSA? And my worry is that there would be no independent review of the DDS which, obviously, there is some need for review of the DDS.

Have you looked at eliminating the judges?

Ms. ROSS. We haven't looked at that at all. It would seem really quite surprising to think of some sort of a benefit determination process that didn't have some level of appeal, short of the Federal court system. So whatever it is you want to make of it, it would seem like a pretty unsatisfactory way for beneficiaries.

Mrs. KENNELLY. And I would never want to eliminate the appeal either. But it just seems to me the way it is set up now, it is setting itself up to have these two very different systems looking at the same situation with different information. We would like to figure out how to make this more efficient, and I will read your report again, and thank you for the good work you have done.

Ms. ROSS. Thank you.

Chairman BUNNING. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Sitting here listening and reading and trying to understand this whole process, it is no wonder folks back home are very confused about this whole matter when they apply for the disability.

I find with interest that the ALJ—all of these acronyms get me—SSA, DDS, OHA, ALJ, and most people think that they are just OL, and that is out of luck, but I find that interesting, too, that the ALJs don't give much weight to the DDS decisions. Why is that? Is the record just not complete enough, or has it just gotten to be a formality that these things are denied and reconsidered and denied and wind up on their desk and so they just take it anew and try to start all over with it without much weight from the previous considerations that were given? What is the problem here?

Ms. ROSS. One of the problems that we identified as part of our study was that the record that comes from a disability determination service examiner explaining why they have denied the case isn't really sufficient in a great many cases. There is not enough

analysis of how they came to their decision for the ALJ to really understand what went on.

So I briefly stated that I think there is inadequate documentation. That is something this Process Unification effort is trying to work with DDSs on in order to improve because you can't expect the ALJ to take seriously something that isn't in the record. So improvement of the analysis of what is in the record seems really important.

Mr. COLLINS. In your table 2, step 3, am I reading that right? Do the medical facts alone show that the claimant's impairment meets or equals the medical criteria for an impairment in SSA's listing of impairments? If the answer is, Yes, stop, the claimant is disabled. Is that accurate? If it is, No, go to step 4, or do you just do steps 4 and 5, regardless of the answer to step 3?

Ms. ROSS. If your impairment meets or equals the medical listings which were designed to suggest if you could—if you had a listed impairment or one in the medical listings that was sufficient evidence that you were disabled, so if you get to step 3 and your impairment is exactly like this one in the listing, you are considered disabled. There isn't any further evaluation of your condition.

Mr. COLLINS. So you don't just go on to steps 4 and 5?

Ms. ROSS. No, you don't.

Mr. COLLINS. OK. In your study, how much training do these people at step 3 have in determining these medical facts?

Ms. ROSS. Well, both the DDS level and the ALJ level go through this same sequence or they are supposed to. And, as Ms. Geier suggested earlier, and I don't have any different information, there is much more extensive medical training in DDSs than there is for ALJs, although she is in a better position than I to tell you exactly how much training is given at each level. Clearly, there is more at the DDS level.

Mr. COLLINS. OK. That is all.

Thank you.

Chairman BUNNING. Mr. Portman.

Mr. PORTMAN. Thank you, Ms. Ross, and for GAO's work on this.

I said earlier, it is sort of a bizarre situation. Let me just look at of your report. You talk about a specific example which is back-related problems. Something seems a little off here when the DDSs are approving back-related problems for disability benefits, 10 percent of the time, and then at the ALJ level, 75 percent of the time.

So I think we have got some real problems in the system, and again, I get back to I think what you are saying, and let me see if I am properly characterizing it. The problem is there are different approaches at different levels. There is different training, and until we have some consistency in the approach, we will continue to have the backlogs and the problems associated with this illustration of the back problems. Is it accurate that consistency is the key?

Ms. ROSS. Consistency is at least the first step. Then we can figure out if there are other issues, but I agree, that is first.

Mr. PORTMAN. Let me follow up, then, on two specific ones. You talked about training. How about training the ALJs and their staff—I assume that that is part of the issue here, is that they are not always writing these decisions—at the same time that you are

training the State folks, the DDS personnel, train them together, give them the same training? Does that make sense?

Ms. ROSS. It makes a lot of sense, and there is precedent that occurred during the past year when SSA took nine rulings on the very toughest kinds of cases to decide, like back pain——

Mr. PORTMAN. Yes.

Ms. ROSS [continuing]. And trained these folks together. I hope they will do that in the future.

Mr. PORTMAN. OK. So training—getting the same training and training together makes sense.

Let me ask you about the different approaches. In response to Mr. Collins, you paraphrased what SSA had said previously as being that there is much more extensive training at the DDS level than at the ALJ level. I didn't hear her say that, but that is how you paraphrase what she said previously, and I think the record probably sustains that. Certainly, your report would indicate that.

Let me just give you one example. I asked SSA the extent to which medical advisers were used at the ALJ level, and I asked whether it was more than half because I was told that that is an option, and I was told it is about 40 percent.

Your report tells us, I am just reading, and I will read your report, "Although ALJs may call on independent medical experts to testify, our analysis shows that they do so in only 8 percent," 8 percent of the cases resulting in awards. Why is there that discrepancy between 40 percent and 8 percent? Did I ask the question wrong, or is there a difference in opinion between you and SSA on this?

I get at this because of this larger question of the different approaches, and I am not sure whether one approach is right or another, frankly, but I do think it is very clear that different approaches are one of the main problems that we have here. Why is there this discrepancy between the 40 percent that is now on the record and the 8 percent?

Ms. ROSS. Our analysis of the 8 percent comes from Social Security data, and it refers to the proportion of cases where a medical expert came to testify at an ALJ hearing.

It is also possible that ALJs asked for medical experts to give them written documentation, and maybe that explains the difference. I don't know, but if you are asking how many times a medical expert came to the hearing, our data show that it was 8 percent of the time.

Mr. PORTMAN. Again, let me just read one thing, and then I will end my questioning, Mr. Chairman.

In your report, you state, "The use of medical expertise appears to influence the decisional differences at the DDS and ALJ levels. At the DDS level, medical consultants are responsible for making functional assessments. In contrast, the ALJs have the sole authority to determine functional capacity and often rely on claimant testimony and the opinions of treating physicians. Although the ALJs may call on these experts, they only do so in 8 percent of the time."

So I think, again, we can't lose sight of the focus here, which I think is consistency in the different approaches and the medical training and the medical expertise involved. Clearly, it is different

at the different levels, and I think that seems to be one of our issues.

Thank you, Mr. Chairman.

Chairman BUNNING. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Let me just pursue this a bit further, and I am sorry I am going to have to go to another hearing. So I won't hear the further testimony that may address our frustrations and I think your natural frustration and all of ours about the difficulties with this process, but there has been reference here to closing a record, but let me just be clear. The DDS determination is done without any hearing. Isn't that correct?

Ms. ROSS. That is correct.

Mr. LEVIN. They do it strictly on the basis of paper that flows into their office?

Ms. ROSS. That is correct.

Mr. LEVIN. And so they don't meet either the claimant or anybody else before they make their determination, right?

Ms. ROSS. That is right.

Mr. LEVIN. I may be wrong, but I don't know of a process within the U.S. system where we close a record when there has been no hearing. I guess it is not fair to ask you that, but I don't see—as we look for improvements, I don't know how you prevent new evidence if it is the first procedure, formal procedure. It would seem to me, the focus has to be on improving the processes before that to try to have a more effective disposition and perhaps to improve the formal procedure, but I don't see how you close off testimony when there has been no hearing.

Are there many more—is there much more legal representation at the ALJ level than at the earlier procedure, the DDS level? Do you know?

Ms. ROSS. Yes, I do know, and there are very few individuals who are represented with legal counsel at the DDS level, and about 80 percent are represented, as I understand it, at the ALJ level, at the hearing level.

May I add one thing to amplify what I said earlier about no in-person review at the DDS level? That is certainly true now, but one of the initiatives that Social Security is pursuing as part of its Process Unification or as part of its reengineering proposal is to have an interview with the claimant at the DDS level.

So, before they would deny a client, they would see this person and make sure they had all the evidence and the person understood what they needed and so on. I am not speaking specifically to the closing-the-record issue, but there would be this opportunity much earlier on to have the client have an in-person interview.

Mr. LEVIN. I would think that might very much improve the process. I don't think it would turn it into a hearing, but it might mean there would be a much greater parallelism between what is done at the DDS level and at the hearing level.

Thank you very much, Mr. Chairman.

Chairman BUNNING. Ms. Ross, Mr. Hill, a senior attorney who is president of the union chapter which represents attorney/advisers in the hearing offices around the country, says in his testimony that the redesign has had no meaningful, measurable effect upon

the workload of OHA, except consuming resources, both human and material, that could have been put to better use.

Have GAO findings been consistent with this statement?

Ms. ROSS. I would like to give you a two-part answer. First of all, most of the reengineering proposals are still in their developmental stages. So you wouldn't expect to have much overall effect on the process. That is not surprising.

In work we did for you, which we issued in December, we said that we thought SSA's reengineering work was much too extensive and much too lengthy and that they ought to try and reduce the scope of what they had in mind and get on with it, and in response to us and I think to their own sense of it, they have cut back on the scope of their reengineering proposals, but it is still quite a long process. So I can sympathize with Mr. Hill, but I think these major things in any case take a lot of time.

Chairman BUNNING. In his testimony, it appears Mr. Hill points out that as is often the case with major initiatives, senior officials who conceive major initiatives are never around long enough to take responsibility for the problems caused by their creations. Aren't these views consistent with testimony GAO has provided this Subcommittee in the past?

Ms. ROSS. Yes, sir, they are. Our concern about this massive project and the very long timeframe they had in mind was that you lose senior people and you lose the enthusiasm of your work force, and I think that is a risk.

Chairman BUNNING. In fact, the reengineering that has been designed was done by the former Acting Commissioner of SSA, and she is no longer there. So somebody else has to pick up the ball, sometimes with less enthusiasm than the prior person because it is not their initiative, and therefore, they lose something in the picking up of the ball to carry it forward?

Ms. ROSS. There is that risk any time you have a major initiative that the people who start it won't be there, and that is a problem SSA is dealing with now.

Chairman BUNNING. I hope the new Commissioner designee will be there as long as the term of office that we put in the new legislation, so that there can be a more consistent outlook at SSA over a 6-year window. Then SSA can become more independent and do things in SSA's and the people's best interest rather than what HHS and the administration might think is in the best interest of SSA. That is why we designed the new independent agency bill.

I thank you for your testimony.

Mrs. Kennelly, do you have anything else?

Mrs. KENNELLY. No, I don't.

Chairman BUNNING. Thank you very much.

Now, we conclude with a panel of professionals who work with the disability process every day, some of whom have previously testified before this Subcommittee: Douglas Willman, president of the National Council of DDS Directors; Hon. Ronald Bernoski, acting president of the Association of ALJs; Debi Gardiner, president-elect of the National Association of Disability Examiners, accompanied by the past president, Tom Christopher; James Hill, president of the National Treasury Employees Union, chapter 224; and Nancy

Shor, executive director of the National Organization of Social Security Claimants' Representatives.

Mr. Willman, will you please begin.

STATEMENT OF DOUGLAS W. WILLMAN, PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

Mr. WILLMAN. Chairman Bunning and Members of the Subcommittee, thank you for the opportunity to appear here today to present the views of State directors on the differences and decisional outcomes between the State DDSs and the SSA Office of Hearings and Appeals.

We believe that presently the disability program is simply failing the reasonable minimum expectations of the American public because too many persons who receive benefits are not allowed until they reach the appeals level.

Even though SSA quality assurance reviews of our work tell us that at the DDSs, our decisional error rate is only about 4 percent, about 60 percent of the persons who appeal their State decisions are awarded benefits by OHA. But first, they must ensure an unreasonably long and anxiety-producing delay and usually hire an attorney to represent them.

According to a statement by the Association of Administrative Law Judges, there is no other appellate system in the entire world with such a consistently high reversal rate. If these reversals are appropriate allowances, they should be allowed earlier in the process. If they are not good allowances, and many are not, they should not be allowed at all.

The decisional outcomes between the two components are so different because the two components have developed along separate tracks with historically inadequate coordination by higher management.

Examples of the ways the components differ would include the following. Each component has its own separate manual of policy and procedural instructions, and the two components conduct entirely separate training in the application of these different policies and procedures.

There are separate and conflicting systems for reviewing decisions to detect and correct errors. Most of the DDS decisions selected for review are allowances, and almost all reviews of ALJ decisions are on denials. There is a vast difference in the relative weight given to different types of medical evidence. DDSs tend to focus more on objective medical facts, while OHA gives more weight to subjective symptoms and to the opinions of the claimant's treating physicians, and DDSs function strictly as part of the executive branch of government, while OHA tends to behave as though it were part of the judicial branch. This results in DDSs adhering strictly to SSA policies while ALJs compromise those policies by, instead, following court decisions that they regard as precedential.

In view of these differences and others, it is no wonder that the two levels fail to produce similar results. In some important ways, things are beginning to get better. Today's top managers in SSA deserve credit and recognition for having taken some important first steps toward bringing the processes closer together.

Under an initiative known as Process Unification, SSA has recently completed the remarkable achievement of training all of its adjudicators in the application of a new set of rulings. The rulings were explained locally by trained traveling facilitators who were supported by a live interactive video presentation originating at SSA headquarters.

Last week, I personally had the opportunity to observe a meeting in which top SSA managers gave careful attention to the recommendations of frontline workers who delivered the training. The SSA managers received information which can be extremely helpful in bringing the two processes together, and I can tell you that in over 20 years as a manager in the disability program, I have never before seen such a rich presentation of useful ideas from frontline workers to top managers, but much more needs to be done.

Some improvements can be made by SSA, and in some other ways, statutory changes will be needed. For SSA, it should accelerate the development of the single policy manual or the "one book" for use by adjudicators in all components. It should develop a quality assurance case review system complete with enforcement power over all components because without enforcement, the very finest policies may be simply inconsequential.

SSA should greatly increase the training of ALJs on medical issues, and it should balance its demands for high productivity with concerns that similar decisional outcomes be produced at all levels of adjudication.

Congress can help both with continued oversight and with legislation. Statutory changes could support SSA's authority to conduct and enforce quality assurance case reviews, could clarify the extent of management control over ALJs, establish SSA's recent acquiescence ruling in the law, and set statutory guides for the weight to be given to the opinions of treating physicians and close the record.

Continued monitoring such as today's hearing, a sort of high inside fast ball, can also help assure that SSA management contains the motivation and the organizational will to continue to address this serious problem in service delivery to the American public.

Thank you.

[The prepared statement follows:]

Statement of Douglas W. Willman, President, National Council of Disability Determination Directors

Chairman Bunning and members of the subcommittee, on behalf of the NCDDD, thank you for the opportunity to appear here today to present our views regarding the differences in decisional outcomes between the state Disability Determination Services (DDSs) and SSA's Office of Hearings and Appeals (OHA).

The NCDDD is a professional organization of the directors and other management staff of the state Disability Determination Services agencies. The DDSs participate in the disability program by making the initial determinations of eligibility for disability benefits. We appear here today experiencing great concern about the public's loss of confidence in the disability program resulting from the huge difference in decision making between the initial and appeal levels of eligibility determinations. We desire a program that produces correct and consistent determinations of eligibility, that makes these determinations in the shortest possible time, and that operates at the least reasonable cost to the tax payer. By "correct" decisions, we mean that benefits are received by persons who are unable to work because of a medical impairment. By "consistent" decisions, we mean that decision making should not substantially vary between the initial and appellate levels of determination. We know that the current process can be and must be improved in terms of its ability to achieve these objectives. We want to work with SSA, with other representatives of

the DDS community and with Congress to increase the accuracy of the process, to reduce processing time, and to control costs.

We believe that presently the disability program is failing the reasonable minimum expectations of the American public. We are failing primarily because too many of the allowed applications are not allowed until they reach the appeals level. Even though SSA quality assurance reviews show a decisional accuracy of more than 96% at the DDS level, the OHA reversal rate for applicants whose cases have been twice denied at the DDS level has, until very recently, been above 65%. According to a statement by the Association of Administrative Law Judges, there is no other appellate system in the entire world with such a consistently high reversal rate. Since about 75% of all denied reconsideration cases are appealed to OHA, the net effect is that about half of all reconsideration denials are subsequently allowed at the OHA level. But first the claimants must endure the hardship of a delay which is usually around eighteen months, and most such applicants feel that they need to hire an attorney or other representative for help in the appeals process. Claimants pay their representatives, collectively, about $500 million a year which is about half of the total cost of operating all the DDSs.

Claimants who successfully appeal their reconsideration denials often ask, "If my case was going to be allowed anyway, why did I have to endure two denials, wait 18 months, and then pay 25% of my back benefits to an attorney?" The disability examiners who process the denials are fully aware of the reversal rate and wonder why they can't save the claimants time and money by making at the beginning of the process the decisions they know will be made at the end. As managers of the state eligibility determination programs, we know that if cases allowed at the OHA level are good allowances, they should have been paid earlier in the process, and if they are not good allowances, they should not be paid at all.

For many years, SSA has been less than completely forthright about the existence, extent, and causes of this service delivery problem. In previous public statements, including those to Congress, SSA has attempted to focus attention on a few minor causes of the decisional differences while attempting to divert attention from comparatively more important causes which a better management system could control. SSA has treated the phenomena of vastly different decision making as a public relations problem that could be finessed with carefully contrived explanations rather than as a serious service delivery problem which could be solved with better management. Recently, as part of disability redesign, SSA has acknowledged the reality, seriousness, and extent of the problem, has formulated and begun to develop some components of a long range plan, and has taken some constructive initial actions toward a solution. SSA's plans and actions in this regard have come to be known as the Process Unification portion of disability redesign. Although NCDDD has very serious reservations about many aspects of disability redesign, we certainly agree with the emphasis that SSA is placing on Process Unification. In the long term, if Process Unification succeeds, and all other Redesign experiments fail, reengineering of the disability process will still be viewed as a success. On the other hand, if Process Unification fails, and other parts of redesign succeed, SSA will have tinkered at the margins of the program, but will have redesigned the disability process on a foundation of sand.

The testimony that follows will focus on the causes of the present decisional disparity, the components of the Process Unification approach, the adequacy of that approach, and on what else needs to be done.

I—Causes of the Present Decisional Differences Between DDSs and OHA

SSA has historically emphasized factors such as the passage of time, worsening of claimants' conditions, availability of new evidence, attorney representation, and face-to-face hearings as the explanations for such a high reversal rate at OHA. While all these factors are present, they account for a minority of the differences between DDS and OHA decision making. The more causative reasons are listed and explained below.

There has historically been an absence of uniformly stated policy instructions for adjudicators at the two levels.

Decision makers at both levels must apply the statutory definition of disability and the regulations. However, the language of the statute and the regulations is far less specific than that of the separate vehicles used to convey policy to DDSs and to OHA. For DDSs there is manual called the POMS (Program Operational Manual System). Adherence to POMS directives is required at the DDS level and ignored at OHA which has its own separate manual. These manuals substantially differ from each other in content.

There has historically been no common training for personnel at the two levels.

Both in the initial orientation of new employees and in communicating program changes, DDS and OHA conduct their training on entirely separate tracks. DDSs have a much stronger emphasis on providing training in medical concepts while OHA provides almost no medical training to its decision makers.

Separate and opposite quality assurance and case review systems tend to drive the two components apart rather than to bring them together.

For DDS decision makers, the majority of cases reviewed and returned as errors by the quality assurance system are allowances. For OHA decision makers, nearly all cases reviewed, either by the Appeals Council or the federal courts, are denials. The feedback tends to focus the attention of the DDS decision maker on not making errors on allowances while the OHA decision maker knows that errors are almost impossible on allowances since almost none are reviewed.

SSA management has permitted the development of an inaccurate view of the immunity from management control of Administrative Law Judges under the Administrative Procedures Act.

ALJs have successfully asserted broad decisional independence and freedom from management control, and the assertion has gone largely unchallenged by management. This accounts not only for the difference in decision making between DDSs and OHS, but also for the extreme differences in allowance rates among individual ALJs. SSA has recently obtained an opinion from its General Counsel that declares management authority for requiring ALJs to attend training, apply the agency policy, conform to administrative rules, etc. Hopefully, exercise of the authority that has existed all along will mitigate the problems that flow from the perception of ALJs that they are free from control.

There is a vast difference in the weight the components give to detailed medical analysis.

At the DDS, decision makers have broad access to physicians and psychologists and a medical or psychological review is completed on each case. At OHA, medical experts participate in the analysis of only about 10% of the cases. The analysis of DDS physicians and psychologists seems to be largely ignored at the OHA level.

Different approaches to the assessment of residual functional capacity are largely responsible for the differences in decisional outcomes.

According to the law and the regulations, decision makers must consider the effect of the medical impairment(s) on the applicant's ability to perform work related tasks. The resulting conclusion is called the claimant's 'residual functional capacity'. This finding is based on the medical facts and any opinions that may have been provided by a claimant's treating physicians. OHA decision makers tend to place much greater weight on the conclusionary statements of treating physicians while DDS decision makers tend to place more weight on objective medical findings.

An extreme difference in decisional outcomes emerges from the conclusions reached about claimants' remaining ability to work. One classification of residual functional capacity is known as the ability to perform less than the full range of sedentary work which has been the subject of careful inquiry by SSA. This finding almost always results in allowance. At the DDS initial level, this finding is reached on about 1% of all cases. At the reconsideration level, the finding is reached on about 3% of the cases. Based on the evidence available at the time of a hearing, the medical reviewers at SSA have concluded that the finding is appropriate in about 7% of the cases. But ALJs, based on the same evidence, find claimants limited to less than the full range of sedentary work in more than 50% of the cases. More than any other quantifiable factor, this difference is responsible for the high reversal rate at OHA.

SSA has permitted what could be called the "judicialization" of OHA, that is the transformation from an administrative to a judicial entity.

Although Administrative Law Judges are employees of the executive branch of government, in many ways they behave as though they were part of the judicial branch. This tends to result in a loss of consistency of decision making among ALJs and in a compromise of the extent to which agency policy is applied correctly. This is especially true when ALJs exercise individual interpretations of federal court decisions and apply them as precedents even if they run contrary to policy.

II—SSA'S PROCESS UNIFICATION INITIATIVE

After a long history of failing to address the problem of the disparity in decision making between DDS and OHA, SSA has, at last, taken some positive steps under a project known as Process Unification. This project consists of a set of rulings by the Commissioner, an ambitious attempt to train more than 14,000 adjudicators at all levels in the application of these rulings, a very limited quality review process for some allowance decisions of ALJs, and a process for remanding to the DDSs some cases awaiting hearing on which new evidence has been received.

With regard to the rulings, many of the historical problems described above have been addressed. If the rulings are correctly applied, they can reasonably be expected to reduce the decisional disparities. The training is a remarkable accomplishment which has now been completed. In addition to acquainting all decision makers with relevant program instructions, the training was valuable just for having brought together case analysts from all components to experience the same training in the same setting at the same time. But the plan for a quality review process of ALJ allowances is disappointingly modest both in scope and in nature. Such a review will be useful only if its intent is to determine if ALJs have applied the rulings correctly and to enforce corrective action on cases found to be in error. Without a means of enforcement of the rulings on ALJ decision making, all other actions will be ineffective. Yet SSA plans to review only about 10,000 OHA cases per year and the nature of the review process will exclude many erroneous cases from being identified as errors and returned.

The number of cases to be reviewed is only about one case per ALJ each month. Even presuming an error rate of, say, 33%, this would result in only about one piece of feedback per ALJ each calendar quarter. This number is not high enough to provide meaningful feedback to ALJs, nor to establish useful enforcement in cases in which ALJs are not correctly applying agency policy, nor to create a quality review system which is reasonably consistent between components.

The standard to be applied for determining errors in this review process is even more discouraging that the size of the case review. While DDS case completions are reviewed under the "preponderance of evidence" rule (meaning that the decision supported by the greater weight of the evidence must be made) the ALJ allowances would be reviewed under a "substantial evidence" rule (meaning that a decision is correct if it is supported by any substantial evidence even if greater and more substantial evidence would support an opposite decision). We understand the definition of the word "substantial" will be "more than a scintilla." Under this case review scenario, a DDS could twice deny a case because most of the evidence supports a denial, the claimant could wait a year for a hearing, an ALJ could allow the case because some evidence supports an allowance, and both decisions would be considered by SSA to be correct.

This is not our idea of Process Unification. We feel that Process Unification must mean that every SSA component will arrive at similar decisions on similar cases. Process Unification must result in one program with similar decisional outcomes across all levels of appeal. Process Unification means a focus on a single SSA Disability program, rather than on differing appearances that applicant due process can take at the different steps in the adjudicatory process.

SSA does report modest but promising changes in the allowance rates at the two levels over the last several months. An increase in the DDS allowance rate in the neighborhood of two or three percent and a decrease in the OHA allowance rate of six to eight percent is reported. While these data are very preliminary and could result from factors other than process unification, this is an encouraging sign.

Any review of the rulings issued under Process Unification would not be complete without comment on the labor intensive nature of some of the requirements and the consequent impact on the resources needed for implementation. Most of the rulings will require additional direct time for obtaining the required evidence, analyzing the evidence, and explaining how the decision was made. DDSs, at their current staffing levels and with their current caseloads, cannot apply these rulings and still process all the cases coming in the door. Hopefully, additional resources invested at the DDS will pay off in the form of a greater number of cases being decided at the DDS level and therefore not being appealed to OHA where a lesser need for personnel and resources should be the result.

III—WHAT ELSE MUST BE DONE

SSA has taken some encouraging first steps toward bringing consistency to the program, but we are not where we need to be yet, and we are not even close. Some of the necessary actions can be taken by SSA, but in other areas, Congress could help.

Recommendations for SSA:

1) SSA should accelerate the development of a single presentation of policy for use by all decision makers at all levels. The "one book" approach was a cornerstone of the SSA plan to redesign the disability program released in October of 1994. Now, more than two and half years later, we are told that the "one book" is still about two years away from being a reality. Until all decision makers are following the same instructions, we cannot reasonably expect their decisions to comport with one another.

2) The "one book" approach must be enforced with a quality assurance system which applies the same policy and review criteria to decision makers at all levels.

3) SSA should find ways to sharply increase the medical training provided to ALJs.

4) SSA should develop a shared vision of the program among all components. SSA must insure that the Office of Disability (SSAs component that sets policy), the Office of Program and Integrity Review (SSAs component that checks quality), Operations, and Budget are reasonably consistent with their expectations as to how the program will operate. The point is that while we often think of Process Unification as being necessary only between DDSs and OHA, in reality, Process Unification also must bring together the many disparate voices among the varied components of SSA as well. We cannot attain real Unification until every component focuses on doing cases accurately, quickly, and cost effectively rather than having one component focus only on accuracy, another only on processing time, and another only on cost.

5) SSA must place its primary emphasis on quality and reallocate resources so that the time is available to apply the rulings as they are written. For at least the last decade the driving force within SSA (as far as the DDSs were concerned) has been productivity improvements. This must change. While we must always strive to improve administrative efficiencies, we must insure that no corners are cut in our efforts to do each case correctly, quickly and cost efficiently and in that order. Process Unification will be neither easy nor cheap. It is, however, critical if we ever expect to build a truly unified SSA disability process that the public will trust.

Considerations for the Congress:

Legislative support for the following changes would help clear the way for reasonable consistency in decision making between the two levels.

1) The evidentiary record should be formally closed at some time between the reconsideration decision and a stated number of days following the hearing.

2) SSA should be authorized and required to conduct a formal quality assurance review of ALJ allowances and denials using the law, regulations, and SSA rulings as the review criteria. SSA should be authorized, in addition to a random sample, to conduct 'high risk' quality assurance reviews of individual ALJs or OHA offices based on any accuracy, productivity, timeliness, or efficiency criteria established by SSA. The quality assurance review must be consistent across all levels of appeal, must use the same standard (preponderance of evidence or substantial evidence), must include a reasonably equal mix of allowances and denials for all levels, and must include enforcement power.

3) The program needs a statutory clarification of the extent of independence of ALJs from management control. Statutory language should more clearly state that ALJs are "independent" decision makers only insofar as the ALJ decision comports with SSA law, regulations, and rulings. The law should make clear that SSA has the full responsibility and authority to set performance standards, workload requirements, work processes and workflows for ALJs and OHA.

4) SSA's "acquiescence ruling" promulgated in July 1997, should be given the force of law. This ruling requires ALJs to use only SSA law, regulations, and rulings as adjudicative standards and prohibits individual ALJ interpretation of court decisions, absent an Acquiescence Ruling by SSA. SSA should be required to publish Acquiescence and Non-acquiescence Rulings in all Circuit Court decisions without unreasonable delay, such as 90 days.

5) Congress should establish by law the adjudicative weight to be given to the statements of treating, examining, and reviewing physicians. The determination of what functional abilities are retained by the applicant after considering the claimant's medical history, nature of the impairment, severity, prognosis, and medical contraindications should be a decision reserved to the Commissioner rather than being placed in the hands of the treating physician.

Because of the very substantial extent to which this single aspect contributes to the variance in allowance rates, some additional perspective in support of a legislated solution is necessary. Please see the attachment which contains a more de-

tailed explanation of the nature of the problem and the need for a legislative solution.

6) SSA's history on this issue shows that it likely will need continued monitoring from the Congress. SSA's history has been to understate the problem, to find creative ways to rationalize why the DDS and OHA outcomes were not really all that different, and to divert attention from problems that ought to have been managed rather than to manage them. While SSA's recent approach is refreshingly different from its history, the comparative ease of denying the problem to fixing it may persuade SSA to return to its old ways.

Mr. Chairman and members of the committee, NCDDD offers the above observations and suggestions in the hope that the disability process can be improved so that claimants who are due benefits can obtain them without unreasonable delay and so that ineligible persons are not added to the disability roles. Presently, the DDSs are probably denying benefits to significant numbers of persons who should be allowed, and OHA is probably allowing benefits to significant numbers of persons who are not disabled. With SSA's continued efforts to bring the processes closer together and with continued Congressional oversight, we hope that consistency will be established to the advantage of both persons applying for benefits and to the tax payers.

Thank you for the opportunity to present our views on this important subject.

Chairman BUNNING. Judge Bernoski.

STATEMENT OF HON. RONALD G. BERNOSKI, ACTING PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, INC.

Judge BERNOSKI. Thank you, Mr. Chairman.

The major focus of this hearing is to examine the dual adjudication standards that are employed at the DDS and OHA levels of the disability process. These systems are based upon a procedure that has been developed by the Social Security Administration, the so-called POMS standard that is used at the DDS, while a more legal-based standard is used by OHA.

We are not here to judge which standard is the best, but we do know that if the claim gets to the Federal courts that the legal standard will be employed to adjudicate the case.

We also know the reversal rate of DDS decisions by ALJs has been declining. In fiscal year 1995, the reversal rate was 65 percent. By fiscal year 1997, it dropped to 54.8 percent.

The GAO has prepared a report for this hearing, and with deep regret, we question the reliability of that report. The GAO did not interview any officer or director of our association for their preparation of this report.

The report does not analyze the reasons for the differences in the approach in assessing the RFC, residual functional capacity, at each level. It does not consider the impact on the RFC of the treating physician rules that may vary between the Federal circuits.

The GAO does not consider that the ALJ hearing is de novo and not certiorari to the DDS determination. The GAO places great weight on the SSA quality assurance systems, but it does not consider the impact of these systems on the constitutional peering. The hearings of this system, the quality assurance system, has considerable potential to abuse the constitutional due process rights of the claimant.

Any attempt to "manage" the ALJ decision process has the potential to lead to the type of undue agency influence that led to the passage of the Administrative Procedures Act.

The GAO fails to acknowledge the agency program of Process Unification. While we do not agree with all aspects of that program, we believe the best solution for the problems raised by the GAO is to develop a single standard of adjudication for all levels. This standard must be based upon the legal model because this is the standard that the claim will ultimately be judged by when he gets to the court system. This single standard will allow the claim to be awarded at the earliest point in the adjudication system and thereby reduce the case backlog for the ALJs at the OHA level.

Now, in summary, GAO has completely failed to consider the relationship between agency policy and the judicial function. The words "due process," "law," "courts," or "constitution" are not mentioned anywhere in that report. Yet, when you consider the *Zebley* case, the *Hyatt* case, the *Samuel*s case, and the *Minnesota Mental Health* case, we see the tremendous impact the court system has on the disability process, and until this relationship is understood by both the GAO and the agency, many of these problems in the disability system will not be corrected.

As ALJs, we take an oath to uphold the law and the constitution, and that we understand our responsibility to follow the constitution and apply the law, and we will enforce the law.

On the other hand, we have considerable difficulty applying agency policy that is inconsistent with the law. If Congress were to change the statutory law to achieve the results of the DDS process, we as ALJs would enforce the new law.

Mr. Chairman, we are neither proclaimant nor proagency. It is our duty to decide each case based on the law and the facts of that particular case.

Thank you for the opportunity to appear here.

Mr. Chairman, I just have one thing that I would like to introduce into evidence, and that is a report. It is called an SSA tracking report, and it sets forth the reversal rate of ALJs and is the reference for my statement. It is 54.8 percent. There have been three or four different numbers cast on it.

Chairman BUNNING. Without objection, it will be put into the record.

[The information follows:]

SSA's TRACKING REPORT

Volume 2, Number 3 December 16, 1996

DDS Allowance Rates

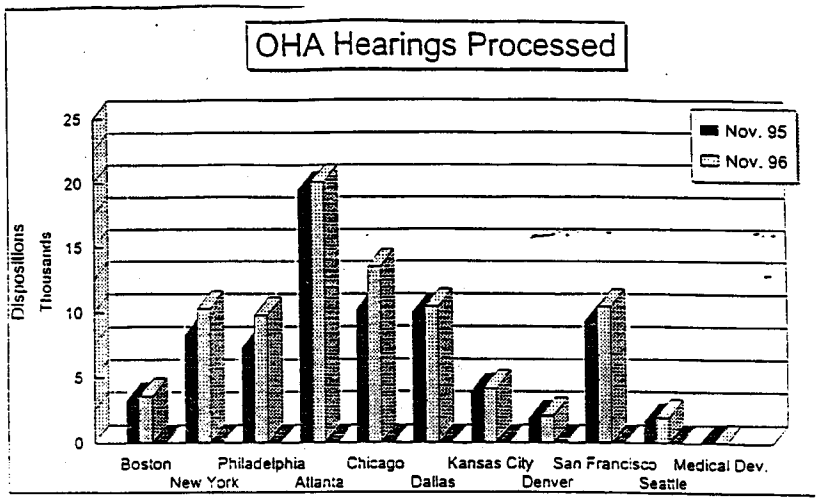
Combined Title II & Title XVI

FY 1997 Through November 1996

	FY 1995 Full Year	FY 1996 Full Year	FY 1997 Year-to-Date	FY 97 YTD/ FY 96
Nation Total	30.9	30.8	33.9	9.1%
Boston	40.1	37.9	41.0	7.6%
Connecticut	34.8	33.0	31.9	-3.4%
Maine	37.3	39.7	45.0	11.8%
Massachusetts	43.4	38.8	44.1	12.0%
New Hampshire	39.6	40.8	42.8	4.7%
Rhode Island	41.0	38.5	38.5	0.0%
Vermont	36.2	36.5	45.9	20.5%
New York	32.6	33.3	36.5	8.8%
New Jersey	34.2	34.7	34.7	0.0%
New York	31.6	32.6	36.7	11.2%
Puerto Rico	38.0	36.7	39.9	8.0%
Philadelphia	31.4	29.7	31.7	6.3%
Delaware	49.2	44.1	44.5	0.9%
Dist of Columbia	40.2	39.1	41.1	4.9%
Maryland	30.2	31.9	33.3	4.2%
Pennsylvania	32.0	28.6	30.9	7.4%
Virginia	32.5	32.2	35.4	9.0%
West Virginia	22.6	21.9	21.9	0.0%
Atlanta	29.9	29.4	31.9	7.8%
Alabama	26.1	24.6	27.2	9.6%
Florida	28.8	29.0	32.0	9.4%
Georgia	27.9	28.2	30.8	8.4%
Kentucky	31.3	30.2	33.3	9.3%
Mississippi	24.2	22.6	25.1	10.0%
North Caroiina	34.0	36.5	40.6	10.1%
S. Carolina (B&D	35.0	40.7	28.9	-40.8%
S. Carolina (VR)	33.8	32.7	33.6	2.7%
Tennessee	33.6	29.6	29.4	-0.7%
Chicago	31.0	32.4	38.8	16.5%
Illinois	26.9	30.0	36.3	17.4%

Indiana				
Michigan	28.2	31.4	43.1	27.1%
Minnesota	38.0	41.0	49.6	17.3%
Ohio	35.7	33.2	36.6	9.3%
Wisconsin	31.9	34.8	42.6	18.3%
Dallas	24.5	23.7	25.0	5.2%
Arkansas	23.3	23.0	22.2	-3.6%
Louisiana	19.8	20.0	22.7	11.9%
New Mexico	23.8	20.8	24.8	16.1%
Oklahoma	25.8	24.3	32.2	24.5%
Texas	26.5	25.5	25.3	-0.8%
Kansas City	31.4	31.3	33.0	5.2%
Iowa	36.9	38.4	38.7	0.8%
Kansas	36.0	34.1	32.5	-4.9%
Missouri	26.9	27.4	30.4	9.9%
Nebraska	34.8	33.9	37.9	10.6%
Denver	37.4	34.4	34.1	-0.9%
Colorado	37.6	34.2	34.3	0.3%
Montana	33.1	31.2	30.7	-1.6%
North Dakota	41.4	36.9	35.2	-4.8%
South Dakota	39.0	35.1	34.1	-2.9%
Utah	39.3	37.2	37.7	1.3%
Wyoming	32.8	30.7	28.6	-7.3%
San Francisco	31.0	31.3	34.2	8.5%
Arizona	38.5	37.7	40.1	6.0%
California	29.4	30.1	33.3	9.6%
Hawaii	32.4	32.8	38.5	14.8%
Nevada	44.1	41.0	37.6	-9.0%
Seattle	37.1	36.5	39.6	7.8%
Alaska	44.9	37.5	37.4	-0.3%
Idaho	35.4	33.0	31.6	-4.4%
Oregon	34.4	36.1	35.4	-2.0%
Washington	38.3	37.5	44.4	15.5%

Last Update: December 12, 1996
Contact: Alan Shafer
OPP, OD: 410-965-0091



Regions	FY 96 Dispositions Through Nov. 95	FY 97 Dispositions Through Nov. 96	Percent Difference FY 97/96
Boston	3,253	3,572	9.8%
New York	8,286	10,240	23.6%
Philadelphia	7,351	9,768	32.9%
Atlanta	19,481	20,056	3.0%
Chicago	10,158	13,470	32.6%
Dallas	9,971	10,397	4.3%
Kansas City	3,873	4,150	7.2%
Denver	1,845	2,066	12.0%
San Francisco	9,281	10,407	12.1%
Seattle	1,644	1,971	19.9%
Medical Development	103	64	-37.9%
AOs	—	940	—
National	75,246	87,101	15.8%

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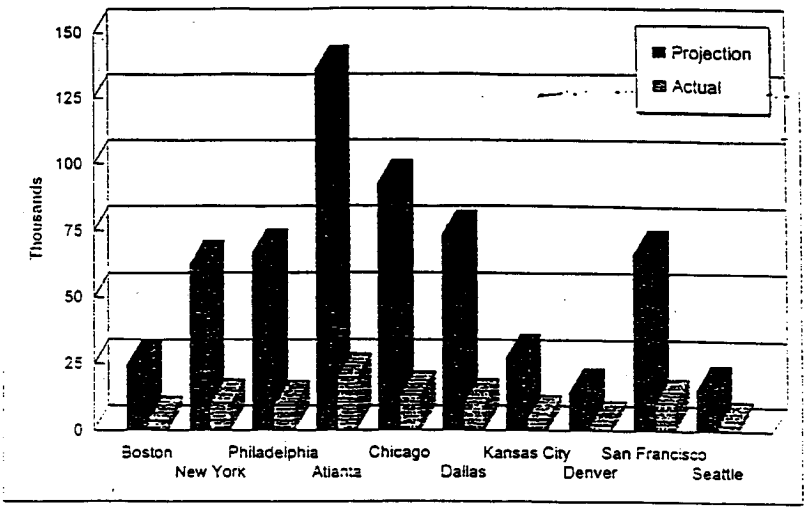
Contact: Kenneth Mackey
OPP, OHA: 703-305-1866

Budgeted Hearing Dispositions

Through November 1996

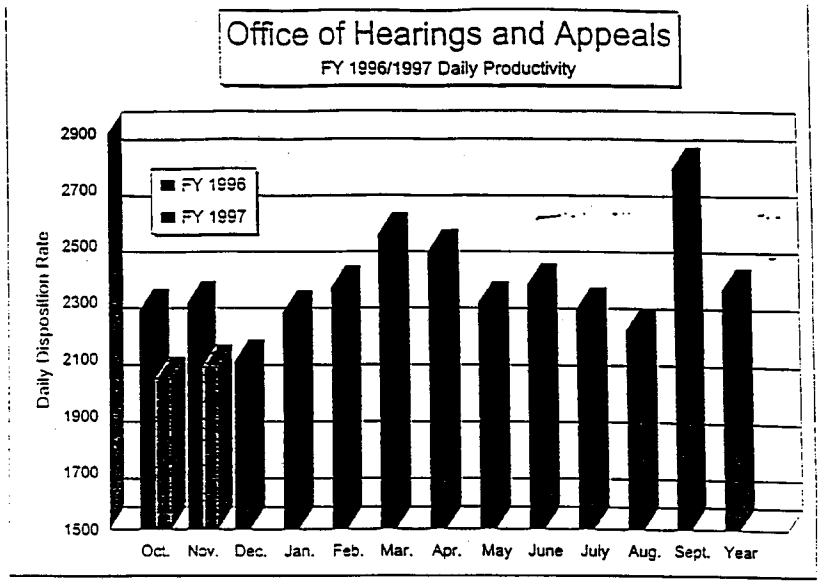


November workload data represent 17 % of FY 1997
FY 1997 projection includes ALJ hearing decsions and Action #7 dispositions.
Other hearing level dispositions include AO decisions (9,200 projected), screening unit dismissals (22,000 projected) and PUTT informal remands (15,000 projected).

Region	Projection	Actual	% of Proj. Through November
Boston	24,549	3,499	14.3%
New York	62,074	9,998	16.1%
Philadelphia	66,477	9,391	14.1%
Atlanta	135,899	19,682	14.5%
Chicago	92,488	13,102	14.2%
Dallas	73,416	10,179	13.9%
Kansas City	27,464	4,113	15.0%
Denver	14,337	2,054	14.3%
San Francisco	66,439	10,331	15.5%
Seattle	15,655	1,961	12.5%
AO Decisions	9,200	940	10.2%
Screening Unit	22,000	1,787	8.1%
PUTT Remands	15,000	0	0.0%
Medicare	—	64	—
Total	624,998	87,037	13.9%

Last Updated: December 12, 1996

87,101



FY 1995 and FY 1996 "Year" entries reflect the full fiscal years.

	FY 1995	FY 1996	FY 1997	1997/1996
October	2,046	2,269	2,028	89.4%
November	1,972	2,295	2,070	90.2%
December	1,778	2,090		
January	2,094	2,262		
February	2,099	2,350		
March	2,041	2,538		
April	2,051	2,477		
May	2,041	2,294		
June	2,035	2,360		
July	2,197	2,276		
August	2,376	2,202		
September	2,549	2,776		
Year	2,107	2,346		

Daily productivity rate calculation does not include AO dispositions.

Last Updated: December 12,,1996
Contact: Steve Sapp
OPP, OHA, OCALJ 703-305-0009

OHA HEARINGS PRODUCTIVITY

Fiscal Years Through October

REGIONS	FY 1996 Production Per Work Year	FY 1997 Production Per Work Year	Percent Difference FY 97/96
BOSTON	110.0	96.9	-11.9%
NEW YORK	124.2	104.9	-15.5%
PHILADELPHIA	92.6	89.0	-3.9%
ATLANTA	109.2	91.5	-16.2%
CHICAGO	84.3	87.4	3.7%
DALLAS	94.6	84.6	-10.6%
KANSAS CITY	102.9	90.3	-12.2%
DENVER	98.6	79.8	-19.1%
SAN FRANCISCO	105.6	96.9	-8.2%
SEATTLE	85.5	74.4	-13.0%
OHA NATIONAL	100.8	89.6	-11.1%

Last Updated: December 10, 1996
Contact: Mark Anderson
OPP, OHA: 703-305-0840

PROCESSING TIMES - HEARINGS

Processing Times (In Days)

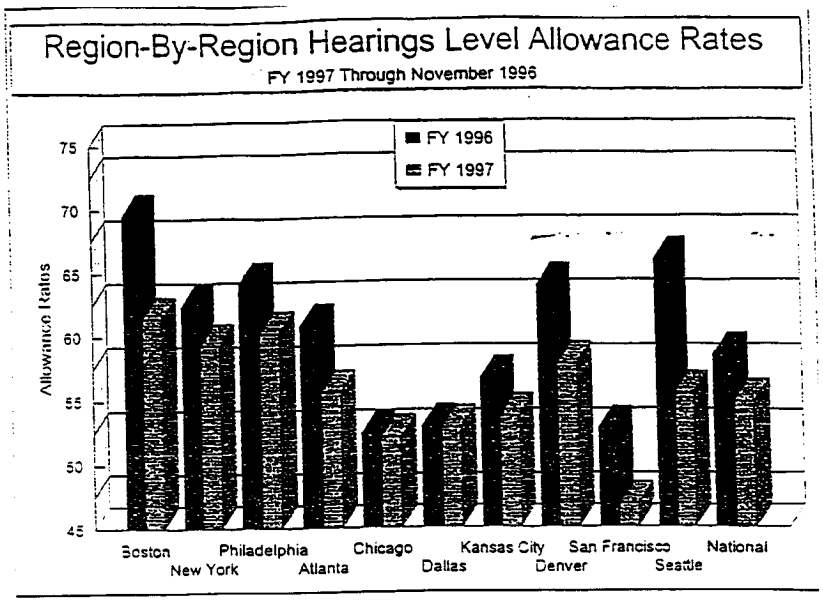
	FY 1995	FY 1996	FY 1997 Thru 11/96	Difference FY 97/FY 96
Hearings				
Boston	318	302	293	-3.0%
New York	265	288	316	9.7%
Philadelphia	367	415	426	2.7%
Atlanta	355	369	353	-4.3%
Chicago	364	448	469	4.7%
Dallas	379	401	400	-0.2%
Kansas City	292	268	268	0.0%
Denver	270	298	310	4.0%
San Francisco	403	436	437	0.2%
Seattle	307	361	409	13.3%
Medicare Center	404	369	262	-29.0%
NATIONAL	349	379	384	1.3%

Commitments:
FY 1997 Column of the FY 1998
Budget Submission to OMB: 367 days

Age of Pending (In Days)

	09/95	09/96	11/96	Difference FY 97/FY 96
Hearings				
Boston	216	217	204	-6.0%
New York	180	222	228	2.7%
Philadelphia	255	307	312	1.6%
Atlanta	250	253	255	0.8%
Chicago	274	321	326	1.6%
Dallas	258	276	283	2.5%
Kansas City	224	266	280	5.3%
Denver	191	293	293	0.0%
San Francisco	288	304	300	-1.3%
Seattle	222	258	263	1.9%
Medicare Center	218	213	239	12.2%
NATIONAL	251	278	280	0.7%

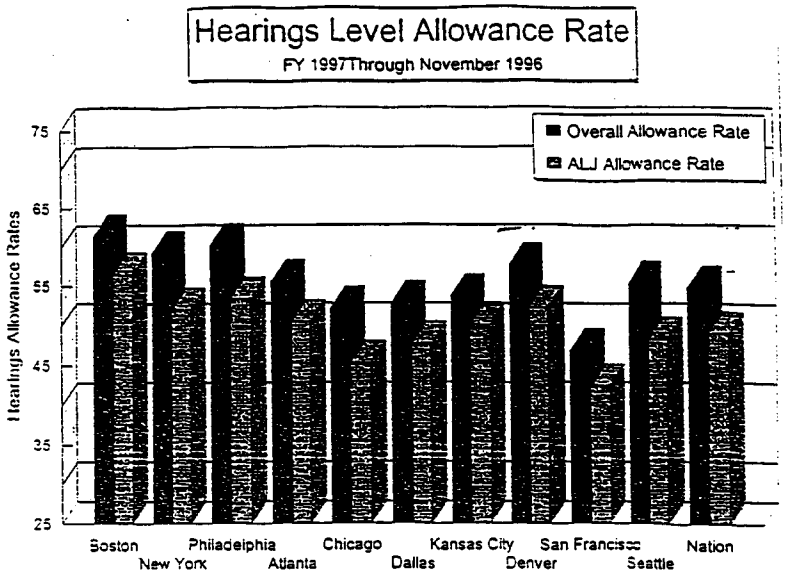
Last Updated: December 12, 1996
Contact: Kenneth Mackey
OPP, OHA: 703-305-1866



These rates are overall hearings allowance rates.
FY 1995 & FY 1996 data are annual, FY 1997 data is through November 1996.

Regions	FY 1995 Annual	FY 1996 Annual	FY 1997 Thru 11/96	Difference FY 97-FY96
Boston	71.6	69.5	61.4	(8.1)
New York	69.0	62.4	59.3	(3.1)
Philadelphia	71.5	64.1	60.2	(3.9)
Atlanta	67.4	60.8	55.6	(5.2)
Chicago	58.9	52.4	52.1	(0.3)
Dallas	61.1	52.9	52.8	(0.1)
Kansas City	59.9	56.6	53.7	(2.9)
Denver	70.6	63.8	57.7	(6.1)
San Francisco	61.0	52.7	46.8	(5.9)
Seattle	67.6	65.8	55.4	(10.4)
National	65.0	58.4	54.8	(3.6)

Last Updated: December 12, 1996
Contact: Steve Sapp
OPP, OHA, OCALJ 703-305-0009



Region	Overall Allowance Rate	ALJ Allowance Rate
Boston	61.4	56.5
New York	59.3	52.0
Philadelphia	60.2	53.4
Atlanta	55.6	50.4
Chicago	52.1	45.2
Dallas	52.8	47.6
Kansas City	53.7	50.1
Denver	57.7	52.3
San Francisco	46.8	42.3
Seattle	55.4	48.3
Nation	54.8	49.0

Last Updated: December 12, 1996
Contact: Steve Sapp
OPP, OHA, OCALJ 703-305-0009

Mr. BERNOSKI. OK. Thank you, Mr. Chairman.
[The prepared statement follows:]

Statement of Hon. Ronald G. Bernoski, Acting President, Association of Administrative Law Judges, Inc.

Mr. Chairman:

I. INTRODUCTION

My name is Ronald G. Bernoski, I am an administrative law judge (ALJ) 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 Acting President of the Association of Administrative Law Judges, Inc. (Association), a professional organization whose purpose is to promote judicial education and full due process hearings for those individuals seeking adjudication of controversies within the Social Security Administration (SSA).

The subject matter of this hearing is to review the effect of reversals of DDS determinations at the SSA appellate level. This is an area of Social Security disability process that has been examined repeatedly over the past years. The Congress expressed concern with this issue when it enacted the Disability Benefits Reform Act of 1984 which provided that "[t]he Secretary shall establish by regulation uniform standards which shall be applied at all levels of determination, review and adjudication in determining whether individuals are under disabilities as defined in section 216(i) of 223(d)." Since SSA has had a long established policy of evaluating disability claims by different standards at both the DDS and appellate levels, it should not be a surprise that a potential exists for a different finding for a single case at each level of review. It probably should be repeated that a Social Security Disability claim at the DDS level is decided under the Program Operations Manual System (POMS). This is less than a full legal review of the claim and it is a system that has been created by the agency for this purpose. At the appellate level the disability claim is adjudicated under the full scope of the legal standard which consists of the statutory law, case law, SSA regulations and SSA rules. Many reasons have been advanced for the difference in results between cases determined at the DDS level and those adjudicated at the administrative law judge level. These reasons have included the following differences at the administrative hearing; the appearance and testimony of the claimant, the use of expert testimony (medical and vocational), attorney representation, additional and different medical evidence, and a more advanced medical impairment. However, the largest distinguishing factor is the use of the legal standard at the appellate level which provides the claimant with the benefit of the full scope of the law for the adjudication of the claim. This factor clearly shows that the SSA disability adjudication system is a "top down" process. The standard to be used to adjudicate SSA disability claims must be the legal standard (which is based upon the Constitution, statutory law and case law) which is established by the courts because "it is, emphatically, the province and duty of the judicial department, to say what the law is" Marbury v. Madison, 1 Cranch 137, 177, 2 L.Ed. 60 (1803). The Association has long recommended a single standard at each level for deciding SSA disability claims which is based upon the law.

II. GAO FINDINGS

The GAO findings, that have been presented by the Subcommittee, appear to be the anchor upon which the major thrust of the hearing in based. It is with deep regret and even dismay that we question the reliability of the GAO findings. The methodology used in creating the report is deficient. No officer or director of the Association was interviewed by the GAO during the preparation of the report. The report fails to develop the history of the dual standards of SSA; it does not analyze the constitutional basis of the due process administrative hearing and it does not describe the agency policy addressing this issue.

The GAO states that the percentage of ALJ reversals of DDS disability determinations has been a long-standing problem for SSA. The report does not state that the dual standards for SSA disability determinations is based upon a long-standing policy of the agency. Within this system the DDS claims are decided by a standard set forth in the POMS while the disability claims at the appellate level are adjudicated under the legal standard. The major defect in the GAO report is that it does not

grasp that if the same fact situation is analyzed under two different standards that two different results can be achieved. The report also fails to acknowledge that the ALJ reversal rate of DDS determinations is declining. SSA records indicate that the ALJ allowance rate was 65% in FY 1995 and that by FY 1997 it had dropped to 54.8%. The GAO report also fails to explain the difference in DDS allowance rates while all DDSs are using the same standard. SSA records show that in FY 1997 differences in DDS allowance rates ranged from 22.2% TO 49.6%.

The GAO states that the ALJs and DDSs each employ a different approach in assessing the residual function capacity of the claimant. The GAO apparently is unaware that this difference in approach is based upon the fact that the ALJs follow the legal standard; may review a more complete medical record; hear the testimony of the claimant and other expert witnesses; and depending on the Federal circuit, may be required to follow a more demanding treating physician when weighing the medical evidence. The agency has been challenged in court for applying a different standard of review at the DDS and the Federal administrative level. These challenges are generally based upon the theory that the DDS does not provide a legally sufficient review of the claim (see Bentley et al. v. Sellars Case No. 92–40–Civ–J–20 Middle Dist. of Florida). We understand that several class actions are pending against the agency which raise this issue.

The GAO places considerable emphasis on the SSA quality assurance system, and claims that the use of this process could "minimize" the inconsistency in the current SSA dual disability system. This contention fails to acknowledge that SSA has by design created a dual process for disability claims, and that the only way to address this issue is to go to the root cause of the problem and adopt a single standard that is to be used by all SSA components. The allegation of the GAO also fails to consider the relationship of any quality assurance system to the constitutional due process rights of the claimants. If the case is to be reviewed by a quality assurance examiner, and the interest of the claimant has the potential of being adversely effected, how will the rights of the claimant be protected? Will the claimant have notice of the review? Will the claimant have a right to be heard? Will the claimant have an opportunity to appear and defend his/her interests? These are complex constitutional issues that were not adequately addressed in the GAO report. The GAO should be requested to address these constitutional issues and present a comprehensive explanation of the impact of any quality assurance system on the due process rights of the claimant.

On January 28, 1997 the Office of General Counsel of Social Security prepared a memorandum entitled Legal Foundations of the Duty of Impartiality in the Hearing Process and its Applicability to Administrative Law Judges. The memorandum appears to be an attempt to provide a legal basis to require administrative law judges to follow SSA policy that is not consistent with the law. The threat of disciplinary action before the Merit Systems Protection Board is the enforcement tool for the same. We are concerned that this hearing is an attempt to strengthen the hand of the agency to enforce this disciplinary action on SSA administrative law judges and the endorsement of the promulgation of agency policy that is not consistent with the law. This policy is contrary to the recommendations of the Judicial Conference of the United States, which is set forth in the Long Range Plan For The Federal Courts (December 1995), which includes recommendations that the Congress and the agencies concerned should be encouraged to take measures to broaden and strengthen the administrative hearing and review process for disputes assigned to agency jurisdiction and to generally prohibit agencies from adopting a policy of nonacquiescence to the precedent established in a particular federal circuit.

The GAO report stated that the SSA procedures contribute to inconsistent results because they limit the usefulness of the DDS decision as a foundation for the administrative law judge decision. The GAO fails to consider that the administrative law judge hearing is de novo and not certiorari to the DDS determination. It is thereby a completely new hearing and is not a continuation of the DDS process. The GAO report also fails to mention that the new SSA policy of Process Unification requires the administrative law judge to give the DDS medical evidence consideration when weighing the medical evidence in the case.

The GAO report stated that SSA must take decisive action to improve management of the decisionmaking process, but the report failed to describe how this is to be accomplished. How does an agency "manage" the administrative hearing process and not trample on the constitutional rights of the claimants? The GAO fails to recognize that the administrative hearing is based upon the due process clause of the 5th and 14th amendments of the U.S. Constitution which provides the claimant with certain guaranteed fundamental rights. The U.S. Supreme Court has held that "a fair trial in a fair tribunal is a basic requirement of due process, In re Murchinson, 349 U.S. 133 (1955). That "when governmental agencies adjudicate or

make binding determinations which directly affect the legal rights of individuals, it is imperative that those agencies use the procedures which have traditionally been associated with the judicial process," Hannah v. Larche, 363 U.S. 420 (1960). The due process requirement of a fair trial in a fair tribunal "applies to administrative agencies which adjudicate as well as to courts," Withrow v. Larkin, 421 U.S. 35 (1975).

In the late 1930's the Congress became aware of the criticism that many agencies were interfering with the function of hearing examiners (now administrative law judges) and thereby denying the litigants their constitutionally protected right of a due process hearing. The Congress enacted the Administrative Procedure Act to correct this problem, Ramspeck et al. v. Federal Trial Examiners Conference et al., 345 U.S. 128 (1953). The legislation elevated the status of the administrative law judge by making them semi-independent agency employees and it further created a procedure which ensured that the constitutionally protected due process hearing was provided to the litigants by the agencies. The U.S. Supreme Court then defined the function of the administrative law judge within this due process hearing system. In the case of Universal Camera Corp. v. National Labor Relations Board, 340 U.S. 474 (1950) the Court stated that one of the important purposes of the Administrative Procedure Act was the "enhancement of the status and function of the trial examiner" in the administrative process. The Court then went further and held that the findings of the hearing examiner would be considered as part of the record when applying the "substantial evidence" standard even if the agency disagreed with the findings of the administrative law judge. In Butz et al. v. Economou et al., 438 U.S. 478 (1978), the Court found that: "There can be little doubt that the role of the modern federal hearing examiner or administrative law judge within this framework is "functionally comparable" to that of a judge. His powers are often, if not generally comparable to those of a trial judge: He may issue subpoenas, rule on proffers of evidence, regulate the course of the hearing, and make or recommend decisions. More importantly, the process of agency adjudication is currently structured so as to assure that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency."

This law clearly establishes that the administrative law judge is to render a decision that is based upon the facts and the law and which is free from undue agency influence. How can the agency "manage" the decisionmaking process without violating this basic constitutional principle? The GAO should be requested to describe the content of its proposal that SSA should manage "the decisionmaking process" and further explain how it is compatible with the U.S. Constitution. If the agency attempts to manage or interfere with the function of the administrative law judge it will be engaging in the very conduct that the Administrative Procedure Act was enacted to correct.

III. New Agency Policy

In 1996 SSA promulgated a policy which addressed many of the issues raised by the GAO report. The agency policy of Process Unification created a single standard for deciding SSA disability claims at all levels in the process which is based upon the legal standard. It mandates a more comprehensive review of the claim at the DDS reconsideration level and requires consideration of the DDS medical review at the hearing level. At a recent SSA Redesign meeting a SSA representative stated that the single standard will be based upon the SSA regulations with certain elements of the POMS incorporated into the regulations. The GAO report did not acknowledge this new agency policy or consider its impact on the SSA disability process.

IV. Recommendation

In 1975 the average number of monthly case dispositions was 16 per administrative law judge. By FY 1996 the administrative law judges in SSA achieved a new high mark of 531,536 case dispositions. This computes to over 44 cases a month per judge. This is a commendable performance in view of the fact that the cases have become complex, more voluminous, require the use of more expert witnesses, have more attorney representation and are more time consuming. Our judges are accustomed to working hard, and we ask only to be permitted to function within the scope of the law.

The Association has long recommended that a single standard be used for the determination of SSA disability claims at all levels of the process. This single standard must be based upon the legal standard, because this is the standard upon which the claim will be decided should the case be appealed to the Federal courts. The

Association has expressed concern with certain aspects of the agency policy of Process Unification. We have raised issue with the failure to develop a policy for compelling the presence of DDS medical authorities at the administrative law judge hearing should the claimants decide to insist upon the production of this evidence with subpoena power using the case of Lidy v. Sullivan, 911 F.2d 1075 (5th Cir. 1990) as authority. We are most concerned with the policy of nonacquiescence which is part of Process Unification. This is a separation of powers issue which caused the agency considerable stress in the 1980's. Our concerns have been expressed to the Commissioner in writing.

Our judges take an oath to uphold the law and the U.S. Constitution which we have a duty to follow. We understand our responsibility to follow the Constitution and apply the law, agency regulations and agency policy which we take very seriously. But we believe that it is beyond the scope of our oath of office to apply agency policy that is inconsistent with the law. It is the rule of law that protects against the abuses of power. This can only be accomplished by respecting the due process of law.

Respectfully submitted,

RONALD G. BERNOSKI
Acting President

Chairman BUNNING. Ms. Gardiner.

STATEMENT OF DEBI GARDINER, PRESIDENT-ELECT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS; ACCOMPANIED BY TOM CHRISTOPHER, PAST PRESIDENT

Ms. GARDINER. Chairman Bunning and Members of the Subcommittee, my name is Debi Gardiner. I am a hearing officer with the Baton Rouge, Louisiana, Disability Hearing Unit, and I am also president-elect of NADE, the National Association of Disability Examiners.

On behalf of the membership of NADE, I would like to thank you for the opportunity to present our views on the differences in the DDS and OHA disability decisions.

NADE is a professional association whose membership includes disability examiners and other professionals in State agencies where Social Security disability decisions are made, as well as within SSA. We also have attorneys, physicians, ALJs, program advocates, and other individuals with interest in the disability program.

Because of the experience our members have in adjudicating Social Security and SSI disability claims, NADE has a keen interest in the issues before this Subcommittee. We believe this is an important hearing. Until now, few within SSA would acknowledge that we do have two different disability programs, one in DDS and one in OHA.

Now that there is more acknowledgement that the problem exists, how do we fix it? NADE believes that SSA took an important first step with the cross component, Process Unification training, which stressed selected critical policy to every individual making or reviewing disability decisions. We understand that preliminary data suggests that following Process Unification, the ALJ allowances have somewhat decreased.

Expansion on this initiative by SSA is a must. Additional training for the ALJs, especially medical training, is essential if the discrepancy is to be resolved. SSA needs to take advantage of new pol-

icy issues to provide consistent training on key policy issues to all decisionmakers within the DDSs and the OHAs.

The general counsel has issued an opinion asserting SSA's authority to establish programmatic policies that ALJs must follow. This should assure their authority over the programmatic policy to all components involved in disability adjudication.

Currently, there is limited review of ALJ allowances. This is an important first step. However, a significant number of reviews must be done prior to effectuation so that inappropriate allowances can be readily corrected. We suggest that this number be sufficient to provide meaningful data and feedback regarding the accuracy of the ALJ decisions, as is currently done in the DDS.

We continue to have concerns that the DDS decisions will be reviewed by SSA's Office of Program and Integrity Review, while the ALJ decisions are reviewed by the appeals counsel. Also, the same evidentiary standards must apply to DDS and ALJ decisions.

The congressionally mandated 50-percent preeffectuation review of DDS allowances lends itself to the perception that DDS are sanctioned with error citations for predominantly favorable decisions. This perception is reversed for the ALJ decisions since there is only very minimal review of ALJ allowances. Thus, the two bodies, the DDSs and the ALJs, are sanctioned with error citations for completely opposite decisions. As a result, NADE recommends Congress require SSA to initiate steps to ensure that a greater percentage of ALJ allowances be subjected to preeffectuation review. We feel this would be an additional step toward resolving this discrepancy.

Reducing OHA backlog is essential. Because of delays, some claimants are much more impaired by the time they receive their hearing than when they were denied at DDS. This further serves to create the perception of discrepancy between the two components and, more importantly, is a hardship on the individual who is deserving of disability benefits.

The ultimate goal for SSA within the umbrella of Process Unification is to create the single book of program policy for decisionmakers. Currently, the DDSs have their procedure and policy vehicles and OHA has theirs. Obviously, we must all be working from the same book in order to have a more uniform system. NADE is very concerned that the delivery date for this critical piece keeps slipping away, and we would encourage SSA to make this a top priority.

One policy area which is being applied differently between the DDSs and the ALJs is proper adjudicative weight being given to the training source opinion. This is a policy area SSA has tried to address, and this is one policy area in which a congressional fix might be in the program's best interest. We would be delighted to work with you on this.

I would like to reiterate that SSA has taken the first tentative steps toward meaningful reform to narrow the gap between the DDS and ALJ allowance rates. We appreciate the Subcommittee's interest in and attention to this critical issue facing the disability program and for the opportunity to appear before you.

[The prepared statement follows:]

Statement of Debi Gardiner, President-Elect, National Association of Disability Examiners; Accompanied by Tom Christopher, Past President

Chairman Bunning and members of the Subcommittee, on behalf of the National Association of Disability Examiners (NADE) I wish to thank you for the opportunity to present our views on the differences in DDS and OHA disability decisions, emphasizing possible remedies to this situation.

NADE is a professional association whose membership includes disability examiners and other professionals in State Agencies where Social Security Disability Decisions are made, and within SSA, as well as physicians, attorneys, administrative law judges, program advocates, and other individuals with interest in the disability program.

Our interest in the issues before this committee today goes back many years and has been the subject of extensive writing by many of our members some of which has been designated as official position papers by the Association. On September 12th of last year we presented testimony to you addressing the discrepancy between DDS and ALJ decisions. These comments were subsequently expanded, to include an analysis of the causes of the discrepancy, and submitted for the hearings record at your request. Today, we would like to review recent initiatives by SSA to confront this problem and, finally, to suggest additional administrative and legislative remedies.

We continue to believe that SSA took an important first step with the cross-component process unification training which emphasized selected critical policy to every individual involved in making or reviewing disability decisions, e.g, restating the requirement that ALJs give appropriate weight, as the opinion of a nonexamining physician or psychologist, to findings of residual functional capacity, and other findings, by DDS medical consultants. Following up on the unification initiative by expanding quality review of ALJ allowances will, we trust, reinforce the positive messages of the training. We understand from SSA officials that very preliminary data suggests that ALJ allowance rates have decreased somewhat following the process unification training. I will make suggestions for additional revisions to the review process later on in my comments.

Also, SSA has, though, perhaps, somewhat belatedly, obtained an opinion from General Counsel that asserts the Agency's authority to establish programmatic policies that ALJs must follow, require ALJs to attend training on the Agency's policy interpretations, and to follow them, while safeguarding the duty of impartiality owed to claimants. We are hopeful that this finding will remove any ambiguity that may remain regarding SSA's authority in matters involving programmatic policy at all levels of adjudication.

SSA must continue and expand each of these initiatives. Additional training for ALJs, particularly medical training, is essential if that part of decisional discrepancy comprised of unsupported allowances by ALJs is to be corrected. I would cite, by way of example, the requirement to afford controlling weight to the opinion evidence of treating physicians when that opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques. This requirement becomes an empty one if ALJs are not sufficiently grounded in knowledge of medically acceptable diagnostic techniques to make supportable determinations in this regard. The alternative is uncritical acceptance of medical opinion.

Initiatives already undertaken to include review of ALJ allowances must be expanded and revised. The current limited review for data gathering and advisory purposes is an important first step; however, without a statistically significant number of reviews, done prior to effectuation so that inappropriate allowances can be readily corrected, true unification will not occur. We applaud SSAs plan to write a regulation requiring a "live" preeffectuation review of ALJ allowances. We suggest to them that the number of such reviews comport with the number of reviews of DDS allowances. We continue to be concerned, however, that DDS determinations will be reviewed by SSA's Office of Program and Integrity Reviews (OPIR) while ALJ decisions will be reviewed by the Appeals Council. We have spoken frequently of the differences that exist between the various regional OPIRs that militate against consistency. We believe that the same kinds of differences, perhaps magnitudes greater, will exist between OPIR and the Appeals Council. Finally, the same evidentiary standards must apply in review of DDS and ALJ decisions.

Full resolution of the quality review-based aspect of discrepant decisions may require legislative remedies. It has become a commonplace to cite the fact that the congressionally mandated 50% preeffectuation review of DDS allowances, in conjunction with the historical fact that the vast preponderance of reviews of ALJ decisions were of denials by the courts has led to the perception that DDSs are sanctioned with error citation predominantly for favorable decisions while ALJs are

sanctioned by court reversals of unfavorable decisions. In that context, we once again recommend creation of a Social Security Court. Additionally, we support closing the record after a hearing by an ALJ.

We also recommend legislative review of the mandated preeffectuation review. Congress might consider requiring the same percentage of DDS and ALJ allowances to correct the discrepant signals these components receive from the review of favorable decisions.

Finally, I would offer a brief comment on OHA backlogs. Efforts to reduce these are absolutely essential. It is well-known that ALJs often decide cases on individuals who, because of delays, are much more impaired than when they were denied by the DDS. This creates a perception that the discrepancy between these two components is greater than it actually is. More importantly, however, it causes an inordinate amount of hardship to individuals deserving of disability benefits. We urge close administrative and legislative scrutiny of this issue.

In closing, I would like to reiterate that SSA has undertaken several important initiatives to narrow the gap between DDS and ALJ allowance rates. These tentative first steps lay the groundwork for meaningful reform. We appreciate the Committee's interest in and attention to these critical issues facing the disability program and the opportunity to appear before you to present our views.

Chairman BUNNING. Mr. Hill, please.

STATEMENT OF JAMES A. HILL, PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION, CHAPTER 224

Mr. HILL. Good morning, Mr. Chairman. My name is James Hill. I am employed by the Office of Hearings and Appeals of the Social Security Administration as a senior attorney in its Cleveland, Ohio, hearing office. I am also the president of the National Treasury Employees Union, chapter 224, which represents attorney-advisers in 96 hearing offices across the United States. I wish to thank the Subcommittee for inviting me to testify this morning.

The massive increase in the disability backlog that OHA experienced from 1992 to 1996 has been contained. There has been no significant change in that backlog since July 1996. While no one at OHA is satisfied with the status quo, we are at least moving in the right direction.

This stabilization of the backlog is due in great part to the senior attorney program which, if continued, will permit significant reductions in case backlog, processing times, and even in the reversal rate, thereby providing greatly improved service to the public.

For some time, the disability program has been beleaguered by two intractable problems, the lack of an effective CDR Program and the OHA backlog. SSA decided to create an entirely new disability adjudication system, the disability process redesign. However, at the outset of the redesign, SSA admitted that it was not intended to deal with either of the aforementioned problems.

In order to cover this somewhat embarrassing oversight, SSA subsequently claimed that one goal of AO, the adjudication officer, initiative was to reduce that backlog.

Testing for the AO project began in November 1995, and despite the highest level of priority, carefully selected personnel, and the establishment of closely controlled ideal test conditions, AO productivity remains at less than one-half of the level predicted by the redesign model.

Through February 21, 1997, despite the resources lavished upon it, the AO had produced only 5,689 decisions. Further, the quality

of those decisions, based on agency quality assurance evaluations, is considerably less than that of similar ALJ and senior attorney decisions. To date, the redesign has had no measurable impact on the workload at OHA except consuming resources, both human and material that could have been put to much better use.

The primary short-term initiative directed at OHA workload is a senior attorney program which is also known as Action 7 of the Short-Term Disability Project. This program produced approximately 47,000 decisions in fiscal year 1996. Recent management initiatives have significantly improved the operational efficiency of this program. During the first 3 months of 1997, nearly 16,000 Action 7 decisions were issued. This is an annual rate of over 62,000 cases.

Quality assurance studies have demonstrated that the accuracy rate of senior attorney decisions significantly exceeds that of adjudication officers and is slightly higher than ALJ on-the-record decisions. The accuracy of the senior attorney decisions, combined with their 22-percent payment rate, refutes any allegation that the program is designed to pay down the backlog.

Additionally, the implementation of Action 7 has not resulted in an unacceptable increase in the number of ALJ decisions awaiting drafting. Action 7 has resulted in deserving claimants receiving favorable decisions with an average processing time of only 120 days.

The prime factors in achieving both decisional accuracy and consistency are expertise, experience, accountability, and decisional independence. A considered effort must be made to ensure that all decisionmakers meet these criteria.

A consistent quality assurance process at all levels and vigorous enforcement of the Process Unification rulings will significantly improve decisional consistency.

The lower payment rate of senior attorneys who are applying the same standards and considering the same factors as ALJs as compared to the payment rates of ALJs is documented, but has not been analyzed. Such an analysis could prove instrumental in achieving a higher level of decisional accuracy and consistency inasmuch as senior attorney decisional behavior seems to fall between the decisional behaviors of the State agencies and the ALJs.

Thank you.

[The prepared statement follows:]

Statement of James A. Hill, President, National Treasury Employees Union, Chapter 224

My name is James A. Hill. I am employed by the Office of Hearings and Appeals (OHA) of the Social Security Administration (SSA) as a Senior Attorney. 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 which formulated the Short Term Disability Project and am a member on the committee that oversaw 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.

SUMMARY

The Current Status of OHA Workloads and Their Impact on Service to the Public

The massive increase in the disability backlog at OHA experienced from 1994 to 1996 has been contained; there has been no significant change in the backlog from July 1996 (529,113 cases) to March 1997 (527,125 cases). This stabilization of the backlog affords OHA the opportunity to effect incremental changes in its processes within its current structure, such as the Senior Attorney Program, which will permit a significant reduction in the case backlog, in processing times, in the average age of pending cases, and in the reversal rate during the next two years.

The Effects of Long-Term Initiatives on OHA Workloads

The primary Long-Term Initiative purporting to improve the OHA workload situation is the Redesigned Disability Process (Redesign). However, at the outset of the Redesign SSA admitted that the Redesign was not intended to deal with the two largest problems plaguing the Social Security disability system: The lack of an effective Continuing Disability Review (CDR) and the backlog at OHA. The Redesign consists of 83 separate initiatives of which GAO recently noted none had been completed. The initiative with the most potential to impact the workload situation of OHA is the Adjudication Officer (AO) Initiative which began testing in November 1995. Despite the highest level of priority, carefully selected personnel, a priority on data processing equipment, and the establishment of closely controlled, ideal test conditions, AO productivity remains at less than half the level predicted by the Redesign model. Through February 21, 1997, despite the resources lavished upon it, the AO test had produced only 5,689 decisions and 12,985 certifications to ALJs. Further, the quality of those decisions, based on Agency quality assurance evaluations, is less than that of similar ALJ and Senior Attorney decisions. The Redesign has had no measurable effect upon the workload of OHA except consuming resources, both human and material, that could have been put to much better use. Furthermore, a full roll out of this initiative would almost certainly require reassignment of substantial numbers of OHA personnel rendering OHA incapable of performing its mission.

The Effects of Short-Term Initiatives on OHA Workloads

The primary short-term initiative directed at the OHA workload was the Short Term Disability Project (STDP) which except for Action # 6 (screening units) and Action #7 (the Senior Attorney Program) ended December 31, 1996. Senior Attorneys spend approximately 25–50% of their time performing Action #7 work and most of the remaining 50–75% of their time drafting ALJ decisions. The ability of Senior Attorneys to perform both tasks significantly increases managerial flexibility allowing human assets to be directed to the highest priority tasks. Action #7 was hindered by a variety of "start-up" problems and fierce resistence from ALJs, including many Hearing Office Chief Administrative Law Judges. Despite this resistence nearly 47,000 Action #7 decisions were produced in FY 1996. However, recent management initiatives have significantly improved the operational efficiency of Action #7 resulting in a significant increase in production. During the first three calendar months of 1997 nearly 16,000 Action #7 decisions were issued; this is an annual rate of over 62,000 cases. Quality Assurance studies have demonstrated that the accuracy rate of Senior Attorney decisions significantly exceeds that of Adjudication Officers and is somewhat higher than that of on-the-record ALJ decisions. During FY 1997 Senior Attorney decisions have been significantly more accurate than ALJ on-the-record decisions. The accuracy of the Senior Attorney decisions combined with the significantly lower payment rate of Senior Attorneys (approximately 22%) than the payment rate of ALJ on the Senior Attorney cases that were not paid by Senior Attorneys (approximately 57.1%) demonstrate that Action #7 is not an effort to "pay down the backlog." Additionally, the implementation of Action #7 has not resulted in an unacceptable increase in the number of ALJ decisions awaiting drafting. Action #7 has resulted in deserving claimants receiving a favorable decision with an average processing time of approximately 120 days as compared to the over 1 year average processing time for a case requiring an ALJ hearing. Finally, Action #7 has caused a decrease of nearly a month and a half in processing time even for those Action #7 cases which were not paid by Senior Attorneys and which still required an ALJ hearing as compared with non-Action #7 cases.

SSA Decisional Inconsistency

A number of well known factors contribute to the decisional inconsistencies between the various adjudicatory levels. A quality assurance process that concentrates upon favorable decisions at the DDS level with insufficient control regarding the

quality of the adverse decisions, and the exact opposite situation at the appellate level is a prime factor in producing decisional inconsistency. However, the failure of the State Agencies to provide adequate written explanations for their decisions, their failure to adequately develop cases, and their failure to consider the effect of the claimant's symptoms not only limits the usefulness of their determinations at the OHA level, but contributes to incorrect determinations. Vigorous enforcement of the Process Unification Rulings at the State Agency level will significantly improve decisional accuracy. In evaluating the situation at the OHA level, and indeed in evaluating the entire matter of decisional consistency, the old paradigm of two levels of decision making (DDS and OHA which really meant ALJ) must be replaced by a paradigm consisting of three levels of decision making (DDS, Senior Attorney, and ALJ). The payment rates of the screening units demonstrate that even using DDS standards, DDS decisions are wrong a significant amount of time. The lower payment rate of Senior Attorneys, who are applying the same standards and considering the same factors as ALJs, as compared to the payment rate of ALJs has been documented but not sufficiently analyzed. Such an analysis could prove enlightening in as much as Senior Attorney payments rates seem to fall between those of the screening units which apply "DDS standards" and ALJ. Inclusion of subject matter expertise in the ALJ selection criteria would ensure a more consistent level of expertise at all decisional levels thereby increasing decisional accuracy. Finally, increasing ALJ and DDS accountability for producing accurate decisions.

RECOMMENDATIONS

- The Adjudication Officer Program should be discontinued and the Senior Attorney Program made permanent.
- The State Agencies must place greater emphasis upon compliance with the Process Unification Rulings and fully developing the medical record.
- A study of the factors affecting the decision making process at the DDS, Senior Attorney, and ALJ level should be conducted to establish best practices which could be applied at all levels.
- Include subject matter expertise in the ALJ selection criteria.
- Increasing the accountability of decision as appropriate.

The Current Status of OHA Workloads and Their Impact on Service to the Public

At the beginning of July 1996 OHA had 529,113 cases pending; at the end of March 1997 OHA had 527,125 cases pending. At the end of July 1996 there were 22,445 cases pending drafting; at the end on March 1997 there were 23,906 cases pending drafting. OHA receipts during that period were at an annualized rate of 562,010 cases. In July 1996 average processing time at OHA was 379.84 days; at the end of March 1997 average processing time at OHA was 369.67 days. In July 1996 average age of pending cases at OHA was 275.00 days; at the end of March 1997 average age of pending cases at OHA was 274.99 days. During the period in question the number of ALJs increased from 1024 to 1064 while the number of decision writers declined from 1703 to 1546. While NTEU is not satisfied by the current status of OHA workloads, the record clearly demonstrates that the days of massive increases in the OHA backlog are finally behind us. This is particularly impressive given the fact that OHA receipts continue to increase, albeit at a significantly slower rate than during 1994–1996. This stabilization of the OHA backlog affords OHA the opportunity to effect incremental changes in its processes within the current structure which will permit a significant reduction in the backlog, in processing times, in the average age of pending cases, and in the reversal rate during the next two years. Action #7 of the Short Term Disability Project, which empowers Senior Attorneys to review, develop and issue fully favorable decisions has demonstrated its ability to increase OHA dispositions without adversely affecting decisional accuracy, payment rate, program costs, and the number of ALJ cases awaiting decision drafting.

Effects of Long-Term Initiatives

The primary long term initiative through which SSA is attempting to modify the disability adjudication system is the Disability Process Redesign (Redesign). During the past several years SSA has had two major problems with its disability program which have significantly reduced the quality of the service provided to the public—the disability case backlog at OHA and the lack of an effective Continuing Disability Review (CDR) program. Amazingly, the Redesign as announced by then Commissioner Shirley Chater specifically excluded rehabilitation or continuing disability issues from consideration, and explicitly stated that Redesign was not designed to reduce the hearings backlog. In order to divert some of the criticism regarding this

oversight, sometime after its inception, SSA officials decided to present one part of the Redesign, the Adjudication Officer, as a vehicle to assist in reducing the current backlog at the Office of Hearings and Appeals. Of course, the Adjudication Officer initiative was not designed for the purpose of reducing the pre-existing backlog.

The Redesign is a prime example of a typical response of a governmental bureaucracy which entails solving a problem by instituting a massive and expensive program which is more responsive to the needs of the bureaucracy that created it than to the needs of the people it purports to serve. SSA is currently involved in an extensive review of its customer service program. To that end a Customer Service Executive Team (CSET) has been charged with the responsibility of reviewing the current plan and suggesting improvements. In a meeting on April 16, 1997 the CSET proposed that the Agency conduct focus groups and surveys of its "disability customers" to update its understanding of the service desired by these customers. At that time a senior SSA executive informed the CSET that such activities would make those managing the Redesign very uneasy because the customers might indicate desires not consistent with the Agency's current plans. This is a clear indication that the driving force behind the Redesign is not improved service to the public, but advantage in the ongoing power struggle at the upper echelon of SSA management. As is often the case with major initiatives in the federal government, those senior officials who conceived the initiative and began its implementation are no longer with the Agency, thereby relieving those individuals from the responsibility of dealing with the problems caused by their creation. I have often wondered how many of the seemingly endless number of projects and initiatives proposed and implemented by senior management would have been commenced had those administrators expected to be employed by the Agency when the inevitable problems developed.

Distilled to its essence, the Disability Process Redesign, as conceived by Rhoda Davis and championed by Shirley Chater and Larry Thompson, is a grandiose scheme whose primary goal is to centralize control of the disability determination process in the hands of an isolated bureaucracy in Baltimore more concerned with its own desire for power than the needs of the public. Indeed, the primary purpose of implementing the aforementioned Adjudication Officer is to effectively eliminate the Office of Hearings and Appeals and further centralize control of the disability process in the hands of the bureaucracy in Baltimore. Unfortunately, this bureaucracy has on countless occasions revealed its lack of understanding and contempt for the concept of due process in the adjudication process.[1] At the time the pilot for the Adjudication Officer began, SSA tried repeatedly to secure an enabling regulation which provided for a full roll out of the position several months after the pilot began. At that time, SSA insisted that the concept of the Adjudication Officer had been confirmed, and that only minimal testing was needed for fine tuning. Fortunately, OMB averted disaster by authorizing only a testing regulation.

Testing of the AO began in November 1995 with the opening of test facilities in 9 state sites. Sixteen additional federal sites were opened in the following several months. Approximately 120 Adjudication Officers have been involved in the test. The initial test period expired in November 1996, but the results of the test were so discouraging that SSA concluded that further testing was needed. Therefore testing has been continued while "modifying/adjusting policies and procedures" Currently, SSA plans to commence a full roll out of the AO process beginning in January 1998.

A review of the results of the test so far demonstrates the magnitude of the Agency's capacity for understatement. A more disinterested observer would likely characterize the AO test as an unmitigated disaster. Productivity for the AO was originally projected to be at least 2 clearances per AO per day. Actual test data demonstrates that productivity has peaked at a production of 0.8 to 0.9 per AO per day. Furthermore, quality assurances reviews have revealed significant deficiencies in areas vital to disability determinations including onset, duration, activities of daily living, past relevant work, transferability of skills, the existence of others jobs, and the effects of symptoms upon an individual's ability to work. The decisions of AOs have consistently had a lower effectuation rate after review by the Appeals Council than either Senior Attorney decisions or ALJ on-the-record decisions. While SSA claims that it is too early to ascertain what the impact of the AO on program costs is, current indications are that it will result in a significant increase in those costs. Finally it should be noted that from its onset in November 1995 through February 21, 1997, the last date for which NTEU has data, the AO test had produced only 5,689 deci-

[1] Similar disregard for the legal system including the role of the courts in that system underlies the Agency's developing controversy with the Federal Courts regarding Agency acquiescence to Circit Court decision.

sions and 12,985 certifications to ALJs. For comparison, in the month of March 1997 alone, Senior Attorneys produced 5,297 decisions and reviewed 21,474 cases.

SSA has provided a number of excuses for the poor performance of the AO test, but has not yet seriously addressed the question of whether the problem is with the program itself rather than its execution. SSA states that training and start up times have adversely affected production. While this is undoubtedly true at the outset, the learning curve has long since stabilized and production has remained essentially unchanged for many months. Interestingly enough, the most successful sites have involved staff attorneys from OHA detailed to the AO test. These individuals, many of whom have years of experience dealing with cases at the appellate level and are far more comfortable dealing with the claimants' attorneys, have provided more efficient service than their non-professional, less experienced colleagues.[2] SSA also attributes reduced production to creating a new hearing level "culture," varying levels of local-site managerial support, and a "lack of traditional organizational ownership which has affected the overall support the AO test has received."

If true, this would be a stunning admission of the ineptitude of SSA management given the fact that the Redesign has the highest priority and the AO test itself has the highest priority on both human and material resources. Many of the AOs and much of the support clerical staff in AO sites are, in the eyes of the DPRT, "the best of the best" and have been recruited from across the country and detailed to the AO test site locations, thereby incurring a considerable cost in lodging and per diem expenses. It is demonstrative of the level of priority given to the Redesign that the Agency is willing to pay lodging and per diem costs to bring AOs and clerical workers to the AO tests sites including areas such as New York City for a "test" that began in some offices in November 1995 and has no end in sight.[3] NTEU believes it would be a far better use of the taxpayers' money to use AOs and clerical support indigenous to the AO work site areas rather than incur the additional lodging and per diem costs. This is a prime example of the high priority given to the AO test by SSA. To solve the "managerial problems" SSA has shifted operational control from DPRT to the Deputy Commissioner for Operations (DCO).[4] In as much as less than half of the AO test sites report to DCO, this change seems more cosmetic than functional. More to the point is a statement made at the Redesign Disability Process Advisory Council meeting in February 1997 when SSA officials stated that the productivity discrepancy is due to a faulty model. Of course it was the results of these flawed models upon which the decision to implement the Redesign was justified.

The anemic level of AO productivity is a matter of grave concern. Based upon the model which predicted that productivity would be in the range of two a day, staffing, material and physical plant estimates were made. It is clear that SSA cannot tolerate any program that causes a significant increase in the disability backlog. Throughout the test cycle, when the AO sites were incapable of handling even the limited number of cases assigned to them, intake to them was diverted to the hearing offices for processing through the current process. These diversions assured that the Agency would be spared the embarrassment of the AO creating yet another backlog in the disability adjudication system, and did little to enhance the viability of the AO process in a "real world" setting. Diverting intake to hearing offices will not be possible if and when the AO roll out is commenced. As conceived by the Redesign, an AO was projected to produce two decisions a day; currently, long after the learning curve has expired, the AO test has demonstrated a productivity of only 0.8–0.9 clearances per day. Such a low level of productivity would require more than doubling the 1250 AOs originally projected. In fact, processing the more than 600,000 cases appealed to OHA a year at the rate of one case a day will require at least 2500–2800 AOs. Additionally, supporting staff, office space and equipment would also have to be more than doubled.

However, that relative lack of productivity is not the only failing of the AO pilot. Decisional accuracy by AOs is less than that of Senior Attorneys or ALJs involving on-the-record cases. Both the productivity and accuracy problems are at least in part traceable to the Agency's choice of personnel to staff the AO position. While SSA loudly, but quite inaccurately, characterizes the AO as a professional adjudicator, the fact of the matter is most AOs had little previous experience in dealing di-

[2] Some of these attorneys received temporary promotions to the GS–13 Senior Attorney position. These individuals were permitted to retain the GS–13 temporary grade despite the fact they were detailed to a GS–12 non-attorney position.

[3] It is rumored that some of these individuals actually receive lodging and per diem payments greater than their salary.

[4] At the same time the DPRT was substantially downsized and its Director, Charles Jones, left the Agency.

rectly with claimant's and their representatives, medical issues, legal issues, or preparing legally defensible decisions. In short, not only are these individuals not "professionals" as that term is normally used, but many, if not most, lacked the necessary education, training, and experience to function successfully as an independent adjudicator. SSA in the form of staff attorneys in OHA has hundreds of true professionals that had the necessary education, training and experience to become successful adjudicators.

Effects of Short-Term Initiatives

The Short Term Disability Project was designed as a short term solution to growing backlogs at the DDS level and the far more serious backlog at the hearings level. STDP formally ended as intended on December 31, 1996 except that Action # 6 and Action #7 have continued. While the backlog at OHA was not significantly diminished during the course of STDP, it did cease to grow. Considering that it had grown at an annual rate of approximately 100,000 cases during the two years preceding the effective implementation of the STDP programs intended to deal with the OHA situation, STDP can be considered to be an unqualified success. The most important initiative in the STDP package regarding backlog reduction at the hearing level was Action #7 which involves Senior Attorneys at OHA reviewing, developing and paying on-the-record, if appropriate, cases determined by a profile to be the most likely payments. Senior Attorneys spend approximately 25–50% of their time performing Action #7 work and most of the remaining 50–75% of their time drafting ALJ decisions. The ability of Senior Attorneys to perform both tasks significantly increases managerial flexibility allowing human assets to be directed to the highest priority tasks. Those cases that could not be paid on-the-record by Senior Attorneys are forwarded to an ALJ for processing consistent with normal OHA procedures.[5] By Senior Attorneys finding, developing and paying appropriate cases, deserving claimants received a favorable decision within months of their filing an appeal and were spared the one to two year wait for a hearing. It should be noted that further development of the medical and non-medical record is an integral part of Action #7; it is this development that both demonstrates that an individual is in fact disabled and measurably improves the quality of the decisions rendered. Despite this development, average processing time for favorable Senior Attorney decisions (August 1995 through the end of March 1997) is only 124 days. This places a favorable decision in the hands of deserving claimants only four months after they file their Request for a Hearing. Current processing time at OHA for cases that go through the hearing process for the same time period is 414 days for non Action #7 cases and 376 days for Action #7 cases. The decrease in processing time of Action #7 cases at the ALJ level can be attributed to the effects of the case development performed by Senior Attorneys on those cases that they forward to the ALJs. Action #7 clearly provides improved service to claimants.

Despite it obvious success, the Senior Attorney program has been unjustly criticized ever since its proposal. It was fiercely opposed by the Association of ALJs, Inc., many of the state agencies and many in the Redesign bureaucracy, who objected to any intrusion onto their "turf." Nonetheless, through the vision and labors of OHA, NTEU, and the STDP Team, the Senior Attorney program came into being. A key element in implementing the program was the creation of regulatory authority. Although the states had the authority to permit Action #7 to be launched without formal regulatory authority, except for the states in the Southeast United States, very few did. Therefore, full implementation of Action #7 had to wait until the end of the rule making process. In July 1995 the necessary regulatory language was finally in place, so in August 1995 the program was commenced in the face of continued hostility. In fact opposition by local hearing office management, usually by Hearing Office Chief Administrative Law Judges, continues to be a major factor in limiting the effectiveness of Act. This opposition takes many forms including lower performance evaluations for individual Senior Attorneys who issue a substantial number of Action #7 cases, failure to provide even minimal staff assistance, failure to conform to Agency policy directives, and return to the "unit system." In fact it was not until late 1996 that OHA management made a concerted attempt to overcome hearing office obstructionism to Action #7. The result of that effort was gratifying. In the first 3 months of 1997 nearly 16,000 fully favorable decisions were released pursuant to Action #7. The record clearly demonstrates that Action #7 has significantly increased the number of dispositions at OHA thereby materially reducing the number of cases which would be awaiting decision.

[5] In many ways the Senior Attorney and the Adjudication Officer perform similar functions; however the Senior Attorney program has been the far more effective of the two programs.

If current trends continue, Action #7 will produce more than 50,000 decisions in FY 1997 and over 100,000 decisions for FY 1996–1997 without significantly impairing any area of OHA decisional productivity. It is these decisions, when added to the decisions of the ALJs which have stopped the increase in the OHA backlog and which if allowed to further develop, provide the mechanism by which the OHA backlog will be eliminated. The following table shows the breakdown by Region of the number of Senior Attorney decisions made and the Senior Attorney payment rate since Action #7 commenced.

Senior Attorney Decisions—August 1995–March 1997

Region	Reviewed	Allowed	Payment Rate
I	9,253	2,384	25.8%
II	42,131	12,567	29.8%
III	37,739	7,638	20.2%
IV	70,891	19,133	27.0%
V	56,252	9,160	16.3%
VI	46,519	7,893	17.0%
VII	11,777	1,914	16.2%
VIII	8,394	1,781	21.2%
IX	38,256	7,023	18.6%
X	11,680	2,710	23.2%
Total	332,892	72,203	21.69%

There are a number of concerns regarding Action #7 which have been expressed. Some claimed that it was merely an attempt to "pay down the backlog"; some feared that Senior Attorneys would be subject to coercion by SSA to expedite these cases; many feared a significant increase in the number of ALJ decisions awaiting drafting; and some feared that the quality of the decisions made by Senior Attorneys would be unacceptable. Many in the state agencies, who bitterly resent any review of their work product and who were already distressed by the high payment rate at OHA, believed that Action #7 would result in reversal rates embarrassing to the state agencies. Experience has demonstrated that none of these fears have come to pass.

Number of Favorable Decisions From August 1995 Through March 1997

	Action #7 OTR	Action #7 After Hearing	Non-Action #7 OTR	Non-Action #7 After Hearing
Senior Attorneys	72,203	NA	NA	NA
ALJs	23,657	69,985	71,170	281,098

Action #7 was designed to assure that deserving claimants were awarded disability benefits as quickly as possible. However, as with any such program there is the danger that those who are not truly disabled would be found disabled. Many, the Association of ALJ, Inc. most notably, constantly proclaimed that the purpose of Action #7 was to "pay down the backlog." To assure that such was not the case, a comprehensive quality assurance program has been put in place to monitor on-the-record decisions of Senior Attorneys, ALJs and Adjudication Officers. The most reliable of the quality assurance reviews is performed by the Appeals Council. The Appeals Council has reviewed a sample of on-the-record cases from Senior Attorneys, Administrative Law Judges, and Adjudication Officers and determined which cases can be effectuated, which cases must be remanded, and which cases the Appeals Council itself would issue a decision. As demonstrated by the Tables below, this review has resulted in a finding that the quality of the decisions made by Senior Attorneys is better than that of the AOs and the on-the-record decisions of ALJs. The tables also reveal that the accuracy of the Senior Attorney decisions has increased as Senior Attorneys have become more experienced.

Appeals Council Review of Unappealed on-the-Record Decisions

Cumulative from August 8, 1995

	Effectuation	Percent	Remand	Percent	AC Decision	Percent	TOTAL CASES
Senior Attorneys	787	85.92%	123	13.43%	6	.66%	916
ALJs OTR	662	85.64%	101	13.07%	10	1.29 %	773
Adjudication Officers	60	73.17%	20	24.39%	2	2.44%	82

Appeals Council Review of Unappealed on-the-Record Decisions

October 1, 1996 to March 12, 1997

	Effectuation	Percent	Remand	Percent	AC Decision	Percent	TOTAL CASES
Senior Attorneys	196	89.09%	23	10.45%	1	0.45%	220
ALJs OTR	163	85.79%	26	13.68%	1	0.53%	190
Adjudication Officers	22	81.48%	4	14.81	1	3.70%	27

Perhaps even more devastating to the arguments of those who argue that Action #7 is merely a vehicle to pay down the backlog, is the results of a review of the "payment rate" of the Senior Attorneys and the "payment rate" of ALJs on the very cases that Senior Attorneys concluded they could not pay on-the-record. As previously noted, the Action #7 favorable rate on a national basis since the beginning of the program is 21.69%.

ALJ Favorable Rates

	March 1997	FY 1997	August 1995–March 1997
Cases Reviewed Under Action #7	55.6%	54.8%	57.1%
Cases not Reviewed Under Action #7	47.8%	47.7%	51.4%

The record demonstrates that the ALJs have a higher pay rate on Action #7 cases than those that do not go through the Action #7 process which gives some level of validity to the profile by which those cases are selected. However, the statistics clearly demonstrate a consistent payment rate by Senior Attorneys which is well below that payment rate of ALJs on the Action #7 cases initially reviewed and not paid by Senior Attorneys. The unmistakable conclusion is that Senior Attorneys have a more conservative payment rate than ALJs, but that they nonetheless identify and render favorable decisions to a large number of deserving claimants in considerably less time than is required for the hearing process. Clearly, Action #7 has not resulted in "paying down the backlog." Indeed, the overall payment rate in OHA has actually declined since the onset of Action #7, an occurrence which is not coincidental.

There is no qualitative or quantitative evidence of coercion by the Agency on Senior Attorneys. However, those advancing the concern, primarily ALJs and to a lesser extent the state agencies, were concerned that Action #7 was an attempt to pay down the backlog. Given the payment rate, it is readily apparent that the feared coercion has simply not occurred. From my personal knowledge, based upon my conversations with Senior Attorneys and the conversations reported to me by other Chapter officials, it is readily apparent that there has been no effort to affect the individual decisions of Senior Attorneys. In those areas in which the payment rate is unusually low, statistical reviews have revealed systemic problems (e.g., lack of effective development) which have been addressed on a a systemic basis. Lack of decisional independence has not been a problem for Action #7 adjudicators.

SSA Decisional Inconsistency

The prime factors in achieving both decisional accuracy and consistency are expertise, experience and accountability. A number of well known factors contribute to the difference between the various adjudicatory levels. A quality assurance process that concentrates upon favorable decisions at the DDS level with insufficient control regarding the quality of the adverse decisions, and the exact opposite situation at

the appellate level is a prime factor in producing decisional inconsistency. However, the failure of the State Agencies to provide adequate written explanations for their decisions, their failure to adequately develop cases, and their failure to consider the effect of the claimant's symptoms not only limits the usefulness of their determinations at the OHA level, but contributes to incorrect determinations. Vigorous enforcement of the Process Unification Rulings at the State Agency level will significantly improve decisional accuracy. In evaluating the situation at the OHA level, and indeed in evaluating the entire matter of decisional consistency, the old paradigm of two levels of decision making (DDS and OHA which really meant ALJ) must be replaced by a paradigm consisting of three levels of decision making (DDS, Senior Attorney, and ALJ). The payment rates of the screening units demonstrate that even using DDS standards, DDS decisions are incorrect a significant amount of time. The lower payment rate of Senior Attorneys, who are applying the same standards and considering the same factors as ALJs, as compared to the payment rate of ALJs has been documented but not sufficiently analyzed. Such an analysis could prove enlightening in as much as Senior Attorney payments rates seem to fall between those of the screening units and ALJ. While three years experience as a staff attorney at OHA is the minimum requirement to become a Senior Attorney, more than half of the Senior Attorneys have over 10 years experience as OHA staff attorneys. During that time a primary duty was drafting the detailed and highly technical denial decisions required to pass muster at the U.S. District Courts. Their work as Staff Attorneys has provided Senior Attorneys with a level expertise unmatched in the Agency. While Senior Attorneys have the decisional independence necessary to render decisions, they have exacting performance standards against which their work activities must be measured insuring a high degree of accountability. Quality assurance and Appeals Council review ensure Senior Attorney decisional accuracy.

Chairman BUNNING. Thank you all for your testimony, and I will start out—Ms. Shor, excuse me. I beg your pardon.

STATEMENT OF NANCY G. SHOR, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Ms. SHOR. Thank you.

Mr. Chairman, I am delighted to be here today to talk about the disability appeals process. The hearings and appeals system is a critical component of the Social Security Disability Program and certainly warrants your attention. We very much appreciate your extending the invitation to us to testify.

I used to represent Social Security disability claimants, and for the past 17 years, I have been executive director of the National Organization of Social Security Claimants' Representatives. This is an organization of approximately 3,300 attorneys and others who represent both Social Security and Supplemental Security Income disability claimants. We have many years of experience at every level of the process. We know how the process looks to claimants. Often, our members are the first person a claimant has come to bewildered as to why they are encountering difficulty with getting disability benefits they believe they are entitled to.

We welcome this opportunity to share some observations and recommendations with you today.

Certainly, your hearing is properly focused on ensuring the process of determining which claimant is entitled to benefits and which claimant is not. We know it is extremely important to today's claimant to know that the process of adjudication is fair, but it is also important to today's taxpayers, some of whom will become to-

morrow's claimants. If we are going to try to instill confidence in the system in the American public, it is important they have confidence that the disability adjudication system is producing fair results.

We share SSA's goal in their reengineering and redesign plan of providing accurate decisions for claimants as early in the process as possible. I want to stress that changes made at the front end can have significant beneficial impact on the hearings and appeals backlog situation. To focus only on the hearings and appeals process may show us too much of the back end of the dog and not enough of the front.

Fundamentally, the hearings and appeals system is sound. A claimant has several levels of appeal from the initial application, the reconsideration, the administrative hearing, the Appeals Council, and subsequently access to the Federal district court. I think it is important to keep in mind that the Social Security Administration has the capacity to step in at any one of those levels and stop effectuation of a favorable decision if the agency believes that that decision is wrong and require it to be readjudicated.

We want to emphasize that the right of a claimant to file a request before an ALJ is central to the fairness of the adjudication process. Certainly, the key factor there is that the ALJ is an independent decisionmaker who provides impartial factfinding and adjudication, free from agency coercion or influence, and considers, evaluates, and weighs all the evidence in accordance with the Social Security Act, SSA policy, as well as circuit court case law.

For claimants, a fundamental principle of this due process right is their opportunity to present new evidence in person to the ALJ and to receive a decision from the ALJ which is based on all available evidence.

We are very supportive of the efforts the Office of Hearings and Appeals is making to try to reduce the size of the backlog, including the allowance of senior staff attorneys as adjudicators, where favorable decisions can be issued, as well as increased emphasis on better development of cases before they reach the ALJs.

Because the issue has materialized on nonacquiescence, we certainly would express our concern. This is a policy that flies in the face of our system of jurisprudence.

I would emphasize that the major shortcoming we see with the process right now is that of development. It is an unreliable process, and the observation of our members would certainly be that the number one factor in cases that their potential clients bring to them is undeveloped, underdeveloped records coming from the DDS. It leads us to readily believe that lots of claims are denied at DDS not because the evidence establishes the person is not disabled, but because the evidence is inconclusive and really doesn't establish anything.

We believe the most crucial change SSA could make is to encourage better development at the very front end of the process, and certainly, part of that is doing a better job in explaining to claimants why it is important to get evidence in and the type of evidence that the agency needs to process their claim.

We don't believe closing the record at the ALJ level is a good solution to this problem for a variety of reasons. First and foremost,

almost everyone has a medical condition which will change, unfortunately often worsen. They are undergoing treatment, and their treating source is normally providing continuously updated medical records. So, virtually, any claimant is going to have new evidence on a fairly routine basis.

Second, many claimants are really not capable of understanding the kinds of evidence they need. They may ask their doctors for it, and their doctors won't respond. The SSA hasn't well explained to the doctors what it is they are looking for. Very often, DDS, because of time pressure, will request the evidence, but not issue followups for it if they don't get it.

Finally, we think closing the record elevates form over substance. It elevates the appearance of a system as opposed to trying to discern truly who is and who is not disabled. For a variety of reasons, closing the record is not a helpful solution to the problem of encouraging claimants to get evidence in earlier.

We commend the Subcommittee for holding the hearing today to look at the hearings and appeals process. We certainly are committed to supporting the basic structure of the system and to working with the agency in all ways to reduce the huge backlogs. Better development of the claims before they reach OHA would produce a great benefit both to claimants and to the hearings and appeals process.

We look forward to working with you, and we would be pleased to answer any questions you may have.

Thank you.

[The prepared statement follows:]

Statement of Nancy G. Shor, Executive Director, National Organization of Social Security Claimants' Representatives

Mr. Chairman and Members of the Subcommittee:

I am very pleased to be here today to talk about the disability appeals process. The hearings and appeals system is a critical component of the Social Security disability program and certainly merits your attention. I appreciate your extending an invitation to me to testify.

For the past seventeen years, I have been the executive director of the National Organization of Social Security Claimants' Representatives (NOSSCR). Our current membership is approximately 3,300 attorneys and others from across the country who represent claimants for Social Security and Supplemental Security Income benefits. We have many years of experience in representing claimants at every level of the process and welcome this opportunity to share some observations and recommendations with you.

Today's hearing should focus on ensuring the fairness of the process of determining which claimant is entitled to receive benefits and which claimant is not. Certainly it is extremely important to today's claimant to know that the process of adjudication is fair. But at a time when opinion polls as well as our own conversations with neighbors tell us that the confidence of the American public that Social Security benefits will be there for them is eroding, we need to assure today's taxpayers that the process will be fair when some of them become disabled in the future and file for their benefits.

We share the Social Security Administration's goal of providing accurate decisions for claimants as early in the process as possible. Changes made at the "front end" can have significant beneficial impact throughout the hearings and appeals backlogs.

THE HEARINGS AND APPEALS SYSTEM—A SOUND STRUCTURE

A claimant files an application for benefits, most often at the Social Security district office. The state disability determination agency will decide whether or not that claimant is eligible for benefits. If the claim is denied, the claimant can file for a reconsideration by the same state agency. If the claim is denied on reconsideration,

the claimant can pursue the appeal to an Administrative Law Judge at SSA's Office of Hearings and Appeals. If the claim is denied by the ALJ, the claimant can file a request for review with the Appeals Council. A claimant who is denied by the Appeals Council can file suit in federal court.

The right of a claimant to file a request for hearing before an Administrative Law Judge is central to the fairness of the adjudication process. This process provides the right to a full and fair administrative hearing by an independent decision-maker who provides impartial fact-finding and adjudication, free from agency coercion or influence. The ALJ asks questions of and takes testimony from the claimant, may develop evidence when necessary, considers and weighs the medical evidence, evaluates the vocational factors, all in accordance with the statute, agency policy, and Circuit caselaw. For claimants, a fundamental principle of this right is the opportunity to present new evidence in person to the ALJ and to receive a decision from the ALJ which is based on all available evidence.

Because of the importance of the administrative hearing step, we support the initiatives of the Office of Hearings and Appeals to address the backlog of cases without infringing on the right of claimants to a full and fair hearing. We support OHA's allowing experienced staff attorneys to review cases and issue fully favorable decisions where warranted. We support the agency's efforts to better develop cases that reach the OHA before those cases go to an ALJ for a hearing, although we would like to see more consideration of alternatives to the adjudication officer program. But we are dismayed by the agency's recent restatements of its policy on nonacquiescence. SSA's position, that it is not bound by Circuit Court precedent, is at odds with fundamental premises of jurisprudence. As we have long advocated, the agency's pursuit of this policy should be abandoned.

For ALJ decisions, SSA's "process unification" plans call for broad own-motion review by the Appeals Council. We understand that the Appeals Council will be reviewing only those ALJ decisions which are favorable to claimants. The plan resonates with overtones of Bellmon review, which resulted from a mandate in the early 1980's to review favorable decisions exclusively from ALJs whose allowance rates were considered "too high." Bellmon review was struck down by the courts as interfering with the decisional independence of ALJs because it "targeted" those ALJs who had higher allowance rates. By its plans to review only claimant-favorable ALJ decisions, this process unification plan is subject to the same criticism. What message does it send to claimants? What message does it send to ALJs? We believe that any own-motion review that the Appeals Council conducts must be even-handed, so that the Council reviews both favorable and unfavorable decisions, so that there is no perception of bias.

The last, and very important, element in the hearings and appeals structure is access to review in the federal district and circuit courts of appeal. At this level, the review is not de novo; rather, judges are applying the substantial evidence test. We believe that both individual claimants and the system as a whole benefit from the 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. Federal court review in Article III courts should be maintained.

HOW EVIDENCE IS OBTAINED—AN UNRELIABLE PROCESS

Developing the record so that relevant evidence from all sources can be considered is fundamental to full and fair adjudication. The decision-maker needs to review a wide variety of evidence in a typical case, including, for example, the medical records of treatment, opinions from medical sources, pharmacy records of prescribed medications, statements from former employers, and vocational assessments. The decision-maker needs these types of information to determine the claimant's residual functional capacity, ability to return to former work, and ability to engage in other work which exists in the national economy in significant numbers.

Unfortunately, very often the files that claimants with denials from the reconsideration level bring to our members show how little development was done at the initial and reconsideration levels. Until this lack of development is addressed, the correct adjudication of the claim cannot be made. Claims are denied not because the evidence establishes that the person is not disabled, but because the limited evidence cannot establish that the person is disabled.

A properly developed file is usually before the ALJ because the claimant's counsel has obtained evidence, or because the ALJ has developed it. This is one part of the explanation for the disparity in the claims files at the DDS and at the OHA. Not surprisingly then, different evidentiary records can readily produce different results on the issue of disability.

To address this, the agency needs to emphasize the full development of the record at the beginning of the claim. This includes encouragement to claimants to submit evidence as early 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. 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. This means that proposals to close the record are not beneficial to claimants, or to the system of fair adjudication.

First, 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 condition. They may be hospitalized or referred to different specialists. Some conditions, such as multiple sclerosis, may take longest to diagnose. Some claimants may also mischaracterize their own impairments, either because they lack understanding of their illness or its treatment. 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.

Second, claimants benefit by submitting evidence early. 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

- DDS failure to obtain necessary and relevant evidence.
- SSA failure to explain to the claimant what evidence is important and necessary.
- Claimants are unable to obtain medical records due to cost.
- 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 ignore, or respond very slowly to, requests for evidence.

So that claimants are not wrongly penalized for events beyond their control, the current system provides a process to submit new evidence. This should not be eliminated in the name of the streamlining.

Third, closing the record at the reconsideration level may make the process more formal but it will not improve the quality of the decision-making on the merits of the disability claim. 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. Additionally, closing the record will not ultimately improve the process from an administrative perspective. A claimant would be required to file a new application merely to have new evidence considered, even though that evidence 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, we anticipate there will be additional 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.

Legislative Reforms—Encouraging Return to Work

NOSSCR supports efforts which encourage disabled beneficiaries to work. Many beneficiaries fear losing medical insurance. They fear that a brief episode of employment will terminate their Social Security benefits, even if they are unable to sustain the employment. Many do not understand the provisions in the current law for trial work periods and extended periods of eligibility. SSA needs to provide more information and answers to specific questions on an on-going basis for those on the disability rolls.

New legislation is necessary to provide the foundation for beneficiaries to test their capacity to return to employment. Key provisions of an ideal return-to-work legislative initiative include a package of access to Medicare, earned income exclusion, tax credit, and options for vocational rehabilitation services.

Conclusion

We commend the Subcommittee for holding this hearing today to look at the Social Security disability appeals process. We are committed to support the basic structure of the hearings and appeals process, and to work with the agency on reducing the huge backlogs. Better development of the claims before they reach the

OHA would produce a great benefit, both to claimants and to the hearings and appeals system. We also commend the Subcommittee for its attention to return-to-work initiatives, which we anticipate will be enthusiastically received by many beneficiaries.

We look forward to working with the Subcommittee to improve the adjudication process and to improve the disability program.

Chairman BUNNING. Now I can thank you all for your testimony, and we will start out with Mr. Willman.

Many of the Process Unification Initiatives will impact resources needed by DDS. Since SSA has put these additional burdens on you to obtain more evidence, more extensive analysis, and so forth, has SSA reduced any of their expectations for your agency in terms of productivity? Doesn't productivity affect your findings?

Mr. WILLMAN. Yes. No, sir. The expectations have not been reduced. Much of the Process Unification rulings, much of the content of that would be good improvements in the program. They will not be free. They will not be easy to administer, and they will not be free.

If we are going to do more, a broader range of tasks on each case, then we either must do fewer cases or obtain more resources to do all the cases better.

Chairman BUNNING. Contrary to Ms. Shor, you recommend closing the record. Why is this?

Mr. WILLMAN. Because at some point, I think we have to say this is the record. If we are going to manage this backlog and produce decisions in reasonable amounts of time, we have to be able to say this is it, it is over now, we are going to analyze this evidence and get on with it.

I certainly—I don't want to close the record so early as to elevate form over substance. That is not the intent at all. I think if we were to have an understanding with claimants and make it clearly understood that at some point the record is going to be closed and explain what closing the record is, we give the claimant every reasonable opportunity to submit all the evidence that she or he wants to have considered while still being able to manage the backlog.

Chairman BUNNING. With 491,000 people in the backlog, we have to do something to make it more credible that we are actually trying to get them on the system. The 491,000 people are now backlogged in this system.

I am going to ask a general question to all of you. How do we do this legitimately and not jeopardize the credibility of the system? In other words, if we are not going to close the record and we have almost a half a million people in the backlog, how do we justifiably go forward and reduce the backlog in a systematic way? We are trying to do this in a systematic way, without jeopardizing the credibility of the system.

Anybody can answer. Speak up.

Judge BERNOSKI. Well, I will take a shot at that, Mr. Chairman.

One way we can do it, as we indicated in our testimony, is to use the single standard of adjudication at all levels in the system, so that would allow——

Chairman BUNNING. I think everybody agrees with that.

Judge BERNOSKI. Agrees with that.

The next thing would be, from the ALJ perspective, that we feel you could consider closing the record after the ALJ hearing because, at that time, the claimant has had an opportunity to appear, provide evidence, testify and, at that time, make a solid record that can go forward on appeal to either the Appeals Council or to the district court.

To close the record before that, you could be—you would be interfering with the de novo hearing because you would be foreclosing evidence that the claimant should have an opportunity to present at the hearing.

Chairman BUNNING. But, Judge, the ALJ hearing may occur 9 months, 12 months down the road——

Judge BERNOSKI. Well——

Chairman BUNNING [continuing]. From the initial claim——

Judge BERNOSKI. Correct.

Chairman BUNNING. We may be 9 months into the process, and that is not acceptable. I am telling you right up front, that is not acceptable.

Judge BERNOSKI. Right.

Chairman BUNNING. That is how we built 491,000 people in the backlog.

Judge BERNOSKI. Right. Now, the redesign system has its theory to move that space between the ALJ hearing and the DDS determination closer, but I can tell you from experience that back in the late eighties, there was a period in time when the caseload shrunk to a very small level, and at the ALJ level, we were actually sitting around at that time waiting for cases.

Chairman BUNNING. Gee, wouldn't that be wonderful now?

Judge BERNOSKI. It would be wonderful today, the good old days, but when those cases——

Chairman BUNNING. Let me hear from others.

Judge BERNOSKI [continuing]. When those cases would come in, we would set them for hearing, and the claimant would say we don't want the case this soon. So there is a period of time that the case has to ripen, and I would say that 5 to 6 months, the claimants—it is difficult to move those cases on for hearing before that time. There is this, and that is——

Chairman BUNNING. Some of the claimants die, and we don't want that to happen.

Judge BERNOSKI. No.

Chairman BUNNING. Other views?

Mr. Hill.

Mr. HILL. Yes. I think that the biggest single problem I see in cases coming into OHA is they are not fully developed. I think when I get a case as a senior attorney, it may have been in the office 10 days, and I can call up, either look through the record, call doctors, or if there is an attorney, call the attorney representing the claimant, and I can get a stack of documents in like this within a couple of weeks that were there, but nobody has gotten them yet. It is time consuming.

Developing cases takes a lot of time. It isn't something—they don't magically come in to you. You have to work on it, and I think that, in fairness to the DDSs, that requires more assets because

you are going to spend human person time, and there is very little substance for that.

Chairman BUNNING. In other words, to build the record more completely?

Mr. HILL. Completely, right at the outset, yes, because——

Chairman BUNNING. Well, that is what we are trying to figure out how to do.

Mr. HILL. Now, currently, the senior attorney program does what I just said. The case comes into the hearing office, and we look at it right off the bat, and if we can pay it, it doesn't have to wait for an OHA hearing. We can pay it within 120 days.

Chairman BUNNING. Do others have an opinion on this?

Mrs. Kennelly, go ahead.

Mrs. KENNELLY. Thank you, Mr. Chairman.

Ms. Shor——

Ms. SHOR. Yes.

Mrs. KENNELLY [continuing]. I heard all of the experience you have in various areas of this situation. I wonder if you would comment on the medical records kept at the DDS level, if you think enough is being done. Do you think it makes sense not to have the individual's doctor at that point? Then, I would like you to comment on the judge's level, what you think the adequacy is of the medical records and the information.

Ms. SHOR. Thank you.

I think the primary difficulty we see with the records being kept at the State agency level is coming from State agency physicians, doctors who have never examined the claimant and who are rendering opinions based upon the record before them.

There is minimal effort made and minimal cooperation in many cases, unfortunately, from claimants' treating doctors to provide anything more than a copy of a hospitalization report or possibly copies of office notes.

For a variety of reasons, unfortunately, treating physicians oftentimes are not particularly cooperative with requests from DDS to submit evidence. There is also very short timeframes and often very little followthrough.

In contrast, when a case reaches OHA, whether performed by personnel within that office or performed by the claimant's attorney, there is a lot more effort made for this medical development. There is much more effort made to explain to the physician what the rules are, what Social Security's criteria are, to get a narrative report from the physician, and to offer a broader assessment than simply a photocopy of office notes.

Mrs. KENNELLY. So if you could choose one thing, it would be to improve the evidence right from the beginning of the system.

Ms. SHOR. Absolutely.

Mrs. KENNELLY. Thank you.

Mr. Willman, at some place, you said in your testimony that the amount spent for attorneys is half the budget for the DDS. Do you think people are getting an attorney for the next step because—I believe you can have an attorney for the DDS step, if you want to, but most people don't. Am I——

Mr. WILLMAN. Right, very few.

Mrs. KENNELLY. Yes. Do you think they are getting an attorney for the next step because they are going into a more judicial atmosphere, or do you think they are getting an attorney because, Oh, my heavens, they didn't realize, I am turned down, I am sick and I am turned down. You go to your government and you are sick and you get turned down, and you say, Oh, I should have hired an attorney. Then, you go to the next level, and this is going to cost money. Is there anything we can do about this?

Mr. WILLMAN. Well, I certainly think there are a couple of reasons and maybe another one as well.

People at their initial reconsideration level feel they don't need an attorney because they don't have much participation in the process. They just fill out an application and indicate who their medical sources are and what their impairment is and sit back and wait for a decision.

Then, when they are denied, they find out the next level is to go for a hearing, and they feel they can't represent themselves at a hearing and so they will need help.

And the third reason a lot of attorneys are involved is because there are attorneys who do a lot of recruiting of claimants to represent them in these processes.

I think the answer——

Mrs. KENNELLY. Yes, but they have been turned down. So there is somewhat of a need for, you know——

Mr. WILLMAN. Yes.

Mrs. KENNELLY. Maybe we should advertise—I am thinking about Mr. Hill's and Ms. Shor's remarks. Maybe we should tell people to get an attorney early so the documents are collected and get them on the DDS desk. Then maybe you won't have to have an attorney for a long and lengthy hearing.

Mr. WILLMAN. We wouldn't need to do that. We should be able to get all the medical evidence on the DDS desk without the claimant being represented by an attorney.

Mrs. KENNELLY. But we are not doing it. But we are not doing it.

Mr. WILLMAN. Pardon me?

Mrs. KENNELLY. Obviously, from the testimony today of 2 hours, it is not happening.

Mr. WILLMAN. We think that when—as far as I can see and what I know from the feedback of the cases I get and from the cases I see every day and those that are returned back to me after they are allowed at the OHA level, I personally am not seeing this difference in the amount of documentation. Certainly, as time goes by and new information becomes available because of the deterioration of the condition or because of treatment that the claimant has sought since the denial at the DDS level, that evidence becomes available, but I really am seeing very few instances of cases where the evidence was available at the time the DDS made the decision and we didn't get it.

Mrs. KENNELLY. I think that is something, Mr. Chairman, we are going to have to continue to look at.

One last question for Ms. Gardiner. You make recommendations about changes for the ALJ level. What do you think should be changed at your level?

Ms. GARDINER. Oh, I think we should have additional training as well. I think it is essential we all have the same training, which is what Process Unification was trying to do or is hopefully going to do for us.

I think we need training equally as much as the ALJs do. It was just an emphasis on the medical portion for the ALJs.

Mrs. KENNELLY. Well, then I have got to ask another question. Who would like to comment on how the present new training is working? Is it worthwhile? Is it making things better? Because we now see that the DDS says we should have that training.

Judge BERNOSKI. Well, I think it is a step in the right direction. I think it is too early to see what is actually going to happen because the program is just in its inception, but it is an attempt to go to the single standard, and it is an attempt to have a more—a complete review of the case at the reconsideration level, which meets the concern GAO raised, and so those are—would be positive.

As Jim Hill indicated, one of the problems—or one of the benefits would be if the record would come to us more complete, the more timely and easier it is to move that case along because sometimes that case goes to a hearing and then the record isn't completed there, and the claimant requests the record be held open for more evidence. So, then, you see that is claimant-induced delay to a certain extent, but still, it is to add to the record.

Mrs. KENNELLY. Well, we are talking about time again, and I have a feeling the Chairman is losing patience, and time is part of the problem.

Judge BERNOSKI. I have a couple of—go ahead.

Mr. CHRISTOPHER. If I could offer just a thought on the training piece of this, that would be if I were starting a program from scratch and I had different appeals processes, which we do and we need to have, it would seem to me there would be two things I would want to do for sure. I would want to be sure everybody receives the same basic training, so that everybody has the same basics on which to work from. It would seem to me, beyond that, I would want to ensure that all the decisionmakers are applying the same rules and regulations in the same way, that is, the same book, and I guess if I had a thought for both of you, I think it would be useful to SSA, it would be to put a much higher priority on the single-book concept, and it would be to put a much higher priority on more consistent training for all the decisionmakers.

There are so many of us out there, we all want to do the right thing. Obviously, we are doing it somewhat differently, and it is frustrating to all of us, and I think we are entitled, if you will, to more consistent training so that we can try to provide the clients with the most consistent process we can.

Chairman BUNNING. Since the problem has been around for a long time and we don't seem to be making as much progress as all of you seem to think we are, I have a couple more questions I would like to ask the judge.

Mrs. KENNELLY. Can I just make a final statement before I finish?

Chairman BUNNING. Oh, go right ahead.

Mrs. KENNELLY. I want to thank the Chairman for having this hearing. It has been very helpful to me, but I would just like to make the comment, often when I deal as a Congresswoman at a Federal level, you get huge numbers. We are talking this morning about a program with $60 billion, 7 million people, but we cannot forget about those individuals who make up those numbers. I just want to end by saying we have got to figure out some way that an individual who got sick and doesn't want to be sick, can't work, has bills, can, in fact, get the fair treatment they need and deserve. I just have to say to you, what I fear so about our country's future is people losing faith in their government. We hear about it all the time.

We are talking this morning about a very arcane issue, but really, at the heart of the matter, if we don't do something, then we will have to answer for the weakness in our Federal Government.

Chairman BUNNING. I have three questions for the judge, since he so violently disagreed with the GAO report we received.

You mention in your testimony that judges understand their responsibility to follow the constitution and apply the law, agency regulations, and agency policy, which you take very seriously. You also say that it is beyond the scope of your oath of office to apply agency policy that is inconsistent with the law. Are you saying it is up to each individual judge to interpret agency policy?

Judge BERNOSKI. No, sir. Mr. Chairman, No, that is not what I am saying.

The agency establishes the policy, and it is not our role to interpret the policy or even the regulations to the point where we create a policy within ourselves. No, sir. We understand that is the agency's role.

What I was referring to there was when the agency adopts a policy, which is inconsistent with the law, such as when it got into conflict with the courts under the pain standard which resulted in the *Hyatt* case, which I referred to, which was a massive class action with thousands of cases coming back for readjudication; the *Samuels* case, the *Minnesota Mental Health* case, the *Zebley* case, these are the types of things I am referring to.

Chairman BUNNING. Are you telling me the SSA is writing agency policy inconsistent with those rulings?

Judge BERNOSKI. Well, there are——

Chairman BUNNING. Their chief counsel sat right here today and didn't indicate to me that they deliberately wrote policy inconsistent with court law or with law that has been determined by the courts.

Judge BERNOSKI. The best way I can answer that, Mr. Chairman, is that the courts certainly have said that. In the *Zebley* case, for instance, the court very clearly said the regulation that was promulgated was contrary to the basic underlying statute, and the *Hyatt* case, the result was the same. The *Minnesota Mental Health* case was the same. So the answer is, Yes. In certain circumstances, the agency has promulgated policy that has been inconsistent with the basic law, and the evidence is there in the form of these massive class actions, which are very, very expensive and very time consuming.

Chairman BUNNING. Yes, I am familiar.

Judge BERNOSKI. And the *Steberger* case is another one in New York—very, very expensive.

Chairman BUNNING. Well, you mentioned the judges have increased their productivity recently. Have you heard of instances where a judge's productivity is being restricted by individual office policy? There are offices whereby according to union agreement, no hearing can be scheduled after 2:30 p.m.

Judge BERNOSKI. Yes, sir, I am familiar with that situation.

The office escapes me at the moment, but, yes, sir, that did come up, and the answer to the question is, Yes.

Chairman BUNNING. But don't you think that restricts productivity just a little bit?

Judge BERNOSKI. Yes, sir. Yes, Mr. Chairman.

Chairman BUNNING. OK. I want to thank you all for your input because, if we are going to get to the bottom of how we can improve this huge SSDI Program, we need to make sure we don't have people dying before they get in and that people who become healthy get out in a timely fashion.

I did see a report which indicated that each percentage point of the ultimate award rate represents $2 billion in lifetime costs. Accurate decisionmaking is critical to the long-term solvency of the trust funds.

We thank you for your testimony.

Judge BERNOSKI. Thank you, Mr. Chairman.

Mr. WILLMAN. Thank you.

[The following questions were subsequently submitted by Chairman Jim Bunning to Mr. Willman:]

1. In your testimony, you recommended a "shared vision" of the disability program among all components. How do you see this happening and why is it so important to you?

2. You indicated that SSA quality reviews show a decisional accuracy of more than 96% at the DDS level, yet ALJs reverse two-thirds of your decisions. How can this happen and how can it be fixed?

3. You expressed concern in your testimony that the quality review process being planned for the ALJs is modest in scope and nature, and may not be useful. Why do you feel this way?

[The response of Mr. Willman follows:]

NATIONAL COUNCIL OF DISABILITY
DETERMINATION DIRECTORS
June 19, 1997

The Honorable Jim Bunning
Chairman, House Subcommittee on Social Security
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Bunning:

This responds to your letter of May 20, 1997, in which you asked three questions in follow up to testimony presented at a hearing on April 24, 1997. I am happy to have the opportunity to respond to your questions.

First, relative to the development of a shared vision common to all components of the disability program, you asked why this is so important and how it could happen.

The various tasks necessary to administer the disability program are completed by personnel in several different organizational components of SSA. I feel that a substantial obstacle to improving service to the American public is the tendency of each component to focus on the program only from its individual point of view. For example, the component responsible for developing policy instructions issues its directives without adequate consideration of the resources that will be needed in the

field to actually apply the instructions; the budget component provides limited resources based on its expectation that productivity must constantly improve and without regard to the fact that new policies are more labor intensive; the quality assurance personnel attempt to "enforce" the labor intensive policy requirements in openly stated disregard of the fact that the operational component lacks the resources to apply the policies; decision makers at the initial level attempt to faithfully apply policies that they know will not be applied by decision makers at the appeals level. All of this creates inefficiencies in service delivery and compromises the morale and day to day efforts of the persons performing the front line work.

The problem can be solved only by management actions that see that the tough decisions are made at the appropriate level and that they are fully communicated and applied consistently across organizational lines. SSA's recent process unification initiative is an example of an overdue attempt to get the several involved components working together.

Second, you asked for an explanation of how DDS decisions that are determined to have been 96% accurate could be overturned at the rate of about two thirds when they are decided by the Office of Hearings and Appeals.

This question has been mystifying knowledgeable observers, including those from the Congress, for two decades that I know of.

I believe that the explanations historically put forth by SSA account for a minor part of the true explanation. Worsening of the claimants' conditions, the development of new evidence, the face-to-face appearance, and attorney representation all account for some of the difference but leave most of it unexplained. I believe that, with respect to cases allowed at OHA, if DDS personnel were to consider the updated evidence, meet face-to-face with the claimants, and hear from the claimants' attorneys, the great majority of the cases would still be found not disabled.

The more important reasons include the following: the policy instructions are not uniformly stated for adjudicators at the two levels, and OHA is permitted to develop policy interpretations not shared or even known to the DDSs; there is no common training for personnel at the two levels; separate and opposite quality assurance and case review systems, with DDSs being reviewed mostly on allowed cases and OHA being reviewed almost exclusively on denials, tend to drive the two components apart; SSA management has permitted the development of a view that ALJs are immune from management control including the adherence to agency policy; the difference in medical training and expertise between the two components is extreme with DDS decision making being driven by detailed medical analysis of claimants' conditions and OHA decision making permitting the medical facts to be overwhelmed by a priority on legal due process and on conclusions about the claimants' credibility; SSA has permitted what could be called the "judicialization" of OHA, that is the transformation from an administrative to a judicial entity.

The path to achieving greater consistency of decision making between the two levels must include the reversal of the factors described above. To these should be added a meaningful system of quality review of ALJ decisions (with enforcement power) and closing the evidentiary record.

Third, you asked why I feel that SSA's current plan for a quality review process for ALJs is too modest in scope and in nature.

Regarding the scope of the review, SSA plans to review only about 10,000 OHA cases per year which amounts to about one case per ALJ each month. Even presuming an error rate of 33%, this would result in only about one piece of feedback per ALJ each calendar quarter. This number is not high enough to provide meaningful feedback to ALJs, nor to establish useful enforcement in cases in which ALJs are not correctly applying agency policy, nor to create a quality review system which is reasonably consistent between components.

Regarding the nature of the review, the differing standards SSA intends to apply to DDS and OHA cases review goes far in the direction of weakening the usefulness of the review. DDS case completions are reviewed under the "preponderance of evidence" rule (meaning that the decision supported by the greater weight of the evidence must be made), but SSA intends to review the ALJ allowances under a "substantial evidence" rule (meaning that a decision is correct if it is supported by any substantial evidence even if greater and more substantial evidence would support an opposite decision). I understand that the definition of the word "substantial" will be "more than a scintilla". Under this case review scenario, a DDS could twice deny a case because most of the evidence supports a denial, the claimant could wait a year for a hearing, the evidence could be unchanged, an ALJ could allow the case because some evidence supports an allowance, and both decisions would be considered by the SSA to have been correct. I would tend to perceive this sequence of actions to be a textbook example of bureaucratic inefficiency and wasted effort rather than a meaningful step toward improving service to the American public.

Thank you for the opportunity to have provided this additional clarification. As always, if I can be of additional help, please contact me at your convenience.

Sincerely,

DOUGLAS WILLMAN
NCDDD President

[The following questions were subsequently submitted by Chairman Jim Bunning to Mr. Hill:]

1. Your testimony included some very encouraging statistics regarding a certain project utilizing Senior Attorneys. Why do you believe this program has been so successful and why doesn't SSA make the project permanent?
2. You also mentioned the Adjudication Officer pilot project and pointed out the many ways that the project seems to be failing, yet, instead of abandoning the project, SSA is extending the project for more testing. Why do you believe so strongly that the project isn't working and why hasn't SSA stopped it?
3. Based on your experience working side-by-side with ALJs, what percentage write their own decisions? When you are asked to write a decision for an ALJ, how specific is their direction to you in terms of what to say in the decision?

[The response of Mr. Hill follows:]

SUMMARY

The Senior Attorney Program

• The Senior Attorney Program is a highly focused program designed to attack a specific set of problems—the disability backlog at OHA and the inability of OHA to timely adjudicate the applications of disability claimants. The Senior Attorney Program involves the use of experienced OHA Senior Attorneys at their normal work sites, within the already existing organization structure, using currently available technology and staff resources, focused upon a set of cases and using a process that identifies and develops only those cases most likely to be paid. This process permits timely payment for many of those claimants who are in fact disabled, and permits SSA to focus its most expensive decision making resource, Administrative Law Judges, on the cases less likely to result in a favorable decision or which for other reasons require an administrative hearing. By facilitating SSA focusing its Administrative Law Judges on its more difficult workload and not upon cases that can be more efficiently and more inexpensively decided by other OHA decision makers, the more difficult work load can be processed in a more timely manner. The Senior Attorney Program will cause a decrease in both processing time and age of pending cases at OHA.

• The Senior Attorney Program has not been made permanent because it is not part of the Disability Process Redesign, and it is inconsistent with the short term goal of the Agency to eliminate OHA and its long term goal to eliminate the due process hearing. Indeed, the antipathy of many in SSA towards traditional American adjudicatory principles as embodied in our legal system and the involvement of legal professionals in the disability adjudication system, whether it be as claimant's representatives, ALJs, Senior Attorneys, Staff Attorneys, or the judges (and justices) of the U.S. court system, is a potent force and the underlying philosophy driving the Disability Process Redesign. The efficient and inexpensive Senior Attorney Program is in marked contrast to the expensive, inefficient, and heretofore unsuccessful Adjudication Officer Program and is therefore a direct threat to the Agency's Disability Process Redesign. To make the successful Senior Attorney Program permanent would be a repudiation of the foundering Adjudication Officer Program and the Disability Process Redesign as a whole.

The Adjudication Officer Program

• To admit that the Adjudication Officer Program is a failure would require abandoning its goal of eliminating the due process adjudication system with its protection of claimant's rights and the vigorous participation of the legal community.

• Abandoning the Adjudication Officer Program would require admitting that the plan was poorly conceived, poorly planned, and poorly executed and has wasted substantial amounts of taxpayer moneys.

• To terminate the Adjudication Officer Program would damage many personal reputations and careers.[1] Since SSA has loudly proclaimed for the last two years that the Disability Process Redesign would solve the Agency's disability problems, admitting failure would place the Agency's reputation at risk.

Administrative Law Judge decision writing and decisional instructions

• The issues of how many decisions are written by ALJs and the nature and extent of ALJ decisions instructions are relatively new to OHA. The staff attorney program was begun in 1975 to relieve ALJs of decision drafting responsibilities, and in fact it is the single most important reason that ALJ productivity has increased from 16 decisions a month to the current 40+ decisions per month.

• However, with the advent of computer technology, ALJs are being encouraged to draft their simplest, fully favorable decisions using Agency developed "macros". Currently, the Agency's approximately 1000 ALJs draft about 4,000–5000 cases per month, approximately 10–15% of the total decision drafting workload. However, ALJs draft virtually none of the more complex, time consuming denial decisions.

• The nature and extent of ALJ decisions instructions is a relatively new issue to OHA. Since the Agency has increasingly relied upon the considerably less skilled paralegal specialists as decision drafters, the importance of more specific instructions has increased. However, except in rare instances, decisional instructions are general in nature and supply very little to the specific rationale explaining the decision. Nonetheless, it remains the responsibility of the individual drafting the decision to create an acceptable rationale explaining the resolution of each issue necessary for a legally defensible decision.

• In my personal experience, instructions have ranged from "you make the decision" to lengthy narratives which the ALJ wants inserted into the decision. However, I have seen decisional instructions from one ALJ (not from Cleveland) that consisted of an ink stamp of a dancing pig (favorable decision) and an homeless waif (a denial). Much more commonly, ALJ instructions indicate the decision (pay or deny) and the step in the sequential evaluation at which the decision was made, for example, "deny—range of light work". It would be most unusual for an ALJ to include specific language for insertion in the decision or to include specifics on assigning probative value to various exhibits, the claimant's credibility, evaluating subjective symptoms, or explaining discrepancies in the record. Quite often the instructions are incomplete and fail to deal with the complete range of issues required for a legally defensible decision.

The Senior Attorney Program

• The Senior Attorney Program, also known as Action #7, was originally developed as the key component of the Short Term Disability Program. It has been successful despite intense ALJ opposition,[2] because it is designed to accomplish a limited goal within the current organizational structure, using currently available technology, and to the greatest extent possible, using existing human and material resources. Action #7 is designed to identify those claimants most likely to be disabled and render favorable disability decisions to those claimants who are in fact disabled and for whom a decision can be made without the time and expense of a hearing before an Administrative Law Judge. Action #7 employs experienced OHA Senior Attorneys, who have temporary regulatory authority to review and develop selected cases and issue fully favorable disability decisions in appropriate situations. Senior Attorneys work in their normal workplace within the current organizational structure and use currently available technology. Unlike the Adjudication Officer Program, there are no new offices, no additional office space, equipment, or support staff, no one is detailed for months (now years) at a per diem expense, and no extensive and expensive off-site training program was required. Aside from additional decision writers, the Senior Attorney Program requires little in the way of additional office space, staff or equipment, and does not require changes in work processes in other SSA components or expensive and not yet available "enablers" as does the Adjudication Officer Program.

• These characteristics are in stark contrast to the Disability Process Redesign which requires global changes in workload, work sites, work processes in multiple SSA components, technology, disability criteria, decisional processes, organizational structure, and fundamental changes in SSA's relationship with claimants, their rep-

[1] Currently, there are a number of "reorganization of OHA" plans floating around SSA headquarters in Baltimore. While the plans are very different, one factor is common: the power and prestige of the official offering the plan will be greatly increased if his/her plan is adopted.

[2] This has resulted in active sabotage of the program by many Hearing Office Chief Administrative Law Judges.

resentatives, and the health care community. The Disability Process Redesign is typical of the large bureaucratic response to a problem which has come to typify the Federal Government in the latter half of the 20th Century. Action #7 is a "small program" that works.

Prime benefits of the Action #7 are:

• Substantial reduction of time, in many cases of more than a year, which many disabled claimants must wait for a favorable disability decision;
• Immediate reduction of the OHA backlog;
• More timely hearings for those claimants for whom hearings must be conducted because cases that can be decided without a hearing are removed from the que;
• A reduction in overall OHA processing time
• Transferring some of the workload of developing cases from OHA employees to the claimant's attorneys;
• A decrease in overall "reversal rate" at the hearing level;
• Senior Attorneys are also available to OHA to assist in the traditional OHA work processes particularly drafting of the more complex Administrative Law Judge denial decisions.
• Substantially increases OHA decision making capacity without hiring more ALJs;
• Provides SSA with additional decision making capacity at a lower marginal cost, significantly less cost than an ALJ or an adjudication officer;
• Has resulted in higher quality decisions, when measured by the Appeals Council effectuation rates, than either comparable ALJ or Adjudication Officer decisions.

The Senior Attorney program involves about 40% of the cases received at OHA, those cases most likely to result in a decision favorable to the claimant. Unlike the AO program which involves reviewing every case in which a Request for Hearing is filed, focusing the attention of the Senior Attorney upon cases more likely to result in a favorable decision is a far more efficient use of the Senior Attorney's time. Concentrating on a work load which is more likely to result in favorable decisions has proved quite productive. An initial review reveals those cases unlikely to result in a favorable decision and those cases are quickly forwarded to the master docket for assignment to an ALJ. This reduces the expenditure of assets on cases requiring ALJ adjudication and permits the concentrated effort to be directed to those cases more likely to result in a favorable decision. Senior Attorneys are comfortable working with claimant attorneys, and perhaps more to the point, claimant attorneys are comfortable working with Senior Attorneys and recognize the advantage of supplying the medical evidence requested by the Senior Attorney. The program is perceived by claimants and their representatives as beneficial to their interests; not because the payment rate of Action #7 cases is high, it is only 22–25% of the cases reviewed, but because they know if they are contacted by a Senior Attorney, there is a good likelihood that a favorable decision will be rendered. This serves as an incentive for the claimant and the claimant's representative to actively cooperate in a timely manner. In many cases, the case development is done by the claimant's representative rather than by Agency personnel. In my personal experience, if I tell a claimant's attorney that unless specific pieces of evidence are in the record, I will have to pass the case to an ALJ, that attorney will quickly secure the evidence and present it to me. Shifting part of the work load to non-OHA employees is an obvious benefit to OHA.

Senior Attorneys have substantial experience in evaluating disability cases; some have as much as 22 years experience as OHA staff attorneys and have analyzed and written thousands of cases. This depth of knowledge in both the medical and legal aspects of the disability program cannot be obtained through a training program of only a few weeks, and permits the Senior Attorney to produce both more accurate, and better written decisions in a shorter period of time.

The Senior Attorney Program functions within the existing structure of OHA and individual hearing offices. It does not require establishing new work sites, the acquisition of office furniture and office equipment, or the hiring of additional support staff. Senior Attorneys continue to bear a substantial responsibility for drafting ALJ denial decisions. This permits OHA management a considerable degree of flexibility to assign assets, both human and material, efficiently and quickly to address short-term as well as long-term operational necessities such as balancing ALJ and Action 7 decision writing work loads.

Why hasn't SSA made the Senior Attorney Program permanent:

Action #7 was originally developed as a "short term" program designed to help decrease the backlog at OHA prior to the implementation of the Adjudication Officer Program. The intent of SSA is that Senior Attorneys would be phased out during

the roll out of the Adjudication Officer Program of the Disability Process Redesign because adjudication officers render continued employment of Senior Attorneys, or for that matter nearly all Staff Attorneys, unnecessary. The expectations of SSA in this regard were first stated in a 1995 memo from then Principal Deputy Commissioner Lawrence Thompson and more recently, and more graphically, demonstrated in the infamous "Fiander Memorandum".

Action #7 was originally scheduled to end no later than December 31, 1996. After a lengthy struggle in which several SSA components vigorously contested extending the program despite its success and despite the lack of any other vehicle available for reducing the OHA backlog, it was subsequently extended to June 30, 1997 and then to December 31, 1997. The authorizing regulatory authority will be extended to September 30, 1998 but not necessarily the program itself. The concept of a small program specifically targeted to solve a major problem with a minimal use of Agency assets is a threat to the expensive comprehensive program favored by many. Many in SSA would be concerned if its Disability Process Redesign was shown to be unnecessary. To make the Senior Attorney Program permanent would be a repudiation of the Disability Process Redesign, and this for a variety of reasons, SSA is loath to do.

At the creation of the Disability Process Redesign, SSA conceded that it was not designed to reduce the already existing backlog. Only when it became obvious that the Agency's comprehensive plan for the future ignored the current backlog problem wan. The inappropriateness of the Adjudication Officer Program as a vehicle for backlog reduction is made quite clear if one reviews the projections of new work loads expected by OHA. However, the propensity of the Agency to advance plans using other components in a backlog reduction scheme is demonstrated by the current plan to "informally remand" 100,000 cases currently in OHA for readjudication by the State Agencies. I was surprised to learn that the State Agencies had the time and resources to deal with such a large workload. I will be surprised if many more than 10% of the 100,000 cases result in favorable decisions at the State Agency. Permitting Senior Attorneys to review those 100,000 cases would require far less in the way of administrative costs and almost certainly result in a more productive program in terms of identifying those cases which deserve favorable decisions.

However, SSA has historically exhibited an antagonism towards OHA and has consistently failed to facilitate its operations. In this instance, permitting OHA to significantly reduce its backlog would prove that the Disability Process Redesign is unnecessary or at least overly inflated. The antipathy of many in SSA towards traditional American adjudicatory principles as embodied in our legal system and the involvement of legal professionals in the disability adjudication system, whether it be as claimant's representatives, ALJs, Senior Attorneys, Staff Attorneys, or the judges (and justices) of the U.S. court system, is a potent force and the underlying philosophy driving the Disability Process Redesign. Indeed, the Disability Process Redesign can only be fully understood in light of this antipathy. The underlying purpose of the Disability Process Redesign is to fundamentally limit the current due process disability appeals process. A permanent and efficiently operated Senior Attorney Program would facilitate OHA successfully handling its disability workload and frussire to eliminate the current dues.

The Failure of the Adjudication Officer Program

The Adjudication Officer Program is doomed to failure, as is most of the Disability Process Redesign, because its success is predicated upon a number of assumptions which are not valid. Perhaps the most fundamental of these assumptions is that claimants will be satisfied with their initial denials because they are impressed by the operation of the disability determination process and not file requests for hearings. Those who work in the field believe that claimants want to be found disabled and will pursue their claims as far as necessary to achieve that goal. Claimants do not want quick accurate decisions, they want favorable decisions as quickly as possible. Other assumptions that in the light of experience seem unlikely are a payment rate of 20% from ALJs, a paperless process, the complete and timely cooperation of medical and mental health professionals in supplying medical evidence, the existence of a simplified disability decisional process, a functioning disability claims manager process, and a completely integrated data processing system. At its outset, the success of the Disability Process Redesign was predicated on a substantial number of "enablers". As far as I can tell, none of those enablers are in place and none are likely to be in the immediate future. GAO recently commented that none of the 83 goals for the Disability Process Redesign had been accomplished. Some will probably never happen. Without the enablers, the Adjudication Officer Program has absolutely no chance of success, a fact vividly demonstrated by the current Adjudication Officer Program testing results.

SSA can expect to receive approximately 600,000 Requests for Hearing per year for the next several fiscal years. According to the Disability Process Redesign, each of these cases must be processed by an Adjudication Officer. After more than a year of testing in the most favorable of situations, AO productivity remains at approximately .8 to .85 dispositions per day per AO. It is my belief that this level of production represents a good and realistic projection of the productivity that can reasonably be expected from an adjudication officer, given the relative difficult job duties. A federal employee has a work year of 2087 hours, approximately 261 days. A federal employee with the amount of service typical for an AO will use about 40 days annual leave and sick leave and approximately 10 holidays. Therefore, only approximately 210 work days are available. One typical AO working one typical year will produce approximately 168 dispositions per year (210 × .8). At that rate approximately 3,600 adjudication officers will be needed. This is at least three times the number originally forecast when DPR was announced. Additionally, it was originally estimated that additional staff supporting the AO would be 5 staff persons for 3 AOs. While this ratio has proven to be somewhat optimistic, even accepting its validity, another 6,000 employees would be required. The total employees associated with the AO Project would be at least 9,600, far more than OHA's current workforce of approximately 6,500 employees. Of course OHA currently handles adjudications through the Appeals Council; the AO would pay approximately 25 % of its cases and forward the rest to ALJs and their staffs for further development. Full implementation of the AO project would double the number of employees involved in the disability appeals process. This is the kind of "progress" that has made us "famous".

The Adjudication Officer Project has failed to meet the expectations of it designers. By 1993 it was's process was failing to provide even minimal levels of service. The backlog was growing at an alarming rate, and the payment rate of OHA ALJs was in the minds of many observers, including the undersigned, significantly higher than what was justified. This presented a unique opportunity for SSA executives to achieve two long term goals—the elimination of OHA and the destruction of the due process disability hearing process, both fueled I believe, by SSA's antipathy towards our legal system and its practitioners. The reasons for eliminating OHA included "empire building" for certain senior SSA executives, elimination of a despised component which was perceived as receiving favored treatment, and removing involvement of the "legal system" including claimant's attorneys and the Office of Hearings and Appeals. SSA has bitterly resented the roles of claimant's attorneys, ALJs, Senior Attorneys, Staff Attorneys, the courts, and the whole legal system in the disability adjudication process which it perceives as thwarting its good judgment regarding disability. The Disability Process Redesign offers a mechanism to eliminate or greatly curtail the influence of the legal system. This attitude which pervades SSA is illustrated in a memorandum dated March 8, 1995 from Manuel J. Vaz, currently the Regional Commissioner of Region I.

"The redesign proposal points out that claimants 'resent the need for attorney assistance to obtain benefits.' However, rather than minimizing the need for attorney involvement at the first level of appeal, the AO process encourages it. Requiring the AO to explain to the claimant his/her right to representation will surely intimidate many individuals (akin to 'reading them their rights') into feeling that legal representation is a critical issue. Providing a list of legal referral sources will only reinforce this perception. The claimant will be further induced to retain legal counsel in the event that the AO is an attorney.

"Since attorney representatives receive 25% of past due benefits, we must take care not to cause an unnecessary increase in their use, particularly at the first level of appeal. Contrast this with the current reconsideration process in which claimants rarely retain legal counsel and it becomes apparent that our present first appeal step is in this respect more 'user friendly'.

"To retain the user friendly approach in the first stage of appeal, we strongly recommend that the subject of representation rights only be brought up by the AO at the point the case is referred for the ALJ hearing (unless the claimant inquires about this earlier in the process). Further, to avoid the natural tendency for claimants to retain their own lawyer when dealing with a government attorney, we firmly believe the AO position should NOT be an attorney."

Properly represented claimants are more likely to receive benefits than unrepresented claimants and certainly more likely to pursue remedies outside the Social Security Administration. I find this anti-claimant attitude, which is widespread in SSA to be troubling indeed. It demonstrates less interest in serving the public than maintaining its proprietary hold on the disability system. SSA has a very proprietary attitude towards the disability system. This attitude is clearly demonstrated in its attitudes towards the public, the courts, and while less obvious, this attitude controls its interaction with the Congress and even other components of the Execu-

tive Branch. This Committee has frequently requested that SSA advise it on what it needed to effectively operate the program. SSA refuses to answer, not I suspect because it does not have any ideas, but rather because it is loath to have the Congress "interfere" with its conduct of the disability system.

To admit that the Adjudication Officer Program is a failure would require abandoning the goal of reducing or eliminating the influence of the legal system and would subject SSA to a good deal of ridicule. SSA has spent enormous amounts of money and other assets on this program. Many of those involved in the current test including the adjudication officers and the clericals, are receiving per diem payments in addition to their salary. Clerical workers have been detailed to AO sites all over the country, even New York City, rather than use clerical workers already in the locales where testing is occurring. Admitting that huge sums of money and other resources have been wasted is difficult to do in today's climate of smaller, more efficient government.

SSA has loudly proclaimed for the last two years that the Disability Process Redesign would solve the Agency's disability problems. Unfortunately many personal reputations and careers [3] and perhaps even the Agency's reputation are at risk. Admitting they were wrong would be difficult and potentially damaging to their careers. The situation is made even more unpalatable because of the attitude and statements of SSA officials as the Disability Process Redesign was designed and amended. At the outset of the Adjudication Officer Program, the Agency sought an implementation regulation. Testing, senior agency officials said was unnecessary. A very high level committee has worked for almost two years on reorganizing the disability appeals process (the elimination of OHA); its charter assumed the success of the Adjudication Officer Program hence reorganization schemes are predicated upon a successful Adjudication Officer Program. OMB did not accept the Agency's opinion that testing was unnecessary. However, the Agency quickly minimized its embarrassment regarding the necessity of testing. Even as OMB demanded a testing program for the Adjudication Officer Program, SSA officials emphasized that the testing was not designed to test the adjudication officer concept, only fine tune implementation. In a memorandum from Charles Jones, then Director of the Disability Process Redesign Team dated June 9, 1995 Mr. Jones stated:

"I recommend that testing and subsequent rollout implementation of the AO process as quickly as possible. A testing as opposed to final regulation was required by OMB to ensure that the AO process does not escalate program costs. We have already concluded favorably the efficacy of the AO process and project dramatic productivity increases and savings both in human and monetary resources within two years of full implementation. The purpose of testing is to reassure OMB regarding program costs and fine tune procedural aspects of the process."

The rationale was that since Commissioner Chater had already decided the Adjudication Officer Program would work, there was no sense in testing the concept. Agency employees were told that after a four month testing period commencing November 1995 which would validate the process, full roll out would commence at the rate of 10 adjudication officer sites per month until the originally planned 200 sites of 5 adjudication officers each were in place. While these officials could be characterized as being overly-optimistic, a better characterization might be "delusional". Over the past several years literally scores of senior agency officials have privately commented to me and other OHA employees that the AO test was a failure, but that the Agency would declare it a success and implement the program anyway. SSA has consistently avoided any forum in which an unbiased decision maker might become involved. SSA illegally terminated impact and implementation negotiations with the National Treasury Employees Union and to this day alleges that such negotiations are unnecessary. This is so even though AO sites remove cases that would normally be processed by Senior Attorneys; SSA contends that this does not impact upon Senior Attorneys. The real reason for the refusal to negotiate is that eventually a impartial party would review the situation; SSA cannot afford such a review. NTEU began litigation contesting the Agency's failure to negotiate, but terminated that process despite our complete faith that this was any easy winner because the failure of the test was so evident that it would fail. We saw no reason to terminate the test which would only prove us right, and we did not want to be cited as a reason for its failure. We made the right decision.

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[3] Currently, there are a number of "reorganization of OHA" plans floating around SSA headquarters in Baltimore. While the plans are very different, one factor is common: the power and prestige of the official offering the plan will be greatly increased if his/her plan is adopted.

ALJs, Decision Writing, and Instructions

The issues of how many decisions are written by ALJs and the nature and extent of ALJ decision instructions are relatively new to OHA. The staff attorney program was begun in 1975 to relieve ALJs of decision drafting responsibilities, and in fact it is the single most important reason that ALJ productivity has increased from 16 decisions a month to the current 40+ decisions per month. Over the years following 1975, as the program was more fully staffed, more and more ALJs wrote fewer and fewer of their own decisions. Additional decision writer resources were added with paralegal specialists to write the easier ALJ decisions so that eventually, few ALJs were writing any decisions at all. However, using "fill-in-the-blank" and other macros, more and more emphasis is being placed on ALJs writing some of their own decisions. The Agency is currently in the process of supplying each ALJ with a notebook computer in order to encourage decision drafting. However, even today, few ALJs draft even their simple favorable decisions and practically none draft the far more complex and demanding affirmation decisions.

Currently, the Agency's approximately 1000 ALJs draft about 4,000–5000 cases per month, approximately 10% of the total decision drafting workload. Again, ALJs draft virtually none of the more complex denial decisions. This is unfortunate because drafting the more complex decisions requires an adjudicator to recognize, understand and explain discrepancies in the record, develop and evaluate the claimant's subjective complaints, consider and assign the appropriate probative weight to all the evidence in the record and weigh the testimony at the Hearing. Decision making, without some decision drafting, does not develop these skills and is a decisional process that leads to increased instances of incorrect (not legally defensible) decisions. While these may seem like skills necessary to the decision making process, they are only necessary to the complete and accurate decision making process. The lack of these skills and the lack of knowledge of the nuances of SSA's disability program results in imprecise decisional processes and increased instances of incorrect (legally indefensible) decisions.

As noted earlier, the issue of specificity of ALJ instructions is relatively new. Many experienced Staff Attorneys neither need nor want more than general directions regarding the decision. We prefer to rely upon our ability to review and analyze a case and rely on our own analytic abilities to craft a legally defensible decision. To such individuals, detailed instructions, unless they are accurate and carefully thought out, which is not usually the case, are often more an impediment than an asset. However, as the Agency has increasingly relied upon the considerably less skilled paralegal specialists as decision drafters, the importance of more specific instructions has increased. These individuals do not have the analytic capacities nor the extensive legal writing experience of staff attorneys and hence require more detailed instructions. However, except in rare instances, decisional instructions are general in nature and supply very little to the specific decision.

There are over a thousand ALJs currently employed by the Social Security Administration. In my personal experience, instructions have ranged from "you make the decision" to lengthy narratives which the ALJ wants inserted into the decision. However, I have seen decisional instructions from one ALJ (not from Cleveland) that consisted of an ink stamp of dancing pig (favorable decision) and an homeless waif (a denial). Much more commonly ALJ instructions indicate the decision (pay or deny) and the step in the sequential evaluation at which the decision was made, for example, "deny—range of light work". It would be most unusual for an ALJ to include specific language for insertion in the decision. Likewise, it would be most unusual for instructions to include specifics on assigning probative value to various exhibits, the claimant's credibility, evaluating subjective symptoms, or explaining discrepancies in the record. Quite often the instructions are incomplete and fail to deal with the complete range of issues required for a legally defensible decision.

The responsibilities of the decision drafter are set forth in considerable detail in the position description of the GS–12 Attorney Advisor.

"Serves as a program/legal expert with full responsibility for formulating legally defensible decisions which address all medical and legal aspects of even the most difficult cases ad as supported by the evidence. Ensures that the decisions are consistent with the Social Security Act and with the Secretary's adjudication policies as reflected in Social Security Regulations and Rulings. Provides the rationale for the ALJ's findings on the relevant issues and on the ultimate decision in the case. The rationale includes appropriate reference to the applicable statutes, regulations and Social Security Rulings and a discussion of the weight assigned to the various pieces of evidence in resolving conflicts in the overall body of evidence; e.g., conflicts between treating and nontreating medical sources, including a statement as to which evidence is more persuasive and the supporting analysis. The rationale in-

cludes a resolution of all the claimant's subjective allegations, especially those regarding symptoms and an assessment of the credibility of the evidence. Ensures that the rationale includes any specific language required by court orders, class action settlements or SSA policy embodied in Acquiescence Rulings, as well as an explanation of how the case law was applied. Is responsible for ensuring the decisions properly address those issues identified by the Circuit Courts as significant. Identifies the pivotal issues in a case and ensures that the decisional rationale includes sufficient discussion to demonstrate that he or she has properly considered the issue according to circuit law"

Given the paucity of specific instructions typically provided by the ALJ to the Staff Attorney, and the complexity of the written decision, the text of most denial ALJ decisions is the intellectual property of the writer not the ALJ. The ALJ normally provides certain "findings", but the rationale supporting each conclusion is the work of the Staff Attorney. Because of the increased importance of ALJ instructions, several offices have prepared "decision format" for use by ALJs. If the decisional format form is complete, it will require the ALJ to address most of the relevant issues, but again, in a very abbreviated format. It remains the responsibility of the individual drafting the decision to create an acceptable rationale explaining the resolution of each issue necessary for a legally defensible decision.

[The following questions were subsequently submitted by Chairman Jim Bunning to Ms. Shor:]

1. You mentioned in your testimony that you would like to see more consideration of alternatives to the Adjudication Officer program. What alternatives did you have in mind?

2. You indicated in your testimony that you are not in favor of closing the record. Can you provide more details as to why you believe the record should not be closed?

3. In testimony before the Subcommittee, we learned that 75% of individuals denied benefits by the State DDS file an appeal to appear before an ALJ. We also learned that in about 75% of all appealed cases, the claimant submits additional evidence. Do you have any sense of how often this evidence is really new, or was simply held back so it could be considered by the ALJ? How can we ensure this doesn't happen?

[The response of Ms. Shor follows:]

NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
6 PROSPECT STREET
MIDLAND, NEW JERSEY 07432
June 19, 1997

Rep. Jim Bunning, Chairman
Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Bunning,

Thank you for the opportunity to respond to questions arising from my testimony to the Subcommittee on April 24. I want to express again our appreciation for the opportunity to testify at that important hearing concerning the disability program.

Adjudication Officer

In my testimony, I indicated that we support the agency's goal of deciding claims correctly at the earliest possible stage. SSA's redesign plan created the Adjudication Officer position to screen cases before they reach an Administrative Law Judge. We would encourage consideration of alternatives which would more successfully achieve this goal. First, there should be a final automatic screening for all cases before a reconsideration denial is issued. Note that in the AO scheme, it is necessary for a dissatisfied claimant to file a request for a hearing before an ALJ before the case can be sent to an AO. As a result, those claimants who are fearful of appearing "in court" before an ALJ and who do not file a request for hearing for that reason will not have an AO look at their claims. Second, we have urged the agency to con-

sider a magistrate-type position instead of the AO. The magistrate would be a lawyer who would draft recommended decision, both allowances and denials, for the ALJ's consideration. Third, we encourage the agency to consider whether increases in staffing at the Offices of Hearings and Appeals for preparation of the record and summaries of the evidence might obviate the need for creation of additional positions altogether.

Closing the Record

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 will be approved and the earlier payment can begin. However, closing the record is not the solution. Past efforts to close the record to new evidence have failed, since such proposals are (1) inconsistent with Supreme Court precedent and the Social Security Act; (2) not beneficial to claimants; and (3) not administratively efficient for SSA.

A. Constitutional and statutory rights of claimants.

1. Claimant's right to impartial decisionmaker's developing the facts of the case.

Closing the record before the hearing level would not be consistent with the due process and statutory rights of disability claimants. Based on due process and the Social Security Act, a claimant has the right to have an impartial decisionmaker gather the evidence and make a decision based on evidence adduced a the hearing. See 42 U.S.C. § 405(b); *Richardson* v. *Perales,* 402 U.S. 387 (1971); *Goldberg* v. *Kelly,* 397 U.S. 254 (1970). Thus, the ALJ has the ultimate responsibility to develop the facts of the case. Richardson, 402 U.S. at 410. Subsequent case law has emphasized the remedial purpose of the [Act] and the duty of the Administrative Law Judge to fully develop the record. *Lashley* v. *Secretary of HHS,* 708 F.2d 1048, 1051 (6th Cir. 1983). Closing the record prior to a hearing would co-opt the ALJ's duty to gather the evidence and develop the record. It further precludes the ALJ from issuing a decision which is based on evidence brought out at, and not before, the hearing.

2. Maintaining informality of the process.

Requiring evidence to be submitted at an earlier point in the process and then closing the record would impose a formality on the appeals process not intended by the Act. 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. Proposals to eliminate this informality have generally been rejected by Congress. In *Richardson,* the Supreme Court noted that from the current procedures:

There emerges an emphasis upon the informal rather than the form. This, we think, is as it should be, for this administrative procedure, and these hearings, should be understandable to the layman claimant, should not necessarily be stiff and comfortable only for the trained attorney, and should be liberal and not strict in tone and operation. This is the obvious intent of Congress so long as the procedures are fundamentally fair.

Richardson, 402 U.S. at 401–01

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. Technical requirements, such as closing the record at an earlier level, raise obstacles to claimants which are inconsistent with the philosophy of the program. Rather, SSA should be encouraged to work with claimants to obtain necessary evidence and more fully develop the claim at an earlier point.

B. Closing the record is not fair to claimants.

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." There are several crucial reasons why closing the record at an earlier level is not beneficial to claimants.

1. Conditions change. Most medical conditions change over time: they may worsen, the diagnosis may change or become more finely tuned after further testing or assessment. Individuals may undergo new treatment or procedures. They may be hospitalized or referred to different specialists. Some conditions, such as multiple sclerosis, may take longer to diagnose. Some claimants misdiagnose their own claims either because they are in denial or lack judgment 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 applica-

tions merely to have new evidence, such as reports from a recent hospitalization or a report which finally assesses and diagnoses a condition, reviewed.

2. Claimants are unable to submit evidence earlier for reasons beyond their control. Claimants are always benefited 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:

- Neither SSA nor DDS explains to the individual what evidence is important and necessary to obtain for the claim.
- 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.
- DDS's fail to obtain necessary and relevant evidence.
- Claimants are unable to obtain medical records either due to cost of because of state laws preventing them from directly obtaining their own medical records.
- 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 eliminated in the name of streamlining the system.

C. Closing the record will cause further administrative problems for SSA.

In addition to the reasons why closing the record would not benefits individuals, closing the record would not improve the process from an administrative perspective. As mentioned above, a claimant would be required 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 could expect to handle more applications, unnecessarily clogging the front end of the process. Further, there would be more administrative cost for SSA since the cost of handling a new application is higher then reviewing new evidence in the context of a pending claim.

New Evidence

As discussed above, there are many reasons that additional evidence is submitted at the hearing level. Most of these reasons are outside the control of claimants, as well as their representatives. Clearly, claimants benefit by submitting evidence as early in the process as possible, and should be so advised throughout the pendency of their claims.

If we may provide additional information and perspective, please do not hesitate to contact me.

Very truly yours,

NANCY G. SHOR
Executive Director

NGS/ct

Chairman BUNNING. In conclusion, I would like to thank everybody that has testified today. Your testimony has been of great value in updating the Subcommittee regarding the disability appeals process at SSA.

The Subcommittee is now adjourned.

[Whereupon, at 11:16 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of James F. Allsup, Founder and President, Allsup, Inc.

Mr. Chairman and members of the subcommittee. My name is James F. Allsup and I am president and CEO of Allsup Incorporated in Belleville, Illinois. My written testimony differs markedly in experience and perspective from the other testimony you will hear today. Specifically, I have experienced the Social Security disability program from multiple perspectives—as a Social Security employee, and as a Social Security disability representative for both individuals and employers.

Since I founded my company in 1984, we have obtained disability awards for about 25,000 people. Prior to starting my company, I was a claims representative and a field representative for four and one-half years with the Social Security Administration. Many of my employees also have Social Security disability claims experience, working both inside and outside the Social Security system. Cumulatively, we have more than 500 years' experience as either claims representatives or claims examiners for SSA and Disability Determination Services or as private non-attorney representatives.

Disability claims can be referred to us by individual claimants, their employers or their insurers. If an individual approaches us directly and does not have private disability coverage, our fee is paid on a contingency basis. We obtain the fee directly from the individual, not from the Social Security Administration. Unlike other organizations, we do not believe it is necessary to strain Social Security's limited resources to collect our fees.

When claimants are referred to us by their employers or insurers, the referring party pays our fee because of its financial stake in the outcome—an offset against the disability benefit they pay. This offset exists because employer-provided disability plans integrate with Social Security disability, and both employers and their employees share the FICA tax burden.

With all due respect to the dedicated Social Security and Disability Determination Services employees who will offer testimony today, their knowledge and perspective is limited—as was my employees and mine before we left the Social Security Administration. While employed by SSA, we were not privy to the actual law we were supposed to be administering. We followed the agency's extremely narrow policy contained in its Program Operations Manual System, or POMS. We assumed the agency's policy was the law. And because our knowledge of the law was obscured by agency policy, we frequently became upset when administrative law judges reversed our denials. We did not understand why and how an administrative law judge could allow a claim that we had denied because we followed the directions given to us in the POMS.

That's why I can understand the concern the Social Security and Disability Determination Services employees have with the high reversal rate of administrative law judges. But I also understand that their viewpoint is limited because they never left the Social Security disability system to represent individuals with disability claims. Only by leaving the agency and subsequently representing disability claimants can one really understand that administrative law judges are simply following the law. Unless you are aware of the law, you will never understand it. So what may appear as inconsistencies in the Social Security disability decision-making process are only inconsistencies because the agency itself takes a narrow view of the law.

The only solution is to replace the dual standards used in the decision-making process with a single standard—the legal standard.

I abhor the attempt by Social Security Administration policy makers to intimidate administrative law judges into abandoning their oath to provide due process and a fair hearing to individual claimants in accordance with the law. This is a brutal attack on working Americans who expect their government to make good on its promise to provide a safety net when they are no longer able to work. If SSA's attempt to overrule the law succeeds, even more claims will be denied and even more people with disabilities will be deprived of the disability income and Medicare coverage they so desperately need. It will also deprive them of extended COBRA coverage if they elected such coverage upon leaving work because of their disability.

Allsup Incorporated is concerned with their welfare. We will not sit back and be silent while they are attacked by policy makers isolated from the world of disabilities. Because our fees are not guaranteed by the Social Security Administration, I am free to speak with total honesty and without restraint in criticizing this attack on disabled claimants. Therefore, I am not concerned about potential retribution through the loss of a guaranteed fee collection system.

In addition to serving as authorized representatives of disabled individuals, we often serve as unofficial representatives of their employers' interests who referred their claims to us. We must recognize that employers also have a big stake in the outcome of these disability claims. Employers not only pay half of the total FICA

taxes for each of their employees, they many times also provide their own disability and health coverage. If the disability claim is denied, the employer is denied the offset against its disability claim, and the Medicare coverage that allows the employer health plan to revert to secondary payer. The employer is left paying the entire bill for both disability income and health insurance coverage, eliminating any incentive to provide this coverage. We must understand that both disabled individuals and active employees are harmed each time Social Security unfairly denies a disability claim.

We will not allow this lawlessness on the part of Social Security policy makers to go unnoticed. We have launched a campaign to rally disability associations, individuals, employers and other organizations to stop this ill-conceived effort. We are gathering petitions throughout the country and demanding that this outrage be terminated immediately. We are also urging all disabled individuals to contact their elected representatives in Congress to put a halt on this attack.

This is the United States of America where the rule of law reigns supreme. As law-abiding taxpayers, we demand law-abiding administrators.

Statement of John H. Pickering, Chair, Senior Lawyers Division and Commissioner Emeritus, Commission on Legal Problems of the Elderly; on Behalf of American Bar Association

Mr. Chairman and Members of the Subcommittee:

My name is John H. Pickering. I chair the American Bar Association's Senior Lawyers Division, and serve as Commissioner Emeritus of the ABA Commission on Legal Problems of the Elderly, which I also chaired for a number of years.

I appreciate the opportunity to submit this statement on behalf of the American Bar Association, in conjunction with the April 24, 1997, Oversight Hearing on the Disability Appeals Process.

As representative of the legal profession in the United States, the American Bar Association is particularly concerned with equal access to justice for those members of our society who are generally least able to protect their own rights—low-income persons, individuals with disabilities and older people. We have a long-standing interest in the Social Security Administration's disability benefits review process, and have worked actively over the years to promote increased efficiency and fairness in this system. In recent years, we have followed carefully the Social Security Administration's efforts to redesign this process, and we commend the agency on its efforts to ensure that the correct decision is made as early in the process as possible. Like members of this Subcommittee, we are concerned about the growing backlog in processing appeals and the impact of those delays, on the public confidence in the system, on agency staff and most importantly, on the claimant. We are quite aware that the timeliness and the quality of decision making can have a profound effect on the lives and well-being of millions of Americans, and that for many individuals, Supplemental Security Income and Social Security disability benefits constitute the sole source of income and access to health care.

Over a decade ago, the ABA joined with the Administrative Conference of the United States (ACUS) to sponsor a national symposium on the Social Security Administrative Appeals process. Since that time, the Association has drawn upon the considerable expertise of a membership with backgrounds as claimant representatives, administrative law judges, academicians and agency staff, to develop a wide ranging body of recommendations that emphasize clarity in communications with and due process protections for claimants, and that urge the application of appropriate, consistent legal standards at all stages of the disability adjudication process. In 1986, in an amicus curiae brief in the landmark U.S. Supreme Court case, Bowen v. City of New York, the Association argued successfully that the Social Security Administration should reopen the cases of thousands of mentally disabled claimants who were denied disability benefits because they failed to meet sub rosa requirements and appeal deadlines Brief for the American Bar Association, Amicus Curiae, in Support of the Respondents, Bowen v. City of New York, 476 U.S. 467 (1986). It is with this background that we offer some recommendations to the Subcommittee for consideration. We believe that implementation of these recommendations can lead to the development of a fair and efficient administrative appeals process, and minimize the delays that are threatening to overwhelm that system.

The stated goal of the Social Security Administration's "process unification" initiative is to improve efficiency and create consistency of decision making at different levels of the disability appeals process. Yet in all too many cases still in the system

today, claims that could have been decided at the initial stages are awarded at the hearing level simply because the evidence presented is more complete by the time it is presented to the administrative law judge. SSA could improve this situation at the front-end of the process, by providing individuals applying for benefits with a clear statement of applicable eligibility requirements, the claimant's responsibilities, a description of the administrative steps in the process, an explanation of relevant medical and vocational evidence and notice of the availability of legal representation.

We agree that many claimants, either independently or with the assistance of a representative or other agent, should be encouraged to take more responsibility for providing documentation in support of their claim. However, many persons eligible for disability benefits are unable, as a result of their disability, or because of linguistic or cultural barriers, to follow through on certain tasks. Moreover, few claimants have a legal representative to assist them at this stage of the process. To improve the quality of medical and vocational evidence at the initial stages and reduce the need for appeal, we suggest that the agency consult the claimant's health care providers, and compensate them adequately for providing relevant medical information. We encourage SSA to take affirmative steps to compile accurate documentation and to supplement reports (particularly those from treating physicians) that are not sufficiently detailed or comprehensive. Agency staff could speed up the process by educating the medical community about eligibility criteria used in the disability program, and the kind of evidence required to establish eligibility for benefits, and by assisting claimants in compiling necessary documentation and in supplementing incomplete reports.

We recommend that, prior to denying claims, the Social Security Administration notify claimants of the pending adverse action; inform claimants of reasons why the finding of disability cannot be made and ensure that they have access to all the evidence in their file, including medical reports; provide them the opportunity to submit further evidence, and advise claimants' health care providers of deficiencies in the medical evidence and give them the opportunity to supply additional information. We recommend that disability claims managers be encouraged to consult with legal as well as medical resources in their evaluation of a claim. Our policies support face-to-face interviews between claimants and agency decision-makers before a final decision is made, and elimination of the reconsideration level of appeal. If the quality of intake and development of evidence at the early stages is improved, there is little reason for reconsideration, particularly given the historically low reversal rate and substantial delays involved at this level.

In the event that the claim is denied after full and complete development of the file, we suggest certain additional steps to enhance the integrity and efficiency of the appeals process while guaranteeing the claimant due process. The Association has long-standing policy supporting the right of claimants to due process, including a hearing on the record, before an administrative law judge whose authority as an independent fact-finder is assured. This hearing is an essential element in ensuring a full and fair review of the claim, providing administrative law judges the opportunity to take testimony from the claimant, develop evidence when necessary, consider and weigh the medical evidence, and evaluate vocational factors in order to reach an impartial decision free from agency coercion.

In 1995, in response to SSA's efforts to eliminate the backlog of cases that threatened (and continues to threaten) the ability of administrative law judges to assure due process, the ABA House of Delegates endorsed additional reforms at the hearing and pre-hearing stages. We recommended the designation of adjudication officers with supporting staff who, immediately following the initial denial of a claim, would work with the disability claims manager to develop the evidence, assemble a file and, where appropriate, allow the claim. Additional evidence may be necessary to establish a change in medical condition, or to include evidence that the claimant was unable to obtain due to cost or other circumstances beyond the claimant's control. Should the case proceed to a hearing, the adjudication officers could be responsible for presenting the agency's position during the hearing. Concerned about the disadvantage such a system might pose to unrepresented claimants, we proposed that the administrative law judge be permitted to assert direct control over the development of the record, and have access to investigative sources.

We are aware of proposals to provide finality to the process by closing the record during the administrative appeal process, and urge that such proposals be carefully considered, and that the record certainly not be closed prior to the hearing. To close the record before the hearing would serve only to penalize claimants who may have been unable through no fault of their own to gather the evidence necessary for a full and fair hearing, and would lead to additional costs for the agency as claimants file new applications simply to submit new evidence. The record should not be closed

until the conclusion of the hearing, and then only if provisions are made for allowing claimants to reopen the record within one year of an adverse decision, upon a showing of good cause (such as newly discovered evidence or a material change in condition).

Finally, we are most concerned that SSA's "process unification" plans provide for the Appeals Council to review decisions of administrative law judges on its own motion. The ABA has advocated for many years for a complete study of Appeals Council procedures and functions, to determine whether such review is necessary and to explore possible changes in the Council's role. Fully aware of past attempts to control the rates at which ALJs allowed claims (e.g. the Bellmon Review), we caution that the independence and impartiality of administrative law judge decision making must not be compromised by discretionary review. The scope of such review should be limited to clear errors of law or lack of substantial evidence for factual conclusions, with the latter based on specific documentation and review of the hearing tapes.

We commend the Subcommittee for holding the hearing on these important issues, and appreciate the opportunity to submit this testimony. We look forward to working with the Subcommittee and with the Social Security Administration on these issues in the future.

SCHEINE, FUSCO, BRANDENSTEIN & RADA, P.C.
WOODBURY, NY
May 15, 1997

A.L. Singleton
Chief of Staff
Social Security Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

RE: Oversight Hearing on the Disability Appeals Process April 24, 1997

Dear Chairman Bunning and Members of the Subcommittee:

I write to you as an experienced practitioner with over twenty years experience in the field of Social Security Disability. As I understand the concerns of your subcommittee, they may be capsulized as follows:

1. Why does it seem to take so long to process a disability claim?
2. Why does there seem to be such a discrepancy between decisions by administrative law judges and the state agency disability determination services?
3. Why don't we get enough people off the rolls?

These are valid questions that deserve honest answers. However, having reviewed the position papers submitted to your subcommittee, by various stakeholders in the system, it seems to me that, at best, you have a great deal of conflicting information, and varying opinions as to why the system is in the state it is in. At worst, you have what appears to be one group back stabbing another, perhaps for the understated purpose of preserving their jobs, even at the other guys' expense.[1]

Allow me to share my observations, based upon twenty years of working with Social Security Disability claims at all adjudicative levels. I am the managing partner

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[1] The most glaring example of this is the statement of Larry Jacks of the Disability Determination Services. Mr. Jacks would have your committee believe the ALJ's are not following the law and giving benefits away on a wholesale basis. He would like to see the private bar removed from the process, and the Federal Courts removed as well. If there ever was a prize given to position paper biased to protect one's own interest this one would take a pulitzer.

Another Disability Examiner, Douglas Willman of the National Council of Disability Determinations Directors, starts out his statement by taking a pot shot at ALJ independence, and supports institutionalized non-acquiescence. This underscores Judge Bernoski's observations that the DDS don't follow the law, and don't want to, and in fact, Willman, doesn't even want to consider the evidence from the treating physician on the issue of disability.

See the statement of James A. Hill, Esq., of the National Treasury Employees Union, at page 8, noting the resistance of both state agencies and the ALJ's to the highly successful Senior Attorney project. Hill alludes facing unjust criticism from the Redesign bureaucracy which had a stake in the largely unsuccssful adjudication officer program, as well as office obstructionism within the confines of local Hearing Offices.

of a firm with a substantial Social Security practice. I have lectured extensively in the area, and serve on the Board of Directors of the National Organization of Social Security Claimant's Representatives. I have handled over 2000 hearings, and over 500 Federal Court appeals. More significant, however, is that I have handled many thousands of cases which were favorably adjudicated at the initial and reconsideration levels, or by on-the-record decisions at the Office of Hearing and Appeals. The views expressed herein however are solely my own, and not necessarily endorsed by NOSSCR.

I. The Disability Standard and The "Duration" Requirement

Before giving my answer to the question as to why is there a backlog, it would do well to remind ourselves that the legal standard of disability under the Social Security Act, requires a showing that the disability has lasted (or is expected to last) for 12 consecutive, continuous months. Curiously, the statement of Carolyn W. Colvin, Deputy Commissioner for Programs and Policy of SSA, neglected to include this rather significant part of the definition of disability. Ms. Colvin's statement was merely that "The Social Security Act broadly defines disability as the inability to engage in substantial gainful activity." That's hardly accurate, in light of the duration requirement. If we don't understand the duration requirement, we will have a very difficult time understanding anything about the disability process at all.

With some minor exceptions, it is very difficult to anticipate whether most impairments will last twelve continuous months. In some instances a State Agency DDS will need to defer a decision until it can determine if the otherwise severe impairment will, in fact, meet the duration requirement. In other cases, they will disallow a claim because administrative experience in similar cases has shown that a particular impairment would ordinarily not last twelve months at a disabling level of severity although it may be quite disabling at the point when a claimant applies. In short, my experience is that many claimants are denied because people file prematurely, and no one ever bothers to explain the duration requirement to them.

Second, as I will demonstrate, there is a backlog because claimants are not generally represented by independent counsel at the initial application stage and many people apply who have no business applying, either because they do not meet and never will meet the disability standard, or they will not meet the duration requirement, or apply so prematurely that they invite a denial, or are unable to produce medical evidence in support of their claim because they are not under regular care. Or, perhaps they are not insured for disability at the time they claim to be disabled due to spotty work records.

The bottom line is there are too many claims of dubious quality coming in to flood the system. These claims help clog the appeals process and delay the disposition of more meritorious claims.

II. Getting People Off the Rolls Early

We can't get people off the system, because we make them such vital stakeholders in getting on the system.

In the first place we (wrongly) convince them that they need to be "permanently totally disabled" to get benefits. Neither permanency nor total disability is a requirement of the Social Security Act, but if you let people think they are permanently and totally disabled, by defining their eligibility for a disability benefit in such terms, they will eventually come around to perceiving themselves as actually being permanently and totally disabled. We do not emphasize the availability of "closed periods of disability," which is really all that many applicants want in the first place.

Most Americans, and I would not be surprised if members of the subcommittee were included in this, may be unaware that Social Security awards closed periods of Social Security Disability for people who are so disabled they can't work, but only for the limited period that they are so disabled. Once they recover, the benefits stop. This doesn't require any legislation. It has been part of the Social Security Disability process for years, but rarely invoked, except by the much aligned Administrative Law Judges.[2]

Congress can hardly expect to purge the rolls of those who have recovered, when SSA is taking five years to get them on the rolls in the first place, and at least another three years to review them. (And, we doubt SSA can keep up with even that

[2] Statistically, when an ALJ awards a "Closed Period" (and they award many) it shows up as a favorable decision, thus skewing the numbers of "favorable" decisions attributable to ALJ's much higher than they should be.

pace of review.) By that time, any transferable skills, or general aptitudes the claimant may possess, have long been neglected by disuse, the claimants are considerably older and may fall into a different disability classification under the medical vocational rules, they are less motivated, are "retired" in their minds, and have adjusted to whatever standard of living they now have. Moreover, as is well known, they are afraid of losing their medical benefits. (The recent proposals by Representative Kennelly and Senator Jeffords may address this latter part of the problem.)

Moreover, think of the actual dollar cost of having to finally pay someone five years of retroactive benefits because it sometimes currently takes that long to resolve a case, and then to pay continuing payments for at least three years before the case is even looked at!

It is my view that the sooner you let someone into the system the sooner you can get them out, if you act fast. However, getting people in sooner, doesn't mean getting them in prematurely, it means expediting the process, once they have applied.

III. Why is There a Backlog at the Hearing Level?

1. The Initial Claims Process is Designed to Exclude Evidence.

It is my view that the main reason there is a hearing backlog is, simply stated, the State Agencies (DDS) do not do their jobs. They do not develop medical evidence, and they base their decisions on scanty files. You've already heard this from Judge Bernoski and from Nancy Shor of NOSSCR, and from OHA Staff Attorney James A. Hill, so it should come as no surprise to hear it from a practitioner. See Ms. Shor's statement at page 4, listing five reasons why the evidentiary record at the State Agency DDS is often lacking. The DDS's also do not follow the law, despite what they've told the subcommittee in their position papers.

Second, the Social Security Administration itself tacitly institutionalizes procedures designed to cause backlogs at the initial levels and forces claims up to the hearing level. District Offices, (with the exception of some on the East Coast, such as the ones on Long Island, where I practice) put major obstacles in the path of an attorney who even tries to represent a claimant at these levels, including the often repeated advice to the claimant that they don't need and shouldn't have an attorney until there is a hearing. SSA's Ms. Colvin's states that "there is some anecdotal evidence that representatives wait until the hearing before submitting new evidence." However, our experience is that it is almost impossible for a representative to get involved in cases before the hearing level, and very difficult to track down a file[3] while it is pending a hearing, and it is for that reason that representatives who have not been on the case since the inception, have no choice but to wait until the hearing to submit evidence.

What generally happens in Social Security Disability claims is that claimants appear at the District Office, a claim is taken, and then sent on to the State Agency to process. Claimants, and probably most people on your subcommittee, believe that the DDS goes about gathering the medical evidence for the claim. (See Ms. Colvin's statement at page 1: "The State DDS requests medical evidence from treating physicians and other sources identified by the claimant." That's the way it's supposed to be anyway.)

For twenty years I have observed that, at best, DDS will send some perfunctory forms to treating sources. These forms are either inadequate to allow the doctor to provide the information SSA really needs to adjudicate a claim, or are so long and involved that it is rare that any busy practitioner would have the time to decipher them and complete them. Lacking timely evidence, and to supposedly "expedite" the claim, the DDS sends the claimant to a volume provider of medical examinations for a substandard exam, and the claim is decided, usually adversely. Moreover, as pointed out by James A. Hill, "The payment rates of the screening units[4] dem-

[3] Once a case is assembled at the District Office it is shipped off to the DDS—when exactly this occurs is a mystery. After the DDS acts, we are told, (but don't believe) the file is then shipped to Baltimore. If a hearing is requested, the request is filed at the District Office and then sent to the servicing hearing office; however, to meet local demands, judges are often brought in from other parts of the country, which means the files are shipped out of the area, and counsel cannot get access to them. I've had the unfortunate experience of submitting medical to the District Office, to have it returned with the notation the case has been decided, though we have no notice to that effect. I have submitted evidence to a local hearing office to have it returned on the grounds the file was not there. Two months later it turns out the file was there—and then the judge was upset that we took so long to submit the evidence that was now two months old!

[4] These are units which re-review cases at the Reconsideration level, after a Hearing Request has been filed, but before the case is shipped to the Office of Hearings and Appeals. Using the

Continued

onstrate that even using DDS standards, DDS decisions are incorrect a significant amount of time."

The process is repeated at Reconsideration, and then, and only then, after the claim has been twice denied and on its way to the hearing level is the claimant advised that he or she may want to secure counsel. Counsel goes about gathering all the medical evidence that you would like to believe should have been gathered by the DDS. Counsel presents the evidence to the judge, who based on that evidence, appropriately grants benefits under the law. For that reason alone the proposal to close the record before the hearing level is problematic. (Yet, this notion is embraced by at least one of the disability examiners, see statement of Larry Jacks at page 2, wherein he advocates closing the record after the DDS reviews the claim, but offers no supporting rationale for the suggestion.)

2. It's the Evidence, Not Standards that Causes the Discrepancy.

In reading the position papers presented to the subcommittee, the great debate appears to be over whether the decisional differences between the DDS and the OHA is due to the use of differing standards or better quality evidence. DDS witnesses seem to be under the impression that ALJ's use widely divergent standards for the assessment of disability, and they don't appreciate that the evidentiary records compiled in their agencies are sorely lacking. Clearly, it's the evidence.

My experience is not that there is a wide disparity between the standards imposed by the State Agency and the standards used by Administrative Law Judges. ALJ's are not push-overs, and not interested in simply giving benefits away, as the statistics may lead one to think. Come to a hearing with me, if you think these judges are giving away the store, you'll be readily disabused of that notion. Most of the ALJ's are quite tough.

Nor are the OHA staff attorneys "paying down the backlog," as James A. Hill has proven statistically. My experience is that there is a great deal more evidence before administrative law judges who are bound by case law and the regulations to help the claimant develop the record, particularly when the claimant is unrepresented. When the claimant is represented, most often the representative will develop the record. And, as Judge Bernoski pointed out, often the medical sources drag their feet in supplying evidence. I would like to believe it is because they have other matters of more pressing concern. Judges can and do subpoena records, attorney can and do badger the doctors until they provide what's necessary.

3. Some Actual Case Studies:

I have ample evidence from my own practice to demonstrate that a disability claim need not be a long drawn out process and that most cases would not have to go to hearing if representation was involved at the early stages.

My office handled 88 cases which were resolved at the initial application level in 1996. These are not necessarily cases RETAINED in 1996, only cases RESOLVED in 1996.

Of these cases, the average length of time between the date retained and the date resolved (date of the wage earner's award notice) is 5 1/2 months. This includes the time we spend developing our files so that the average amount of time between the actual filing of the application is substantially less than 5 1/2 months.

Let me tell you about a few of these cases:

[a] Mark C. is a forty-one year old truck driver. He last worked on March 28, 1995 when he was severely injured in an on-the-job accident. He consulted us about his Social Security case on September 23, 1996. We began to prepare and to investigate[5] the case and filed his application on December 12, 1996. On February 25, 1997, we received a favorable award certificate in his case. Total elapsed time—two and half months.

[b] Linda T. consulted us in October 1996. She was a fifty year old who had battled MS for many years, and finally had to stop working in June of 1996. We sent for her medical records and her vocational rehabilitation assessment. We had her examined by a neurologist to determine her functional capacity. In February of 1997

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same "standards" as the DDS, they still find a great deal of error requiring reversal of DDS denials.

[5] This consisted of obtaining files from his Workers' Compensation case files and from his personal injury case, visiting the Workers' Compensation Board to review their file, writing to his doctors and hospitals for their records, and obtaining a narrative report from his treating doctor and arranging a consultation with a specialist for a functional capacity evaluation. When and only when all of this was completed, and we were convinced of the validity of the claim, did we file the application for benefits. As officers of the court we view our duty as requiring reasonable investigation so that frivolous or fraudulent claims are not filed.

her application was filed. In April a favorable decision was issued. Elapsed time in the system was about 2 months.

[c] Nilda C., our S96–0148, consulted us on March 7, 1996. We investigated her claim and had sufficient information to file her application as of April 1996. She was a fifty year old person with a ninth grade education, who had worked as an assembler for fifteen years. She suffered severe depression and left hip pain since August of 1995. Her date of entitlement, if she was successful, would be February 1996. The application that we filed on April 15, 1996, was favorably adjudicated on September 27, 1996, by the issuance of an award certificate. Social Security completed all the work on the claimant within a period of five months.

[d] Jack T., (our S96–0328), was a chiropractor who became disabled as a result of post traumatic stress disorder following an accident in which several of his friends were killed. He became disabled in December of 1995, and consulted us in July of 1996, when his short-term disability benefits expired. It was too early to file a claim for disability as we could not determine whether his disability would last for twelve months. We began to gather medical evidence and in September of 1996, decided to file his application. The application was filed on September 18 and denied on October 10th. (Three weeks!) Reconsideration was filed on November 8 and that was denied on December 12, 1996. (Five weeks!) Jack had been disabled only for a year at this point, and the denial by the state agency at both levels was not unreasonable considering the fact that the claimant had hardly met the duration requirement.

The total adjudicative time for Jack's claim was September 18, 1996; the initial filing, to the hearing decision of January 14, 1997—approximately four months. Hardly a long drawn out appeals process.

The case also points out why so many cases would be denied at the state agency level, that are obviously grants at the Administrative Law Judge level. Many of these cases have not yet met the duration requirement and DDS personnel are reluctant to presume disabilities will persist for twelve months, the statutory requirement. DDS examiners have no crystal ball; some people do get better and yes, some get worse. Had I been an employee of the DDS, I too, would have been reluctant to grant benefits on this case. However, by the time the case reached the Office of Hearing and Appeals, it had aged appropriately, and the award of benefits was warranted.

[e] Robert J. H. (our file S96–0487) first consulted us on November 5, 1996. We investigated his workers' compensation file and found sufficient enough medical evidence upon which to base the filing of an application. The application was filed on November 15, 1996. Robert had become disabled as a result of and on-the-job injury involving his back, right leg, and right foot. On April 26, 1997, the Social Security Administration issued a fully favorable decision once the claimant had reached the one-year threshold.

Apparently SSA refrained from making a decision until the claimant had attained the duration requirement. Shortly after his disability met the one year mark, a fully favorable decision was issued, presumably once they had verification that the claimant remained disabled for twelve continuous months.

The favorable decision was issued a mere five days after the one-year anniversary of disability.

As Ms. Colvin observes on page 6 of her prepared statement: "....cases denied by the DDS based on expected improvement in the claimant's condition within 12 months of the onset of the condition are allowed by the ALJ because improvement has not occurred since the DDS determination." (However, if anyone thinks that remanding of these cases back to the DDS as envisioned in process unification will speed up claims, they are misguided. It can't possibly do anything but slow down the process by bouncing files back and forth. Since an ALJ makes a de novo (fresh) determination, why shouldn't the ALJ be able to consider that the DDS was right at the time it made its decision, but that subsequent events have changed the picture?)

Merely because we take a case in at the initial application level, however, does not mean that it will be granted at that level. Some cases do require the intervention of judges or the accumulation of medical evidence over a period of time in order to prove that the disability will be longstanding and continuous.

[f] Consider the case of Mei Shi L., our S96–0280. We were retained in this case on June 11, 1996. We filed our application shortly thereafter, on July 2, 1996. This application was denied on September 5, 1996. That is within two months. We think that any charge of unnecessary delay by Social Security or the DDS is simply not supported by the speed in which this case was initially adjudicated. We immediately filed a request for reconsideration and that was adjudicated on October 29, 1996.

It is important to note that the claimant's date of entitlement was January 1996 based on disability beginning July 1995. A hearing request was filed and adjudicated by an Administrative Law Judge on March 18, 1997—within nine months of the initial application filing. As you can well appreciate, the speedy adjudication of this claim made it possible to limit attorneys fees to only $970 out of the claimant's past due benefits.

Unfortunately, upon review of the award certificate, it became apparent that Social Security miscomputed the Workers' Compensation award and it was the award certificate that had to be appealed, but this is not something that goes to the merits of disability.

[g] Gary L. was a forty-two year old police officer who had sustained serious injuries to both of his legs. However, because of his age and vocational profile, skilled work and education (a B.S.) this was not an easy claim for disability.

Gary alleged disability as of July 1995. He consulted us in April of 1996, and we began collecting medical evidence at that time. The filing of an application at that point in time would have been premature in our view, as the claimant could quite possibly have recovered within a year. The nature of his condition was either that he was going to recover or probably become worse.

By July of 1996, we determined that the claimant had not yet recovered and we filed an application. The state agency acted on this application in less than two months, issuing a denial. Reconsideration was filed in November of 1996 after reevaluating the case and obtaining more evidence to see if the claimant still, in fact, was disabled. The denial was issued within a month. We do not think the DDS dragged its feet. Nor could we convincingly argue that in light of the vocational issues in this case, DDS necessarily should have granted the case. This was the type of case which should have gone on to additional scrutiny to consider the impact of the limitations on the claimant's vocational capacity.

The case went to the Office of Hearing and Appeals and after a conference with a staff attorney, at which the additional issues were explored in depth,[6] benefits were approved for Gary. The decision was dated January 17, 1997. Gary's case was in the system for a total of six months. We do not think Social Security in any way dragged its feet. The claimant did have a severe condition, there was a question at the outset of duration, and there was a very significant vocational issue to be considered in this case. By the time the case reached the hearing level, it became clear that the claimant's condition approached, but did not meet the listings. Additionally, it was very difficult getting information from the claimant's treating physician. However, by the time the case reached the Office of Hearing and Appeals, we did have the necessary information from the treating physician, which buttressed information from consultants, to whom both we and the Social Security Administration had referred the claimant.

[h] The case file of Police Officer Daniel R. is an instructive one on two counts. First of all, it shows how quickly a case can go through the system. Second, it shows that despite state agencies claims that they have far more medical sophistication than an Administrative Law Judge, experience has shown the opposite to be true. Dan was a forty-two year old police officer who stopped working in January 1995 due to cardiac symptoms. He suffered idiopathic cardiomyopathy with a markedly depressed ejection fraction of 15%. This condition far surpassed the criteria of the listings of impairments. Dan was a very disabled man. Somehow, the fact that this man's condition objectively met the listings escaped disability examiners and state agency review physicians at the initial level, and at the reconsideration level. Dan's disability claim was filed on February 14, 1996. This was approximately a year and a month after he had become disabled. He clearly had met the duration requirement. Nonetheless, the state agency denied his claim on June 4, 1996. Reconsideration was filed and was denied on July 15, 1996, (within six weeks).

A hearing request was filed on July 23, 1996, and this case was resolved by favorable decision on the record, as it should have been, on September 20, 1996. Dan's case was in the system for approximately seven months from application to hearing. Again, although this claim probably should have been paid at the time of the initial application, the appeals process worked quickly enough so that one would be hard pressed to state that the adjudication of this claim was unduly prolonged.

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[6] This largely supports the observations by James Hill referring to the success of the Senior Attorney program at the Office of Hearing and Appeals, which permits experienced Senior attorneys to screen out the obvious cases, and issue favorable decisions. Generally, these are cases that should have been granted by the State Agency, had the law been followed. (See Hill at page 8.)

4. The Myth that ALJ's Are Not Medically Trained.

I take great issue with the insinuation by Debi Gardiner of the National Organization of Disability Examiners to the effect that ALJ's are not sufficiently grounded in the knowledge of medically acceptable diagnostic techniques to make supportable determinations, and instead exercise uncritical acceptance of medical opinion. That is not, and has not been, my experience over a twenty year career in which I have appeared before approximately 150 different Administrative Law Judges from all over the country. The statement that these judges are not medically trained is at best preposterous, and amounts to nothing more than judge bashing.

In the first instance, many of the hearings have medical advisors present;[7] second, some of the judges are experienced trial attorneys and know as much medical evidence as do doctors. If anything, the state agency examiners appear to think they know more than do treating physicians.[8] Thus on three separate occasions within the same case, I recently had to stop a local DDS examiner from trying to put one of my clients with severe hypokinesia of the heart, and two prior heart attacks, from taking an exercise stress test prohibited by his treating physician. The problem is not that ALJ's don't understand medical evidence, the problem is that disability examiners begin to play doctor after they've been in the job for a while and think they know more than the treating doctors do. State agency doctors rarely do more than sign off on perfunctory rationales prepared by examiners. Rarely does one find a probing intelligent analysis by a DDS doctor in a disability file.

5. Misplaced Concern Over Attorneys Fees.

A reading of the statements of Mr. Willman, and Mr. Jacks of the disability examiner community, clearly indicates their extreme displeasure with the attorneys role in the disability process. Mr. Jacks suggests that Congress should "deregulate attorneys fees...SSA should not expend resources arranging or collecting attorneys fees." This issue had been debated before the Subcommittee last year, in connection with a similar provision in the Senior Citizens Right to Work bill. That provision was deleted by bi-partisan action in the Senate Finance Committee where members of both parties unanimously agreed that removal of the attorney fee collection mechanics would effectively deprive most claimants of representation. We need not revisit the debate here. We suggest that the disability examiners would like nothing more than to see claimants deprived of effective representation, which would, undoubtedly, negatively effect the number of OHA reversals and, as such, perhaps "make the DDS folks look better."

As to the notion that attorneys' fees are unjustified or excessive, or that attorneys are ambulance chasing to bring in Social Security cases, I must again tell you about real cases:

[i] My firm has represented Kurt H. since June 1, 1994. We filed an application on his behalf and finally resolved the matter on August 30, 1995, after going through three stages of the process. The total attorney fee in this case for some sixty-five hours of work on a file, approximately ten inches thick, was $2,798.75, or about $46.64 per hour. I doubt you could find an auto mechanic who would work for $46.64 per hour. (Doing away with contingency fees, for a client such as Mr. H., would have precluded his ability to obtain any representation whatsoever had he been required to pay an hourly rate on a pay-as-you-go basis.)

[j] Roseanne G. was a forty-nine year old woman who had worked as an electronics assembler and became disabled due to an on-the-job back injury. We took the case in May of 1990. We developed all available evidence and ultimately filed a claim on behalf of the claimant. This claim was denied initially and upon reconsideration, then by the Administrative Law Judge, and then by the Appeals Council. However, it was reversed in federal court. When all was said and done, we exerted 72 and a half hours on administrative level services, including extensive appeal and file development. The total fee on this case was $3,705, or about $51.11per hour.

[k] Maria P. (our S96–0261) retained us in May of 1996. We obtained a favorable result by December 24, 1996. We put in approximately thirty-six hours on the case and our total fee was $92.50. You read it right. The claimant was significantly offset as a result of Workers' Compensation. Nonetheless, although we realized this at the

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[7] One commentator decried the fact that only 8% of ALJ favorable decisions resulted from hearings with medical advisors. Of course, this doesn't tell us how many denials resulted from the availability of a medical advisor. Also, a number of commentators, particularly, Jane Ross of the GAO, Carolyn Colvin of SSA, Judge Bernoski and Staff Attorney Hill have reported that the DDS medical analyses were routinely found to be poorly articulated, and lacking evidentiary support or rationale.

[8] Mr. Willman, apparently would give reports from treating physicians no weight at all.

outset of the case, we still accepted the case in order that the claimant's rights could be protected.

As you might have gathered, we do not look to see how much of an ultimate fee a case will pay, we look to the merits of the case in deciding whether to represent the claimant.

6. Re-examination of the Role of an Attorney in the Disability Process.

We interview a great many people. We only accept a small portion of these prospective clients for representation in Social Security Disability matters. (Maybe 20% of those we interview.) We screen out most of the claims, not by discouraging people from applying, but by suggesting alternatives. So many people come to us who are fearful of working because they might lose their Workers' Compensation, yet they are not disabled enough for Social Security Disability. We explain to them that New York has a reduced earnings statute under Workers' Compensation which allows them to work and still get partial Workers' Compensation for any disparity in earnings. Others we refer to the State Division of Vocational Rehabilitation. We take very seriously the responsibility of supporting someone's notion and encouraging someone's notion that they are in fact "disabled." Much like the members of the Subcommittee, we too believe that people who can work should and that Social Security disability is an extraordinary remedy for extraordinary circumstances. Along with all of you, we are very concerned about clogging the system with cases of dubious merit. It simply delays disposition of the meritorious cases; moreover, it doesn't bolster our credibility before the agency or before Congress.

One of the problems that plagues the disability process is the apparent perception that the attorneys and the agency are in an adversarial position to each other. It is a perception which is more that of the agency, than the organized bar. It causes great delay and other problems in administering the program. From observations made at the oral hearing before the Subcommittee, I gather that there are those on the subcommittee who do not appreciate the role the bar can play to expedite the disability process if only we would be permitted to do so. The role of an attorney in the Social Security Disability process should mirror what attorneys do in society. Think of your own legal needs. Many of us consult attorneys as a preventative measure, not for the purpose of litigation. We consult attorneys for counsel, for advice, for help by preparing our contracts and agreements, and for formulating our legislation. We utilize attorneys in every facet of our lives, and businesses, and yet most attorneys rarely, perhaps never, need to see the inside of a court room.

I would suggest that the role of attorney in a Social Security case should be first and foremost to investigate the claim.

(1) An attorney should determine that it is a legally viable claim. That does not necessarily mean that the claim is a winner, but attorneys should screen out claims that don't belong in the system—at least as a preliminary screening.

(2) In advising a claimant, the Social Security law is complex. One needs to know issues such as Workers' Compensation offset, tax consequences, insured status, what the effect would be if the claimant chooses a later onset date than merely trying to win benefits based on a date last worked (which may not be supportable). The effect of Social Security benefits on other benefits claimant may be receiving such as long-term disability insurance or pensions, and issues such as taxability or the effect of an SSD award on a matrimonial or an ADA action.

These are complex legal questions, and it is unlikely that any disability case manager will ever have the answers to these types of questions. Certainly, most claimants cannot, at present, get these answers from Social Security. Social Security can certainly answer questions about Social Security, but they cannot answer questions about the ramifications that a Social Security Disability award has on other legal rights and entitlements. These are legal questions requiring legal knowledge of other areas of law. Did you know, for example, that we have had to counsel to withdraw claims because of taxable consequences would have exceeded the amount of the award?

The attorneys role should be to help the claimant produce the evidence and then to file an application—not to stuff undocumented applications into an already overburdened system and not to come in late in the game at the last minute to try to resurrect a claim that could have been granted early on in the process with similar intensity of effort. One of the reasons that the system is bogged down is because there are many applications filed which should never have been filed in the first place. Social Security rushes people into filing applications. Private carriers rush people into filing applications. Doesn't anyone investigate these applications to see if they are at least colorable claims? That should or could be the role of the bar.

The key to all of this is a contingency fee system. If we allow attorneys to be paid only when the claims are successful, then the attorneys will have every incentive

to thoroughly develop the cases and to make sure "clunkers" don't get in the system. If we stop putting false barriers in the way of attorneys representing people at the initial application level, and if process unification truly works, as it should, then you would see more claimants getting paid on the application and fewer claimants being paid at the Administrative Law Judge level. One, there will be fewer claimants going to the hearing level and, two, the claims that do need to go, will have already been developed. Those claims will be the ones that rise and fall in close legal questions or vocational issues, extremely complex medical issues, and credibility issues.

Because we are bound by the ethical rules of conduct which apply to all attorneys, we are duty bound to remove from the system claims of doubtful veracity.

[l] For example, on October 8, 1996, we were retained by Mr. Albert W. in connection with a possible claim for Social Security Disability benefits. We began to represent Mr. W. and based on the evidence that we were able to obtain, it appeared that Mr. W had a viable claim. We, therefore, filed his application. While that application was pending, we continued to develop evidence which led us to conclude Mr. W. was not disabled. Based on that evidence, we withdrew the claim for disability.

The risk of developing the claim was ours, not SSA's, and the responsibility for withdrawing the claim was also ours. SSA didn't have to waste time adjudicating a claim that we withdrew on the merits. We have withdrawn hundreds of claims, when the facts did not support them, or we felt there was even a suggestion of fraud on the claimant's part.[9]

7. The Danger of Closing the Record.

As we have discussed above, the evidentiary record established by DDS offices for unrepresented claimant's is usually scanty, often for reasons beyond the control of DDS. It is often only the clout of an attorney or a judge that can compel the doctors to produce records. Second the manner in which SSA bounces files around from one component to another also makes it difficult for evidentiary submission to reach the person adjudicating the file. (Hopefully some of SSA's re-engineering initiatives will deal with these problems. The re-engineering model certainly recognizes and appreciates the depth of the problems.) To close the record before the hearing will essentially preclude most claimants from producing any evidence at all, so they will have no option but to lose at the hearing. Then they will file new claims, and the system will be even more clogged than it is now, as Nancy Shor has observed in her statement pages 4 & 5.

Another danger in closing the administrative record at any time prior to the hearing level is that the claimant may actually recover from the disability. If Administrative Law Judges are restricted to a review of only the record available, the DDS in such cases, they may be constrained to award ongoing disability benefits rather than closed periods of benefits only through the date of the claimant's recovery. If the record is closed and additional evidence is not allowed in, it is possible that Social Security will be paying on-going benefits to many people whose claims should merely be closed periods. One of the reasons that Social Security has such a terrible backlog is that all components of the agency are too quick to deny, rather than to determine that all the claimant is really seeking is a closed period.

8. DDS Perspective is Biased.

Some of Social Security's re-engineering models suggested the State DDS would be eliminated as part of the disability process. Understandably, the DDS community is afraid their jobs could be eliminated. As a result, they have made unprecedented attacks upon all other components of the Social Security process, particularly the judges and the claimants' representatives. I do not believe they have given an accurate depiction of what is wrong with the disability process, and there is plenty wrong.

The problems start at the inception of the process. SSA's re-engineering model recognizes this. The ALJ's recognize it. Nancy Shor recognizes it. Even the DDS witnesses recognize it. However, it is interesting that no representative of the Disability Examiner community understands the grave legal implications of an institutionalized non-acquiescence policy as recently announced by SSA in one of its much

[9] Our incentives for keeping fraudulent and dubious claims out of the system should be obvious: (1) We are taxpayers and stakeholders in the system too; (2) We are officers of the court and by implication the agency, sworn to uphold the law; (3) We are subject to suspension by SSA, censure and even disbarment; (4) An attorney is bound to avoid even the appearance of impropriety; (5) Allowing phonies on to the rolls makes it harder for the legitimately disabled people we represent; (6) Promoting a fraudulent claim is a felony; (7) Our interest is in promoting a stable disability system, as our own livelihoods, in part, revolve around the stability of the system; and (8) It is important for us to maintain our credibility before SSA and the ALJs.

touted recent rulings. Debi Gardiner, of the National Association of Disability Examiners, and Mr. Willman applaud SSA's ruling that it will disregard Circuit Court decisions. This position clearly backs up Judge Bernoski's (and my) assertion that State Agencies routinely disregard the law.

The proposal for a Social Security Court seems to be something supported by disability examiners, but by no one else in the process. Why do we need to set up an expensive new bureaucracy to do what Federal Courts have been doing well, and inexpensively, for the last forty years?

As Nancy Shor stated, "Given the wide variety of cases they adjudicate, federal courts have a broad background against which to measure the reasonableness of SSA's practices."

The Social Security Bulletin's Annual Statistical Supplement for 1996 establishes that in 1985 only 9076 new Social Security cases were filed in federal courts at a time when over 588,596 hearing requests were filed. This averages out to 182 cases per each state.

This means that the total number of court cases amounted to less than 2% of the total hearing load. That year, Federal Courts decided 6867 cases of which only 673 were reversed, (about 10%). If the notion of limiting Federal Court jurisdiction is based on the premise that the Federal Courts have too many SS cases and are reversing too many; such is clearly not borne out by SSA's own statistics. Only a very small number of cases are appealed into the Federal Courts, and of that, even a much smaller number are reversed.

In 1996 there were 630,000 hearing dispositions. Comparing 673 Federal Court reversals to total administrative dispositions shows that only about 1/100 Federal court cases result in a reversals vis-a-vis total administrative dispositions.

IN SUMMARY

I agree with Judge Bernoski, that the extent to which there are two different standards utilized between the DDS and the ALJs, is a phenomenon of agency creation, in that the Social Security Administration has permitted the State agencies to disregard the law, and instead decide claims on the basis of the POMS and other unpublished, and illegal guidelines. Like other commentators, I do expect process unification training to obviate this issue to a significant degree.

I also agree with Judge Bernoski that the ALJ's review quite a different evidentiary record, because the state agencies don't bother to develop the record and SSA basically places obstacles in the ability of claimants to secure counsel at the early stage. This sentiment was echoed in the statement of Nancy Shor to the effect that: "Very often the files that claimants with denials from the reconsideration level coming to our members show how little development was done at the initial and reconsideration levels. Until this lack of development is addressed, the correct adjudication of the claim cannot be made. Claims are denied not because the evidence established that the person is not disabled, but because the limited evidence cannot establish that the person is disabled.... a properly developed file is usually before the ALJ because the claimant's counsel has obtained evidence or because the ALJ has developed it."

Judge Bernoski and James A. Hill and other commentators including the DDS people are all correct when they point out that the recent process unification initiative should help narrow the gap between the ALJ allowances and state agency adjudications, if, and only if, the state agencies follow the unified standards.

Nancy Shor's statement that "changes made at the 'front end' of the process can have a significant, beneficial impact throughout the hearings and appeals backlogs," also is entirely correct and borne out not only by my personal twenty years of experience, but also by the thrust behind the redesign proposals—proposals which are receiving more resistance from within SSA than from the outside. This is echoed in Mr. Hill's observation that State Agencies fail to "provide adequate written explanation for the decisions" and fail to "adequately develop cases...."

Expediting the process may not require massive reengineering, it may simply require SSA to use rules and regulations which they've had for years but have steadfastly ignored.

Encouraging representation at the earlier levels rather than discouraging it, could significantly impact the backlog at the hearing level, and help foreshorten the wait at the hearing level. Clients will benefit by paying lower attorney fees, as cases get resolved more quickly. Attorneys benefit because they would have more rapid case turn around. Contrary to conventional wisdom, we don't make more money as a case drags on, we make less per each hour of additional work. Attorneys are better off with high turnover and happy clients who refer more clients, not with unhappy clients who waste the attorneys time with incessant telephone calls about "what's hap-

pening with my case" and think the attorney, rather than the system is delaying their cases. SSA would benefit by having lower processing times, and having cases be reviewed that much sooner. Some readers may take the position that I am merely trying to bolster the employment of attorneys. In response to that I argue:

1. My proposals result in lower attorneys fees for claimants;
2. My proposals result in privatizing, at no cost to SSA, much of the file development chores which are time consuming and expensive;
3. My proposals would be unnecessary if the DDS did their job.
4. I am for the following:

(a) discouraging premature claims that clog the system;
(b) screening out of cases of dubious merit;
(c) quicker resolution, by better development;
(d) providing the DDS with better and more complete evidentiary records so that they can do their job of adjudicating in a quality manner and concentrate on adjudicating rather than chasing after evidence.
(e) paying the obviously meritorious claims as early in the process as is possible.

In my own practice, I have (not without battling certain obstructionists within the Social Security Administration and Office of Disability Determinations) achieved these goals. I believe they can be achieved nationwide without massive re-engineering, threatening the jobs of state agency DDS personnel; or unduly clogging the system with unnecessary repeated re-applications for benefits. I firmly believe that if all components to the disability process (SSA, DDS, OHA, and the bar) concentrate on what they do best, and stop the back stabbing, the entire process will function with the high degree of efficiency that Congress envisions when it enacts Social Security legislation.

Respectfully submitted,

VICTOR FUSCO, ESQ.

MOONEY & PARK
THE NATHANIEL ROPES BUILDING
May 6, 1997

A. L. Singleton
Chief of Staff
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Sir:

I am responding to the invitation for public comment on the following: The current status of OH&A workloads; their impact on service to the public; Social Security's initiatives for addressing those workloads, including how the system can be improved, and; timeliness and consistency issues with respect to SSA disability decisions. I am submitting these comments on my own behalf, the statements do not necessarily represent the position of any of my clients or other persons.

By way of background, I have been an attorney for 25 years, I represented my first Social Security client in 1974 and have practiced almost exclusively in the Social Security disability area for the last 7–8 years. I'd like to add that I am consistently impressed with the competence, intelligence and dedication of the employees of the government who process disability claims—if there is a problem it is not due to "lazy bureaucrats."

The major focus of the hearings, apparently, is whether the current hearing and appeals system makes sense. I believe with some fine tuning, the existing system could be made to work much more efficiently with the result that decisions could be made more quickly and accurately, thus benefiting both claimants and the government.

The initial problem with the existing system is that, while there are two separate methods of qualifying for disability benefits, Social Security only uses one of those two methods at the application and reconsideration levels. The two methods of qualifying for Social Security disability are: 1) establishing the individual has a physical or emotional impairment that is so severe that it has been "listed" by Social Security as automatically qualifying an individual for benefits. The Social Security regulations contain numerous such "listed" impairments. Assuming an individual does not meet a "listing" then, 2) they must demonstrate that the limitations caused

by their emotional and physical impairments, either separately or in combination, make it impossible to do their former work or any other work.

As may be obvious, if only one of two methods of qualifying for disability benefits is considered at the application level and at the reconsideration level (the first level of appeal) then many claims that otherwise would be granted are denied. Thus, the first change to the existing system that should be adopted would be to instruct the decisional apparatus at the application and reconsideration levels to consider whether an individual qualifies under the second method of establishing disability and to provide adequate training and support so that they are knowledgeable as to how to apply that second standard.

The second recommendation for modifying the current system would be to simply eliminate the reconsideration level. In my experience this is basically a useless step which results in precisely the same decision being made for precisely the same reasons by the same people who denied the initial claim. All it really does is slow the process up.

The third recommendation for making the first two steps of the process more efficient would be to require the individuals preparing the decision on the initial application to actually describe to the applicant's treating physicians what the Social Security standard for that particular disability is. For instance, if an individual has a severe heart impairment, Social Security now asks for the treating physician's records. Remarkably, however, Social Security will not send the doctor its definition (its "listing") of when a heart impairment is bad enough to qualify for benefits or ask the doctor whether his patient satisfies that definition. Thus, on the key issue of whether an individual satisfies Social Security's disability standard for heart conditions, the one physician in the best position to provide an accurate answer, the patient's treating physician, is never asked that question. Instead, his records are sent to Social Security doctors who have never met the patient, and have no familiarity with his long-term history, and those individuals, based purely on a review of paperwork, determine whether or not the standard has been met.

When claimants visit my office for representation, one of the first things I do is send a copy of the listings for their particular medical condition and ask the doctor whether his patient satisfies that condition. I then forward that response to Social Security Judge assigned to the case who is often persuaded by the treating doctor's rationale for concluding the patient does satisfy the listing standard and grants benefits. Why should the claimant have to hire an attorney to seek this important information and why couldn't this information be obtained by Social Security at the early stages of the claim thus avoiding the one year delay in granting benefits while the case is appealed and then pends at the ALJ level for a decision?

Neither of the above two changes are radical and could be adopted with much less effort than the various wholesale proposals currently under consideration. They would also do much to bring a prompt resolution of the claim and, if an appeal to an ALJ follows, these changes would do much to bring down the reversal rate by ALJ's which, as described, is in significant part a result of the ALJ having more relevant evidence as well as being able to use the second method of granting disability benefits.

When assessing the current system's efficiency, please remember that the various recent changes in the disability law are causing hundreds of thousands of claims to be re-decided e.g.: the new regulations for children's claims and drug and alcohol claims means that all of those cases which were decided in the past must now be re-decided. In addition, the new disability standards must be mastered. This will inevitably cause delay but it would not be appropriate to fault the system for this.

With regard to the suggestion that the ALJ hearing itself be modified in some fashion, I would strongly oppose that. Just as the expression "A picture is worth a thousand words," is commonly recognized as true, a personal appearance is worth "a thousand pictures." That is, when a claimant actually appears before an ALJ, it is the first time in the 1–2 year history of a claim that anyone in a position of deciding the claim actually has seen the claimant. Such in-person experience in extremely educational. A medical record cannot convey any of the following:

- The fact that a 40 year old looks 85.
- The fact that a claimant has great difficulty understanding even basic questions and cannot recall simple facts, including his birthdate.
- How severe the personal experience of pain is for an individual claimant.
- How humiliating it is for a claimant to have to apply for disability after years of self-sufficiency and self-support.

All of these and thousand of others bits of information are presented directly, and indirectly, by a personal appearance at an ALJ hearing. In addition, the claimant has the opportunity to have a dialogue with the ALJ, to answer his or her questions, to explain inconsistencies in the record, to describe details of his condition that have

escaped the evaluations done by Social Security doctors in their 15 minute, one-shot consultative exams. Because it is a dynamic process with much give and take, the ALJ hearing is the best method of gathering evidence, processing that evidence, learning about the claimant as an individual, and understanding the dimensions of his or her physical and mental impairments. Therefore, the ALJ hearing should be preserved in its entirety.

Unlike many of my colleagues I am not a strong believer in the Appeals Council as a source of review of ALJ decisions. Currently, it takes the Appeals Council 18 months to review claims and virtually every appeal I have made in the last two years has been denied anyhow. Given the enormous delay and the fact that, at this point, the Appeals Council is simply rubber stamping its approval of all ALJ denials without any critical review, it would seem that this method of review could be eliminated without any denial of fairness to claimants.

Also, unlike some of my colleagues, I would strongly support the establishment of a Social Security Court to review decisions. This is currently being done in the veterans' disability area and I have practiced before the Court of Veterans Appeals on numerous occasions. The contrast between appealing a VA disability case to COVA and appealing a Social Security case to District Court or to a Circuit Court is striking. The COVA Judges and staff are extremely well informed as to the law, it's nuances and precedents, and have a global view of how the system should work. District Court Judges and Circuit Court of Appeals Judges are, by and large, entirely uninformed and uninterested in Social Security and are entirely unenthused about hearing "yet another" Social Security Disability claim. I do not believe the current federal court system provides meaningful review of Social Security decisions and, therefore, would actively support its abolishment and replacement by a specialized review court hearing only Social Security claims. Such a court would have to be adequately staffed, however, to handle the sizeable workload that would be expected. Otherwise the change would be meaningless.

It would also be a mistake to close the record to new medical evidence prior to the ALJ level. The result of this will simply be numerous re-applications, as the ALJ's decision will not be based on all of the medical evidence. The proposal that new evidence would trigger a remand from the ALJ for consideration by the initial reconsideration staff is similarly flawed. It would cause enormous delay as the file bounced back and forth between the lower level and the ALJ level. A similar system is currently used by the VA and is a constant barrier to reaching a prompt final decision (which frequently takes 4–6 years).

With regard to the proposal for own motion review of favorable ALJ decisions, this can only produce cynicism about the decisional process. If accurate decisions are the goal of the change, then review of unfavorable decisions should be mandatory. Otherwise, the obvious message to claimants is that they are playing with a deck stacked to increase their odds of losing.

Thank you for taking the time to consider these comments. I will be happy to provide any additional information deemed relevant.

Sincerely yours,

MICHAEL J. MOONEY

MJM/jrr

CC: Congressman Robert J. Portman
Nancy Shor

Statement of Larry Jacks, Division Leader, Public Employees Federation, Office of Disability Determinations

THE SOCIAL SECURITY DISABILITY PROGRAM

SENSIBLE SOLUTIONS TO RESTORING PROGRAM INTENT

While understanding Congressional reluctance to micro-manage a huge Federal agency such as the Social Security Administration (SSA), we are very appreciative of recent Congressional interest and efforts to restore efficiency and to maintain the integrity of the Disability Program.

Everyone agrees that the present processing time at the Office of Hearings and Appeals (OHA) is unacceptable. Short term initiatives have reduced the OHA backlog from 547,690 at the end of FY 1995 to 503,481 at the close of FY 1996, but this is still far in excess of the 172,756 cases pending at OHA as recently as 1990. Most of the reduction was achieved by reallocating experienced SSA personnel, in effect robbing Peter to pay Paul, rather than a true long term solution.

SSA has had a Re-Design plan since 1994. We agree with many of its goals, but unfortunately many elements of the Plan have had very limited value. The Re-Design has the following current priorities:

1. Adjudication Officer (AO).
2. Single Decision Maker (SDM).
3. Full Process Model (FPM).
4. Disability Claims Manager (DCM).
5. Process Unification.
6. Quality Assurance.
7. Simplified Disability Methodology.
8. Computer Systems Development.

SSA recently decided to expand the number of AO's even though it concedes that the expected production levels have never materialized and probably never will. The SDM and FPM are precursors to the DCM position that is the cornerstone of the Re-Design Plan. SSA has persistently ignored concerns from SSA employees, DDS's, and its own Advisory Council Members, that the DCM is too grandiose to be workable.

The "Simplified Disability Methodology" has shown very little progress. This is not surprising because "simplifying" increasingly complicated fields like law and medicine will never be easy.

SSA has tried to achieve some measure of Process Unification, and had national training for both OHA and DDS personnel. This was a useful introductory step, but does not seem to have had any dramatic effect on either level. At some of the sessions, ALJ's announced that they had no intention of following SSA's recommendations regarding assessment of Residual Functional Capacity, weighing evidence, and paying careful attention to medical analyses provided by Review Physicians at the DDS. These ALJ's were adamant and insisted they would follow court interpretations and holdings rather than be bound by SSA's nationwide policy.

SSA would like to include in-line as well as end of line reviews in its Quality Assurance process, but has not piloted this in any efficient way. We remain concerned that under the Re-design Plan, SSA will not automatically return deficient cases and erroneous decisions for corrective action. Instead, it will simply tabulate the data for training purposes. We strongly object to any agency knowingly implementing incorrect decisions.

Re-Design also suffers from changing management. The four principal officials responsible for the Re-Design have now left SSA. The new Director of Re-design candidly admitted that she had little experience with Re-Design, and was unfamiliar with its particulars. A project of this scope requires consistent leadership.

We need to look beyond the Re-Design plan of SSA and envision what sensible changes are required. It was never Congress's intent that 85% of claimants at the OHA level would need attorney representation, or that the process would be so delayed and expensive to both claimants and taxpayers, or that two inconsistent standards of adjudication would be allowed to evolve. There are steps we can take that will get the Program back on track and keep it there:

- Create a Social Security Court to provide uniform review of SSA decisions and consistent interpretations of regulations, replacing the current system of 89 Federal District Courts and 13 Circuit Courts each issuing disparate decisions.

• Revise the Administrative Procedure's Act to give SSA the requisite authority to manage the OHA's, including an effective quality assurance system for ALJ's. This was highlighted in GAO report GAO/HE'S 96–87.

• Clarify the adjudicative weight given objective evidence vs. subjective elements such as allegations, treating source opinions. This would help achieve authentic Process Unification between the DDS's and ALJ's.

• Congress should provide a uniform standard for reviewing decisions. A legislated "preponderance of the evidence" standard would help ensure uniform decisions at all levels.

• SSA and OHA must address the lack of input by program trained physicians at the OHA level and the lack of medical training for ALJ's.

• SSA should better identify optimum caseloads for DDS examiners and ensure that necessary resources are available to DDS administrators.

• Close the case file after DDS actions are completed, unless there is good cause for late submission of these reports. This should decrease the incidence of individuals withholding relevant medical evidence which causes further backlogs at OHA.

• Remand targeted OHA cases to DDS's.

• Deregulate attorney's fees for disability representation. SSA should not expend resources arranging or collecting attorney fees.

• In the event that these steps are insufficient, or meet with excessive resistance, we recommend that the Committee revisit the testimony of former Social Security Commissioner Lou Enoff (8/3/95), in which he recommended placing the initial decision and the hearing decision within the DDS with the use of an ombudsman to safeguard the applicants. This would combine more consistent and timely decisions with protection for the claimants.