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SOCIAL SECURITY ADMINISTRATION'S MANAGEMENT OF THE OFFICE OF HEARINGS AND APPEALS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

SEPTEMBER 25, 2003

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CONTENTS

	Page
Advisories announcing the hearing	2

WITNESSES

Social Security Administration, Hon. Jo Anne B. Barnhart, Commissioner; accompanied by Martin Gerry, Deputy Commissioner for Disability and Income Security Programs	9
Social Security Administration, Hon. James G. Huse, Jr., Inspector General	34
Social Security Advisory Board, Sylvester J. Schieber	38
Consortium For Citizens With Disabilities, The Arc, and United Cerebral Palsy Public Policy Collaboration, Marty Ford	48
National Organization of Social Security Claimants' Representatives, Richard P. Morris	54
Association of Administrative Law Judges, Hon. Ronald G. Bernoski	60
American Federation of government Employees, Social Security General Committee, Witold Skwierczynski	70
National Treasury Employees Union, Chapter 224, James A. Hill	76

SUBMISSIONS FOR THE RECORD

Adams, M.J., Seattle Office of Hearings and Appeals, Social Security Administration, Seattle, WA, statement	157
AIDS Resource Center of Wisconsin, Milwaukee, WI, Dawn R. Caldart, statement	97
American Bar Association, Robert D. Evans, letter	98
American Federation of Government Employees Council 215, Falls Church, VA, James E. Marshall, statement	99
Bartel, Jennifer L., Sheboygan, WI, letter	101
Caldart, Dawn R., AIDS Resource Center of Wisconsin, Milwaukee, WI, statement	97
Clark, Terry G., Sparta, GA, statement	103
Clark, Paul C., Cibola, AZ, statement	103
Dane, Dan, Midland, TX, letter	104
Dann, Richard, Auburn, CA, statement	104
Davis, Stephen W., Annandale, VA, statement	106
deVries, Margaret, Ladson, SC, statement	107
Evans, Robert D., American Bar Association, letter	98
Federal Managers Association, Alexandria, VA, Kristin Royster, statement	107
Flitsch, Kristen L., Watertown, WI, statement	112
Frederick, Phyllis, Hickory Flat, MS, statement	114
Fullerton, Linda, Social Security Disability Coalition, Rochester, NY, statement and attachments	161
Gilbert, Mary Jo, Vancouver, WA, statement	114
Glennon, Frances, Barton, NY, statement	115
Halas, Fran, Whitefish Bay, WI, statement	116
Hall, Nancy, Wauwatosa, WI, statement	116
Henderson, Tanya, Waynesville, GA, statement	117
Holland, Elizabeth S., Dallas, NC, statement	118
Holt, Margaret, Chapel Hill, NC, statement	118
Innes, Janet L., Cambridge, MA, statement	119
Innovative Community Solutions, Nashville, TN, Stephanie Varnado, statement	120
Jennings, Melissa, Freeport, TX, statement	121
Kelly, John, Clovis, NM, statement	121

Page
Kindel, Mary Ann, Cincinnati, OH, letter 122
Krippendorf, Jr., Donald Ray, Knoxville, TN, statement 123
Lankford, Richard, Milwaukee, WI, statement 124
Marshall, James E., American Federation of Government Employees Council 215, and National Council of Social Security Administration Office of Hearings and Appeals Locals, Falls Church, VA, statement 99
Martinelli, Peter J., Office of Hearings and Appeals, Social Security Administration, letter 135
Masch, Kathy, Milwaukee, WI, statement 124
Maynard, Tracy, Milwaukee, WI, statement 124
McFadden, Stephen A., Dallas, TX, statement 125
Miller, Ladonna, Lima, OH, statement 132
Moya, Abel, Milwaukee, WI, letter 133
National Council of Social Security Administration Office of Hearings and Appeals Locals, Falls Church, VA, James E. Marshall, statement 99
Office of Hearings and Appeals, Social Security Administration, Peter J. Martinelli, letter 135
Osbon, Connie M., Beaverton, OR, statement 140
Palmer, Kelleen, Massillon, OH, statement 143
Parker, Beckie, Olathe, KS, statement 144
Pastorini, Bruce and Susan, Jacksonville, FL, letter 144
Perkins, Barbara Licha, Middlesboro, KY, letter 146
Petri, Hon. Thomas E., a Representative in Congress from the State of Wisconsin, statement 148
Plumlee, Lawrence A., Dallas, TX, statement 149
Robertson, Stephen P., Chesapeake Beach, MD, statement 157
Rodriguez, Alice, Odessa, TX, statement 157
Royster, Kristin, Federal Managers Association, Alexandria, VA, statement 107
Seattle Office of Hearings and Appeals, Social Security Administration, Seattle, WA, M.J. Adams, statement 157
Shapiro, Sarah, Washington, D.C., statement 160
Shaull, Judith A., Fair Grove, MO, statement 160
Sherman, Deborah L., Kansas City, MO, statement 161
Social Security Disability Coalition, Rochester, NY, Linda Fullerton, statement and attachments 161
Sonders, Dawn L., Williamsburg, VA, statement 170
Stone, Diane, Columbus, OH, statement 171
Sullivan, Carolyn U., Ozark, AL, statement 171
Sullivan, Vicki L., Philadelphia, PA, statement 172
Taliaferro, Carolyn, Jersey City, NJ, statement 172
Thorpe, George J., Cochran, GA, statement 173
Upperton, Karen, Janesville, WI, statement 174
Varnado, Stephanie, Innovative Community Solutions, Nashville, TN, statement 120
Videan, Glenda, Hilton, NY, statement 176
Vobach, Lucinda L., Milwaukee, WI, letter 177
Weatherton, Dorothy A., Minden, LA, statement 179

SOCIAL SECURITY ADMINISTRATION'S MANAGEMENT OF THE OFFICE OF HEARINGS AND APPEALS

THURSDAY, SEPTEMBER 25, 2003

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

The Subcommittee met, pursuant to notice, at 10:06 a.m., in room B–318, Rayburn House Office Building, Hon. E. Clay Shaw, Jr. (Chairman of the Subcommittee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
September 11, 2003
SS–5

CONTACT: (202) 225–1721

Shaw Announces Hearing on the Social Security Administration's Management of the Office of Hearings and Appeals

Congressman E. Clay Shaw, Jr. (R–FL), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Social Security Administration's (SSA's) management of the Office of Hearings and Appeals (OHA). **The hearing will take place on Thursday, September 18, 2003, in room B–318 of the Rayburn House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from invited witnesses only. Also, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

The OHA is responsible for holding hearings and issuing decisions as part of the SSA's process of determining whether an individual qualifies for Social Security benefits. The OHA directs a nationwide field organization of 1,150 Administrative Law Judges (ALJs) who conduct impartial hearings and make decisions on appeals of retirement, survivors, disability, Supplemental Security Income (SSI) and Medicare claims. For fiscal year 2003, the SSA estimates that the ALJs will hold approximately 602,000 hearings, most of which are for claimants seeking disability benefits provided through the Social Security Disability Insurance (DI) or SSI programs.

In January 2003, the U.S. General Accounting Office (GAO) added Federal disability programs, including DI, to their list of high-risk programs, noting that the disability determination process is time-consuming and complex and that disability programs rely on outdated disability criteria. According to the GAO, one of the most pressing problems facing disability programs is the management and workload crisis at the OHA. The case backlog at the OHA has risen to record levels, from 311,958 cases in September 1999 to 581,521 cases in June 2003. As the backlog has increased, so has the waiting period; applicants who appeal their claim to the OHA must now wait 343 days on average for a hearing and a decision. If the applicant receives an unfavorable decision and files an appeal, he or she must wait an additional 307 days on average for a decision by the OHA Appeals Council. These delays are unconscionable and often devastating to individuals with disabilities and their families.

To address the long-standing problems and reduce delays at the OHA, the SSA implemented the Hearing Process Improvement (HPI) initiative in November 2000. According to GAO the HPI failed because the SSA implemented the initiative without any testing and without any agreement between key stakeholders, including agency employees. The Commissioner promised new recommendations for the hearing process in the Service Delivery Budget Plan but these recommendations have not yet been transmitted to Congress.

Recent events involving OHA offices in Milwaukee and Chicago also underscore the crisis in management at the OHA. In February 2003, representatives from the Chicago regional OHA led a management review of the Milwaukee OHA. The internal review identified serious operational deficiencies and lapses in management. For example, employees in the Milwaukee office had not opened 700 pieces of mail dating back several months and had not entered 1,400 cases into the office's computer system. Upon receiving the review, the Regional Chief Administrative Law Judge designated the Milwaukee OHA as an "office in need of assistance" and dispatched six different action teams made up of employees throughout the region to address the deficiencies. The Chicago regional OHA plans to closely monitor the performance of the Milwaukee OHA for the next 2 years.

In addition, in July the SSA confirmed that private contractors hired by the Chicago regional OHA to organize medical records and mark exhibits in claimants' files improperly tossed documents from those files into a recycling bin. The SSA terminated the contract in May when the problem was discovered. Although there is no indication that any claimants were harmed, the SSA is notifying all impacted claimants who have not received a fully favorable decision and allowing them the opportunity to review their files.

In announcing the hearing, Chairman Shaw stated, "Individuals with disabilities wait months, if not years to receive a decision from the OHA. That's wrong, and they deserve better. Each claim is more than a thick file of papers; it represents a person who is suffering and needs help. The hard working employees of the OHA must get beyond finger pointing and take personal responsibility to make their program work better. We must find ways to eliminate this bottleneck so that individuals with disabilities can receive the prompt and accurate service they deserve."

FOCUS OF THE HEARING:

The Subcommittee will examine the key management challenges facing the SSA's OHA, along with actions underway or recommended to improve service delivery.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by the close of business, Thursday, October 2, 2003. Those filing written statements that wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Social Security in room B–316 Rayburn House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

*** * * NOTICE—CHANGE IN DATE * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON SOCIAL SECURITY

FOR IMMEDIATE RELEASE
September 17, 2003
SS–5–REV

CONTACT: (202) 225–1721

Change in Date for Hearing on the Social Security Administration's Management of the Office of Hearings and Appeals

Congressman E. Clay Shaw, Jr. (R–FL), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced the Subcommittee's hearing on the Social Security Administration's Management of the Office of Hearings and Appeals, previously scheduled for Thursday, September 18, 2003, at 10:00 a.m., in room B–318 of the Rayburn House Office Building, **will now take place on Thursday, September 25, 2003, at 10:00 a.m., in room B–318 Rayburn House Office Building.**

All other details for the hearing remain the same. (See Subcommittee Advisory No. SS–5, dated September 11, 2003).

Chairman SHAW. Good morning. Today we will hear testimony on the current management and workload crisis facing the Social Security Administration's (SSA) Office of Hearings and Appeals (OHA). This office directs a nationwide organization, including over 1,000 administrative law judges who conduct impartial hearings and make decisions on appeals of retirement, survivors, disability, Supplemental Security Income (SSI), and Medicare claims. Members of this Subcommittee have long been concerned about the unacceptable delays experienced by individuals with disabilities who appeal their claims to the OHA. Today individuals wait almost a year to receive a hearing and a decision. If the applicant, who is an appellant, by the way, receives an unfavorable decision and files a further appeal, they might wait another 10 months on average for a decision by the Appeals Council. These delays are unaccept-

able and often devastating to individuals with disabilities and their families. It is no wonder that the U.S. General Accounting Office (GAO) has added disability programs to its 2003 high-risk list. The GAO is rightfully concerned that the program is stuck in outdated concepts of disabilities, experiences significant management problems, and has no sufficient game plan to address the increased number of individuals with disabilities seeking help from the agency. Recent revelations of mismanagement involving offices in Milwaukee and Chicago underscore the need for change. In June, a Milwaukee newspaper reported the existence of an internal agency audit that outlined gross mismanagement of the Milwaukee OHA. After receiving requests from Members of Congress from Wisconsin—including Mr. Kleczka who is with us today, and Paul Ryan, who is a Member of this Subcommittee—the agency released the audit to the public. The results were alarming: over 1,230 cases were not entered into the office's computer system. Another 712 pieces of mail had not been added to the claimants' files. While the agency took quick and decisive action to correct the worst problems in the Milwaukee office, the question remains: "How many other offices are experiencing these or similar problems?"

In July, the SSA confirmed that private contractors in the Chicago regional office hired in November 2002 had dumped documents from almost 1,200 disability cases into a recycling bin. This action could have violated individuals' medical privacy and potentially harmed the documentation of nearly 1,200 cases. The agency terminated the contract in May 2003 when the problem was discovered. Affected individuals have the right to review their case file, and a supplemental hearing will be offered if they did not receive a favorable decision. Following the disclosure of the Chicago events, Members of the Wisconsin congressional delegation requested an investigation by the SSA's Inspector General. While the final report is not expected until the end of this month, Inspector General Huse is with us today to report on the preliminary findings of this investigation. While the agency is addressing the Milwaukee and Chicago region's management and claim processing problems, the Commissioner has for many months been developing a long-term strategy to improve the entire disability determination process. We have just learned that the Commissioner will announce her recommendation this morning at this hearing. I know I speak for all of the Members of the Subcommittee along with our witnesses and audience present, when I say how pleased we are to be the first to hear her strategy. Soon, after thorough review and consultation, we will have a separate Subcommittee hearing to consider her proposal. In addition to Inspector General Huse and Commissioner Barnhart, we look forward to hearing from our other distinguished witnesses. Regardless of the organization they represent, all of our witnesses share a common goal of wanting to improve the appeal process for individuals with disabilities. I thank them for traveling to Washington, and I look forward to hearing their testimony. Every claim folder represents a person who is suffering and needs help. Individuals with disabilities deserve prompt and accurate services from the agency charged to deliver them that help. Today I hope we will get beyond finger-pointing and focus on finding an-

swers. Without objection, we will accept a statement by Mr. Matsui or his designate. Yes, ma'am.

[The opening statement of Chairman Shaw follows:]

Opening Statement of The Honorable E. Clay Shaw, Jr., Chairman, and a Representative in Congress from the State of Florida

Good morning. Today, we will hear testimony on the current management and workload crisis facing the Social Security Administration's Office of Hearings and Appeals. This office directs a nationwide organization, including over 1,000 administrative law judges, who conduct impartial hearings and make decisions on appeals of retirement, survivors, disability, Supplemental Security Income and Medicare claims.

Members of this Subcommittee have long been concerned about the unacceptable delays experienced by individuals with disabilities who appeal their claim to the Office of Hearings and Appeals. Today, individuals wait almost a year to receive a hearing and a decision. If the applicant receives an unfavorable decision and files a further appeal, they must wait another 10 months on average for a decision by the Appeals Council. These delays are unacceptable and often devastating to individuals with disabilities and their families.

It's no wonder the U.S. General Accounting Office has added disability programs to its 2003 high-risk list. GAO is rightfully concerned that the program is stuck in outdated concepts of disability, experiences significant management problems, and has no sufficient game plan to address the increased number of individuals with disabilities seeking help from the agency.

Recent revelations of mismanagement involving offices in Milwaukee and Chicago underscore the need for change. In June, a Milwaukee newspaper reported the existence of an internal agency audit that outlined gross mismanagement of the Milwaukee Office of Hearings and Appeals. After receiving requests from Members of Congress in Wisconsin, including Congressman Paul Ryan, a member of this Subcommittee, the agency released the audit to the public. The results were alarming. Over 1,230 cases had not been entered into the office's computer system. Nearly 712 pieces of mailed documentation had not been added to claimants' files. While the agency took quick and decisive action to correct the worst problems in the Milwaukee office, the question remains how many other offices are experiencing these or similar problems?

In July, the Social Security Administration confirmed that private contractors in the Chicago regional office hired in November 2002 had dumped documents from almost 1200 disability cases into a recycling bin. This action could have violated the individuals' medical privacy and potentially harmed the documentation of nearly 1200 individuals' cases. The agency terminated the contract in May 2003 when the problem was discovered. Affected individuals have the right to review their case file and a supplemental hearing will be offered if they did not receive a favorable decision.

Following the disclosure of the Chicago events, members of the Wisconsin Congressional delegation requested an investigation by the Social Security Administration's Inspector General. While the final report is not expected until the end of this month, Inspector General Huse is with us today to report on the preliminary findings of the investigation.

While the agency is addressing the Milwaukee and Chicago Region's management and claim processing problems, the Commissioner has for many months been developing a long-term strategy to improve the entire disability determination process. We have just learned that the Commissioner will announce her recommendations at this hearing.

I know I speak for all the Members of this Subcommittee, along with our witnesses and audience present, when I say how pleased we are to be the first to hear her strategy. Soon, after thorough review and consultation, we will have a separate Subcommittee hearing to consider these proposals.

In addition to Inspector General Huse, and Commissioner Barnhart, we look forward to hearing from our other distinguished witnesses. Regardless of the organization they represent, all of our witnesses share the common goal of wanting to improve the appeal process for individuals with disabilities. I thank them for traveling to Washington and look forward to hearing their testimony.

Every claim folder represents a person who is suffering and needs help. Individuals with disabilities deserve prompt and accurate service from the agency charged to deliver them help. Today, I hope we can get beyond finger pointing and focus on finding answers.

Ms. TUBBS JONES. Thank you, Chairman Shaw. I would like to thank my Ranking Member, Mr. Matsui, for designating me to give an opening statement this morning. I would like to welcome Commissioner Barnhart back again, and Inspector Huse, and Mr. Schieber. I also would like to welcome my constituent James Hill, who is the president of the National Treasury Employees Union, to present his testimony as well. The SSA OHA continues to experience large backlogs with resulting lengthy delays for claimants. Earlier this year, the SSA projected that the number of undecided cases at the Ohio hearing office would be about 532,000 by the end of this fiscal year, and would rise to 557,000 at the end of fiscal year 2004. The reality has already exceeded those projections, and as of June of this year, OHA had some 582,000 undecided cases. The average wait between a request for an appeal and a final decision at OHA is 341 days. In 2003, SSA's original forecast for appeal and a final decision was 352 days. The Cleveland, Ohio hearing office has more than 10,000 cases pending. At the end of 2003, the average processing time for Cleveland cases was 523.93 days. I look forward to hearing from the witnesses how the backlog in Cleveland, Ohio, and throughout the United States, will provide Americans a disability decision in a decent amount of time. At the same time, I am concerned about the reports of significant mismanagement at the Milwaukee office; and Mr. Kleczka, a Member of our Subcommittee, has already been recognized—also, a situation in Chicago where there is some allegations of mishandling of sensitive information. I understand that the Commissioner is going to tell us about her plan to reform the determination process, and I look forward to working with her as we go through to try and address that particular issue. I would say to the other witnesses and to the Chairman, today is the second day of the congressional Black Caucus legislative weekend, so I am going to be coming and going, Mr. Chairman. No disrespect to what is going on, but I also have a hearing on an urban cancer project that I am putting on today, too. So, I am going to be going back and forth. I thank the Chairman for the opportunity to be heard.

[The opening statement of Ms. Tubbs Jones follows:]

Opening Statement of The Honorable Stephanie Tubbs Jones, a Representative in Congress from the State of Ohio

Chairman Shaw, thank you for calling this hearing on the Social Security Administration's management of the Office of Hearings and Appeals.

SSA's Office of Hearings and Appeals continues to experience large backlogs with resulting lengthy delays for claimants. Earlier this year, SSA projected that the number of undecided cases at OHA would be about 532,000 by the end of this fiscal year, and would rise to 557,000 at the end of fiscal year 2004. But the reality has already exceeded those projections. As of June this year, OHA had some 582,000 undecided cases.

The average wait between a request for appeal and a final decision at OHA is 341 days. In 2003, the SSA's original forecast for an appeal and a final decision at OHA is 352 days.

The Cleveland Hearing Office has moreover than 10,000 cases pending. **At the end of August 2003, the average processing time for Cleveland cases is 523.93 days.** I look forward to hearing from you on how the backlog in Cleveland, Ohio and throughout the United States will provide Americans a disability decision in a decent amount of time?

At the same time, I am concerned about reports of significant mismanagement at a Milwaukee hearing office, and I understand that Mr. Kleczka will be attending the hearing today. Also, the situation in Chicago whereby a private contractor mishandled sensitive personal information about disability applicants is very troubling. I am eager to learn what steps the Commissioner has taken to correct these problems and prevent future occurrences.

I commend Commissioner Barnhart and her staff for their hard work in developing a 5-year Service Delivery Budget Plan that aims to eliminate the disability backlog and dramatically reduce waiting times.

Mr. Chairman, I look forward to hearing the testimony of Commissioner Barnhart about her plans for improvements at OHA, as well as the recommendations of the other distinguished panelists.

Chairman SHAW. Thank you. Now we will recognize the Commissioner of Social Security.

Mr. KLECZKA. Mr. Chairman, before we start, could I ask unanimous consent that my statement be entered into the record?

Chairman SHAW. Yes. The gentleman's statement will be entered into the record, as will all Members' statements. Without objection. Thank you for being with us. I am not going to turn the clock on for Ms. Barnhart, because I think what she has to say is tremendously important and will come as news to probably everybody on this panel.

[The opening statement of Mr. Kleczka follows:]

Opening Statement of The Honorable Gerald D. Kleczka, a Representative in Congress from the State of Wisconsin

I would like to start by thanking you, Mr. Chairman, for holding this hearing.

Over the course of this year, my hometown paper, the *Milwaukee Journal Sentinel,* has published a number of articles that detailed significant problems in how various Social Security Administration offices were executing their duties, as well as institutional practices that hinder efforts to counter identity theft.

To begin with, earlier this year, it was discovered that over 1,000 cases at the Milwaukee Office of Hearings and Appeals were "off the books," meaning they had not been entered into the SSA database, and there were boxes of unopened mail that contained important information for disability hearings. In addition, a slow processing rate resulted in over 900 cases that were over a year old, and some that were over 1,000 days old. SSA acted to correct this problem, but this cannot obscure the fact that far too many people who needed timely assistance failed to get it.

A second issue concerns the conduct of contractors hired to ease the backlog in the Chicago regional office. The contractors improperly disposed of evidence contained in disability files. This not only complicates the ability of claimants to present all the necessary evidence at hearings, but also will require hundreds of individuals to again review their files for completeness. In some cases an additional hearing may even be required. Although I cannot comment on the overall contracting process, clearly something was seriously wrong in how things were handled in Chicago, which affected residents of Wisconsin that I represent.

There are two further issues that I believe should be addressed, although they are not directly related to the subject of this hearing. First is the current SSA policy of allowing those who use fraudulent documents to apply for a Social Security number to retain possession of them.

The crime of identity theft has grown exponentially over the years, and the economic damage done on an annual basis costs individuals and businesses billions of dollars. In addition, in an age when we face a serious threat of terrorism, is it obvious that those that would do us harm will try to obtain a Social Security number to obtain a driver's license, credit cards, and other documents that allow them to carry out their plans. We cannot simply allow those who try to falsely obtain a Social Security number—an identifier that confers legitimacy—to simply walk away when they use fake documents. SSA's policy should be changed to allow its employees to retain suspect documents until and unless they are conclusively proved otherwise.

Lastly, another roadblock to countering identity theft is SSA's administrative rule that requires 30 days' notice before an employee can testify in court. A district attorney in my state has told me how a case he had brought against a man in possession of someone else's personal information was dropped because it took too long to get an SSA employee to testify that he had used someone else's identity. This is because Wisconsin requires an initial hearing within 10 days of an arrest to ensure a speedy trial, consistent with the Constitution. Although SSA has offered a myriad of reasons for its 30-day rule, it should make exceptions where prudent, such as felony identity theft cases. The current rule is handcuffing justice in Wisconsin, and I wonder whether prosecutors in other states have encountered the same dilemma.

I look forward to hearing the testimony of the witnesses, and to resolving some of the issues before the committee.

STATEMENT OF THE HONORABLE JO ANNE B. BARNHART, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION; ACCOMPANIED BY MARTIN GERRY, DEPUTY COMMISSIONER FOR DISABILITY AND INCOME SECURITY PROGRAMS

Ms. BARNHART. Thank you, Mr. Chairman. I want to thank you and the entire Subcommittee for your continuing support for the people and the programs of the SSA, and most especially for your interest in and your commitment to improving the disability process. I also want to thank you for holding this hearing which provides the opportunity for me to describe my approach for improving the Social Security and SSI disability process. Our disability programs are critically important in the lives of almost 13-million Americans. Claimants and their families expect and deserve fair, accurate, consistent, and timely decisions. Electronic Disability is a major disability initiative that will move all components involved in disability claims adjudication and review to an electronic business process through the use of an electronic disability folder. Implementation of an electronic disability folder is essential for process improvements. Therefore, structurally, my long-term strategy for achieving process improvements is predicated on successful implementation of our Electronic Disability System. In designing my approach to improve the overall disability determination process, I was guided by three questions the President posed during our first meeting to discuss the disability programs: Why does it take so long to make a disability decision? Why can't people who are obviously disabled get a decision immediately? Why would anyone want to go back to work after going through such a long process to receive benefits? I realize that designing an approach to fully address the central and important issues raised by the President required a focus on two overarching operational goals: first, to make the right decision as early in the process as possible; and second, to foster return to work at all stages of the process.

I also decided to focus on improvements that could be effectuated by regulation and improvements that ensure that no SSA employee would be adversely affected by my approach. I want to make clear that my reference to SSA employees includes State Disability Determination Services (DDS), employees, and administrative law judges. As I developed my approach for improvement, I met with and I talked to many people—SSA employees and other interested organizations, individually and in small and in large groups. I met

to listen to their concerns about the current process at both the initial and appeals levels, and their recommendations for improvement. I became convinced that improvements must be looked at from a system-wide perspective, and that to be successful, perspectives from all parts of the system must be considered. I believe that an open and collaborative process is critically important to the development of disability process improvements. To that end, members of my staff and I visited our regional offices, field offices, hearing offices, State DDS, and private disability insurers to identify and discuss possible improvements to the current process. Finally, a number of organizations provided written recommendations for changing the disability process. Most recently, the Social Security Advisory Board issued a report that was prepared by outside experts making recommendations for process change. My approach for changing the disability process was developed after a careful review of these discussions and written recommendations. As we move ahead, I look forward to working within the administration and with Congress, as well as interested organizations and advocacy groups.

I would now like to highlight some of the major and recurring recommendations made by these various parties. The need for additional resources to eliminate the backlog and reduce the lengthy processing time was a common theme. This important issue is being addressed through my Service Delivery Plan starting with the President's fiscal year 2004 budget submission, which is currently before Congress. Another important and often-heard concern was the necessity of improving the quality of the administrative record. The DDS have expressed concerns about receiving incomplete applications from the field office. Administrative law judges expressed concerns about the quality of the adjudicated record they receive, and emphasized the extensive pre-hearing work that is required to thoroughly and adequately present the case for their consideration. In addition, the number of remands by the Appeals Council and the Federal courts make clear the need for fully documenting the administrative hearing record. Applying policy consistently in terms of, first, the DDS decision and administrative law judge decision; two, variations among State DDS; and, three, variations among individual administrative law judges, was a great concern. Concerns related to the effectiveness of the existing regional quality control reviews and administrative law judge peer review were also expressed. Staff from the Judicial Conference expressed strong concern that the process assure quality prior to the appeal of cases to the Federal court.

The administrative law judges, claimant advocacy, and claimant representative organizations strongly recommended retaining the de novo hearing before an administrative law judge. The U.S. Department of Justice litigators and the Judicial Conference stressed the importance of timely case retrieval, transcription, and transmission. Early screening and analysis of cases to make expedited decisions for clear cases of disability was emphasized time and again, as was the need to remove barriers to returning to work. My approach for disability process improvements is designed to address these concerns. It incorporates some of the significant features of the current disability process. For example, initial claims

for disability will continue to be handled by SSA's field offices. The State DDS will continue to adjudicate claims for benefits, and administrative law judges will continue to conduct hearings and issue decisions. My approach, however, does envision some significant differences. I intend to propose a quick decision step at the very earliest stages of the claims process for people who are obviously disabled. Cases will be sorted based on disabling conditions for early identification and expedited action. Examples of such claimants would be those with Amyotrophic Lateral Sclerosis, aggressive cancers, and end-stage renal disease. Once a disability claim has been completed in a SSA field office, these quick decision claims will be adjudicated in regional expert review units across the country without going to a State DDS. This approach would have the twofold benefit of allowing the claimant to receive a decision as soon as possible, and allowing the State DDS to devote resources to more complex claims.

Centralized medical expertise within the regional expert review units would be available to disability decisionmakers at all levels, including the DDS and the OHA. These units would be organized around clinical specialties such as musculoskeletal, neurological, cardiac, and psychiatric. Most of these units would be established in SSA's regional offices. The initial claims not adjudicated through the quick-decision process would be decided by the DDS. However, I would also propose some changes in the initial claims process that would require changes in the way the DDS are operating. An in-line quality review process managed by the DDS and a centralized quality control unit would replace the current SSA quality control system. I believe that a shift to in-line quality review would provide greater opportunities for identifying problem areas and implementing corrective actions and related training. The disability prototype would be terminated, and the DDS reconsideration step would be eliminated. Medical expertise would be provided to the DDS by the regional expert review units that I described a moment ago. State DDS examiners would be required to fully document and explain the basis for their determination. More complete documentation should result in more accurate initial decisions. The increased time required to accomplish this would be supported by redirecting DDS resources freed up by the quick decision cases being handled by the expert units, the elimination of the reconsideration step, and the shift in medical expertise responsibility to the regional units. A reviewing official position would be created to evaluate claims at the next stage of the process. If a claimant files a request for review of the DDS determination, the claim would be reviewed by a SSA reviewing official. The reviewing official, who would be an attorney, would be authorized to issue an allowance decision or to concur in the DDS denial of the claim. If the claim is not allowed by the reviewing official, the reviewing official would prepare either a recommended disallowance or a pre-hearing report.

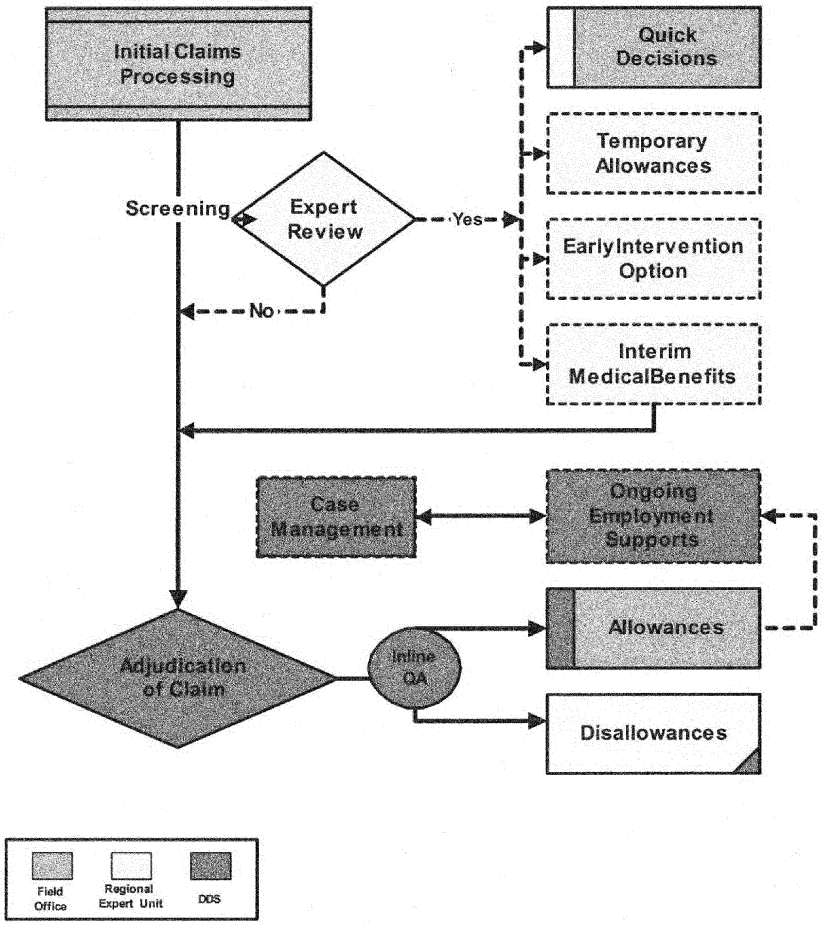
A recommended disallowance would be prepared if the reviewing official believes that the evidence in the record shows that the claimant is ineligible for benefits. It would set forth in detail the reasons the claim should be denied. A pre-hearing report would be prepared if the reviewing official believes that the evidence in the

record is insufficient to show that the claimant is eligible for benefits, but also fails to show that the claimant is ineligible for benefits. The report would outline the evidence needed to fully support the claim. Disparity in decisions at the DDS level has been a longstanding issue, and the SSA reviewing official and the creation of regional expert medical units would promote consistency of decisions at an earlier stage in the process. If requested by a claimant whose claim has been denied by the reviewing official, an administrative law judge would conduct a de novo administrative hearing. The record would be closed following the administrative law judge hearing. If, following the conclusion of the hearing, the administrative law judge determines that a claim accompanied by a recommended disallowance should be allowed, the administrative law judge would describe in detail in the written opinion the basis for rejecting the reviewing official's recommended disallowance. If, following the conclusion of the hearing, the administrative law judge determines that a claim accompanied by a pre-hearing report should be allowed, the administrative law judge would describe the evidence gathered during the hearing that responds to the description of the evidence needed to successfully support the claim contained in the pre-hearing report. Because of the consistent finding that the Appeals Council review adds processing time and generally supports the administrative law judge decision, the Appeals Council stage of the current process would be eliminated.

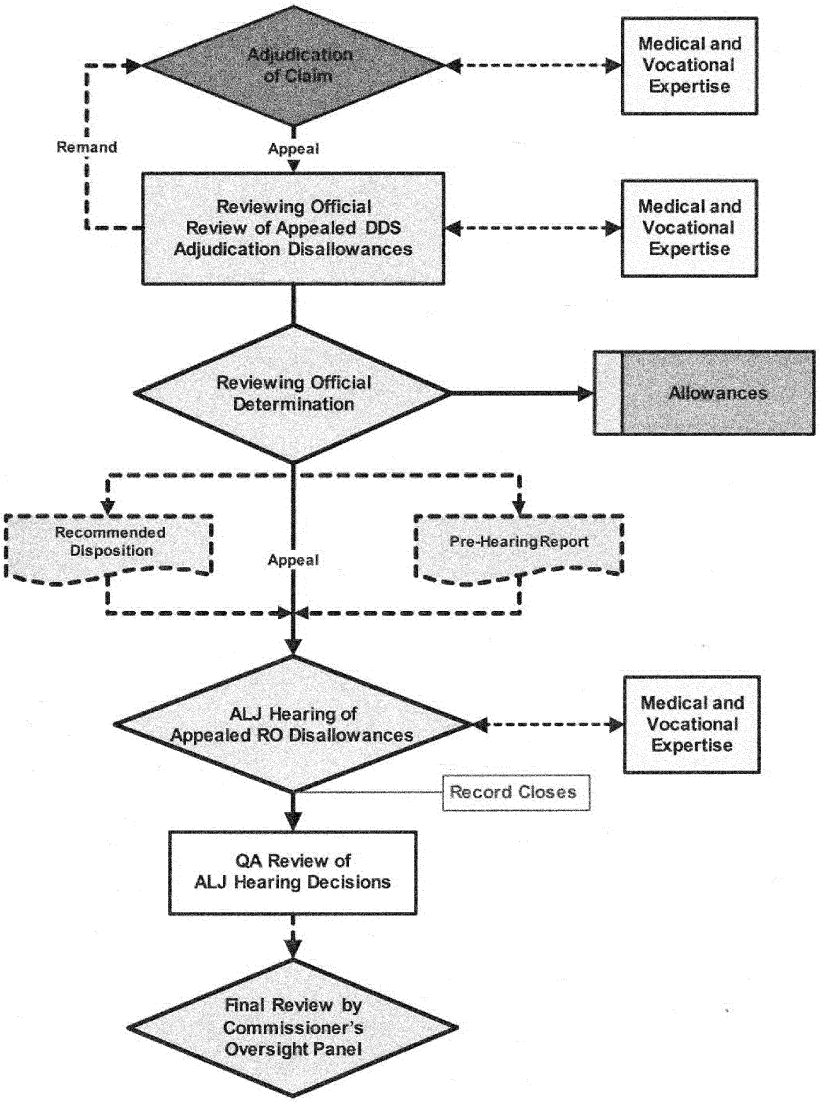
Quality control for disability claims would be centralized, with end-of-line reviews and administrative law judge oversight. If an administrative law judge decision is not reviewed by the centralized quality control staff, the decision of the administrative law judge will become final agency action. If the centralized quality control review disagrees with an allowance or disallowance determination made by an administrative law judge, the claim would be referred to an oversight panel for determination of the claim. The oversight panel would consist of two administrative law judges and one administrative appeals judge. If the oversight panel affirms the administrative law judge's decision, it becomes the final agency action. If the panel reverses the administrative law judge's decision, the oversight panel decision becomes the final agency action. As is currently the case, claimants would be able to appeal any final agency action to a Federal court. At the same time that these changes are being implemented to improve the process, we plan to conduct several demonstration projects aimed at helping people with disabilities return to work. These projects would support the President's New Freedom Initiative, and provide work incentives and opportunities earlier in the process. I believe these changes and demonstrations would address the major concerns I highlighted earlier. I also believe they offer a number of important improvements. People who are obviously disabled will receive quick decisions. Adjudicative accountability will be reinforced at every step in the process. Processing time will be reduced by at least 25 percent. Decisional consistency and accuracy will be increased. Barriers for those who can and want to work would be removed.

[The information follows:]

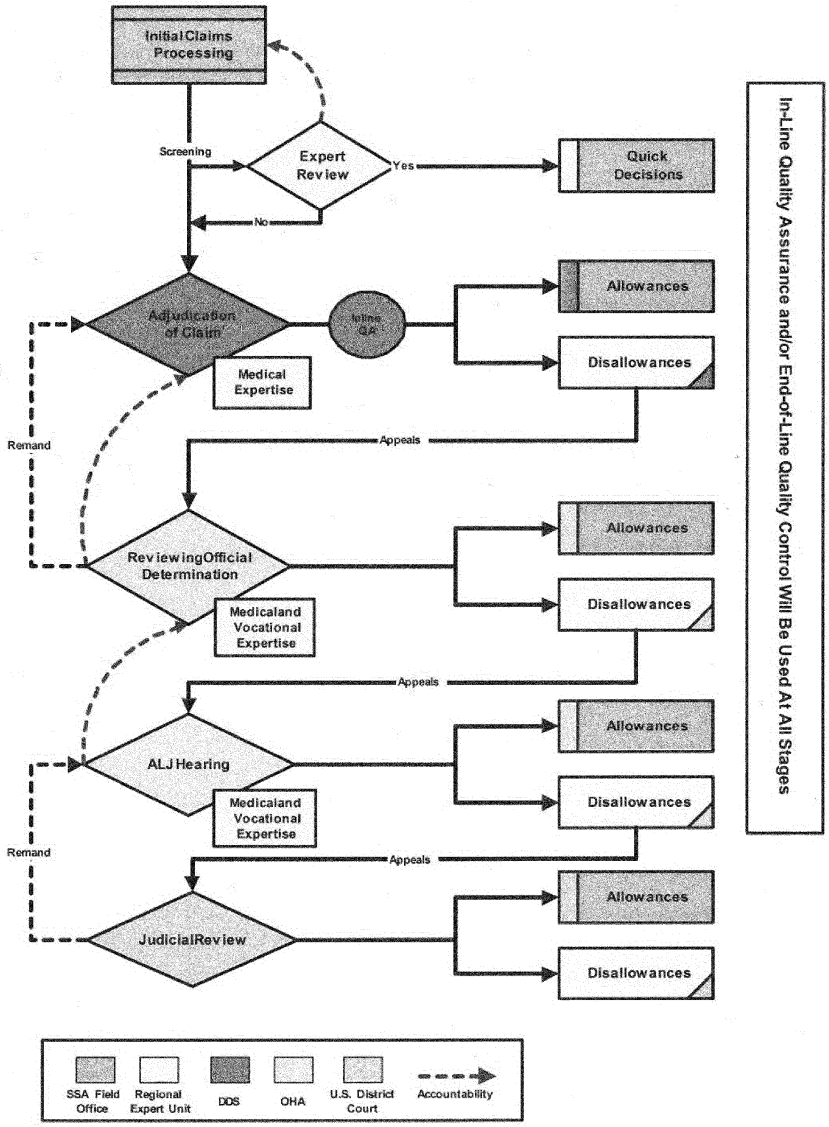
Work Opportunity Demonstrations



Reviewing Official - ALJ Work Flow



A New Approach to SSA Disability Determination



Describing my approach for improving the process is the first step of what I believe must be—and I assure you I will work to make—a collaborative process. I will work within the administration, with Congress, the State DDS, and interested organizations and advocacy groups before putting pen to paper to write regulations. As I said earlier, and I say again: to be successful, perspec-

tives from all parts of the system must be considered. Later today, I hope to conduct a briefing for congressional staff of the Committee on Ways and Means and the Senate Committee on Finance. I will also brief SSA and DDS management today. In addition, next week I will provide a videotape of the management briefing describing my approach for improvement to all SSA regional field and hearing offices, State DDS, and headquarters and regional office employees involved in the disability program. Tomorrow I will be inviting individuals to come to briefings that I plan to conduct for representatives of SSA employee unions, and interested organizations and advocacy groups, and I will schedule meetings to provide an opportunity for those representatives to express their views and provide assistance in working through details as the final package of this process improvement is fully developed. I believe that if we work together, we will create a disability system that responds to the challenge inherent in the President's questions. We will look beyond the status quo to the possibility of what can be, and we will achieve our ultimate goal of providing accurate, timely service for the American people. Again, Mr. Chairman, I thank the Subcommittee for your continuing help and support. I look forward to working closely with you to improve the hearing process, and I will be happy to try and answer any questions that you may have.

[The prepared statement of Ms. Barnhart follows:]

Statement of The Honorable Jo Anne B. Barnhart, Commissioner, Social Security Administration

Mr. Chairman and Members of the Subcommittee:

I want to thank you and the entire Subcommittee for your continuing support for the people and programs of the Social Security Administration, and most especially for your interest in and commitment to improving the disability process. I also want to thank you for holding this hearing which provides the opportunity for me to describe my approach for improving the Social Security and Supplemental Security Income disability process. As I told you and the other members of the committee when I first appeared before you, I did not assume the position of Commissioner of Social Security to manage the status quo.

As a member of the Social Security Advisory Board, I was well aware that the administration of our disability programs represented one of the biggest challenges facing SSA. These essential and complex programs are critically important in the lives of almost 13 million Americans. Claimants and their families expect and deserve fair, accurate, consistent, and timely decisions.

Early in my tenure I began a comprehensive Service Delivery Assessment to thoroughly examine all of SSA's workloads. We began that assessment with the disability claims process and mapped out each step from the initial claim through a final administrative appeal. Our analysis of the process showed that the length of time required to move through the entire appeals process was 1153 days—525 days due to backlogged cases and 628 days to move through the process.

Based on that analysis, I developed a Service Delivery Plan which formed the basis of our FY 2004 budget submission. The President responded to that plan by recommending an 8.5% increase in the administrative budget for SSA workloads. Passage of the President's budget will put us on a path to eliminating by 2008 backlogs in all workloads—including disability.

While eliminating backlogs is essential to improving processing times, we recognized that improving workload management and the process itself were also required to achieve our goal of providing timely and accurate service. To tackle the management and process issues, we developed both a short-term and long-term strategy.

The short-term strategy is focused on identifying areas where immediate action was possible, while the long-term strategy would focus on improving the overall disability determination process. Over the past year and a half, we have implemented a number of short-term initiatives. These include:

- including Administrative Law Judges (ALJs) in early screening for on-the-record decisions;
- developing a short form for fully favorable decisions;
- creating a law clerk (attorney intern) position;
- deploying speech recognition technology to hearing offices;
- ending the practice of rotating hearing office technicians among different positions;
- using scanning technology to track and retrieve folders;
- eliminating the tape transcription backlog, and
- eliminating delays in presenting cases to the U.S. District Courts.

We are in the process of implementing two other initiatives:

- allowing ALJs to issue decisions from the bench immediately after a hearing; and
- expanding video teleconference hearings.

And we are preparing to implement an initiative to digitally record hearings.

I am pleased to report that we have achieved some positive results.

- In FY 2001, it took an average of 447 days to get a decision on a hearing appeal. As of July 2003, that time had dropped to 259 days.
- In FY 2002, our hearings offices cleared over 530,000 hearings—almost 10 percent above their goal. This year we are on track to process 20,000 more hearings than last year.
- At the end of FY 2002, there were 593,000 initial disability claims pending. As of July 2003, there were approximately 15,000 fewer pendings despite a significant increase in the number of claims filed. In addition, we have already processed in excess of a hundred thousand more initial disability claims compared to this time last year.

We are proud of our progress, but we know we have a long way to go to provide the kind of service the American people expect.

A prerequisite for our long-term strategy is development and implementation of an electronic disability claims system. The Accelerated Electronic Disability System (AeDIB) is a major Agency initiative that will move all components involved in disability claims adjudication and review to an electronic business process through the use of an electronic disability folder. These components include the field office, regional office, the program service center, the State Disability Determination Service (DDS), the hearings and appeals office, and the quality assurance staff. When the process is fully implemented, each component will be able to work claims by electronically accessing and retrieving information that is collected, produced and stored as part of the electronic disability folder. This will reduce delays that result from mailing, locating, and organizing paper folders.

SSA field offices are currently collecting disability information for initial adult and child cases using the Electronic Disability Collect System (EDCS). Also, claimants can now use the Internet to submit disability information which is then propagated into EDCS. We will begin national roll-out of AeDIB in January 2004 starting in the Atlanta region. Additional DDS offices and States will come up on a flow basis during the 18-month roll-out.

Implementation of an electronic disability folder is essential for process improvements. Therefore, structurally, my long-term strategy for achieving process improvements is predicated on successful implementation of our electronic disability system.

In designing my approach to improve the overall disability determination process, I was guided by three questions the President posed during our first meeting to discuss the disability programs.

- Why does it take so long to make a disability decision?
- Why can't people who are obviously disabled get a decision immediately?
- Why would anyone want to go back to work after going through such a long process to receive benefits?

I realized that designing an approach to fully address the central and important issues raised by the President required a focus on two over-arching operational goals: (1) to make the right decision as early in the process as possible; and (2) to foster return to work at all stages of the process. I also decided to focus on improvements that could be effectuated by regulation and to ensure that no SSA employee would be adversely affected by my approach. My reference to SSA employees includes State Disability Determination Service employees and Administrative Law Judges (ALJs).

As I developed my approach for improvement, I met with and talked to many people—SSA employees and other interested organizations, individually and in small and large groups—to listen to their concerns about the current process at both the initial and appeals levels and their recommendations for improvement. I became convinced that improvements must be looked at from a system-wide perspective and, to be successful, perspectives from all parts of the system must be considered. I believe an open and collaborative process is critically important to the development of disability process improvements. To that end, members of my staff and I visited our regional offices, field offices, hearing offices, and State Disability Determination Services, and private disability insurers to identify and discuss possible improvements to the current process.

Finally, a number of organizations provided written recommendations for changing the disability process. Most recently, the Social Security Advisory Board issued a report prepared by outside experts making recommendations for process change. My approach for changing the disability process was developed after a careful review of these discussions and written recommendations. As we move ahead, I look forward to working within the Administration and with Congress, as well as interested organizations and advocacy groups. I would now like to highlight some of the major and recurring recommendations made by these various parties.

The need for additional resources to eliminate the backlog and reduce the lengthy processing time was a common theme. This important issue is being addressed through my Service Delivery Plan, starting with the President's FY 2004 budget submission which is currently before Congress. Another important and often heard concern was the necessity of improving the quality of the administrative record. DDSs expressed concerns about receiving incomplete applications from the field office; ALJs expressed concerns about the quality of the adjudicated record they receive and emphasized the extensive pre-hearing work required to thoroughly and adequately present the case for their consideration. In addition, the number of remands by the Appeals Council and the Federal Courts make clear the need for fully documenting the administrative hearing record.

Applying policy consistently in terms of: 1) the DDS decision and ALJ decision; 2) variations among state DDSs; and 3) variations among individual ALJs—was of great concern. Concerns related to the effectiveness of the existing regional quality control reviews and ALJ peer review were also expressed. Staff from the Judicial Conference expressed strong concern that the process assure quality prior to the appeal of cases to the Federal Courts.

ALJs and claimant advocacy and claimant representative organizations strongly recommended retaining the *de novo* hearing before an ALJ. Department of Justice litigators and the Judicial Conference stressed the importance of timely case retrieval, transcription, and transmission. Early screening and analysis of cases to make expedited decisions for clear cases of disability was emphasized time and again as was the need to remove barriers to returning to work.

My approach for disability process improvement is designed to address these concerns. It incorporates some of the significant features of the current disability process. For example, initial claims for disability will continue to be handled by SSA's field offices. The State Disability Determination Services will continue to adjudicate claims for benefits, and Administrative Law Judges will continue to conduct hearings and issue decisions. My approach envisions some significant differences.

I intend to propose a quick decision step at the very earliest stages of the claims process for people who are obviously disabled. Cases will be sorted based on disabling conditions for early identification and expedited action.

Examples of such claimants would be those with ALS, aggressive cancers, and end-stage renal disease. Once a disability claim has been completed at an SSA field office, these Quick Decision claims would be adjudicated in Regional Expert Review Units across the country, without going to a State Disability Determination Service. This approach would have the two-fold benefit of allowing the claimant to receive a decision as soon as possible, and allowing the State DDSs to devote resources to more complex claims.

Centralized medical expertise within the Regional Expert Review Units would be available to disability decision makers at all levels, including the DDSs and the Office of Hearings and Appeals (OHA). These units would be organized around clinical specialties such as musculoskeletal, neurological, cardiac, and psychiatric. Most of these units would be established in SSA's regional offices.

The initial claims not adjudicated through the Quick Decision process would be decided by the DDSs. However, I would also propose some changes in the initial claims process that would require changes in the way DDSs are operating. An in-line quality review process managed by the DDSs and a centralized quality control unit would replace the current SSA quality control system. I believe a shift to in-

line quality review would provide greater opportunities for identifying problem areas and implementing corrective actions and related training. The Disability Prototype would be terminated and the DDS Reconsideration step would be eliminated. Medical expertise would be provided to the DDSs by the Regional Expert Review units that I described earlier.

State DDS examiners would be required to fully document and explain the basis for their determination. More complete documentation should result in more accurate initial decisions. The increased time required to accomplish this would be supported by redirecting DDS resources freed up by the Quick Decision cases being handled by the expert units, the elimination of the Reconsideration step, and the shift in medical expertise responsibilities to the regional units.

A Reviewing Official (RO) position would be created to evaluate claims at the next stage of the process. If a claimant files a request for review of the DDS determination, the claim would be reviewed by an SSA Reviewing Official. The RO, who would be an attorney, would be authorized to issue an allowance decision or to concur in the DDS denial of the claim. If the claim is not allowed by the RO, the RO will prepare either a Recommended Disallowance or a Pre-Hearing Report. A Recommended Disallowance would be prepared if the RO believes that the evidence in the record shows that the claimant is ineligible for benefits. It would set forth in detail the reasons the claim should be denied. A Pre-Hearing Report would be prepared if the RO believes that the evidence in the record is insufficient to show that the claimant is eligible for benefits but also fails to show that the claimant is ineligible for benefits. The report would outline the evidence needed to fully support the claim. Disparity in decisions at the DDS level has been a long-standing issue and the SSA Reviewing Official and creation of Regional Expert Medical Units would promote consistency of decisions at an earlier stage in the process.

If requested by a claimant whose claim has been denied by an RO, an ALJ would conduct a *de novo* administrative hearing. The record would be closed following the ALJ hearing. If, following the conclusion of the hearing, the ALJ determines that a claim accompanied by a Recommended Disallowance should be allowed, the ALJ would describe in detail in the written opinion the basis for rejecting the RO's Recommended Disallowance. If, following the conclusion of the hearing, the ALJ determines that a claim accompanied by a Pre-Hearing Report should be allowed, the ALJ would describe the evidence gathered during the hearing that responds to the description of the evidence needed to successfully support the claim contained in the Pre-Hearing Report.

Because of the consistent finding that the Appeals Council review adds processing time and generally supports the ALJ decision, the Appeals Council stage of the current process would be eliminated. Quality control for disability claims would be centralized with end-of-line reviews and ALJ oversight. If an ALJ decision is not reviewed by the centralized quality control staff, the decision of the ALJ will become a final agency action. If the centralized quality control review disagrees with an allowance or disallowance determination made by an ALJ, the claim would be referred to an Oversight Panel for determination of the claim. The Oversight Panel would consist of two Administrative Law Judges and one Administrative Appeals Judge. If the Oversight Panel affirms the ALJ's decision, it becomes the final agency action. If the Panel reverses the ALJ's decision, the oversight Panel decision becomes the final agency action. As is currently the case, claimants would be able to appeal any final agency action to a Federal Court.

At the same time these changes are being implemented to improve the process, we plan to conduct several demonstration projects aimed at helping people with disabilities return to work. These projects would support the President's New Freedom Initiative and provide work incentives and opportunities earlier in the process.

Early Intervention demonstration projects will provide medical and cash benefits and employment supports to Disability Insurance (DI) applicants who have impairments reasonably presumed to be disabling and elect to pursue work rather than proceeding through the disability determination process. Temporary Allowance demonstration projects will provide immediate cash and medical benefits for a specified period (12–24 months) to applicants who are highly likely to benefit from aggressive medical care. Interim Medical Benefits demonstration projects will provide health insurance coverage to certain applicants throughout the disability determination process. Eligible applicants will be those without such insurance whose medical condition is likely to improve with medical treatment or where consistent, treating source evidence will be necessary to enable SSA to make a benefit eligibility determination. Ongoing Employment Supports to assist beneficiaries to obtain and sustain employment will be tested, including a Benefit Offset demonstration to test to effects of allowing DI beneficiaries to work without total loss of benefits by reducing their monthly benefit $1 for every $2 of earnings above a specified level and Ongo-

ing Medical Benefits demonstration to test the effects of providing ongoing health insurance coverage to beneficiaries who wish to work but have no other affordable access to health insurance.

I believe these changes and demonstrations will address the major concerns I highlighted earlier. I also believe they offer a number of important improvements:

- People who are obviously disabled will receive quick decisions.
- Adjudicative accountability will be reinforced at every step in the process.
- Processing time will be reduced by at least 25%.
- Decisional consistency and accuracy will be increased.
- Barriers for those who can and want to work would be removed.

Describing my approach for improving the process is the first step of what I believe must be—and will work to make—a collaborative process. I will work within the Administration, with Congress, the State Disability Determination Services and interested organizations and advocacy groups before putting pen to paper to write regulations. As I said earlier, and I say again that to be successful, perspectives from all parts of the system must be considered.

Later today, I will conduct a briefing for Congressional staff of the Ways and Means and Senate Finance Committees. I will also brief SSA and DDS management. In addition, next week I will provide a video tape of the management briefing describing my approach for improvement to all SSA regional, field, and hearing offices, State Disability Determination Services, and headquarters and regional office employees involved in the disability program. Tomorrow, I will be conducting briefings for representatives of SSA employee unions and interested organizations and advocacy groups, and I will schedule meetings to provide an opportunity for those representatives to express their views and provide assistance in working through details, as the final package of process improvements is fully developed.

I believe that if we work together, we will create a disability system that responds to the challenge inherent in the President's questions. We will look beyond the status quo to the possibility of what can be. We will achieve our ultimate goal of providing accurate, timely service for the American people.

As to the issue with the file assembly contract in Chicago, it cannot be emphasized enough that no member of the public will be disadvantaged in any way as a result of this situation. All indications are that no medical evidence has been lost. But just to be certain, we are contacting every single person whose case has not already been favorably decided and providing an opportunity to review the file for completeness. We will also provide the opportunity to submit additional evidence, and to request a supplementary hearing.

The contractor behavior was unacceptable and we have terminated the contracts in question. We are also fully cooperating with the Office of the Inspector General (IG) in its investigation of this incident. Additionally, even though the contractors in question were not taking work home, future contractors will be forbidden to take work home in order to further protect the integrity of the claims folder.

Regarding the problems in the Milwaukee Hearing Office, while I was disturbed that the problems existed, I want to assure you that upon discovery of the problems, immediate steps were taken to address them. As you know, while press reports characterized the review of office performance as an audit, the review was actually carried out as a routine part of SSA's internal management oversight. We uncovered the shortcomings in the office and we worked to address them expeditiously.

We sent in a team of 35 staff to correct the problems. Seven of them stayed for several weeks, monitoring our efforts to fix the problems. We also put in place controls to improve local office management and conducted many hours of employee training. We are also fully cooperating with the IG who has already confirmed that there was no criminal activity involved.

I have asked my Deputy Commissioner for Disability and Income Security Programs, Martin Gerry, to oversee that process personally. Recently, Mr. Gerry and other senior staff members visited the Milwaukee office. They will continue to make visits and do onsite checks of operations, as well as conducting another full review of the office early next year.

Again, I thank the Subcommittee for your continuing help and support. I look forward to working closely with you to improve the disability determination process, and I would be happy to answer any questions you may have.

Chairman SHAW. Commissioner, the summary of the changes that you have made is like a breath of fresh air in this hearing

room, I can assure you, because for many years and through the many administrations we have been through, it seems to be falling further and further behind. I am very pleased and appreciative that you have taken this bull by the horns and tried to get this moving as quickly as possible. The reviewing official, the stage for the reviewing officer, these are new employees, aren't they?

Ms. BARNHART. We would anticipate that many of our current SSA employees would move into that position. As I indicated, we are planning to have no adverse effect on SSA employees.

Chairman SHAW. They would have to be lawyers, as I understand it.

Ms. BARNHART. They do. We believe that it is important for them to be attorneys. Those would be new positions, absolutely, in the agency, and probably would provide for promotions for many individuals.

Chairman SHAW. From the point of taking the original hearing to the reviewing official, what time span are we thinking about or are we looking for?

Ms. BARNHART. There are two different ways that I have tried to look at that, Mr. Chairman, and one of those has to do with the average processing time. Actually, the numbers that I brought look at what it takes to go all the way through to the quality control and oversight panel as well. We anticipate, absent the quality control, absent the oversight panel, if the case did not go through, there are 191 days per average case processing time, which would compare to a comparable number in the process today of 266 days. So, we anticipate a reduction of at least 75 workdays. So, we actually believe that we are looking at at least 3 months.

Of course, one of the things that I should point out, too, is that we do pick up time depending on whether or not people use all of the time that they are allowed to request hearings and so forth, because that does add an additional 140 days—60 days to request the review of the regional official and another 80 days to request the review of an appeal at the administrative law judge. So, you would have to add 140 if they exercised all of their appeal rights and took the entire time for that, and that would compare to 628 days that we currently take for that.

Chairman SHAW. Mr. Collins.

Mr. COLLINS. Thank you, Commissioner. Listening as you went through your report, I think you are making some very good positive moves. That is on the surface. Let us get into the actual day-to-day operation of those who are involved. Well, will there be any new guidelines for employees? I am not talking about the reviewing officer or administrative law judges, but those who are the support base for each of those; not only reviewing officers and you, but the administrative law judges in particular. Will there be any guidelines to how those who work to support the administrative law judges and such, are there any changes there?

Ms. BARNHART. Well, yes. We actually believe that in terms of the reason the reviewing official position is very important is because the administrative law judges have expressed real concern. I think this is what you are talking about, Mr. Collins, because we have had discussions about this before. The administrative law judges have expressed very real and definite concerns about the

quality of the case that is presented to them and the fact that oftentimes by the time it gets to their level, sometimes months have had to be spent preparing the case and getting it adequately ready for the administrative law judge. One of the things that is built into this approach that I have described here today is to ensure the quality of the record all along; and that, by the time the case would come before an administrative law judge for consideration, that it would be laid out very quickly for the administrative law judge, and it would come to the administrative law judge in much better shape than it does today. That is the purpose of the pre-hearing report or the recommended disposition that would be provided by the reviewing official.

Mr. COLLINS. Who would have the authority over those who prepare the cases for the administrative law judge?

Ms. BARNHART. Well, we have a structure, as you know, that provides for a hearing office director, and the staff reports to the hearing office director, who is an OHA employee. We have not gotten into the details of that. Those are the kinds of things, quite frankly, that once we have a final package—this is an approach, and I indicated I want to have an open discussion with all interested parties. Once we get to that point and look at the absolute implementation, we would certainly address those kinds of issues.

Mr. COLLINS. Well, and I think that is where the critical part of this whole change has got to come in. It is great to lay it out on paper and have charts, charts with arrows that show you going here and you going there. It is the people who are involved in every step and who they are accountable to and their work patterns and the process in which they deliver them, their portion of the load. So, that gets down to the day-to-day operation of this, and that is where you have a lot of bog-down and a lot of delay.

Ms. BARNHART. I understand. Many of those issues arose, quite frankly, as a result of the hearing process improvement (HPI) project that was begun in, I believe, fiscal year 2000. As you may be aware, we actually ended HPI. One of the major complaints of HPI was the rotation of the staff that provided the support to the administrative law judges in terms of preparing the cases. That was one reason we got so far behind as an agency in terms of cases that have been polled or put together and assembled for administrative law judge and prepared for administrative law judge consideration. We ended the rotation of the employees. We have taken a number of steps to try to undo some of the issues that arose as a result of HPI. So, I am very much aware of those on-the-ground operational issues that you are talking about.

Mr. COLLINS. Well, I have heard of instances where even on hearing days there would be a shortage of staff because of the flexibility hours or working from home through the telecommunications and such. A lot of those things, they are important as to how you actually reach the end resolution of what you are trying to do, and that is to process the case to determine, yes or no, whether an individual is eligible for disability.

Ms. BARNHART. You make a very important point about resources. This approach would work hand-in-glove actually with the service delivery budget that I developed. The President's fiscal year 2004 budget request is the first year of the request that was a part

of my service delivery budget, which spoke very clearly to increasing resources for the agency. The President recommended an 8.5 percent administrative increase for the agency. If that were passed, as well as the transfer of the hearings, the Medicare hearings function, to Centers for Medicare and Medicaid Services (CMS), I would be able to redirect 347 additional work years to precisely what you are talking about, to administering the disability program. So, the increase in resources that we have requested and that currently is pending before the Congress in the U.S. Department of Labor-U.S. Department of Health and Human Services appropriation bill is critically important and certainly a part of it. As I said at the time that I testified on the service delivery budget, one of the major focuses there in terms of that resource increase was to eliminate backlogs. My plan was to have those all eliminated within 5 years of the first year of the service delivery budget.

Mr. COLLINS. Well, I understand that, but I caution you, oftentimes piling more money on won't get the end results if you don't have the necessary changes and the people doing the job that they are supposed to do. I received this question as kind of an analysis of how frustrating some people have been in this process. It says: "Congressman, what if you were to walk into your office 1 day and find that your entire staff had been selected by someone else? This assembled staff upon whom you are expected to depend to perform your duties no longer answered to you. You did not hire them, could not fire them, supervise them, or evaluate them. Do you think you would be able to successfully accomplish your objectives given this scenario? No."

Ms. BARNHART. I understand that you are talking about the fact that—and, again, this goes back to, I think, what happened in HPI when the staff was not assigned to a particular judge. The unit concept was abandoned, and you had individuals rotating around doing different functions for different judges. Certainly, I can appreciate that there is a certain way I like to have things done, and I am sure you do, too. So, I definitely understand.

Mr. COLLINS. It gets back to accountability, and we are having to be accountable. Thank you.

Chairman SHAW. Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. Madam Commissioner, I echo the Chairman's comments about our concern for the backlogs and our appreciation of efforts being made under your leadership to address them, but the situation is rather dire, as I understand it. A projection earlier in the fiscal year of the 532,000 backlog, now actually has jumped by 50,000. So, the actual backlog is 582,000 individual cases pending presently in the system; is that correct?

Ms. BARNHART. It is correct that we do have 582,000 pending initial cases, yes. We had had unprecedented receipts—and let me just explain. I don't want to take too much time, but part of the reason that we have such an increasing backlog at the OHA, at the appeals level, is because our DDS are moving more and more cases through every year. We had anticipated having approximately 894,000 claims pending in the DDS level at the end of the last fiscal year, and instead we are at about 582,000 initial claims. I made the decision that we didn't want to increase the initial claims pend-

ing, so what that has meant is, OHA has gotten more claims than we had anticipated.

Mr. POMEROY. At the end of the line, we have got more than half a million people in indeterminate status. Now, what that means in real life is you have got someone who can't work, who has an application for Social Security determination—they are not getting benefits pending resolution. They are just somehow out there. The backlog, as I understand it, presently—on average the case from request for appeal to final disposition is actually longer than a year, about—well, actually a little less than a year, but about a year—341 days.

Ms. BARNHART. That is correct. It is a little less than we thought it was going to be, which is really a tribute to the fact that OHA has increased productivity. The judges have definitely increased the dispositions to date and are working at record levels. So, because the staff is working so hard, we are doing better than we thought we would. You are absolutely right, they are still unacceptably high levels.

Mr. POMEROY. That is precisely correct. I appreciate your perspective from the position of running the whole shop, and what an enormous shop it is. On the other hand, the perspective of the individual entering the system is just not an acceptable situation at all at the present time. I think it was even the last time you were here, you talked about the resolution of the case that had stopped you from hiring more into the administrative law judge ranks. Now, how are we coming then at addressing that judicially imposed backlog, hiring freeze that created this shortage in the first place?

Ms. BARNHART. Well, I wish I could give you a better report. It is true that the issue has been resolved, but now the Office of Personnel Management (OPM) has to develop another register, a new administrative law judge register, and go through the whole process. I was advised just this week that it looks like the entire process is probably going to take a year. So, it may well be a year before we can hire administrative law judges. We need to hire an additional 200 administrative law judges. We have 1,023 administrative law judges on board.

Mr. POMEROY. How many administrative law judges are you short?

Ms. BARNHART. We estimate that we are at least 200 short.

Mr. POMEROY. These are the people who ultimately make the determination?

Ms. BARNHART. That is correct.

Mr. POMEROY. So, I am pleased about the actual productivity out of those in the system, but I must say, you want to make sure they are spending adequate time on each file as well. So, there is only so much that can be achieved by efficiencies there. To be 200 short and have some bureaucracy say that we can't do anything to fill these 200 position for more than a year doesn't strike me as making any sense whatsoever. Can we help you put pressure on the OPM to get this done?

Ms. BARNHART. I have asked my human resources staff to identify exactly what the issues are.

Mr. POMEROY. Mr. Chairman, I would ask that we consider holding a hearing on what would cause a backlog, why the Com-

missioner should wait 1 year before being able to move in place this backlog of more than 200 vacant positions for the very individuals who are determining these claims. We ought to run this down and look into it.

Chairman SHAW. Well, we have covered this issue in previous hearings, and I think that the Commissioner's statement here is——

Mr. POMEROY. I don't think it is her fault at all. She has been stuck from a lawsuit from hiring these people, and now that the lawsuit is resolved, she can go ahead and hire them; except she hears from some bureaucrat over at the OPM that a year has got to go by before she can get this done.

Chairman SHAW. Oh, you want a hearing on why she can't fill these positions.

Mr. POMEROY. Right. I commend the Commissioner.

Chairman SHAW. I think we ought to look into it.

Mr. POMEROY. I think she is trying her heart out.

Chairman SHAW. If we see that this is something that really should be aired at a congressional hearing, we can certainly do that.

Mr. POMEROY. Excellent.

Ms. BARNHART. We will be happy to provide information, everything we have, Mr. Chairman, and Mr. Pomeroy, to your staffs on why it takes a year and what we have been advised. I have my folks looking into it, and when I get—because, believe me, I was not happy to hear a year either. I was ready to start acting almost immediately to hire.

Mr. POMEROY. A year is unacceptable. I have got to believe we can bust this loose within a year. If this Committee could give somebody a kick in the "hinder" to move that along, that is exactly what we ought to do. I thank the Commissioner. My time is up.

Chairman SHAW. That is what we are here for, to kick somebody. Mr. Ryan.

Mr. RYAN. It is my turn to do the kicking? Okay.

Chairman SHAW. You are the designated kicker. Go ahead.

Mr. RYAN. Okay. Where do you start? Last time you were here, we talked about the Milwaukee office, we talked about 700 unopened mail pieces, 1,230 cases that hadn't been logged into the computer system, basically no one getting service, complete management—terrible mismanagement in the Milwaukee office. You had an investigation on the Milwaukee case since then. We are familiar with the progress that is being made. Then we learn about the Chicago office. The last time you were here, we talked about the stories that broke in the media essentially documenting the fact that contract employees were throwing away documents from files before their cases were judged by administrative law judges. The impression I was given from your testimony and questions the last time was that this was sort of an isolated incident, that these were wayward contractors, that they had been fired and the problems solved. Well, what we have learned since then is that these weren't wayward contractors; that these contractors were working under the specific direction of their SSA employees who were overseeing them. So, we find out that the contractors were in charge of, I think, 1,230 cases and—I am sorry, 1,200 cases, and the con-

tractors threw out a lot of material in the recycling bin, in the trash, paper all over the floor, under the management and direction of SSA employees, took cases home with them to modify these files. What we essentially don't know is, did people lose their case because of this kind of mismanagement? Did they have a full hearing? We don't know the answers to these questions, and my big concern—and I am going to ask more detailed, specific concerns of the Inspector General who is up next, but my question is, number one, how did this happen? Number two, how did it come to the point where people could take these cases home, contractors, modify their files, throw things away? Number three, I know you have contacted these 1,200 people. What is the status of that? Number four, is this the tip of the iceberg? Is this something that is occurring all over the country? Do we have contractors all over the country modifying files, removing files from people's disability claims? How many contractors? I am for contracting. I think that is a good government thing that can save money, improve quality, all of those things, but is this happening all over the country? What is happening?

Ms. BARNHART. Well, you have asked a lot of questions.

Mr. RYAN. I know. I have got many more, too.

Ms. BARNHART. Let me try. If I omit any, it certainly is not intentionally. Let me say, first of all, that this notion that Social Security employees were advising contractors to take documents and throw them in the recycling bin is simply not correct. There was training conducted for the contractors. I can't personally speak to the quality of the training because I wasn't in the class. I can tell you, from my discussions with the Inspector General after his preliminary investigation, it appears the training was not everything that it should have been. You are absolutely correct on that.

Mr. RYAN. If I can interject for a second. Having spoken to some of the workers, they were told to throw things away.

Ms. BARNHART. Well, what they were actually told was that, as they went through the files, if there were duplicate documents, they were to discard duplicate documents. Certainly, they were not advised to discard significant original documents, Mr. Ryan. I really think that that is a very important point to make.

Mr. RYAN. Well, your own spokesman Mark Hinkle said that all improperly removed material was removed, and reportedly it was recovered. Your own spokesman said that improper material was removed from these files.

Ms. BARNHART. Absolutely. I am not disputing that improper material was removed by the contractors. What I am trying to make clear is that SSA employees did not direct them to remove that material. The instructions for the contractor were to remove documents that were duplicate documents, not to put all the documents they put, certainly not original sole copies of documents, in the recycle bin. I think that is the point. There is no question that documents were put in the recycle bin that shouldn't have been. It was approximately 603 cases that were affected. We began an exhaustive process—you had the situation exactly right. When we found out, we put a stop order on the contracts, and we found out as a result of quality reviews that we were doing as an agency, we put a stop order on the contracts. We followed the Federal con-

tracting procedures and terminated the contracts in July with both contractors. As a result of this, to get to your point of, is this happening in other places or is this the tip of the iceberg, I certainly required a review and that phone calls be made, and analysis done of any other issues that may be occurring, any other issues that exist in other offices where contractors are assembling folders, and I have gotten some reports back about various kinds of issues. Nothing of this scope at all; really rather minor things, and things that have been taken care of and taken care of in a really timely fashion. At the same time, there have also been some issues that have come up in terms of SSA employees. We are trying to deal with those. Nothing in the scope or range of what happened in Chicago. It was a totally unacceptable situation. I want to be very clear about that. I was very upset about it. I continue to be very upset about it, as you and I have discussed. I am doing everything that I possibly can to ensure that it, first of all, that the people who were affected, whose files were affected by this action on the part of the contractors, receive no adverse action.

Mr. RYAN. What is the status of all that right now?

Ms. BARNHART. The status of that is, we have identified where every case is, the cases that are pending, the cases that have moved ahead. We are sending letters to every single person whose file was, I guess I would say, tampered with, certainly affected, and letting them know that that occurred. We are giving them the opportunity for a supplemental hearing if they have had one. Further, I have directed that if the claimant does not request a supplemental hearing and is found not to be eligible, we are going to send another letter to the claimant to say, you did not request a supplemental hearing; you may at this time. In other words, I am going every extra step. I want to make absolutely sure, because some of our claimants, obviously—it is a complicated situation, and I want to make sure they are not disadvantaged. We are offering to have our staff sit down and go through the files with our claimants, and also to be responsible to take the steps to recover and get copies of any documents that may be missing. We are taking that on ourselves.

Mr. RYAN. I think it is also clear that they threw them away in, not just the recycling bin, but in the daily trash. That also we will have to ask the Inspector General about. One thing that just doesn't add up here is the employees of SSA who are overseeing the contractors, who purportedly gave them direction to say, remove duplication, duplicative documents, were they—they were the people who, after they did this, were fishing through the recycling bin to pull these documents out. So, why is it that the employees gave direction to the contractors and then that evening said, oh, my gosh, look at what they are doing. They are going into the recycling bin fishing them out. You have an employee, Michelle Lloyd of the Social Security office in Chicago, who said: "These were records unstapled and thrown in the bins. Some of the records had no identification marks. I am picking up maybe 50, maybe 100 pieces of paper. This was a hush-hush secret project." If you gave them the proper direction, then they are just throwing away duplicative pieces of paper.

Ms. BARNHART. That is what it should have been.

Mr. RYAN. Why later on that day were your employees going back into the trash bins trying to fish this paper out because—and that just doesn't add up.

Ms. BARNHART. Well, I can't speak to that particular day, but I can tell you that we did go back and fish all the papers out so that we could go through and determine what was thrown away improperly. In terms of the quality of the direction given and project oversight, I completely agree with you that it needs to be improved. In fact, several months ago I directed our contract staff and our training staff to develop a training specifically for project officers, specifically because the government has been doing more contracting out. I was very concerned about the quality of the project officers throughout government, certainly in our agency where I had more direct experience. I attended every single one of those myself and spoke to the groups. I oversaw the development of that training. We just completed videotaping so we could send it out to project officers all over the country, including, no doubt, those in the Chicago region. The point I make is, I share your concern about the quality of the project officers. It is absolutely critical, particularly with the number of contractors being——

Mr. RYAN. That then extends beyond—was this rampant, that this was done all over the country? I just have no idea whether that is the case or not, but I am very concerned that people got their cases thrown out because of this kind of mismanagement.

Chairman SHAW. The time of the gentleman has long expired. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. Let me follow up on the other reason that we are here having a Subcommittee hearing today, and that is the order of the Milwaukee hearing office, wherein boxes of mail was unopened, the backlog was exceedingly high. Commissioner, could you briefly inform the Subcommittee where we are on that specific problem, which also led to us meeting here today?

Ms. BARNHART. Yes. I would be very happy to discuss that. You absolutely stated the case correctly, Mr. Kleczka. The situation was, we had unassociated documents with files; we had cases that had not been docketed. There clearly was a huge management issue in the Milwaukee office. I want to point out the management problems were discovered because of an internal management review that we do as a matter of course in the agency. So, we essentially discovered the problem ourselves, just as we did the problem with the contracting and file assembly in Chicago. Judge Paul Lillios, who is our regional chief judge in Chicago, took immediate action upon getting the report, the management report that described the problems in the Milwaukee office. He sent 35 people into the Milwaukee office to deal with it. Really, within a matter of, I believe, less than a month, all of the documents were associated with the correct file, all the cases were docketed, and he left seven people onsite to continue to oversee the management, to work to make sure that that office did not continue to experience problems. I took the additional step after the hearing we had here the last time and my discussions, and my correspondence with you, Mr. Ryan, and others, as a result of that. I actually asked Martin Gerry, who is here with me today, the Deputy Commissioner for

Disability and Income Security Programs, personally oversee the running of the Milwaukee office. I brought Deputy Commissioner Gerry with me today because he has actually done an onsite visit there, and took senior management from the OHA, and I thought you might be interested in hearing what he found and where we are. If you were interested, I would ask Mr. Gerry to come to the table and provide that information.

Mr. KLECZKA. With the indulgence of the Chairman? I have a couple other questions.

Chairman SHAW. I will give the gentleman a few extra moments as I did Mr. Ryan.

Mr. GERRY. Well, as Commissioner Barnhart indicated, I visited the Milwaukee hearing office myself and have been getting biweekly reports since that visit. So, I think I am pretty up to date, at least through last week. Let me just go quickly through the problems and the status of them. As far as undocketed cases, as far as I can tell, and we can tell, there are no undocketed cases at this point in time. The same thing is true of what we call Hearing Office Tracking System (HOTS) coding; that is, the entry of the case into the case tracking system. That has been completed in all cases. Actually, the productivity of the administrative law judge, which was another issue that was brought up, has increased fairly dramatically over the last few months from a level of 1.53 cases per day to 2.15 cases, which is much closer to the average in the country. I think that problem is under good control. I won't go through the details. We have improved security measures that were also mentioned in the report. The integrity problems that were mentioned in the report have been resolved. So, at this point in time, it is my judgment that this office is functioning not only in curing the identified problems, but functioning well.

Mr. KLECZKA. You are going to keep monitoring the situation every 2 weeks?

Mr. GERRY. Yes, I am. We haven't set a time limit, so I am going to keep doing it until I am told to stop doing it.

Mr. KLECZKA. Commissioner, I did appreciate hearing of your changes to the disability determination operation in the agency. My question is, how long will it take under your new provisions here from a filing of an application to a quick decision? Because we have cases in our offices where the person is totally disabled and waiting a year for determination. Under this new system, from the minute the person files the application to the quick determination, what are we looking at?

Ms. BARNHART. We are looking at no more than 20 days, Mr. Kleczka, and that is all as a result of Electronic Disability and the electronic data collection system taking place in the field office, the regional expert units that will screen these cases out, simply medically document that the individual suffers from the condition and is not working. It is a much speeded-up process.

Mr. KLECZKA. Before the public thinks that all cases are going to be adjudicated in 20 days, the individuals we are talking about are the most disabled of the disabled.

Ms. BARNHART. Absolutely. Very important point.

Mr. KLECZKA. With an untrained eye, we know this person is totally disabled, and let us not put that person and their family through an elongated process.

Ms. BARNHART. The examples that I often use are individuals with Amyotrophic Lateral Sclerosis, people with aggressive cancers, people with end-stage renal disease. Absolutely.

Mr. KLECZKA. This is a very ambitious plan. How long do you envision having this plan be put into total operation? How long is this going to take?

Ms. BARNHART. Well, one of the things I think is very important is, since it is predicated on Electronic Disability—we are able to do a lot of the quality reviews and the different consideration of the cases all over the country as a result of Electronic Disability. That is one of the things that provides protections for the SSA employees in terms of not having to move, not having to be adversely affected. Very important. We are rolling out Electronic Disability starting in January; we have three pilots up and operating at this time. The schedule for Electronic Disability is that nationally it should be completed in 15 to 18 months from January. Because of the regional nature of some of the components of my approach, it is important that an entire region be up and operating under Electronic Disability before we move on to implementing this approach. So, I estimate that probably we are looking at October 2005 before we really start to implement these changes any place across the country. As I say, this is the approach. I want to provide this time for discussion, to solicit views from the interested organizations, many of whom are going to testify after me today. There are countless others that are being invited to briefings and so forth. So, from a standpoint in making sure the Electronic Disability is up and has been up and functioning in the area where we would implement changes, I think it needs to be there for at least 9 months before we would move ahead, just to be responsible and ensure that the system would work.

Mr. KLECZKA. Totally operational, October 2005. That is over 2 years away. That is a very long time. Mr. Chairman, thank you very much.

Chairman SHAW. I would like to inquire for just a moment about the efficiency of our administrative law judges. That has come to our attention on numerous occasions. Judge Bernoski's testimony on page 6 says that the Associate Commissioner of the OHA states that the judges of the agency are issuing case depositions at the rate of 2.6 cases per judge per day, or 52 to 65 cases per month, which is characterized as a record level of productivity. Do you concur with that?

Ms. BARNHART. Well, let me say, the 2.6 figure—and I am not exactly sure where Judge Bernoski got that, but I think it was probably accurate for a particular month. My understanding is that the average for the year based on discussions I had recently with the head of OHA is going to be somewhere around 2.3 cases per day, which is still a very high productivity rate. For example, going back—I have data before me going back to 1994. The highest I see other than that was in 1995, 2.23 a day; in 2002, just last year, 2.2. The rest are all around two cases a day. So, yes, it is the highest productivity in probably 10 years. Certainly the 2.6 that I be-

lieve we did experience for 1 month this fiscal year would have probably been the highest ever.

Chairman SHAW. Is there a backlog? At what point are the backlogs accumulating? Is it before they get to the courtroom, or at what point in this process?

Ms. BARNHART. There are backlogs throughout the process, as I indicated. We have backlogs at the initial disability claims level, probably around 300,000 at this point. At the hearing level, we have backlogs of somewhere approaching 200,000 at this point. Frankly, it is all—I assume you are talking about the hearing stage, once it would move on to the administrative law judge. The backlog is not just the judges, and part of the backlog with the judges is due to the fact that we have not had as many judges as we need, as I discussed with Mr. Pomeroy earlier. We believe we are 200 judges down. The file assembly contracts that I was just discussing with Mr. Ryan, quite frankly—I put those in place to deal with the backlog that we had, because when I came into this job in 2001, judges couldn't get cases, which speaks to Mr. Collins's point. There were not enough cases being prepared for them to consider them. So, there are backlogs throughout the process, Mr. Chairman.

Chairman SHAW. Do we have a report card on the various judges to see—I know from many years of practicing law that there are some judges that work harder than other judges, just as some Members of Congress work harder than others.

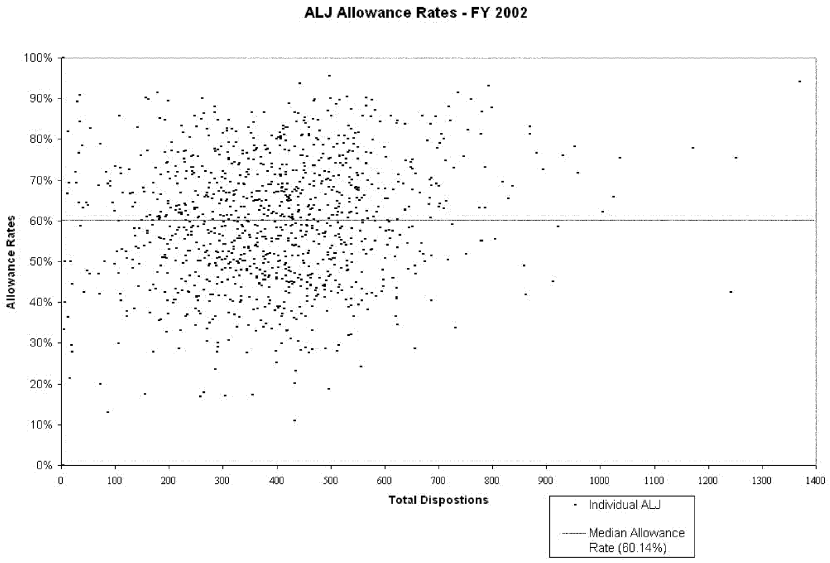
Ms. BARNHART. Well, we do keep track of the——

Chairman SHAW. We do have a report card—it is called an election.

Ms. BARNHART. We do keep track of the number of cases that each judge deals with every year, yes, we do; and it is quite a range. The range exists—it is for various factors. There are many judges who are on assignment and away from the office. There are judges who are union representatives and engage in official time activities on behalf of the union as opposed to being full time. Also, details take judges away from the office. Our managers—our regional chief judges or managers—don't actually do cases. So, when we look at the available judges that we have, we are really at 958 as opposed to the 1,023 that are on board at any given point in time. You factor in vacations, time away, and the training, continuing legal education, all those things, we are really at about 958, which is even worse than the situation. There are issues there. I would be happy to submit for the record if you would like—I have a chart, actually, that I thought perhaps told the story of the judges' disposition rates the best. I am having trouble locating it.

Chairman SHAW. If you could submit it for the record, that would be fine.

[The information follows:]



Ms. BARNHART. Basically what it does is, it shows dots on the page—we have one right here. We have copies for the Members if you would like them. Each of these represents an administrative law judge and the dispositions—the number of cases that they deal with in a year. So, basically, what you can see is most of them are centered pretty much grouped together. There are some outliers. There is no question. There are some that are way over here, and some that are way over here, but we would be happy to provide this to your staff and any other supplementary information that you have.

Chairman SHAW. If you see a judge who isn't really fulfilling his responsibility, taking on his caseload, do you have any way of reprimanding him?

Ms. BARNHART. Well, we are not allowed to set production schedules for judges because they are independent judges. I am allowed to have the judges follow procedures, and that is, quite frankly, one of the things in my approach that I described in terms of the reviewing official providing the report to the judge and the judge responding in the decision to each of the things laid out by the reviewing official. That is one of the procedural authorities that I do have. I do not have authority to tell a judge that they must work so many cases a day, because, I guess, of the fear of interfering with the judicial discretion and the ability to do their job. We do let judges know if they are outliers. We do. Our managers—it is something that we have started in the last few years. We do notify them and say, we thought you should know that everybody else in your region is at this level, or everybody else in your office is at this level, and the average administrative law judge is doing this and you are in this place, to let them know where they stand. As I say, sometimes there are good reasons for the fact that they

have a lower disposition rate, and some judges are not as productive as other judges, just like I think in any profession.

Chairman SHAW. I think, for the record, this independence was established by Congress back in 1946.

Ms. BARNHART. That is right.

Chairman SHAW. So, it has been in place for a long time. As usual, it is a treat to have you come before our Committee, and we are particularly pleased today that you chose this as the hearing to roll out your proposal. You certainly are reacting to many of our concerns, and we look forward to watching your progress. Thank you.

Mr. POMEROY. Mr. Chairman.

Chairman SHAW. Yes.

Mr. POMEROY. I just would submit a written question relative to the proposed overhaul of the handling of disability claims. I am a little bit worried about the elimination of the Appeals Council leading to—within the administrative process has the appearance of streamlined and accelerated resolution, but by dumping people into the Federal court system for their perspective actually prolonging the resolution of these matters. So, I will submit a question.

Chairman SHAW. The record will remain open for any questions that any of the Members might have that they weren't able to ask.

Ms. BARNHART. I have many points to make on that, Mr. Pomeroy. I would be happy to do them for the record, but I would like to make just one point now, if I might, Mr. Chairman. The Appeals Council currently allows 2 percent of the cases that come before it. It remands 26 percent to the administrative law judges, and it sustains 72 percent of the administrative law judge decisions. So, that suggests that one of the major issues for the Appeals Council is the quality of the record. We are trying to address that through the quality and oversight panel that my approach would suggest. I think perhaps the most telling fact, though, is the fact that the Federal courts remand 60 percent of the cases that go through the Appeals Council back for consideration. So, it suggests to me that we need to do something to address the quality of the cases moving—even looking at the current situation. As I say, I have many other points, and I know you are interested. I will try to do my best to lay out an entire——

Mr. POMEROY. If you will give us some time before implementation to really wrestle this down and understand it better—but I will want to have some extended conversations on this one. Thank you.

Chairman SHAW. Thank you. We have a vote on the floor. If the Members would vote and come back quickly. I believe it is only one vote, and I think we will be able to visit with Mr. Huse. I am sure there are a lot of questions coming out of Milwaukee that Mr. Huse will have all the answers to.

[Recess.]

Chairman SHAW. Okay. Mr. Huse.

STATEMENT OF THE HONORABLE JAMES G. HUSE, JR., INSPECTOR GENERAL, SOCIAL SECURITY ADMINISTRATION

Mr. HUSE. Good morning, Mr. Chairman. I guess it is still morning.

Chairman SHAW. Welcome back to the Committee.

Mr. HUSE. Thank you. I would like to begin by expressing my appreciation for this opportunity to testify today. The concerns raised by this Subcommittee regarding recent reports of improprieties within SSA's OHA, are shared by me as well. Currently, as a result of a congressional request, my office is conducting audit reviews of OHA's Chicago regional office and the Milwaukee hearings office. The Office of the Inspector General has also conducted investigations of both these matters. The SSA notified our office about both situations when they were discovered, and that is an important point. While this is not the first time we have reviewed OHA, we are continuing to conduct additional audits, broader in nature, of OHA management. I have submitted my written testimony, which contains more detailed information, but our Office of the Inspector General investigation of the Milwaukee hearings office resulted from two allegations. While no evidence of criminal activity was determined, a number of issues and concerns were raised as to certain supervisory practices, which will need to be resolved. This case was also referred to the OHA management for appropriate administrative action. The audit of the Chicago OHA regional office, which was requested by Wisconsin's congressional delegation, is the second issue raised, and that particular audit is continuing. The audit centers around allegations that pertinent documents received in the office's contract-based file assembly unit had not been included in the correct claim folders. Our investigative findings resulted in corroboration of the allegation that original documents in question had, in some cases, been discarded. Further findings indicated that oversight of the contractor's activities did not appear adequate. Our investigative findings have resulted in the initiation of an audit of the Chicago regional office, which we anticipate will be completed in November of this year.

Issues which surfaced as a result of our investigative findings regarding OHA personnel in the Chicago regional office are: evidence of mismanagement by OHA, which may have in part led to the poor performance by the contractor, and instances of improper handling of documents. Further, I would like the Subcommittee to be aware that the Office of the Inspector General has previously conducted a number of audits of OHA management practices. A number of these audits raised concerns that still await resolution. One audit about OHA's management process—that was the process of how complaints about OHA activities were handled—revealed instances where no record of allegations had been received, and in certain instances, these allegations had been referred to OHA by my office. Frequent delays were discovered in the processing of allegations, and OHA had no record of one-third of the referrals it had supposedly received. As a result of further congressional inquiries, audits of OHA operations and productivity were undertaken, resulting in findings that there were inadequate safeguards in place during the destruction of claimant files, significant delays occurred in processing times, the case management process re-

quired improvement, and that the processes regulating the use of interpreters and claimant representatives were susceptible to fraud. Not all OHA offices received and/or reviewed lists of claimant representatives who had been disqualified or suspended, and not all hearings offices reviewed the qualifications of interpreters or monitored their performance. On a broader level, we have looked at how OHA measures its own hearings and appeals performance. While we find the existing system to be in general compliance with Government Performance and Results Act (P.L. 103–62) requirements, we also identified opportunities for SSA to improve the reliability of OHA's key performance measures. We are committed to continue the work I have summarized today, and we will continue to report our findings to the Subcommittee. Mr. Chairman, I would like to thank you for the opportunity to provide this testimony today, and to thank you for your attention and concern. I will be happy to answer any questions.

[The prepared statement of Mr. Huse follows:]

Statement of The Honorable James G. Huse, Jr., Inspector General, Social Security Administration

Good Morning, Mr. Chairman, Mr. Matsui, and members of the Subcommittee on Social Security. Recent newspaper accounts and concerns from Members of Congress have placed the Social Security Administration's (SSA) Office of Hearings and Appeals (OHA) under public scrutiny. My office has been asked to conduct an independent and objective investigation of the Milwaukee Hearings Office (HO) and the OHA Chicago Regional Office (RO) because of complaints that the Agency refused to release a management report criticizing the Milwaukee HO. There are also allegations that SSA supervisors told contract workers in its Chicago RO to throw away documents from the files of disabled people applying for benefits from the Government.

My office takes these allegations very seriously, and we are looking into them. The charter of SSA's Office of the Inspector General (OIG) is to identify and prevent fraud, waste, and abuse in SSA-administered programs. The issues raised with regard to these offices, as well as their implications for OHA on the whole, are of serious and vital concern to my office.

At the outset, I would like to assure this Subcommittee, Congress, and the American people, that most SSA offices run effectively and efficiently. Nationally, Social Security continues to be one of the best-run agencies in the Federal Government, as witnessed by the July 14 announcement from the Office of Management and Budget (OMB) that SSA is making progress in all five management categories on the President's Management Agenda (PMA) scorecard. SSA also holds the distinction of being the only Federal agency to receive a Certificate of Excellence in Accountability Reporting from the Association of Government Accountants every year since the award program began.

However, the fact remains that some SSA offices have had persistent management problems which have a negative impact on those who seek their services. Despite significant strides, the Agency knows it must do more.

As you know, Mr. Chairman, in recent weeks we have briefed this Subcommittee on investigative and audit information relative to OHA issues around the country. We have provided this Subcommittee with audit work that contains recommendations made over the last 5 years to improve OHA's operations, and we have briefed the Subcommittee on the recommendations SSA has implemented. We have also looked into every allegation noted in the recent news articles. Let me summarize what we have found with regard to these two offices, and with regard to management of OHA.

The Chicago and Milwaukee Offices

Our Office of Investigations (OI) has conducted investigations of both offices, and based on these investigations, our Office of Audit (OA) has initiated a review regarding these offices. SSA had notified our office about both situations upon discovering the problems. OI has not found evidence of criminal conduct in either SSA's Milwaukee OHA HO or its Chicago RO. We ***have*** found instances of mismanage-

ment and poor performance. These findings require SSA to take serious and direct action.

Let's look first at ***the Chicago Regional Office***. We began by initiating an investigation, which we have completed, upon receipt of a letter from the Wisconsin Congressional Delegation. The Delegation requested that we investigate the activities of a contract "File Assembly Unit" within the Chicago RO, which reportedly discarded pertinent information from the disability claims folders of applicants for both SSI and Title II disability during the file assembly process.

With regard to the contractors, our investigation has revealed that:

- SSA chose the contractors and performed security checks.
- Under certain circumstances, SSA policy allows contractors to take home claimant files, which may contain medical and other personal information. There were 14 contracts in the Chicago Region, 10 of which allowed vendors to take files offsite. The 2 contracts we reviewed required contractors to perform work onsite.
- The contracts required that documents not be destroyed by the contractor, not even duplicate documents.
- According to OHA officials, the unit was assigned 1,254 cases for assembly by the contractors. Some of the 1,254 claimants have been notified that portions of their claim files may have been discarded. OHA is still reviewing files and is developing a policy and procedure which will allow claimants to review their files for completeness and add necessary evidence, and will allow denied claimants another review and appeal.
- There were 198 claims files of residents of Wisconsin included in the 1,254 claims files sent to the "File Assembly Unit." Discarded original documents of claims files of 86 Wisconsin residents were discovered in the unit's recycle bins.
- Trash cans were overflowing with discarded documents prior to the arrival of the recycling bins. The trash cans were emptied daily, and the recycling bins were emptied once. OHA does not know whether discarded documents were thrown out or shredded. One contract employee admitted that some documents containing sensitive information were put into the normal trash.
- Of the 1,254 cases involved, OHA has made a decision on 176. For those 176 that have been decided, 129 were favorable to the claimant and benefits were awarded, 17 cases resulted in an unfavorable decision to the claimant, 29 cases were dismissed either because claimants withdrew or abandoned their claim. An additional case was dismissed because the claimant is now deceased. The remaining 1,078 cases are pending decisions by OHA.

With regard to OHA personnel, our investigation of the Chicago Region has found evidence of mismanagement and poor performance. One problem area was the security of sensitive information. Contractors assembled folders out of sight of the reviewer/trainer. The project officer took no action to address the initial report that contractors were throwing out original documents.

The process used in the Chicago RO was based on a pilot program that had used retired OHA personnel, who knew how to assemble the folders, but only one such person was used. Not enough OHA personnel were assigned to train, review, or observe the other contractor workers. Management did not pay enough attention to the process:

- A manual for assembling files according to SSA's Program Operations Manual System and regulatory requirements was written but not used.
- Trainers and reviewers gave conflicting instructions.
- Not enough reviewers were assigned to observe the contractors and review their work in a timely manner.

Building on our investigation, we have initiated an audit of the Chicago office. Our specific concerns are:

- The disposition of claimant medical records at the Chicago RO.
- SSA policy concerning security checks of contractors.
- SSA policy concerning contractors and/or SSA employees taking claimant files home.

We expect to report the results of this audit later this year. I will keep this Subcommittee apprised of this audit when it has been completed.

I would like to look next at ***the Milwaukee Hearings Office***. As a result of an OHA internal review of the Milwaukee HO that the office of the Regional Chief Judge conducted in February, our Chicago office received two allegations. We inves-

tigated these allegations, and found no evidence of criminal activity. However, that investigation identified significant management concerns. As a result of our investigation into the actions taken to address the findings of SSA's own OHA internal review, our OA has initiated a separate audit report of the Milwaukee office. The most serious concerns our review will address include:

- The discovery of over 700 pieces of unopened mail.
- 1,200 cases that were not recorded in the Hearing Office Tracking System (HOTS).
- Significant processing delays for disability claims.

We expect to report the results of this audit later this year, and we will report to this Subcommittee on the results.

Prior Reviews Concerning OHA Management

Prior OIG audits have revealed some problematic conditions regarding OHA management. Some of our prior work has focused on issues unique to specific OHA offices, while others looked at programmatic issues. Although most SSA offices function effectively, we noted some areas where improved oversight and management are required. This history of audit work yields invaluable insights to OHA's operations.

For instance, we conducted one review of OHA's allegation management process. In this review, we looked at the policies and procedures for addressing allegations of mismanagement we referred to OHA for resolution, and identified shortcomings in their ability to manage allegations properly. Not only were there instances where there was no record of referrals, there were significant time delays in closing out the referrals that were resolved. For example, OHA had no record of 37.5 percent of these referrals and it took an average of 331 days to process the 29 allegations that had been closed.

As a result of Congressional inquiries, we also reviewed OHA's Huntington, WV and Washington, DC offices to address concerns about their operations and productivity. At the Huntington facility, adequate safeguards were not taken during the destruction of claimant files, and some files were placed in unsecured trash bins outside the office building. Productivity statistics for the Washington office indicate significant delays in processing times—an indication of potential performance problems.

On a broader perspective, we looked at a number of issues related to OHA performance. We identified opportunities for SSA to improve its case management process to ensure that file data is consistent with the decisions issued by the HOs. We also identified a need for OHA to do a better job of screening individuals who are used as interpreters and claimant representatives. Specifically, prior audit work revealed instances where HOs did not review the qualifications or monitor the performance of individuals hired for interpreter services, and did not ensure administering of oaths obligating interpreters to translate the hearing accurately under penalty of perjury. More importantly, not all OHA offices receive and/or review lists that contain information on claimant representatives who have been disqualified or suspended. The failure to manage both of these functions properly renders SSA susceptible to fraud.

Finally, other prior audit work on OHA has focused on how the Agency measures its Hearings and Appeals performance. Although these reports concluded that SSA was in compliance with Government Performance and Results Act reporting requirements, they identified opportunities for SSA to improve the reliability of key OHA-related performance measures.

In general, SSA agreed with the majority of our recommendations and has taken steps to implement some of them. Concerning allegation management issues, SSA staff were receptive to our findings and suggestions for improvement, and had already begun to take corrective actions to improve OHA's review of allegations of mismanagement. Additionally, SSA issued a memorandum requiring all OHA field offices to confirm that a proper records disposal process was in place.

Conclusion

Mr. Chairman, any allegations of fraud, waste, and abuse in SSA-administered programs are of serious and vital concern to my office. I thank you for your continuing commitment to these critical issues. I would be happy to answer any questions members of the Subcommittee might have.

Chairman SHAW. Thank you, Mr. Huse. Mr. Collins. Oh, I beg your pardon. That is her job, to keep me from making these mistakes. She corrected me. Mr. Schieber, I beg your pardon.

STATEMENT OF SYLVESTER J. SCHIEBER, MEMBER, SOCIAL SECURITY ADVISORY BOARD

Mr. SCHIEBER. Thank you, Mr. Chairman, and Members of the Subcommittee. I am pleased to be here this morning and to have this opportunity to testify on this important issue. I am a member of the Social Security Advisory Board. Hal Daub, the chairman of the Board, sends his regrets. He had a prior commitment and could not be here today, but he did ask me to convey to you how important he feels these issues are that you are addressing, and he applauds your holding these hearings.

Chairman SHAW. Mr. Daub used to be a Member of this Committee.

Mr. SCHIEBER. Yes, I recall that. The four cornerstones of the social security disability program should be fairness, efficiency, quality, and consistency; and although the SSA today devotes a disproportionate share of its administrative resources to its disability programs, we believe that none of these goals is being fully met. It is not so much that any particular part of the program is broken. It is that the whole administrative design is in need of basic restructuring to make all of the parts work together in a more coordinated and correct way. I am happy personally to hear of the progress that Commissioner Barnhart is making in terms of moving forward in this regard. In January 2001, the Social Security Advisory Board issued a report on the need for fundamental change in the disability programs. In that report we identified many areas that need reform. Some were of general applicability, such as the urgent need for a new quality management system to bring about the sorely missing consistency and produce the information needed to make sound policy decisions. Others dealt specifically with the hearings and appeals process, such as revisiting the concept of having an agency representative who could explain and defend the initial decision, closing the record after the hearing, and reexamining the role of the Appeals Council. Our reports in the past have noted a chronic resource problem in the system leading to inadequate case documentation, frequent appeals, and significant backlogs at various stages in the determination process. Not getting timely benefits to someone truly disabled is unfair to the vulnerable people the program is intended to serve. Awarding benefits to those who should not qualify is equally unfair, as it adds to the financing burden we face in an aging society. The additional resources requested in the President's budget should help, as should the significant system improvements now being developed, but there remains a need to address many serious problems. These include inconsistent decisionmaking from region to region, and at different levels of adjudication. That in turn reflects problems of policy development, training, and communication.

To some extent, today's hearing arises from the problems of the Chicago region with the file assembly contracts. This is an issue the Board has been reviewing as a result of information brought to our attention during our visit to the Boston region in early May,

before the public disclosure of the problems in Chicago came to light. While the contract has apparently been a significant help in reducing backlogs, there have been problems even apart from the situation in Chicago. Our examination thus far indicates that some of the problems could have been avoided by better communication between the various parts of the agency. Let me repeat that the real answer to providing the kind of prompt, efficient, accurate, and consistent decisionmaking that disabled claimants and citizens generally deserve depends not so much on introducing a laundry list of ad hoc fixes. It requires a comprehensive effort to revise and rationalize the structure of the program. Commissioner Barnhart has indicated that she is proposing a major reform of the administrative processes in these programs, and we encourage her in this regard, but the Advisory Board believes that we must look beyond the need for administrative restructuring to examine some of the underlying features of the program. For example, within a month the Advisory Board will issue a report that addresses whether the program's definition of disability, set in the fifties, is appropriate in the technologically advanced economy of the 21st century. We hope you will seriously consider our suggestions, and we stand ready to provide you input as you deliberate the ways to firm up the foundations of this program. Thank you very much.

[The prepared statement of Mr. Schieber follows:]

Statement of Sylvester J. Schieber, Member, Social Security Advisory Board

Mr. Chairman, Mr. Matsui, and members of the Subcommittee, I am pleased to have this opportunity to address the Subcommittee on the issue of management of the Office of Hearings and Appeals. The Chairman of the Advisory Board, Hal Daub, could not be here this morning because of a prior personal commitment. He has asked that I convey to the Committee that he believes the issues you are considering today to be of utmost importance and he applauds your holding these hearings.

The Social Security disability programs are a vital part of our nation's system of economic security. Over 5 million disabled workers and their families receive income support from disability insurance and about 3.5 million additional disabled individuals depend on payments from the Supplemental Security Income program. Payments under these disability programs total more than $90 billion annually.

The four cornerstones of these major national programs should be fairness, efficiency, quality, and consistency. Although the Social Security Administration today devotes a disproportionate share of its administrative resources on its disability programs, none of these goals is being fully met.

In January 2001, the Social Security Advisory Board issued a report, *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change*. In that report, we pointed out:

> . . . over the last half-century the original Federal-State administrative structure has had to accommodate a dramatic growth in program size and complexity that it has been ill-equipped to handle. In addition to working within a fragmented administrative structure, employees at all levels have been buffeted by periodic surges in workloads and funding shortfalls.

It is thus not so much that any particular part of the program is broken. The whole administrative design is in need of a basic restructuring to make all the parts work together in a much more carefully coordinated way. We are aware, of course, that the Commissioner of Social Security has been developing proposals for revising the program. Commissioner Barnhart was, as you know, a member of the Advisory Board at the time we issued the report. We will not be surprised if her proposals reflect some of our thinking. Many of the problems we identified could be addressed administratively, although some might need legislative change.

This hearing is about the Office of Hearings and Appeals, but many of the Advisory Board's findings and recommendations apply to the entire process. For exam-

ple, there is an urgent need to develop and implement a new quality management system that incorporates all parts of the disability determination process. Only such a system can bring about the sorely missing consistency among different levels of adjudication and produce the information needed to make sound policy decisions.

But let me focus on some of the Board's findings that are particularly relevant to the hearings and appeals process.

At any given moment, there are roughly a half million appeals pending in Social Security hearing offices. We hear two major and somewhat related issues as to why those appeals are so hard to process promptly. One is that they are not adequately developed. The second is that they do not contain a comprehensible explanation of the rationale for the initial decision. The Board has suggested that one answer to these problems might be the use of an individual who would be responsible for defending the initial decision in the hearings process as a way to clarify the issues and introduce greater consistency and accountability. We also suggested that Congress and the agency revisit the possibility of closing the record after the hearing decision is made. Many Administrative Law Judges feel that the current system provides undesirable incentives that work against prompt and complete development of the record. Earlier this year, the Board printed and sent to you a copy of a study of these issues that was done for us by Professors Verkuil, Lubbers, and Bloch.

The final step in the appeals process is review by the Appeals Council. In the Board's 2001 report, we noted that, while the Appeals Council performs certain case correction and review functions, it has been subject to considerable criticism over the years. We suggested that Congress and the agency carefully review and rationalize this part of the process.

These are some elements of the hearings and appeals system that need to be addressed. Others are detailed in our January 2001 report. But, as I indicated at the start of my testimony, real improvements will require a thorough streamlining and rationalizing of the entire system.

Certainly many claims are handled expeditiously, but many—particularly when they enter the appeals process—drag on and on, sometimes for years.

Our reports in the past have noted a chronic resource problem in the system as a whole. Inadequate resources at the State agency level lead to backlogs. Backlogs, in turn, can create pressures whose results ultimately have adverse effects on the appeals process in the form of more appeals, cases requiring additional documentation, and absence of clear explanations of the basis for the State agency decision. Improvements in the earlier stages, just by reducing the number of appeals, could make the hearings process more manageable. Not getting timely benefits to someone truly disabled is unfair to the vulnerable people the program is intended to serve. Awarding benefits to those who should not qualify is equally unfair as it adds to the financing burden we face in an aging society.

Consistency is another serious problem. The Advisory Board has been very troubled by the wide discrepancies it sees in the program. This is a problem that affects all levels of program administration, but since this hearing is focused on the appeals process, let me read you this paragraph, again from our January 2001 report on the need for fundamental change in the disability programs:

The percentage of decisions at the hearing level that were favorable for both DI and SSI claimants stood at 58 percent in 1985, grew to nearly 72 percent in 1995, fell to 63 percent in 1998, and grew again to 66 percent in 2000. Hearing offices also vary greatly from State to State in the percentage of decisions that are decided favorably for claimants. In 2000, the range went from 35 percent in the District of Columbia to 86 percent in Maine, with a national average of 66 percent.

Unexplained discrepancies of this magnitude are simply unacceptable in what Congress intended to be a fair and uniform national program.

The causes of these problems are many, and they are interrelated.

There is a problem of policy uniformity. Year after year, six or even seven cases out of every ten are decided differently at the hearing office than they were in the State agency. That magnitude of reversals leads to a strong presumption that different policies are being applied at different levels of adjudication.

There is a problem of communication and teamwork. The Social Security Advisory Board makes a practice of going out into the field to talk with those who operate the program and to get the views of the public. We have visited every one of the agency's regions, some of them more than once. At every level of administration, we find hard-working, dedicated employees who are doing their very best to make the right decisions, to provide a high level of service to the public, and to carry out their stewardship obligations to the taxpayers. But we do not always find that those at one level have great confidence that the rules are being applied correctly at other

levels; and we do not always find that employees believe that their efforts are being measured accurately and that their concerns are being heard.

Today's hearing, in part, addresses the problems in the Chicago region with respect to the file assembly contracts. Even before the Chicago reports surfaced, the Board had begun to look into those contracts as a result of some problems that we heard about both during our visit to the Boston region in May and through other reports that came to us. As we now understand it, one hearing office conducted a very successful pilot project that was subsequently converted into a national contract. Overall, the contract seems to have been very helpful in reducing hearing office backlogs. But there were a number of places, including, but not limited to, Chicago, where the contract did not go smoothly. From what the Board has seen so far, at least a part of the reason for the problems is traceable to inadequate communication. The national contract may have been developed without adequate understanding of all the factors that made the pilot successful. Those responsible for the contract at the national level may not have adequately communicated how it was to be implemented. And, when problems arose, the existence of those problems appears not to have been quickly communicated and acknowledged. As the Board said in its February 2001 report *Agenda for Social Security*:

SSA has a strong institutional resistance to open discussion of the agency's problems . . . This kind of problem is difficult to correct. It requires a fundamental change in agency culture.

The problems in the management of the Social Security disability process and, in particular, the hearing process are real but they are not insoluble. To the extent that the problems arise from administrative overload, the additional resources requested in the President's budget should help, as should the significant system improvements that are currently under development. But more fundamental changes are needed as well. There needs to be a greater emphasis on developing policy that can be applied more objectively and more consistently at all levels of adjudication. There needs to be better communication in general and communication of policy in particular. To some extent this is a matter of training. A few years ago, the agency conducted an experiment in joint training of State agency and hearings level personnel. In the Board's conversations with field personnel, we sense general agreement that that experiment was very useful, but it was never adopted as an ongoing practice.

As I indicated at the start of my testimony, however, the real answer to providing the kind of prompt, efficient, accurate, and consistent decision-making that disabled claimants—and citizens generally—deserve depends not so much on introducing a laundry list of ad hoc fixes. It requires a recognition that the basic administrative structure needs to be rationalized and revised in way that addresses the problems in a comprehensive manner. And we also must look even beyond the need for administrative restructuring to examine some of the underlying features of the disability programs. For example, later this month the Board will issue a report that addresses whether the programs' definition of disability set in the 1950s is appropriate in the technologically advanced economy of the twenty-first century. We hope you will seriously consider our suggestions, and we stand ready to provide input as you deliberate the ways to firm up the foundations of these programs.

Chairman SHAW. Thank you. Let me ask a question of you, Mr. Huse; and again, excuse me Mr. Schieber for——

Mr. SCHIEBER. Not a problem.

Chairman SHAW. I think this is the first time that Mr. Huse has sat at the table with anybody else. He usually comes in here by himself.

Mr. SCHIEBER. I feel very privileged.

Chairman SHAW. Well, we are privileged to have both of you here. Mr. Huse, we have found problems in several offices now. Do you think that it goes beyond this? Do you think this could be going on elsewhere in the country that we have yet to discover?

Mr. HUSE. Mr. Chairman, we have investigated these cases because they were referred to us.

Chairman SHAW. That is three of them, right? Milwaukee, Boston, and Chicago?

Mr. HUSE. We have not investigated Boston. We have only anecdotal information about the issues in Boston, but to date no referral has come to us to look into them. I can only speak to the issues in Milwaukee and Chicago, because we have reviews under way. Our approach is, if we are referred a matter, then we look into it. To date, no one has referred anything to us other than these matters in Milwaukee and Chicago.

Chairman SHAW. Maybe a spot audit of some other offices might be worthwhile. In your determination, did the contractor in any way profit, or could have profited, from the actions of the employees who contaminated certain files?

Mr. HUSE. Not in the sense of a monetary profit, no, I don't think so. I think this was——

Chairman SHAW. Just——

Mr. HUSE. Other than to complete the processing of these folders so that they could be placed back into the system.

Chairman SHAW. Well, it would appear then, as you said in your testimony, that there was no criminal intent. I think if it were intentional and malicious, there would certainly have been some criminal intent.

Mr. HUSE. We looked for that motivation, and it isn't present. We did present the results of our investigations to the U.S. Attorney, in both Wisconsin and in Chicago, to see if there were any charges——

Chairman SHAW. Well, it sounds like it was just a product of incompetence.

Mr. HUSE. I would agree with that.

Chairman SHAW. Yes, sir. Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman. Mr. Chairman, I think the reason Mr. Huse has someone here with him—it kind of reminds me of the Jerry Clower story of Marcel and Bobcat, a shoot-up mystery. One has got to have some relief. I appreciate the fact that you are a member of the Advisory Board—and that is actually what it is, an Advisory Board. Basically, when you look at the authority of the Commissioner, it is just the one step above you. Doesn't have a great deal of authority as the Commissioner, because there are a lot of things down through the ladder that take hold and prevent that authority from being actually there in the first place. It is a difficult situation to be in for each of you, and I find that the one thing that is consistent that both of you have said, though, is you need more money. More money won't help this problem in the long run. The problem is down beneath the dollar, the dollars that are already being spent. How many areas in the country do we have contractors, Mr. Huse?

Mr. HUSE. I know that the use of contractors does extend to other regions than the Chicago region. We haven't——

Mr. COLLINS. You don't have that answer.

Mr. HUSE. We don't have that answer, but we can get it for you.

[The information follows:]

SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235
October 7, 2003

The Honorable Mac Collins
Committee on Ways and Means
Subcommittee on Social Security
House of Representatives
Washington, D.C. 20515

Dear Mr. Collins:

This is in response to your inquiry during the hearing held on September 25, 2003 concerning the number of file assembly contracts nationwide. According to the Social Security Administration's Office of Acquisition and Grants, there are 89 contracts nationwide with a total value of $1.7 million. Enclosed is a table showing the number of contracts per region as of August 2003.

If you have any questions, please contact my Executive Assistant, H. Douglas Cunningham.

Sincerely,

JAMES G. HUSE, JR.
Inspector General

Social Security Administration Region	Total Number of Contracts	Total Contract Dollars
I—Boston	1	$65,880
II—New York	14	$282,090
III—Philadelphia	11	$182,346
IV—Atlanta	1	$275,382
V—Chicago	26	$457,630
VI—Dallas	11	$176,508
VII—Kansas City	1	$2,750
VIII—Denver	12	$36,103
IX—San Francisco	7	$124,768
X—Seattle	5	$101,122
Totals for All Contracts	89	$1,704,579

Mr. COLLINS. Well, I think that would be interesting. In the private sector, if you are operating a company with organized labor and contract, you will get yourself in trouble when you talk about outsourcing, and that is exactly what this is. It is outsourcing. It is contracting. Particularly when you get into the area of governments, you can go to outsourcing. We get it all the time in the different areas of the government and different agencies where they are attempting to contract and outsource. It brings on real heartache and turmoil for those who are trying to manage and administer it. It is kind of like throwing cats and dogs in the same pen. You are going to have some problems if you go and attempt to do it. That is what worries me about the Chicago situation here. It is too easy to have the conflict within the operation when you have agency people working with contract people. There is just a lot of displeasure in the fact that that is going on within those who are working within that arena. So, it kind of reminds me, too, of trying

to run an asylum and letting inmates be in charge. It can get real critical for you and be a disaster, and that is what is happening in Chicago. The problem with what is happening in Chicago and what worries me is the fact that there are those who actually file the applications, people across that region who were waiting on some type of decision as to whether or not they were going to be accepted or denied the benefits under the disability program. I think, overall, the Congress needs to review this thing about how we do outsourcing, where the areas are that we are going to try to do contracting. If you are going to do it, you do it overall. Don't just piecemeal it. You get in trouble.

We also should review with the authority who is given to people who are in charge like the Commissioner, and the Advisory Board is an Advisory Board. That is exactly what it is. Having sat here and watched and observed and listened to the Commissioner, I asked this question, I made this comment to her when she came back up to the dais. I asked her what type of authority did she have. Why did she hire these 200 administrative law judges that are unneeded? They can't do it. They didn't have the authority to do so. I tell her that is the very reason that I didn't take Commissioner of the Internal Revenue Service when it was offered to me in August, a year ago. I wouldn't have any authority. Those within the agency see them come, see them go. I would be one of those who come and go. Probably go a lot quicker than the other people, because I have a tendency to run a business in the way that the business should be run. This is the people's business, and we are not conducting it in the fashion it should be conducted when it comes to those we are serving, and that is the population of this country, those who are paying into this system and are eligible for the benefit. We know we have some people that apply that may not be eligible, but that has to be the process—to prove whether or not. So, it is not easy, not easy for the administration. It is not easy for us. We appreciate your report, appreciate your service on the Advisory Board, and just hope that the Congress will adhere to its jurisdiction and what needs to be done within the halls of this building and the other buildings. Thank you for your service, sir. Thank you, too.

Chairman SHAW. Mr. Ryan.

Mr. RYAN. I, too, would like to concur with my colleagues in saying that I am very pleased Commissioner Barnhart is taking on this challenge of really revising and revamping the system, and going to an electronic system. That is very encouraging. If you are going to fix the system, you first have to see how deep the problems lie, and that is why I press this Chicago and Milwaukee issue, because my concern is that this could be the tip of the iceberg. This could be a rampant problem, and we just don't know the answer to that. So, Mr. Huse, most of my questions, as you can probably predict, are for you. I have a couple of questions. Number one, from your testimony and your investigation, you say that SSA policy allows contractors to take home claimant files which may contain medical or other personal information, but that is not consistent with each contract, correct?

Mr. HUSE. That is correct. For example, in the case of the Chicago contracts, there was no allowance for these files to be taken home.

Mr. RYAN. So, some contractors can take documents home, some cannot, and the ones in Chicago could not.

Mr. HUSE. It depends on how the contract was let.

Mr. RYAN. Did you examine the contracts from the Chicago office, and did the contracts—the contractors at the Chicago office prohibit them from destroying or removing documents?

Mr. HUSE. Yes, there was no allowance for the destruction of documents. There was to be a removal of duplicative material, that was the function of the contract.

Mr. RYAN. Not to destroy documents.

Mr. HUSE. Not to destroy documents.

Mr. RYAN. Even duplicative documents.

Mr. HUSE. Even duplicative documents were to be separated and then——

Mr. RYAN. Not thrown on the floor or in the trash or in the recycling bin.

Mr. HUSE. They were to be destroyed by the processes normally——

Mr. RYAN. Under a secure system.

Mr. HUSE. Right.

Mr. RYAN. So, did you find that documents were discarded, destroyed, and under insecure systems, insecure trash, things like that?

Mr. HUSE. We found that the documents were initially placed into photocopy boxes as the process went forward. There is some interview testimony that in several instances these documents may have been taken out in the trash. However, the idea for the photocopy boxes was that these documents were to be put into the recycling and document destruction process.

Mr. RYAN. You said in your opening statement that original documents were discarded, meaning it went beyond just removing duplicative documents to actually discarding original documents. Is that the case?

Mr. HUSE. That is correct.

Mr. RYAN. So, I guess the conclusion is, improper controls were placed upon the contractors, and they didn't have the right safeguards. Is that——

Mr. HUSE. This is a case of mismanagement across the board.

Mr. RYAN. Not criminal wrongdoing.

Mr. HUSE. Not criminal wrongdoing. From the results of our investigation, there is no criminal wrongdoing, correct.

Mr. RYAN. The Social Security employees who were overseeing the contractors, were they the people who after the contractors discarded these documents, the ones who fished it out of the trash, basically, who realized a mistake was made, realized a problem was occurring, and went back and retrieved these documents from the trash? Can you shed some light on that chain of events?

Mr. HUSE. There is a long timeline from December 2002 to July of this year when a lot of these actions occurred, and there are a succession of Social Security employees who come in and out of this process. Therefore, there is no easy answer to your question, other

than in some instances, yes, they were the same people, and in other instances they were not. It adds to this picture of mismanagement——

Mr. RYAN. Give me your general take on all of this and your impression. Also, it is the whole tip of the iceberg question, and I guess you haven't done, maybe, spot audits. I think the Chairman's suggestion was probably a pretty good one. Maybe spot audits are warranted around the country in certain OHA areas. Give me your take on whether or not this is an isolated incident or whether or not this is a systematic problem that needs to be addressed. The contracts with outside contractors, do they need to be uniform? Should they be allowed to take this documentation home with them? Could you just shed some light on that—your opinion on that?

Mr. HUSE. As an Inspector General, I am pretty conservative in my opinions. If I don't have the work, I don't really opine on these things, and you can understand——

Mr. RYAN. Yes.

Mr. HUSE. That that is the basis for my office. I would say that there is no evidence that this is a pandemic problem. We have a process where we get allegations about the OHA, both from field referrals, and to our hotline. We investigate or review all of the allegations. So, I can say, I don't think this is pandemic across the entire OHA. There are enough instances to say that there are aspects of mismanagement in this system. However, I don't want to characterize this system as totally failed. That is why I am being careful here; but there is a management issue. That is correct.

Mr. RYAN. Now, since original documents were discarded and it wasn't just an unduplicating effort, are you satisfied from your investigation that the 1,200—I think you said 1,254 cases in question—are you satisfied from your investigation that those people have been contacted and that they have been given an appropriate second chance to clean up their files and get real justice?

Mr. HUSE. That particular issue is why we are holding our audit till we report back to you and the rest of the Wisconsin delegation on what you referred to us. We will answer you in our audit.

Mr. RYAN. Please let us know when you—Mr. Schieber, one quick question. From your vantage on the Advisory Board, what is your opinion not just of the situation, but of whether or not this is a systemic problem that runs throughout the country or not? What is your take on this?

Mr. SCHIEBER. Well, in this particular case, the only other evidence that I have seen specifically is when we visited Boston. Now when we visit some of the areas—and I think we have gone to all of the regions. I have now been on the Advisory Board for nearly 6 years. So, I have been there for a while. We usually meet with groups from different levels of the staff, and this issue came up in Boston, not of the same character or scope of problem that has turned up in Chicago, but there were specific concerns about this set of contracts related to this file creation process. One of the things we have found as we have gone around the country, though, is that there are consistent administrative concerns about this program all the way up and down. When I called, in my testimony, for review of this thing on a broader systemic basis, that is what

I was relating to. We certainly do not serve in nearly the same kind of capacity as Mr. Huse and his staff do, and we are not doing audits in any way, shape, or form. We are an advisory board. We are dealing at fairly high levels. We are trying to identify systematic problems and issues that we need to bring to the Commissioner and we need to bring to you, and I think we have done that. We have done it, certainly, extensively in relation to the disability program. I agree with Mr. Collins. I have spent many, many years in the private sector myself. I am there today, have been for the last 20 years; and I think there are very definite accountability problems. There are authority issues here also that need to be addressed.

Mr. RYAN. All right. Thank you. Thank you, Mr. Chairman.

Chairman SHAW. Mr. Huse, one quick question. Did your staff have the opportunity to interview some of the contracted-out employees to determine what was going through their heads, what were they thinking?

Mr. HUSE. We did, Mr. Chairman. We interviewed all of them concerned. The original conception of this contract was that these contracts would be let to vendors who re-employed retired social security employees who would have some skill sets to bring to this type of work. They would be familiar with the documents, familiar with the folder issues, and have some sense of what they were doing. In these two particular contracts in Chicago, this did not occur. These were people that were off the street doing piecework. Of course, the more work that was performed, the bigger the reward.

Mr. RYAN. Mr. Chairman, would you yield for just 1 quick second——

Chairman SHAW. I will.

Mr. RYAN. For an additional question on that point.

Chairman SHAW. Well, let him finish answering this, and then I will.

Mr. HUSE. The point is, what was going through their head was just getting the job done. They earnestly were confused about what they were supposed to do and asked questions, but the management process was so insufficient they never got the answers.

Chairman SHAW. Well, what was their job? To make the files thinner?

Mr. HUSE. Their job was merely to move duplicative material to the back of the section, and then to organize these folders in a fashion so that they could go to an administrative law judge for a hearing. The folders being organized——

Chairman SHAW. It sounds like a good idea.

Mr. HUSE. It does.

Chairman SHAW. They were throwing out the only copy of some things.

Mr. HUSE. I learned many, many years ago when I was a young lieutenant in the army, a unit only does well what its leader checks. That is what this is all about. There was no management.

Chairman SHAW. No accountability. Go ahead.

Mr. RYAN. Just a quick question on that. Did the Chicago office have the option or opportunity to hire a contractor that had former Social Security employees?

Mr. HUSE. We will look at that in our audit, but the answer is, there were other applicants or——

Mr. RYAN. Bids or whatever you call it.

Mr. HUSE. Bids—that is the word I was looking for . . . for this particular contract.

Mr. RYAN. Some of those bids did include former Social Security employees.

Mr. HUSE. My understanding was, one of the contractors would have re-employed, former Social Security employees.

Mr. RYAN. Thank you, Mr. Chairman.

Chairman SHAW. Go ahead.

Mr. HUSE. One of the employees involved with one of these two vendors was a retired Social Security employee.

Chairman SHAW. Well, I thank both of you for being here with us. We appreciate your insight into what is going on; and we look forward, Mr. Huse, to receiving a copy of your audit.

Mr. HUSE. Thank you, Mr. Chairman.

Chairman SHAW. The final panel that we have is made up of Marty Ford, who is Co-Chair of the Social Security Task Force, Consortium for Citizens With Disabilities; Richard Morris, who is President of the National Organization of Social Security Claimants' Representatives (NOSSCR), from Midland Park, New Jersey; the Honorable Ron Bernoski, who we have talked about already today, Association of Administrative Law Judges in Milwaukee, Wisconsin; Witold Skwierczynski, who is the President of American Federation of government Employees Council 220, the National Council of the SSA; and James Hill, President of the National Treasury Employees Union, from Cleveland Heights, Ohio. Welcome, all of you. We have your full statements, which will be made a part of the record, and you may proceed as you see fit. Ms. Ford, welcome back to the Committee.

STATEMENT OF MARTY FORD, DIRECTOR OF LEGAL ADVOCACY, THE ARC, AND UNITED CEREBRAL PALSY PUBLIC POLICY COLLABORATION, CO–CHAIR, SOCIAL SECURITY TASK FORCE, AND WORK INCENTIVES IMPLEMENTATION TASK FORCE, CONSORTIUM FOR CITIZENS WITH DISABILITIES

Ms. FORD. Thank you, Mr. Chairman, and Members of the Committee, for this opportunity to testify on behalf of the Consortium for Citizens with Disabilities. Once again, thank you for all of your work on H.R. 743. We look forward to final enactment. Ten million people with disabilities under age 65 rely on Title II and SSI disability programs. These beneficiaries and claimants can be very vulnerable. Their average monthly benefits are relatively low. Applicants have low earnings due to their impairments and may have mental impairments that complicate the application process and their understanding of the requirements for hearings and appeals. The Commissioner's proposal that she is announcing today is of great interest to us, because excessive delays in the disability determination process have a major impact on the daily lives of people with disabilities. In May of 2002, the Commissioner unveiled a chart here in this Subcommittee that vividly illustrates that the process from application through final Appeals Council decision can

exceed 1,153 days. Granted, some improvements have been made in the last year. However, using the chart's estimated averages, a claimant who submits an application today could wait until November of 2006 before the claim clears the Appeals Council's step. Imagine the stress of trying to cope with a severe disability with little or no income and possibly—or probably—no health insurance until November of 2006.

For the 5 percent of cases that go beyond the hearing stage and the 1 percent that go to the Federal courts, this is devastating to claimants and their families. It also damages the public perception of the SSA. Real improvements to this process must have a high priority. We support the Commissioner's efforts to make technological improvements and support the necessary appropriations to do that. Much delay is still caused by the need for manual handling and transmission of paper files. The Commissioner has instituted initiatives which could reduce the delays and provide better service to the public that do not necessarily require fundamental changes to the current process. These include electronic folders, which she mentioned earlier, digital recording of hearings, and teleconference hearings. We support such improvements to ensure a full and fair evaluation of a claim and to ensure the claimant's right to a full and fair hearing on appeal. We have testified that SSA should ensure collection of accurate information as early as possible so that correct decisions are made the first time, and I understand that is a goal in the Commissioner's new proposal. The SSA should also provide claimants special assistance when they are unable to read, show evidence of cognitive or other mental impairments, or give other indications of being unable to negotiate the process alone. A claimant's evidence must be protected and preserved by SSA. We are concerned about the loss of evidence and failure to open mail for months at a time in OHA offices. It goes without saying that allowing contractors to discard potentially important evidence from case files can seriously harm claimants. SSA must be vigilant in fulfilling its responsibilities.

We are also disturbed by reports that SSA employees and contractors have been allowed to remove files from OHA offices and take the files to work at home. This practice should be halted. Case files contain very personal information about an individual's medical conditions and the impact on their daily life. They include names of health care providers and hospitals, recommended courses of treatment, and prescribed medications. Files contain names, addresses, dates of birth, and Social Security numbers. Access to this information would make identity theft very possible. Files can be lost, misplaced, damaged or destroyed when removed from OHA offices. Loss of evidence can create even more devastating delays for individuals waiting for decisions. Even if SSA could assure that all workers would handle files with utmost care and responsibility, SSA can make no assurances about workers' family members, house guests, or visitors. There are also many opportunities for damaging or losing files during transportation by car, bus, or subway. We urge the immediate halt of this work-at-home practice until such time as SSA can reliably ensure that all privacy and security concerns have been addressed with adequate safeguards. We believe the solutions to management issues must

respect the required functions of SSA and that key elements must remain in the hearings and appeals process. These include preserving a requirement for a full and fair hearing before an administrative law judge, allowing new evidence at the administrative law judge and Appeals Council stages, and maintaining a non-adversarial administrative law judge hearing. I want to reemphasize the importance of protecting claimants' rights and ensuring that improvements to OHA do not circumvent these critical rights. We will be looking carefully at the Commissioner's proposal and look forward to working with the Commissioner and this Subcommittee in improving disability determination and appeals processes. Thank you.

[The prepared statement of Ms. Ford follows:]

Statement of Marty Ford, Co-Chair, Social Security Task Force, Consortium for Citizens with Disabilities, and Director, Legal Advocacy, The Arc, and United Cerebral Palsy Public Policy Collaboration

Chairman Shaw, Representative Matsui, and Members of the Subcommittee, thank you for this opportunity to testify regarding management of the Social Security Administration's Office of Hearings and Appeals.

I am Director of Legal Advocacy for The Arc and UCP Public Policy Collaboration, which is a joint effort of The Arc of the United States and United Cerebral Palsy. I am testifying here today in my role as co-chair of the Social Security Task Force and the Work Incentives Implementation Task Force of the Consortium for Citizens with Disabilities. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security and Work Incentives Implementation Task Forces focus on disability policy issues in the Title XVI Supplemental Security Income program and the Title II disability programs.

The CCD Task Forces welcome the opportunity to testify here today and appreciate your holding a hearing regarding management of the Office of Hearings and Appeals.

As the Subcommittee is aware, 10 million people with disabilities under age 65 receive disability benefits: 5.2million people with disabilities depend upon Title II disability benefits, 3.5 million depend upon Supplemental Security Income disability benefits, and 1.3 million depend upon a combination of both Title II and SSI disability benefits. Therefore, the management and administration of the Title II and SSI disability programs are of critical importance to people with disabilities and to the members of CCD.

Claimants for Title II and SSI disability benefits can be very vulnerable. The average monthly benefit of people with disabilities in the Social Security Disability Insurance program is $834. People with disabilities of working age in the SSI program have monthly benefits that average $428. Many people applying for disability benefits have very low incomes, due to their impairments, and many have mental impairments that further complicate the application process and their understanding of the requirements for hearings and appeals. Claimants for the SSI program tend to have less work experience and education than their counterparts applying for Title II disability benefits.

Unlike most of the witnesses here today, we cannot provide insight about the day-to-day management of the Office of Hearings and Appeals. What we can provide, however, is an understanding of the impact of management problems and failures on people who are intended beneficiaries of the Social Security disability programs. I also hope that we can imbue a sense of urgency to the discussion, because management problems that result in delay impact on the daily lives of people with disabilities who must turn to the Office of Hearings and Appeals to appeal unfavorable decisions on their claims for benefits under Title II or SSI.

Further, since solutions to management issues are inextricably tied to the expected functions of OHA, I also want to reinforce the key elements that we believe must remain in the hearings and appeals process. This includes preserving a requirement for an Administrative Law Judge hearing on the record, allowing new evidence at the ALJ and Appeals Council stages, and not having SSA represented at ALJ hearings.

For people with disabilities, it is critical that the Social Security Administration address and significantly improve the process for hearings and appeals. The backlog of cases waiting for ALJ and Appeals Council decisions is clearly unacceptably long, as so vividly and visually illustrated by the Commissioner at this Subcommittee's hearing on May 2, 2002. People with severe disabilities who by definition have limited earnings from work are often forced to wait years for a final decision, from the time of application through the final Appeals Council decision. This is damaging not only to the individual with a disability and his/her family, but also to the public perception of and integrity of the program.

We believe that it is necessary to reduce unnecessary delays for claimants and to make the process more efficient. Improving how the OHA functions should not require any significant changes that would diminish the fairness of the process in determining a claimant's entitlement to benefits.

I. Improving the Office of Hearings and Appeals

While we cannot address all of the factors that go into making an office efficient and productive, there are some elements of the OHA structure and practices which come to our attention regularly and could be resolved to contribute to a more efficient and productive system of hearings and appeals.

Technological Improvements

We support the Commissioner's efforts to make technological improvements at SSA. Whatever funds are necessary should be appropriated to ensure that the process works as intended by the law. Much of the delay in the current process is caused by a system that still requires a great deal of manual labor, including handling and transmission of paper files. Several initiatives have been announced that could reduce delays, provide better service to the public, and would not require fundamental changes to the current process. They include: electronic folders (eDIB), digital recording of hearings, and video teleconference hearings. We support such modernizations where they are used to ensure a full and fair evaluation of a claim and ensure the claimant's access to a full and fair hearing on appeal, where necessary.

The electronic folder: "eDIB." The Commissioner is moving forward to develop the electronic disability folder, "eDIB," as soon as practicable in light of available resources. This would reduce delay caused by moving and handing-off folders, allowing for immediate access by whichever component of SSA or the DDS is working on the claim. Further, this would allow adjudicators to organize files to suit their preference.

In terms of preparing a record for federal district court, eDIB would allow for electronic filing of the administrative record, which is consistent with the Judicial Conference of the United States' policy and initiative to move towards electronic filing of documents and pleadings. The Appeals Council has had difficulty reproducing copies of the record, whether needed by the claimant or for federal court filing. Files are too often lost or difficult to locate, leading to delays at the Appeals Council and district court levels. The electronic folder would certainly ease the workload in this regard and, consequently, reduce delays.

We believe that using electronic folders will allow much faster processing, eliminating delays while folders are moved from place to place, avoiding loss of valuable records, and allowing immediate recording of updates, new evidence, or other actions regarding the file. However, we believe that it is critical to establish that electronic files contain all of the claimants' evidence in an exact, unalterable electronic copy of the original, including complete copies of originals that are received electronically. Important details and nuances in the paper reports must not be lost. In addition, nothing should preclude the claimant from presenting available evidence in any format.

We do not consider summaries or partial documents acceptable substitutes for inclusion in a folder. Technology is now widely available to allow such "paper" evidence to be fully included in the electronic folder without alteration. We urge the Commissioner to ensure protection of this valuable, sometimes irreplaceable, evidence by requiring that exact, unalterable electronic copies of all originals be permanently maintained in the electronic folder. Otherwise, we could not support this move toward a fully electronic record.

Digital recording of hearings. Another important component of technological improvement is digital recording of ALJ hearings. Currently, hearings are often taped on obsolete tape recorders, which are no longer manufactured. If copies are needed, they must be transferred to cassette tapes, which is time-consuming. Tapes are frequently lost because they are stored separately from the paper folder. Given the age of the taping equipment, the quality of tapes is often quite poor, which also results in remands from the Appeals Council or the district court. A digitally re-

corded hearing would not only be of high audio quality but also would be easy to copy or transfer to the district court as part of the administrative record.

Use of video teleconferencing at ALJ hearings. The Commissioner also has announced an initiative to expand the use of video teleconference ALJ hearings. This allows ALJs to conduct hearings without being at the same geographical site as the claimant and representative and has the potential to reduce processing times and increase productivity. Claimants and their representatives have participated in pilots conducted by SSA and have reported a mixed experience, depending on the travel benefit for claimants, the quality of the equipment used, and the hearing room set-up.

In February 2003, SSA published final rules on video teleconference hearings before ALJs. In general, we support the rules and the use of video teleconference hearings so long as the right to a full and fair hearing is adequately protected and the quality of video teleconference hearings is assured.

Gather and Protecting Evidence

It is critical that SSA collect the correct information at the earliest possible time in the process to ensure that correct decisions are made the first time. SSA must improve the collection of medical and non-medical evidence by explaining what is needed and asking the correct questions, with appropriate variations for different treatment sources.

Claimants should be encouraged to participate to the extent they are able. To that end, SSA should assess, as early in the process as possible, the claimant's need for special assistance and provide it. Such assistance could be triggered when applicants are unable to read, show evidence of cognitive or other mental impairments, or give other indications of being unable to negotiate the process alone.

Evidence that has been gathered must be protected and preserved by SSA. We are concerned about the loss of evidence from the Chicago office (mentioned in the Advisory for this hearing). It goes without saying that allowing contractors to discard potentially important evidence from case files can seriously harm claimants. SSA must be vigilant in fulfilling its stewardship responsibilities. This is also true for the failure to open mail for months at a time in the Milwaukee office (as mentioned in the hearing Advisory).

Need to Protect Personal Privacy

We are disturbed by the reports in the press, discussed at this Subcommittee's hearing on July 24, 2003, that contractors for SSA have removed files from the OHA offices and taken the files to employees' homes to telecommute or work from home. We also learned during the hearing that SSA employees are allowed to work on these files at home. We are very concerned about this practice and urge that it be halted for contractors as well as employees. At a minimum, the following concerns should be addressed:

- **Personal Medical Information—**Case files, by their nature, contain very personal information about an individual's medical conditions and the impact of those conditions on the individual's daily life. Names of health care providers and hospitals are included, as are recommended courses of treatment and prescribed medications.
- **Personal Identification Information—**Files contain names, addresses, dates of birth, and Social Security Numbers. Access to this information would make identity theft possible.
- **Impact of Loss of Files—**Files can easily be lost, misplaced, damaged, or destroyed when allowed to be removed from OHA offices. The loss of evidence can create devastating delays for individuals waiting for decisions.

Even if SSA could assure that its employees and contractors would handle all files with the utmost care and responsibility, SSA can make no such assurances about the employees'/contractors' family members, roommates, houseguests, visitors, or household employees. There are also many opportunities for damaging or losing files during transportation by car, bus, subway, etc. We urge the immediate halt of this "work at home" practice, until such time as SSA can reliably ensure that all privacy and security concerns have been addressed with adequate safeguards.

II. Preserving Major Characteristics of the Current System

In the effort to ensure that the Office of Hearings and Appeals achieves higher efficiency and productivity, it is important not to "throw the baby out with the bathwater". The purpose of OHA is to provide claimants with a fair opportunity to appeal unfavorable decisions regarding benefits that the individual needs and to which he/she may be entitled. Improvements in the implementation of OHA's responsibilities should not alter the purpose of those responsibilities or the rights of

the claimants. This Subcommittee has addressed many of these issues in past hearings; however, in repeating some of the CCD Task Forces' positions here, I wish to emphasize the importance of protecting claimants' rights and ensuring that improvements to OHA do not circumvent these critical rights.

The Right To A Full And Fair Hearing Befor An Administrative Law Judge

A claimant's right to a hearing before an Administrative Law Judge (ALJ) is central to the fairness of the adjudication process. This is the right to a full and fair administrative hearing by an independent decision maker who provides impartial fact-finding and adjudication, free from any agency coercion or influence. The ALJ asks questions of and takes testimony from the claimant, may develop evidence when necessary, considers and weighs the medical evidence, evaluates the vocational factors, all in accordance with the statute, agency policy, including Social Security Rulings and Acquiescence Rulings, and circuit case law. Claimants have the right to present new evidence in person to the ALJ and to receive a decision from the ALJ that is based on all available evidence. These elements of the ALJ hearing should be preserved.

Importance of Considering New and Material Evidence

For claimants, a fundamental principle of the right to an ALJ hearing is the opportunity to present new evidence in person to the ALJ, and to receive a decision from the ALJ that is based on all available evidence. If new and material evidence were available, but not allowed at the ALJ hearing, SSA would suffer from public perceptions of an agency that makes arbitrary decisions regardless of the weight of the evidence available. If the Appeals Council were to ignore new and material evidence that relates to the time period before the ALJ decision, the public would similarly conclude that the disability determination process is arbitrary and flawed.

Restoring the Senior Attorney Position

In the 1990's, as an initiative to reduce the backlog of cases at hearings offices, senior staff attorneys were given the authority to issue fully favorable decisions in cases that could be decided without a hearing (i.e. "on the record"). This program was well received by claimants' advocates because it provided an opportunity to present a case and obtain a favorable result efficiently and promptly. And, of most importance, thousands of claimants benefited. While the Senior Attorney Program existed, it helped to reduce the backlog by issuing approximately 200,000 decisions. Unfortunately, the initiative was phased out in 2000.

We support reinstating senior attorney authority to issue decisions in cases that can be favorably decided on the record and support expanding ways that they can assist ALJs. For instance, they also can provide a point person for claimants' representatives to contact for narrowing issues, pointing out complicated issues, or holding pre-hearing conferences.

Retaining an Informal ALJ Hearings

We do not support efforts to have SSA represented at the ALJ hearing because past experience shows that it does not result in better decision-making and reducing delays, but instead injects an adversarial element and increases formality and technicality in a system meant to be informal and non-adversarial. In the 1980's, SSA tested, and abandoned, a pilot project to have the agency represented. It was terminated following Congressional criticism and a judicial finding that it was unconstitutional and violated the Social Security Act. In the end, the pilot did not enhance the integrity of the administrative process.

SSA and the claimant should not be viewed as parties on opposite sides of a legal dispute. SSA already has a very heavy say in what goes on: SSA implements the law through development and publication of regulations, including the medical listings; provides guidance to claims workers and Disability Determination Services staff through its Program Operations Manual System (POMS); contracts with the states for determinations made in accordance with its regulations and POMS; and hires the ALJs. The claimant's role is to show that he/she has an impairment with limitations that fit within the parameters constructed by Congress and implemented by SSA. Very few claimants would have the wherewithal to know and understand all of the things that could or should pertain to their cases. SSA has a vital role in helping the claimant through a very complex process. SSA's role is not to "oppose" the individual's claim; but rather to ensure that people who are eligible as contemplated by Congress are enabled, as a result of the claims process, to receive the benefits to which they are entitled. Where an individual has representation, whether legal or lay representation, SSA should view the individual's representative as an ally in facilitating the collection of relevant evidence and highlighting the important questions to be addressed in making the disability determination.

Review By The Appeals Council

SSA has been testing the elimination of a claimant's right to request review of a hearing decision by the Appeals Council. We strongly oppose the elimination of a claimant's right to request review by the Appeals Council. The Appeals Council currently provides relief to nearly one-fourth of the claimants who request review of ALJ denials, either through outright reversal or remand back to the ALJ. The Appeals Council has made significant improvements in reducing processing times and its backlog.

The Appeals Council, when it is able to operate properly and in a timely manner, provides claimants with effective review of ALJ decisions. In addition, elimination of Appeals Council review could have a serious negative impact on the federal courts. In 1994, the Judicial Conference of the United States opposed elimination of the claimant's request for review by the Appeals Council prior to seeking judicial review in the district courts, stating that such a proposal was "likely to be inefficient and counter-productive." The Judicial Conference also recognized the Appeals Council's role as a screen between the ALJ and federal court levels, noting that "[c]laimants largely accept the outcome of Appeals Council review." Further, the Conference expressed concern that allowing direct appeal from the ALJ denial to federal district court could result in a significant increase in the courts' caseloads.

We agree with the conclusion of the Judicial Conference of the United States. Access to review in the federal courts is the last and very important component of the hearings and appeals structure. Court review is not *de novo*, but rather, is based on the substantial evidence test. We believe that both individual claimants and the system as a whole benefit from federal court review. The district courts are not equipped, given their many other responsibilities, to act as the initial screen for ALJ denials.

Again, thank you for this opportunity to testify on these important issues. The CCD Social Security and Work Incentives Implementation Task Forces looks forward to working with the Subcommittee and the Commissioner on improving the disability determination and appeals processes.

ON BEHALF OF:

American Association on Mental Retardation
American Council of the Blind
American Foundation for the Blind
American Network of Community Options and Resources
Association for Persons in Supported Employment
Association of University Centers on Disabilities
Brain Injury Association of America
International Association of Psychosocial Rehabilitation Services
National Alliance for the Mentally Ill
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Association of Protection and Advocacy Systems
National Mental Health Association
National Organization of Social Security Claimants' Representatives
NISH
Paralyzed Veterans of America
Research Institute for Independent Living
The Arc of the United States
United Cerebral Palsy

Chairman SHAW. Thank you, Ms. Ford. Mr. Morris.

STATEMENT OF RICHARD P. MORRIS, PRESIDENT, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Mr. MORRIS. Mr. Chairman, Members of the Subcommittee, I want to thank you for inviting me to testify at today's hearing. My name is Richard Morris. I am the current President of the NOSSCR. The NOSSCR is a national organization with a current

membership of approximately 3,400 members from both the private and public sectors and is committed to the highest quality of legal representation for claimants. As an attorney in a law firm, I have been representing claimants for the last 26 years. The majority of my cases are hearings before Social Security administrative law judges as well as appeals to the SSA's Appeals Council. This is also true for most NOSSCR members. A claimant's right to file a request or hearing before an administrative law judge is central to the fairness of the adjudication process. In addition, the Appeals Council, when it is able to operate properly and in a timely manner, provides claimants with effective review of administrative law judge decisions. Because the administrative law judge hearing is a key part of the appeals process, and of critical importance to claimants, we have been very concerned that OHA processing times continue to be unacceptably high. We agree with the Commissioner that reducing the backlog and processing time must be a high priority, and we urge commitment to resources and personnel to reduce delays and make the process work better for the public. We strongly support efforts so long as they don't affect the fairness of the process to determine a claimant's entitlement to benefits.

We must provide SSA with adequate resources to meet current and future needs. To reduce delays, better develop cases, and implement technological advances, SSA requires adequate staffing and resources; and we urge commitment of these resources and personnel to help resolve the waiting times and make the process work better for the benefit of the public. An additional personnel problem at OHA is that SSA has not been able to fill administrative law judge vacancies for several years, and we feel that allowing SSA to operate at a full complement of administrative law judges will be an important factor in improving processing times. In March, Commissioner Barnhart announced an initial series of initiatives that SSA planned to implement to improve the hearings and appeals process. The NOSSCR generally supports these initiatives. We are in favor of short-form favorable decisions, and we feel they should be adopted for favorable decisions. When I began practicing back in the seventies and eighties, short-form decisions were widely and often utilized, and they speeded up the processing time of getting out a decision and closing out cases. To borrow a phrase, it may be time to go back to the future for SSA. Bench decisions ought to be utilized by administrative law judges in connection with voice recognition software to speed up the processing of cases. Video conferencing has the potential to reduce processing time and increase productivity. My personal experience with video conferencing has been very favorable. It has enabled cases to be heard by out-of-town judges that would take many extra months to be heard by local judges.

I am told that digital recording of hearings would result in a higher quality product and fewer lost tapes. The quality of the present tapes used is often poor because of antiquated tape and equipment which results in remands from the Appeals Council and the Federal courts rather than adjudication by these appellate bodies. It is my understanding that the agency has abandoned the HPI initiative, and we applaud this decision. My clients and their cases have spent countless months trapped in the conundrums caused by

HPI, and the delays have proven to be unconscionable. However, we strongly urge the continuation of the practice of keeping evidentiary records open for new evidence. While NOSSCR supports the submission of evidence as early as possible so a correct decision may be made as soon as possible, there are many legitimate reasons for keeping a record open. Often, with managed care being what it is today, insurance companies cause long delays in permitting diagnostic tests to be performed, and it often takes longer for physicians to diagnosis a condition and arrive at an opinion. We do not believe, however, that SSA should be represented at the hearing level by counsel. I can only imagine how much more delayed the scheduling of hearings will be and how much longer the actual hearing will take, causing even fewer cases to be heard and fewer decisions made each month. I thank you for this opportunity to testify, and I would be glad to answer any questions that you might have.

[The prepared statement of Mr. Morris follows:]

Statement of Richard P. Morris, President, National Organization of Social Security Claimants' Representatives, Midland Park, New Jersey

Mr. Chairman, Congressman Matsui, and the Members of the Social Security Subcommittee, thank you for inviting me to testify at today's hearing on the Social Security Administration's Management of the Office of Hearings and Appeals (OHA). My name is Richard P. Morris and I am the current president of the National Organization of Social Security Claimants' Representatives (NOSSCR).

Founded in 1979, NOSSCR is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability or Supplemental Security Income (SSI) benefits. NOSSCR members represent these individuals with disabilities in legal proceedings before the Social Security Administration and in federal court. NOSSCR is a national organization with a current membership of 3,400 members from the private and public sectors and is committed to the highest quality legal representation for claimants.

As an attorney in a four-person law firm in New York City, I have represented claimants for the past twenty-six years. While I represent claimants from the initial application through the Federal court appellate process, the majority of my cases are hearings before Social Security Administrative Law Judges and appeals to the Social Security Administration's Appeals Council. This also is true for most NOSSCR members.

Initially, I would like to thank the Subcommittee for its support of H.R. 743, the Social Security Improvement Act of 2003, which was passed by the full House of Representatives in April 2003. The bill includes many provisions that will expand protections for claimants and beneficiaries. In particular, we thank you for supporting the expansion of direct payment of attorneys fees to the SSI program. SSI claimants are represented at a significantly lower rate than Title II claimants, which is, undoubtedly, one factor in the lower rate of favorable decisions for SSI claimants. This provision of H.R. 743 will improve the access of SSI applicants to representation, since more attorneys will be willing to represent claimants if payment is guaranteed.

A claimant's right to file a request for hearing before an Administrative Law Judge (ALJ) is central to the fairness of the adjudication process. This is the right to a full and fair administrative hearing by an independent decision-maker who provides impartial fact-finding and adjudication, free from any agency coercion or influence. The ALJ asks questions 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 including Social Security Rulings and Acquiescence Rulings, and circuit case law. For claimants, a fundamental principle of this right is the opportunity to present new evidence in person to the ALJ and to receive a decision from the ALJ that is based on all available evidence.

In addition, the Appeals Council, when it is able to operate properly and in a timely manner, provides claimants with effective review of ALJ decisions. The Appeals Council currently provides relief to nearly one-fourth of claimants who request review of ALJ denials, either through outright reversal or remand back to the ALJ.

The Appeals Council has made significant improvements in reducing processing times and its backlog. SSA has been testing the elimination of a claimant's right to request review of an ALJ hearing decision by the Appeals Council. We support the continued right to request review by the Appeals Council and oppose implementation of this pilot.

Because the ALJ hearing is a key part of the appeals process and of critical importance to claimants, we have been very concerned that OHA processing times continue to be unacceptably high. A claimant cannot proceed with an appeal in federal district court until the ALJ and Appeals Council have acted. Thus, while their medical and financial situations are deteriorating, claimants are forced to wait for many months, if not years, before receiving a decision.

We agree with the Commissioner that reducing the backlog and processing time must be a high priority and we urge commitment of resources and personnel to reduce delays and make the process work better for the public. We strongly support such efforts so long as they do not affect the fairness of the process to determine a claimant's entitlement to benefits.

PROVIDE SSA WITH ADEQUATE RESOURCES TO MEET CURRENT AND FUTURE NEEDS

To reduce delays, better develop cases and implement technological advances, SSA requires adequate staffing and resources. We urge commitment of sufficient resources and personnel to resolve the waiting times and make the process work better for the benefit of the public. To this end, NOSSCR has testified previously before this Subcommittee that it supports removing SSA's administrative budget, like its program budget, from the discretionary domestic spending caps.

An additional personnel problem at the OHA level is that SSA has not been able to fill ALJ vacancies for several years, at the same time that processing times have increased. This is due to ongoing litigation regarding the scoring formula for the ALJ examination used by the Office of Personnel Management (OPM). A recent court decision permits OPM to resume its examination process. Effective August 25, 2003, OPM lifted the suspension on the ALJ examination, which had been in place since 1999. This means that OPM will be able to respond to SSA's need to fill vacant ALJ positions.

While the hiring of additional ALJs is not the only answer to management issues at OHA, allowing SSA to operate at a full complement of ALJs will be an important factor in improving processing times.

SHORT-TERM INITIATIVES TO IMPROVE THE HEARINGS AND APPEALS PROCESS

In March 2002, Commissioner Barnhart announced an initial series of initiatives that SSA planned to implement to improve the hearings and appeals process. NOSSCR generally supports these initiatives:

1. Early screening and analysis

The goal is to review cases as early as possible. Screening would be mandatory and would be done either by senior attorneys or ALJs. Cases to be targeted in the screening would include:

- dismissals
- on-the-record decisions
- "difficult cases" that need to be set aside for more work

OHA believes this would involve about 28% of the cases, based on FY 2001 records.

We support the expansion of early screening, particularly as it pertains to on-the-record decisions. While we strongly believe that claimants for disability benefits should retain the right to a *de novo* hearing before an ALJ, we support the use of non-ALJs in one decision making situation that could assist ALJs: when a fully favorable decision can be issued, without the need for a hearing, i.e., an "on the record" decision.

There is precedent for this limited use of non-ALJ decision makers at the hearing level. In the 1990's, as an initiative to reduce the backlog of cases at hearings offices, OHA senior staff attorneys were given the authority to issue fully favorable decisions in cases that could be decided without a hearing. At the time, this program was well received by claimants' advocates because it offered an opportunity to present a case and obtain a favorable result in an efficient and prompt manner.

This program did not impair the claimant's right to a hearing before an ALJ. Procedurally, notice of the wholly favorable decision was sent to the claimant who, if he or she made the request, could still proceed with a hearing before an ALJ. If

the senior staff attorney could not issue a wholly favorable decision on the record, the case was sent to the ALJ who then held a hearing.

Of most importance, thousands of claimants benefited from this program. While the program existed, it helped to reduce the backlog by issuing approximately 200,000 decisions. Unfortunately, the initiative was phased out in 2000.

2. Short form favorable decisions

A short form decision will be adopted for favorable decisions and ALJs will be required to use it. The form will meet all regulatory requirements. It is estimated that this initiative could reduce processing times by 15 days.

3. Bench decisions

ALJs would have the discretion to issue bench decisions. Voice recognition software would be part of the process. Processing time could be reduced by 25 days for the case involved and 2–3 days for total processing time.

4. Expand video teleconferencing

The Commissioner has announced her plan to expand the use of video teleconferencing for ALJ hearings. The initiative has the potential to reduce processing times and increase productivity.

Where available, ALJs can conduct hearings without being at the same location as the claimant and representative. Final regulations were issued in February 2003. In general, we support the use of video teleconference hearings, so long as the right to a full and fair hearing is adequately protected and the quality of video teleconference hearings is assured. NOSSCR members who have participated in pilots have reported a mixed experience, depending on the travel benefit for claimants, the quality of the equipment used, and the hearing room set-up.

5. Expand use of speech recognition software

This would be coordinated with the bench decision process.

6. Digital recording of hearings

Digital recording of hearings would result in a higher quality product, fewer lost tapes at the Appeals Council, and the need for less storage space. Currently, hearings are taped on obsolete tape recorders. If copies are needed, they must be transferred to cassette tapes, which is time-consuming. Our members report that tapes are frequently lost at the Appeals Council and federal court levels, resulting in yet more delays for claimants. Further, the quality of tapes is often quite poor because of the antiquated equipment, which also results in remands from the Appeals Council and the federal courts.

Allowing representatives to submit draft favorable decisions. While not part of the short-term initiatives announced in March 2002, we would like the Commissioner to consider allowing representatives, on a nationwide basis, to submit draft favorable decisions to ALJs. Currently in some OHAs, but not on a system wide basis, ALJs ask representatives to draft a favorable decision, which the ALJ then reviews and edits as needed. This process is similar to that used by judges in courts and can expedite the decision-writing process where delays exist.

As an experiment, some OHAs are sharing a decision-drafting software program, the Favorable Electronic Decisional Shell (FEDS), with experienced representatives in the local community. FEDS produces a draft Microsoft Word document for use in favorable disabled adult claims. With appropriate user input, FEDS distinguishes between Title II, Title XVI and concurrent claims and produces suitable language. At the end of the FEDS process, a Word document is produced that can be proofed, edited and assembled in a final product that is suitable for signature by an Administrative Law Judge.

We believe that expanded use of FEDS for submission of draft decisions could reduce the time between the hearing and issuance of the decision, especially since use would be limited to favorable decisions.

HEARINGS PROCESS IMPROVEMENT INITIATIVE

The Hearings Process Improvement Initiative (HPI) was intended to improve the ALJ hearing process for claimants by reducing the time to receive a decision. It was implemented nationwide in November 2000.

After the full implementation, NOSSCR members raised numerous, critical concerns about the current state of affairs in hearing offices around the country. In response to a request from the Office of Hearings and Appeals (OHA) in 2001, we asked the more than 3000 NOSSCR members for information, observations, and suggestions in order to improve the process for claimants. NOSSCR received hundreds of responses from members across the country. While there was some positive

feedback, the overwhelming majority of reports expressed extreme dissatisfaction with HPI.

Clearly, the key concern of our members then, as it is now, was the delay in getting a hearing scheduled, and the delay in receiving a decision after the hearing was held. After HPI was implemented, the average length of time between filing a request for hearing and scheduling the hearing drastically increased. In some cases, claimants waited more than one year just to have a hearing scheduled. Further, because of problems in preparing files for ALJ review, the number of hearings scheduled plummeted. A brief sample of comments from our members describes the impact of delays on their clients. While these refer to the situation in the 2001, the concerns are just as applicable today:

- "My clients are losing their life savings, going without medical treatment and, in some cases, losing their homes." *New York*
- "Clients call me often asking about the status of their claims—Our clients continue to learn a lot about patience and perseverance." *Connecticut*
- "My clients are losing their cars, their homes, their spouses, and their sanity." *Tennessee*
- "The clients don't understand the delays—Despite the fact that these are all TERI [terminally ill] cases, we are running 8–12 months between the request for hearing and the hearing." *California*

An SSA Executive Task Force, established by former Acting Commissioner Massanari to evaluate HPI, provided NOSSCR an opportunity to present the complaints voiced by its members. The main problem areas we identified included:

- Processing times after the Request for Hearing is filed;
- Development of evidence;
- Lack of on-the-record decisions;
- Conduct of hearings; and
- Processing times after the hearing

Specific concerns included duplicate requests for medical evidence; inability to speak to a "point" person on the case; mail not being associated with the file prior to the hearing; organization of files; preparing cases for hearing; and confusion over when a case is ready for hearing.

Some of the recommendations NOSSCR presented to the Task Force included:

- Creating the same claims folder earlier in the process;
- Reinstating senior attorney authority to issue decisions in certain cases;
- Identifying a "point" person who is available to ensure that a case is ready for hearing;
- Better mechanism for review of requests for on-the-record decisions;
- Single requests for information; and
- Advance notice of hearings so that submission of evidence can be targeted.

It previously was announced that the Executive Task Force would issue a final evaluation report on HPI by October 31, 2001. It is our understanding that a report was not issued. However, in 2002, Commissioner Barnhart announced that she was not going to implement HPI. NOSSCR supported this decision.

While NOSSCR supported the goals of HPI, we approached the HPI plan, as we would any plan to change the hearings process, with serious concerns for any violations of a claimant's due process rights to a full and fair hearing, as well as any encroachments on the decisional independence of ALJs.

OTHER ISSUES AT THE OHA LEVEL

Last year, the Commissioner stated that she would be proposing changes to the administrative appeals process. Though not yet announced, a number of proposals to change the disability determination process have been issued. We strongly support efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as these changes do not affect the fairness of proceedings and protect the rights of claimants. In addition to retaining the right to a hearing before an ALJ, there are other concerns that are of critical importance to claimants.

Keep the record open for new evidence. Many of the recent proposals recommend that the record be closed to new evidence after the ALJ hearing level. In the past, similar proposals have been rejected by both SSA and Congress because they are neither beneficial to claimants nor administratively efficient for the agency.

Under current law, new evidence can be submitted to an ALJ and it must be considered in reaching a decision. However, the ability to submit new evidence and have it considered becomes more limited at later levels of appeal.

NOSSCR strongly supports the submission of evidence as early as possible, since it means that a correct decision can be made at the earliest point possible. However, there are many legitimate reasons why evidence is not submitted earlier and thus why closing the record is not beneficial to claimants, including: (1) worsening of the medical condition which forms the basis of the claim; (2) factors outside the claimant's control, such as medical provider delay in sending evidence; and (3) the need to keep the process informal and focused on determining whether the individual is eligible for disability benefits to which he or she is statutorily entitled.

SSA should not be represented at the ALJ level. We do not support proposals to have SSA represented at the hearing level. Past experience, based on a failed project in the 1980's, demonstrated that government representation at the hearing level led to extensive delays and made hearings inappropriately adversarial, formal, and technical. Based on the intended goals of better decision-making and reducing delays, the pilot project was an utter failure.

In addition, the financial costs could be very high. Given the past experience and the high costs, we believe that the limited dollars available to SSA could be put to better use by assuring adequate staffing at the DDSs and OHAs and developing better procedures to obtain evidence.

Thank you for this opportunity to testify before the Subcommittee on issues of critical importance to claimants regarding management of OHA. I would be glad to answer any questions that you have.

Chairman SHAW. Thank you, Mr. Morris. Judge.

STATEMENT OF THE HONORABLE RONALD G. BERNOSKI, PRESIDENT, ASSOCIATION OF ADMINISTRATIVE LAW JUDGES

Mr. BERNOSKI. Thank you, Mr. Chairman. We believe that the Commissioner's statement this morning was positive and constructive, and we will cooperate with her in any way that we can to make the process more efficient for the American people. There has been, Mr. Chairman, a longstanding problem with the relationship of Social Security with the adjudication function in the agency. This problem developed when the policymaking part of the agency started asserting its influence on the adjudication component, which led to conflict. The problem was elevated during the eighties during the Bellman review program, and again appeared when the agency started the new HPI plan without conferring with us or other employee groups in the agency. The chief judge of the agency was also against the adoption of HPI. The HPI has been a failure because it removed the support staff from the judges and placed them in work groups. The judges lost control of their work products. Staff employees were moved from positions they performed well to decision-writing positions that they were not trained or qualified to perform. The hearing offices were placed in a state of confusion. Mail and exhibits were frequently not filed, and files were frequently lost. There has been an elimination of individual responsibility for staff work product, and the quality of the decision writing has declined. As a result of HPI, case backlogs have increased, and employee morale is declining. By the end of 2002, as the Commissioner noted, there was an increase of 191,000 cases waiting to be prepared for judge review; and as the Commissioner also noted, we did a survey of our judges which showed that many of them would have scheduled more hearings if they had had the cases available.

Most of these problems, I want to emphasize, were present in the Milwaukee office, and were highlighted in the articles that ap-

peared in the newspaper. However, despite these problems, the judges have tried to make some changes and have produced large numbers of cases. During the last year, the Social Security judges disposed of about 531,000 cases. This production actually exceeds the projections of the redesign program, which estimated that a judge could produce between 25 to 55 cases a month. At recent meetings with the Associate Commissioner, which you alluded to, with our organization, he stated that the judges were now producing 2.6 cases a day, which, as we indicated, translates to 52 to 65 cases a month. The Commissioner refined these facts during her testimony. I want to bring to your attention, that this production has not been easy in the difficult work environment that has been presented by HPI. Some judges in the Cleveland office tried to improve the system and reduce processing time by using pre-hearing orders to have all of the evidence at the hearing. The agency resisted this effort and has filed insubordination charges against them before the Merit Systems Protection Board. The Association of Administrative Law Judges has been a leader in calling for change. We have met with agency officials, Members of Congress, their staffs, the Social Security Advisory Board, and other groups. Some of the suggestions that we have made included the following—a support staff should be assigned to a particular judge. Each judge must be in charge of their work product. Decision writing must be improved, and each judge should be assigned a clerical worker, a paralegal, and a staff attorney.

I was encouraged to hear that the Commissioner said today that she is going to address these issues as part of her reform program. The change, however, that we believe is essential is that there should be a separation of the adjudication function from the policymaking function of the agency. A separate adjudication agency should be created or, in the alternative, the adjudication function within the agency should be placed under the control of a chief judge who reports directly to the Commissioner. We have presented these reforms to the Committee in some detail in other written statements. One of the tenets of our reform, Mr. Chairman, is increased accountability for the entire system. Accordingly, we have recommended adopting the American Bar Association Code for administrative law judges. This Code provides a standard for maintaining, enforcing, and observing the highest standards of professional conduct. We also believe that the current disciplinary process for the administrative law judges under the Administrative Procedures Act (P.L. 79–404) should continue. In closing, with regard to the Chicago regional office and the newspaper articles that reported the destruction of exhibits in the contracting-out process for the assembly of case files, I think the lesson to be learned from that experience is that this is not a simple task. It cannot be done at minimal occupational levels. There is some skill and some expertise involved in this particular function. The destruction of evidence is not acceptable and could result in serious harm to claimants, as you have stated; and we believe that these charges should be investigated by either the agency or this Subcommittee. Thank you very much.

[The prepared statement of Mr. Bernoski follows:]

Statement of The Honorable Ronald G. Bernoski, President, Association of Administrative Law Judges, and Administrative Law Judge, Office of Hearings and Appeals, Milwaukee, Wisconsin

Mr. Chairman and Members of the Subcommittee:

I. INTRODUCTION

Thank you for the opportunity to testify before you today. My name is Ronald G. Bernoski. I am an Administrative Law Judge ("ALJ") who has been hearing Social Security disability cases at the Office of Hearings and Appeals ("OHA") of the Social Security Administration ("SSA") in Milwaukee, Wisconsin, for over 20 years.

This statement is presented in my capacity as the President of the Association of Administrative Law Judges ("AALJ"), which represents the administrative law judges employed in the SSA OHA and the Department of Health and Human Services ("DHHS"). One of the stated purposes of the AALJ is to promote and preserve full due process hearings in compliance with the Administrative Procedure Act ("APA") for those individuals who seek adjudication of Social Security Act benefits program entitlement disputes within the SSA.

II. THE ROLE OF SSA ADMINISTRATIVE LAW JUDGES

A. The ALJ Function

The hearing system of the SSA is one of the oldest in the Federal system. The Social Security hearings and appeals system started in 1940 with 12 referees and it has grown into the largest institution for the administration of justice in the western world. The first Chairman of the Office of the Appeals Council (now Office of Hearings and Appeals) was the Honorable Joseph E. McElvain. Chairman McElvain was particularly interested in the decisional independence of the referees. In fact, in 1966 he told an interviewer that decisional independence of the Appeals Council had been a concern to him even before he agreed to head the organization. Chairman McElvain went on to tell the interviewer that he continued to protect the independence of the referees, even insisting on completely separate office space for the referees in the Regional Offices.[1]

In 1946, the Congress adopted the APA to ensure that the American people were provided hearings that were not prejudiced by undue agency influence. The securing of fair and competent hearing adjudicators was viewed as the heart of the APA.

The U.S. Supreme Court acknowledged the history and tradition of the Social Security hearing system in the case of *Richardson v. Perales,* 402 U.S. 389, 409 (1971), when the Court stated that:

> We need not decide whether the APA has general application to Social Security disability claims, for the Social Security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act.

In *Universal Camera Corp. v. National Labor Relations Board*, 340 U.S. 474, 495 (1951), the U. S. Supreme Court discussed the impact of the APA on the function of the hearing examiners (now Administrative law judges) as follows:

> Sec. 11 of the Administrative Procedure Act contains detailed provisions designed to maintain high standards of independence and competence in examiners. . . . Both statutes thus evince a purpose to increase the importance of the role of examiners in the administrative process.

In *Butz v. Economou*, 438 U.S. 478, 513–514 (1978), the U.S. Supreme Court defined the function and authority of a Federal ALJ in some detail. The Court described this function as follows:

> There can be little doubt that the role of the modern hearing examiner or administrative law judge within this framework is "functionally comparable' to that of a judge. His powers are often, if not generally, comparable to those of a trial judge. He may issue subpoenas, rule on proffers of evidence, regulate the course of the hearing, and make or recommend decisions. . .More importantly, the process of agency adjudications is currently structured so as to assure that the hearing examiner exercises his independent judgment on the evidence before him, free from pressures by the parties or other officials within the agency. Prior to the Administrative Procedure Act, there was considerable concern that persons hearing administrative cases at the trial level could not exercise inde-

[1] *A Quest For Quality, Speedy Justice,* Department of Health and Human Services, Social Security Administration, (1991, pages 1 and 2).

> pendent judgment because they were required to perform prosecutorial and investigative functions as well as their judicial work . . . and because they were often subordinate to executive officials within the agency. . . . Since the securing of fair and competent hearing personnel was viewed as "the heart of formal administrative adjudication," . . . the Administrative Procedure Act contains a number of provisions designed to guarantee the independence of hearing examiners. They may not perform duties inconsistent with their duties as hearing examiners. . . . When conducting a hearing under the APA, a hearing examiner is not responsible to or subject to the supervision or direction of employees or agents engaged in the performance of investigative or prosecution functions for the agency. . . . Nor may a hearing examiner consult any person or party, including other agency officials, concerning a fact at issue in the hearing, unless on notice and opportunity for all parties to participate. . . . Hearing examiners must be assigned to cases in rotation so far as practicable. . . . They may be removed only for good cause established and determined by the Civil Service Commission after a hearing on the record. . . . Their pay is also controlled by the Civil Service Commission.

The Supreme Court recently reaffirmed its holdings in *Butz* that a Federal ALJ's role is similar to that of a trial judge and that administrative adjudications are similar to judicial proceedings when it held that state sovereign immunity bars the Federal Maritime Commission from adjudicating a private party's complaint against a non-consenting state. *Federal Maritime Commission v. South Carolina State Ports Authority*, 535 U.S. 743, 756–757 (2002).

It was to protect this decisional independence, that Congress established the APA system which kept the ALJs in the agencies as "qualified employees," but then provided them with additional safeguards to protect their judicial independence. Congress did consider establishing a separate corps of ALJs, but instead decided to maintain the ALJs within the agencies. In *Ramspeck v. Federal Trial Examiners Conference*, 345 U.S. 128, 131–32 (footnotes omitted) (1953), the U.S. Supreme Court stated that the Committee recommended that hearing examiners (now administrative law judges) be made partially independent of the agency by which they are employed. The Court stated that:

> Several proposals were considered, and in the final bill Congress provided that hearing examiners should be given independence and tenure within the existing Civil Service system.
>
> Congress intended to make hearing examiners "a special class of semi-independent subordinate hearing officers" by vesting control of their compensation, promotion and tenure in the Civil Service Commission to a much greater extent than in the case of other federal employees.

There is a long history of conflict from SSA management's intrusion of its policy-making function into the adjudication function of the SSA ALJs. In the 1980s, the SSA attempted to assert undue influence on the ALJs to force them to award fewer disability claims. This devastating agency action led to litigation between the AALJ and the agency. This agency policy shows the effect that undue agency influence on decisional independence can have on the American people. In *Association of Administrative Law Judges, Inc. v. Heckler*, 594 F.Supp. 1132 (1984),the Federal District Court Judge stated that:

> In sum, the Court concludes, that defendants' unremitting focus on allowance rates in the individual ALJ portion of the Bellmon Review Program created an untenable atmosphere of tension and unfairness which violated the spirit of the APA, if no specific provision thereof. Defendants' insensitivity to that degree of decisional independence the APA affords to administrative law judges and the injudicious use of phrases such as "targeting", "goals" and "behavior modification" could have tended to corrupt the ability of administrative law judges to exercise that independence in the vital cases that they decide.

The American Bar Association also recognized the valor of the SSA ALJs in resisting agency action and in protecting the Constitutional due process rights of the American people. In 1986, the American Bar Association issued a citation to the SSA ALJs that provided as follows:

> Be It Resolved, the American Bar Association hereby commends the Social Security Administrative Law Judge Corps for its outstanding efforts during the period from 1982 **to** 1984 to protect the integrity of administrative adjudication within their agency, to preserve the public's confidence in the fairness of governmental institutions and to uphold the rule of law.

This citation is an outstanding tribute to the honesty and professionalism of the SSA ALJ corps. It commends the Social Security judges in three areas of distinction; (1) protecting the integrity of the administrative adjudication process in the agency, (2) preserving the public's confidence in the fairness of governmental institutions, and (3) upholding the rule of law. Any of these tributes standing alone merit distinction.

The Congress also has recognized the importance of the ALJ as an independent decision maker in Social Security cases. The Congress has reviewed the function of the ALJ in the SSA. In 1983, a Senate Subcommittee on Oversight of Government Management of the Committee on Governmental Affairs conducted a hearing that inquired into the role of the ALJ in the Title II Social Security Disability Insurance Program. The Committee issued its findings on September 16, 1983, which provided in part as follows:

> The APA mandates that the ALJ be an independent impartial adjudicator in the administrative process and in so doing separates the adjudicative and prosecutorial functions of an agency. The ALJ is the only impartial, independent adjudicator available to the claimant in the administrative process, and the only person who stands between the claimant and the whim of agency bias and policy. If the ALJ is subordinated to the role of a mere employee, and instrument and mouthpiece for the SSA, then we will have returned to the days when the agency was both prosecutor and judge.[2]

The conflict from SSA management's intrusion of its policymaking function into the adjudication process of the SSA ALJs has continued, as is stated below.

B. Recent Abuse of the Merit System Protection Board Disciplinary Process for ALJs by SSA

The law provides that an action may be taken against an ALJ by an agency for good cause established and determined by the Merit Systems Protection Board ("MSPB"). The actions permitted by the law include removal, suspension, reduction in grade, reduction in pay, and furlough for 30 days or less.[3]

We are concerned that the SSA now has adopted a policy to use the disciplinary process of the MSPB as a means to interfere with the legally protected judicial independence of ALJs in the wake of a recent MSPB decision to end an ALJ's right to file a constructive removal complaint with the MSPB pursuant to the APA to redress his or her employing agency's interference with the ALJ's judicial independence that is guaranteed by the APA, unless the interference results in an actual involuntary termination of the ALJ's employment.[4] In the Chicago Region, the agen-

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[2] S. Report 98–111.

[3] 5 U.S.C. § 7521.

[4] A significant means by which the APA provisions for ALJ judicial independence is enforced has been removed by the MSPB in *Tunik v. Social Security Administration*, 2003 MSPB LEXIS 361 (June 27, 2003). In *Tunik*, the MSPB barred an ALJ constructive removal complaint that was brought by an ALJ employed by SSA under 5 U.S.C. § 7521, the removal section of the APA, and 5 C.F.R. § 1201.142 to redress agency interference with the ALJ's judicial independence on the ground that the MSPB has jurisdiction over such a constructive removal action under that statute only when the ALJ is involuntarily separated, and thus "removed," from his ALJ position. Examples given of involuntary separation include a retirement or resignation that was not voluntary.

In this decision, the MSPB expressly overturned its 1985 decision in *In re Doyle*, 29 M.S.P.R. 170. *Doyle* states that an ALJ who still is employed as an ALJ may file a complaint with the MSPB under 5 U.S.C. § 7521 that alleges that his employing agency has interfered with his qualified decisional independence to the extent that the interference constitutes an unauthorized action under 5 U.S.C. § 7521. After issuing *Doyle*, the MSPB promulgated a regulation, 5 C.F.R. 1201.142, that is in accord with the *Doyle* holding. The MSPB states in *Tunik* that *Doyle* and the related regulation permitted an ALJ who still is employed as an ALJ to establish that he has been constructively removed from his ALJ position under 5 U.S.C. § 7521 if his employing agency interferes with his decisional independence by actions such as reassigning some of his work, giving him directions on how his duties should be carried out, seeking to send him to training, or not assigning cases to him that he should have received. The MSPB now states the *Doyle* interpretation of what is a "removal" under 5 U.S.C. § 7521 is incorrect, and that the MSPB will overrule *Doyle* and later issue new regulations to conform to its new interpretation of the statute that is set forth in *Tunik*.

The MSPB's strict construction of the APA removal section eliminates a currently employed ALJ's legal capacity to challenge independence-destroying agency action, such as the agency's changing the ALJ's workload or cases assigned, the agency telling the ALJ how to handle hearings, decide cases, and otherwise do the ALJ's work, and sending the judge to "counseling" or "training" simply because the agency does not like the outcome of the ALJ's cases. In fact, in reliance upon *Tunik*, the MSPB has reopened and dismissed appeals in two other pending SSA ALJ constructive removal cases on the ground that a prerequisite for the MSPB's "jurisdiction over such a removal appeal is that the appellant no longer occupies an ALJ position. In other

cy has filed charges against three ALJs in the Cleveland, Ohio, hearing office for sending pre-hearing orders to claimant representatives requesting that they have the evidence in the case submitted prior to the hearing date. The letter requests the representatives to send the evidence to the group leader. The agency claims that this is an "assignment of work" which is a function that only management personnel can perform. The Regional Chief ALJ ordered the judges to stop sending these letters which has lead to a charge of insubordination and a request for a 15 day suspension from duty. This action will have a "chilling effect" on judicial independence. It is of even greater concern because the orders are consistent with the directions of the SSA OHA Associate Commissioner to use pre-hearing orders to aid in having cases ready to decide at the close of the hearings.

The SSA ALJs have devoted their professional careers to providing full and fair hearings for the American people, as required by the Constitution and the APA. The SSA ALJs have a rich and proud history dedicated to protecting the rights of the American people. As the foregoing shows, this feat has not been accomplished without personal risk to the ALJs, including threats of discipline. These actions by the SSA ALJs show that judicial independence is for the protection of the American people and not for the protection of the judge.

C. SSA ALJ Productivity

1. Using Agency Data, Overall ALJ Productivity Is at a Record High Level

ALJs in the SSA have responded to the expectations of the Congress and have worked hard to protect the rights of the American people by providing them with full and fair hearings for benefits claims arising under the Social Security Act. During fiscal year 2002, the approximately 1,150 to 1,200 ALJs of the SSA issued about 531,000 cases.[5] This is more cases than any other administrative judicial system in the world.

At recent meetings with representatives of the AALJ, the Associate Commissioner of OHA stated that the ALJs of the agency were issuing case dispositions at the rate of 2.6 cases per judge per day (or 52.0 to 65.0 cases on a monthly basis), which he characterized as a "record high level of productivity."

This level of case dispositions is at the high end or exceeds agency expectations. During the 1990's, the agency worked on developing a plan for a new disability process which became known as "Redesign." As part of this plan, a timeline or benchmark criteria was created for the times required to complete the various parts of the disability process. Based on this criterion, the SSA concluded that an ALJ can reasonably produce between 24.7 to 54.5 cases a month.[6] Present overall ALJ productivity of 52.0 to 65.0 cases per month (depending on if it is a four or five week month) is at the high end or exceeds this agency benchmark.

2. The Agency Formula for Calculating ALJ Productivity Understates ALJ Productivity

The disposition productivity index for ALJs should be the ratio of total dispositions divided by actual time the ALJ is at work. This is the formula that the agency uses to calculate the productivity index for Senior Attorneys and decision writers.[7] Each hour a Senior Attorney or decision writer is absent from duty due to "leave, holiday, or compensatory time" is deducted from availability. However, with regard to ALJs, the agency understates ALJ productivity by using a different formula that significantly overstates ALJs' actual time at work. Unlike any other SSA OHA employee, an ALJ must be absent for many days during a month before there is any reduction in the time that the ALJ is considered to be at work.[8] This results in an understatement of the ALJ's productivity. Congress should require the agency to justify its method of calculating ALJ productivity.

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words, the [MSPB] has jurisdiction over a complaint filed by an ALJ . . . only if the agency has separated or reassigned an ALJ from his position as an ALJ, or the ALJ establishes that a separation which he requested, such as a resignation, was actually involuntary and thus should be treated as a removal." *Dethloff, et al. v. Social Security Administration*, 2003 MSPB LEXIS 411 (July 28, 2003); *Schloss v. Social Security Administration*, 2003 MSPB LEXIS 423 (July 28, 2003).

[5] Memorandum, From Associate Commissioner A. Jacy Thurmond, Jr., dated October 1, 2002.

[6] *Plan for a New Disability Claim Process,* Social Security Administration, September 1994.

[7] *Hearing Office Tracking System (HOTS) Report Manual, Section C—Monthly Activity Report* 20, 29 (MARS INSTRUCTIONS—SEPTEMBER 2000*) hereinafter MARS.*

[8] *MARS at* 3.

3. The OHA Associate Commissioner Agrees that Productivity of Individual ALJs cannot be Compared to Each Other

On April 29, 2003, the OHA Associate Commissioner issued a memorandum to all OHA employees, the purpose of which was to clarify information that the agency recently had released in response to a FOIA request for certain "ALJ-specific information." The memorandum contained an attachment which responded to the question of "why numbers of hearing decisions and allowance rates sometimes vary by administrative law judge." The Associate Commissioner explained:

Why Numbers of Hearing Decisions and Allowance Rates Sometimes Vary By Administrative Law Judge

Attached are the decisional outcomes for the administrative law judges (ALJ) covered by your FOIA request. When reviewing the data, one must be careful to avoid misinterpretation. For example: There are significant differences in the number of cases decided by each ALJ during fiscal year (FY) 2002. A simple comparison of these totals can be misleading. Some of these Judges did not work on cases fulltime for the entire FY. For example, some served on details for part of the year; others were not on duty for the full year. Still others are management administrative law judges not expected to carry full dockets. There is also a large Medicare workload not included in these numbers which may have fallen more heavily on some Judges.

All Administrative law judges do not allow, deny or dismiss the same percentage of cases. That such variance exists should not be surprising given the many factors at play in the hearing process. Examples include:

- The ALJs who serve as Hearing Office Chief Judges sometimes handle a large portion of the dismissal workload, particularly those that involve late filing.
- Depending upon the types of cases worked, these differences could either increase or decrease individual allowance rates. Factors such as the age of claimants, their education and work history, and the nature of their impairments can affect outcomes.
- The demographics of different regions play a part in the "mix" of cases, and thus the allowance/denial/dismissal rates vary from region to region.
- To expedite the hearing process, some Judges are involved in Agency initiatives identifying cases that can be paid without a hearing. Decisions on a large number of those cases will increase a given Judge's allowance rate.
- ALJs are independent decision-makers. They cannot be influenced by the Agency into issuing specific decision (i.e., favorable or unfavorable). A part of the variation seen here is evidence of that independence.
- When issuing decisions, Judges rely on SSA law, regulations and rulings. However, they are also influenced by case law, which can and does vary among the judicial circuits.[9]

D. Other Needs to Ensure that the American Public Receives Timely and High Quality Hearings and Decisions from SSA ALJs

1. The Need to Adopt the ABA Model Code of Judicial Conduct for Federal Administrative Law Judges

We recognize that judicial independence of ALJs is for the protection of the American public and not for the protection of the judges. We have long requested the agency to join with us in an effort to adopt the American Bar Association *Model Code of Judicial Conduct for Federal Administrative Law Judges.* The Code covers the professional conduct of ALJs. The goal of the Code is to provide for an independent and responsive administrative judiciary that is indispensable to justice in our society. It provides that ALJs should participate in establishing, maintaining, enforcing, and observing the highest standards of conduct so that the integrity and independence of the administrative judiciary may be preserved.[10] We believe that the Code should be made applicable to all ALJs in the Federal service.

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[9] Memorandum, To All OHA employees, From A. Jacy Thurmond, Jr., Associate Commissioner, Office of Hearings and Appeals, Social Security Administration, dated April 29, 2003, Refer to: 73–300–4410.

[10] American Bar Association, *Model Code of Judicial Conduct for Federal Administrative Law Judges*, February, 1989.

2. The Need for Judicial Deliberativeness

According to information published in *The OHA Law Journal*, a Social Security Disability case is valued at about $200,000.[11] We suggest that it is not too much to allow a judge to spend on the average of four hours of work time on a case that could cost the Social Security trust fund $200,000 or more.

3. The Need for a Permanent Chief Administrative Law Judge

We have been without a Chief ALJ for over two years and in the last ten years we have had a permanent Chief Judge for only half of the time. This professional leadership is necessary to provide national guidance and policy for ALJ adjudication function of the agency. The Chief ALJ is a vital component of the agency and is responsible for all field adjudication operations.

4. The Need for the Agency to Access the ALJs as a Resource for Improvements of the Adjudication Process

The ALJs are a valuable resource for the agency and are employed after a rigorous merit-based civil service selection process. Our ALJs have a broad range of legal, judicial and other leadership experience upon which the agency can draw for suggestions to improve the adjudication process. The AALJ stands ready to work with the Commissioner on improving the hearing process for the benefit of the American people.

III. THE MILWAUKEE HEARING OFFICE

Recent articles have appeared in a local newspaper in the city of Milwaukee that reported "wide-ranging mismanagement at the Milwaukee office." The articles reported problems in the office which include hundreds of backlogged cases, more than 700 pieces of unopened mail, delay, mail not filed, a chaotic work environment, unprocessed mail, and medical exhibits not filed. The problems described in the Milwaukee office are generally correct. However, according to the information that we have received from our judges, these same problems are present to a greater or lesser extent in many other Social Security hearing offices. It also is clear that the problems in the Milwaukee hearing office are not directly related to the employees in the office, but instead are directly related to the agency reform plan known as *the Hearing Office Improvement Plan* ("HPI"). HPI was implemented without meaningful consultation with the AALJ by the agency in January 2000. The goal of HPI was to (1) reduce processing times; (2) improve quality and productivity; (3) promote individualized case management; and (4) increase employee job satisfaction.[12] The "key element of the HPI process was the creation of "processing groups." This change removed the support staff from the ALJs and placed them in several small teams under the control of management personnel. The plan also resulted in many support staff employees being moved from positions that they could perform very well to decision writer positions that they were not qualified to perform. The result has been devastating. The hearing offices have been placed in a state of confusion, mail has been frequently lost or not filed, hearing exhibits frequently have been misplaced and often are not included in the hearing exhibit file, sufficient cases have not been prepared for administrative law judge hearings, and the quality of the decision writing has substantially declined and in many cases is not legally sufficient at a minimum level. The judges have no assigned staff. No particular staff person is dedicated to work on the work product of a particular judge. The result has been the elimination of individual responsibility for staff work product and the creation of general office confusion and employee despair. The HPI experiment has been a failure and it has not accomplished any of its intended goals. Processing times are increasing, quality and productivity is declining, individual responsibility for staff work product has been eliminated, and employee morale has substantially declined. Reports and studies by the SSA Office of the Inspector General, SSA Office of Workforce Analysis, and United States General Accounting Office all have been critical of HPI.

Additional problems in the Milwaukee hearing office relate to the fact that the office is authorized to have approximately 14 ALJs and 10 ALJs are currently assigned to the office. The office is authorized to have about 50 support staff employees (including management) and 43 support staff employees are currently assigned to the office. During the last year, 7 support staff employees have left the office and no new employees have been hired to fill these vacancies. The Milwaukee hearing

[11] *The OHA Law Journal*, The Social Security Administration, The Office of Hearings and Appeals, Vol.5/No.1, Appellate Administrative: A Comparative Survey, Winter 1995, page 12.

[12] The *New Hearing Office Process Hearings Process Improvement Plan*, October 21, 1999, page 1.

office has a satellite office in Madison, Wisconsin, which is authorized to have 2 ALJs and 8 support staff employees. The service area for the Milwaukee hearing office includes most of the State of Wisconsin and most of the Upper Peninsula of Michigan.

The agency long has encouraged us to "do more with less," but any organization or system will show severe signs of stress when it reaches its culmination point. Therefore, we strongly recommend that the problems caused by HPI be immediately addressed by this Subcommittee and the agency. The ALJs should be placed in control of their work products with dedicated support staff assigned to work on the work product of each ALJ. The hearing offices should be brought to full authorized staffing levels and the quality of decision writing must be improved by hiring more attorney writers. As is stated below, the adjudication function of the SSA should be removed from the agency or placed in a separate organization under the operational control of a chief judge who reports directly to the Commissioner. Also as is stated below, the Appeals Council should be replaced with local panels ofthree ALJs modeled after the existing Bankruptcy Court system.

IV. CHICAGO REGIONAL OFFICE

Recent articles in a local Milwaukee newspaper reported that SSA supervisors in the Chicago Regional Office told contract workers to "throw away documents" from the files of people seeking disability benefits. The AALJ has no first hand knowledge of the reported problems in the Chicago Regional Office and we first learned of this situation in the newspaper articles.

However, the reported problem in the Chicago Regional Office does raise caution signs for the "contracting out" of Social Security disability case file exhibit preparation (known as "pulling"). This reported problem clearly shows that it is not practical to use untrained contract workers, paid at a minimum level, to assemble hearing exhibit records for disability cases. It has been reported that the contracted workers were making decisions on which exhibits to include in the exhibit record and then destroying the excluded documents. This is extremely troubling, because in a regular hearing or trial setting a record is made in the form of an "offer of proof" for any document that is offered but not received into evidence. This record later can be reviewed on appeal and any error can be corrected. However, if the rejected document is destroyed, there can be no review of the action and any error can not be subsequently corrected. This destruction policy is more problematic if the destroyed document is the only copy of the document preventing replacement. This action could cause permanent damage for the Social Security claimant if the destroyed document can not be replaced.

Therefore, the AALJ recommends that a complete review be conducted by this Subcommittee and the agency of the program for "contracting out" of the exhibit record assembly for Social Security disability cases before permanent damage is caused to the American people.

V. STRATEGIES TO REDUCE CASE PROCESSING TIME AND INCREASE QUALITY OF SERVICE AT OHA WHILE PRESERVING DUE PROCESS

On numerous occasions during the past several years, the AALJ has advised both the agency and the several Congressional Subcommittees of the problems resulting from HPI. We repeatedly have advised the agency of the disruption to the hearing process caused by lost files, exhibits not being filed in case files, judges being assisted by inadequately trained support staff, poor quality decision writing, lost hearing files, insufficient number of cases pulled for judges to schedule for hearing, judges spending more time on clerical tasks (filing exhibits, "pulling" case files, etc.), judges not having assigned staff to work on their work products, judges spending more time reviewing and rewriting decisions, lack of a stated person for the claimants to contact on a claim, and general office confusion. On June 20, 2002, the AALJ appeared before this Subcommittee and presented both oral and written statements for the record.[13] In part, the AALJ suggested reforms for the Social Security hearing process as follows:

Needed Reforms for the SSA Hearing Process: Because of the failure of HPI, SSA should reorganize the hearing office process. The reorganization should correct the defects in HPI. We propose that the recommendations of the Commissioner's HPI Steering Committee be used as a guide for the reorganization. The reorganization should consist of both short term and long term changes. The short term changes should be structured in a manner that permits easy transition to the long

[13] United States House of Representatives, Committee on Ways and Means, Subcommittee on Social Security, Hearing on the *Social Security Disability Programs' Challenges and Opportunities*, June 20, 2002.

term reforms. The objective should be to immediately return to the efficiency and level of case production that existed in the hearing offices immediately before the introduction of HPI (over 500,000 cases a year). The long term reform should then build on that base. There is no single change that will accomplish this objective. It instead must be accomplished by a series of coordinated changes in several different areas. The changes will allow the agency to improve the service provided to the American public.

1. **Short term recommendations:** We recommend that the short term changes should include the following elements:

   (a) The process must be simple, and ALJs should be assigned to cases from master docket according to law.
   (b) Each ALJ should have adequate and properly trained support staff. The support staff should include a clerical worker, paralegal and attorney/writer.
   (c) The support staff should be assigned to perform the work product of a particular ALJ according to the instructions and guidance of the judge.
   (d) The ALJ should have control of all case development.
   (e) The ALJ should have the responsibility to determine when a case decision is legally sufficient and the judge should have the authority to return the decision for rewrite to achieve the same.
   (f) Case files of each ALJ should be maintained separately.
   (g) The assigned support staff of each ALJ should be under the supervision of the hearing office management staff for personnel actions.
   (h) Staff members should be accountable for their work product. Case work should be assigned on an individual basis to support staff to provide for accountability and enhance the employees' sense of ownership.

2. **Long term recommendations:** We recommend that the long term changes should include the following elements:

   (a) Close the hearing record after the ALJ hearing as of the date of the ALJ's decision.
   (b) Assignment of SSA representatives to represent the agency at administrative hearings. Such representatives would be responsible to defend the position of the agency at the hearing, recommend favorable cases, exercise settlement authority, and assist unrepresented claimants. When most claimants were unrepresented, having a non-adversarial process made sense to keep the benefits process simple and not intimidating. However, now, approximately 82% of the claimants who have an ALJ hearing are represented, according to recent statistics assembled by the SSA OHA Office of the Chief ALJ.
   (c) Create a case manager and law clerk position for the support staff of each ALJ (as recommended by the Commissioner's HPI Steering Committee).
   (d) Allow ALJs to issue bench decisions and short form decisions.
   (e) Adopt regulations for issue exhaustion as suggested by the United States Supreme Court in the case of *Sims v. Apfel*, 530 U.S. 103 (2000), if SSA representatives are available to assist the unrepresented claimants.
   (f) Reform the Appeals Council to issue decisions in some cases, limit the scope of appeal for claimants who have received the requested relief from the ALJs, and support the ALJ in "no-show" dismissals.
   (g) Implement a sustainable agency policy on the issue of pain and the treating physician rule and defend the same if challenged.
   (h) Require the DDS to follow the same legal standard as the ALJs when determining disability, which is based upon the Social Security Act, the SSA regulations and rulings, and the federal case law that interpret them.
   (i) Improve the use of technology in the hearing process (i.e. an improved case processing and management system, an electronic file, voice to print software, improved equipment for recording hearings, etc., most of which already is in the planning and pilot stages).
   (j) Adopt a policy to implement training to improve the quality of the decision writing work product to meet the expectations of the federal courts and to restore the confidence of the federal courts in the Commissioner's decisions.

(k) Adopt rules of procedure for the hearing process. (The SSA/AALJ Joint Rules Committee recently completed proposed rules of procedure that have been submitted to the OHA Associate Commissioner for the agency to consider promulgating as SSA regulations.)

(l) **Reorganize the Office of Hearings and Appeals:** Congress has expressed frustration for decades with the intractable problems that SSA has had in managing the OHA adjudication function. AALJ believes that the chronic mismanagement of OHA is a result of the conflict inherent in having the managers who are responsible for the policymaking function of the SSA programs also be responsible for the appellate adjudication function that determines the correctness of the managers' initial decisions of who is eligible for benefits. Consistent with the APA, which mandates a separation of the policymaking and adjudication functions of the agency, the AALJ recommendsthat the Congress reform the hearing system by creating a separate organization either within the SSA or separate from the SSA for the final adjudication of all benefits claims arising under the Social Security Act.

The new organization would be under the operational control of a chief ALJ. The final administrative adjudication step that now is performed by the Appeals Council would be replaced by numerous regional panels of three ALJs. The appellate recommendation is modeled on the Bankruptcy Court appellate panel system, which has been working well. Based upon the Bankruptcy Court experience, the appellate panel model (1) is an appellate system that can handle a large caseload, unlike a small body like the Appeals Council, (2) results in higher quality decisions because of expertise, (3) results in substantially fewer appeals to the courts and a substantially lower reversal rate by the courts because of the confidence in the high quality of the decisions, which reflects a higher degree of decision accuracy, (4) results in a substantially reduced federal court caseload, (5) results in a shorter disposition time because the large pool of over 1,000 ALJs permits the timely determination of appeals that cannot take place with a small body such as the Appeals Council or a Commission, and (6) affords the claimants access to a local appellate process.[14] The details of this recommendation were presented to this Subcommittee in both oral and written testimony during a hearing conducted on June 28, 2001.[15] A copy of AALJ's full Report and Recommendations for the Transfer of the Authority to Make Final Administrative Adjudications of Social Security Act Benefits Claims from the Social Security Administration to a New Independent Adjudication Agency accompanies this statement as an exhibit.

Chairman SHAW. Thank you, Judge. Mr. Skwierczynski, if you had one more letter in your name, it wouldn't have fit on your nameplate.

STATEMENT OF WITOLD SKWIERCZYNSKI, SPOKESPERSON, SOCIAL SECURITY GENERAL COMMITTEE, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. SKWIERCZYNSKI. That is a common problem that I run into. Thank you, Chairman Shaw, for the opportunity to testify at this hearing. My name is Witold Skwierczynski. I am with the American Federation of Government Employees. It is the union that represents the bulk of the Social Security bargaining unit em-

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[14] Thalia L. Downing Carroll, *Why Practicality Should Trump Technicality: A Brief Argument for the Precedential Value of Bankruptcy Appellate Panel* Decisions, 33 Creighton L. Rev. 565 (2000); Hon. Barbara B. Crabb, *In Defense of Direct Appeals*, 71 Am. Bankr. L.J. 137 (1997); Tisha Morris, *The Establishment of Bankruptcy Panels Under the Bankruptcy Reform Act of 1994: Historical Background and Sixth Circuit Analysis*, 26 U. Memphis L. Rev. 1501 (1996); Thomas A. Wiseman, Jr., *The Case Against Bankruptcy Appellate Panels*, 4 Geo. Mason L. Rev. 1 (1995).

[15] United States House of Representatives, Committee on Ways and Means, Subcommittee on Social Security, Hearing on June 28, 2001.

ployees, about 50,000 of them. We work in OHA offices, field offices, program service centers, headquarters, data operations center, and program integrity. We do represent about 5,000 people in OHA. I would like to comment on the Commissioner's presentation. It is interesting that she presented this new disability idea of hers here at this hearing. Despite her statements, she has made no effort to communicate with the union prior to this time to solicit our ideas and our proposals with regards to what would cure the problems in the disability program in Social Security, and she also hasn't discussed this with our employees. The plan that she has laid out is a plan that was put together by a very few high-level people after she consulted basically with managers around the country. So, we haven't had an opportunity to see it or hear about it or know anything about it, but this approach of decisionmaking is similar to what happened with HPI, and this is the kind of approach that makes things fail within the agency. The HPI was put together by a small group of people, no bargaining unit people. It was implemented. Employees were sort of forced to buy into it, and they didn't. Unless the Commissioner changes her approach with the union at this time, she is going to run into this same problem, because you are talking about some very radical changes, just from listening to her, that will affect people's jobs and entire components.

We would hope that she would be more open in the future with us and bring us into the process so that any changes that are made to improve the disability process would have employee buy-in. Claimants—and just some reactions to some of her proposals. Claimants, as was evidenced in the Disability Claim Manager project, want to deal with a decisionmaker. They want a caseworker approach. They want to deal with the person who is going to make a decision on their disability claim. The Commissioner's proposal lacks that. There is a hand-off to some person on supposedly cases that are easily determined where people are obviously disabled. There is a hand-off to another person in a regional office setting. Right now, our claims representatives can make presumptive disability decisions on obvious disabilities, effectuate payment, send it to the State disability determination service for an actual decision; and the person gets paid quickly. That could be expanded so that the initial person that a claimant deals with, the claims representative, can have an expanded number of so-called obvious disabilities where they can make decisions. I think also her solution to the hearing backlog situation is—and I think you are going to have to look at this very closely—is certainly you can cut the processing time if you eliminate appellate steps. What the Commissioner is proposing is to eliminate the five appellate steps she sliced in two, the reconsideration and the Appeals Council. By doing that, you are going to flood, literally, the hearings office with appeals, because there will be no reconsideration step that will eliminate a chunk of those cases; and you are going to flood the courts with appeals on the back end by not having an Appeals Council. She even said there was a 28 percent number of cases that are remanded or reversed by the Appeals Council.

Now if that is the last step of the appeals procedure, anyone who can't find an attorney is in trouble because—can't afford an attor-

ney is in trouble—because they are not going to have the ability to have a non-judicial step of further appeal, and it appears about over a quarter of those are either sent back or reversed. So, you need to look at that. The linchpin to the proposal, which would be the computer system, is not working now at the initial step. When somebody comes in and files a claim on Electronic Disability, on the new Electronic Disability Collect System, interviews are taking 45 minutes longer. No staff has been provided for field office employees to take into account that extra workload. There is a big, huge, additional workload up on the front end because of this computer system, because what it does is it eliminates self help. The claimants before would fill out the form, and we would sort of fill in the blanks. Now every claim we have to type in the entire thing. It takes 45 minutes longer per claim. The agency has made no staffing consideration for that. Our people in the field offices, our employees are dying because they are expected to pump out the same amount of work, and it is taking longer. The adjudication officer position I wanted to point out I think, which was piloted which was a step before—between the reconsideration and the administrative law judge, when that was piloted back between 1997 and 1999, those adjudicative officers were able to make favorable decisions on 17 percent of all hearings that were filed, and that cut the workload back down to the judges, and they also worked—met with claimants and attorneys to explain the process. They secured additional evidence. A part of their job was to narrow the issues of the case. They prepared stipulations which would be used at the hearing, and they made favorable decisions on the record where the evidence warranted. I think that is the answer.

[The prepared statement of Mr. Skwierczynski follows:]

Statement of Witold Skwierczynski, Spokesperson, American Federation of Government Employees (AFGE), Social Security General Committee, and President, AFGE Council 220, National Council of SSA Field Operation Locals, Baltimore, Maryland

Chairman Shaw, Ranking Member Matsui, and members of the Social Security Subcommittee, I thank you for the opportunity to present this testimony regarding the Social Security Administration's Management of the Office of Hearings and Appeals (OHA).

As the Spokesperson of AFGE Social Security General Committee, I speak on behalf of approximately 50,000 Social Security Administration (SSA) employees in over 1500 facilities. These employees work in Field Offices, Program Service Centers, Teleservice Centers, Regional Offices of Quality Assurance, Offices of Hearings & Appeals, and Regional offices, Headquarters offices, the Wilkes-Barre Data Operations Center, and other facilities throughout the country where retirement and disability benefit applications and appeal requests are received, processed, and reviewed.

I regret that James Marshall, the President of the AFGE Office of Hearings and Appeals Council, could not be here today to assist with AFGE's testimony. However, Mr. Marshall will submit a statement for the record and I would encourage each member, after reading his statement, to contact him about these important issues. Notwithstanding his AFGE leadership role, Mr. Marshall has 45 years experience with the Social Security Administration and OHA.

HEARING PROCESS IMPROVEMENT INITIATIVE ("HPI")

As verified in GAO's report of February 2002, entitled "Social Security Disability-Disappointing Results From SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Action,"[1] this initiative was implemented nationwide in 2000.

[1] GAO Report 02–322, dated February 2002, "Social Security Disability-Disappointing Results From SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Action."

This was done without any testing or piloting by SSA. The changes through this initiative were expected to reduce the time it takes to process cases, increase productivity and enhance the quality of service proved to customers.

HPI has failed to meet any of its objectives. The initiative has failed to improve the timeliness of decisions of appeals. Instead, it has slowed processing in hearings offices from 318 days to 341[2] days. As a result, the backlog of cases waiting to be processed has reached an all time high of more than 580,000 cases and may exceed 600,000 by the end of the fiscal year. This is a sixty percent (60%) increase in pending claims than just 10 years ago. Unfortunately, OHA has not had a 60% increase in staff to keep up with the workloads. In addition, productivity has not increased. Delays in decisions have resulted in diminished customer service.

Additionally, the HPI failed because of Agency decisions in not recognizing the need to include OHA's employees and AFGE leaders as continuing key stakeholders in the process. HPI was designed by a committee composed of managers who had no recent experience in processing the hearings workload. Neither AFGE nor bargaining unit employees were consulted by the management committee prior to the decision to implement HPI. If the Agency wants to move forward to eliminate the longstanding problems in not providing and accurate service to the individuals with disabilities, it must recognize that AFGE leaders and the long term dedicated OHA employees have the insight and knowledge to improve service delivery to the claimants that they service. They should be included in meetings to discuss the continuing problems and their resolution at OHA.

President Marshall has on many occasions requested Agency officials to meet with him to discuss the failures of the HPI and ways to improve it. SSA has refused to meet with him. The Union does not understand why the Commissioner and her deputies refuse to meet with AFGE leaders to discuss ways to improve the disability process at OHA, increase morale of employees, and address the processing problems that occur within hearing offices to negate timely processing of disability claims. I submit Chairman Shaw and members of the Subcommittee that such a lack of effort by the leadership of this Agency is not conducive to creating a workable improved hearing process which will benefit disability applicants.

The Union and management organizations, which represent all of the employees of SSA have been on record with this Subcommittee for more than 3 years, regarding the failure of the Hearing Process Improvement Initiative ("HPI"). Our participation in this discussion in years past was not to use these hearings to attack or insult SSA's Commissioner, but to shed light on a bad investment of Social Security Trust Fund dollars. As stated many times before, AFGE is committed to serve, as not only the employees' advocate, but also a watchdog for clients, for taxpayers, and for their elected representatives.

Let me be clear, AFGE continues to be committed to working with Commissioner Barnhart regarding these complex issues, as well as other issues that affect SSA's ability to provide expeditious, high quality service.

Recommendations:

1. While it is the Union's understanding that SSA is now considering new initiatives for the OHA hearing process, it is imperative that AFGE leaders and OHA employees be afforded pre-decisional input. We believe that this would eliminate a repeat of the HPI debacle and a further waste of Trust Fund dollars.
2. We strongly urge this Subcommittee and SSA to reconsider the following recommendations by the Social Security Advisory Board made in February 2001:
   a. Provide SSA the necessary additional resources that are critically necessary to properly administer SSA's disability programs.
   b. Reconsider federalizing the disability determination process.
   c. Reconsider giving field offices increased responsibility for taking disability claims.
3. We strongly encourage that this Subcommittee, Commissioner Barnhart and President Bush request the additional staff needed to address the many problems that plague SSA disability programs. SSA's Management Association has advocated the need for 5000 FTE's for more than 3 years. It is AFGE's belief that 5000 FTE's would barely meet the needs of the field offices in processing disability claims. Thenew Electronic Disability Claims System (EDCS) has increased initial claims interview time by about 45 minutes. No staff has been provided for this additional work.

[2] OHA Key Workload Indicator Quarterly Report of June 2003.

With increasing workloads caused by disabled and retiring baby boomers, legislative changes (i.e. Ticket to Work) and morale responsibility (i.e. Special T2 Disability Workload), even more than 5000 FTEs will be needed for all components, including OHA, to process increasing disability workloads.

ADJUDICATIVE OFFICER

It is unfortunate that *SSA's Plan For A New Disability Claims Process*, that was issued in September 1994, has been discarded by the Agency despite extensive piloting which indicated that various aspects of this plan resulted in faster and more accurate disability decisions. The Disability Claims Manager (DCM) position of the 1994 plan was tested for over 3 years and dumped by SSA despite the fact that processing time for disability claims in the pilot offices was reduced to half (61 days) of the Agency goal of 120 days. Productivity, accuracy and cost were equal to or less than the current process. Why would SSA discontinue the DCM when it was a proven success story that received many accolades from disability claimants.

Another portion of the 1994 Disability Plan included the establishment of the Adjudicative Officer (AO) position. This position was established to expedite processing of Hearings requests on denied disability claims. The AO provided claimants and/or their representatives with an explanation of the hearings process. The AO also was responsible for obtaining new evidence and for attempts to narrow the issues in the claim to optimize the possibilities for an expeditious and focused hearing. The AO was responsible for fully developing the record in preparation of the hearing. The AO also had the authority to issue favorable decisions before the hearing, if supported by the evidence of record. The AO could be either a federal or state employee and, in fact, was located in Disability Determination Service (DDS) offices, Administrative Law Judge (ALJ) Hearing offices, SSA Field Office and Program Service Centers. By locating the position in multiple locations, the Agency insured the public more accessibility and individualized service in processing there hearing requests. In addition, by situating AO's away from hearing offices, SSA was separating these employees from the bureaucratic OHA management structure.

Although SSA never released any valid pilot results for the AO, preliminary data indicated that the AO's were able to issue favorable decisions in seventeen percent (17%) of the hearings cases. These cases were decided based on the evidence of record and did not require hearings before an ALJ. For the remaining cases, the preliminary data indicated that AO's did a good job of fully developing the record and preparing the case for hearing.

Many hearings offices reported that the AOs work resulted in significant time savings in cases decided by an ALJ. The preliminary data indicated that the quality of the AO was approaching that of the ALJ's midway through the pilot.

Unfortunately, SSA abolished the AO position in March 1999 despite the fact that AO's were responsible for quicker decisions for some applicants and a streamlined, efficient, expedition hearing for others. The Union suspects that management resistance to their disability improvement was centered on OHA bureaucratic flaws of losing institutional control of a position of the hearings process. (I.e. AOs' could be located in the DDS, field offices, PSC's or OHA offices.)

Recommendations:

1. AFGE urges Congress to request final pilot results and evaluation of the AO from SSA.
2. AFGE strongly urges Congress and Commissioner Barnhart to reinstitute the AO which results in quicker hearing decisions and a streamline process.

PRIVATE CONTRACTORS HIRED BY SSA

AFGE is encouraged by the Subcommittee's willingness to look at the recent issue involving a private contractor hired by SSA/OHA officials in the Chicago Region. However, this incident is just one of many problems that SSA has had with contractors.

The Subcommittee should be very concerned with the serious issues that surround these events. Identity theft, privacy act violations, and other fraud, waste and abuse are some alarming possibilities. Contracting out tasks has long been used by some governmental agencies. However, contracting out for an electrician or a plumber is not the same as contracting out sensitive aspects of the Social Security claims process. President Bush's demands that all Agencies establish contracting out quotas has forced SSA to utilize contracting out for functions which potentially expose beneficiary privacy and expose SSA customers to possible identity theft.

The recent incident highlighted many of these very issues. For example:

- Sensitive medical evidence was improperly disposed of by contract employees. Much of the evidence was considered "key" to the claimant's claim for disability benefits. This not only may have violated the privacy of the individual, but would require the agency to reconstruct the file. Such reconstruction will delay the hearing and cause additional staff and time expenditures for duplicating medical records.
- Each page of medical evidence would have contained the claimant's Social Security number (SSN) with other identifying information. This would only promote unnecessary and otherwise preventable identity theft.
- The appeals process was undermined and/or corrupted. Each case may likely require a new hearing and/or decision to ensure that each claimant was properly afforded their appeal rights.
- Efforts to recover medical evidence for approximately 570 cases required OHA employees to sort through hundreds of pieces of paper after the situation was discovered in May. Therefore, abandoning their regular work assignments.
- Although agency officials reported the original number of cases was a mere 109, it was confirmed that medical evidence was recovered for 570 cases. The contractor had handled approximately 1200 cases for that servicing area. OHA employees informed management officials as early as February 2003 that documentation was missing from files handled by contract employees. No action was taken until May 2003.
- Contract employees were allowed to remove claimant's medical files from the OHA offices and do assembly work at home. Documents discarded by contract employees at home may have been done in a manner that compromises medical information and SSNs.

Prior to the media exposing this problem, employees were directed to not disclose the Chicago incident. Subsequent to the press disclosure of the improper disposal of medical records by contractors, employees in other OHA offices have reported that files handled by contractors are incomplete. Also the Union has received numerous reports of poor work by contractors, file assemblers, which required SSA OHA employees to reassemble files. In some cases, complete files have been lost and reconstruction of the files is necessary.

As previously stated, this is not the first time that SSA has experienced problems with contractors. On these occasions, contractors have sent the Personal Earnings and Benefit Estimate Statements (PEBES) to many incorrect addresses. Contractors have sent notices of appeal rights to claimants weeks late, adversely affecting their appeal rights. The Union has discovered that contractors have sent formal SSA notices to the wrong addresses. Such errors have resulted in improper disclosing privacy act information.

When SSA's services are contracted out, accountability is often weakened. Many contractors subcontract. SSA exercises little to no oversight over subcontractors. In the past when subcontracted services have been discovered, the Agency must address theirconcerns or problems with the contractor rather than directly with the subcontractor. It is not unusual to discover many layers of subcontracting as a result of one government contract. Unfortunately, it is difficult to adequately scrutinize subcontractor performance. When citizens complain about services that have been contracted out, SSA can do very little until it's too late. It is difficult for SSA to remedy substandard contractor or subcontractor performance.

Unfortunately, SSA does not have a systematic approach for scrutinizing contractor performance. It is even more alarming that neither GAO nor SSA review maintenance and security of SSN and other personal information that may violate the privacy of our SSA claimants. **The information SSA stores on each of us is personal and *is* entitled maximum protection.** Documents and records that contain personal and/or identifying information of a taxpayer or a member of their family should be safeguarded at all costs.

Recently, the Federal Trade Commission announced that identity theft cost American taxpayers and business more than $53 billion in 2002. Nearly 10 million people lives were personally affected by this crime. Last July, James Huse, SSA's Inspector General testified that *"each SSN begins and ends at SSA, and true stewardship over that number must reside in the ACT that created it, the Social Security Act. That stewardship must focus not only on punishment and deterrence, but also on prevention."*

AFGE and the employees of SSA believe much more should be done to safeguard the privacy and SSN of each number holder. While social security numbers are issued by SSA, the responsibility for protecting its integrity reaches far beyond SSA. SSA cannot have true stewardship over SSNs if contractors are given free reign

with SSA records. Contractors currently have access to electronic records either sent or received by SSA computers. SSA does not conduct or require routine audits of other governmental agencies or third parties that received personal, identifying SSA records electronically. The security of an individuals SSN and personal records are as safe as the computer firewalls permit. In GAO's May 2002 report, GAO stated that Government agencies are taking some steps to safeguard the numbers [SSNs], but some protections are not uniformly in place at any level of government." In that report, GAO found that many of state and county records contain SSNs.

Additionally, SSA's own electronic firewalls are constantly being infiltrated by computer viruses and worms. In July 2002, the problem became so significant that SSA had to shut down its Web Applications due to the discovery of a vulnerability in the SSA application Web servers that could permit hackers to launch an attack and access the server files. As recently as last weekend, SSA officials were scrambling to install a patch on its computer system to prevent the latest threat to the Microsoft Window Operating system.

If SSA is to truly safeguard its records that are entrusted to SSA, immediate action is needed to address these issues.

Recommendations:

1. AFGE strongly urges this Subcommittee torequest GAO to evaluate the effects of contracting out and the privacy of SSN number holders. The GAO should report its finding and make necessary recommendations to Congress and Commissioner Barnhart.
2. Until the GAO findings and recommendations can be properly evaluated and considered by Congress and Commissioner Barnhart, AFGE urges this Subcommittee to seek a legislative means to freeze all contracting out of SSA services that can otherwise be performed by SSA's own workforce.
3. AFGE strongly recommends that SSA require all parties (governmental and non-governmental) who receive SSA records electronically to provide bi-annual security evaluations of their computer systems to the Commissioner. The purpose of the evaluations is to establish that appropriate protections are in place to prevent the identity theft of any SSA record holder. Because the expertise of computer hackers seems to advance much faster than protections can be developed, SSA should require routine computer firewall evaluations from those receiving SSN and other information protected by the Privacy Act from SSA electronically. This is the least SSA could do to assure the taxpayers that the information provided to SSA and meant to be maintained in SSA records remains private and cannot be subject to from preventable identity theft. Failure to submit timely evaluations should result in the suspension of access to SSA records.

Mr. Chairman, this concludes my prepared statement. On behalf of the AFGE General Committee and the employees AFGE represents, I thank the Chairman and the Members of the Subcommittee for the opportunity to testify and I look forward to any questions you may have.

Chairman SHAW. We have your complete statement, which will be part of the record. I am going to try to finish this up before we go to a vote so that everybody won't have to hang around. Mr. Hill.

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

Mr. HILL. Good morning, Chairman Shaw. It is good to see you, particularly with the hurricane not bearing down on us. My name is James Hill. I have been employed as an attorney-advisor at the OHA for 20 years. I am also the president of Chapter 224 of the National Treasury Employees Union that represents attorney-advisors and other staff members in approximately 110 OHA hearing and regional offices across the United States. I thank the Subcommittee for providing me with the opportunity to testify about management challenges facing OHA. I have testified before the Subcommittee on more than a few occasions since 1994, and the

central issue has consistently been a backlog at OHA. The temptation to fix responsibility for this chronic deficiency is hard to resist. In preparing my testimony I was struck by the statement of Chairman Shaw that the hardworking employees of OHA must get beyond finger-pointing and take personal responsibility to make the program work better. That is good advice. I am pleased that the Commissioner has announced comprehensive initiatives to improve the disability process. I am concerned, of course, that the devil is always in the details. Additionally, I am concerned about the present. Her plan deals with the future. We have hundreds of thousands of people waiting for disability decisions today. The disability program is in crisis, and this is not a time for timid half measures. The SSA needs bold, decisive leadership. Simply having effective leadership will not in and of itself solve the disability crisis. We must focus on the primary cause of the backlog, which is an insufficient number of decisionmakers to efficiently handle the caseload. Solve that problem, and the others become far less intractable.

One solution to this problem is to hire enough administrative law judges and support staff to effectively handle the current and future caseloads as well as the current backlog within an acceptable period of time. Because of the current backlog, we estimate that an additional 440 administrative law judges, and between 1,500 and 2,000 additional staff persons would be required. Even then, the learning curve ensures relief would be years away. The cost of that solution is enormous; and, quite frankly, such an expenditure would be fiscally irresponsible. This is not the first time OHA has faced such a crisis. In the mid-nineties, the situation was nearly as bad as the present. In 1995, SSA implemented a bold initiative, the senior attorney program, which was instrumental in alleviating the backlog program. It was terminated because SSA believed HPI rendered it unnecessary. Since that time, the backlog has nearly doubled. That is not a coincidence. An attorney-adjudicator program worked then, and it will work now, but only if SSA avoids limited, timid half-measures more directed toward overcoming internal institutional resistance than serving the public. The OHA may be the only high-volume judicial body in the country that does not provide a viable method for making determinations without employing a whole formal hearings process. The lack of a mechanism for efficiently disposing cases that do not require an administrative law judge hearing is a major flaw in the OHA adjudicatory system. An attorney-adjudicator remedies that deficiency. By authorizing OHA, skilled and experienced attorney-advisors to issue fully favorable on-the-record decisions, OHA could immediately increase its decision capacity by a factor of nearly 20 percent in a very economical manner. I estimate that a properly managed—and I emphasize properly managed—attorney-adjudicator program utilizing all of OHA's experienced attorney-advisors as part-time decisionmakers could produce as many as an additional 100,000 quality OHA decisions a year. Experience from the old program showed that the processing time for these cases would be less than 120 days. That is the kind of service the public deserves. There are a number of other issues, but time constraints preclude a discussion at this time. Please feel free to ask any questions that you think will help you better understand the situation at OHA.

[The prepared statement of Mr. Hill follows:]

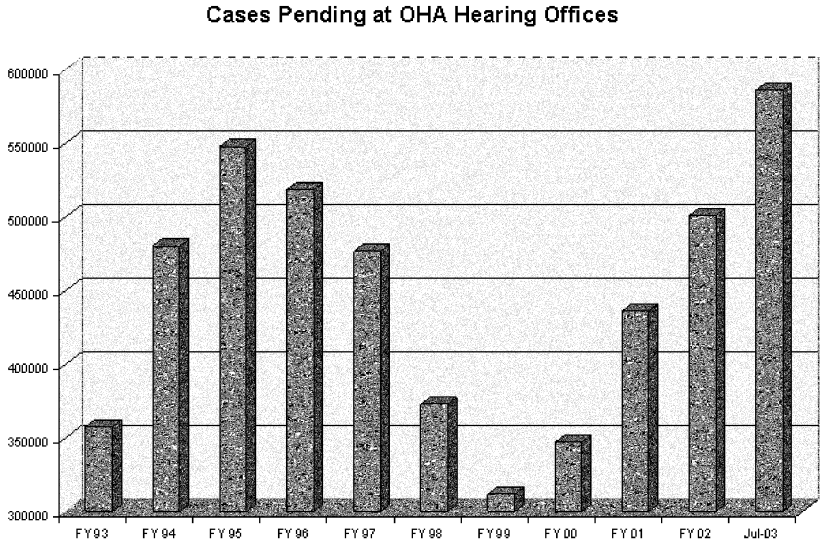
Statement of James A. Hill, Attorney-Adviser, Office of Hearings and Appeals, and President, Chapter 224, National Treasury Employees Union, Cleveland Heights, Ohio

My name is James Hill. I have worked as an Attorney-Adviser in the Office of Hearings and Appeals for over 20 years. I am also the President of Chapter 224 of the National Treasury Employees Union (NTEU) that represents Attorney-Advisers and other staff members in approximately 110 OHA Hearing and Regional Offices across the United States. I thank the Subcommittee for allowing me to testify about management challenges facing OHA and to recommend actions which will improve service delivery.

The Backlog at OHA

The salient fact about the SSA disability adjudication process is that it is unconscionably slow causing untold harm to some of the most vulnerable members of society. None will dispute that the public deserves far better service than SSA is presently providing. Because of a persistent lack of vision and leadership at SSA, poor service seems to be the norm rather than the exception.

Disability adjudication at SSA has a long and troubled history. The current problems with the SSA disability program began in the early 1990s when the cases pending at OHA hearing offices rose from approximately 180,000 in 1991 to approximately 550,000 in mid-1995. Currently the backlog is approaching 600,000 cases and processing times in some hearing offices are significantly in excess of one year. A quick review of the history of the number of cases pending at OHA demonstrates that the backlog problem is not altogether intractable.



The Senior Attorney Program that commenced in 1995 ensured in a cost effective manner that there were an adequate number of adjudicators to deal with both the new filings and the accumulated older cases. During the original Senior Attorney Program, where experienced OHA Attorney Advisors were granted limited decisional authority to issue fully favorable on-the-record decisions, the number of cases pending fell from approximately 550,000 to a nearly optimal 311,000 cases. The demise of the Senior Attorney Program and the rise of the backlog are not coincidental and are illustrative of the management deficiencies that have plagued the disability program. However, before exploring the management problems that have severely hampered the disability program, I wish to discuss the solution to the backlog situation.

Reinstitute an Attorney Adjudicator Program

1. The delay in disability decisions caused by the backlog is unconscionable.
2. The direct causal factor for the backlog at OHA is an inadequate number of decision makers to efficiently process OHA's caseload.
3. We have a duty to the taxpayer to find the most efficient use of our resources.

The solution is a comprehensive Attorney Adjudicator Program at OHA.

OHA may be the only high volume judicial or quasi-judicial body in the country that does not provide a viable method for making determinations without employing a whole formal hearing process. The emphasis placed by every court in reaching settlements without going through a trial is recognition that providing a formal hearing for all results in an uncontrollable backlog. OHA certainly proves that point. The experience of the original Senior Attorney Program certainly provides justification for establishing a method of identifying and disposing of those cases that do not require a hearing. SSA must immediately reinstall an attorney decision maker program that is large enough to efficiently address the current backlog and the anticipated increase of OHA receipts. The Agency should aggressively attack the backlog and not rely upon half measures doomed to failure or so limited as to prolong the period during which the public is being poorly served. This is not a time for timid half measures. It is time to solve the problem once and for all. OHA must permanently adopt a structure that permits greater flexibility in decision making without the necessity of a formal hearing before an ALJ.

The only viable way to deal with the ever increasing backlog is to engage a larger number of adjudicators. Currently the only adjudicators at the OHA hearing office level are the Administrative Law Judges (ALJs). Based upon the traditional measure of evaluating ALJ productivity, dispositions (decisions plus dismissals) per month per ALJ, it appears ALJ productivity has shown a steady increase. However, when one views ALJ productivity in terms of *actual number of dispositions* (decisions plus dismissals), dispositions per year per ALJ have remained remarkably consistent at approximately 500 dispositions (decisions plus dismissals) per ALJ. It appears that SSA is better at creative accounting than increasing productivity. While it is essential that SSA maintain an adequate corps of ALJs, its duty to efficiently use taxpayer dollars demands that SSA do so in a fiscally responsible manner.

The simple fact of the matter is that a hearing, or for that matter an ALJ, is not needed to dispose of every case handled by OHA. Experience indicates that each ALJ will dispose of approximately 500 cases on the average per year, but about 14% to 15% of those cases are dismissals. Most dismissals result from untimely filings or failure to appear. The actual dismissal notices are prepared by staff and signed by an ALJ. That is the extent of ALJ participation in most dismissals, yet each dismissal is afforded the same degree of weight in determining ALJ productivity as a case in which a hearing is held and a formal ALJ written decision made.

In FY 2003 OHA hearing offices will receive approximately 600,000 cases, and even more are expected during the next several years. At that rate 1200 ALJs are required merely to keep pace with the current rate of receipts. That is 241 more ALJs than were available in July of this year. OHA believes that a pending caseload of 300,000 is optimum, but currently OHA has almost 600,000 cases. In order to reduce the pending to optimum levels, in addition to disposing of the annual receipts, at least 300,000 other cases must be adjudicated. Assuming that the Agency is prepared to allow this reduction of the backlog to take 3 years, at least an additional 200 ALJs would be required, or a total of 441 new ALJs. Even with this prodigious increase in the number of ALJs, given the length of the learning curve for new ALJs (6–12 months), processing times well in excess of one year would continue for at least 4 years.

The problem cannot be solved by merely hiring large numbers of ALJs. In order for the ALJs to accomplish this task, however, they would have to be fully staffed. Currently, OHA's staffing goals dictate a support staff of 4.5 employees for each ALJ. Assuming that OHA is not overstaffed at the present, that means OHA must hire an additional 2000 employees, including an additional 300—400 attorneys. The cost of adding 441 new ALJs and the necessary support staff and office space is prohibitive.

The lack of a sufficient number of decision makers is the fundamental reason for the OHA backlog. The decision to terminate the Senior Attorney Program was a huge mistake resulting from the traditionally poor management of OHA and the lack of accountability by SSA leadership. The question is how to repair the damage in the most expeditious, cost effective manner. The Senior Attorney experience of 1995–1999 should be applied to the current situation. This would immediately add a substantial number of qualified decision makers with a minimal learning curve,

who could immediately begin to work the large number of new and pending cases. While there is a cost, that cost is significantly less than hiring over 400 new ALJs and the associated staff. While additional ALJs are certainly needed, with a well designed attorney decision maker program, as many as 100,000 decisions and 80,000 dismissals could be issued within 4 months of their receipt at OHA. The average processing time for the original Senior Attorney Program was less than 120 days. That is the kind of service the public deserves.

Ideally, the Attorney Adjudicators would continue to draft ALJ decisions in addition to handling their own adjudicatory dockets including the drafting of their own decisions. Skilled decision drafting remains a vital component of the ALJ adjudicatory process. The value of retaining the services of experienced attorney advisers to draft ALJ decisions on even a part time basis should not be underestimated. Retaining OHA's most skilled staff to perform that duty is essential if OHA is to continue to produce quality decisions. Assigning decision making duties to attorneys whose primary duty now is to advise ALJs and draft decisions is obviously going to result in a decrease in decision drafting capacity. The Agency would have to hire an additional 250–300 attorneys to maintain sufficient decision drafting capacity and perhaps another 100 additional staff people to process the increased number of decisions. Even considering the cost of the promotions of current employees consistent with their new duties, the total expense is far less than that involved with hiring a massive number of ALJs and the necessary staff. Additionally, NTEU is ready to work with SSA on reaching an agreement on a new Flexiplace program that could eliminate or reduce to a minimum the office space cost for these additional attorneys.

If the current experienced OHA attorney advisers were invested with limited decisional authority to pay cases on the record and to dismiss cases not entitled to Hearing they could dispose of 180,000 (100,000 fully favorable decisions and 80,000 dismissals) or more each year, while still spending nearly half their time drafting ALJ decisions and advising ALJs. These cases would not require the expenditure of any ALJ resources and if the basic program of the original Senior Attorney Program was reintroduced, very little staff work would be required. This would allow the Agency to commit a greater amount of its resources to the cases that required ALJ adjudication.

The Senior Attorney Program was extremely successful and helped produce as many as 60,000 decisions a year despite substantial managerial resistance at the hearing office and regional office levels and in spite of the fact that many Senior Attorneys spent only 25% of their time or less making and issuing decisions. With vigorous managerial support, I believe attorney adjudicators could produce as many as 100,000 or more quality fully favorable decisions and 80,000 dismissals each year. It is clear that had the original Senior Attorney Program been continued, OHA would not have a significant backlog problem today. In the original senior attorney program attorney decision makers handled, for the most part, what are known as "unpulled" or "unassembled" files. Had the program continued, the crisis in "unpulled" cases could have been avoided, and there would not be a need to spend additional taxpayer dollars to contract out case assembly. When SSA downsized and later terminated the Senior Attorney Program it snatched defeat from the jaws of victory.

The basic tenets that should be applied in crafting an attorney adjudicator role should approximate those that were tried and successful in the 1995 Senior Attorney Program. The current GS–13 Attorney Adviser position description should be amended to include decision making duties and to ensure proper grade level. Creating a large and diverse group of adjudicators is essential to permit each hearing office's management to have the flexibility to deal with its caseload as needed. This flexibility is essential for efficient hearing office operations and to more efficiently serve the public.

This necessarily means that Attorney Adjudicators must also retain the role of decision writers for ALJ decisions, also a characteristic of the original Senior Attorney Program. For a brief time in 1998 OHA tested the concept of a smaller number of Senior Attorneys who would devote all their time to decision making. The test was unsuccessful after only four (4) months and Senior Attorneys returned to a part-time decision making and part-time decision writing role. It is foolish to implement a limited program that has already shown itself to be less effective than a program that assigns a decision making and decision drafting workload to all qualified attorney advisers.

There was one area of intractable controversy that quite frankly plagued the original Senior Attorney Program. That was the question of quality. There is no question that one of the shortcomings of the entire disability program is the lack of a coordinated, effective or even realistic quality assurance program. Any adjudicator posi-

tion, whether attorney or ALJ, should be accompanied by an effective quality assurance program directed at ensuring the competence of those making the disability decisions. To date, none of the SSA quality assurance programs have been directed to that end.

That being said, the issue of unacceptable quality regarding the original Senior Attorney Program is unfounded. Within SSA, there has been a long-term and almost irrational antipathy toward OHA, centered in the Office of Quality Assurance (OQA) and its predecessor entity (OPIR). OPIR and many ALJs see attorney adjudicators as a direct threat. Certainly, ALJs were no longer the only decision makers at OHA hearing offices, but they feared this was the first step in the Agency's plan to replace them. The allegations frequently made by ALJs that the Senior Attorney Program was intended to pay down the backlog were completely baseless. The cases selected for Senior Attorney review were those on a historical basis most likely to be favorable to the claimant. The payment rate for Senior Attorney reviews was approximately 25% of these selective cases which shows remarkable restraint in an Agency which has an overall payment rate of 60–70%. In fact, the payment rate of OHA actually declined during the pendancy of the Senior Attorney Program and increased after its demise.

Given that perspective, ALJs vigorously opposed the commencement of the Senior Attorney Program, and when given the opportunity to attack it as part of a "quality assurance effort" did so in an unconscionable manner. OPIR provided that opportunity by creating a review system that was unabashedly biased. While ALJs and other OHA reviewers (including eventually the Appeals Council) differed in their review of Senior Attorney decisions, there was some consistency. Medical Consultants and Disability Examiners from SSA and the State Agencies found the accuracy rate of both ALJs and Senior Attorneys to be 35% vividly demonstrated one of the fundamental problems in the disability system; the difference in perspective of the State Agencies and OHA and the courts. The difference in the accuracy rate between ALJ and Senior Attorney decisions as found by ALJs was the result of bias. The entire review system was in fact biased.

OHA suspected as much and began a program in which the Appeals Council reviewed Senior Attorney and ALJ on-the-record decisions and found no statistically significant difference in accuracy. That unbiased study should be the final word on the matter of Senior Attorney accuracy.

NTEU recommends that SSA as quickly as practicable commence a program of OHA attorney adjudicators based upon the 1995 Senior Attorney Program. That program demonstrated over the course of several years that it could produce a significant reduction in the OHA backlog in a fiscally and programmatically responsible manner. That the reintroduction of an attorney decision maker has not occurred is a microcosm of managerial inadequacies and indifference that are endemic to SSA's management of the disability program.

Mismanagement of the Disability Program by SSA

Chairman Shaw has quite accurately pointed out that it is time for us to stop finger pointing and get to the task of providing the level of service the public deserves. So rather than restate in considerable detail all the errors of the past, only a brief mention should be made to provide a degree of perspective.

During the early 1990's the disability backlog skyrocketed. Eventually, SSA reacted, but not to the immediate problem at hand. Rather than deal with the backlog, SSA decided to fundamentally redesign the disability system. In 1994 SSA embarked upon a program called the Disability Process Redesign (DPR) to radically redesign its disability claims process by completing 83 different initiatives over a six year period. DPR failed.

While DPR was a complete failure, a "shoestring" program, the Short Term Disability Plan, achieved remarkable results with little expense primarily due to the Senior Attorney Program. **Rather than attempt to redesign or remake the entire SSA adjudication process the Senior Attorney Program addressed the basic problem that produced the backlog, the lack of a sufficient number of adjudicators.** By affording qualified, experienced OHA Attorney Advisors the authority to issue fully favorable on-the-record decisions where the documentary evidence established disability, the problem of an insufficient number of adjudicators was eliminated, and done so with minimum expense. The backlog at OHA declined to a manageable and nearly optimal level of 311,000 cases.

However, SSA failed to learn from its own successes. After finally regaining control of its pending caseload and beginning to deliver the service that the public has a right to expect, SSA chose to introduce arbitrary and fundamental changes into hearing office operations on the excuse that future receipts would deluge the agency. The resulting program, the Hearings Process Improvement Plan (HPI), many parts

of which were first proposed as part of DPR, has proven to be an unmitigated disaster. SSA has also failed to learn from its own failures.

Despite the fact that HPI is regarded by nearly everyone, including Commissioner Barnhart, as a failure, it remains largely in place today. To date SSA has made no substantial effort to effectively address the growing backlog. In mid-2002 SSA initiated what it called its "Short Term Initiatives" which were intended to at least mitigate the adverse effects of HPI but have had no significant impact upon the primary problem; the growing backlog. Unfortunately, at the operational level, OHA employees knew that the "Short Term Initiatives" would have no significant impact on the growing backlog problem, leading many to question the understanding and vision of the Agency's leaders. Indeed, the lack of faith of OHA's employees (including many managers) in the ability of the SSA's (and OHA's) leadership to solve the backlog situation is one of the crucial problems facing the Agency.

GAO contends, and rightly so, that former SSA initiatives such as DPR and HPI suffered from a lack of "buy-in" by key stakeholders including SSA and OHA employees. GAO could have added the "Short Term Initiatives" and Accelerate e-dib to that list. It is important that this Subcommittee understand the nature of employee skepticism. It does not emanate from a reluctance to face changes. It is not the result of obstructionism. It does not indicate a lack of desire to change or improve the process. The lack of buy-in is the result of a belief that the initiatives would not meet operational necessities at the site where work is actually being performed. Employees at OHA have frequently been subjected to programs designed by individuals who do not understand the details or nature of the work at the operational level. In short, the planned initiatives have been and continue to be unrealistic and unresponsive to the problems that they purport to address. Recently, inaction and an apparent indecision seem to best characterize SSA's current leadership. In fact, many OHA employees believe that SSA has no interest in resolving the backlog problem.

SSA management does not accept the basic theoretical, organizational, or operational tenets of OHA. SSA is a typical hierarchical organization in which the superior makes the decisions and the lower ranked employees carry out those decisions. Disability decision makers in OHA are much less constrained in their decision making process. To some extent, the process at OHA results in a loss of control by Management. Many in SSA find this intolerable.

The reason that SSA Management repeatedly conceives and implements programs that not only fail, but actually make the situation at OHA even worse is that the primary purpose of these programs is not to improve the adjudication process at OHA. They are intended to bring the adjudication process at OHA in conformance with the administrative process at SSA. Each of the unsuccessful programs has been designed to reduce the quasi-judicial nature of OHA proceedings. Depriving or at least limiting the public's access to the quasi-judicial determination of their rights currently afforded by OHA and placing it in the hands of a bureaucrat easily controlled by the Agency. Administering a judicial entity is certainly more difficult than administering a more traditional subordinate component.

NTEU recommends that SSA accept the quasi-judicial nature of OHA and formulate operational programs that enhance rather than impede OHA's judicial function. SSA needs to look to various court systems, including federal as well as state and local court systems for programs that can be adapted to serve OHA's function. This could include concepts such as magistrates, referees, government representatives, and a viable effective appeal process within OHA.

Mismanagement in OHA

There are serious management deficiencies in OHA which impede the efficient accomplishment of its mission. There is a widespread and I fear justified perception that the business of OHA is directed toward serving the ALJs rather than serving the public. Often the terms OHA and ALJ are used interchangeably such as "at the ALJ level" and "at the OHA level". Many in OHA believe that the purpose of OHA is to provide claimants with an ALJ hearing. I assure you that the claimants' primary interest is securing a favorable decision, and that they could care less about who makes the favorable decision. The purpose of OHA is to decide the appeals of disability determinations made at a lower level. As already noted, requiring every claimant to go through the entire process is unnecessary and constitutes an irresponsible use of the taxpayers' money.

One of the inescapable facts about OHA is the necessity of the decisional independence of ALJs. This decisional independence is essential if the claimants are to believe that they will receive a fair and unbiased hearing. However, previous administrations have allowed the concept of decisional independence to permeate to every aspect of the ALJ—Agency relationship, severely eroding the normal employer-em-

ployee relationship. For far too long OHA has permitted the decisional independence of ALJs to extend to their personal conduct. A balance needs to be struck. The Agency and the ALJs need to come to an understanding of where decisional independence begins and ends and the extent to which OHA may rightfully exercise administrative control over the actions of ALJs. The importance of ALJs to the OHA adjudicatory process is undeniable. However, the ALJs must recognize that service to the public rather than pursuing their parochial institutional interests must take precedence, and they must behave accordingly.

OHA suffers from a massive loss of accountability at many levels. HPI destroyed any concept of accountability of individual employees at the group level. Hearing Office managers frequently provide inaccurate information to higher level management officials to protect their interests but at the cost of discrediting the reliability of management information upon which agency operations are based. Management officials cannot realistically be held accountable for the non-productivity of the hearing office because in most cases the productivity or lack thereof is beyond their control. In order to ensure the essential level of accountability, the Office of Hearings and Appeals needs to strengthen managerial control of field operations consistent with the maintenance of decisional independence.

Finally, the lack of even a superficial quality control function in OHA permits an overwide variance in decision making damaging both the claimants and the trust fund. Currently, OHA's ALJs pay nearly two thirds of the cases upon which a decision (as opposed to a dismissal) is made. The difference in the payment rates between individual ALJs, between hearing offices, and between regions is difficult to explain. While the decisional independence afforded ALJs rightfully accounts for some of the discrepancies, it does not account for all of them.

Milwaukee and Chicago

While OHA management has many failures, the Chicago Regional Office timely discovered the problems in the Milwaukee office and acted with dispatch to correct them. Within a month the situation was normalized and since that time Milwaukee operations have improved markedly. The problem was discovered and corrected long before it became public. In fact, had SSA permitted OHA officials to present a full and open accounting of the problems and the solution to those problems, a public relations disaster could have been avoided. With as many hearing offices as there are, instances will develop resulting from poor local management. It is far more important to recognize that the Chicago Regional Office quickly addressed the problem than it is to overreact to inevitable local managerial shortcomings.

Contracting Out Agency Work

The recent incident in which contract workers improperly discarded medical evidence while engaging in file assembly is an unavoidable consequence of contracting out work. That this problem was not quickly identified should be a matter of concern. The delay in discovering irregularities was directly related to the lack of managerial control Agency managers had over the work at the contract site. I note that the IRS had a similar problem with contract workers destroying tax returns. SSA needs to devise a process to assure the integrity of its medical records files before it proceeds to further contract out case assembly.

Leadership

Last, but certainly not least, is the failure of the current SSA management team to provide the leadership required. Providing effective leadership is very different from providing effective management. Leaders forge a bond with those whom they lead. Leaders inspire those they lead to greater accomplishments than they believed possible. Leaders engage in a dialogue with those whom they lead. Leaders are concerned with the welfare of those they lead. Under Commissioner Barnhart's "leadership" SSA is nearly unique in that it does not pay its employees' fees for the Flexible Spending Accounts. Her attack on another of the quality of life issues so important to employees (flexiplace) sends a clear message that the Commissioner has little regard for her own employees. SSA is an Agency in crisis, and more than anything else it needs effective leadership.

Chairman SHAW. Thank you, Mr. Hill. I want to thank all of you. I do have a number of questions, as I am sure Mr. Collins and other Members of this Subcommittee will have. We will submit the questions to you in writing and would ask that you please respond

to them as best you can. There is a series of votes—this hearing was supposed to last only 2 hours, but you can see we have gone substantially beyond that. Rather than impose upon your time and make you wait around until we finish voting, and there are some four votes on the floor, I believe, we will just submit the questions in writing. Thank you for being with us, and this hearing is concluded.

[Whereupon, at 12:25 p.m., the hearing was adjourned.]

[Questions submitted from Chairman Shaw to Mr. Barnhart, Mr. Bernoski, and Mr. Hill, and their responses follow:]

Questions from Chairman E. Clay Shaw, Jr. to the Honorable Jo Anne B. Barnhart

Question: How you will proceed from this point onward in obtaining and incorporating further input as you draft the regulations to implement the new process and who is responsible?

Answer: In my testimony I pledged that I would work collaboratively with the administration, Congress, the State Disability Determination Services and interested organizations and advocacy groups before drafting regulations. Immediately after the announcement, I met with employees, advocacy groups, union representatives and the leadership of interested organizations to discuss the approach. These groups were offered the opportunity to meet again with either myself or Martin Gerry, the Deputy Commissioner for Disability and Income Security Programs. Many of those follow-up meetings have already been scheduled. In addition, feedback, suggestions and questions are being solicited and the answers to questions will be posted on an SSA Internet website. No regulations will be prepared until I have considered the feedback and finalize my approach.

Question: How many contracts does the SSA have nationwide? What is the dollar value of these contracts? Are you confident your employees are able to provide adequate oversight of its contract employees?

Answer: As of September 25, 2003, SSA had 77 active folder assembly contracts with a value of $1.4 million. OHA has initiated a training plan to ensure that all project officers fully understand their role. Under the new contracts for FY 2004, all contractors will work onsite in SSA space, where project officers will be available to provide oversight of the contractors.3. What is the policy regarding SSA employees or private contractors taking claims home? What is the rationale for this policy? Who can do this? Employees? Contractors? Can you tell us how many files were taken home by SSA employees and by contractor employees in the past year? How does the OHA keep track of files taken out of the office, what procedures must they follow to make sure that the case files are kept intact and confidential?

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Answer:

Employees:

Consistent with the May 2003 guidance from the Office of Personnel Management (OPM), the Social Security Administration (SSA) has implemented a flexiplace program, also referred to as telework. We are obligated by our collective bargaining agreements, negotiated in 2000, to continue a flexiplace program in which the home is referred to as an alternate duty station. All SSA employees who work at home are reminded of their obligation to safeguard SSA records and not to share the information with anyone. At SSA, where flexiplace arrangements are in place, employees are required to sign a "flexiplace program participant agreement," and abide by their component's negotiated flexiplace agreement. These agreements require adherence to applicable government regulations in place at SSA governing information management and electronic security procedures for safeguarding data and data bases. The following conditions are required with regard to safeguarding SSA confidential documents in all flexiplace arrangements:

- Employees must have a locking file cabinet or desk drawer for storage of confidential material at the alternate duty station.
- Alternate duty stations are subject to inspection by the employees' supervisors.
- A tracking system is utilized when case files are taken to the alternate duty site and returned to the office.
- Employees are required through the use of a locking device, such as a brief case or satchel, to ensure that all Government and/or Agency records are safeguarded and protected from theft and damage while being transported.
- Employees who work at home do not have access to the Agency's main frame computer systems from the alternate duty site.

When and if there are instances of violations of the above conditions, an employee who improperly discloses confidential information or who fails to take appropriate steps to protect the information in their care is subject to disciplinary action. These penalties may range from reprimand to removal, depending on the seriousness of the violation.

As noted above, a tracking system is utilized in flexiplace arrangements; however the numbers of cases removed from the offices under the Flexiplace program is not tracked nationally. We estimate that several thousand cases are taken out of the office for work at home each year.

Some employees also take cases home to work under SSA's Work-at-Home by Exception procedure. Under this program, SSA employees with a medical condition limiting their ability to commute to work are permitted to work-at-home if their job duties are compatible with performance at an alternate worksite.

Contractors:

During FY 2002–2003, contractors assembled more than 40,000 files, affording OHA's Senior Case Technicians more time to complete the case preparation process and schedule more cases for hearings. When contractors were given cases to assemble, they completed and signed a form (generally an invoice form) that was also signed by the Project Officer. The Project Officers tracked the cases that were given to the contractors to assemble and those that were returned from the contractors.

The contract itself contained provisions to protect the confidentiality of the information in the folders. For example, the contractor was required to protect the confidentiality of the records and in such a way that unauthorized individuals could not retrieve them, including storing them in areas that are physically safe from unauthorized access. The contract informed the parties that violation of these safeguards could subject them to various criminal penalties prescribed by the Privacy Act, the Social Security Act and the Internal Revenue Code (5 USC 552, 42 USC 1306, 28 USC 7213).

During FY 2002–2003, it was common practice to allow contractors to take work home because space was not provided for the contractors. However, FY 2003–2004 contracts for file assembly require that all work be done onsite in SSA facilities.

Question: It has recently been brought to our attention that OHA managers have asked current OHA employees whether they know of anyone who would be interested in working for a contractor to assemble case files. Is this standard practice of managers to solicit information for a contractor? Is it legal for SSA employees to use government e-mail to gather this type of information?

Answer: It is acceptable for a contractor to contact the OHA Project Officer to ask for referrals of interested workers. OHA is not obligated to provide any information. Providing referrals may allow the contractor to provide better service to the Agency. It is neither standard practice nor is it acceptable for OHA managers to solicit employment opportunities on behalf of the contractor. Such an act constitutes inappropriate use of the Agency's computer system.

Question: By our calculations, the SSA paid the contractors in the Chicago Regional OHA about $48,000 to assemble the 1,200 cases files in question. How much taxpayer money will be spent to correct the mistakes made by the contractors and to contact affected individuals? In addition, how much taxpayer money has been spent to investigate this issue to prevent mistakes like this in the future?

Answer: The estimated cost to correct mistakes made by the contractors and to contact affected individuals is $122,925. The OHA cost to investigate the issue is currently $13,392. These figures were calculated using actual hours worked to reconstruct the cases in the regional office and estimated figures for work performed on these cases in hearing offices. Our ongoing management analysis and review will employ these findings to prevent similar problems in the future. It is not possible to quantify these costs.

It is important to note that folder assembly contracts were implemented in late Fiscal Year (FY) 2002 as part of our short-term initiatives to reduce the volume of cases awaiting hearing and to improve the efficiency of the hearing process. Before we began contract folder assembly some offices did not have enough cases ready for hearing to fully utilize available ALJs. The folder assembly contracts help ensure that there are an adequate number of cases ready for hearing and free office staff from routine clerical tasks, allowing them to concentrate on more complex case preparation duties. Although we experienced some problems in Chicago, nationally the contractors assembled over 40,000 cases, which assisted the hearing office staff in filling ALJ hearing dockets with over 605,000 hearings in FY 2003, nearly 39,000 more than in FY 2002.

Question: As you know, the *Azdell and Fishman v. OPM* court case has prevented the SSA from hiring administrative law judges (ALJs) in recent years. Now that the Court of Appeals has ruled in favor of the Office of Personnel Management (OPM), and agencies can now ask for lists of eligible ALJ candidates, what are the SSA's hiring plans? What steps are in this process, how long will these steps take, and what is the role of the SSA and the role of the OPM in this process? When do you expect new judges to be brought on board, and how many?

Answer: SSA is working with OPM to bring on qualified ALJs as soon as we can, given the rules that bind us and the limitations imposed by the age of the hiring register, which dates to 1999 and was last used by SSA in 2001.

Usually, SSA begins the hiring process by performing a "needs assessment." Under the needs assessment, SSA considers workload data from its offices, available office space, support staff resources and available budget authority and determines the hearing office locations where ALJ needs are greatest and the number of additional ALJs needed in each office. Upon completion of these tasks, SSA is required under its collective bargaining agreement with the Association of administrative law judges to consider meeting those ALJ needs with incumbent ALJs whose names appear on a "reassignment register." Once SSA has finished the reassignment process, and OPM has approved these reassignments, it has completed the final step in the ALJ needs assessment. SSA then readjusts the locations where ALJs are needed and prepares a request for a certificate of eligibles from OPM.

OPM is responsible for developing an ALJ examination, determining the qualifications of applicants, conducting examinations, scoring applicants, maintaining a register, preparing certificates of eligibles in response to requests from employing agencies and auditing the selection process to ensure compliance with applicable civil service laws. As you know, because of the *Azdell* case, OPM has not been able to perform these functions since 1999.

The names of all eligible ALJ candidates are maintained by OPM on a register that reflects, among other things, their examination score, veteran's status, and geographic preferences. In response to SSA's request, OPM prepares a certificate of eligibles containing the names of the highest scoring ALJ candidates who have expressed a willingness to accept ALJ appointments in the geographic areas where SSA has identified vacancies. Generally, OPM provides the names of three or four candidates for each vacancy identified. SSA then interviews the candidates and subsequently makes selections.

After the U.S. Court of Appeals for the Federal Circuit issued its decision allowing OPM to issue certificates of eligibles, OPM took the following steps: on August 25, 2003, OPM reactivated the existing register but closed it to the receipt of new applications. Current ALJ eligibles and applicants were provided the option to update their resumes for informational purposes. OPM is continuing to develop a new ALJ examination. When the new examination is completed and announced, OPM will terminate this register and require the candidates on it to apply as new candidates. This will be a complicated process.

In the interim, SSA is working with the Office of Personnel Management (OPM) to begin the process of hiring new administrative law judges (ALJs) from the current OPM register of candidates. Considering that the current OPM register of candidates has not been significantly refreshed for several years due to the *Azdell* litigation, SSA is concerned about the likelihood of obtaining a strong list of interested and qualified candidates. This is the same list that we used when we hired 126 ALJs with the help of this Committee in 2001. OPM has recently taken some measures to update the current register. They have contacted the ALJ register candidates and requested a response regarding the candidates' continued interest in being considered for an ALJ position. Additionally, they have begun to place a limited number of new candidates on the register for those individuals whose applications were being held in abeyance while the litigation was pending for the last few years. Nevertheless, given the importance of these selections to the disability pro-

gram, we have chosen to proceed cautiously by pursuing a register of candidates for the 20 most heavily impacted hearing offices. We believe that this will give us an opportunity to carefully consider the candidates and determine whether the steps that OPM has taken to "refresh" the register have been effective. If we are able to make acceptable selections from this current register for these offices, we will consider proceeding to request another certificate of candidates to hire additional ALJs.

Question: Several initiatives to improve the disability insurance process have failed, in part because the SSA failed to secure the support of various stakeholders, including employees in the OHA. On several occasions, the U.S. General Accounting Office has recommended that SSA management work harder to secure support from employee groups before implementing large changes. Given this recommendation, can you respond to the allegation by Witold Skwierczynski of the American Federation of government Employees that the agency continues to refuse to meet with union leaders to discuss ways to improve the disability process at OHA, increase morale of employees, and address the processing problems with disability claims?

Answer: SSA has made extensive efforts to involve various groups in our current plans to redesign the disability process. As I was developing my new approach to improving the disability determination process, I met with Agency employees in our field components and OHA, representatives from the State Disability Determination Services and other interest groups to discuss possible improvements to the disability process. The approach would not affect the work of SSA field office staff, and I have made clear that no SSA or DDS employee will be adversely affected by the approach.

In the course of a number of meetings with SSA employees to discuss my new approach, I recently met with officials, including Mr. Skwierczynski, from each of the unions that represent SSA's employees. The meeting provided an opportunity for these employee representatives to express their views and to work through their concerns as the final package of process improvements is fully developed. These unions were offered the opportunity to meet again with either myself or Martin Gerry, the Deputy Commissioner for Disability and Income Security Programs.

Question: Inspector General Huse's testimony gives several examples of where prior audits have revealed problematic conditions at the OHA. In one instance, the Office of the Inspector General (OIG) conducted a review of the OHA's allegation management process. The Office of the Inspector General found that: "not only were there instances where there was no record of referrals, there were significant time delays in closing out the referrals that were resolved. For example, OHA had no record of 37.7 percent of these referrals and it took an average of 331 days to process the 29 allegations that had been closed." Could you please comment on whether this issue has been resolved?

Answer: We believe that the issues involving the allegation management process have largely been resolved. The concern that OHA had no record of 37.7 percent of the referrals was due to Office of the Inspector General's original practice of sending Hotline referrals directly to the OHA regional office in which the complaint arose, rather than to the central OHA Headquarters location responsible for tracking and monitoring referrals. It was only when Office of the Inspector General performed the allegation management audit that OHA learned that not all referrals were coming to OHA Headquarters for login and processing. The percentage for which Office of the Inspector General records that OHA had no record reflects those referrals sent directly to the field, without any notice to OHA Headquarters. Office of the Inspector General revised its practice, and now sends all referrals to one person at OHA Headquarters, which we believe has resolved this issue.

Processing times continue to be lengthy, largely because many of the referrals involve complaints against Administrative Law Judges (ALJ) that fall under SSA's procedures for handling complaints of bias or unfair hearing. Resolution of these types of referrals is dependent on a final decision by an ALJ or the Appeals Council, which may take several months or more.

Question: Judge Bernoski, who testified representing the Association of Administrative Law Judges, is concerned that the SSA has adopted a policy to refer judges to the Merit Systems Protection Board (MSPB) for what he sees as minor infractions of agency procedures. Has the SSA changed its policy to when to use the disciplinary process of the MSPB?

Answer: There has been no change in Agency policy on referral of ALJ conduct or performance issues to the MSPB to initiate an adverse action. SSA follows a policy of progressive discipline and tries to handle issues in a way that will most effectively and efficiently resolve the Agency's concerns. In determining the appropriate penalty to pursue, SSA considers the well-known factors set forth in *Douglas v. Vet-*

erans Administration, 5 MSPR 280, 305–06 (1981). These ask agencies to examine, among other things, the nature and seriousness of the offense; its relation to the employee's job duties; the employee's job level, work record, past disciplinary record and potential for rehabilitation; the clarity with which the employee was on notice of the rules that were violated or had been warned about the conduct in question; and the adequacy and effectiveness of alternative sanctions to deter such conduct in the future. Only after weighing the relevant factors does SSA determine the course of action it wants to follow.

Progressive discipline usually entails first counseling the ALJ for an offense, then issuing an oral warning if the improper conduct continues and, finally, issuing a formal reprimand if the inappropriate conduct persists in spite of earlier disciplinary actions. However, any of the outlined steps may be bypassed if the nature of the incident is severe enough to warrant the Agency taking a more forceful action.

Hearing Office Chief ALJs and Regional Chief ALJs may counsel and give oral warnings. Reprimands may only be issued by the Chief ALJ. The Office of Hearings and Appeals must file a complaint with the MSPB if a particular action of a judge warrants a penalty. The Board hears and decides the complaint and possesses sole authority to select a penalty and authorize its imposition. Longstanding MSPB precedent states that an agency's suggestion of a penalty is not due a high degree of deference. *SSA v. Glover*, 23 MSPR 57, 78–79 (1984); *Department of Commerce v. Dolan*, 39 MSPR 314, 317 (1988).

Question: How does OHA management at the regional and national levels receive and respond to concerns from front-line staff about workloads, office management and other hearing office issues?

Answer: OHA employees may submit concerns at any time to any level—local, regional, or national—including SSA's Hotline. Submitting concerns first to the local hearing office (HO) level enables onsite managers, who often are in the best position to investigate and resolve matters, to take immediate action.

OHA's Equal Employment Staff and SSA's Office of Inspector General also contribute to OHA's efforts to assure that informal and formal complaints are addressed aggressively and timely.

Question: Do you consider employee morale in hearing offices to be a problem? Is anything being done to address low morale in offices where there is a problem?

Answer: SSA is always concerned about the well being of its employees and strives to provide a safe, functional, and rewarding work environment. SSA has a proven track record in providing its employees the necessary training and tools, career development opportunities, recognition of achievements through monetary and honor awards, and listening to employee input regarding operational issues. This year, OHA solicited a number of suggestions and recommendations from the regions and updated its guide of best practices for efficient processing of the hearings workload.

Nevertheless, SSA recognizes that heavy hearing office workloads present a significant morale challenge to our frontline employees striving to better serve the public. Since I became Commissioner, I have visited our local field offices, teleservice centers, hearings offices, program service centers and regional offices. During each visit, I make it a point to meet with employees to get their perspective and ideas, communicate my vision for the agency and make clear my expectations. I am impressed with the talent in our work force and moved by their commitment to serving the American people.

My service delivery plan and the President's Fiscal Year (FY) 2004 budget request called for sufficient funding for 1,000 new staff in SSA's field offices and 300 new disability determination services staff. Unfortunately, it appears that the FY 2004 appropriation will provide in excess of $200 million less than the budget request. I do not know how serious a blow this reduction will be to our staffing plans. The 2004 budget also redirected 347 workyears to OHA based on our plan to transfer the Medicare appeals workload to the Department of Health and Human Services (HHS).[1]

In addition, we expect to make a substantial investment in automated systems development and the supporting technology infrastructure throughout the hearings and appeals process. The strategy includes digital recording of hearings, video teleconferencing, speech recognition software and, most importantly, implementation of the accelerated electronic disability process, or AeDib, which is central to achieving process improvements. All SSA staff will benefit from these initiatives, and they

[1] This transfer has not taken place yet, but Secretary Thompson and I recently signed a cost reimbursable agreement with HHS for the processing of the Medicare appeals workload.

should help relieve pressure on the hearing process. SSA will begin to roll out the new electronic process nationally in January 2004.

SSA is also working closely with the Office of Personnel Management to initiate the ALJ hiring process. We hope to be able to hire additional ALJs in FY 2004, which should improve morale and eventually make an impact in reducing the backlog.

Question: When an ALJ is performing poorly, what kinds of corrective action does the SSA management take? What tools are available to the SSA managers to improve performance while protecting the decisional independence of ALJs?

Answer: The Chief administrative law judge in OHA develops the broad policies, goals, and objectives for SSA's ALJ corps. SSA's primary concern regarding decisions by individual ALJs is decisional accuracy and quality. In this regard SSA has created various quality assurance mechanisms such as the current ALJ peer review program, reports issued by the Office of Quality Assurance, ongoing ALJ training initiatives and strengthening key program instruction material.

Moreover, local hearing office management constantly monitors management information reports to ensure that the scheduling needs of all ALJs are met on a monthly basis. If there is a specific situation regarding individual ALJ performance that the hearing office cannot resolve, it will raise the issue with the Regional Chief Administrative Law Judge (RCALJ) who provides direction, leadership, management, and guidance to the ALJs and hearing offices within his/her region. RCALJs may counsel the ALJ and/or correspond with the ALJ asking for cooperation in moving cases along.

In providing ALJ oversight, the Office of Personnel Management regulations govern various aspects of the ALJ program that restrict SSA's ability to involuntarily reassign or transfer an ALJ, preclude SSA from rating ALJ performance or establish the procedures for dismissing an ALJ.

Question: How does the SSA determine the number of ALJs assigned to a hearing office? How does the SSA determine the number of support staff assigned to a hearing office? Who has the authority to allocate or reallocate staffing at any specific hearing office?

Answer: OHA regularly assesses the needs of its hearing offices with respect to ALJ and support staff placement in an effort to balance workloads. ALJs and staff are strategically placed in those offices with the most critical need. Of course, we must honor our bargaining unit obligations, including pending ALJ reassignment requests, when considering placement. However, staffing imbalances can and do occur not only among regions but also among HOs, and this can result in some service disruption. It is the responsibility of regional management to ensure, within approved staffing levels, the appropriate mix of staff based on each office's unique workload requirements.

Question: How is productivity and performance in a hearing office measured? If a particular hearing office is found to be performing below expectations, what kinds of corrective actions does the SSA take?

Answer: Basically, hearing offices are measured by their performance in achieving core fiscal year goals, including:

Dispositions
Average Processing Time
Percent of Aged Cases

Hearing office management continually monitors hearing office performance, and if the office is experiencing operational problems, redirects resources to address the specific problem or advises their regional office management that they need assistance. RO management identifies other hearing offices in the region that have the capacity to assist in a specific need (e.g., case preparation, decision drafting, and so forth.) and directs intraregional assistance.

If there are no such offices in the region that can provide the needed assistance, RO staff contacts the Office of the Chief Administrative Law Judge to request interregional assistance. The Office of the Chief Judge will review the management information at the hearing and regional levels and direct interregional assistance, as appropriate. The goal of this collaboration is to achieve the highest performance possible for all hearing offices throughout the country. Assistance can take many forms: additional staff or overtime, temporary or permanent workload transfer, reexamining local procedures that are not producing the hoped for results, or sharing "best practices" that have been beneficial in other offices.

Hearing offices with persistent performance issues undergo a comprehensive management review so that corrective actions can be implemented to help the office achieve its performance goals. We recognize that more can be done to proactively

improve hearing offices with persistent productivity problems. OHA headquarters plans to conduct management reviews in as many as 30 hearing offices this fiscal year. Offices will be selected based on several factors including known performance and management/administrative issues. These reviews are in addition to routine hearing office management reviews conducted by regional office management.

Question: The Judicial Conference, representing district courts, reportedly has requested that the SSA not eliminate the Appeals Council, fearing that their courts would be flooded with appeals. Also, consumer groups have testified that the Appeals Council provides meaningful relief to claimants in a significant fraction of cases and should not be eliminated. How does your proposal to eliminate this third level of administrative appeal and replace it with a quality review step address these concerns?

Answer: We have heard the concerns that elimination of the Appeals Council might result in an increase in the number of cases being appealed to the District Courts. If the only change to the current process was the elimination of the Appeals Council, the number of cases moving to the Courts would likely increase. However, my approach includes substantive changes at all levels of the disability determination process as well as strengthened quality reviews. These changes are in part designed to ensure a more complete record at every stage in the process. The approach, which contains a quality assurance review of ALJ decisions and Oversight Panels, would enhance the quality of the decisions that are of concern to the Judicial Conference. It is expected that the Agency could increase or decrease the percentage of the ALJ decisions that were selected for review by the quality review process, thus managing to some extent, the percentage of cases that were immediately subject to appeal by the Courts. This, along with the substantive changes in the process, and the establishment of Oversight Panels, should address concerns of a flood of cases moving to the District Courts.

Although the Appeals Council does remand 26 percent of the cases back to ALJs, a more significant fact is that the Federal courts remand 60 percent of the cases that passed through the Appeals Council. These Federal court remand numbers indicate that many claimants must pay a high price for relief, having to wait even longer and incur additional expense, only to have their claims returned to the Appeals Council and the ALJ. A more aggressive quality review process at each stage, as well as implementation of an oversight panel, will ensure that the right decisions are being made as soon as possible in the process so that claimants will not have to endure lengthy waits to receive the appropriate decision.

Since announcing my approach, Martin Gerry, my Deputy Commissioner for Disability and Income Security Programs, and I have had several meetings with various advocacy organizations, as well as a number of representatives from the American Bar Association, to hear their thoughts and concerns. We will also be meeting again with representatives of the Judicial Conference to review the approach, answer their questions and discuss their concerns. I also look forward to meeting with individual members of Congress to discuss the approach.

I remain committed to ensuring that all interested parties are provided an opportunity to share their comments, concerns and suggestions.

Questions from Chairman E. Clay Shaw, Jr. to Mr. Ronald G. Bernoski

Question: Recently the Subcommittee on Social Security obtained the audit from the February 2003 review of the Milwaukee Hearing Office conducted by Regional Chief Administrative Law Judge (ALJ), Paul Lillios. In that audit, Judge Lillios expressed concern over the low ALJ disposition rate of 1.53 cases per day, the lowest rate in the 20-office region. Since you work in the Milwaukee office, do you believe the findings of the audit report were accurate? How do you account for the low disposition rate your office was experiencing?

Answer: The finding of the Milwaukee Hearing Office audit as to the number of cases disposed of per judge per day (1.53) for the 5 month period from October 2002 through February 2003 may or may not be accurate. The Association of administrative law judges was not given a complete copy of the audit report and we can not comment on its accuracy or on the manner in which it was prepared. However, in any case, that statistic does not accurately reflect the work effort of the judges in the office.

As discussed in more detail in the answer to your question number 2, the reorganization of the hearing offices in the Office of Hearings and Appeals (OHA), known as HPI, destroyed the last vestiges of any direct oversight judges had over their own dockets and case flow. Prior to HPI, in the Milwaukee OHA two clericals were specifically assigned to each judge to work on that judge's cases. This included, inter

alia, setting up the case files in preparation for hearing, scheduling the cases for hearing, associating mail and documents with files, handling correspondence and telephone calls for that judge's cases and typing and mailing out decisions. With the advent of HPI, that relationship between a judge and the two clericals was destroyed. Now it is difficult hold any staff member accountable for a given work flow task on a given case for a given judge.

In the context of statistical "productivity" of judges and when questions of "accountability" of judges are raised, the fact that judges have no supervisory authority over any staff—including staff attorneys, paralegals, and clericals—is often overlooked. Because judges themselves are not allowed to supervise any of the staff under the current system, they must rely on and are at the mercy of OHA management to effectively do so. Those hearing offices that are blessed with good managers and supervisors, and that have staff with a good work ethic, may have been able to overcome some of the obstacles impeding case flow that HPI created. Unfortunately, the Milwaukee Hearing Office was not one of those offices. The former Hearing Office Director (HOD), who was appointed in Milwaukee at the beginning of HPI, was completely inexperienced with OHA and had no knowledge of how a good hearing office is supposed to run. That individual also had a "hands off" management style and was disinclined to learn how the office should operate. To further exacerbate the problem, the HOD would reject suggestions from experienced judges and supervisors which were made to improve or correct matters in areas that needed attention. Regional Chief Judge Lillios' expressed "concern" over the result of the audit should have come as no surprise to him. The former Milwaukee Hearing Office Chief Judge and other judges had for over two years prior to the audit explained the problem with the HOD to Judge Lillios and yet no action was taken until after the results of the audit appeared in the local newspaper and Members of Congress began to make inquiries. To this date the administrative law judges in the Milwaukee office have not been brought into any planning process for correction of any deficiencies in the office.

In addition, and perhaps just as important, the Milwaukee Hearing Office had been, for a long time, very understaffed, as Associate Commissioner Thurmond himself acknowledged during his visit to the Milwaukee office in Spring, 2003. Again, judges in Milwaukee had requested Regional Chief Judge Lillios to provide more staff and for help in taking action to correct deficiencies in the quality of the work of some of the employees. However, it was not until the adverse publicity occurred that any new employees were given to Milwaukee.

Further, to completely understand the situation in the Milwaukee office, one must consider that the Milwaukee Hearing office is hard-pressed in comparison to other hearing offices in terms of the territory and the population base it serves. Milwaukee (and its Madison "satellite") receives all appeals from nearly the entire State of Wisconsin plus the Upper Peninsula of Michigan. A simple arithmetic comparison between Wisconsin and the nearby States of Illinois, Michigan, Indiana and Ohio in terms of both the number of hearing offices and the number of judges per state clearly shows that Wisconsin has gotten short-shrift and our judges serve a larger population on a proportional basis. As a general rule, smaller hearing offices which cover smaller areas and smaller population tend to be more efficient than larger offices with more judges serving larger populations.

Question: In your testimony, you state that the problems in the Milwaukee office are present to a greater or lesser extent in many other Social Security hearing offices. Please provide more detail as to why you believe this is the case?

Answer: As described in both our oral and written testimony for the hearing, the major factor leading to the problems in the Milwaukee hearing office was a direct result of the changes implemented pursuant to the Hearings Process Improvement Plan (HPI) coupled with agency mismanagement. HPI was implemented in January 2000 in a three phrase process. The basic change in HPI was to remove the support staff employees from the direct support of the administrative law judges and to instead place them in groups under the control of management employees. With this change, support staff now provides indirect support to the administrative law judges. The administrative law judges do not have any particular staff person dedicated to work on the work product of a particular judge. The result has been the elimination of individual responsibility for staff work product. The offices have been placed in a state of confusion with resulting employee despair. Mail is frequently lost or not filed, hearing exhibits are frequently misplaced or not filed in the hearing record, and frequently sufficient cases are not prepared to be scheduled for hearing. The quality of decision writing has substantially declined and in many cases it is not legally sufficient at a minimum level. These problems are present to a greater or lesser extent in many hearing offices and they were also present in the Mil-

waukee hearing office. The evidence shows that HPI has been a general failure through out the OHA system. This finding is supported by reports and studies by the SSA Office of the Inspector General, SSA Office of Workforce Analysis and the United States Accounting Office which have all been critical of HPI. The Commissioner's HPI Steering Committee conducted an extensive study of HPI in 2001. As part of the study the Committee visited about 40 OHA hearing offices and concluded that "HPI did not meet its stated objectives". The Committee found that the HPI work process resulted in more handoffs, confusion, lost files, inadequate mail association, lack of individual accountability for case work, case pulling backlogs and management unable to assign staff. The evidence developed by the HPI Steering Committee clearly shows that the problems from HPI were common in the OHA hearing offices. The committee also found that smaller offices performed better and had higher morale. This evidence shows the HPI problems were present in OHA hearing offices to a "greater or lesser extent". The Milwaukee hearing office is a larger office with an authorization for up to 14 administrative law judges which explains why the HPI problems were more profound in this office. The stated HPI problems together with the mismanagement described in the answer to question number 1, explain the source of the difficulties found in the Milwaukee hearing office.

The problems with staff support in OHA was most dramatically demonstrated by Rep. Collins during the hearing when he read part of a letter from a constituent asking him if he could function as a member of Congress if his support staff was in a pool, if they were selected by someone else, if they were managed by someone else, and if he could not direct their work or rate their performance? His answer was "no". This is the HPI environment that SSA administrative law judges function in on a daily basis.

Question: ALJs have a long history of judicial independence that was established by Congress through the Administrative Procedure Act 1946 and supported by a number of court cases. While this tradition of judicial independence ensures that disability claimants receive a fair and impartial hearing, some would claim that it also makes it more difficult for ALJs to be held accountable for their performance. How should Judges be held accountable in your view?

Answer: It is correct that Congress intended to provide administrative law judges with decisionmaking independence within the scope of the Administrative Procedure Act. During the debate on the Administrative Procedure Act the Congress considered creating a separate Corps of administrative law judges to adjudicate administrative claims. The Congress decided to leave the administrative law judges within the various agencies and provide them with additional protections that did not extend to other Federal employees. In the case of *Ramspeck v. Federal Trial Examiners Conference, 345 U.S. 128 (1953)*, the United States Supreme Court stated that Congress provided "that 'hearing examiners' (now administrative law judges) should be given independence and tenure within the existing Civil Service system. Congress intended to make hearing examiners 'a special class of semi-independent subordinate hearing officers' by vesting control of their compensation, promotion and tenure in the Civil Service Commission to a greater extent than in the case of other Federal employees." The Court went on to explain that this independence was further protected by the requirement that administrative law judges can only be removed for good cause established by the Civil Service Commission after opportunity for hearing on the record.

The law currently contains a process to ensure accountability of Federal administrative law judges. The disciplinary provisions of the Administrative Procedure Act are implemented by 5 U.S.C. section 7521 which provides that "an action may be taken against an administrative law judge appointed under section 3105 of this title by the agency in which the administrative law judge is employed only for good cause established and determined by the Merit Systems Protection Board on the record after opportunity for hearing before the Board." The actions permitted by the law include removal, suspension, reduction in grade, reduction in pay and furlough for 30 days or less. The elements for the various causes of action are established by the case law of the Merit Systems Protection Board and include a cause of action for inefficiency.

The Association of administrative law judges has long been an advocate of accountability at all levels of the Social Security Administration. We recognize that judicial independence is for the protection of the American public and not for the protection of the judges. In this regard, we have long requested that the agency join us in an effort to have the Federal government adopt the American Bar Association (ABA) Model Code of Judicial Conduct for Federal administrative law judges. The goal of the Code is to provide for an independent and responsive administrative ju-

diciary that is indispensable to justice in our society. It provides that administrative law judges should participate in establishing, maintaining, enforcing, and observing the highest standards of conduct so the integrity and independence of the administrative judiciary may be preserved. This code should be applicable to all Federal administrative law judges. Governance by a code of professional conduct such as this, is the manner by which members of professional groups are held accountable to both their profession and the American people.

In the 106th Congress Rep. George Gekas (R–PA) introduced legislation to create an administrative law judge Conference of the United States (H.R. 5177). The bill was modeled on the Judicial Conference of the United States Conference for the Federal Courts. The legislation transferred the responsibilities for administrative law judges from the OPM Office of administrative law judges to the Conference, left the administrative law judges in the agencies and placed the operational control of the conference under a Chief Judge. The Chief Judge was also mandated to develop a code of professional conduct for administrative law judges based on the ABA model code.

The legislation would address current problems relating to the inability to appoint new administrative law judges raised by Rep. Pomeroy (D–ND) at the hearing. This is much needed reform legislation and should be supported by all members of this Subcommittee in cooperation with the House Judiciary Committee. This legislation will create a formal system to regulate the administrative law judge system in the Federal government.

Questions from Chairman E. Clay Shaw, Jr. to Mr. James A. Hill

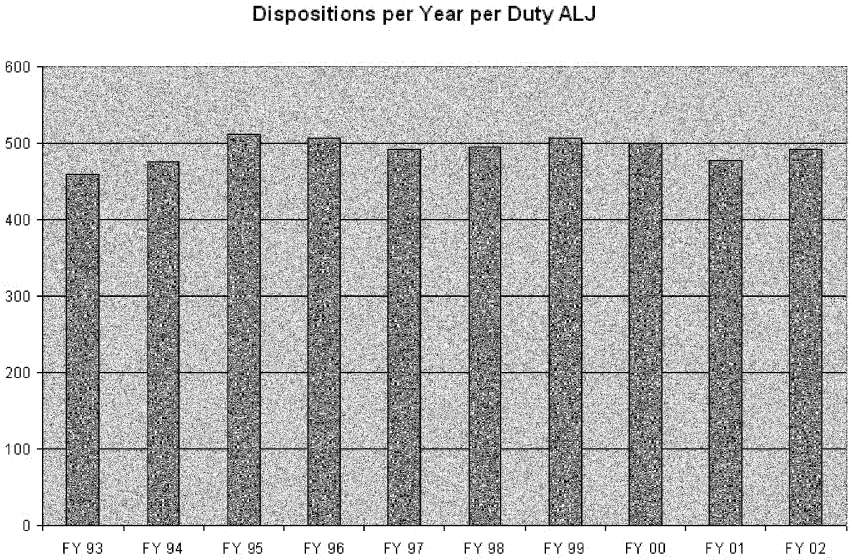
Question: In your testimony, you state that the SSA is engaging in creative accounting to show improvement in productivity among administrative law judges (ALJs). You believe that productivity has remained remarkably consistent at approximately 500 dispositions per year per ALJ. Can you explain why you do not trust the productivity numbers that the SSA releases?

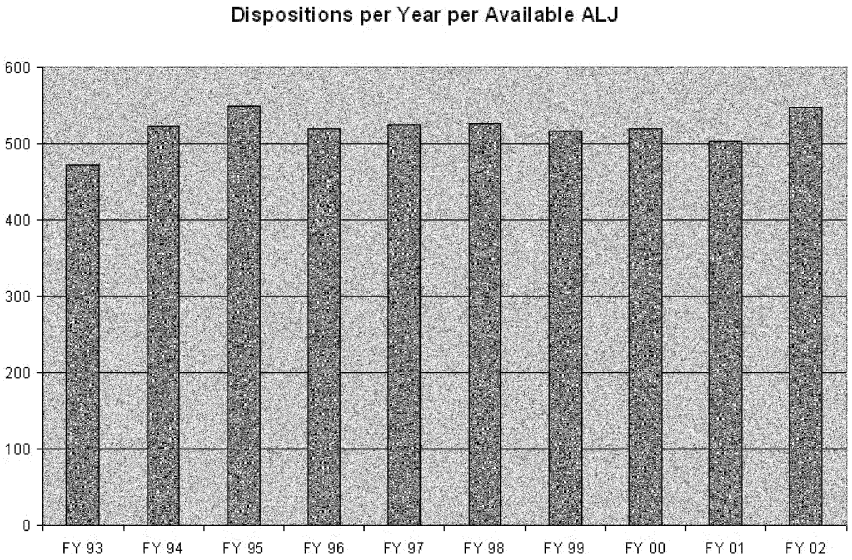
Answer: The issue of the reliability of OHA management information data is a complex matter. It must be understood that production statistics are prepared in each hearing office, and that these statistics are used by higher level management as a measure of the competence of hearing office management. Needless to say, there is an interest in presenting data in as favorable a light as possible. While many hearing offices rigorously document case flow, many others neglect to do so through carelessness or intent. Perhaps the extreme example is the Milwaukee Hearing Office situation. While the magnitude and nature of the problem in that office rendered the problem visible, less flagrant situations go unnoticed or uncorrected.

Nonetheless, it is clear that much of the management information data is tainted. Few have faith in the integrity of the management information system leading to a healthy skepticism of all the data produced. The chain of command for all personnel in hearing offices includes a Hearing Office Chief administrative law judge, a Regional Chief Administrative Law Judge, and a Chief administrative law judge, all of whom have a vested interest in presenting ALJ performance in the best light.

Additionally, SSA management eliminated the Senior Attorney Program, thereby relying entirely on ALJs for decisionmaking in OHA's hearing offices. Enhancing apparent ALJ productivity is essential to justify that decision. An example of the extent some will go to inflate ALJ productivity is seen in the instructions issued in several regions to attribute the number of cases identified by Senior Attorneys in a screening process as on-the-record (OTR) fully favorable decisions to ALJs enhancing the productivity of a parallel ALJ file review program.

When one views the statistic usually cited for demonstrating ALJ productivity (Dispositions per ALJ per day), the alleged improvement is significantly impacted by the methodology employed. That occurs because the factors that go into making that statistic have changed over the years. A major change occurred in FY 2003 involving the counting of management ALJs as less than a full ALJ thereby reducing the number of available ALJs. While that would seem to make sense, ALJs with management responsibilities have less time to devote to decisionmaking, nonetheless it results in a higher production index with the same number of ALJs and dispositions. Ironically, because these individuals are accountable for the performance of their hearing office, they tend to be very productive judges despite their other duties. Nonetheless, over the course of time, ALJ productivity measured in dispositions per ALJ per year has shown a remarkable consistency as demonstrated below.





However, the problem with basing productivity on the number of dispositions per ALJ per day is far more fundamental. ALJ productivity is based on a 250 day work year. Usually, there are 250 work days in a work year. Few if any ALJs work 250 days a year. The calculation of productivity does not take into account annual, sick, or administrative leave.

In addition to the unrealistic 250 day work year, ALJ productivity is based on dispositions consisting of decisions and dismissals. This would be reasonable if there was a level of equality between decisions and dismissals. The simple fact of the matter is that most dismissals are usually the result of a failure to timely file a Request for Hearing without just cause or failure to appear. The dismissal notices are drafted by the staff and signed by the ALJ. ALJs spend very little time disposing of most

dismissals. A far more accurate picture of ALJ productivity would be presented by considering decisions issued and not dismissals. Finally, the inclusion of the Medicare workload, which is not equally distributed from hearing office to hearing office, can significantly distort ALJ productivity.

It is difficult to give much credibility to a production measure that is so unrealistic. Such an artificial and meaningless figure is not likely to inspire ALJs to increase productivity. Evaluating the productivity of ALJs based upon this single, very suspect, figure is nonsensical. OHA needs better measures of productivity.

Of course none of the above precludes an actual increase in ALJ productivity as alleged by SSA. In fact, recently released production statistics (unavailable when I testified) indicate that there has been an increase in ALJ productivity based upon the number of dispositions (including Medicare cases) in September 2003.

Question: In your testimony, you state that there is a widespread perception that the business of OHA is directed toward serving the ALJs rather than serving the public. Can you explain this statement further?

Answer: As I indicated in my testimony, there is a widespread perception in OHA that the business of OHA is directed toward serving the ALJ rather than serving the public. It is difficult to explain why that is so without appearing to engage in "ALJ bashing" and that is not my intent. There are many fine ALJs in OHA who put public service first and who recognize the proper role for ALJs in an administrative decisionmaking process. However, too often, when the idiosyncrasies of individual or small groups of ALJs and service to the public are in conflict, OHA management places a higher priority in accommodating the ALJs that it does on providing the best possible service to the public. I suspect that there are two major factors contributing to this unfortunate scenario. The senior management officials in hearing offices and regional offices are themselves ALJs. Additionally, ALJs are the only decisionmakers in hearing offices.

When SSA had a problem with a clerical employees fraudulently issuing a favorable decision in cases that an ALJ did not intend to make a favorable decision on it instituted a security system (AVID) that required the ALJ to take a moment to make a computer entry to assure that he intended to issue that favorable decision. OHA has instructed ALJs to make that AVID entry and no other employee, other than the Hearing Office Chief administrative law judge (e.g., if the ALJ is unavailable), can make that entry on behalf of the ALJ. However, it is common practice for some ALJs to rarely if ever make the AVID entry, forcing the HOCALJ or some other employee to make the entry. In spite of the fact that this is common knowledge to management officials, the Agency has made no serious attempt to make ALJs follow this security practice. The desire of individual ALJs not to have to make a computer entry is given precedence over the duty of the Agency to protect the disability trust fund from fraud.

Another example of management serving the whims of the ALJs to the detriment of disability applicants involves stylistic changes to decision drafts. SSA does not require that the decision be drafted to comply with the stylistic mannerisms of the individual ALJ, but nonetheless recognizes that the ALJ has nearly unlimited freedom to craft his/her decision. However, each individual decision writer prepares decisions drafts for many different ALJs, some of whom have somewhat exotic idiosyncrasies. Many decisions are drafted by writers who are not located in the ALJ's hearing office and have no or little contact with the ALJ. OHA has long recognized that requiring decision writers to meet the specific stylistic demands of individual ALJs would negatively impact on decision drafting productivity thereby increasing processing time. As a matter of policy, OHA requires that it is the responsibility of the individual who drafts an ALJ decision to produce a legally defensible decision draft that conforms to the instructions of the ALJ, and that purely stylistic changes desired by the ALJ should be made by the ALJ in the ALJ editing process.

Nonetheless, individual ALJs still demand that each draft be tailored to his/her individual whims regarding stylistic matters, and in order to placate these ALJs, individual Hearing Office Chief administrative law judges frequently require Agency attorneys and paralegals to make stylistic changes in ALJ draft decisions thereby slowing the whole process. Fewer decisions are drafted and those that are drafted take longer than necessary, all to satisfy the whim of an individual ALJ. For example, some ALJs require that all their decisions be in the first person, which requires significant editing to the Agency's decision drafting macros. Other requests are simply ridiculous, such as requiring that the terms "whether" or "due to" be excised from the decision, or refusing to allow the use of the word "the" in front of the word "claimant" when referring to the claimant. The issue is that given a caseload of almost 600,000 cases and a processing time approaching a full year, should Agency assets be diverted from drafting as many legally defensible decisions as quickly as

possible in order to placate the stylistic whims of individual ALJs? All too often management opts to placate the ALJ.

Many ALJs, and their Union, AALJ/IFPTE of the AFL–CIO were correctly perceived as opponents of the Senior Attorney Program from its inception in 1995 and they were instrumental in convincing SSA that the Program was unreliable, unwarranted, and unnecessary and should be terminated. They viewed the program as competition for ALJs and a threat to their jobs. The persistent opposition of ALJs including many ALJs in management limited the effectiveness of the program and eventually ended it. The program, in spite of active opposition from these ALJs produced over 220,000 cases in an average of 110 days. Most of those 220,000 cases did not require any staff time for pulling or any ALJ time at all. It is not a coincidence that the huge rise in the number of unpulled cases is concurrent with the advent of HPI and the demise of the Senior Attorney Program. Since the program ended the number of on-the-record cases has dropped dramatically thereby subjecting those claimants to an unnecessary hearing, and significantly delaying the award of disability benefits to needy and deserving claimants. Had the Program been continued the number of cases waiting to be pulled would not have risen dramatically causing substantial delays in case processing. Further, there would have been no need to contract out case assembly and more than 1200 claimants in the Chicago Region would not have had their applications put at risk by contract workers who threw out medical evidence. Had the Program been continued as many as 150,000 claimants would have timely received a decision and not be part of the record backlog of cases currently pending at the Office of Hearings and Appeals. The ALJs were placated but at what cost.

Had the Agency put the needs of the public first rather than serving the wishes of ALJs, it never would have terminated the Senior Attorney program and it would not have failed to resurrect it for the last 3 years even after GAO recommended it be revived. However, it was terminated and has not yet been revived. However, the pressure to revive the program from GAO, claimant advocacy groups, NOSSCR, and others has forced the Agency to consider reinstituting an attorney decisionmaker duty. But the pressure from some groups internal to SSA, including many ALJs, is leading the Agency to propose a program which simply cannot meet the needs of the Agency or the public. OHA senior officials have stated for some time that they are under constraints to limit the size and effectiveness of an attorney adjudicator program. The plan currently under consideration (for well more than a year) is entirely inadequate to meet the demands of the current receipt of cases to say nothing of reducing the size of the backlog. Timid, half measures, limited by pandering to the institutional concerns of SSA components and factions, should be rejected out of hand. The backlog crisis must be effectively addressed now, and it should be done with an eye to the future.

NTEU recognizes that the program recently announced by Commissioner Barnhart will significantly improve the adjudicatory system, but that the Program will not begin earlier than October 2005. We need a bridge to that program that addresses the current crisis. It is self evident that to seriously address the backlog problem OHA must substantially increase the number of adjudicators. Indeed, that is exactly what the Commissioner's plan for the future will do. She proposes to do that by creating an attorney position, the Reviewing Official (RO), which will have the responsibility of reviewing every case appealed from the DDS. The RO will be invested with full decisional authority. Unless the claimant files an appeal for a hearing before an ALJ, the RO's decision becomes the final decision of the Commissioner. In short the RO is a very responsible position.

It is clear that the Commissioner intends to fill the over 1000 RO positions with experienced attorneys from the Office of Hearings and Appeals. Most of these attorneys are presently employed in hearing offices across the United States as Attorney Advisers and Senior Attorneys. These are the people from whom Management proposes to select a limited number of attorney decisionmakers in a temporary program until the Commissioner's Disability Plan is commenced. At that point many of the attorneys that have not participated in the attorney decisionmaker program will become ROs, a much more difficult and responsible position.

NTEU suggests that SSA address two issues, reducing the current backlog and training and preparing its current attorneys for the responsibilities they will assume as RO at the same time, now. What better training for the decisionmaking position of RO than actually gaining long term experience in a similar, but less demanding decisionmaking position. Additionally, few could dispute that evaluating the decisionmaking performance of individuals over a several year period certainly provides a better basis for identifying those individuals who will be successful ROs than any merit promotion process. Providing all qualified attorney advisers and senior attorneys will decisional authority now not only serves the interests of the future, but

also will deal effectively with OHA's current caseload. These individuals, in addition to decisionmaking responsibilities, would continue to draft ALJ decisions, thereby providing continuity and maximizing current productivity. Individual hearing offices could assign work in the manner necessary to most effectively deal with its individual and unique caseload. As many as 100,000 fully favorable on-the-record (OTR) decisions could be issued by these attorney adjudicators in addition to dispositions made by ALJs.

Obviously, some decision writing capacity will be lost due to the decisionmaking activities of the attorney adjudicators. It is however, a considerable smaller loss of capacity than will occur when the RO positions are filled. It makes a good deal of sense to begin to address the issue of decision writing expertise for hearing offices under the Commissioner's Plan now rather than wait until it is implemented. The acquisition of decision writing assets now, when the Agency still retains its full reservoir of decision writing talent, will facilitate the integration of newly hired attorney decision writers in the disability process ensuring that they will have acquired the expertise to produce high quality decision drafts for ALJs after the Commissioner's Plan is implemented. In the interim they will provide the additional decision writing resource permitting experienced attorneys to adjudicate as well as draft decisions. This would permit the greatest number of both ALJ and attorney adjudicator decisions to be issued thereby effectively reducing the backlog now.

It is time for the Social Security Administration to maximize the effectiveness of its current and future resources to ensure that claimants applying for disability benefits have there claims adjudicated in a fair and timely manner. The Commissioner has presented a plan, which if implemented properly, holds the promise of finally solving the chronic problems that plague the current system. Until that Plan is implemented, SSA must promote programs that meaningfully address the current backlog crisis. It must avoid the pitfalls of placing its institutional interests or those of any of its internal factions ahead of the interests of the people. SSA adopt policies and programs consistent with its duty to serve the public. Internal constraints, particularly those without operational basis, should not dictate the policies and programs of the Agency. It is time to address both the needs of the present and the needs of the future with an extensive attorney adjudicator program based upon the tested and successful original Senior Attorney Program commenced in 1995 and move resolutely toward finally providing the level of service that the public deserves.

[Submissions for the record follow:]

Statement of Dawn R. Caldart, AIDS Resource Center of Wisconsin, Milwaukee, Wisconsin

To Whom It May Concern:

In Milwaukee, questions have been raised regarding the creditials of a vocational expert, Ms. Victoria Rei. Ms. Rei's curriculum vitae reveals a doctorate in Philosophy of Religion from "UCL." (See Janisiak v. Barnhart, 01–CV–648 (ED. WI 2001). A private investigator has determined that UCL does not exist and that it appears Ms. Rei paid the Universal Life Church in Modesto, California $100, read a book and answered 20 true/false questions to earn her 'Doctorate.' (See id.). If true, this misrepresentation implies dishonesty and casts doubt upon her ability to honestly assess claimant's ability to work.

The Commissioner has been aware of the issues surrounding Ms. Rei's credibility as an expert since 2001. Despite questions about her credibility, Ms. Rei was still used as an expert at the time of the claimant's hearing on June 13, 2002. The claimant and his attorney had no reason to believe the Commissioner would use a VE under investigation for misrepresentation and dishonesty. The case is know being reviewed at the AC.

Not only is the thought of this unfathomable but it is extremely unjust. There are no safeguard mechanisms in place to prevent this from happening. Even after the issues were raised regarding the VE's veracity, OHA in Milwaukee continued to use her as an "expert" at the expense of some very sick and disabled individuals. This conduct is egregious and inhumane.

Respectfully Submitted.

AMERICAN BAR ASSOCIATION
WASHINGTON, DC 20005
October 6, 2003

The Honorable Clay Shaw
Chair, Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515–4315

Dear Chairman Shaw:

On behalf of the American Bar Association, I thank you and the Subcommittee members for your continued focus on the Social Security Administration's management of disability cases. SSA is confronting few challenges as pressing as that of reducing unnecessary backlogs and delays while ensuring that the system is efficient, accurate, and fair. We are pleased that the Commissioner has taken on this challenge, and we look forward to examining her proposal in more detail.

We support the Commissioner's premise that a correct decision should be made as early in the process as possible. If the quality of intake and the development of evidence is improved at the early stages, it follows that there will be fewer appeals and a reduction in backlogs. Indeed, we have urged the Social Security Administration for many years to provide claimants with information to help them understand the determination process and their responsibilities, and to notify them of the availability of legal representation. We have encouraged SSA to take affirmative steps to compile accurate documentation and supplement insufficient reports, and to provide claimants the opportunity to submit further evidence before a claim is denied. We have recommended pre-decision interviews between SSA staff and claimants, and we have urged that these interviews be face-to-face wherever possible. In cases where denial is possible, the interview could provide the opportunity for staff to inform claimants of reasons why the finding of disability cannot be made, ensure that the file includes all evidence submitted, provide claimants the opportunity to submit further evidence, and advise health providers of deficiencies in the medical evidence and give them the opportunity to supply additional information. We have also suggested eliminating the reconsideration level of appeal.

While we have encouraged a focus on improvements to the early stages of the process, we recognize the need for additional resources and for changes at the hearing level. The ABA strongly believes that each and every claimant for disability benefits under the Social Security Act, Title 42 U.S.C. § 223 et seq., is entitled to a due process hearing, on the record, before an administrative law judge appointed pursuant to § 3105 of the Administrative Procedure Act, Title 5 U.S.C., applying standards consistent with the law and published regulations. We support having staff attorneys and law clerks assigned to individual judges, and we have also recommended the addition of federal adjudication officers or similarly positioned staff who could develop evidence, make a decision to allow a claim, and in appropriate cases act as a "presenter" at the hearing, provided that administrative law judges retain authority for developing the record when the claimant is not represented. This recommendation is not intended to support a return to the days of the "Government Representation Project," and we are pleased to see that the Commissioner's proposal does not appear to envision an adversarial setting. The ABA has not taken a specific position on the question of when to close the record following the hearing, and we understand that neither the agency nor the court should be required to consider an unlimited stream of additional evidence that undermines the ability to make a decision on the claim. However, we would be concerned about a bar to reopening within a reasonable amount of time upon a showing of good cause. With regard to the final level of administrative appeal, we have recommended that Appeals Council review be limited to cases of clear error of law or a lack of substantial evidence.

We have testified before the Committee on these issues in the past, and in recent months have explained our positions to Commissioner Barnhart's staff and to members of the Social Security Advisory Board. We ask that this letter be included in the record of your September 25th hearing. We look forward to reviewing the Commissioner's proposal in more detail, and would appreciate the opportunity to share our observations with the Subcommittee. Lillian Gaskin, ABA Senior Legislative Counsel, stands ready to work with you and your staff. Ms. Gaskin can be reached at (202) 662–1768.

Sincerely,

ROBERT D. EVANS
Director
Governmental Affairs Office

Statement of James E. Marshall, American Federation of Government Employees Council 215, and National Council of Social Security Administration Office of Hearings and Appeals Locals, Falls Church, Virginia

My name is James E. Marshall. I have been employed by the Social Security Administration for more than 45 years and have been an employee of the Office of Hearings and Appeals for 31½ years at OHA Headquarters in Falls Church, Virginia. I am also the President of AFGE Council 215, National Council of Social Security Administration OHA Locals, which represents approximately 5,000 employees in 132 hearing offices across the United States, as well as employees at OHA Headquarters in Falls Church, Virginia, and employees at SSA Headquarters in Baltimore, Maryland.

In his testimony, Mr. Witold Skwierczynski, Spokesperson, SSA General Committee, American Federation of Government Employees, AFL–CIO, informed you that I would be submitting a statement for the record for your consideration and appropriate action as you deem necessary. In submission of this statement, I have reviewed the oral testimony and statement of Honorable Jo Anne Barnhart, Commissioner of Social Security, presented to the Subcommittee on September 25, 2003, as well as having attended the Commissioner's briefing with SSA Union leadership on September 26, 2003, which addressed her future plans for the disability program as set forth in her testimony.

The Commissioner in her testimony and briefing described her future approach for achieving disability process improvements within the Agency. The prerequisite for her long-term strategy is predicated on the development and implementation of an electronic disability claim systems (EDIB) which is expected to begin in October, 2005.

While I fully support the Commissioner's dream to make such technological improvements at the Social Security Administration, there are insurmountable roadblocks and questions that must be answered in order to expect SSA to possibly begin implementation of EDIB to commence in October, 2005, or later. Given the current shortage of personnel within DDS and OHA to handle the current and future disability claims, careful attention must be devoted to staffing and training plans for those employees who will utilize and maintain the system. It is vital to note that the Commissioner and approximately 140 Hearing Office Systems Administrators (HOSAs) throughout the United States, during the past several years, have had a significant disagreement regarding the computer classification series and grade level for the HOSA position. This disagreement, in my opinion, will have a significant impact on this redesign initiative and serious consideration must be devoted to upgrading systems related positions within the Office of Hearings and Appeals. In addition, the Commissioner failed to address the impact that will occur due to the loss of approximately 25% of the Agency's personnel by the end of 2005 due to retirements and other means. I submit that many new hires do not intend to make SSA a lifetime career, but are waiting for an improved economy so that they will have a better opportunity for career enhancements in private industry. As such, this Agency could lose up to 40% of its personnel before full implementation of the electronic disability claim file. While it is clear from the Commissioner's presentation that using electronic folders will allow faster processing of disability claims, there is significant skepticism as to how such evidence will be copied into an electronic format to preserve its originality. Important details and nuances in medical reports and related documents must not be lost or altered in the electronic transfer. To my knowledge, there is no available system currently in existence that would allow such paper evidence to be fully included into an electronic format.

Now turning to the Commissioner's plan of establishing Regional Expert Review Units organized around clinical specialties, it is interesting to note that the Commissioner advised the Union that the clinical specialists would primarily be nurses. In my opinion, to staff these Regional Expert Review Units with sufficient clinical nurses to process the expected workload would require hiring at least 500 nurses nationally. The Subcommittee obviously is aware there is a significant shortage of nurses within the United States and that the Government pay scale is lower for skilled nurses than private industry. Accordingly, I find it highly unlikely that staffing of these units could be accomplished to enhance the processing of disability claims. Additionally, while the Commissioner indicated that these units would be responsible for adjudication of quick decision claims, normally within 20 days, and such decisions would constitute 10% of the allowances of disability claims, she failed to recognize that the majority of these disability claims would be allowed during the

five month waiting period, thereby no benefits would be payable immediately to the disabled even though the Agency processed the cases expeditiously. In my opinion, this is not an enhancement to providing quality service to the American people since historically these types of seriously ill claimants' claims were expeditiously processed so that there were no essential delays in the disabled receiving payment.

The Commissioner has indicated that these Regional Expert Review Units would also be available to disability decision makers at all levels, including the DDS and OHA, which, in my opinion, will create a roadblock and delay in processing disability claims rather than improve the process. More specifically, the Commissioner indicated that these units would be responsible for contacting claimants' treating sources to clarify and/or obtain additional information, essentially approve the types of consultative examinations and medical/laboratory testing required, as well as providing vocational information to assist the decision makers. Common sense would indicate that to effectively perform the duties and responsibilities that are set forth for these units would require staffing of approximately 5,000 highly professional employees to handle the massive projected future disability claim workload. As such, I believe that the Agency would require an additional 5,000 FTEs to meet the needs of staffing and processing disability claims by these review units.

While I support the Commissioner in eliminating the reconsideration step and creating a reviewing official position to evaluate disability claims as the second stage of the process if a claimant files a request for review of a DDS determination, I do not believe this position would require that the individual be an attorney. I note that in response to several questions by me at the briefing, Commissioner Barnhart indicated that this reviewing official position would be staffed in excess of 1,000 attorneys. I note that if OHA utilized every attorney decision writer for this new reviewing official position, the Agency would still be required to hire approximately 500 attorneys to fully staff the position. Thereafter, the Agency would be required to backfill the loss of decision writers for drafting decisions for the ALJs. The training needs and loss of productivity by essentially depleting ⅔ of the decision writers and replacing them would be extremely costly and obviously would create a significant unnecessary backlog of claims at the hearing level. Also, since it is reasonable to believe that numerous ALJs' support staff personnel would be promoted to the decision writer position, delays would immediately incur in scheduling hearings and writing decisions. In retrospect, I submit HPI would seem to be a success when compared to the anticipated failures of the Commissioner's plan. It is clear that this position must be staffed with attorneys and nonattorneys and that clerical support must be provided to the reviewing officials to possibly achieve any desired success within three years of implementation. Further, I note that the Commissioner's proposed plan to solely use attorneys for this review step would bring forth a more legalistic process prior to a hearing and not a user friendly process that the American people deserve. Finally, I submit that approximately an additional 3,000 FTEs would be required to fully implement this new second stage of the Commissioner's new process.

I fully support the Commissioner's proposal to continue the de novo administrative hearing process and the closing of the hearing record upon issuance of an ALJ's decision. I note that the proposed new decisional format which an ALJ will be required to utilize will require substantial training for decision writers and, most likely, be more time consuming to provide a defensible decision. As previously stated above, approximately an additional 1,000 FTEs will be required to fully implement the hearing process changes.

I totally oppose the elimination of the claimant's right to request review of a hearing decision by the Appeals Council. As the Subcommittee is aware, the Appeals Council currently provides relief to approximately 30% of the claimants who request review of the ALJs'decisions, primarily by remanding the cases back to the ALJs. I submit that the end result of this remand process generally is a favorable decision being issued to a disabled claimant. Based on available information provided to me, I note that during the past several years, the Appeals Council has made significant improvements in reducing processing time and its backlog, notwithstanding some staffing decreases due to retirements and other reasons. With this significant improvement, the Appeals Council's pending caseload should be at a workable level by the end of this year, noting that some staffing enhancements may be required for certain positions. I submit that when the Appeals Council has been able to operate properly and in a timely manner, it has provided an effective review of ALJs' decisions. Unfortunately, the backlog of cases, Management's various initiatives and sporadic staffing problems have hampered the Appeals Council's primary responsibility to act as a screen between an ALJ and the Federal Court level. I believe with the closing of the hearing record upon issuance of the decision, the use of digital recording of hearings, several other technology changes, as well as other proposed

short-term initiatives, the Appeals Council review process will be streamlined and result in a substantial decrease in voluntary court remands. In fact, it is my belief that the majority of cases that will be pursued through the Federal Court level will be defensible decisions and once claimants' attorneys realize this fact, there will be a significant decrease in filings of civil actions. In plain words, both the claimants and the legal profession will accept the decision by the Appeals Council as the final adjudication of a claim. The Commissioner's apparent alternative to create a quality control for disability claims by an Oversight Panel will not have the same effect in the adjudication of a claim and I submit there will be a substantial increase in civil action filings for many years to come if the Appeals Council is eliminated.

In closing, I thank the Chairman and Members of the Subcommittee for the opportunity to submit this statement to you for appropriate consideration and action regarding the Commissioner's proposed changes to the disability process within the Agency.

Thank you.

SHEBOYGAN, WISCONSIN 53081
September 23, 2003

Congressman E. Clay Shaw, Jr.
Chairman,
Subcommittee on Social Security
Committee on Ways and Means
1102 LHOB
Washington, DC 20515

Dear Congressman Shaw:

My name is Jennifer L. Bartel, and I suffer from a debilitating illness which has rendered me unable to work.

In July of 2002, when after five months on short term disability it became apparent I would not be returning, I filed my initial claim for social security disability.

My illness is well documented and has progressed steadily worsening over the course of 18 years, with the most sudden drastic change beginning two and a half years ago.

The afore mentioned documentation comes from Walter reed army hospital, Bethesda naval hospital, The mayo clinic at Rochester mn. And many specialists and medical professionals in between.

Before becoming ill, I was a single mother of two girls, one 16 and the other 9, we lived in a decent three bedroom duplex in a middleclass subdivision, I drove a safe reliable vehicle which enabled the three of us to get where we needed to go without worrying that we would be left stranded on the side of a highway somewhere.

While I was not able to afford much in the way of extra's as a single mother, I was able to provide my girls and myself with clothes, food, medical care, medications, a good safe home, and occasionally managed a treat like a new bike for one of them.

Becoming ill as I'm sure you can imagine brought forth many changes in not only my life, but the lives of my children as well, they witnessed their mother going from a strong independent unstoppable force, to a woman who on most days is too ill and in too much pain to keep food down, sleep, pick them up from school etc, certainly not the least of these changes is the financial change.

I was advised when I submitted my initial ssdi application the decision would be made in 3 to 6 months, if or when I was approved, they would back pay my benefits appropriately, by this time, I had been living on 60% of my regular income [via short term disability from my employer] for five months and was very close to financial ruin.

In late Oct. 2002 I was denied ssdi, and given 60 days to appeal, that appeal was received on dec 2, 2002 by that time, five months had passed since my initial application was submitted, and my children and I had lost our home.

My daughter turned 10 and imagine her heart break when she learned there would be no party, no presents, not even a cake, because mommy had no money to provide it.

Christmas came, I watched ill and in pain both physically and mentally as I saw two children fighting back tears when on Christmas morning there was nothing from their mother to unwrap under the Christmas tree provided for us by my husband to be, and the heartbreakingly painful reality that I was failing as their mother.

Each month that passes represents $327.00 [whats left after my ltd subrogates] that we do not have to help support us, $327.00 may not seem like enough to make a difference however, when winter coats and clothes have to be gotten at good will, and gloves or mittens can't be purchased at all, $327.00 is a great deal.

When you have lost 120+ pounds due to your illness and you literally have no clothes to wear because of it, and no money to buy them even at yard sales, $327.00 is a huge amount.

When once again you have to tell your 10 year old daughter she can't go on a class field trip because you can't pay the fee, $327.00 is a fortune when you desperately need two root canals done on teeth that have weakened and broken because you are so undernourished from being ill, but you can't afford to have the teeth pulled let alone fixed, $327.00 is allot of money not to have.

The reconsideration, I was told, would take 60–90 days, we waited, going without even the most basic things, and then we waited some more:

90 days passed . . . No new clothes for Easter

120 days passed no new bikes or clothes this summer

150 days passed, no, we don't have enough money to stop and get ice cream

180 days passed no you can't go to the pool with your friends, I don't have the money for you to get in, no I can't afford to pay for you to get your hair cut, my credit cards are maxed out just buying food and paying for medication co-pays, my teeth still broken and painful, my illness still rendering me unable to work to support myself or my children, depression caused by chronic illness and constant pain from it is compounded over and over with each "I can't afford it" and "we have no money", each "past due final notice" stamped across the only mail that arrives.

The stress of being so ill worsened daily as you wait and all you get from social security when you call is "we're working on it".

210 days—finally, an envelope arrives from social security—your hands shake, your mind racing, "please god let this be good news" is all you can think for a moment followed by complete and total devastation, fear and rage when you see the words "you are denied".

That's when the tears come, exhausted by an illness that has already robbed you of literally everything, even your self respect, and betrayed by the very system that is supposed to be there to help you.

Suicide crosses your mind—since than at least your children will be provided for and you won't be in pain anymore, then more tears, as you try to read and understand the form letter that says despite the fact that all of your medical professionals say you are too ill to work, "we" those who have never seen you, never spoken to you, feel your not ill enough to not be able to work, and despite the fact that it has already taken them four months longer than it was supposed to, it is going to take up to two more years if you appeal this decision.

They might just as well come right out and say "oh by the way, if you die of your illness in the mean time, we're sorry, we were wrong."

365 days—from the initial application I retained an attorney, who warned me, "Jennifer try not to get too frustrated, the process can take up to two years".

I was so profoundly sad, and feeling completely beaten by the process already, at that moment I knew things would get worse.

380 days—my children and I unable to afford the car payment anymore lost our vehicle.

400 days—no new school; clothes again this year

420 days—no senior pictures for my eldest daughter, and even if she were to be accepted at a college, there is no way I can help her even buy a book let alone with tuition.

You little one won't be getting the filling in a cavity any time soon, and we can pretty much forget about braces for her teeth, or a birthday present from mommy again this year.

I won't be getting all of the medication I need, nor will those two teeth get fixed, my already dangerously low weight will continue to drop, and by the time I get a letter telling me when my alj hearing is, it may be too late to matter.

We are only one family, this is only one story, there are thousands like us, many who's stories are even worse.

Please change this system before too many more of us literally die waiting.

Sincerely,

JENNIFER L. BARTEL

Statement of Terry G. Clark, Sparta, Georgia

Radical reorganization of the hearing and appeal process is needed immediately if the best interests of disabled citizens are truly to be served. While it is true incidences of fraud exist, the internal stopgaps imposed currently be the Social Security Administration seem to have had only minimal impact on the would-be offenders and have greatly impeded the legitimate claims of those with real disabilities.

In my own case, I have been denied disability payments twice—even after two highly qualified cardiologists who have treated me personally have attested in writing to my condition. The decision to deny was supposedly made by Social Security appointed physicians who reviewed only my medical documents. It is interesting to me that no physicians within my knowledge find it to be standard operating practice to examine and treat patients without having some personal knowledge of them, yet the Social Security Administration seems to have no problem making decisions in this manner. This, of course, is added to the fact that the initial decisions to deny claims are routinely made by hourly employees who barely have high school diplomas.

The current process of applying for and receiving disability benefits does contribute to the economy. Routinely attorneys receive 25 percent of any back disability payments owed to the client once a settlement is made. This is because is it impossible for the average person to negotiate alone the superhighway of red tape which has been laid by the Social Security Administration. Most people retain attorneys to assist them after they have been denied benefits at least twice. The system takes a minimum of 2 years to act and by that time, a person with no income is in dire straights indeed. If my wife were not gainfully employed, we would be on welfare.

I encourage you to stop studying a problem that any average citizen who has had any dealings with the Social Security Administration can articulate for you clearly. Reconstitute the Social Security Administration. Hire educated, highly qualify staff with a background in social services and abbreviate the process for citizens needing disability assistance. Impose stiff penalties for fraud and return to relying on the democratic principle that people are innocent until proven guilty. The time would be better spent investigating suspected fraud than penalizing honest citizens with needless delays and red tape.

Statement of Paul C. Clark, Cibola, Arizona

The local SSA office lost my claim for more than ten months. I could not work because of my disabilities received in an automobile verses pedestrian accident. My home is 20 miles out of town. I was given EBT food stamps and no money for gas or mandatory car insurance to drive to town to use the EBT food stamps. Because the local SSA office lost my claim for more than ten months, my credit was ruined, I had zero income and my home was within 30 days of being repossessed, I could not pay any of my creditors, utilities, credit cards or any other financial obligations, because of the gross errors of the SSA local office. If it were not for the fact that Congressman J.D. Hayworth intervened on my behalf, I would surely be dead by now. The SSA has never even considered trying to get my credit cleared up due to their mistakes and gross negligence. My credit is now ruined for at least the next seven years, through no fault of my own. The SSA made no effort to apologize for their errors or accept any responsibility for ruining my credit. My claim took more than 24 months to settle. The stress of this ordeal has caused me to have Chronic High Blood Pressure. The Veterans Administration is cheating me out of my Service connected disabilities for my Military Service and service in Viet Nam. If I were thirty years younger you would know who I am, I would be the one in your face. I can not believe how this government has treated an Honorably Discharged Veteran of the Armed Forces of this Great Country.

MIDLAND, TEXAS 79701
September 23, 2003

Hon. E. Clay Shaw
Chairman Subcommittee on Social Security
U.S. House of Representatives
2408 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Shaw:

Please consider this letter as part of the record of the hearing your Subcommittee will conduct on September 25th concerning Social Security's management of its Office of Hearings and Appeals.

Although I have served as an ALJ for Social Security for the past eight years I am writing this letter in the exercise of my right as a private citizen to communicate with Congress. These remarks are made in my individual capacity and not as an administrative law judge or government employee.

I say, "administrative law judge or government employee" because that is precisely the problem. The SSA Commissioner has historically taken the position that the Social Security ALJ's are not judges as described under the Administrative Procedures Act. At the same time the Commissioner has historically maintained that the OHA division of the agency provides a due process hearing at the end of the claims process. The discord produced by this fundamental inconsistency has led to the mess that exists today in the management of the OHA.

Undoubtedly, many witnesses will offer different solutions before your subcommittee. Most of the proposals will probably be beyond anything you can do legislatively.

One thing is easily within your capacity as legislators. You can amend the Administrative Procedures Act to provide that the ALJ's appointed by the SSA Commissioner either are or are not covered under the Act.

If they are not judges, but mere employees, then it makes little sense to continue expending federal funds to maintain an elaborate OHA division under the pretense that they are preparing cases to be heard by a judge. If they are not judges, then the present ALJ's should be re-designated as government employee hearing officers to provide a federal administrative review of the decisions made by the state disability determination agencies. There would be no need for a record, marking exhibits, Appeals Council review and all the things that now delay the process.

If they are judges, as contemplated by APA, then it makes little sense to place them under the control of SSA managers who have no idea what a judge is supposed to know or do. If they are judges, then the Chief ALJ should have the authority and the appropriate portion of the agency budget to make the ALJ's productive and accountable in a judicious way. Judges could direct the expeditious preparation of cases for hearings and write decisions in ways that would eliminate many time consuming and counterproductive practices now imposed by non-lawyer managers.

I am happy to work as an adjudicator for SSA. I think this is the most important work a lawyer could be doing in America today. I don't care whether I am called a hearing officer or a judge, as long as I have a chance to insure that the correct decision is made on the claim at the earliest possible time. I am not happy about the amount of time and resources I see wasted everyday in this schizophrenic struggle which has resulted in little, if any, true accountability by anyone.

I believe an amendment to the APA would be a significant step toward resolving the underlying conflict that results in recurrent management crises at OHA.

Very truly yours,

DAN DANE

Statement of Richard Dann, M.D., Auburn, California

This e-mail is in regards to SSA Commissioner's Broadcast dated 9/25/03 and her testimony to the Ways and Means Committee re: SSA Disability Redesign. Major changes are proposed, but the integrity of the process is threatened. The three questions posed by President Bush to Commissioner Barnhart can be answered as follows: "Why does it take so long. . . . decision?"—It is a WEIGHTY decision, costing SSA and US taxpayers an average of >$100,000 for single folks, $200,000 for married with dependents. I realize that Federal politicos don't always consider government expenditures in their decisions, but taking 60–70 days to assess whether an individual has a long term disability IS APPROPRIATE! If the politicos are so con-

cerned about the time involved, it is wiser to provide TEMPORARY BENEFITS to those awaiting a Title 16 decision (Title 2 decisions already mandate a 5 month waiting period between date of Disability and start of benefits—Is that right, that individuals who actually pay into the system, get a later start on their benefits than the indigent who may never have worked a day or paid a cent of taxes?!). Three months of temporary benefits are a lot cheaper than a rushed, inaccurate decision that could last a lifetime. "Why can't people who have an obvious disability get a decision immediately?"—This area of concern has some merit, but it applies to a tiny percentage of the total number of decisions. The individual with a transected spinal cord, or pancreatic cancer, or brain dead on a ventilator, or <1200 grams birth weight are clear allowances. These cases do not take any substantial time to decide at the DDS level, and ALREADY frequently are put into Pay Status immediately via the "Presumptive Disability" (PD) determination by the DDS, pending full evaluation. This is an area where further improvements could be made by placing the equivalent of a DEA III trained individual at the SSA Field Offices to TRIAGE applications for these RARE special circumstances. I do not see the need for an attorney in the process. "Why would anyone want to go back to work after going through such a long process to get benefits?"—Quite simply, the benefits are a pittance—how would any of our Congressional lawmaker friends retiring on their full salary for the rest of their lives feel about living on the <$1500/mo.? Can they even relate? Most individuals will want more money to live on than the modest monthly SSA allowance, and will either strive to find work commensurate with their capabilities, or will settle for a very modest existence. What we do need to consider is that there are entire families living on SSA Disability, sometimes for multiple generations, still occurring even with the careful evaluation at DDS with a physician input—if you have 4, 5 or 6 individuals in a household getting $1500/mo, the household income can be fairly substantial, so the disability status of those in the household should be carefully assessed and reassessed as appropriate.

There are a number of problems with the system in my opinion, having worked in it for over 5 years. The fact that claimants have infinite filing and appeals opportunities is one problem that wastes endless time and resources at the DDS—what would be wrong with a filing moratorium for a year after the last denial and Reconsideration unless substantial new evidence could be shown to the SSA Field Office, preferably evaluated by a DEA III trained individual at the Field Office? The concept of the Medical Improvement Review Standard at the Continuing Disability Review (CDR) is another problem; ongoing disability is assessed by comparison to condition at last evaluation, aka Comparison Point Decision (CPD), and if no significant changes are evident at the CDR compared to the CPD, by statute, Disability continues. There is currently NO APPEAL PROCESS FOR SSA in the situation of a poor quality allowance decision that allows a claimant at CPD but clearly the individual is not disabled by that condition. For instance, I have done many, many cases of CDR's where Listings were misinterpreted or med/voc rules were misapplied or an ALJ assessed Disabled after two full teams of DDS Disability Evaluator Analyst/Medical Consultants had decided otherwise, and the individual is clearly NOT disabled at the CDR. Due to MIRS, the bad decision has to be perpetuated ad infinitum, despite a current completely normal exam, because the individual was allowed with a similar exam. The best example of MIRS gone wrong is the CDR case where the prior folder has been lost; rather than reassess the individual for current disability status, they MUST be continued due to inability to compare current findings to those at the CPD. The current (sometimes completely normal) exam becomes the new standard by which the next CDR is done; I have seen COMPLETELY NORMAL adults continued on SSA Disability many times, due to bureaucratic rules and a total lack of any appeal process of inappropriate allowances when such individuals are found by the DDS at the CDR process.

I applaud efforts to streamline SSA Disability Claims processing, but the integrity of the system and its large payouts are more important than the speed of the decision. A fast erroneous decision is much more expensive than a thorough assessment to claimants and taxpayers alike. Keep Medical Consultants in the DDS's! Thank you for your consideration.

SSA Commissioner Jo Anne B. Barnhart is proposing some changes to the current system for SSA Disability. Unfortunately part of what she proposes would eliminate all State level Disability Determination Services Medical Consultants and depend only on Regional Medical Consultants for medical expertise in evaluating SSA Disability applications. There is clear merit to allowing rare obvious clear cut cases without going through the full State DDS process, and allow more difficult cases to be processed by the State DDS. The problem is that Commissioner Barnhart proposes to simultaneously remove the medical consultants from those State DDS's! Many attempts have been made to decrease the use of "expensive" physicians (an

MC gets paid $120,000 per year in CA) from the process in the past e.g. Single Decision Maker, Disability Claims Manager, etc. and all attempts have shown that the non—medically trained Disability Evaluation Analysts (a six month training period is not even close to a medical doctor education!) NEED the expertise of medical doctors to help evaluate medical records from treating physicians in some instances point out very inappropriate "Medical Source Statements" attesting to their patient's level of disability. Attorneys will tell you that only a physician can adequately contest another physicians opinion in court. I am an Occupational Medicine physician with additional training and certification in Disability Examinations, and have worked in the Roseville CA DDS for over 5 years. I can tell you that very few community physicians have ANY formal training in Disability assessment, and that many of their Medical Source Statements (a statement of their patients capabilities) are "shot from the hip". These MSS's are frequently inconsistent with the person's activities of daily living, treating physicians own medical records, and Consultative Medical Examinations done at DDS expense. Increased dependence on treating physician MSS's without professional review at the DDS level will cost the SSA far more than it will save. The inclusion of physicians at the DDS level enables SSA to avoid paying benefits to those who are not disabled. The average cost of an allowance for SSA Disability is >$100,000, $200,000 if married with children! Integrity and accountaility of the system depends on having MD input on the cases, especially the "difficult" cases that Commissioner Barnhart intends to now concentrate into the DDS's. Bad decisions cost a fortune, much more than any savings that will be realized from eliminating Medical Doctors from the DDS. Additionally, the current model has MD's working steps away from the DEA's in the DDS's, and our expertise is frequently sought informally by DEA's as to what medical findings and evidence are needed for various cases to properly evaluate them. The Regional medical consultants would have to be contacted by phone or e-mail, which is much more impersonal and less convenient, so it just won't happen. The quality of decision will suffer, and the already difficult DEA's job will become even more difficult. I have heard that the operating costs of the SSA Disability system run <1% of total budget—what is wrong with that!!! There is great merit to training ALJ's more extensively-they get a skimpy two week course in medical/disability training and then have the power to overturn decisions by DDS personnel (typically after assessment by TWO different teams consisting of experienced medical doctors and a DEA by the time an ALJ gets a case) and frequently their decisions appear irrational and emotionally based. Please look into the situation further; I believe what I am telling you is a fair assessment. All of the Commissioner's plans are outlined in the Commissioner's Broadcast dated 9/25/03. Please help to maintain the integrity of the SSA Disability application process—keep MC's in the DDS! It is in the interest of the claimants, American taxpayers, DEA's and obviously the DDS Medical Consultants. Thank you, Chairman Thomas.

Statement of Stephen W. Davis, Annandale, Virginia

I've just read Commissioner Barnhardt's proposal to reform the disability process, in part by eliminating claimant's opportunity to request review of Administrative Law Judge decisions by the Appeals Council of the Office of Hearings and Appeals.

This proposal, a rehash of an old and bad idea, has floated for years. I have been an analyst with the Appeals Council since 1979, during which time I have processed thousands of requests for review. A significant percentage of those cases were remanded to an Administrative Law Judge, as Barnhardt admits, but not solely or primarily because the record was incomplete. Most often, the decision itself was flawed by legal error, insufficient or inaccurate summation of evidence, inadequate consideration of opinion evidence. The problems here are like the problems elsewhere in government, where inadequate human resources, pressed for production, make errors of logic and judgement in service of numbers. Eliminating the request for review would deprive literally hundreds of thousands of individual claimants the opportunity of having the merits of their claims and the legal and evidentiary sufficiency of the decisions made on those claims reviewed by a highly experienced cadre of analysts and Administrative Appeals Judge's and Officers.

Further, elimination of the Appeals Council's function would, under Barnhardt's proposal, appear to allow claimant's to directly appeal the Administrative Law Judge's decision to Federal Court, thereby inundating the Courts with a workload they have not the time or resources to manage. The Appeals Council serves as a filter whereby claims with merit are given every administrative opportunity to prove

their case. Barnhardt says nothing about individual's whose claims are dismissed by Administrative Law Judge's, often in a fashion inconsistent with policy and/or fact. Currently, dismissals upheld by the Appeals Council cannot be appealed to Federal Court. Does Barnhardt propose that appeal rights to Federal Court be given to such dismissals, thereby increasing yet again the number of claims on already overburdened dockets.

Since I have been an analyst, including 7 years with the Civil Actions Division of the Office of Hearings and Appeals, I have seen countless political appointees wander to the podium with schemes like these; simple minded and driven by ambition to gut the federal workplace. I must protest and I urge the Committee to take her proposals with several tons of Morton's.

Statement of Margaret deVries, Ladson, South Carolina

I have tried and failed to get any help from the SS administration, Up until 6 years ago I was a productive member of society, for years I paid self employment taxes and SS, finally I had to admit I could no longer continue to work, I was diagnosed with Fibromyalgia, Myofacial pain syndrome, chronic fatigue, osteoarthritis in back and I also have a severe hearing loss in both ears. . . . I have since endured 2 major back surgeries to fuse the L4 and L5 discs in back this leaves me unable to bend or lift, yet the SS seems to think I can lift 20lbs?? I am at a loss to describe the letter they send me saying I was still employable, suffice to say with all the restrictions they put on me and which I have, there is no one who would employ me! Yet they seem to think I can get a job! I suffer extreme pain in back and hip area, fatigue and depression from trying to cope with my limitations and days when I can barely get out of bed. . . . It saddens me to realize few people in congress are willing to help us! I am still waiting on a reply to my own Congressman here in SC from a letter I wrote in April. . . . Why are thousands of people in pain being ignored by those we trusted to look out for us? I assure you we all have family, friends and neighbors who are appalled by the treatment we get! For many years I paid approximately a third of my wages into Taxes and SS and now when I need a little help there is none available! It saddens me that such a great country as ours can ignore its own people in need.

Thanks for your time.

Statement of Kristin Royster, Federal Managers Association, Alexandria, Virginia

Mr. Chairman, thank you for allowing us at the Federal Managers Association (FMA) to submit a statement on the challenges and opportunities facing the Office of Hearings and Appeals (OHA) in the Social Security Administration (SSA).

FMA represents the interests of the 200,000 executives, managers, and supervisors in the Federal government. Within FMA, we have Conferences divided along agency lines, one of which is the FMA–Social Security Administration (SSA) Conference representing executives, managers, and supervisors in all Social Security Program Service Centers, the Office of Central Operations, and the Office of Hearings and Appeals.

We have read, with significant interest, the testimony of all of the Office of Hearings and Appeals stakeholders who testified on September 25, 2003 regarding management issues within OHA. Since the hearing, we have also examined Social Security Commissioner Jo Anne Barnhart's recently released proposal on restructuring OHA and the appeals process. While FMA supports certain aspects of the Commissioner's proposed plan, we have concerns that there will continue to be underlying problems which, if not specifically addressed, will continue to inhibit the success of any reform plan. Briefly, FMA supports the Commissioner's and other witnesses' remarks on:

- The Due Process Hearing;
- The recommendation to close the hearing record following the decision by the Administrative Law Judge (ALJ);
- Accelerating the use of the Accelerated Electronic Disability Folder (AeDIB), video teleconferencing, digitally recorded hearings, and a strong management information system;

- The need to aggressively address the staffing issue in the Social Security Administration (SSA);
- Agency efforts to make meaningful improvements to the OHA process;
- Elimination of the reconsideration step only after the full implementation of the Reviewing Official (RO) position; and,
- The establishment of the Regional Expert Medical Units.

Our main concern with the Commissioner's reform proposal is the elimination of the Appeals Council in favor of the creation of Oversight Panels. Underlying problems that will inhibit the successful implementation of these proposals and the full realization of the benefits of any reform plan include:

- The lack of a meaningful performance appraisal system;
- Severe staffing imbalances; and,
- The cumbersome and lengthy process to hire and assign ALJs.

While we believe that some of Commissioner Barnhart's proposals may have a positive impact on OHA processes in the long term, others, such as the elimination of the Appeals Council, should not be implemented. It is also important to note that full implementation of other aspects of the proposal will take time. The plan is predicated on the successful implementation of AeDIB, which even the most optimistic forecasts indicate will take two to three years. Additional changes will then be followed by the necessary learning curve for affected employees, which will also be a two—to three-year process.

Meanwhile, OHA is facing a growing backlog of pending cases which need immediate attention. Over the past two years OHA has made tremendous strides in improving its disposition rate and efficiency. However, because of the aging of the American population, OHA is receiving more new cases than ever before—while staffing levels remain static. The rate of receipts is projected to continue to rise; therefore, the backlog will not decrease until staffing levels are increased. OHA desperately needs some short-term relief in the form of additional employees to deal with the current situation.

Hearing Process Improvement Initiative (HPI)

Many of the comments presented at the hearing focused on the failure of the Hearing Process Improvement Initiative (HPI). However, in the last few years, OHA has reached a number of milestones:

- In fiscal 2002, OHA resolved the highest number of cases in its history;
- In FY03, according to preliminary figures, OHA will resolve 563,000 cases, which is an increase of 31,000 cases from FY02; and,
- OHA will report a record daily dispositions-per-ALJ rate of 2.30.

While we concede that HPI was not a perfect system, it is important to acknowledge the beneficial results that it has had on OHA. HPI gave OHA an enhanced management structure in which both the clerical and attorney/paralegal staff were brought under one umbrella. This was a very important enhancement which allowed for a more coordinated effort for all levels of ALJ support. There is one source of direction for all the support staff—the Hearing Office Chief Administrative Law Judges (HOCALJ), Hearing Office Directors (HOD), and Group Supervisors (GS). This structure must be maintained and must be given the flexibility to manage all the resources in a process that will be more responsive to the individual ALJs. It must also allow for recognition of the differences in offices, workloads, and, most importantly, staffing resources. OHA must allow their managers to do what they were hired to do—and that is to manage their programs and people.

The structure of HPI also introduced group accountability. This resulted in a sense of disenfranchisement on the part of most ALJs, and initially, there was a lack of personal accountability on the part of almost all involved. However, over time, the situation has improved, and there now exists a better understanding of group accountability on the part of our employees. Nevertheless, measurable performance standards would assure individual accountability—and they are sorely needed in SSA. We would agree that clear assignments would enhance individual accountability; it is imperative that accountability be returned to the system. We believe that this would allow for a staff that is responsive to the individual ALJ's needs. However, we feel this can be achieved under the existing management structure.

While it is appropriate to be responsive to the individual ALJ, there is also an obligation to maintain management oversight of the process. Ultimately, this is not about the ALJ, but rather about providing the best service possible to the claimants, or to use the words of the Association of Administrative Law Judges (AALJ), a unit of the Independent Federation of Professional and Technical Engineers (IFPTE)/

AFL–CIO, in testimony provided in June 2002, it is about a "citizen-centered" process. Resources must always be balanced and used appropriately to achieve maximum results for the entire office. This cannot be accomplished in an environment in which each ALJ operates as an independent entity. The ALJs, while independent, are employees of the Agency and are responsible for the Agency's work. The ALJs, as part of a different bargaining unit with separate interests, cannot be given the authority to direct the work of others.

Management is obligated to complete all of the Agency's work in the best manner possible, and to work with each ALJ to determine the best use of available resources in order to achieve the best possible working arrangements for all. We would propose that this supervision continue to be provided by those with the experience to manage and, when necessary, redirect the resources—the group supervisors (GS). There is no reason that staff cannot be assigned to do work for an ALJ (with appropriate input from the ALJ) and with oversight responsibility being done by a GS. It is only with such cooperation that the work of OHA is accomplished.

We need a system that will give us the flexibility to use the skills and strengths of individuals across a broad band of tasks. We should not be bound by negotiations that dictate who will do what for how long.

Automation Initiatives

Potentially, these initiatives—including AeDIB, video-teleconferencing, voice recognition, and the use of Reminder Pro software—will have the greatest impact on productivity and will significantly alter the way we do business. All necessary resources need to be devoted to AeDIB, as it will virtually eliminate case preparation, in addition to providing significant savings on mail & storage. As we move closer to this reality, we need to look at the entire structure of the field office and the positions within. We cannot start too early on this project considering the impact on the senior case technicians (SCTs) and the potential to easily distribute work to where the resources are. The positive impact that AeDIB can have on the SCTs who spend much of their time preparing the cases for review right now would be substantial. The full implementation of AeDIB will allow SCTs to spend time on other functions that will help to decrease the backlog OHA currently faces.

The increased use of video-teleconferencing should also be a focus area for the Agency. Videoconferencing will have an immediate effect on the number of backlogged cases by allowing ALJs with smaller caseloads to decide cases in other areas where the workload is higher, thus creating a more balanced workload.

Meaningful Performance Measurement

As we previously mentioned in testimony submitted to the subcommittee in June 2002, the development of a meaningful performance management system should be a top priority for OHA. The success or failure of any of these initiatives will be directly related to management's ability to hold all employees accountable for their work. Without meaningful performance measurements, we will witness only limited success at best.

Many of the problems within the disability process have run parallel to the deterioration of our performance management system. Our performance management system began to decay in the late 1980s and has steadily regressed. Group-based accountability, under HPI, only moved us further from individual accountability. The current Pass/Fail appraisal system does not provide incentives for high performance, and we are seeing the grave consequences of that.

Each year the Social Security Administration presents its Government Performance and Results Act Annual Performance Plan. This plan describes specific levels of performance and outlines the means and strategies for achieving those objectives. The objectives are supported by indicators, which are used to measure the agency's success in achieving the objectives. The performance indicators are translated into goals that are shared with SSA executives. These goals are then clearly presented to managers and supervisors as expectations for performance. At OHA, for example, the indicators are expressed in terms of dispositions per day per ALJ, processing time, percent of aged cases, etc. As noted above, SSA holds managers and supervisors responsible for communicating performance goals to agency employees. However, when the goals are communicated to the employees, managers are required to communicate in very generic terms due to the absence of numeric standards.

Our current Performance management system in SSA addresses these elements, but at an organizational level rather than an individual level. We certainly have set performance expectations (**Planning**), but these are agency goals, not individual goals. As directed by the system, progress reviews are held (**Monitoring**), but since there is no individual measurement, the discussions are generic. Ideally, we would spend time training (**Developing**) our employees, but in reality, most of our offices

suffer from significant staffing imbalances and struggle just to accomplish our most basic missions. We rate (**Rating**) our employees on a Pass/Fail appraisal system, which fails to distinguish individual performance. Finally, our rewards (**Rewarding**) system is essentially a "do-it-yourself" process. Rewards are currently determined by regional and national panels, which make their decisions almost exclusively using written recommendations with little knowledge of the offices or the nominees. The recommendations—written by the employees themselves—do not always provide an accurate view of an employee's workload or their ability. We propose that rewards be awarded by local panels as is done in SSA field offices, which allows awards to be made by officials who are well-informed about the accomplishments of an office and its employees.

In a September 2003 poll conducted by FedNews Online, many Federal employees expressed their displeasure with the current Pass/Fail appraisal system that is used throughout the government. Seventy-six percent of the poll's respondents do not believe that the Pass/Fail system is an improvement from the more traditional five-level performance appraisal system. Sixty-eight percent of respondents indicated the biggest problem with the Pass/Fail system was that outstanding employees were given the same performance rating as mediocre employees.

Our current performance management system sends the message that performance does not need to be individualized. Because the standards are so generic, performance cannot be measured on an individual level. The labor-management contract requires that data focus on the process, not the individual. For all intents and purposes, the system is one of non-accountability. In spite of an employee's best effort, the employee will simply "pass" under current criteria. Award money is distributed according to a formula based on the number of employees on the payroll. This distribution is completely devoid of any recognition for performance, even at the office level. Since we have no individually measurable standards (numerics) that can be taken into consideration, overtime/credit hours/flexiplace must be given to anyone interested.

It is absolutely critical that our employees are provided with clear goals. These goals must be understandable, measurable, verifiable, equitable, and achievable. An Associated Press article dated May 27, 2002 describes how the Department of Veterans Affairs has succeeded in slashing their backlog of pending claims. VA Secretary Anthony Principi was quoted as saying, "We decided to really declare war on that backlog and took some rather bold steps to address it. We're really getting this backlog under control, and we did it through sheer focus and discipline, performance measurements and production goals." When employees know what is expected of them, they are better able to focus their efforts.

There is an old adage that states, "What gets measured gets done." Implementing an effective performance plan within SSA given the current culture will be difficult. But if the Agency expects to meet its objectives it must be done. OPM has prepared *A Handbook for Measuring Employee Performance*. This Handbook outlines the guiding principles for performance measurement as follows: 1) performance management must be viewed as a valuable tool, not as an evil; 2) acceptance of the process is essential to its success; 3) we must measure what is important, not what is easy; 4) the plan must be flexible enough to allow for changes in goals to keep the process credible; 5) we must rely on multiple measures; 6) employees must perceive that performance measurement is important; and, 7) management must demonstrate that performance is critical to organizational and individual success. These are the principles which must guide efforts to reform the current system.

A strong performance management system will go a long way in restoring the Social Security Disability Program to the status of a premier program. Our current leadership is committed to reforming our performance management system, but we realize it will take several years to have an effective system in place. Nonetheless, any initiative implemented prior to having a meaningful performance management system will have minimal impact.

Staffing Imbalances

In an April 18, 2003 letter sent to A. Jacy Thurmond Jr., Associate Commissioner of OHA, we outlined a number of issues related to the staffing of OHA offices. Since the late 1980s, OHA has used the employee-to-ALJ ratio of 4.5-to-1 to determine staffing in its OHA offices. This ratio is basically applied to all hearing offices regardless of individual office dynamics. However, since the ratio was established, conditions have changed at OHA offices, therefore making it necessary that the staffing of OHA offices reflect the current needs of OHA offices.

We at FMA fully recognize that there must be a general formula in place in order for a central office to be able to compare the regions' staffing levels. However, a useful staffing formula must be derived by performing work studies on various posi-

tions to determine the amount of time that is required on average to support an ALJ. Since the current 4.5: 1 ratio was established, OHA's technology capabilities have advanced significantly and these advancements have dramatically altered numerous work functions and, correspondingly, the time it takes to perform the functions. Furthermore, we feel that it is shortsighted to use such a formula in the strictest sense, regardless of how much effort was devoted to work-studies. Focusing only on the pre-set, "ideal" ratio—without considering other internal or external factors that impact an office's ability to serve the public—will prevent OHA from placing itself in the best position to meet coming challenges. The formula needs to be reviewed and updated as procedures, technologies, and dynamics change to ensure a true staffing picture. We believe that our actual staffing needs will be better realized with the following changes:

- Regions should have the flexibility to staff based on "actual" needs and not just "predetermined" ratios.
- Position mix must be considered in any staffing determination.
- Ratios or guidelines have their place, but must be reviewed and updated as advancements in technology are realized. In addition, the regions should have the flexibility to surpass the pre-determined ratio when office dynamics warrant additional staffing.
- For purposes of a general guideline ratio, only "pure" production employees should be included.

In order to be in a position to handle the anticipated increase in workload, we must have the flexibility to staff offices according to their actual needs. Should the agency move forward with its proposal to eliminate the reconsideration step, the workload of OHA will likely increase immediately. This is currently the experience in prototype states which operate with no reconsideration step. Reviewing officers should be in place and fully trained before the reconsideration step is eliminated nationwide. If this does not occur, employees new to their positions will be faced with the inevitable increase in receipts that will follow the elimination of this step. In our view, this could create another backlog situation. It is critical that new staff is already on board, trained, and ready to meet the challenge of this anticipated spike in workload.

Appeals Council

We are most concerned with the Commissioner's proposal to replace the Appeals Council with Oversight Panels consisting of two ALJs and one Administrative Appeals Judge. As part of her plan to achieve these goals, the Commissioner concluded that the Appeals Council level of the current process should be eliminated because it, ". . . adds processing time and generally supports the ALJ decision." We disagree with that conclusion, and submit rather that the Appeals Council level of the process contributes to the achievement of the Commissioner's goals and provides important benefits to disability claimants.

While it does require some time for the Appeals Council to consider requests for review, great strides have already been made in more effectively processing the Appeals Council workload. Pending requests for review have decreased by over 100,000 cases in the last three years. During the same time period, average processing time has been reduced from over 500 days to 229 days, and it continues to fall. Technological changes currently being developed (e.g., digital recording of hearings and the development of an electronic folder) and policy changes being considered (closing the administrative record after the hearing) will result in further significant improvements.

The benefits added to the disability adjudication process by Appeals Council review make a substantive positive contribution to achieving the goals stressed by the Commissioner:

- Three to four percent of requests for review result in the issuance of a favorable decision without the necessity of the much longer appeal process to Federal court. The Council also remands about 24 percent of the request-for-review cases it considers, ultimately resulting in additional favorable decisions without court action or unfavorable decisions more likely to withstand court scrutiny on appeal.
- Review by the Appeals Council is the only recourse available to claimants who have had their requests for hearing dismissed. The Council grants review in a large percentage of these cases, providing an avenue for the claimant to receive due process and a substantive decision.
- Many claimants are not represented. The Appeals Council is the last recourse for those who lack the understanding or resources to pursue their

case in Federal court. For them, the Council provides an avenue to appeal the Administrative Law Judge's decision in a non-adversarial setting.

- The Council's workload also includes review of favorable hearing decisions that have not been appealed. Exercise of this function prevents payment of benefits in cases where an allowance is not warranted by the law and facts of the case.
- The Council also plays a vital role in the preparation of cases for court review, processing requests for voluntary remand, preparing court remands, and reviewing final decisions after court remand. These functions are essential to the efficient processing of the civil action workload.

In her testimony, the Commissioner stressed the need for disability claims to be better developed and indicated the need for consistency in disability adjudication. The Appeals Council contributes to the achievement of both these objectives. By remanding cases, the Council sets a higher standard for case development. The Council is the only body that reviews disability cases on a national basis. The Council has developed principles and guidelines that have insured consistent actions by Administrative Law Judges throughout the country. If national consistency is the objective, the Appeals Council is the logical body to be tasked with continuing oversight of this effort.

Stakeholders in the disability process, including claimants' representatives and advocacy groups, value the contribution of the Appeals Council and support retention of the request for review. Previous studies dealing with the elimination of the request for review indicated that the workload of the courts would increase dramatically if the Appeals Council review level were to be abolished. Reports by the Judicial Conference of the United States have indicated that most claimants do not seek judicial review after Appeals Council action, and that Appeals Council review lessens clogging of court dockets. The Conference viewed the prospect of eliminating Appeals Council review unfavorably.

The Office of Hearings and Appeals Management Association (FMA–Chapter 275) agrees that the disability adjudication process needs to foster fully developed case records to support accurate and timely decisions which are consistent and of high quality. For 63 years the Appeals Council has contributed to the achievement of these goals by providing a final level of appeal and review within the Social Security Administration. Such experience and public service is extremely valuable. The Council should continue to be a driving force in improving the disability adjudication process.

Conclusion

The Office of Hearings and Appeals within the Social Security Administration affects the lives of millions of Americans with its disability services. With increased staffing and funding, the Agency would be able to improve its service to its customers—the American public. The missions performed by OHA could be completed at an even higher level of proficiency if a meaningful performance management system were instituted within the Agency. These changes would allow OHA to provide to the public the level of service that is both expected and needed by taxpayers.

FMA has long served as a sounding board for the Legislative and Executive branches in an effort to ensure that policy decisions are made rationally and provide the best value for the American taxpayer, while recognizing the importance and value of a top-notch civil service for the future. We at FMA would welcome the opportunity to do the same for any initiatives that this Subcommittee, as well as SSA, would like to create to further enhance the mission of the Office of Hearings and Appeals.

We want to thank you again, Mr. Chairman, for providing FMA an opportunity to present our views and for the hard work and interest of the Subcommittee members on this very important topic.

We look forward to working with Congress, the Commissioner, and other stakeholders in finding solutions to the challenges facing SSA in our collective pursuit of excellence in public service.

Statement of Kristen L. Flitsch, Watertown, Wisconsin

I am a 28-year-old female living in Wisconsin. I have applied for Social Security/SSI and been denied twice already. I entered my original application about 1 year ago. I am now at the hearing stage. The main reason for my application is due to Epilepsy.

I was diagnosed as a child as having Petite-Mal Seizures and was put on medication at around the age of 8. I have been on theses meds since then. Until fairly recently, I have not really noticed a significant interference in my life due to my condition.

About 3 years ago I had the first of numerous serious Grand-Mal Seizures. It is unclear to my neurologist the cause of suddenly developing this type of seizures. For this reason he now states that I suffer from Idiopathic Generalized Seizures. I have only started to really try to keep track of the frequency of my seizures, taking note of any possible triggers and/or patterns that may develop. The only commonality that has shown it's self is stress.

The stress factor presents a problem of it's own in the way that I was diagnosed as a teenager with manic depression, more commonly referred to as Bi-Polar Disorder. This causes my stress level to be unusually high at times that are sometimes inappropriate. At other times, when it would be expected, my stress level can cause anxiety attacks and sometimes even trigger my asthma.

I have tried to keep the SSA updated as to seizure activity as it happens but they seem to have little concern for me or my well-being. For example, when I called to let them know that I had fallen down my back stairs and chipped my ankle due to a seizure they just said thanks and seemed to blow me off. A few weeks later I had another seizure while walking through my living room and literally broke an end-table/lamp with my face during the fall. There have been many times when I have done damage to my body that caused me to not be able to leave my home until I healed, and also many in which I just strained my muscles making it very difficult to leave the house due to pain. My pain levels usually range from 5 or 6 to a 10+ on a scale of 1 to 10.

A large part of that pain is in my lower back, my hip, and my left leg. This, I believe, is mainly due to the injuries that I incurred during that first seizure, 3 years ago. I was at work, and went into a seizure. When I fell to the ground, I injured my back. I ended up with 2 lower disk bulges, a pinched psyatic nerve, much bruising, and months of physical therapy and chiropractor appointments. I was given a tens unit to use at home but was slow to recover due to additional seizure activity.

I have tried to explain to the best of my ability why it is that I am unable to retain "gainful" employment and feel that I am disabled, but the SSA seems to put off and put off everything so long that by the time they get around to dealing with it, there is no evidence. I have no medical insurance and no income. I cannot afford to go to the doctor or the ER every time a have a seizure so that a physician documents it how each debilitate me. I have friends that work in the medical field that have witnessed my seizures and wrote up letters and filled out questionnaires for the SSA and still there is not enough evidence for them. I am getting very frustrated, and frankly feel that this has taken entirely too long. I understand that they need to be careful that they are not giving benefits to people that don't deserve it but I am not one of these people. I mean, what do I have to do . . . Fall down the stairs and break my neck so that I'm paralyzed from the neck down . . . maybe bite my tongue completely off next time . . .

I hope that you people can do something because as I said before, I understand that the screening process needs to be thorough, but what about those of us who are slipping through the cracks and not getting the help we need.

I am also concerned about the fact that my last denial letter gave me absolutely no reason what so ever for the denial. It provided me with a few names of a couple of my doctors and the date of a report from them that was used in making the decision but nothing as to why I did not qualify. This struck me as odd due to the fact that I had applied for temporary/partial disability at the time of my back injury and when they denied me for that It stated very specifically why they had denied me. (i.e. my prior work history, trainability, and education.) I was not happy with this either but didn't know what I could do and frankly between all of the doctor visits and seizures at that time, I just didn't have the energy. So I muddled through on my workman's comp and then struggled to find a new job as I had been fired from that one.

I am an intelligent woman, but that isn't going to do anything for my back or the fact that I have Epilepsy. I have tried to provide as much info as I can to the SSA and yet it doesn't seem to be enough and it seems that I am not "wording" things correctly for them. I do not feel that my case is being taken seriously or that my situation is being viewed as a "big picture". I am afraid that I am not going to get the help I need and that I am going to end up with much more permanent damage if I don't. It is my hope that you are able to help people like me to be able to get that help, if even only in the way of insurance to cover the cost of meds and doctor visits. I am not sure what else I can do to speed up the process of making a decision

on my case but I hope that the argument you are presenting will help. Thank you for taking the time to read my letter. I am not entirely sure it is the kind of letter that you were expecting but thanks nonetheless. I hope it will help in some small way.

Statement of Phyllis Frederick, Hickory Flat, Mississippi

I am 48 years old. I first applied Aug 2002 after having knee surgery for the second time on my right knee. The knee is totally shot and the orthopedic surgeon backed my SSD claim. I also stated that I have arthritis in all my joints, severe chronic fatigue but I was never sent to any doctors for exam. I was denied twice and since my last denial I have been to see a rheumatologist that has diagnosed me with rheumatoid arthritis, osteo arthritis multiple sites, fibromyalgia and an MRI shows possible herniated discs. My fingers are going crooked and I am sick all the time. It is impossible for me to hold a job. This has caused terrible stress and I am struggling to try and survive and not loose my home. My son helps me financially but is unable to completely support me. How can this happen in this country. I am a nurse, LPN. I would rather be able to work and earn a decent income than to live on SSD, but as things stand I MUST have the SSD. I am awaiting a hearing and from what I've been told this could take over a year. How can I keep struggling to live? I worked and did my best to be a productive citizen. Now that I can't work I am being denied the benefits that my tax money paid for. This is a travesty of justice.

Statement of Mary Jo Gilbert, Vancouver, Washington

Dear Mr. Chairman,

Social Security is flawed but there is one major flaw that is incomprehensible. Without going into too much history—I have been diagnosed by 3 physicians as having a chronic disabling condition which prevents me from working—Chronic Fatigue Syndrome. In order to fully understand the situation there are key points in my claim that are pertinent.

The following are examples of some of the evidence presented at the hearing:

- Letters from the three doctors confirming my disability.
- One of the doctors is Dr. Paul Cheney, a world recognized CFS specialist and researcher since the early 80's when he was involved in the Lake Tahoe outbreak. He used objective tests, physical findings that are supported by peer-reviewed medical literature on CFS to reach his conclusions.
- Some of the objective laboratory tests provided as evidence show:
  - T-cell activation by two-color flow cytometry
  - Decrease in Natural Killer cells
  - Increased Interleukin 1-alpha of 53 (normal is 0–40) and TGF–Beta 1:80 (normal 0–40)
  - Immune system R–Nase-L level of 26, normal is 1—10.
  - Impaired liver function
  - Impaired activation of the hypothalamic-pituitary-adrenal axis
  - Metabolic dysfunction
- Functional Capacity Exam. (see below for conclusion)
- Tilt Table Test results in which I passed out after approx 15 minutes of standing (30 minutes is required to pass). This resulted in loss of my driving privileges for a period of one month.
- Affidavits from a co-worker, a friend and several family members explaining their observations about my decline in health and abilities.

I have also been diagnosed with Encephalopathy, and near cardiogenic syncope.

At the first hearing the judge questioned my credibility and alluded that my position at the high tech firm I worked for was no longer needed. That was not the case and later that was confirmed when he obtained my employee evaluations. The fact that they had to hire a contractor to replace me speaks to the need for someone in my position.

The doctor attending the hearing on behalf of social security agreed that I met the criteria for Chronic Fatigue Syndrome.

However the judge provided an unfavorable ruling. His letter included misinterpretations, was revealing and I was personally shocked by it. Here are examples:

- The judges letter states that Dr. West, found the blood chemistries normal and that he prescribed exercise. Meed West, N.D., a naturopath, does not run blood tests. Regardless it is well known that the standard blood tests are typically in the normal range for CFS patients. The exercise that Dr. West prescribed is stretching exercises.
- The judge made the comment that I did not continue to see Dr. Bryant because he did not give me a CFS diagnosis. That is not the case and I'm baffled that the judge felt he knew my motives and is using that to deny the claim.
- During the hearing the judge roared "Oh yea! You have medical insurance. Your husband works at Freightliner!" This was revealing and I am shocked at his blatant bias.
- Due to extreme exhaustion during the second hearing I was unable to remain sitting upright. Although my attorney said that I could stand up during the hearing he said I should avoid lying down. However, I simply could not sit up any longer and standing was not an option either. It was extremely embarrassing but I simply could not go on. As the tilt table test showed I have trouble standing. The judge's letter pointed to that situation as "her dramatic laying on the floor".
- The functional capacity exam conclusion states: "I feel her fatigue syndrome and it's interference in her daily function would make her a very difficult, if not impossible, person to place into the workforce". The FCE took 4 hours of one day and afterward I had to lay down for 2 days to recover—which is stated in the report. The judge's letter states that the physical therapist "opined that she could work four to six hours per day". Are we reading the same report?
- According to the judge's letter, Dr. Rullman testified that "there was no evidence of immune system activation in the medical record". The doctor admitted during the hearing that he was not familiar with the R Nase-L test. That test has been around since the early 1990's. However what's totally baffling is how the doctor would be unaware of the significance of the University of Miami's Natural Killer Cell test and the T-cell tests, which clearly show immune dysfunction. AIDS made these terms common vernacular.

COMPLAINT

Given the above how can I expect a fair appeal to the hearing if my claim is referred back to the SAME judge? I am informed that that is standard procedure for hearings claims. What judge will reverse his own decision? Especially given his handling of this claim to date!

Statement of Frances Glennon, Barton, New York

This is my story:

Over ten years ago I was declared totally and permanently disabled by my physician due to Severe Osteoarthritis and Fibromyalgia. At that time I applied for SSD and SSI was made to endure several tests, doctors appointments, and fill out endless repeated paperwork, I then waited a year to be denied the help I so needed . . . of course I appealed the decision then waited again for reconsideration and was denied . . . I quit trying for about six months then reapplied again and went through the whole vicious circle again only to be denied because of my age and previous work history . . . I would more than likely be able to live a fuller life now had I not been denied . . . but since I was denied and that forced me to live for 8 years at below poverty level barely able to afford food on my table To feed my daughter and myself let alone The rent, utility bills and the medical care I so needed . . . I was forced to repeatedly try and fail to return to work causing me to have a load of unpaid bills, more stress than any one should have to handle, more pain then anyone should ever have to bear and I have now destroyed what few joints I had at that time which had not yet been affected . . . because of having to return to work I now have bulging discs in my back, carpel Tunnel syndrome in my wrist, and the added misery of degenerative disk disease. . . . I can't feed my family and I hurt too much to get out of bed. I can't afford my meds and doctors visits are fi-

nancially impossible . . . therefore I cannot get the treatment and therapy that I need to give me the ever wished for minor amount of relief that comes with the proper care . . . I spend most of my time now crying and trying hard to get things that need doing done without much success . . . I have applied for welfare and will also apply again for SSI but I know that after endless appointments, paper work, and waiting a year or more for their decision they will find some reason why I should not be able to get it . . . I am really not looking forward to the stress and extra irritation to my condition that stress will undoubtedly cause . . . I so wish that it was different and I did not have to ask for help . . . but it isn't so i do ask and I suffer for it and so does my family. . . . I Keep going round and round in this vicious cycle and no one out there seems to care . . . So show us you do care and Please if you do nothing else this year find a way to make this program work and work for all who need it . . .

Statement of Fran Halas, Whitefish Bay, Wisconsin

If this is how the Milwaukee and Chicago office of SSI handle disability claims how do you think they monitor private party disability claims? Answer: THEY DON'T.

I have been writing, calling and even have personally twice visited the Chicago ERISA enforcement office to report Major infractions of UNUM Provident's handling of our disability policy that was obtained through employment which would fall under ERISA ENFORCEMENT. There is no enforcement, the main function of the office is to send out a brochure.

UNUM Provident hides behind the ERISA pre-emption which basically they deny a claim without reading it and then force you into costly litigation. We have spent $10,000 on an appeal and even though it sounds ludicrous, they did not read it. We have been quoted $150,000 to go to federal court which is the process of a denied appeal.

Besides the above, UNUM has twice released sensitive financial data of others (names, social security numbers, earnings) of other plan participants. We have learned that our financial data was compromised as well. UNUM had a physician who did not even have current license contend to have review our file.

The Missouri Insurance Commission and the NAIC are now reviewing our matter. I understand 40 states are investigating UNUM. When will the Federal Government wake up?

Please note: I am a 20+ year risk manager and have the responsibility for corporate employee benefits. I was trained that if plans were non-compliant with ERISA, they would be disallowed by the IRS. I have tried calling them as well and that is another runaround.

Statement of Nancy Hall, Wauwatosa, Wisconsin

To Whom It May Concern,

I am an individual with a disabling illness who has been adversely affected by the Social Security Administration's handling of my claim for Social Security Disability Insurance benefits. I became disabled due to a chronic medical condition in 1996. I had been ill for 29 years, at that point, but had been able to complete two degrees and to work. I applied for SSDI benefits in March of that year, when my employer advised me that my work was suffering as a result of my illness and my personal physician suggested that my efforts to continue working were compromising my health.

I am an art therapist and rehabilitation counselor, nationally certified in both fields and licensed to practice psychotherapy in Wisconsin. I have a master's degree in art therapy and I worked through various human services agencies in Massachusetts and New York from 1972 through 1995. My last full-time job was on the forensic satellite unit at Attica Correctional Facility, where I worked from June 1991 through February 1996. I applied for benefits in the Buffalo, New York Social Security office.

It took two years for benefits to be approved for my two children and me. My claim was denied at the first and second steps and approved at the third step by an administrative law judge on the basis of the evidence in my medical record. By the time the claim was approved, I had statements confirming disability from five

physicians whom I had consulted myself, two physicians hired by my employer, and a neuropsychologist who did personality and intelligence testing. Despite the evidence that I submitted, the SSA sent me to see two physicians and a psychologist at government expense.

After the second step denial, I retained an attorney. According to Social Security guidelines and state law, she could not require a retainer but she was entitled to 25% of my lump sum back benefits with a cap of $4,800 if benefits were awarded at the third step. As noted, my appeal was successful and she received $4,800 from my back benefits.

I was more fortunate than many who apply for SSDI benefits as I had private insurance and savings to help me through the first year of my disability. By the second year, I had no income, our savings were gone, and my husband was supporting the family on a small stipend from the NIH postdoctoral fellowship that he needed to complete in order to qualify for work in his field. When my benefits were awarded at the end of the second year, we were deeply in debt and struggling to provide basic necessities for our two children.

My application was processed through the Buffalo, New York office so I have had little experience with the troubled Milwaukee office. My medical review was handled through the Milwaukee office and this was a slow process, but not as critical to my well being as the initial application because my benefits were not affected during the review. Based on my personal experiences, as well stories from friends and acquaintances with disabling conditions, it appears that delays in processing SSDI claims are not exclusive to the Milwaukee office. This is an inefficient system and one that creates enormous and unnecessary hardship for Americans who are unable to work due to illness or injury and who are entitled to pension benefits based on their contributions to the Social Security fund.

As the Subcommittee on Social Security investigates problems in Milwaukee and Chicago, I hope that you will also address some of the larger questions. The high rate of first step denial of claims that are, ultimately, approved at the third step suggests that the examiners who handle claims at the early stages are simply rubber stamping denials. It could be argued that claimants are not providing enough medical documentation at the early stages, but my claim was denied despite that fact that I had a great deal of documentation including independent medical examinations ordered by my employer. I have heard enough stories similar to mine to believe that my experience was not unusual. Many people who apply for SSD have experienced physical problems and collected medical information for years before applying for benefits.

The fact that most claimants need legal representation in this process is another problem for many people seeking SSDI benefits. While attorneys who handle SSDI claims cannot request retainers and are generally not paid unless the claim is successful, the fact remains that hiring an attorney is a substantial expense for people who can ill afford to lose any of their hard won benefits. Attorneys who handle SSDI claims are generally paid 25% of a claimant's back benefits up to $5,300. This means that substantial sums of money from the Social Security fund are being paid not to beneficiaries, but to their attorneys.

I am grateful for your efforts on behalf of those of us who worked hard throughout our lives and who must now depend on Social Security benefits in order to survive. None of us chose to be in this position and I believe that most people receiving SSDI benefits would rather be working and pursuing the careers that were left behind when we became to ill to work. Although I have already cleared the hurdles and completed the SSD obstacle course myself, I hope that you will succeed in making this a more efficient, more humane system for others like me who are struggling to live while waiting for benefits now or who will need this program in the future.

Statement of Tanya Henderson, Waynesville, Georgia

I would like to comment on the backlog of cases at the OHA offices. I worked in the Indianapolis, IN office from Aug. 1991 until Oct. 2002 when I transferred to the Jacksonville, FL office. The backlog occurs when you have the Senior Case Techs doing a lot of the pre hearing and post hearing work that an administrative law judge wants done. That can take up a tremendous amount of your time daily and therefore, you can't get a case worked up and ready for hearing. I currently work up cases at home on Mondays and can work up 4 to 6 cases each Monday (depending on how thick the file is). The main reason that it could take a great deal of time to do the pre/post hearing work is that I have worked with an ALJ that has cases

that are 2 years old (request for hearing date). He sends out interrogatories to any and all doctors in the claimant's file (treating physicians), his interrogatories have questions regarding smoking, drinking, obesity and estrogen use. I recently had a case where the doctor did not respond to the interrogatory after 30 days, but the judge told be to send the interrogatory a 2nd time, therefore, we wait for another 30 days and when that time frame is done he will send out more interrogatories. I've had a case where the judge has requested 3 different consultative examinations. I can work up cases on a daily basis if I did not have to do the majority of the pre/post hearing work. Senior case techs should only have to deal with working up cases, answering phone calls and pre hearing development. Hearings and post hearing development should be done by the case techs. HPI DID NOT WORK. I was a legal assistant before HPI and I worked up cases daily, but after HPI went into effect I had to mail decisions, send out notices, file mail, update files, pre hearing development, post hearing development—my first response after HPI was "What happened to my promotion?" I applied for a legal assistant job to get away from doing notices and mailing decisions. It all boils down to the fact that the ALJs must move the cases and not delay with unnecessary interrogatories or consultative examinations and the people who can work up cases on a daily basis should be freed up to do so. You also have some employees who don't want to work as a team to move cases as quickly as possible. Maybe you should have more cases go to the decision writers for possible on the record decisions. At the present time a case is reviewed if the claimant is age 55 or older, why not go down to age 50—with the number of cases waiting to be worked up in this office I would almost bet you that 1/4 of the are age 50 and older and could have possible on the record decisions issued.

Statement of Elizabeth S. Holland, Dallas, North Carolina

I am a 48 year old woman from North Carolina. I am disabled. My on going battle is to convince Social Security of what my doctors have already told me. This is such a battle that should not be!

I have lost my home to foreclosure and moved into a rural mobile home. My marriage has dissolved as a direct result of this uphill battle for Social Security. Now, I must rely on my 2 children, who have homes and children of their own, to pay my bills, and buy what of my medications they can. I really don't know how much longer than can continue to do this. I guess I will be homeless or hospitalized then. I am waiting on the results of my Reconsideration Appeal right now. My only hope is that it will be approved, and NOT have to go through a hearing with a judge. As that will take about a year to be heard. There will be NO hope for me if that takes place.

As I stated, I am 48 years old. I have major depression, panic attacks, agoraphobia, which lives me home bound completely. I also have crippling rheumatoid arthritis in my spine, neck, hips, knees, hands and shoulders. I also have Hepatitis C, that is worsening each day that I cannot afford to take the Interferon injections for, because I have no insurance! These are just a few of my well documented heath problems.

Speak up for us, the sick, in pain, and hurting people right here in the greatest country in the world, America! WE need help.

Statement of Margaret Holt, Chapel Hill, North Carolina

I hope the following information and observations from nine years as a disability support group co-facilitator will be helpful.

I have observed the following results repeatedly:

> Initial delays by sending persons with existing disability documentation by multiple physicians to the same SSA "specialist" who have been observed to be more concerned about in-office time than integrity in diagnosis.
> 6 months for initial application to be processed
> 6 months more for reconsideration to be processed
> 6 months more for Administrative Law Judge decision to be processed

In the mean time, many persons lose their homes, credit, and illness is worsened and families disrupted by the severe financial stress of navigating an obstructionist

system. Many women are eventually added to the burgeoning Medicaid roles as a result, and all of society foots the burden as they are abandoned by spouses in our disposable society. Many weep, many feel as if they are living in a nightmare, some commit suicide.

These persons are upright, hardworking, moral people for the most part, who have paid into the system in good faith throughout their lives, and through no fault of their own are victimized by that very system when they are least able to advocate because of severe and permanent disability.

One ALJ in the Greensboro, NC area was overheard saying at a cocktail party; "I don't want to give these people disability, but what can you do when the evidence all points to the contrary?"

This misuse of process is abuse of the disabled in a nutshell. Many times I have noticed that the gender issue also crops up, with men receiving their disability at an earlier stage than women. I have also seen discrimination based on particular disabilities, with the blind receiving a higher level of allowed earnings. The combination of minority status, gender and physical disability become a triple disability, as was recently pointed out by other countries' disability representatives at the United Nations Second Ad Hoc Committee on a Convention for Rights and Dignity for Persons with Disabilities. (www.rightsforall.org) Our US representative to the Committee, contrary to the recommendation of our National Council on Disability, told the other member states in essence, that America had it "all under control" but that we would be happy to advise the other countries. If we can't police our own system effectively, how can we be a "role model?" And what an opportunity we miss to reach out to the world to build good will, in these deadly times, by streamlining our model and signing on to a non-precedent setting international disability convention.

Surely, in our great nation, this abuse towards American citizens by a government agency must stop. Fraud can be filtered out by examination at the initial stages by competent medical examiners without victimizing the weakest and most vulnerable in our society by this extended delay/abuse of process.

Thank you for addressing this issue, and for bringing in line this misuse of power. Please feel free to contact me if I may be of any assistance.

Statement of Janet L. Innes, Cambridge, Massachusetts

This letter is written to share with you my experiences in attempting to obtain Social Security disability income.

In early 1994, I contracted Lyme Disease, which was not identified for a number of months. In that time I suffered neurological and immune system damage which rendered me severely disabled, unable to continue work, and which led to further diagnoses at Johns Hopkins of Chronic Fatigue Immune Dysfunction Syndrome and orthostatic hypotension resulting from neuro-immune compromise.

In late 1994, I applied for SSDI. In 1995 my application was turned down. I appealed the decision, and that, too, was turned down in 1996. In 1997, my husband left me, and I moved from Baltimore MD to Pittsburgh PA, then to Arlington VA. My case "followed" me and, on September 23, 1998, I had an Appeals Court hearing before Judge Eugene Bond in Washington, DC.

Judge Bond, at the time of the hearing, did not have my file and had not read it because it had been "misplaced." However, it was apparently found several days after the hearing, which made his decision legal. He rejected my claim in January 1999, noting lack of adequate medical evidence and inability to read several doctors' handwriting.

My attorney urged an appeal, especially since the Social Security files showed that the physician hired by SS to examine me on my very first application had reported that I was, indeed, fully disabled. The attorney told me to proceed with asking Social Security for a copy of the tape of the hearing, without which an appeal could not be filed.

Since early 1999, I have been attempting to get that tape and, as of now, September 2003, I still have not received it.

On my first call to the Appeals Council Branch in Leesburg, VA in February 1999, I was told they had not yet received the tape and to call back in a month or so. Subsequent calls, which I made every two months, yielded the same response: that the tape was "somewhere in the warehouse" and I had to understand that they were very under-staffed.

In early 2001, the woman I spoke with on my regular bi-monthly call to the Appeals Council Branch said that she would put through a request to expedite getting the tape to me. That was over two years ago.

In the meantime, I had moved to Boston, and I informed her of that. She took my new address and said that my records would have to be switched to whomever in that office handled the Boston region. She said that then, when the tape arrived, it would be sent to the "Boston group," and they would send it to me. When I asked about timing, she said there was no way to predict how long it would take.

After settling in Boston, I found a new attorney to help me with the appeal. He recommended filing a new case at the same time the appeal was being pursued. I did file a second case in early 2002, and I was granted SSDI on July 17, 2002. However, my disability was backdated only to April 1, 2000.

Finally, in July of this year, I received an SSA "Notice of Affirmation" that Judge Bond's 1998 ruling had been overturned by the Appeals Council on a number of grounds.

I am now still waiting for my records to be transferred to Boston so that the appeal hearing can go forward.

I fell ill almost ten years ago. It took me eight of those ten years to secure SSDI, many of them waiting for a hearing tape that—if it even exists—appears lost somewhere in the "wilds" of Northern Virginia.

I extend my deepest and most sincere gratitude on behalf of myself—and speaking for numerous people I know who have experienced unreasonable delays and demands in trying to obtain disability—that this issue is being looked into.

Statement of Stephanie Varnado, Social Security Disability Coalition, and Innovative Community Solutions, Nashville, Tennessee

The Social Security Disability Coalition (SSDC) is a grassroots organization that began in January of 2003 as a result of a letter I discovered on the Congress.org site to various New York State Representatives and Senators. This series of letters were written by Ms. Linda Fullerton the SSDC's current Chair. After I'd read her letter I began a thorough search of the Social Security category in search of others like her. That evening yielded approximately 30 heartrending pleas for assistance, the bulk of which, based on Ms. Fullerton's letter, were probably going unanswered. The very next day I contacted Ms. Fullerton and proposed beginning a grass roots movement to push for change. At the time Ms. Fullerton was very down regarding the difficulties she was experiencing with the SSDI process, and more than a bit abject regarding the possibility of implementing real change. To counter that, I began a web community on MSN to assist us in building our base.

To date the Social Security Disability Coalition has 495 members and has achieved 2,738 signatures on a petition calling for change. These members are not lawyers, or disability providers; they are real people who are struggling with one of the most debilitating and humiliating systems out there. Their needs are many:

- Respect for them as human beings.
- A process that doesn't take so long that they die before benefits become available.
- A process that doesn't leave them destitute and homeless.
- A process that doesn't exacerbate their already frail conditions by creating so much stress that even suicide becomes and option.
- A process that doesn't require them to sacrifice 25% of their desperately needed back pay benefit to attorneys, who if the process worked appropriately, wouldn't even be needed.
- Sick people need medical and pharmacy assistance—they should not have to wait two years to achieve this after an award. Not providing healthcare creates a bigger expense on the backend as they wind up in crisis.

As an individual who develops and evaluates systems I can safely say that I have never seen one that was such a complete failure. The SSDI process is not something I would wish on my worst enemy. In working with low-income people, folks who have spent a lifetime performing the most menial and physically difficult jobs available, I've had the misfortune to watch this process in action. When hard working American citizens whose bodies have failed them through illness or accident are treated like they were some kind of pariah or evil person there is something grossly wrong with the system. I've watched as they've lost homes, cars, and other assets.

I've seen them go without medications and medical assistance due to cost. I am sickened at each situation I see.

This system MUST be fixed immediately. The problems don't just exist in the OHA; they exist in the DDS's where random untrained personnel are allowed to determine the outcomes of people they have absolutely no knowledge off. The system relies on CE's who see patients for 15 minutes and then dispute the findings of multiple treating physicians. The whole situation is ridiculous; the fix will be expensive but necessary if we are to do what we have promised as a country to the people who help make America function everyday.

Our grassroots coalition grows everyday and we are committed to making this a national issue. The days of hiding these abuses, is over. We will no longer accept others "speaking for us". If you want an assessment of your system then you must go to the people involved in it for appropriate feedback.

I hope this meeting will be successful. We do appreciate the addition of our information to the record and hope that you will include us in other meetings. This system has struggled for decades and is in crisis now due to the prototype sites that evolved through a poorly thought out "reform" effort, the ALJ lawsuit, and certainly a lack of funding for operations. The only way the SSA will get what it needs to function is if a national movement for reform and funding is launched through the people. Then perhaps our legislators will take notice of the massive number of casualties caused by this failing system. American citizens, the disabled, their family support groups, and providers like myself are fast losing faith in the ability of this country to protect our safety net investments.

Thank you for your consideration.

Statement of Melissa Jennings, Freeport, Texas

My name is Melissa Jennings. I filed for disability on October 25, 2001. I have just had my hearing with the Judge and he found my case favorable, which was a great relief. I do not understand why it would take 2 years to receive this. My husband, myself, and my 2 sons 8 and 10, have had some very hard times financially because of the wait. Now I am told it will be 30 to 90 days before I will see a check from the time they receive my file back from the Judge, which could take 30 days. So basically I am still looking at almost 6 months before I will get anything.

We have faced eviction and utilities being turned off. Both my sons are ADHD and I can't afford their medication or mine. I am waiting to see about Medicaid for them but that takes forever to.

I have fibromyalgia and severe depression. The depression is worse, because I can not help provide for my family and give the kids what they need to make it in school.

I am 38 years old and have worked since I was 16 years old.

I do not believe anyone should have to go through the 2 year wait to receive something they paid into for 19 years.

I understand that there are people who take advantage of Disability, but there are others like myself who would be willing to still be working but cannot.

Statement of John Kelly, Clovis, New Mexico

Please help us! After 4½ years I was approved for Social Security benefits for Disability Insurance. However, they only approved sixteen months pack pay. How can I pay back loans that I received from others who were so generous to me during this nightmare of application. The present system of Social Security Disability Determinations needs to be razed, and a totally new set of guidelines installed to protect claimants from this unfair ordeal. The laws are so stringent that no one fully understands them, and almost any interpretation of them can be made. Again, Please help new claimants and others that have gone through the system for a more fair and timely decision making process.

CINCINNATI, OHIO 45236
September 29, 2003

Committee On Ways And Means
Subcommittee On Social Security
Congressman E. Clay Shaw, Jr., Chairman
1102 LHOB
Washington, DC 20515

To Whom It May Concern:

After a year of being unable to work, I filed for SSDI on July 9, 2001. I have a listed impairment, chronic fatigue syndome, along with 5 ancilliary impairments. I had enough medical evidence that it was not necessary for me to be seen SS's doctors for evaluation. Along with much other medical evidence, DDS had received a letter from my treating physician dated October 18, 2001, but did not use it in the determination. The treating physician's evidence is weighted the most out of all the evidence.

While waiting for a determination, I finally ran out of money. I had previously been denied for Long Term Disability, retained counsel, appealed again, and was denied again. I had spent all of my savings, and sold $10,000 worth of my personal items to make ends meet. To make matters worse, after I was terminated from my job for being denied LTD, the company went bankrupt, so I no longer had health insurance coverage, even under COBRA. At this point, faced with the prospect of spending down my 401k and trying to get on SSI, I was able to negotiate a monthly loan agreement from my sister. This enabled me to stay in my house, instead of moving back in with my elderly parents.

I received my first denial from DDS on December 10, 2001. I appealed the decision and submitted additional medical evidence. At this point DDS used the previous evidence I had submitted, and the new evidence, including the letter from my treating physician.

I received my second denial on March 28, 2002. I retained counsel and submitted a request for a hearing on April 16, 2002. We continued to submit additional evidence of continuing disability from my physicians every 6 months or so. My lawyer thought that I had a very strong case with much evidence.

On October 4, 2002 I contacted my congressman to get assistance with speeding up the process. They told me, they would do what they could, but there were so many other people asking for assistance, that were a lot worse off than I was. I checked back with them in December and was told to keep waiting. I never heard from them again.

My hearing was finally set for August 18, 2003. On July 29, 2003 my lawyer called and stated that the judge was looking over my file and might be able to make a determination, but he had a few questions. I answered the questions and the next day, my lawyer called and said that I was approved. My case was so strong that I was approved on the evidence alone; I actually did not have to go to the hearing. I received my official approval letter on August 29, 2003, preceded by a considerable back pay check.

Ironically enough, now that I have actually been approved, SS has proven to be the model of efficiency, sending me multiple notice letters, checks, and Medicare info in short order. The financial stress of trying to get on disability was much worse than the actual illnesses that I have. I am so relieved and feel so much better now that I can pay back my considerable debts, have a monthly income, and can be an independant adult once again. Now I can spend what little energy I have on healing (and hopefully getting off disability), instead of figuring out how to make ends meet. My case with the LTD is still pending, but even that seems not so bad, now that I have some financial security.

Yes, the wait for a hearing was ridiculously lengthy. The time between submitting a request for a hearing and getting the approval letter was approximately 493 days, much longer than the national average. The time to get through two denials at DDS was approximately 241 days. While waiting 493 days for a hearing was bad, waiting 241 days and then getting a denial wasn't so great either.

My point is, that if the judge could look at essentially the same paperwork and approve me on the spot, why couldn't DDS have done the same thing 2 years before? To help the people waiting right now, the quick fix would be to quadruple the number of judges to deal with the backlog. However, in the long run, there would be a lot less people being sent to the OHA, clogging up the system, if DDS was doing a better job in the first place.

Sincerely,

MARY ANN KINDEL

Statement of Donald Ray Krippendorf, Jr., Knoxville, Tennessee

My wife is writing this for me since it is hard for me to correspond and understand questioning. I am 32 years old. I was a Police Officer and a member of United States Army. I am a disabled veteran. I was injured in a chemical inhalation on September 27, 2000. I was working at my employer, Americopy, in San Antonio, Texas, when I started to feel sick from inhaling the fumes of the chemical. When I went home that day I was very sick at my stomach. When I woke up the next day I was coughing up blood, could not eat, and could hardly breathe. I called my Family Physician and was told to come to the office. When I got there they ran some tests and took X-Rays. They showed that I had a chemical burn. The doctor said it should heal within a few days. I was given medications and sent home. That weekend I continued to get worse and called the Doctor on Monday morning. This went on for over a week. The doctor said that I could not return to work and I could hardly breathe. My employer told me to take time to get better. After 2 weeks of not getting any better, I was sent to a Pulmonologist who ran more tests and more X-Rays. I was diagnosed with Reactive Airway Dysfunction Syndrome (RADS). I was told I could not return to work until they could make me better. I was tried on many medications and none that helped with the pain or the fact that I could not breathe. In December 2000, I had my first attack of paralysis. I suddenly started having temporary paralysis in my body. It started out that it happened occasionally but after a year it progressed to a daily occurrence. At this time, I currently have at least one to three paralysis episodes a day. These episodes can happen at any time of day, anywhere, any activity, and can happen one right after the other. I am in constant pain in my lungs and throughout my body. My ailments are as follows: RADS, Hypokalemic Periodic Paralysis, Chronic Fatigue Syndrome, Fibromyalgia, Migraines, Degenerative Arthritis in both legs, Knees, and feet, Multiple Chemical Sensitivity, low immune system, chronic sinusitis, chronic pain, depression, anxiety disorder, memory loss, sleep apneas, carpal tunnel syndrome and obesity. I was in good health before the incident on September 27, 2000 except for the arthritis in the feet. I was honorably discharged medically from the service after a surgery done by the Army caused arthritis in my right big toe, which spread to both feet. I filed for SSD 2½ years ago. I have not returned to work since my accident. I am barely able to spend a few functioning hours in a day with my family. I can no longer do normal things with my family. Due to most of my illnesses I can no longer be affectionate with my family members. I can't go to places where there are a lot of chemicals (perfumes, smoke, petroleum, etc.). I can't even wash my own hair because the chemicals set off an attack. When paralyzed I may be paralyzed through out my whole body or only parts of my body. I can't drive. I have been ordered by all doctors to not drive due to the fact that I can't control the attacks. When paralyzed I have to drag myself across the floor to use the restroom. I sometimes can't get out of bed because I am paralyzed in sleep. I can't read or watch television for long because I can't concentrate on what is happening. I don't go anywhere with out my wife because of my anxieties. When the ALJ heard my case in March 2003 he denied me and told me that I could do the job of a courier. He said it was low stress and no chemical interaction. He didn't even take into consideration all of my problems or the fact that I am not even allowed to drive due to my paralysis. In a 7-day week, I might have 1 good day where I can actually get out of the house and do things with my family. Even then my wife must drive me and I am still in chronic pain. I am on 7 different medications right now. Due to the types of illnesses the doctors are changing the medications constantly trying to find one that will work. This does not include the medications for the paralysis since the doctors are still testing and trying to figure out how it happens. I can no longer function on my own. I tell you my story because I am upset. I have fought a losing battle with SSD and it has really hurt my family. We lost our home in Texas, we lost our car, we are in debt to the tune of 40K (not including house since it was guaranteed by VA) and we are hounded everyday by bill collectors. We moved from Texas to Tennessee to be closer to family to help with the children and with me when my wife is at work. My wife had to take a considerable pay cut. We no longer understand why this happened to us and we are so tired of fighting. It is draining on our relationship, our health, and our family. I ask that you consider our plight when making your decisions today.

Statement of Richard Lankford, Milwaukee, Wisconsin

My wife is 53 years old and has had a claim in process for over a year, 14 months to be exact. The social security dept. has been of very little help and at times un helpful to my wife's case.

She suffers from several different ailments and has been well documented by her physicians from the beginning. She suffers from Diabetic neuropathy, hypertension, fibromyalgia, hypothyriodism, and osteoarthritis. She takes insulin twice daily and synthrroid as well as topamax and darvocet-n 100 for pain. she suffers from constant Migraines and lower back pain as well.

The reason I write you now is because after 14 months of trying to get through the system we finally gave up and hired a lawyer to represent her, I think that this is a shame because now after she is approved for benefits, and she will be approved; money that should have gone to her will now go to a lawyer. and after having to wait such a long period there are bills that will eat up most of the rest but in the mean while we must put up with a system that neither care or helps people who are applying for much needed benefits.

Statement of Kathy Masch, Milwaukee, Wisconsin

Hi my name is Kathy Masch and I have been fighting an up hill battle for SSI/DISABILITY. I've been fighting for fourteen months now. I had to sell most of my belongings just to get by. My doctors filled out all paperwork stating I am no longer capable of working. I was issued a disabled parking permit from the motor vehicle department. I have been denied twice and then hired and attorney to help with the case. I suffer everyday with arthritis, chronic liver disease, diabetes (insulin dependent) and severe depression. I finally went for a hearing in front of an administrative law judge on Sept. 3rd, 2003. Of course I'm still waiting for a decision. And I suppose I'll wait until someone finally decides to make that decision even though it was a pretty clear cut case at the hearing. There has to be a change in the way things are handled now. People who are disabled shouldn't have to beg and fight a very steep uphill battle to get some help from the federal government. After all the same federal government helps other countries. Why not help here at home first. If they are so backlogged then why not hire some more people who are out of work to get caught up and stay caught up. I guess maybe the people working there now can't handle the work so why not clean house and and get people in there that can. It is not pleasant to go from being very active to not being able to get around easily. It is especially hard not to be able to pick my grandchildren up anymore. I live on pain medication daily. Please help to speed things up. Years ago all you had to be was a drunk or have a naughty child and you recieved it quickly. Now you can have legitimate doctors records and tests and you still have to wait for a decision forever. Like I said I've been waiting for fourteen long months. Thanks for your help.

Statement of Tracy Maynard, Milwaukee, Wisconsin

To Whom It May Concern: my name is Tracy Maynard I'm a 27 yrs old female from Milwaukee Wisconsin. I was diagnosed with primary progressive multiple sclerosis. When I was first diagnosed In august 2002 I was relapsing remitting multiple sclerosis it has been over one year since I found out what was wrong with me. I applied for s.s. and disability and have been denied both times. They told me I have to wait until the middle of 2004 to even get a court date. I went to get help from the state with food stamps, rent; anything that would help get my family by until court nobody will help us not even with daycare. Title 19 told me if I paid a 540.00 deductible every month then they could help us with just insurance. With my husband being the only one able to work we can't afford that. I have always worked since I was 16 years old. When I found out I had m.s. I was working full time at Walgreen's health initiatives. My last day of work was August 5 2002 I lost my job August 6 2003 due to it has been 1 year on medical leave. I have been on permanent disability since August 2002 my doctor will testify to that. I also can't take care of my 3 year old due to my blackouts, fatigue, dizziness, lightheaded, and loss of feeling in my legs. So our daughter still has to go to daycare why my husband goes to work. He tries his best around the house doing dishes, cleaning, washing the clothes and playing with our daughter after work. I try the best I can but I get light

headed or have blackouts so I have to go lay down. With us waiting for court and only my husband's income our bill's are getting far behind in rent, gas, electric and living with little food. We are trying to keep our heads up but it's getting hard knowing we'll be on the street soon if something doesn't happen soon. I have taken all the shots that they have right know on the market I have also been on the I.V steroids twice. I'm on copaxone and taking steroids pill for the third time. My doctor Dr. V. Misra has told me I'm his one in a hundred patients that the m.s. is so active they can't get it under control. I have seen three different neurologists and a total of four mri's and it keeps growing. Now that I lost my job and can not afford title nineteen co pay and my husband does not have insurance were he works my shots alone are 1700.00 a month not including the other meds I have to take. Some of the other pills I have to take everyday are levora, hydrocodone, amantadine, neuron tin, ambien, prednisone, ibuprofen. I have to use a cane eighty percent of the time if I don't take my shot and my pills every day I will be in a wheelchair by the time I am 29 please don't let that happen to me. If I don't qualify please tell me who does. Thank you for your time.

Statement of Stephen A. McFadden, M.S., Dallas, Texas

I. Introduction:

I appreciate the Subcommittee on Social Security holding this "Hearing on the Social Security Administration's Management of the Office of Hearings and Appeals." I testify here today on behalf of myself, about how I feel operation of the Texas Rehabilitation (TRC) Disability Determination Services (DDS) in Austin prejudices the determination of Social Security disability in Texas, including determinations subsequently made at the Office of Hearing and Appeals (OHA).

Most of what I am going to talk about today pertains to the operation of TRC–DDS in Austin and the Houston OHA's, because that is what I have facts on. That does not mean that we do not believe that similar policies have not been in effect at the Dallas OHA's for the last 20 years; rather, we do not have the badges to go behind those locked doors—but the Subcommittee does.

II. Blowback: 1990 Gulf War Meets Texas Oil Patch in the Determination of Social Security Disability in Texas: How the Gulf War Vets Debate Documented a 1996 Austin TRC–DDS Memo Which May have Resulted in Depravation of Rights Among Houston Oil Workers by 2000.

What I am going to do is wind a plausible tale involving the 1990 Gulf War and its Oil Well fires, blue collar workers in the Houston oil industry and elsewhere, basic toxicology, the Fall 1996 blowup of the Gulf War Veterans health effects issue, an October 1996 Austin TRC–DDS internal memo, the fact that Texas had the lowest Social Security initial approval rate in the nation in 2000, the varied explanations for that low rate in 2001 by SSA Region VI officials, "Oil Patch" political interests in Texas over the past 7 decades, the abuse of the somatoform psychiatric diagnosis, and the operation in 2001–3 of a Houston area SSA anti-fraud unit, to explain why Social Security disability determination in Texas is, for claimants with a class of medical conditions, and who utilize several specific medical treatment providers, in violation of national program standards of SSA, violating Texan's rights to due process and equal protection of the laws. This hypothesis has not been proven—I do not, for instance, have a list of Social Security numbers of denied claims of Houston oil industry workers; that is the task of a Congressional investigation. Time and public scrutiny will determine the extent to which this plausible hypothesis is valid.

If my perspective on this matter seems unique, it may be because I am a child of the U.S. Department of Energy (DOE) nuclear fuels and weapons laboratories out West with a graduate degree from "Teller Tech", rather than being a child of the Texas "Oil Patch".

This situation is worthy of investigation by the House Ways and Means Committee Subcommittee on Social Security because 1) its similarity to the Gulf War health effects issue addressed by Congress over the past few years, and 2) given the nature of the Social Security Administration, ONLY CONGRESS has the authority to investigate the operation of the SSA for administrative purposes.

III. Social Security Officials Try to Explain in 2001 Why Texas Had the Lowest Initial Approval Rate in the Nation in 2000 for Social Security Disability:

A. Spokesman for Federal Region VI Blames "Blue Collar Workers" "in the Oil Industry and Elsewhere" for the Low Social Security Initial Approval Rate:

"Asked why the Texas Rehabilitation Commission has the lowest initial approval rate in the nation, agency spokesman Glenn Neal Promised the Chronicle a full answer. A few days later, he said the Social Security Administration had asked to speak on the issue for the commission. Wesley Davis, a spokesman in the Dallas regional office, essentially said the rate stems from misunderstandings by blue-collar workers. He said the reason starts with an abundance in Texas of under-educated manual laborers in the oil industry and elsewhere. They commonly get injured on the job but don't understand that their condition is not totall disability, which is required for Social Security aid, he said. From: Social Insecurity: Local Judges Prove Stingy in Deciding Appeals Cases, Alan Bernstein, Houston Chronicle, 3–11–01 A.1.

B. U.S. Representative States that the "Blue Collar" "Oil Worker" is Explanation Has Been Retracted by the Social Security Administration:

[U.S. Rep. Sheila Jackson Lee] "side [Social Security Administration] agency officials also disavowed regional spokesman Wesley Davis' recent explanations that Texas approves applications at the low rate because it has a high proportion of injury-prone blue collar workers who misunderstand the disability rules. the officials indicated instead that the problem stems from inadequate documentation of disability claims, Jackson Lee said." From: Julie Mason and Alan Bernstein, Houston Chronicle, 3–23–01 p1.

C. Spokesman for Federal Region VI Admits that TRC–DDS Reaches "Different Conclusion on Cases that Require Certain Judgments"—Thus Conceding the Violation of Texans' Rights to Due Process and Equal Protection of the Laws as Compared to the Residents of Other States:

"In February, when the Social Security Advisory Board revealed that the Texas Rehabilitation Commission approved disability applications at the lowest rate in the nation, Social Security officials said Texas has a high share of industrial laborers who mistakenly think that their job injuries meet the agency's test for disability. Under questioning in March by Green and other lawmakers from Houston, Social Security officials disavowed that explanation and issued an apology. This month, a Social Security spokesman said the gap—a 31 percent approval rate in Texas, compared to the national average of 45 percent—may be a result of the way the Rehabilitation Commission interprets the law. Texas case examiners 'can have accurate decisions under the law and still have a lower allowance rate than other states because they reach different conclusions on cases that require certain judgments to be made on an individual's capacity to work', spokesman Wes Davis said. But the advisory board, appointed by the president to monitor Social Security programs, says variations in how the law is applied across the country defy explanation and undermine the fairness of the program" From: "Social Security Disability Under Probe for Race Bias", Alan Bernstein, Houston Chronicle, 6–10–01 A.8.

IV. Background:

Let's step back a decade. In 1990, Iraq invaded Kuwait. In January 1991 the U.S. invaded Kuwait and pushed back the Iraquis. During the invasion, Iraq blew up thousands of oil wells while retreating. These oil well fires were put out by "blue collar" "roughneck" oil well firefighters, some of whom worked for American companies, many of which were based in the Houston area. The amount of oil and smoke released in Kuwait by these fires was unprecedented as human activity.

Basic toxicology indicates that the human body cannot directly excrete "oily" substances because they are renally conserved by the kidneys. Nonpolar "oily" substances must first be detoxified by oxidation in the liver to a more reactive form (phase I), then conjugated (phase II) with an endogenous substances—e.g. glucuronide—which is a metabolite of glucose, sulfate, or glutathione, in order to be excreted in urine or the bile (phase III). The oxidation step is done by the Cytochrome P–450 liver enzyme, whose porphyrin-ringed iron center makes the liver red, just like the porphyrin-ringed iron center in hemoglobin makes blood red. The problem is that, in some persons, when the CYP450 synthesis pathway is induced, whether

by exposure to alcohol, barbituates, or toxic hydrocarbons such as oil and smoke, abnormal intermediate porphyrin compounds can build up in the blood, which can result in disabling medical symptoms, such as liver pain, photosensitivity, and colored urine, but many of which are neurological. This is known as porphyria in its extreme genetic form, but the milder acquired form is known as porphyrinopathy.

There are other ways that exposure to oil can cause injury. One of the simplest is solvent neurotoxicity. This results when volatile hydrocarbons solvate the insulating fatty covering on nerves, destroying their conductivity, causing permanent neurological or brain damage. The best known example of solvent neurotoxicity is "glue sniffing" (e.g. of toluene "model airplane glue").

In short, a lot of Houston oil workers were exposed in 1991 to a lot of oil and smoke from the Kuwaiti oil well fires, and exposure to oil and smoke can induce disability by solvent neurotoxicity at exposure to high levels to volatiles, and by porphyria in susceptible individuals.

In the Fall of 1996, the Clinton Administration was "rattling sabers" for a "Wag-the-Dog" war in Iraq on the eve of the 1996 presidential election. The issue of Gulf War health effects was just beginning to heat up, with estimates of 10–50,000 disabled, far short of the current estimate of over 200,000 as of 2003. The Kamasiyah incident, wherein a U.S. demolition unit blew up a nerve gas bunker with tens of thousands of U.S. troops nearby, was revealed about August. By October, a month prior to the 1996 presidential election, the estimates of the Gulf War veterans exposed to the nerve gas at Kamasiyah were running between 10 and 20,000.

As the 1990–1 Gulf War veterans went after the Pentagon in the media over their health problems on the eve of a U.S. deployment to Iraq, which culminated with the President's Commission on Gulf War Illness report, released just days before the so called "Aberdeen Rape Incident", shortly before the 1996 Presidential election, some industry sympathizers went after the civilian physicians diagnosing chemical injury in what appears to be a counter-strike.

That Fall, John Stossel sent "fake patients" undercover into the medical office of Dr. Grace Ziem, founder and medical director of the organization "MCS Referral and Resources", www.MCSRR.org, which publishes information on porphyria.

Ziem quenched the undercover story by suing Stossel under the Maryland wiretap law. The "Wiretap" news story was reported by Todd Spangler and distributed by the Associated Press, and was published in the Austin American Statesman on October 19, 1996.

We have been provided by an anonymous source out of Austin an internal TRC–DDS memo of unknown provenance. We have done our best to authenticate it, but are limited by the constraints of the Social Security Act. The memo, dated October 21, 1996, comments on the Stossel/Ziem "Wiretap" news story, and makes statements regarding the legitimacy of a class of medical conditions, and credibility of several specific medical treatment sources in Texas.

The 'October 1996 TRC "MCS" Memo', as we call it, which refers to Dr. Ziem's practice, is relevant to the condition of blue collar workers in the oil industry in places like Houston because Ziem's organization, MCSR&R, distributes medical literature on porphyria, which is a condition that can be induced in some individuals by exposure to large amounts of toxic hydrocarbons—such as might occur when fighting an oil well fire, and because many blue collar workers in the Houston oil industry were exposed to such toxics, including some during the 1991 Kuwaiti oil well fires.

The October 1996 TRC "MCS" Memo has the potential to effect an official TRC–DDS policy in Texas—to become in effect an unpublished state law—in violation of national program standards of the Social Security Administration, in that its distribution list includes "All SAMC's", the State Agency Medical Consultants evaluating disability at the central office of TRC–DDS in Austin. Further, Dave Ward, named on the distribution list of the October 1996 TRC "MCS" Memo, became the TRC Deputy Commissioner for Disability Determination Service in October 1996, the month that the memo was written, and held that position until 2002.

Coincidently, by 2000, Texas had the lowest initial approval rate for Social Security disability claims in the nation. It is notable that the "initial approval rate" is a statistic which directly reflects the approval rate of both initial and reconsideration Social Security disability claims by the central office of TRC–DDS in Austin, and does not refer to subsequent decisions by the OHA's, AC, and FDC. It is thus a statistic that uniquely reflects activity at TRC–DDS in Austin.

When the low Texas initial approval rate became known in the Spring of 2001, a number of explanations were provided. Most telling is the initial statement by the SSA Region VI spokesman who blamed "blue collar workers" "in the oil industry and elsewhere".

The SSA Region VI spokesman subsequently stated that it "may be a result of the way the Rehabilitation Commission interprets the law. Texas case examiners "can have accurate decisions under the law and still have a lower allowance rate than other states because they reach different conclusions on cases that require certain judgments to be made on an individual's capacity to work" thus conceding in a statement against interest that TRC–DDS violated Texans' rights to due process and equal protection of the laws as compared to residents of other states.

We believe that both of these explanations are correct. We think that the October 1996 TRC "MCS" Memo "red-lined" a class of medical conditions and several specific medical treatment sources in Texas, and that this de-facto policy resulted in a regionally disproportionate impact in the Houston area, where we suspect a large number of the Kuwait oil well firefighters had been disabled by that chemical exposure. We also think that this policy, a de-facto unpublished state law, constitutes a violation of Texans' rights to due process and equal protection of the laws as compared to residents of other states.

To understand how such a de-facto policy can systematically be effected in Texas, one must look at the process of disability determination at the central office of TRC–DDS in Austin.

V. Processing of Social Security Disability Claims by the TRC–DDS Central Office in Austin.

The Initial Consideration and Reconsideration of all Social Security disability claims in Texas is done at the TRC–DDS central office in Austin. Cases are assigned to one of roughly 25 medical evaluation units working under 5 Program Directors based on the medical characteristics of the claim. (For instance, in 1994 all AIDS cases in Texas were determined by Unit 22.) These units are staffed by about 300 or so Claims Examiners and 50–60 State Agency Medical Consultants (SAMC's).

Thus, no matter where a person lives in Texas, if they have a particular medical diagnosis, their claim will be directed to the medical evaluation unit handling that specific medical diagnosis at DDS in Austin, and will be evaluated by one of about a half dozen to a dozen claims examiners working on cases with that diagnosis, as advised by a couple of State Agency Medical Consultants with expertise in that area who work with that group.

This method of assigning claims to medical evaluation units for determination based on diagnosis allows the opinions of TRC's Chief Medical Consultant to control all Social Security Disability Cases in the state of Texas uniformly. In short, if the TRC–DDS Chief Medical Consultant sets a policy on the credibility of a class of medical conditions or of specific medical treatment sources, it can be effected by the actions of just 2–3 State Agency Medical Consultants (SAMC's) working in a single medical evaluation unit.

VI. The October 1996 TRC "MCS'" Memo:

1. Authentication of the October 1996 TRC "MCS'" Memo:

A. We received the memo from a source "in Austin" who knew we were interested in this subject. That it exists outside TRC suggests that it was widely distributed inside TRC–DDS.

B. The memo is apparently on "Texas Rehabilitation Commission Office Memorandum" letterhead. TRC is the parent agency of TRC–DDS.

C. We have verified the date of the memo, in that it refers to an AP news article by Todd Spangler published in the Austin American Statesman on page A10 on Saturday, October 19, 1996, titled "ABC Correspondent, 4 Others Charged With Secret Taping".

D. We have been able to authenticate some of the recipients on the distribution list:

- Dave Ward was head of TRC–DDS Administrative Services in 1994, and was promoted to TRC Deputy Commissioner for Disability Determination Service in October 1996—the month the memo was written, and held that position until 2002, including during the "fake examiner" scandal.
- David Norman was director of the TRC–DDS Public Information Office in 1994.
- The SAMC's are the 50–60 State Agency Medical Consultants who provide medical consultation to the roughly 300 disability claims examiners in the roughly 25 medical evaluation units at the central office of TRC–DDS in Austin.
- The name Rosemary may or may not refer to Rosemary Calk, who was system manager of the Medical Consultants Service in 1994. In any case, the

head of the office employing the SAMC's might be expected to be on the distribution list, given that the SAMC's are on the list.

E. We have been able to establish the identities of the individuals named in the memo.

- Dr. Ziem, M.D., Dr.P.H. is a physician practicing in Baltimore, Maryland, and is President and Medical Director of "MCS Referral and Resources", www.mcsrr.org.
- Dr. William J. Rea, M.D. is a physician in private practice in Dallas, Texas, who has testified before Congress on health effects of the 1990–1 Gulf War, see www.ehc-d.com.
- Dr. Alfred R. Johnson, D.O. is a physician in private practice in Dallas, Texas, and is a former member of the Texas State Board of Medical Examiners.

F. We have not been able to establish the identify the author of the memo, "Dr. Vickers". It would appear that the Doctor is someone with sufficient authority to use "TRC Office Memorandum" letterhead to address "All SAMC's" consulting on the determination of disability at TRC–DDS in October 1996 on the subject of the handling of a class of medical conditions and on the credibility of specific medical treatment sources and treating source medical opinions for the 170–330,000 disability claims that TRC–DDS processes each year as a contractor for SSA.

G. Further authentication of the memo is precluded by the fact that 1) the Texas open government laws do not have jurisdiction over TRC–DDS, which is fully funded by federal funds and operated under federal law; because 2) Federal FOIA requests to SSA have in the past required a lawsuit to get even basic information such as ALJ approval rates, much less to obtain internal policy documents of state agency contractors; because 3) DDS and the OHA's are locked government facilities; and 4) the barriers to a Federal District Court lawsuit. Investigation into this matter is thus properly in the jurisdiction a Congressional oversight committee.

2. The Text of the October 1996 "MCS'" Memo:

TEXAS REHABILITATION COMMISSION OFFICE MEMORANDUM

TO: C.C. List Below:

FROM: Dr. Vickers (initialed)

SUBJECT: Austin-American Statement News Item: Saturday October 19, 1996 Continued Media Interest in Multiple Chemical Sensitivity

DATE: October 21, 1996

I am distributing a copy of this release in case any of you missed it over the weekend in the local paper. The practice of Dr. Ziem parallels that of Dr's Rea and Alfred Johnson in Dallas with whom the agency is very familiar. I had not heard reports from any other Regional Offices other than San Francisco as having problems with claimants with these problem issues.

It would appear that the ABC Network team has already concluded that this non-standard medical practice constitutes "junk science".

When Dr. Rea first brought this issue to the forefront all three major networks did evening news or special show revelations on this topic as did several news magazines and several major city newspapers.

The courts did not accept a suit by Dr. Rea against the American Academy of Allergy and the American Society of Allergists when they criticized his practices as "non-scientific" and "non-standard medically".

There are now many other physicians in our claimant area following this type of practice and these cases continue to constitute major medical support issues for acceptable diagnoses to meet program medical standards.

C.C.:

David Norman

Kathleen and Rosemary

SAMC's

3. Analysis of the October 1996 TRC "MCS" Memo:

A. The Memo as "Red Lining" of a Class of Medical Conditions and Named Medical Treatment Sources:

The Memo cites "**Continued Media Interest in 'Multiple Chemical Sensitivity'**" as its topic. "MCS" is a term which describes a class of medical conditions, including porphyria, solvent neurotoxicity, and pesticide poisoning, but also shares many commonalities with the conditions of "Gulf War Illness", Chronic Fatigue Syndrome, and Fibromyalgia. The memo invokes authority by saying '**It would appear that the ABC Network team has already concluded that this non-standard medical practice constitutes "junk science"**'. The news media is not, however, a scientific source of medical information. The statement that "**these cases continue to constitute major medical support issues for acceptable diagnoses to meet program medical standards.**" would suggest that the writer intended that disability claimants with this class of medical conditions or who used the 3 named physicians as treatment sources ought to be given special scrutiny. In the insurance business this behavior is called "red lining".

B. The Memo as a Violation of National Program Standards of the Social Security Administration: Chemical Sensitivity as Acknowledged by SSA:

National Program Standards of the Social Security Administration directly acknowledge the existence of chemical sensitivity as a medical condition. Specifically:

- POMS DI 24515.065: "Evaluation of Specific Issues—Environmental illness", promulgated in February, 1988, states that "This evaluation should be made on an individual case-by-case basis to determine if the impairment prevents substantial gainful activity". This transmittal was issued 8 years before the Memo.
- The stipulation was made by SSA that it "recognizes multiple chemical sensitivity as a medically determinable impairment" in Creamer v. Callahan, 981 F.Supp. 703 (D. Mass 1997), issued approximately one year after the Memo.
- Social Security Ruling SSR–99–2p "Policy Interpretation Ruling: Titles II and XVI: "Evaluating Cases Involving Chronic Fatigue Syndrome (CFS)" cites multiple chemical sensitivities as a possible contributing factor. This regulation was issued 3 years after the Memo.

In addition, there is no question to the validity of a number of medical conditions which might be labeled as "MCS" or chemical sensitivity, such as solvent neurotoxicity.

C. The Memo as a Violation of National Program Standards of the Social Security Administration: A Direct Attempt to Violate SSR–96–2p: "The Treating Physician's Rule" Against Specific Treating Physicians:

The publication of the October 1996 TRC "MCS" Memo must be taken in the context of policy changes occurring in the national SSA program at the time. "SSR–96–2, known as the "Treating Physician's Rule", was published that year with an effective date of 7/2/1996. The Memo, published 3½ months later, would appear to lay the foundation for the systematic violation of the "Treating Physician's Rule" against individuals using as medical treatment sources or treating source medical opinions two named Texas physicians, Dr. William J. Rea and Dr. Alfred R. Johnson, both with practices in Dallas. The memo notes, however, **"There are now many other physicians in our claimant area following this type of practice . . ."**

The October 1996 TRC "MCS" Memo, taken in the context of its writing just months after the publication of SSR–96–2p, strongly suggests an official and systematic policy at TRC–DDS—a de-facto unpublished state law—of discrimination against a class of medical conditions and specific medical treatment sources, an action taken in direct violation of National Program Standards of the Social Security Administration.

D. Impact of the October 1996 TRC "MCS" Memo:

In effect, TRC-DDS has, as a result of 'Oil Patch' politics, denied a class of individuals the right to Social Security disability benefits, for reasons of medical diagnosis which are often related to genetics (e.g. susceptibility to porphyria) or chance (e.g. solvent neurotoxicity), or by choice of treatment provider or medical opinion (e.g. one of the named physicians).

VII. The Politics of Power: Abuse of the Somatoform Disorder Psychiatric Diagnosis, the Handling of Psychiatric Claims, and the Operation of the Houston Anti-Fraud Unit in 2001–3:

TRC–DDS apparently does not believe in certain diseases associated with chemical injury. (We believe this also extends to the Texas SSA ALJ's at the OHA's at least in Dallas, given the number of ALJ decisions written over the past 15 years there labeling claimants who have been treated by doctors named in the October 1996 TRC "MCS" Memo as having a medical condition that is "iatrogenic"—caused by the doctor.) As a result, the only way that many of these desperate injured individuals can get Social Security disability is on grounds of "somatoform disorder", a psychiatric condition similar to being a hypochrondriac. It is notable that the overall approval rate for SSD claims for psychiatric conditions in Texas has been about ⅔ of the national average.

The Houston Chronicle articles reviewed the operation of a SSA anti-fraud unit in the Houston area during 2001–3, whose tactics included subjecting claimants including some with mental problems to "ruse interviews", including by falsely accusing some individuals of crimes in order to evaluate their mental response. This ceased after protests to the SSA Inspector General. These events, taken together, demonstrate the violations of national program standards of the SSA in Texas and of Texans' rights to due process and equal protection of the laws as compared to residents of other states, for instance against Houston area workers injured in the oil industry.

VIII. Closing:

The management of rehabilitation in Texas has striking longevity, being directed by 4 individuals for 70 of the past 74 years. Further, appointments to the TRC Board have not been made on a timely basis in recent history. We feel that this lack of management renewal has resulted in an inability of TRC to deal with change, including to recognize new medical diagnosies such as "Oil Well Firefighter Syndrome".

We have established that medical decisions at TRC–DDS are highly centralized, being controlled by the Chief Medical Consultant, with determinations made in units sorted by diagnosis.

We have established, subject to rebuttal, that an October 1996 memo whose distribution list includes "All SAMC's", and the director of TRC–DDS appointed that month—who held that position for at least the next 5 years, appears to red-line a class of medical conditions—including porphyria, in violation of several SSA precidents, and to red-line several specific medical treatment sources in Texas, in violation of SSR–96–2p, "The Treating Physician's Rule". We feel that this memo affirmed an unwritten standing policy and instituted it as a de-facto unpublished state law.

Coincidently, by 2000, TRC–DDS presided over the worst initial approval rate in the nation for SSD claims. Multiple news articles in the Houston Chronicle indicate that there was a regionally disproportionate impact of disability claim denials in the Houston area in 2000–2, which is populated by a large number of "blue collar workers" "in the oil industry".

The initial explanation for the low initial approval rate in Texas given by the spokesman of SSA Region VI was to blame **the large number of "blue collar workers" "in the oil industry and elsewhere"**. It is common knowledge that many of the Kuwaiti oil well firefighters worked for American oil companies headquartered in the Houston area. Toxicology indicates that exposure to hydrocarbons such as produced by oil well fires can cause disability by several mechanisms, including solvent neurotoxicity, and the induction of porphyria in susceptible individuals.

The second explanation for the low initial approval rate in Texas given by the spokesman of SSA Region VI was to state that it **"may be a result of the way the Rehabilitation Commission interprets the law. Texas case examiners "can have accurate decisions under the law and still have a lower allowance rate than other states because they reach different conclusions on cases that require certain judgments to be made on an individual's capacity to work"**. We agree with this statement against interest, a concession by SSA

Region VI that this situation constitutes a violation of Texans' rights to due process and equal protection of the laws as compared to residents of other states.

We have seen the operation of a SSA anti-fraud unit in Houston targeting individuals including some with "psychiatric disorders", that "somatoform disorder" is the only way many desperate chemically injured individuals can get Social Security disability in Texas, and that the overall approval rate for psychiatric disorders in Texas is about ⅔ of the national average.

In conclusion, we believe that the policies of TRC–DDS directly prejudice the operation of Social Security disability determinations at the Office of Hearings and Appeals in Texas, in violation of national program standards of the SSA, which constitutes a violation of Texans' rights to due process and equal protection of the laws as compared to residents of other states.

IX. References: Relevant SSA Policy Documents, Legal Precedents, and Federal Law:

1. **Social Security Ruling SSR 96–2p (7/2/96): Policy Interpretation Ruling: Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions: ("The Treating Physician's Rule"):**
2. **Social Security Ruling SSR 97–2p (8/8/97): Policy Interpretation Ruling: Titles II and XVI: Prehearing Case Review by Disability Determination Services:**
3. **DI 24515.064 Evaluation Of Specific Issues—Environmental Illness. Social Security POMS section DI 24515.064, 08–29–96.**
4. **Social Security Ruling SSR 99–2p (4/30/99): Policy Interpretation Ruling: Titles II and XVI: Evaluating Cases Involving Chronic Fatigue Syndrome (CFS):**
5. **Creamer v. Callahan, 981 F.Supp. 703 (D. Mass 1997); 1047. Creamer v. Callahan. List of Available Materials 1996–2001, NOSSCR, www.nosscr.org.**
6. **Vlantis v. Apfel, Cause No. 3:99CV1306 U.S. District Ct. Connecticut 10–18–2000; 1185. Vlantis v. Apfel. List of Available Materials 1996–2001, NOSSCR, www.nosscr.org.**
7. **Greenspan v. Shalala 38 F.3d 232 238–239, 46 S.S.R.S. 3, 9–10, CCH S14,224B (5th Cir. 1994), HALLEX II–1–5–9 Impairments—Environmental Illness:**
8. **Brown v. Shalala 15 F.3d 97, 98,99,100, 43 S.S.R.S. 504,505,506,507, CCH S17,686A (8th Cir. 1994), HALLEX II–1–8–9 Impairments—Environmental Illness:**
9. **Grant v. COSS, Cause No. 3:CV–88–0921, U.S. District Ct. of the Middle District of Pennsylvania, Opinion 8–23–00, http://www.pamd.uscourts.gov/opinions/muir/88v0921.pdf. ALJ was biased generally against disability claimants, and determined their cases according to prejudices—e.g. marking many of the instruction sheets to the opinion writers with "no-goodnik", and unlawfully concluding that the claimant was not credible. This action "deprived them of their right to a full and fair hearing in violation of the Social Security Act and the due process clause of the Fifth Amendment to the U.S. Constitution.**
10. **DI 525510.001 Goodnight, et al., v. Apfel Settlement Agreement. Social Security POMS section DI 525510.001, 01–12–00.**
11. **Amendment V, Constitution of the United States.**
12. **Amendment XIV Section 1, Constitution of the United States.**
13. **42 U.S.C. 421—Disability Determinations.**
14. **42 U.S.C. Chapter 21—Civil Rights, Subchapter I—Generally.**
15. **42 U.S.C. 1981—Equal rights under the law.**
16. **42 U.S.C. 1983—Civil Action for depravation of rights.**
17. **42 U.S.C. 1985—Conspiracy to interfere with civil rights.**
18. **42 U.S.C. 1987—Action for neglect to prevent.**
19. **42 U.S.C. 1988—Proceedings in vindication of civil rights.**

Statement of Ladonna Miller, Lima, Ohio

Solving the problems with OHA will be pointless and perhaps impossible unless the problems with the Disability Determination Services are solved first. If unwarranted denials were not given on valid claims, the OHA would not be overloaded

and backlogged. Aside from other reasons in a variety of individual cases, simply because of the system of listed impairments, thousands of qualified claimants are denied at DDS level. Almost everyone with an unlisted impairment must wait for an ALJ to use common sense and find the claimant disabled. If some system of common sense were permitted on the DDS level, instead of absurd adherence to the listings, the OHA would have only those cases that legitimately belong in a hearing room. Severely disabled claimants whose medical conditions happen not to be listed impairments do not belong at OHA, should not be at OHA, would not be clogging OHA, if the Listing of Impairments was either greatly expanded or abolished.

Fibromyalgia victim, including, neurological problems, weakness, lack of concentration, memory, & balance. Tremors, degenarative spinal arthritis, 2 herniated discs, 1 in neck, 1 in lower back, drop foot which I wear a brace on. Irritable bowel, diverticulosis, with flares of diverticulitis, chronic & severe pain, 24 hrs a day. Also being treated for depression. Neurologist tells me that the pain will cause the depression, and the depression will cause the pain. I will have to learn to live with it, because I will be in a vicious cycle of this for the rest of my life. I lost my job in February of 2002 because of my poor attendance due to all of these symptoms coming on, before I was diagnosed. I have not been able to drive for a year now. And have been using a walker for a year now. I had gotten so weak that carrying a loaf of bread took me to my knees. Your social security offices here in Ohio have had reports from 3 neurologists, 2 family drs., 2 hospitals, including all kinds of blood tests, x-rays, MRIs, etc. But that was not enough for them. They have sent me to 2 more drs for evidence. I truly believe that this is nothing but a waste of our governments money! The people in Columbus could have made an appointment with me & saw for themselves what kind of condition I am in. Not just from this condition and all of it's symptoms that come along, but from all of the medications and their side affects as well. And what really hurts me is that I have been turned down for benefits, after I have worked all those years, and paid into this system, just in case something would happen that I would need it. I would much rather be out there working and making good money than sitting here living with all of this pain and everything else with it. It has caused me to sit back and really have doubts about my government, when I can go out on the streets and see drug addicts and alcoholics receiving ss disability when they did this to themselves! I sure didn't do this to myself! And that really hurts. Especially when they, or you, are fighting me about a puny little $382 a month!

As I said before, thank you for listening. God bless. You and my country are in my prayers.

MILWAUKEE, WISCONSIN 53219
October 2, 2003

Subcommittee on Social Security
C/O Honorable E. Clay Shaw Jr.
Room B–318
Rayburn House Office Building
Washington, D.C.

Dear Congressman Shaw:

There are other problems besides management problems here in Milwaukee, WI at Social Security.

Although, my son Joshua had been born with a seizure disorder, he had suffered no ill effects and could do anything a four year old could do. His seizures had long been controlled with Pyridoxine (a Vitamin B6).

In December 1984, the State of Wisconsin Department of Health & Social Services Division of Community Services, Bureau of Social Security Disability Insurance (that's on their letterhead) tried to have Joshua declared disabled due to his seizure disorder. The application for Social Security Disability was denied on January 15, 1985. The Disability Specialist's name was Betty A. Fischer.

In August 1985, the same people mentioned in the above paragraph tried again to have my son Joshua declared disabled, this time claiming retardation and hyperactivity unlike in the prior attempt where my son's doctor's reports were used. The disability specialists name was Rosemary Dykman. The State of Wisconsin hired and paid a Dr. Walter J. Cleason to give my son Joshua "a special examination at our expense". I don't know the name of the drug that was given to Joshua prior to the examination or if he acted as described by the doctor. Joshua was a good, well-behaved boy.

In September 1985, the Social Security Administration (S.S.A.) declared Joshua disabled even though he was not. His Mother started collecting benefits in October 1985. Why would the government go through all of this trouble to pay out benefits to someone who is not disabled?

- First, to file a bogus lawsuit. It is a big plus when the S.S.A. hands out it's endorsement & benefits
- Second, since my son's mother was and is mentally unbalanced and functions at about a sixth grade level. A well-known personal injury lawyer who had been working on my son's mother for about a year filed a suit August 27, 1986 against Children's Hospital. Doctors from Children's Hospital had been working on my son's mother also.
- Third, the State of Wisconsin, who provided and paid the Doctor for the exam that got Joshua declared disabled filed a suit on Joshua's fourth birthday, September 16, 1986. (which is also Mexican Independence Day)
- Fourth, Now that Joshua has been declared disabled and is receiving benefits and the lawsuits have been filed it's time for Joshua to really become disabled. Now the suits can be amended. Now the government Social Services, S.S.A. lawyers can claim catastrophic brain injury

On December 17, 1986 the Vitamin B6 that used to stop Joshua's brain seizures was withheld. He went to Children's Hospital in the early morning on the 18th, where he spent three weeks in I.C.U.; three months at Children's Hospital and was transported to an institution where he remained for 7 years.

I, Abel Moya, the natural father of Joshua Thomas received custody in 1993. I brought Joshua home in August of 1994. I had informed Children's Hospital and their lawyer in 1987 of my son's mother and the lawyer's intentions.

In early 1991, the case was quietly settled out of court. This was done to shield the various government agencies and the rest of the "prominent" participants who desecrated my son Joshua and my family. Social Security started the ball rolling when they declared my son disabled.

The defendants bought an annuity for Joshua in the amount of $2,000.00 monthly. From 1991 to the time I brought Joshua home in August 1994, Social Security excluded that amount monthly as a resource for Joshua because the State of Wisconsin was a major participant.

Because I had ruined the conspirators' vision of a big pay off, Social Security said Joshua did not qualify for benefits or the medical card. Joshua and I paid out of pocket for all expenses. I set up an irrevocable trust November 7, 1997. On December 3, 1997, I applied for disability for myself and Joshua. Social Security denied Joshua and did not want to look at the trust at all. I appealed mine and it is sitting in Federal Court. Social Security says they don't see how having to care for a quadriplegic son caused by them would cause me to suffer depression, stress and anger. This diagnosis can be verified by my doctor. Mr. Bachinski of the Forest Home Social Security Office told me it could not be appealed and that I should not come there because S.S.I. was a welfare program.

I applied again September 19, 2000 and February 20, 2001 and was twice more denied.

In March of 2002, I applied again. This time Joshua qualified. This was the same Trust I applied with the previous times. I was told, by Mr. Brian Matusiak, that Joshua qualified for $363.00 a month. I later found out that this was a lie.

The following month I received $238.00 that was for May 2002. I was told that Social Services had told them that I was receiving child support. That was a lie. Social Services was a conspirator also.

I asked Social Security to show me, in writing, where I was receiving child support. They could not, but nevertheless, I did not start receiving checks again until January of this year.

In May I started receiving $370.00 per month, which is way below what Joshua is supposed to get.

They are deducting $206.00 per month for P.M.V. Twice I went to appeal and was told outright "No" by Brian Matusiak of the 9th Street Office and once by Steve Lund of the Forest Home Office. Twice Social Security went through the motion on the computer and told me that the appeal was in. The last time I believe was in February or March of this year. The 37th & Wisconsin Avenue Social Security Office called me three weeks ago and told me there was no appeal pending and that I had to file again.

I am sick and tired of Social Security's lies. They owe my son a lot more than the maximum of benefits from the time he left the institution in Madison, WI.

I've written to Mr. Kleczka, Mr. Kohl and Mr. Feingold. It does no good. Social Security lies to their staff just as easily as they do to you. Now I have the staff

from three of your Representatives and Social Security telling me I'm not entitled to benefits.

On Monday, the 22nd of September, I called the 37th & Wisconsin Avenue Social Security Office and left a message with a Ms. Arnold to call me back so I could make an appointment. As of this writing she has not called.

Congressman Gerald D. Kleczka has known about this scam where you leave healthy Latino kids to try and enrich themselves since 1992. I don't know how many times the government and lawyers have done this but you can be sure that it's the taxpayer that is picking up the tab.

I am very, very serious about the governments' participation. I feel that my and my son's lives are in real danger. When you've upset the legal profession and the government you're at their mercy. I don't know what to expect after you receive this letter.

Sincerely signed,

ABEL MOYA

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals
Springfield, Massachusetts 01103
September 30, 2003

Hon. E. Clay Shaw, Jr.
Representative in Congress
Chair—Subcommittee on Social Security
Committee on Ways and Means
1102 LHOB
Washington, DC 20515

Dear Rep. Shaw and Honorable Members of the Subcommittee:

I am an Administrative Law Judge with the Social Security Administration [SSA], Office of Hearings and Appeals [OHA], and have served as such since October 1996. Since September 2000 I have had the additional responsibilities of a Hearings Office Chief.

The job of a judge in these proceedings is very challenging. We are required to wear three hats: [1] to provide full and fair hearings; [2] to assist claimants with developing the record and presenting their cases—***even if represented;*** and [3] last, **but definitely least,** to act as trustee for the Social Security Trust and General Tax Funds. The last two duties require a judge to, in essence, "represent" opposing sides.

I am elated at hearing that Congress will take a close look at the Social Security disability program management, and pray that the less than inspired changes implement-ed and in the works by its administrators, will be reviewed closely, but also broadly, so as to encompass the larger goals of the disability program. I fear the administrators of the program have lost sight of the forest, having allowed it to be blocked by the minutia of the trees. I find it difficult to maintain faith in those the President has appointed to administer the Social Security Administration, particularly as pertains to due process disability hearings. They appear hell-bent on applying bureaucratic remedies to judicial problems, when the true impediment to due process and expeditious case movement is the latter. While having short term, and all too often short sighted, immediate effect, the bureaucratic remedies avoid dealing with the true problems of the disability program, and amount to being penny-wise and pound-foolish.

A big part of the complexity and time involved in disposing disability claims is the product of the Agency having succumbed to obfuscation in the definition of disability, as well as having ceded control of the process to the representative community. These representatives are generally paid on a contingent basis, with a success rate well in excess of 50%, not because reconsidered decisions are wrong, but due to factors addressed below. They are allowed a top fee of $5,300.00, and, more often than not, work in a fast food restaurant fashion—i.e., high volume, doing a sloppy job and simply depending on the above noted success percentage, to collect $10,000 to $15,000 each month, doing little more than holding enough claimants' hands in a high number of hearings, and soliciting a few documents, as will be further addressed below.

An article, which appeared in the New York Times [*Laid-off Workers Swelling Cost of Disability Pay,* September 2, 2002] deals in general terms with a problem that could grow to the point of severely depleting the Social Security Trust and the General Tax funds. This is not just the product of baby-boomers coming of age, and

the past Commissioner's loosening of the standards for mental disability. The general attitude that has developed is one by which this tribunal is not viewed seriously, and misrepresenta-tion within these proceedings is regarded as the proverbial "white lie." This was virtually admitted by one representative, who took offense when I pointed out the inconsistency in his client claiming to have been "ready, *willing and able*" to work for purposes of collecting Unemployment Insurance Benefits, while claiming the opposite for the same period of time for purposes of SSA disability. This representative actually argued that disingenuousness, if needed to collect benefits, should not be viewed unfavorably in assessing the claimant's credibility.

The courts and the SSA Appeals Council have created and applied case law in a manner such as to have, effectively, shifted the burden of proof in contested disability cases to the Administration. This is primarily accomplished by having declared the opinions of treating physicians as controlling, unless the longitudinal record clearly overcomes those opinions [20 CFR §§ 404.1527 (d)(2), 416.927(d)(2)]. In a tribunal, in which around 75% of the claimants are represented, and the Agency not represented, this permits easy solicitation of favorable reports from treating physicians, who are already naturally in sympathy with their patients. There are no countervailing forces in play, nor any incentives for these treating physicians not to succumb to their patients' entreaties for a favorable report. These reports are not sworn under the pains and penalties of perjury, as is generally done in Workers' Compensation tribunals. The treating physician is never subjected to cross-examination, let alone prosecution for misrepresentation. When the end "goal" of transferring wealth is thrown into the mix, such as to salve any guilt the treating physicians may have about exaggerating their patients' limitations, the flood gates are wide open to abuse. Thus an Administrative Law Judge [ALJ] is boxed into a corner, and forced to grant benefits, even when knowing the individual is not truly disabled. A very typical 40-year-old spine, with a sympathetic treating physician, can easily result in qualification for benefits, despite a claimant being fully capable of some type of work. The United States Supreme Court is to be applauded for not permitting the expansion of this foolish notion beyond the realm of Social Security hearings, and it should be reversed here [see: *Black & Decker Disability Plan v. Nord,* 538 US _____(2003), No. 02–469. Argued April 28, 2003—Decided May 27, 2003]. SSA should re-think the wisdom of this invitation to misrepresentation.

Administrative Law Judges dedicated to a diligent search for the truth, who take seriously the third duty noted above [i.e., to act as trustee for the SSA and General Tax Funds], are put into the awkward position of having to act as a contestant rather than a neutral in order to be true to the so-called "third hat." The alternative is to simply pay cases inappropriately, the road all too many are bludgeoned into by the Administration's constant push for numbers. As noted above, the solicitation of these highly suspect treating physician opinions is often the only thing a representative does, but it is suffici-ent to, effectively if not formally, transfer the burden of proof to the Commissioner.

The abuses of the disability system via the mental impairment route are even worse. Limitations imposed by amorphous diagnoses such as depressive disorders, anxiety, personality disorders and a plethora of other such impairments, leave the system literally at the mercy of a sympathetic treating professional, who is solicited by a representative to supply an opinion.

As I once suggested in a letter to the Commissioner, the law and regulations are the engine, which drives this agency, and must be reviewed and revised to respond to the factors making disability almost a presumed fact by the mere act of applying, with the Commissioner, through an ALJ ill equipped to investigate matters, then having to prove its absence. The law must be refurbished to return the burden of proof to the claimant, and to hold those claimants with representatives to a higher standard of duty to produce truly probative evidence. As I stated in that letter to the Commissioner, which went unacknowledged, the actions to which she spoke for most of her testimony, are akin to working on only the transmission of a car with a leaky head gasket and sludge throughout the engine, and expecting it to perform well, and go faster. The engine cannot be ignored.

Honorable Committee Members, we are in a position much akin to that in the labor relations sphere decades ago. There Congress responded to the imbalance of power be-tween employers and organized workers by passage of the Wagner Act in 1935, favoring only the rights of workers. By 1947 it was recognized that labor had come into its own, and that the balance of power had actually shifted in its direction. Thus, we saw passage of the Taft-Hartley Act, to even the playing field. Rest assured, claimants have come of age, and are very powerful. It's time to level the playing field for those who fund the programs.

As noted above, around 75% of the claimants in Social Security disability cases are represented, ***and this in a tribunal with no opposition.*** To say that the taxpayers are at a distinct disadvantage puts it mildly. The regulations that are presently in place to control the practice of these representatives do not require them to submit evidence, which would tend to disprove disability. Thus, if a representative comes into possession of informa-tion disproving disability, there is no requirement to present it. How one-sided can a program be?

We are charged to give the claimant every benefit of doubt. Superimpose the treating physician rules and the one-sided rules mentioned above upon this duty, and you can see how many people capable of working slip through the system. ***Social Security Disability is quickly becoming the "wink and nod" with which President Clinton signed welfare reform.***

A few ideas for changes run along the following lines:

- Tighten up the definition of disability, keying in on case law which has blurred that definition, and return the burden of proof to the claimant. I would suggest a "blue ribbon" committee of legal and medical experts, members of the disability and workers' compensation insurance industry, active and/or retired ALJs, personal injury lawyers from both sides, and representatives who practice in this tribunal regularly. The charge should be to clarify the definition of disability, such as to more closely reflect that in the collective mind of those who work to fund these programs. Somehow a person with a typical 40-year old spine, who simply doesn't want to work for a lower wage than obtained in a previous vocation, as may be dictated by his condition, is not that which the average taxpayer envisages when picturing a disabled person.
- Eliminate Childhood Disability benefits [see: *Costs Soar for Children's Disability Program; How 26 Words Cost the Taxpayers Billions in New Entitlement Payments,* Washington Post, February 4, 1994]. Children are not generally sources of income in a household. The bottom line purpose of these benefits is to replace income that would, but for a disability, be coming into the household. There is simply no basis other than transfer of wealth for children's bene-fits. To make this change more politically palatable, I have suggested, through the Associate Commissioner, that we eliminate all cash payments, but provide Medicare coverage to ***all*** children below the poverty line, without regard to disability. This would eliminate that which has become a complicated and costly disability analysis, and clear up a plethora of frivolous cases engendered by the desire of parents to simply get another check in the mail. Since the vast majority of children found disabled are found so for learning disabilities and attention deficit hyperactive disorder, the amount expended by this trade-off would go down, as most of the services needed for these impairments are already provided gratis by the school districts. This would represent a direct response to a specific need, rather than simply throwing more money into the household, with no logical nexus between it and the need.
- After five years living in those portions of United States of America in which English is the commonly used language, the inability to speak English should no longer be considered a vocational detriment in the disability assessment.
- In the true sense of the SSA being part of the *Village* rearing the nation's children, psychiatric reports by which a primary caretaker of children is described as incapable of main-taining sufficient concentration, persistence and pace to perform even the simplest routine task, should be reported immediately to the local child protective service agency for investigation.
- 20 CFR §§ 404.1527(d)(2) and 416.927(d)(2) should be rescinded

In a more esoteric sense, changes in the hearing process should be along the following lines:

- The hearing process should be adversarial, similar to that in the Workers' Compensation system. Since there are no insurers to provide representation, a former President of the Hearing Office Chief Judges Association has suggested the Bankruptcy Court as a model, with an equivalent to the United States Trustee being assigned the role of representing the Commissioner's position. This office could be staffed by eliminating the present Appeals Council, allowing the ALJs to truly act as trial level fact finders without being second-guessed, and using the personnel from the Appeals Council to represent the Commissioner. Another alternative, which would more sensibly follow the President's mandate for use of private contractors than

the present delegation of clerical tasks [which has not helped us move cases], would be to replace the State Disability Determination Services [DDSs] with private insurers, and then have them provide investigative work and representation at the hearings.

An adversarial hearing process would likely resolve another source of consternation, specifically, the inconsistency of hearing results from hearing office to hearing office, and from region to region. Specifically, judges who do not take the third hat seriously are now able to stay under the proverbial radar screen by simply finding favorably, with the knowledge that only 7% of such decisions are ever reviewed, while a much higher percentage of unfavorable decisions are reviewed. Placing both favorable and unfavorable decisions on the same footing would, I believe, infuse much more consistency in the decision making process. All decisions should stand the same probability of being reviewed.

- Once retained the claimant's representative should be primarily responsible for developing the record from the claimant's side, and the Commissioner's representative from that side. There should be strict rules for the timing of such development, and the availability of sanctions for poor performance by those representatives.
- Strict rules of professional and judicial conduct should be implemented, along with rules for practice and procedure. It should be noted that such rules, as manifested in the Model Rules for both Professional and Judicial conduct, do have provisions for expeditious case movement, and would give the Administration a tool it presently lacks to encourage such. [e.g., see: *Model Code of Judicial Conduct,* Canon 3 (B) (8)].
- The method of payment of representatives should also be revamped. The contingent fee method encourages representatives to drag out the proceedings as long as possible, so as to grow the back payments from which their fee is paid *and calculated.* A better method would be to pay representatives of both winning and losing cases, but at an hourly rate in line with the Federal Assigned counsel program, used in the Federal Article III courts. Indeed, I would take that suggestion a step further, by having fee payment administrated out of that program, rather than duplicating such administration at the agency level. In addition to discouraging procrastination, this would lower the incentive to engage in misrepresentation. ALJs should be allowed to assign counsel from a panel maintained by the Assigned Counsel program.
- Eliminate the third step in the sequential analysis, by which disability determina-tions are made. The statutory definition of disability ties an impairment directly to the limita-tions it imposes upon the ability to work; ***it is a functional definition*** [see: Social Security Act §§ 216(i), 223, 1614(a)(3)(A)]. The third step in the sequential analysis requires the judge to review the medical signs and symptoms, to see if they match a list of such signs and symptoms associated with specific maladies. The notion is that the presence of specific signs and symptoms will lead to a presumption that limitations precluding work exist. The problem is that medicine moves more quickly than law, and products ameliorating the limitations imposed by specific signs and symptoms are discovered daily. The presumptions simply do not hold up to medical progress. Furthermore, some of the signs and symptoms leading to the presumption of disability do not truly do so. I had at least one incident of an individual meeting a listing, whose treating physician opined as capable of working. I've had more than one vocational expert advise that the mental retardation listing is overly broad, and qualifies individuals capable of placement. Suffice it to say, the Listings impose a complicated analysis, often requiring the testimony of medical experts, and often provide that, to which I refer as a "black hole of obfuscation," into which representatives throw the truth.

Some of these ideas are along the lines of those proposed by the Social Security Advisory Board in its January 2001 publication, *Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change.* Indeed, one of my greatest disappointments is the new Commissioner's tendency to engage in the diminution of due process, concentrating her efforts on the minutia of the ways in which files are handed off, despite her background with the Social Security Advisory Board. While honing down due process may give the illusion of streamlining the system, eventually it will have to be achieved, and having that take place at the level of Article III courts will certainly be much more costly and cumbersome in the long run. Putting off real due process, until a matter reaches a court of general jurisdic-

tion and no specialized expertise, will be a disservice to the claimants and the taxpayers. Yet this seems the underlying theme to the constant bureaucratization of the Office of Hearings and Appeals.

The concentration of effort on the movement of cases, coupled with ignoring the substantive changes that need to be made to prevent abuse of the program, leads to many, many inappropriately paid cases. These have been estimated at a cost of $200,000.00 to $250,000.00 each. With over 1,000 judges, each pushed to dispose of about 50 cases per month, and ill equipped to get to the truth, you can see where inappropriately paid cases could mount up pretty quickly. Paraphrasing, I think it was Sen. Everett Dirkson, $200K here and $250K there—pretty soon you're talking real money. The Administration seems to have lost sight of a notion once addressed by Woodrow Wilson, who said:

> *We need laymen who understand the necessity for law and the right uses of it too well to be unduly impatient of its restraints.*

The present Associate Commissioner in charge of the Office of Hearings and Appeals has set a disposition goal for each judge to issue 2.72 decisions per day. When taking into account time off for annual leave, which is not considered in applying the above referenced "goal", that actually calculates to a judge spending a total of 2 hours and 39 minutes on each case. This is to accomplish the following:

- Development review, to see what additional evidence may be needed;
- Thorough pre-hearing review of medical records, generally averaging the size of a phone book for a city of over 100,000 population [this usually takes me about 2.5 hours alone];
- Conducting the hearing [generally about an hour];
- Reviewing new submissions of evidence;
- Deliberating the decisions and drafting instructions for the decision writers;
- Editing the draft of the final decision.

I think it a sad anomaly that that which Congress sought, in first outlining the need for ALJs and what it hoped to achieve through them, has gotten lost in the flurry to bureaucratize this quasi-judicial body. Congress, and the Agency in its earlier stages, saw the value to seeking judges, whose experience was primarily attained in the day-to-day grind of arguing cases. The emphasis in terms of qualification for the position was placed on the development of an innate sense for the truth, developed through practice experience. It was understood that any lawyer could become familiar with specific statutes and regulations, but only those with a keen sense of fact-finding, honed by trial experience, could be entrusted with the practical application of the "three hats", spoken to above. The appropriateness of that priority has recently been re-affirmed in *Meeker and James (OPM) v. Merit Systems Protection Board and Azdell,* decided February 20, 2003 by the U.S. Court of Appeals for the Federal Circuit. Indeed, the failure of a previously implemented "Senior Attorney" program, in which less than judges were actually given decision-making authority, underlines the importance of the experience of judges in this process. Having served as a Quality Assurance Review judge during the ending of this program, I had the opportunity to have reviewed many such decisions, and, as a taxpayer, felt literally raped at the ease with which cases were paid. This was the product of more than one factor, but primarily two: (1) the administrations adoption of a "could pay" rather than "should pay" basis, meaning that, despite a claimant's actual ability, if you can get the right blocks on your ticket punched [primarily by way of a solicited accommodation from the treating physician, with all the problems therewith noted above]; and (2) the fact that the Senior Attorneys making these decisions were only given production credit for cases paid. The philosophical change in the first of these two factors haunts us to this day, and must be addressed in the statutory and regulatory study I suggested above.

This was a mistake, which is rumored to now be reconsidered. I hope it isn't, but, if indeed, the Administration wants to cede decision making powers to senior attorneys again, the more sensible way would be to limit such to overpayment and Medicare cases. These are cases dealing with finite amounts of money (disability payments often go on until the recipient dies), and, more importantly, are much less dependent on credibility determinations, which require the very experience and concomitant innate sense spoken to above. This would allow judges to give disability cases the time, analyses and deliberation they deserve.

The Administration's constant emphasis on pumping out more and more cases, undermines the goals sought to be achieved via having experienced fact-finders applying the time and analyses necessary to arrive at just decisions. Its emphasis on

the assembly line while ignoring the end product, has and will continue to lead to far more havoc than would the reverse. Undermining judges' ability to properly hear and decide via unrealist-ic quantitative goals, leads to more and more inappropriately paid cases, which, in turn, attracts the filing of more and more specious claims, as the probability of winning increases with every short cut imposed upon judges. This vicious cycle makes achievement of the goal of expeditious case handling an impossible dream, while costing the taxpayers more and more in the way of inappropriately paid cases.

Your anticipated kind consideration of the points herein is appreciated.

Very truly yours,

PETER J. MARTINELLI
U.S. Administrative Law Judge
Hearing Office Chief

Statement of Connie M. Osbon, Beaverton, Oregon

Mr. Chairman:

Thank you for opening these hearings re: SSA's negligence in processing, approving and denying valid claims for disability. This is a topic which is long overdue for investigation and which has been the bane of many individuals including myself seeking disability.

Firstly, I am a disabled citizen now age 59. I attained disabled status effective 12/31/99 which was backdated to August 1997. I originally applied in September 1983 due to the same medical problems then which were only more exascerbated in 1997. Granted my doctors in 1983 had not sufficiently investigated and diagnosed my chronic poor health conditions, but the basis was there.

As a support group coordinator since 1997 and active participant in 3 other support groups, I have been party to hearing many other individual difficulties in attaining disability status some bordering on the absurd given the medical documentation provided.

It is my understanding that 25–33% of initial applications are approved, thus 75–66% of applicants are denied on the first round.

In the State of Oregon, the Department of Vocational Rehabilitation Services in Salem is the contract agency with SSA to handle initial claims processing. Additionally, you need to know this same state agency as well as the SSA was sued in a class action suit in l994 over unjustified and blatant denial of valid claims by Oregon Legal Services, et al where

VHS consistently denied the initial claims, for which later, 70% of those claims were approved at the administrative law judicial hearing. The SSA was dismissed from the suit on the grounds that the state contract agency was not following the policies, procedures and medical guidelines of the SSA. From news reports, VHS was to be under continued judicial scrutiny and the SSA Seattle Regional Office for 3 years upon the determination of the lawsuit in 2000.

My complaint consists of these points:

1. **Unreasonable delays in initiating claim, too many caseworkers on claim, not responding to followup calls by claimant—**my claim went unopened for 3 weeks, and through 3 caseworkers. I received no help when I could have used it due to handwriting, organizational dysfunction and the need for a time extension for medical reasons. I later heard from others that help from the office was offered to them. I had to drop the 2nd initial application due to serious health problems which did not allow me time and energy to deal with the disability application. That cost me time and benefit dollars ultimately.
2. **Unreasonable demand for return information/forms to SSA contract office** within 10 days, difficult even for doctor reports including the office visit, yet alone the disabled. Most applicants do not know they can ask for an extension.
3. **Stressful process for sick applicants—**I am a mentally strong person, but when I was seriously physically injured, including swollen rigid hands and chronic pain, there was no way I could work on the numerous page packets sent to me on a continuous basis and have legible handwriting. I did word process some pages on my computer but all took more time than I was given, before the time extension. The application is also rigged with trick questions meant to contradict the applicant's condition,

all to deny the claim, and sufficient to discourage the application and appeal process.

4. **VHS employees give out incorrect information regarding the support documentation:** I was told to get all my doctor's reports and tests results to submit with my application. That was too time consuming, and a repetitive task which the agency ignored my documents and ordered them from the providers anyway. Since I was incurring ongoing testing in the application process, it meant that I couldn't provide complete support documents also. This is why I did not complete the May 1997 filing process. I then had to refile in Jan/Feb. 1998.

4a. **SSA employees questioning applicant re: unnecessary and privileged information of other outside income as a possible justification for denials and continued delays.** I personally do not think the agency needs to know about your other outside nonearned income. The benefits are based on your working quarters. That is none of their business.

5. **Administrative directive to agency caseworkers to deny the claim on the first application as routine—again an another attempt to discourage and reduce applicants' claims.** Many applicants, exhausted by the initial process, simply give up at this stage. I was denied the same day of a prescheduled angiogram, which the caseworker was aware of. I felt she could have waited 10 days more for that report, which in my case showed worsening heart valve function and the necessity for valve replacement surgery in the next 12–36 months. **Given the seriousness of this diagnosis and how it affected my life function, there was no reason to deny me and cause an appeal.** I did handle my own appeal fortunately, because I had the mental strength and acumen to do so. I simply harped on the agency's failure to consider the debilitating conditions I incurred on 7 criteria (as best as I recall.)

6. **Failure to approve the disability in a timely manner in the face of numerous serious medical conditions and pending surgeries validating the claim** when accompanied with doctor's reports, tests, and photo support of applicant. My medical conditions were Scleroderman & Lupus, 2 potentially fatal autoimmune diseases which had been lifelong, Severe Aortic Valve Stenosis, Severe Osteoporosis, unconfirmed Pulmonary Hypertension (later confirmed as COPD), severe injury to my right hip and leg limiting walking for my past job/occupation in Education, a mini stroke with paralysis, chronic infections of sinuses, bronchitis and pneumonia requiring constant antibiotic use, chronic swollen glands (from 1994), degenerative right hip socket, gall bladder attacks and the need for removal surgery asap, GERD, severe muscle spasms in the back and legs, Restless Leg Syndrome, Fibromyaglia—severe, and TMJ (affecting talking and speaking to classes). This was even more pertinent on the appeal than for the initial application, because my claim went to the Seattle Regional office on a random audit selection, and then to the Baltimore office for an unknown reason. VHS did not notify me of this in anyway, but which took more time. Additionally, it was the Baltimore office contract doctor who apparently knew more of my diseases and heart condition that 5 other contract doctors because he was the one who approved my claim. That led me to believe other doctors under contract were not fully knowledgeable of the conditions I listed.

7. **Ordering unnecessary diagnostic tests and failure to accept ongoing primary care physician's, specialists' diagnoses, reports, and tests, ignoring SSA/SSD regulations:** thereby increasing the costs to taxpayers and increasing the inefficiency of the agency. I even stated that to the caseworker emphatically when one of them wanted me to go to another SSD paid doctor. I reminded the case—worker that that need was contradictory to SSA provisions and I did not need to do that. I did go to the psychiatric review, even though I had been seeing a Master of Counseling regularly and felt those records should suffice to substantiate the angst I was going through.

8. **Agency caseworkers second guessing doctors' diagnoses without medical training and making case judgments without doctor oversight:** the Osteoporosis diagnosis of 5/98 stated "*Moderately Severe*" that following three falls to the right hip in Oct. 96 and Jan. 97 on the job and which affected my ability to sit, stand or walk per my job requirements. The dx of "Severe Aortic Stenosis" backed by echocardigrams (2) and a pending angiogramsufficiently indicated worsening conditions with

each test. The Aortic function from 65% eventually to 59% 5 months before surgery, validated my decline, high fatigue, low energy and stamina. I finally asked, "How many conditions did a claimant have to have to be considered disabled?" because this was absurd. The caseworker stated the heart surgery was too far off, that I could work in the meantime. Course the fact that I was barely meeting my basic needs did not matter. The valve condition was also considered congenital but was consistent with Lupus SLE. I think this baseless dialogue with the caseworker proves my feeling the agencies (both of them) are not interested in the claimants welfare and health.

9. **Hiring and paying outside doctors to minimize, and refute patients' documentation of a valid claim and to "rubberstamp" non-disability status with the goal of claim denial:** The psychiatrist stated in his report that I suffered from "undifferentiated somatoform disorder"—a common label for supposedly nonphysical basis of medical conditions. This demeans and undermines the patient's medical status, jeopardizing his/her health and mental stress. I would not be surprised if suicide increases with this abuse of professional ethics. I would have taken my reports with me had I known this DOCTOR was going to report bogus statements. Additionally, the 5 doctors who reviewed my file prior to the 6th Dr. in Baltimore also appeared to be inept in lieu of financial rewards.
10. **A 5 or 6 month offset in benefits once approved, thus aggravating declining the financial status of the claimant, creating proverty in itself and with the prior delays:** Since most claims take up to 2 yrs to effect, most claimants don't have financial resources to survive especially when they do not receive work-men's compensation as with my case. I lived on $375. for one year, then $875for the next year with monthly expenses of $1150. It should be no surprise I had to resort to local food banks and assistance agencies for utility payments while many of my other homeowner expenses were unpaid. Since 1984 I had only worked partime to accommodate my marginal health status.
11. **Claimants having to resort to legal representation to force benefit approval thus reducing their benefits.** I was able to save that expense, but it has been mentioned to me many times that as soon as an attorney is brought into the case, the claim is approved, thus perhaps, suggesting the position and power of an attorney is understood beyond the doctors' reports, etc.
12. **SSA, its contracting agencies and AlJ's ignoring SSA recent regulations recognizing Chronic Fatigue Immune Deficiency Syndrome as a legitimate, debilitating condition, but deny claimants continually.** Fibromyaglia is not even in the SSA jargon, despite the fact that many autoimmune disorders are now known to have FMS as an accompanying condition, compounding multiple muscle pain and immobility much like Multiple Sclerosis. One CFIDS Portland patient has one of the leading US doctors for her claim and she has been denied two times. Scott Davis, an Arizona attorney handling her appeals (onto 2nd one), who specializes in CFIDS/FMS cannot believe the Oregon SSA/AJL mindset in the continual denials.
13. **Failure to backdate my claim to 1983/84 when I was reduced to partime work basis for the remainder of my career.** My benefits thus in 1997 reflected lower earnings in addition to being a woman getting unequal pay in our society. Granted the doctors at that time failed to investigate my chronic unhealthiness, but one wrote on my chart notes that he suspected Non Hodkins Lymphoma which I submitted in 1997. The result meant I struggled to keep on top of life with being a wife, mother, divorced mother. It certainly would have been less stressful to have gotten the '83 approval for the same conditions as in '97. I did not remember my '83 application until recently and probably too late to do anything about it.
14. **Presumption of most all claimants filing fraudulent claims:** Here is a case of the majority of disabled paying for the crimes of the minority. And just because a person may have 2–3 good days a week does not mean he/she can tolerate working conditions or hours.

Conclusion: SSA is an agency intended to effect disability benefits for Americans who have already paid for those benefits through payroll deductions over the life of their working career . This is not a consistent image

with the majority of applicantsapplying for SSD. The process is equivalent to another job for the disabled, one that eliminates many persons alone due to their health status and which I incurred both of the 2 of 3 times. And lastly, the agency publicly announces that most Americans on disability are on it for a psychiatric disorder: depression. When in fact, that is an outcome of the process and the disability itself.

Thank you for this opportunity to submit my experiences to your committee. I hope that I have helped in someway to effect necessary changes for future applicants.

Statement of Kelleen Palmer, Massillon, Ohio

I was made aware of an investigation into the improper handling of Social Security Disability Claims and inappropriate delays of same. I am in Ohio and began the long disability process in September of 2001. First I would like to state that people with disabilities require special assistance and this fact does not seem to be addressed in the entire disability process. The amount of paperwork and the short time in which they require that paperwork to be submitted is extremely difficult due to our disabilities. I have Fibromyalgia and the chronic pain and brain "fog" that goes along with it, as well as TMJ, and a sleep disorder and obsessive-compulsive disorder. If I could comply with all that Social Security asked in a successful manner, I could re-engage myself in being an independent, contributing human being. Here are the details of my Social Security fiasco:

I filled out the paperwork for my original claim as well as getting the necessary doctor statements and records. I sent this to social security. I was then denied. I resubmitted my claim, and, again gathered all my doctor statements and supporting records and sent them to Social Security. While waiting for this decision, my father, who resides in Florida, collapsed and was diagnosed with a strep infection in the mitral valve of his heart. It was therefore, necessary for me to go to Florida for the valve replacement surgery he underwent. Following the surgery he had complications and I stayed for two months to get him back on his feet. In the meantime, I had someone from Ohio forwarding my mail to Florida. I tried to contact the Social Security offices and when I called the Canton office they referred me to an 800# and I tried several times to get through on that number and was on hold for over 20 minutes on several different occasions. This may be a minor inconvenience to some, however, because of the condition of my muscles, I cannot hold the phone (or anything else, for that matter) in one position for an extended amount of time. So I never got through to a real person. I received a letter towards the end of December notifying me that I had until December 17th to file for a hearing. I didn't even receive the letter until after the deadline. I sent a letter to the same person who had sent me the letter notifying them of the extenuating circumstances and asking for a hearing. Upon my return home (at the end of January) there was a letter from SS stating that they were unable to process my request because I failed to put my social security number on my letter. So I sent another letter with my social security number requesting a hearing. A month later I had not heard anything. I contacted the individual in the Canton office who had sent the letters to me and was told that they had no record of me ever sending a letter! I was then told that I would have to start my request from the beginning. I went to a disability attorney to get some help and was told that they don't typically handle fibromyalgia cases but that mine had enough additional issues that they felt it was a case they could win. However, it was to my detriment that in traveling from Florida I misplaced the letter from SS and the letter I sent in response. So the disability attorneys said I would have to start the whole process over again.

Stress is such a contributing factor to many people with disabilities and though I understand that the government has to protect themselves from fraudulent claims, it is not necessary to treat people the way Social Security treats their "clients". I am one of the lucky individuals who have a private disability to fall back on. I truly feel for those who don't. There are huge holes in the government disability system and I am glad to see someone investigating this. On a positive note, I have had the pleasure of working with the Ohio Bureau of Vocational Rehabilitation and was very impressed with the manner in which they treated us as respectable individuals and actually offered themselves as a service to those in need. Isn't this the purpose of the Social Security disability system also? Perhaps upper management in the social security sector could sit down with upper management from the Ohio Bureau of Vocational Rehabilitation and do a "best practices" overview.

For your information, just providing the information in this email has left my fingers and arms numb and past experience tells me that they will stay this way for a couple days. This is why I need the social security assistance. But I have put myself through the work because I feel it is important for government to be made aware of what the "people" are going through.

Thank you for your time.

Statement of Beckie Parker, Olathe, Kansas

Dear Mr. Chairman,

At the request of the Social Security Disability Coalition, a grassroots organization representing disabled individuals attempting to navigate the SSDI process, I would like to request that you add my statement below to the record for the House Ways and Means Committee Hearing scheduled for Thursday, September 25, 2003. As a grassroots organization we feel that is it important for our representatives to fully understand the human toll that the SSDI process is taking on previously hard-working American citizens. This system has been deemed in "crisis" by the General Accounting Office and its time our representatives received a first hand look at the causalities.

My story begins in May of 2001 I had what Drs. believed was a stroke at that time. Now two years later they say it was not a stroke they do not know what it is. It has effected my speech to the point I no longer can work at my previous job, which was a customer service Repetitive for a cell phone company. I have very bad fatigue. I can not work constant at any thing. I have sent every thing to social security and I have appealed again and been turned down. The social security physcologist stated in his report that he felt I would not be able to work in the public any more and that there is a problem with my brain processing information and bringing it up again.

This is a great dilemma for me since I can not understand their thinking. When I sent in the first papers my diagnosis was CVA. I did not falsify any papers and I am still with the aphsia and the tremors. The Drs. do not know what is wrong with me I have had a lot of tests. It leaves me with no way to work and Money is very tight. I worked and paid into Social Security but when I need it very badly it is not there for me.

I think the ways and means needs to check in to the process that social security puts us through to get what we paid in for years. When illness strikes the last thing we need is the ridiculous and cruel process we are being subjected to.

Thank you very much for hearing my side of the story.

JACKSONVILLE, FLORIDA 32246
September 17, 2003

Chairman Shaw
Committee on Ways and Means
1102 LHOB
Washington, DC 20515

Congressman Shaw,

I am a 50 year old GS12 Government Employee from Jacksonville FL. I have been in contact with Mr. Lee Smith of Cong. Crenshaw's staff on this matter. My wife is an RN but is also a highly trained Certified Emergency Nurse. My family is a victim of this horrible Social Security Administration—Office of Hearings and Appeals delay waiting game. Even our lawyer says this is one big delay tactic to force good taxpayers to return to the workforce. I asked Congressman Crenshaw for help to get the Jacksonville docket reduced. I got a letter back that it was SSA's policy that I had to be having financial problems to the level of my home mortgage foreclosed to get a hearing priority upgrade. These bureaucrats have it all wrong, it is not their money, social security disability is an individual entitlement that a worker EARNS over their working life by payroll deduction contributions.

The SSA–OHA program has become is a nightmare of application, send all medical records, waiting, denial one, more waiting, send updated records, denial two, appeal for judicial hearing, more waiting and then with a good lawyer the disabled persons gets a hearing and if lucky gets the benefits they earned and deserved in the first place.

American taxpayers should not have to hire a lawyer for an agency administrative action. I pity the poor and ignorant because they are screwed. My co-worker Monteen Tuten died of cancer before she and her disabled husband got benefits for her. Bill never got a hearing for the lung damage he got from chemical fumes. He now gets survivor benefits and Monteen's widower.

This OHA program, the managers who run it, the employees and contractors who administer it are not serving the taxpayer. It is hard to say this as a Federal Employee but the taxpayers would be much better served by getting rid of every manager and every employee involved with the SSA OHA disability evaluation system and reprogramming all the salaries, fringes, pensions and office budgets to direct payment of the claimants.

Instead of a money hole bureaucratic OHA agency which relies on administrative judges, develop forums for alternate dispute resolution. The current system is very much like Contractor claims system where the Contracting Officer makes a ruling and then the case goes to an Agency Board of Appeals and then to US Court of Federal Court of Claims.

End this nightmare—

1. Stop the marriage penalty—these are individual contributions.
2. Change the paradigm—Look at the numbers for first time acceptance versus rejection. Change from "denial and delay" to "fair treatment and trust."
3. Cash flow is killing applicants families—Applicants can't apply for unemployment since they are not medically cleared to work. Give benefits while on the waiting list and put burden on Government to prove ability to work in order to remove them.
4. Clear the docket backload—if you have no waiting list in Boise, Idaho and long waiting lists in Miami, Florida involuntarily send SSA–OHA folks from Idaho to temporary duty (TDY) in Miami.
5. Why use Judges?—We don't need Judges to determine if a person is disabled and deserves to obtain benefits. Expand the pool and create Hearing Officers with a warrant to bind US Government like Contracting Officers. Use in-house and contract Nurses, Physician Assistants, Occupational Hygienists, and Lawyers with Health Specialty experience as hearing officers. Use Military Reservists, VA and Public Health Service as case reviewers hearing officers to supplement SSA–OHA.
6. Use ADR in place of SSA–OHA—basically these are disputes, develop a means for Alternate Dispute Resolution. Use the American Arbitration Association to resolve cases in place of OHA.

Background—My Family's Nightmare

My wife has had declining health and long periods of unemployment since 1994. Before 2001 we were able to pay and keep my oldest daughter Tina in Florida State University as a full time student. When our financial problems started Tina was forced to get a job, lost her bright futures scholarship and attended Tallahassee Community College for two years evening school. She is back in FSU with a job and due to graduate in June only in 6 years instead of 4.

My second daughter Lisa was not able to leave home for FSU and enrolled at UNF in Jacksonville. She works full time and attends ¾ time in UNF. We've been helping her with books and tuition. In August 2000 my Mom died and my blind/deaf elderly Dad moved in and Lisa moved into an apartment with three other coeds. Lisa lives on a shoestring and we help her when she needs help, when we can; a sample was a $1,000 transmission repair last spring.

My oldest son Brian has Attention Deficit Disorder/Hyperactivity with Oppositional Defiance Disorder. He works with me at Corps of Engineers as a stay in school GS–3 and goes to Florida Community College Jacksonville. Because of the financial strain, fighting in my home and my wife's health we just asked Brian to move out. He is in a private dorm next to UNF. We help with his rent.

My youngest son Daniel is a senior at Bishop Kenny. He is on scholarship from our parish. Because we could not afford car insurance for Dan and because he wants to help the family he is working 20+ hours per week at Chuckie Cheese restaurant.

I've just taken a second HELOC mortgage and loan from my Thrift Savings Plan to help pay college expenses and reduce $26,000 credit card debt. My oldest son Brian and I just took second jobs as a weekend Pop Warner football referees to slow the rate of my family's debt growth.

I am hoping I can hang on until the hearing and the money doesn't run out cause after the 401 K loan there is no more money.

Although we've had some prior health and financial issues, our nightmare with SSA–OHA system started in February 2002 when my wife Susan severely injured her back and neck picking up her bag and twisting to put it on her hotel bed on a business trip. She tried to return to work but the pain grew so severe a few days later she could not get out of bed for a week. She has not been medically cleared to return to work since that bed rest incident. Once her sick and vacation time ran out in March 2001 it cut our gross family income by $40,000 per year (38% cut). We incurred medical and drug bills that are about $10,000. Of course her employer's insurance company fought the claim as being off-the-clock time while traveling and that it aggravated a pre-existing back condition. We did not receive workman's comp because it was disputed and she was fired. Since she was not cleared to work she was not eligible for unemployment. In Dec 2002 we obtained $10,000 lump sum workman's comp settlement that I promptly used to pay off credit card debt from medical bills. We also filed for SSA Disability since their was no chance for re-employment.

My wife is 49 year old Nurse who loves nursing. Unfortunately she experienced the profession's typical "Nurse's Back" of multiple back and neck injuries, with resulting nerve damage. In her work life she has had three workman's comp events. She has been disabled with three ruptured disks in her neck and three more in her lower back since February 2002. In addition to the "nurse's back," she has an amputated toe, an ankle replacement and is dependent on narcotics delivered through a patch and pain pills and anti-inflametories in order to function. She has had dizzy spells from elevated blood pressure and recently had drug side effects of heart-beat abnormalities. She is suffering from depression, had a breast reduction to remove stress from the neck, a hysterectomy for ovarian cancer last spring, just this month had a staphylococcus infection in the ankle with the implant. What Hospital or Doctor in their right mind would hire a nurse with this work record, health record and narcotic dependence?

Mean while the idiots at OHA have twice denied her claim and telling us none of it matters because when you figure in the GS12 salary we make too much to get disability payments. Meanwhile the hearing waiting list grows.

Although we've cut back our lifestyle to one of no vacations, only needed minor home repairs, no eating out and little leisure recreation, cars with 150,000 miles we are doomed to bankruptcy unless my wife receives her deserved benefits. As a result of this financial crisis we've talked seriously about separation or divorce. At least she would be eligible for some assistance if we separated.

We are not alone as hard working middle class Americans being driven into bankruptcy by this horrible system. Since February 2002 (19 months) we have more money going out than is coming in. Others who are not as lucky as me to have a steady job to support my sick wife and family are being driven into much more dire straits very quickly.

She has been using the narcotic patch, pain pills and physical therapy massage in order to just function. What hospital is going to hire her as a nurse? Sue can't stand nor sit more than 15 minutes, can't lift 10 lbs, needs to lie down every 2 hours to relieve back pain.

Because I make $67,000 gross the Free Application for Federal Student Aid formula requires a $7,000 annual family contribution in order to get student financial aid. Basically I am a middle class working stiff caught between the rock and a hard spot, my kids are suffering. The SSA disability is my son Daniel's college tuition.

Congressman Shaw please call for the resignation of every SES, Judge, GS15 and GS14 involved with SSA—OHA. Make the changes I've recommended. If you can't get rid of the agency at least you should ask for a major house cleaning!

Sincerely,

BRUCE AND SUSAN PASTORINI

MIDDLESBORO, KENTUCKY 40965
September 26, 2003

The Honorable Earl Ralph Pomeroy, III
Congressman for the District of North Dakota
Washington, D.C. 20515

Dear Congressman Pomeroy:

I hope this message reaches you in time to register my input on a very important matter. I am an administrative law judge with the Office of Hearings and Appeals, although I am writing in my personal capacity and not as spokesperson for OHA.

I was holding hearings myself yesterday, hearings that did not have the policy impact your hearing will have, but which nevertheless, were monumentous in the lives of five people. They are the claimants in appeals to the Office of Hearings and Appeals. I am concerned about the job that is being done for them, for several reasons.

First, assume a forty-hour work week in terms of "billable hours", i.e., every hour of that work week is attributed to case work. Also assume that judges are expected to close forty appeals cases each month.[1] This would leave a judge with about 4.25 hours per case to which he/she can allocate his or her time. This break down does not take into account the travel time to remote hearing sites where the cases are heard, or the complexity of the case, i.e., whether the case is a first time appeal, or a third remand. Actual hearing times vary with judges. I spend about one hour in face-to-face time with claimants. That leaves 3.25 hours to review the case for readiness, write directions to remedy deficiencies and review again for hearing preparation, and post hearing action; i.e., if everything goes "smoothly", written instructions for the writer, review and or editing of the writer's draft, signature of the finished product and verification in the computerized data base if a case is favorable to the claimant.

Obviously, the expectations above can only be accomplished with a well managed, support staff. However, that is not the case in my office, nor is it the case in most offices, as my colleagues have related. A typical, non remand case sits without any attention for about one year after it is received in our office. By the time it is assigned to me it is old enough that it requires additional development that would not have been necessary with more timely workup. Rather than tackling the backlog at both ends, i.e., workup and assign cases on a "LIFO" as well as "FIFO" basis, management initiatives have instead, focused on clerical screening of certain categories in which the judges are expected to wade through unworked, unindexed and untabbed files to decide whether a favorable decision should be made "on the record".[2] If, after such review, the judge decides that the case is not a candidate for such a decision, the case is put back into the unworked queue to wait with the rest of the files on a FIFO basis, regardless of the time spent by the judge. This happens regularly, even when I record my impressions and instructions to staff on what is necessary to develop the case for hearing. Thus, I have wasted my time, that claimant's time, and time of other pending claimants.

Judges have no real control of their dockets, as the prior paragraph suggests. There are specific examples I can cite in which I have given specific written instructions on development, scheduling, service and necessary witnesses that have been ignored in toto. And, despite the good intentions of your colleagues, I have had cases pulled out of my docket, cases earmarked for hearing, that have been assigned to Senior attorneys for review of possible OTR decisions. Apparently no one in management has told congressional staffers that Senior attorneys no longer have authority to issue OTR decisions; they can only recommend such decisions to the judge. Thus, rather than saving a claimant valuable time, this practice only increases the claimant's waiting time.

When I refer to directions and instructions I give in case development and disposition, I am talking about written instructions on a case narrative sheet. I do not know who will be reading or implementing the instructions. My only knowledge is limited to initials on notes of the person generated after my input. This is true with paralegal and attorney writers, as well as clerical staff. Because abilities and motivation vary so much in people, I feel I must write my input in terms of the "lowest common denominator". Regardless, it still doesn't work And, if I try to communicate directly with staff, I am often told that the person is at home on "flexiplace". Congressman, do you know how a support person can provide support when he or she is at home two or three days each week?

Cases are also churned. That is, if a file has been in one status too long, some staff simply move the file to another status unnecessarily, usually to the judge's "court". For example, I and the other judges in my office were told that the writing unit electronically "moves" cases to "Edit" (for judges to review), even though the

[1] It is my understanding that there is no official policy of production quotas. However, the unoffical policy is to publish each judge's tally identified by judge, to the support staff every month, and to approve transfer requests and reassignments on the basis of numbers of cases closed. In a June, 2003 conference, Associate Commissioner Thurmond told me and my colleagues that he approves transfers on the basis of production, and that judges who don't put out the expected number of cases will not be transferred.

[2] For reasons unexplained, another system exists whereby Senior Attorneys in our office are assigned organized, worked—up files to review for recommendations to the judges for OTR decisions. This is clearly inconsistent with utilization of judges for review of unorganized, unworked files not first reviewed by attorneys.

decision draft is not completed and the file is still physically with the writer. Support staff rarely refer back to the last note I made in the file; therefore, if I have a prior instruction for action, it is ignored, and the file comes back to me for the same instructions I already rendered. For example, I will instruct the staff to obtain a medical consultative examination, and to schedule the hearing as soon as the consultation report comes back. This never happens. Instead, the consultative report comes back, and the file is routed to me with the question, "ready to schedule?".

Finally, once I do decide whether a claimant is disabled, I write decision instructions for a writer. I cannot choose the writer. Decisions that are unfavorable to the claimant, per policy, require more attention to analysis, probably for the simple fact that claimants are unlikely to appeal favorable decisions. Consequently, favorable decisions are much easier and faster to write. Because of the emphasis on production over quality, there is a tremendous pressure on ALJs to issue decisions favorable to claimants. While this sounds good in the short run, and certainly for that particular claimant, it is this sort of unintended result that is jeopardizing the financial viability of the Social Security program.

Furthermore, for those of us who have not been "worn down" into accepting poor work products from writers, the task of extensive editing or rewriting falls to us. In my naivete' as a new judge, I went to the Hearing Office Chief ALJ to complain about the quality of work I was getting on decision drafts. My concerns were written off as merely issues of "style" (believe me, they were not). Several months later the HOCALJ told me, "this is not Burger King—you can't have it your way."

I have come almost full circle since that time; however, I am now enmeshed in a backlog of cases because I have tried to do others' work as well as my own. I have become an expert in word processing and have dabbled in computer programming so that I can automate a system whereby I can efficiently write my own decisions. This has come at tremendous cost to my "production" and to my family life (not to mention, the tendons in my hands). I work about 60 hours a week. I have bought my own lap top computer to use at hearings, because the red tape it takes to check out an office laptop is so user-unfriendly.[3] Those of us who do have a better quality of life and who do "produce", have also paid a cost. One colleague told me that after he reviews a written decision, "I hold my nose and sign". Another told me something he first said long ago, "This agency doesn't fire people for doing shitty work—they fire people for not doing enough shitty work."

In closing, I note that the Association of Administrative Law Judges has an agenda to increase ALJ pay, in addition to improving the effectiveness of OHA operations. As much as I applaud these efforts, I would care not one whit whether I got paid more for what I do, if the working conditions of my office were remedied. Given the tremendous base of knowledge and experience in our judges, I am hopeful that our input can be assistive to you and your colleagues as you deliberate the future of Social Security.

Sincerely,

BARBARA LICHA PERKINS

Statement of The Honorable Thomas E. Petri, a Representative in Congress from the State of Wisconsin

Mr. Chairman,

I would like to commend Chairman Clay Shaw for holding this hearing to look into the management problems which have beset the Social Security Administration's Office of Hearings and Appeals. Millions of Americans rely on Social Security's disability program, and it is the responsibility of Congress to ensure that the program is being implemented in accordance with our laws as well as with a sense of common decency. It is encouraging that this Subcommittee is exercising its oversight powers to look beyond the media stories and the corresponding official responses. These problems are important, and I am confident that we are now on our way to a proper solution.

The people of my state have twice been roiled by reports of problems at the Office of Hearings and Appeals. Early this year, Wisconsinites were told of outrageous delays in processing applications at the Milwaukee office. Those disclosures were followed by the discovery that certain contract employees at the Chicago Office of

[3] There are four relatively new notebook computers in our office, supposedly for the judge's use. However, no one told us when they arrived, and to my knowledge, they are kept in a locked cabinet most of the time, not having been used even once by half of our judges.

Hearings and Appeals had removed documents from applicants' files and thrown these papers away. Needless to say, discarding important supporting documentation is a serious breach of trust and by itself represents a substantial breakdown of management protocols.

It is my hope that this hearing will be the beginning of a cooperative effort between the Congress and responsible parties at the Social Security Administration to identify the root of these failures and begin the process of ensuring that they are never repeated. I am confident that everyone in this room today shares with me the goal of resolving these difficulties and rebuilding the systems involved in the determination of eligibility for disability benefits. Our constituents across the country deserve and expect no less than this. Again, I commend this Subcommittee for tackling this important problem and I am optimistic that we have started on our way towards this goal.

Statement of Lawrence A. Plumlee, M.D., Dallas, Texas

I. Introduction:

I appreciate the House Subcommittee on Social Security holding this "Hearing on the Social Security Administration's Management of the Office of Hearings and Appeals". I testify here today on behalf of myself, a physician trained at Johns Hopkins University, a former EPA health official, who is president or on the board of directors of several disability groups. We have read on the Internet the newspaper articles about the "Mess in Milwaukee" and the "Culling of Files" in Chicago. I wish to tell you today that we also have some problems in Texas.

Many of the items I will cite here today refer to the policies of the State Agency Disability Determination Service (DDS). These policies are directly relevant to the operation of the Office of Hearings and Appeals (OHA), in that for many claimants, particularly those who are pro-se, case development by DDS provides the record on which the OHA Administrative Law Judge (ALJ) makes his or her decision. Failure to properly develop a case by DDS prejudices its consideration by the ALJ at the OHA, and may lead to remand by the Appeals Council (AC) or a denial of rights.

Some of the items I will cite here are historic, in that they happened several years ago. However, these items are in some cases yet relevant. Given the pendency of Social Security Disability cases—roughly 3 years to Appeals Council review, some of the claims impacted may still be up at the Appeals Council, some of the cases may be in Federal District Court, and some denied cases may have been or may yet be reopened, which may occur up to 4 years after a denial.

The items I will cite here, however, have a common theme: Lack of due process and equal protection of the laws in the determination of Social Security disability in Texas.

II. The Operation of TRC–DDS: A Policy of Systematic Failure to Properly Develop Evidence of Disability During Claim Development:

Texas had the lowest initial approval rate in the nation in 2000 for Social Security disability claims. A number of reasons were suggested to explain this situation in 2001. Many were cultural:

> **[U.S. Rep. Gene] "Greene and U.S. Rep. Nick Lampson, D-Beaumont, said that the Texas approval rate is probably affected by a pervasive idea that some applicants are trying to cheat the system."** From: Julie Mason and Alan Bernstein, Houston Chronicle, 3–23–01 p1.
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> **"There is no official explanation for the relatively low rate. Critics say it stems from a cultural bias against government aid programs."** From: "Disability Reform Still Lags in Area: D.C. Houston Hearings Sought About Backlog", Alan Bernstein, Houston Chronicle, 4–22–01 p37.
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> **"Dave Ward, a top Rehabilitation Commission official, took a somewhat different approach to explaining the Texas approval rate. He said it is due partly to demographics—its relatively young work force, for instance—and differences in the way that Social Security workers make sure that each state agency is interpreting federal rules correctly. But Carol Schaper, a Plano advocate for the disabled, told the audience of about 130 people that the state's "cowboy culture" of self-reliance prevents Texas government from providing more assistance to those who can't work."** From: "State Needs More Funds for Disability Services", Alan Bernstein, Houston Chronicle 10–18–01 A.29.

Preconceptions about cultural issues aside, let's look at TRC—DDS workflow. A half million Texans receive Social Security disability benefits totaling about $4 billion per year. Initial and Reconsideration disability determination in Texas are done by TRC–DDS. TRC–DDS has during the past decade processed roughly 170–330,000 claims for disability each year, receiving 3–6,000 claims per day, being funded by the Social Security Administration between $53–83 million per year, for an average cost per claim of between $275–$330.

In '94, each examiner determined about 3 claims per day, but volume has increased while staffing has not. Extrapolation suggests that the average claim will be determined at an average cost of about $275 by an examiner determining maybe 3–5 claims per day. The average case would thus appear to get not more than a couple hours of preparation total, maybe a medical evaluation, and a consultative evaluation or two, before a decision of maybe a third of a page.

> **The obvious consequence of those cost numbers is that TRC-DDS CAN NOT be doing many claimant examinations, given a total program cost of between $275 and $300 per claim—there is just not enough money to pay the outside experts.** In particular, we believe that TRC–DDS is not doing claimant Vocational Evaluations (VE) in accordance with National Program Standards of the SSA, and the failure of TRC–DDS to develop vocational evidence of disability may have an industrial scale impact upon the initial approval rate for Texas disability claims.

An article in the Houston Chronicle on a seminar sponsored by the Disability Policy Consortium on the subject of Social Security Disability in Texas quoted former SSA Commissioner Ken Apfel on this matter:

> **"Kenneth S. Apfel, Commissioner of the Social Security Administration under President Clinton, spoke at a seminar where government officials and other experts said they were unable to completely explain the state's relatively low approval rates in disability cases. 'Half the answer is known, half the answer is not known', said Apfel, now a University of Texas professor. But Texas can start on increasing its approval rates by training case workers at the Texas Rehabilitation Commission to take a wider approach to whether disability applicants can no longer work, he said. Case workers in many other states grant disability benefits more often by looking beyond purely medical evidence to see whether people can continue to function at work, Apfel said. 'I don't think you've done enough in Texas', he said."** From: "State needs more funds for disability services", Alan Bernstein, Houston Chronicle, 10–18–01 A.29.

Former SSA Commissioner Kenneth S. Apfel has "put a finger" on a policy of TRC–DDS that contributed to their singularly low initial approval rate in 2000, resulting in an industrial scale violation of Texan's right to due process and equal protection of the laws: systematic failure to do Vocational Evaluations.

A similar problem also existed in 2001 with Medical Examinations. Administrative Law Judge Christopher Lee Williams, one of 17 ALJ's at the OHA's in Dallas, sued TRC–DDS and SSA for the failure of TRC–DDS to perform psychiatric Medical Evaluations (ME) on indigent claimants in cases he remanded back to TRC–DDS for further development. (See cause no. 03:01CV816, Williams v. Massanari, et al. U.S. District Court, Dallas Texas, filed 04–30 2001.) Williams alleged that a TRC–DDS per-judge funding quota and subsequent refusal to do psychiatric medical examinations in excess of that quota were impairing his judicial independence to decide cases lawfully. Eventually, the Motions to Dismiss made by both the federal and State defendants were granted and his case was dismissed as moot—on grounds that he had no standing to prosecute the case because he had not been personally harmed by this policy. It must be presumed that the indigent claimants denied such examinations could not afford to litigate a Federal District Court (FDC) civil rights action. Whether the claimants had a right to sue for violation of their rights to due process and equal protection of the laws when TRC–DDS refused to do an examination after the ALJ indicated that a medical examination was necessary to determine their claim properly remains an open question.

> **It is a critical point that the failure of TRC–DDS to develop VE and/or ME evidence in accordance with national program standards of the SSA is in fact an OHA administration problem, because the Christopher Lee Williams case in Dallas demonstrates that TRC–DDS would not in 2001 do such examinations on remand in any significant quantity FOR EVEN ONE ALJ—in a city with 17 ALJ's, even though a SSR ruling provides for such remand.** Further, such remands in any significant quantity would mess up the OHA hearing docket by causing hearings to be rescheduled.

It must be concluded that DDS remand for further case development in Texas is a remedy available in theory but not in practice.

There is a non-obvious incentive for TRC–DDS to find "difficult" cases not disabled, and to fail to do vocational evaluations on a significant percentage of disability claimants:

> **"Scarborough, of the Texas Council for Developmental Disabilities project, offered a third theory. He said the Rehabilitation Commission is reluctant to classify people as disabled because the agency would then have to provide rehabilitation services and related help to a greater portion of the Texas population than state government is willing to serve."** From: Social Insecurity: Local Judges Prove Stingy in Deciding Appeals Cases, Alan Bernstein, Houston Chronicle, 3–11–01 A.1.

This hypothesis is supported by the fact that there are roughly 250–300,000 new Social Security Disability and SSI claims per year in Texas submitted to TRC–DDS (of which about 31%–40% are eventually approved), while the number of vocational rehabilitation cases handled by TRC Department of Vocational Rehabilitation is roughly 25,000. In short, conditions that TRC–DVR cannot easily rehabilitate TRC–DDS may not be inclined to find disabling.

If one takes the cost of determination of disability in Texas, roughly $82M per year at present, and compare it to disability benefits paid in Texas, roughly $4B per year, one ends up with the statistic that the cost of determination is about 2 percent of the cost of benefits paid.

> **"[Social Security Administration] officials indicated instead that the problem stems from inadequate documentation of disability claims, [U.S. Rep. Sheila] Jackson Lee said."** From: Julie Mason and Alan Bernstein, Houston Chronicle, 3–23–01 p1.

That inadequate documentation, as compared to other states, is a direct consequence of TRC–DDS and SSA trying to process up to a third of a million cases per year for about $275 apiece. **The failure by TRC–DDS to request and SSA to fund case development properly, e.g. by doing VE and ME examinations, which might add maybe 1% to total program cost, renders the process of determining disability in Texas a "lottery" of first impressions punctuated by multiple remands and long delays, with grossly unpredictable results. It also introduces a class bias into the system as a result of the financial ability to obtain private medical documentation and legal representation in such cases, and ultimately to litigate a FDC case.**

III. The Houston Chronicle Investigation of Social Security Disability Determination in Texas:

During 2001–2, the Houston Chronicle did a series of about 45 articles on Social Security disability determination in Texas. They were concerned because Texas had the lowest initial approval rate in the nation in 2000, Houston had a lower initial approval rate than the State average, and Houston residents had to wait longer than the State average to get an AL hearing, and Houston residents faced a greater AL hearing rejection rate than the State average. These articles are cited below for your convenience. To briefly summarize what they found:

- In 2000, TRC–DDS had the lowest initial claim approval rate in the nation, 31% compared to a national average of 45%. After hearings before the state legislature and meetings between SSA officials and the Houston area Congressional delegation, and Congressional hearings in Houston, the approval rate increased to 40% during the following year, 2001.
- The Houston Chronicle stated that "Many people in the appeals process complain that the Social Security agency loses records . . ." The example given was a fibromyalgia case where records listed by TRC–DDS as having been received were missing from the case file of a pro-se claimant. I cite this individual case because we have also heard of unrequested, wrongly requested, missing, and culled medical records during TRC–DDS case development in a Dallas chemical sensitivity case of that era. The consequence of TRC–DDS' refusal to properly develop a case for such a diagnosis is that the Consultative Evaluations (CE) review a grossly incomplete case file, the claimant first sees the case file when it goes to the ALJ—who fails to remand to DDS, and the case ends up at the Appeals Council after about 3 years with a laundry list of grounds for remand.
- TRC–DDS had a backlog of 77,000 cases in 2001, about 3 months worth of processing. (We suspect that the backlog, coupled with the low approval rate, may have induced pressure within TRC–DDS to speed case processing, and may have resulted in failure to develop cases completely.)

- In 2001, TRC–DDS was caught using code names instead of the names of examiners on 12,000 cases evaluated using staff overtime to reduce a backlog, and on at least one occasion, submitted such a fake name to SSA. A photograph of a management memo implementing this practice and a forged name sent to SSA were published in the Houston Chronicle. National SSA officials apparently did not know about this practice. The practice, which at a minimum obscures transparency in legal proceedings but also raises the question of industrial scale falsification of government documents, was promptly halted after the intervention of the Texas Governor's office. It demonstrates, however, the attitude at TRC–DDS toward transparency, equal protection, and due process, at least during this era.
- One Houston ALJ had a reputation so stringent that members of a local union repeatedly picketed his house due to his low approval rate, a rate which was suspected from records kept by local law firms. When the Houston Chronicle was finally able to obtain ALJ approval rate data after FOIA litigation in 2001–2, the approval rates of the Houston ALJ's were found to vary from 37 to 69 percent—nearly a factor of two within the same city, in what is supposed to be a uniformly administered federal entitlement program.
- In 1998, an accusation was made to a U.S. Representative by a former Houston OHA staff lawyer, who retired after 15 years in the Houston office, indicating that some Houston ALJ's were biased against blacks and hispanics. A GAO study of race discrimination by ALJ's was subsequently requested by Congress.
- Texas has a much lower Social Security disability approval rate for "psychiatric disorders" than other states:

"Of Texans who received disability benefits in 1999, only 22.8 percent had a psychiatric disability, compared to the national average of 32.1 percent, which is nearly one and a half times higher. Only Arkansas, Louisiana, and West Virginia enrolled a smaller percentage of people with a psychiatric disability." From: "Viewpoints: Disability System Blamed? Needy Social Security", editorial by Leslie Gerber, director of public policy, Mental Health Association, Houston; Houston Chronicle, 3–18–01 C.3.

Note that the percentage of psychiatric recipients in Texas is about 70% of the national average in a state where the initial approval rate was 31% the following year—the lowest in the nation—compared to a national average initial approval rate of 45%. The rate is doubly low.

- The TRC–DDS' attitude toward public scrutiny was demonstrated the following passage in the Houston Chronicle:

"The Texas Rehabilitation Commission doesn't want state Rep. Garnet Coleman criticizing the agency to the news media anymore, at least not before checking in first. . . . The Chronicle has reported on the agency having the lowest approval rate in the nation on applications for federal benefits from sick or injured Texans, on a record-high backlog of applications and on the agency's use of code words in place of case worker's names. Coleman, who specializes in health care issues, reacted to the articles by arranging a legislative examination of the agency's policies and saying a 'culture of denial' leads to the low approval rate. In an Oct. 5 letter, Rehabilitation Commission officials asked Coleman for a chance to work with legislative leaders 'to ensure the facts are duly considered before making statements to the press'. The officials said there was no 'culture of denial' because the agency decides whether people deserve disability status based only on the law. 'There is nothing to gain by addressing the issues in a way that causes the public unnecessary concern,' according to the letter, signed by agency board chairman A. Kent Waldrep Jr. and written on the stationary of deputy commissioner Mary Wolfe" From: "Letter by Rehabilitation Panel Won't Stop Legislator's Criticism", Alan Bernstein, Houston Chronicle, 10–14–01 A.39.

Apparently a TRC deputy commissioner and the TRC board chairman do not feel that the systematic deprivation of disabled Texans' rights to federal Social Security benefits is something that ought to be addressed **"in a way that causes the public unnecessary concern"**

IV. The Management of TRC and TRC–DDS:

Let us look consider the ability of the TRC and TRC–DDS to respond to change. I find that the management of TRC shows striking longevity over the past 7 decades.

- The **TRC Commissioner** is Vernon M. "Max" Arrell, who was appointed in 1981, and thus, as of 2003, has held the office for 22 years. Jess Irwin was appointed TRC commissioner in 1969 soon after TRC was formed, and held the position for 9 years. Thus two TRC Commissioners have managed TRC for 31 of its 34 years. J.J. Brown was director of Vocational Rehabilitation Services of the Texas Vocational Education Board for 31 years, from 1929–1960. C.G. Fairchild held the same position for 8 years from 1960–1967. Thus two directors of VRS directed the TRC's predicessor agency for 39 of 40 years. In total, of 4 individuals have controlled rehabilitation in the State of Texas for 70 of the past 74 years.
- The **TRC Board:** The Guide to Texas State Agencies, 11th ed. states "The policy making body of the commission is a six-member board, appointed by the governor with the advice and consent of the Senate for overlapping six-year terms. Members must be Texas citizens with a demonstrated interest in rehabilitation services. **These are nonsalaried positions,** and the governor designates the chair." There are 6 positions on the TRC board. One position is vacant as of 2003. Three other filled positions are held based on a policy where "Board members with expired terms will continue to serve until reappointed or new appointments are made". Two positions are filled by persons with valid terms of office, of which one is no longer listed as a board member in the 2003 Strategic Plan, and presumably has resigned.
- The **TRC Deputy Commissioner for Disability Determination Services** is Ed Bloom. His predicessor from October 1996 until 2002 was Dave Ward, whose watch included the year TRC–DDS had the lowest initial approval rate in the nation in 2000, and the 2001 "fake examiner" scandal. Mr. Ward replaced Kenneth Wayne Vogel, who was promoted to Assistant Commissioner in October, 1996, but died in a hunting accident on December 14, 1996, roughly 2 months later.

It seems to me that if there is an absence of change in a state agency which has serious problems over an extended period of time, it might be inferred that someone in that state may think that things are good enough as they are. One might suspect that disability determination in Texas is broken by design, because it somehow serves powerful economic interests. Unfortunately, any statement by myself as to why or how that may be the case would be speculative.

Congress does not need to be told of the power of the "Oil Patch" in Texas. The Summer 2003 Texas redistricting conflict demonstrated that power. When a redistricting plan that would have disenfranchized minority voters in Texas was proposed, Texas elected representatives from first one legislative body and then another fled the state to break quorum to block the plan, while representatives of the other party tried to use both federal forces and State police authority to try to hunt down those elected officials, arrest them, and haul them back to Austin in order to achieve their partisan goals. There is no less a concern about abuse of federal authority in the Social Security disability system in Texas. A Houston area SSA anti-fraud team targeted 300 Houston area Social Security disability claimants in 2001–2, including some with psychiatric disorders:

> **"Two plainclothes officers with badges told Cheryl Braxton at her northwest Houston apartment two years ago that she was a possible suspect in a robery investigation. It was a lie. They were Harris County sheriff's deputies. But they were working undercover for a little-known Social Security Administration antifraud unit based near Bush Intercontinental Airport. They were secretly testing Braxton to see if she could think and talk crisply, which would contradict her earlier claim that she was disabled, mostly due to mental illness. There was no robbery case. The 'ruse interview,' as Social Security agents call it, was not an isolated tactic. Knowing that such crimes never actually took place, the federal agency's investigators have routinely told several Houston-area disability applicants—including mentally ill and mentally retarded people—that they could be suspects in specific criminal cases, according to documents, testimony and interviews obtained by the Houston Chronicle. Advocates for the disabled say the tactics are out of bounds. . . . The tactics are commonly used against people who claim disability because of mental illness, said Philip Senturia, a lawyer for a Missouri legal aid agency, 'and these are people who aren't good at describing what their problems are in the first place'."** From: "Social Security unit uses lies to find fraud: Advocates of disabled decry 'ruse' tactics," Alan Bernstein, Houston Chronicle, 3/2/02 A.1.

"After reading about a series of Houston cases, the Social Security Administration's top investigator has curbed some of the tactics his agents used when they looked into possible fraud by people applying for disability benefits. James Huse Jr., Social Security's inspector general, took action after the Houston Chronicle reported that undercover agents conducted fake robbery investigations as part of their interrogation of local disability applicants, some with proven mental illness. . . . Starting in July 2000, Social Security's anti-fraud unit in Houston has investigated more than 300 cases in which a claim for disability benefits was suspicious, according to Huse. In about 220 cases, the applicants were denied benefits by the Texas Rehabilitation Commission, which decides from medical evidence whether illness or injury makes Texas applicants no longer able to work. Huse did not say how many cases, if any, led to fraud charges against the applicants. . . . Federal funds pay for two sheriff's deputies and a clerk to work with the Houston unit, which sometimes secretly photographs and videotapes the public activities of disability applicants to see if their physical actions match their disability claims. Undercover agents took pictures of Braxton as she went to visit her doctor." From: "Agents' Tactics in Probing Disability Fraud Curtailed," Alan Bernstein, Houston Chronicle, 4–30–03 p1.

Note that the Houston Chronicle states that **"the applicants were denied benefits by the Texas Rehabilitation Commission".** It does not mention the SSA or OHA. While this may be a loose description of events, it appears that this very knowledgeable reporter is suggesting that TRC–DDS, a STATE AGENCY, was supplying targets to a FEDERAL anti-fraud unit, which used FEDERAL FUNDS to hire COUNTY sheriff's deputies to go after those targets. **The problem with TRC–DDS doing targeting for a federal SSA anti-fraud unit against claimants with mental disorders in Houston is that, notwithstanding national program standards of the SSA, the only way a chemically injured Houston oil well firefighter is going to get Social Security disability in Texas is on grounds of "somatoform disorder", a psychiatric diagnosis, and to hit 300 claimants over 2 years in a city with about 7,000 disability claims per year is striking.**

V. The Social Security Disability System: A Program Out of Control:

The Social Security disability system is a system out of control. It provides security to workers in name only. It is a patchwork of 50+ state subcontractors which has resulted from the historical incrementalization of the Social Security Act, coupled with the delegation of determination to the states. This was historically done because, when the Act was first passed in the late 1920's, the states were the only ones who had the capability of doing disability assessment.

I feel that it is time that Congress commission a General Accounting Office (GAO) study on the feasibility of federalizing Social Security disability determiniation in the U.S. Federal control is the only way that there will be uniformity in determinations across what is purportedly a fair and uniform federal benefits program.

In the alternative, I wish to point out that the **Commissioner of SSA has the power to decertify any State Disability Determination Service** under "42 U.S.C. 421—Disability Determinations." I also wish to point out that, given that ability to prevent the operation of state Disability Determination Services in violation of claimant's rights to due process and equal protection of the laws, the **Commissioner of SSA consequently has a personal responsibility** under "42 U.S.C. 1987—Action for neglect to prevent" to ensure such violations do not occur.

VI. Reform: A Matter of Justice:

"No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any pseron within its jurisdiction equal protection of the laws." The 14th Amendment of the Constitution of the United States, Section 1, sentence 2:

The actions of TRC–DDS enumerated above place artificial barriers to the approval of Social Security disability claims during case development and initial consideration, and prejudice such cases at the Administrative Law level. This has the potential effect of forcing those claimants out of the "non-adversarial process" created by Congress in writing the Act, in order to force such individuals either forfeit rights or file a suit in U.S. District Court. The harm resulting from such violation of the rights of disabled Texans to due process and equal protection of the laws can

be seen by looking at the Social Security case flow statistics: In 1995, of the 2.5 million initial cases, only 2% reached the Appeals Council, of which 73% were dismissed and only 3% approved; and of those which were then filed in Federal District Court, only 10% prevailed. **In total, 2,220 out of 2.56 million initial cases—one in a thousand, or 4% of the 51,400 Appeals Council cases—were approved ABOVE the ALJ level**, although 12,340—over 5 times as many—were remanded for rehearing. The policies and behavior of TRC–DDS in disability determination, and the consequent bias at the ALJ level, compromises "on an industrial scale" Texans' rights to due process and equal protection of the laws.

VII. Closing:

Three quotes seems relevant to the consideration of Texans' rights to due process and equal protection of the laws in Social Security disability determinations:

"It rings a very serious fire bell that the Social Security justice system isn ot treating all of the applicants equally or consistently' said U.S. Rep. John Culberson, R-Houston. 'And that is a recipe for disaster under our America system of law.'" From: "Judges Vary Sharply on Disability Approval: Social Security Rulings Concern Lawmakers", Alan Bernstein and Dan Feldstein, Houston Chronicle, 7–14–02 A.1.

"However, Green said the gap in allowance rates by each judge is troubling by itself, and csts doublt on the fairness and integrity of the disability program. 'If we are having that kind of disparity . . . it's just wong,' he said". From: "Judges Vary Sharply on Disability Approval: Social Security Rulings Concern Lawmakers", Alan Bernstein and Dan Feldstein, Houston Chronicle, 7–14–02 A.1.

The percentage of decisions at the hearing level that were favorable for both DI and SSI claimants stood at 58 percent in 1985, grew to nearly 72 percent in 1995, fell to 63 percent in 1998, and grew again to 66 percent in 2000. Hearing offices also vary greatly from State to State in the percentage of decisions that are decided favorably for claimants. In 2000, the range went from 35 percent in the District of Columbia to 86 percent in Maine, with a national average of 66 percent. Unexplained discrepancies of this magnitude are simply unacceptable in what Congress intended to be a fair and uniform national program. "Charting the Future of Social Security's Disability Programs: The Need for Fundamental Change", Social Security Advisory Board, January 2001.

VIII. References: The Houston Chronicle News Articles on Social Security Disability in Texas:

1. **Disability hearings can leave applicants baffled, frustrated / Lost medical records among the problems. Alan Bernstein, Houston Chronicle, 03–11–01 A.20.**
2. **Social Insecurity / Local judges prove stingy in deciding appeal cases. Alan Bernstein, Houston Chronicle, 03–11–01 A.1.**
3. **Social Security disability insurance—by the numbers. B.C. Oren, Houston Chronicle, 03–11–01 A.20.**
4. **Area Social Security judges built careers in other areas. Alan Bernstein, 03–11–01 A.20.**
5. **System to speed disability appeals may delay them. Alan Bernstein, Houston Chronicle 03–12–01 A.1.**
6. **Answers sought from Social Security / 4 area lawmakers want explanation for disability rejection rates, delays. Alan Bernstein, Houston Chronicle, 03–13–01 A.21.**
7. **Corrections. Houston Chronicle 3–14–01 p2.**
8. **Viewpoints. (Letter to the editor). Boon to rehab lawyers. Marcella P. Phillips, Pasadena. Houston Chronicle 03–14–01 p25.**
9. **Disability application process eyed / Rehabilitation agency chief testifies before House panel. Alan Bernstein, Houston Chronicle, 03–15–01 A.1.**
10. **Disability woes to be discussed / Special meeting set next week. Alan Bernstein, Houston Chronicle, 03–17–01–A.1.**
11. **Debilitating: Answers needed on why Texas lags on disability claims. Editorial, Houston Chronicle 03–18–01 C.2.**
12. **Viewpoints: Disability system blamed? Needy Social Security. Leslie Gerber, Houston Chronicle 03–18–01 C.3.**
13. **Viewpoints: Disability system blamed? Poor reasons for claims. Diana Sewell, Houston Chronicle 03–18–01 C.3.**

14. **Agency vows more judges to fix log jam / Disability case problems get high-level attention. Julie Mason, Alan Bernstein. Houston Chronicle, 03–23–01, A.1.**
15. **Disability reform still lags in area. D.C., Houston hearings sought about backlog. Alan Bernstein, Houston Chronicle 4–22–01 p.37.**
16. **Budget cuts delay expansion of disability benefits project. Julie Mason, Alan Bernstein, Houston Chronicle, 4–28–01 p4.**
17. **Disability claims outpace reviewers / Social Security backlog grows. Alan Bernstein, Houston Chronicle 05–03–01, A.1.**
18. **Corrections. Houston Chronicle 05–08–01 p2.**
19. **Longevity has its perks. Alan Bernstein, Houston Chronicle, 05–12–01 A.39**
20. **Dealing out rejection: / Local Social Security Judge Kline is criticized for frequent denials in disability-benefits cases. Alan Bernstein, Houston Chronicle 05–13–01, A.1.**
21. **Social Security disability under probe for race bias, Alan Bernstein, Houston Chronicle, 06–10–01 A.8.**
22. **Panel hears of woes in disability system / Social security official asks for help. Julie Mason, Houston Chronicle, 06–29–01 A.8.**
23. **Social Security agency's conduct draws scrutiny / Pending case damages woman's personal credit. Alan Bernstein, Houston Chronicle, 07–16–01 A.1.**
24. **Judges' freeze hurts sick. Alan Bernstein, Houston Chronicle, 08–11–01 p35.**
25. **Social Security benefits process can take a deadly toll / Texas woman's case reveals system's flaws. Alan Bernstein, Houston Chronicle, 08–27–01 A.1.**
26. **Initial shock on disability / Social Security claims assigned to examiners whose names are codes. Alan Bernstein, Houston Chronicle, 09–09–01 A.1.**
27. **These examiners perpetually 'not in'. Alan Bernstein, Houston Chronicle, 09–09–01 A.20.**
28. **State review urged of agency providing services for disabled. Dale Lezon, Houston Chronicle, 09–11–01 A.1.**
29. **State agency will halt codes for caseworkers. Alan Bernstein, Houston Chronicle, 09–26–01 A.1.**
30. **More judges are approved for disability appeals cases. Alan Bernstein, Houston Chronicle, 09–27–01 p19.**
31. **Letter by rehabilitation panel won't stop legislator's criticism. Alan Bernstein, Houston Chronicle, 10–14–01 A.39.**
32. **Coleman's Criticism: Elected officials supposed to watch agency performance. Alan Bernstein, Houston Chronicle, 10–17–01 p28.**
33. **State told more funds needed to improve disability benefits. Alan Bernstein, Houston Chronicle, 10–18–01 A.29.**
34. **Nurse wins long fight over death benefits. Alan Bernstein, Houston Chronicle, 08–23–01 A.17.**
35. **Wrap-up: Relief for the disabled. Alan Bernstein, Houston Chronicle, 12–01–01 p35.**
36. **Government grinds slowly. Alan Bernstein, Houston Chronicle, 03–09–02 p41.**
37. **Social Security chief to hear from disabled. Alan Bernstein, Houston Chronicle, 05–22–02 p33.**
38. **The pain of denied benefits / Social Security chief agrees system has flaws. Alan Bernstein, Houston Chronicle, 05–30–02 p1.**
39. **Social Security's backlog reaching 'breaking point'. Alan Bernstein, Houston Chronicle, 06–12–02 A.7.**
40. **Judges vary sharply on disability approval / Social Security rulings concern lawmakers. Alan Bernstein, Houston Chronicle, 07–14–02 p1.**
41. **Access to Social Security files granted only after legal battle. Alan Bernstein, Houston Chronicle, 07–14–02 A.19.**
42. **Pickets for disabled stir national debate / Judges' group says protest violate law. Alan Bernstein, Houston Chronicle, 07–25–02 A.19.**
43. **Judges call for public hearings. Alan Bernstein, Houston Chronicle, 08–10–02 p33.**
44. **Social Securty unit uses lies to find fraud / Advocates of disabled decry 'ruse' tactics. Alan Bernstein, Houston Chronicle, 03–02–03 A.1.**
45. **Agents' tactics in probing disability fraud curtailed. Alan Bernstein, Houston Chronicle, 04–30–03 p1.**

Statement of Stephen P. Robertson, Chesapeake Beach, Maryland

My attorney can provide the Congress with information not only on my case, but about 1,000 others. Each of whom faced the same faceless monster. Please; I beg you to contact his office and he will gladly share some real horror stories. Angela Martin, his assistant would also prove a valuable resource.

With this e-mail, I grant permission to the CONGRESS to make contact with and discuss with my attorney my case, including the actions of "ROSE", an SSA reviewer whom my attorney called in open court, ". . . a disgusting human being . . ." while explaining to the judge how she routinely refuses cases without fair and proper review of the evidence.

Senators Sarbanes and Mikulski have been notified in this matter, and are aware of my individual case.

Statement of Alice Rodriguez, Odessa, Texas

Hi my name is Alice Rodriguez, I am writing about my husband Reynaldo Rodriguez, my husband had a massive heart attack 08/14/2002 and had 3 stents placed in. On 12/05/2002 he had to undergo a triple by pass surgery, 02/03 he had to have another stent put in he also has 2 herniated disk that he has has steroid shots and doctor has had to go in and burn a nerve to ease the pain that should only be temporary, Since August he has had to go in the hospital a least every two months with chest pains and anxiety. My son 04/25/03 was in a horrible accident and was pulled out of the car with the jaws of life and my husband had to witness that broke his femur and had surgery to put in a rod and screws, a couple of days before that I had to have a complete hysterectomy. We applied for Social Security on 09/09/2002 on June/2003 Social Security Denied the claim and said although you can not go back to commercial framing and construction you are able to do less demanding jobs. He has an 8th grade education repeated 8th grade 3 times. On 09/14/03 since we are financially struggling he went to look for some yard work and and asked a lady if he could do her yard she said no she wanted the limbs of the tree cut. My husband was about 10 feet up on the tree when he sliped back, and feel right on his head and fractured his vertebrae in 2 places. He now has a brace on his neck and because his heart there not able to do surgery on him. I have to sponge bath him dress him up. The hole family is going through so much. If social security with had help him to began with. He would not have gotten hurt, I am thinking of going to the news paper about this and any one that can help this is ridiculous thank you so much for your time.

Statement of M.J. Adams, Seattle Office of Hearings and Appeals, Social Security Administration, Seattle, Washington

Disclaimer: I am an Administrative Law Judge employed by the Social Security Administration Office of Hearings and Appeals. I am currently serving as and Administrative Law Judge in the Seattle Office of Hearings and Appeals. I also perform additional management duties of a Hearing Office Chief Administrative Law Judge. The statements below do not express or imply any position held by the Social Security Administration. The statements below are solely for the purpose of expressing my concerns about the issues before the Subcommittee on Social Security of the Committee on Ways and Means.

Re: Subcommittee on Social Security of the Committee on Ways and Means hearing focusing on examination of key management challenges facing the SSA's OHA, along with actions underway or recommended to improve service delivery.

Chairman Shaw states that:

> Individuals with disabilities wait months, if not years to receive a decision from the OHA. That's wrong, and they deserve better. Each claim is more than a thick file of papers; it represents a person who is suffering and needs help. The hard working employees of the OHA must get beyond finger pointing and take personal responsibility to make their program work better. We must find

> ways to eliminate this bottleneck so that individuals with disabilities can receive the prompt and accurate service they deserve.

This statement overlooks the achievements of the current process. The Supreme Court of the United States described the current process in ***Heckler v. Day et al.,*** 104 S. Ct. 2249 (1984):

> To facilitate the orderly and sympathetic administration of the disability program of Title II, the Secretary and Congress have established an unusually protective four-step process for the review and adjudication of disputed claims.

The four-step process noted by the Supreme Court may be functionally divided into two distinctly different categories. The first category is the first two steps in the process, initial determination and reconsideration, performed by the State Agency Disability and Determination Services (DDS). Second category is the third and fourth steps which are performed by the Office of Hearings and Appeals (OHA) and the Appeals Council. At the Office of Hearings and Appeals, the process is Claims Adjudication following the requirements set forth by Congress for the Commissioner to give reasonable notice and opportunity for a hearing to any individual denied benefits at the first and second steps.

When the current process is analyzed using these two distinct categories: Claims Determination versus Claims Adjudication, it becomes apparent that claimants are not being denied timely and fair resolution of their claims. To argue otherwise is to discredit the work of the State Agencies at the initial and reconsideration levels where thousands of claimants with severe medical impairments receive prompt, favorable determinations. None of these claimants are complaining to their Congressman.

Once the Claims Determination process has been exhausted at the State Agency level, the claimant may request a hearing before and Administrative Law Judge at the Office of Hearings and Appeals. This begins the process of Claim Adjudication. This process is analogous to a claim against an insurance company that has denied coverage. The denied policy holder files suit in state or federal district court and begins the long process of civil litigation that can last for years.

The Social Security Administration may be characterized as the largest insurance company in the country. Contrast SSA's "orderly and sympathetic administration of the disability program . . ." ***supra***, with the civil litigation remedy available to the policy holder of a public insurance company.

Rather than proceed through the lengthy process of civil litigation in state or federal court, the claimant denied by the State Agency is provided the benefit of a hearing applying the rules of Administrative Law. Administrative Law Judges follow procedures that are the most efficient for determination of claims involving large sums of money for lifetime benefits. ALJ's conduct hundreds of hearings annually resulting in decisions to award or deny benefits. Decisions that involve hundreds of thousands of dollars. Each one of these hearings requires a support staff performing similar functions to a support staff for a civil jurist conducting one trial a week. Each ALJ may conduct four to six hearings per day. Each hearing may last from one to two hours or longer. Each hearing involves support staff organizing the hearing and making certain that all parties arrive at the same place and time ready to proceed to hearing. This involves obtaining the appearance of witnesses, reporters, the claimants and usually a representative. All of these schedules must be coordinated. This is accomplished by the support staff at OHA hundreds of times a month in the average office. The task is monumental and extremely labor intensive.

Once the claimant has had a hearing before an ALJ, the ALJ must prepare a written decision as prescribed in the act and court decisions. In all cases where the ALJ has affirmed or denied benefits, the decisions require extensive drafting and legal review before release.

Fundamental distinctions between Claims Determination by the State Agency employees versus Claim Adjudication by the ALJ's at OHA requires more time and more expense at the ALJ level. For example: the State Agency employees designated to make determinations at the initial and reconsideration level are not required to develop a record of evidence that is complete. They may determine a case adverse to the claimant with a finding of insufficient evidence when development of the evidence of medical impairments falls short.

At every step of the four-step process, supra, evidence may be developed to support the finding of disability. Development of this evidence takes time and cost money. The development of the evidence is usually where the "bottleneck" occurs.

At the third step or hearing level before the ALJ's at OHA, development of a complete record of evidence to support the decision is not an option. The ALJ has the duty to fully develop the record. It is axiomatic that development of a complete

record of the evidence takes time and costs money. This is necessary to insure the integrity of the system by which it is decided who shall receive benefits and who shall be denied.

A second distinction, between Claims Determination by the State Agency employees versus Claim Adjudication by the ALJ's at OHA, affects the process and outcomes or results. This distinction is based on what the Social Security Administration "counts". "Counts" as used in this analysis means what is the focus of quality review by the Social Security Administration.

What "counts" at the first and second steps of Claims Determination by the State Agency employees is the cases that are paid. These cases must withstand second and sometime third review before a favorable decision may be released to a claimant. SSA quality assurance requires this review at the first and second steps in the four-step process, *supra*. The favorable or pay case must be developed by the State Agency employees with quality review overseeing the process. Development of the evidence to support the favorable or pay case takes time and costs money.

Denial of the claim by the State Agency employees at the first and second step of the four-step process, supra, does not undergo the same quality review by SSA. The claimant is informed of the right to appeal and this counts in number of case dispositions for the State Agency employees at the first and second steps of the four-step process, supra.

What "counts" at the ALJ level are the decisions for denial of benefits or affirmations after hearing. These cases have a built-in quality review process since the claimant may appeal to the Appeals Council and to Federal District Court if needed. Contrast that quality review process afforded the claimant with the Social Security Administration's "own motion" review of an ALJ decision. Incidence of "own motion" review of other ALJ pay or reversal decisions is unknown to this author. However, personal experience of issuing thousands of decisions since 1986 indicates the number of "own motion" reviews of my pay or reversal cases is probably less than three 3 percent.

A focus on what SSA "counts" at step one and two versus step three and four of the four-step process, ***supra***, reveals that outcomes are determined when combined with the need to produce "numbers" of case dispositions. This is crucial to determining processing times at the first and second Claims Determination steps versus the third and fourth Claims Adjudication steps.

At the State Agency Claims Determination steps, it is easier to deny a claim due to the quality assurance review of pay cases by SSA.

At the OHA level it is easier to pay a case. Pay cases ("reversals") are rarely reviewed by the "own motion" process. Experienced claimant advocates and attorneys appear before judges at the hearings. SSA is not represented by an advocate at the OHA hearing level. Under the current practice and implementing various initiatives to increase "numbers", cases may be paid by an ALJ without the necessity of development of evidence, processing the file for hearing, or conducting a hearing with multiple witnesses. Fewer resources are spent to issue a pay case than to issue a legally-sufficient affirmation, or denial, decision. The written decision or reversal may be a "short form" or other abbreviated form of written document containing minimal evidence to support the decision. Agency and Congressional pressure to produce "numbers" and reduce processing time results in higher incidence of paying or reversing cases.

Improvement

A prescription for improvement includes supporting the current four-step process for the review and adjudication of disputed claims. Support should not be in the form of initiatives that destroy the integrity of the system. Nine states are currently involved in a process that includes elimination of the second step or reconsideration determination. Personal experience with adjudicating Alaska cases, one of the nine "prototype" states, reveals many of these cases come to the hearing level at OHA without sufficient development of the evidence and without sufficient time elapsed to establish the duration element for disability.

Replacement of the current ALJ decision maker with other adjudicators who are not protected by the Administrative Procedure Act safeguards would destroy the rights of claimants to have a fair and unbiased judge conduct their hearing and issue decisions without fear of Management retaliation.

Summary & Conclusion

In summary, Claim Determination at steps one and two is analogous to the review and determination of claims by an insurance company. SSA has a high duty to process these claims timely and accurately by either the State Agency or some other substituted informal process. This should be the focus of Chairman Shaw. It

may be accomplished by changing what "counts" at the initial and reconsideration, step one and two Claim determination levels. It requires resources dedicated to the early development of the medical information necessary to support a claim. Quality review at the first two steps should include a review of all decisions, not just the pay cases.

Once denied after a fair review and determination by the State Agency at steps one and two, the role of the claimant becomes analogous to the civil litigant. Claim Adjudication is civil litigation. Administrative Law Procedures followed at the hearing level in step three are the most efficient civil litigation model in existence for determination of claims for money that may approach hundreds of thousands of dollars.

At the third step in the four-step process, **supra**, due process is provided the claimant seeking an award of benefits. Due process takes time. Due process costs money. Congress should make sure that the money is spent and the time allowed providing each claimant due process. The time and money is necessary to insure the integrity of the process by which the Social Security Administration decides who shall receive benefits and who shall be denied.

Statement of Sarah Shapiro, Washington, D.C.

Solving the problems with OHA will be pointless and perhaps impossible unless the problems with the Disability Determination Services are solved first. If unwarranted denials were not given on valid claims, the OHA would not be overloaded and backlogged. Aside from other reasons in a variety of individual cases, thousands of qualified claimants are denied at DDS level simply because of the system of listed impairments. Almost everyone with an unlisted impairment must wait for an ALJ to use common sense and find the claimant disabled. If some system of common sense were permitted on the DDS level, instead of absurd adherence to the listings, the OHA would have only those cases that legitimately belong in a hearing room.

Severely disabled claimants whose medical conditions happen not to be listed impairments do not belong at OHA, should not be at OHA, would not be clogging OHA, if the Listing of Impairments was either greatly expanded or abolished.

I am myself disabled, and was approved for Social Security benefits only after a 28-month wait from initial application to approval by an ALJ after a hearing at OHA. I am also one of the moderators of an email group with about 1400 members with "invisible" illnesses, whose experience applying for disability benefits is similar to mine. We encourage newcomers to hang in there, to wait for approval at the ALJ level. We are all physically impaired, but not by listed impairments. Our financial, emotional, and even medical burdens grow with the delay, some members even lose housing while waiting for approval, despite medical records and doctors' opinions supporting findings of disability. There is no clear reason for denial at DDS levels, other than the restrictive Listing of Impairments and the procedural inability of the medical review teams to exercise the common sense permitted, if not always evidenced, only at OHA.

Statement of Judith A. Shaull, Fair Grove, Missouri

My name is Judith A. Shaull. I have been unable to work ever since July 2001. I was having very bad headaches and doctors discovered I have 4 bulging disc in my neck all in a row. When my orthopedic doctor informed me of this I was in disbelief. He also told me he would not perform surgery on me and said I could ask the other doctors in his office but he knew they would not attempt it either. The weeks started to pass by and my pain continued to get worse. It affects my head, neck and shoulders. I was in agony for seven months before I could find a doctor to treat me for pain. I already had depression but the pain made it terribly worse. I laid in bed or sat in a chair for seven months and gained 50 pounds. My husband and I struggled to pay our bills. This has put us under unbearable stress. I have been diagnosed with chronic pain, Fibromyalja and chronic depression and anxiety. I take medicine for the pain and depression. The medicine for the pain makes me groggy and affects my personality. It took seven months before I could even find a doctor to treat my pain. I don't go anywhere but to see my doctors so my husband who works all week and is exhausted has to take care of everything else on his days off. We have spent all of our retirement money on bills and all of his vacation pay

and sick days. If he misses work we will lose our home. I have lost contact with my friends and have not seen my brother and his family in a year. I am frozen with fear and the chronic pain has beat me down mentally and physically. I have an attorney but he still can not tell me when my case will be heard.

The stress is also taking as huge toll on our marriage. I am not living, only existing. I wish someone could help us before we lose everything we have ever worked for.

Statement of Deborah L. Sherman, Kansas City, Missouri

Dear sir/madam,

First, I'd like to say that we are extremely fortunate and grateful to have my ltd. My former employer was USDA, and we did not also have to endure the nightmare so many do trying to get LTD through a private insurer, ERISA or otherwise. We're not destitute, living in a shelter, on the street, or had to move in with family that really doesn't understand, or want us there.

I've been sick with CFS/ME since sept. 1980. My daughter, now 17, became ill with the same disease the summer of 1998. I was retired on FERS disability in Sept. 1990. SSD I came through a few months later.

My CDR started in June/July 1998. I have been in front of my ALJ two or three times. He totally discounts anything I, and the doctors I've seen since 1989, say. He instead uses his own opinion, and that of doctors SSA sends me to, that don't know me, and have never seen me before. Except for one they sent me to, and told them I was disabled. He happened to be my doctor before I found the current one in 1989, but SSA people didn't know that. My ALJ then said this doctor could not possibly have made the determination in that one visit that I was disabled.

My attorney has done everything "right", and my doctors have done everything "right". I seem to be stuck with an ALJ and SSA docs that know very little, if anything, and don't personally "believe" in cfs/me, or the debilitation it causes. It's been a little over five years since the CDR started. It looks like until the ALJ retires or passes (and NO, I don't wish him dead, maybe just that he could have cfs/me for a month, and/or watch it knock his healthy, bright, bubbly 12 year old child or grandchild flat) or the appeals council finally overturns him, we're just in "limbo".

We had to move from the apartment my daughter pretty much grew up in, and I still had to file bankruptcy a little over a year ago. Consumer Credit Counseling was unable to help me, because there was no money to make payments. Very fortunately, we still have the health insurance from my former employer, but we are accumulating hundreds of dollars in medical bills because of co-pays and deductibles I can't pay more than $25 a month on. We've also burdened my mother with medication expense, and car repairs. We wouldn't have a car anymore if it weren't for her. And she paid for four years ($150–300 mo) for my daughter to continue an over the counter supplement when I could no longer buy it.

Please, PLEASE, help us, and all the patients out there in much, much worse situations than we are!

Statement of Linda Fullerton, Social Security Disability Coalition, Rochester, New York

Be aware that what I am going to say is 100% fact and is very gruesome. I need to tell you all the gory details so you can truly understand what a miracle it is that I am alive today. On Sunday 11/3/96, I bumped my head on the doorframe while exiting from my car. It stung a bit for a few moments and I thought nothing else about it. On Wednesday of that same week I started to get headaches, and a huge lump called a hematoma (blood clot) formed on the back of my skull so I starting taking Advil for the pain. I called my doctor and was told that it would be very painful for at least a month until the blood reabsorbs back into my system. On 11/23 I called the doctor because by this time the pain was getting worse not better like he said it would. I was referred to an after hours doctor who confirmed that I had a blood clot and sent me home. On 12/9 I saw the doctor again and by this time the blood clot had grown to a size of 6x2½" and could be seen from across the room. The doctor ordered a CAT scan to check for a skull fracture. The blood clot did not show up on the scan because the contrast medium was not ordered and there was no fracture.

For the next month I went to the emergency room twice and was sent home both times with no results. I had x-rays, saw a neurologist, went to a pain clinic, saw a neurosurgeon and visited my own doctor several times with no relief in sight. I was given every pain killer known to man: Fiorinal, Daypro, Amitriptyline, Tylenol 3 with Codeine, Ambien, Demerol, Clonazepam, Darvoset and finally Roxicet (Morphine)—none of which helped at all. I was taking a regimen of 3 extra strength or 1 prescription Advil and alternating with 2 extra strength Tylenol every 2 hours for over a month. Even this did not help me. I even tried alternative medicine: feverfew which is normally taken for migraines which I have never had, and a topical herbal mixture of St John's Wort oil, Arnica oil and Aloe Vera Gel which had a salad dressing consistency. I would plaster this greasy mixture onto my head every day, which made my long hair a nightmare to look at and had a nasty smell to it. During this period I only missed one day of work and worked 45 hours a week even though I was not getting any sleep at all. I have never been a fan of suicide but Dr Kevorkian was looking real good at this point. I could truly understand for the first time why someone would not want to live if that was how the rest of his or her life was going to be. I would get down on my knees literally crying and praying to God to take my life so I would not have to suffer that horrible pain anymore. It really felt like something was eating my brain!

On Sunday 1/12/97, I was at my boyfriend Arnold's house and I was having a very difficult time walking. The pain was extremely excruciating and I had to lie down on the bed. After that I lapsed into a coma. The following scenario is what he told me happened, while I was in the coma since I remember nothing of the next three days. Sunday, after Arnold realized I was in trouble, he called the doctor and he told him to let me sleep it off and call him in the morning. Next day Arnold called them back and insisted that the doctor see me. He had to drag me into the office since I could not walk on my own. The doctor then told him that I probably was suffering from a drug overdose and sent me home. By Tuesday morning when I still did not wake up, Arnold was furious and called the doctor's office back and told them he was going to call an ambulance and get me to the hospital. When I arrived at the hospital Arnold talked with the neurologist that I had seen previously about what was happening and they ordered another CAT scan for me, and this time they put the contrast medium in. To the doctor's horror they saw a white mass in my cerebellum, which they could not identify. At this point a neurosurgeon was called in. He checked out the pictures and said that he would need to perform brain surgery on me the next day when he could get his team together. Thank God I was in the coma because I would have said no way! He said he was going to get his people together and be back in the morning.

After a few minutes he came back and said that after assessing the situation further, he felt that he must do emergency surgery on me that night instead of waiting because he felt I would not live until the next day. Here comes the gory part. My brain was so swollen with fluid, he had to put a hole in the top left side of my skull the size of a quarter and insert a drainage tube in. He then made an incision from the base all the way to the top of my skull. All the neck muscles were then stripped from the back of my head. When he opened me up he saw that the skull bone was full of holes and soft at the base due to an infection (Osteomyelitis) that had eaten it away. He had to cut it all away to keep it from spreading further. He then had to remove a tablespoon of pus from the cerebellum area, which ended up being the white area that had shown up in the CAT scan. The hematoma that was originally the source of my pain had become infected with two forms of strep and a staph infection, which had eaten it's way through my skull and formed an abscess in my cerebellum. If the doctors had only ordered a blood test when I was having so much pain, they would have seen that my white count was in triple digits and could have given me antibiotics, which may have killed the infection and I never would have had to have this horrible surgery. Instead they just kept taking my temperature, which was never elevated during this whole time. I usually don't get a temperature when I am sick, and the all Advil and Tylenol they had me on probably kept my temperature down as well. The next thing I personally remember was waking up in the ICU with all kinds of tubes hanging out of me, and a reverse Mohawk hair cut. They closed the huge incision with metal staples so I felt like I had a zipper up the back of my head. They had me on a mixture of three different very strong antibiotics for the first week because they had to make sure they killed all three forms of the infections. These were very strong and caused very nasty side effects. After spending two weeks in the hospital they sent me home with an IV Pic line implanted in my arm and I had to administer IV Vancomyacin to myself several times a day for the next month. I eventually developed an allergic reaction to the drug called Red Person syndrome. I was covered from head to toe with a horrible rash and had trouble breathing. Needless to say they made me stop taking the anti-

biotic. Since there was no other drug that would kill this type of infection I had to hope that it had done its work. I was put on a pill form of antibiotic called Biaxin for precautionary measures. By March I felt that I might be ready to go back to work but the story doesn't end here . . .

A few days before I was scheduled to go back to work I started having horrible pain again in the back of my head and neck. It started out as a mild stiffness and very quickly got unbearable. It was very frightening—it felt like something was eating away at my spinal cord. I thought that the Osteomyelitis (bone infection) was back again! I had several doctor visits and they could not find anything wrong with me. I learned a lot from the ordeal I had just been through and got very efficient at surfing the web. I took my life in my own hands now—you would think after all I had just been through they would listen to me but being a woman they very often don't take you seriously. I discovered on the web that one of the best tests to show up a bone infection is an MRI with contrast and I insisted that they give me one immediately. They put up a fight but I was in no mood to deal with incompetence again and I won the battle and had the test. Because I did the research myself and insisted on this test—I saved my own life this time. The MRI revealed that I had a blood clot in my brain in a very dangerous in-operable area—the left internal jugular vein. I had to make the decision to take Coumadin, which is the medical name for Warfarin (RAT POISIN). This was a tough decision because if I didn't take the Coumadin I would die for sure and the Coumadin could cause a deadly brain hemorrhage as well. I chose the risk of taking the medicine. As you can see, I made the right choice at the time but eventually my brain surgeon took me off the Coumadin after he lost a patient who bled to death from a brain hemorrhage that he couldn't save.

I now take an aspirin a day and pray as my only treatment for this huge clot in my brain. I also now suffer from several autoimmune disorders including: Hashimoto's Thyroiditis, Crest Syndrome/Scleroderma, Raynaud's, Rheumatoid Arthritis, and Fibromyalgia, which I believe were caused from my autoimmune system working so hard to fight the brain infection, that it never turned off and now is attacking the good parts of my body. The symptoms so far are Telangiectasias—red spots all over my face, and extreme intolerance to cold caused by the Raynaud's. I have already been hospitalized again from what I thought was a heart attack but was ruled to be a result of the Crest Syndrome/Scleroderma affecting my esophagus. It seems to also be affecting my digestive tract, swelling of fingers and toes, hardening of skin on my hands, and now possibly even my eyes. Scleroderma is a collagen disease, which in its extreme form hardens tissues and vital organs throughout the body and eventually kills you. The worsening Rheumatoid Arthritis causes fatigue and lots of pain in the joints throughout the whole body, and Fibromyalgia causes fatigue and pain in the muscle tissues and nervous system. I live in a city that is experiencing a critical shortage of Rheumatologists and have resorted again to the Internet to find a specialist in another part of the country who may be able to consult with my doctor about my situation. Since there is no cure for these diseases, I just live each day as if it will be my last, making the most of every second that I have.

You may be wondering why I did not sue for tons of money. I thought it best to let the New York State Medical Misconduct Board investigate, and they found my primary care physician not guilty 2 times because it was too unusual of a case to find him guilty. I am not bitter and am using the whole ordeal as a learning experience. Hatred is the worse form of disease that anyone can have and is very destructive and a waste of time and energy. I believe with my whole heart and soul that it is very important for my story to be heard by as many people as possible especially women who are dying by the day as I write this to you because doctors do not take their medical problems seriously enough. I have heard many horror stories since this has happened to me, and people need to know that they must start taking charge of their lives and their healthcare. If they are too sick to do it themselves they must appoint someone they trust to be an advocate for them.

If Arnold was not there, I would be dead and if I did not take charge when I was functional I would have been dead a second time! I was saved for a reason and I believe part of it is to help others by what I have learned and hopefully save some lives in the process. I am very grateful for the support of my family and friends without whom I may never had made it through this nightmare.

What am I doing now? I used to work 40 hrs a week as a computer hardware & software, purchasing agent until I became a casualty of company downsizing. I was hospitalized in the spring of 2001 for what I thought was I thought was a heart attack but was ruled to be a result of the Crest Syndrome/Scleroderma affecting my esophagus. It seems to also be affecting my digestive tract, swelling of fingers and toes, hardening of skin on my hands, and now possibly even my eyes, as a result

of my worsening autoimmune disorders, which are becoming more of a challenge each day. I have been recently diagnosed with Osteopenia of the hips, Calcinosis and Tendonitis and drying eyes. As a result of a car accident in August and my progressively worsening autoimmune disorders I also am now suffering from severe neck, spine and back pain, numbness, tingling and pain in my arms, hands and feet, headaches, major fatigue, severe nosebleeds, irritable bowels, memory loss, inability to sleep or concentrate, anxiety and severe depression. In November 2002 I was back in the hospital emergency room with a horribly painful form of the chicken pox virus called shingles.

To learn more about the various diseases I have, check out the following websites:

SCLERODERMA AND CREST SYNDROME: http://www.scleroderma.org
RAYNAUD'S DISEASE: http://www.nhlbi.nih.gov/health/public/blood/other/raynaud.htm
FIBROMYALGIA: http://www.fibromyalgia.com
RHEUMATOID ARTHRITIS: http://www.arthritis.org
HASHIMOTO'S THYROIDITIS: http://www.tsh.org
TELANGIECTASIA: http://tinyurl.com/mddh
AUTOIMMUNE DISORDERS: http://www.aarda.org
SHINGLES: http://www.aftershingles.com/faq.html

I am now unable to work and have become permanently disabled with no income. For the last 30 years of my life I have contributed to the Social Security System as many millions of people do every day. I never expected to have to use the funds till I was old enough to retire. In December of 2001 I applied for Social Security Disability which I assumed would be there to help me in my time of need. I had heard nothing but discouraging stories from others but figured every case was different and anyone with the laundry list of illnesses that I have would surely be able to get the help that I needed. I was sorely mistaken and the following is what I have discovered in the process.

After filling out several pages of paperwork which I was told was greatly reduced from which it had originally been and submitting a huge stack of medical records supporting my claim I was told that it would take 4–6 months to go through the process. I was shocked and asked what I was supposed to live on and I was told to apply for social services (Medicaid, food stamps and cash assistance) while my claim was being reviewed. I did just that and was denied any sort of help based on the cash value of a life insurance policy that is not even enough to bury me when I die. Due to all my illnesses if I cashed in that policy I would never be able to get insurance again! That process and paperwork was very difficult and humiliating and then to be denied, just added even more to my stress and misery. I was hoping beyond hope that I would get news that my claim would be processed and accepted. On 4/25/02, I got the incredible news that my claim had been denied! I found out that it is common knowledge on the streets and in legal circles that almost NOBODY gets accepted the first time they apply and SSD is set up to discourage everyone, even those who feel brave enough to tackle the system.

I had heard too many horror stories in doctor's waiting rooms and other places I have been, of people who have lost everything, were in homeless shelters, totally bankrupt, no health insurance and still having to deal with the stress of all their illnesses. I could not understand how it was possible that anyone could read about all the medical problems I have, and it is not totally transparent that I should qualify for benefits and should never have been denied in the first place! I know what they meant now since I was almost there myself. I immediately filed for an appeal, had to go through an even more complicated process and was told it would be at least August of 2003 before I got my hearing if I didn't die first—where is the justice?

I have also discovered that the Social Security Disability System process is set up to suck the life out of it's applicants in hope that they die in the process so they don't have to pay out any benefits to them. Millions of people across the country become disabled unexpectedly (12,000 per week in this country apply for long-term disability benefits—over 300,000 annually in NYS alone). Keep in mind when reading this, that while this is a nationwide problem, for NY State applicants it is worse than most other states in the country. The federal offices of the Social Security Administration and the Social Security Office of Public Inquiries in MD gave me that information when I contacted them about the problem yet even they were not able to help.

Something is extremely wrong when you have to deal with the pain and suffering physically and mentally that comes along with the illnesses you have, and then have to struggle so hard to get the benefits that you have worked for all your life. The SSD process is also set up to line the pockets of the legal system, as you are

encouraged from the minute you apply to get a lawyer. Why should you need to pay a lawyer to get benefits that you have earned? Even a lawyer cannot speed up this process any more than if you file on your own. The system is structured so that it is in a lawyer's best interest for your case to drag on since they get paid a percentage of a claimant's retro pay up to $5300—the longer it takes the more they get. This is highway robbery without the ski mask and gun and this travesty needs to change immediately! I don't know what constitutes a dire needs case in the eyes of the Social Security System but I should think that not being able to afford health insurance, medicine and other necessities of life, wiping out all your financial resources when you have no income at all because of your inability to work, is a dire need! There is no cure for any of the illnesses I have, which I stated earlier and all the diseases are getting worse by their clinical nature with each day that goes by, due to the ever increasing stressful conditions I have had to live under—yet that is not considered a dire need? The clot in my brain and my worsening financial situation kept me from taking the medicines and seeing doctors that could help me deal with this horrible existence. As mentioned earlier, I ended up in the emergency room in November 2002 with an attack of the shingles virus which may have caused permanent nerve damage in my right arm. As far as I could tell worsening health was not a factor in speeding up SSD claims as there are several reported cases of people who have died while waiting to get their benefits.

When I called the Office of Hearings and Appeals in Buffalo NY to check on my claim on 9/13/02, to see if I could speed up my claim, the receptionist told me, that my file was still in the un-worked status, which means that no human has even looked at the file at all since March when I originally filed my appeal. She said that nobody had been assigned to even look at the folder. I expressed my disgust that after six months in their possession that it had not even been looked at yet! I called them again on 1/23/03 and they told me that STILL nobody had been assigned to my case and it would be a MINIMUM of five months or more since they were just starting to work on cases that were filed in November of 2001! This is outrageous when something this serious, and a matter of life and death could be handled in such a poor manner. No other company or other government organization that I know of operates with such horrible turn around times. She expressed her sympathy for my cause and literally begged me to let others know (especially the government and press) about how much of a problem they are having. I was told that there are only 50 employees handling hundreds of thousands of cases and they, along with all us claimants critically need help now! Since my conversation with the Buffalo office I have done just that. I contacted several national media outlets (TV, radio, print), to no avail even though this issue affects thousands of people all across the country. I wrote to my congressperson Louise Slaughter, three NY state senators, the attorney general, Governor Pataki, President Bush, Vice President Cheney, Senator Charles Schumer, all of the NY State members of the House of Representatives, Senator Tom Daschle, Senator Edward Kennedy with little or no response. Louise Slaughter, Hilary Clinton and Senator Schumer's office informed me that unless I was homeless or facing utility shutoff that there is nothing they would be able to do to expedite any claim! Even though they can help fix the problem none of them has done anything to address the issue or initiate reform in this area. The Social Security Office of Inquiries and Inspector General's office in MD told me the same thing after doing an investigation with the Buffalo office of Hearings and Appeals. The government obviously does not care, as they are too busy worrying about dropping bombs, invading and investing millions in foreign countries while thousands of us are suffering and dying here at home. Little is heard about the service men and women who are injured and have to go through this same scenario to get their benefits too. Horrible treatment for those who give of their lives to protect our country. We also keep hearing about the 9/11 victims who were killed and that was a horrible thing for sure. What you are not hearing about is all the people who survived but are now disabled and facing a similar fate and nobody cares about them either. We are all being victimized all over again. Keep in mind a country is only as strong as the citizens that live there.

I called the hearings and appeals office again in March 2003 and now they were saying that it would be at least August 2003 before someone would look at my case. I then did some research and found out that I could request copies of the reports of the SSD doctor I was sent to, and the notes of the original claim examiner that denied me, and when I received them, my worst allegations were then confirmed. Even though I have no neurological problems they sent me to a neurologist to examine me so of course he would find nothing wrong with me and say that I did not qualify as disabled. Even though I filed my disability claim based on all physical problems I have as a PRIMARY diagnosis for disability, the examiner purposely wrote depression as a primary diagnosis instead of a secondary one, so of course I

would be denied on that as well. This was after I had already submitted tons of documents to prove my physical disability—reports/documents that he chose to ignore. I also filed a formal willful misconduct complaint to the Office of Inspector General's Office in Washington against the DDS office. In April 2003 I requested an immediate pre-hearing review of my case on the grounds of misconduct and more physical evidence. In order to get that process going I had to fax the hearing and appeals office copies of their own regulations since the person I spoke with in the office had no clue what I was talking about. Once they got all my paperwork to request the review a senior attorney and then a hearing and appeals judge granted my request and then my case was sent back to the DDS office that originally denied my claim. Finally it was seen by a person who actually knew how to do their job. In two weeks my case was approved at the DDS level and then it was selected randomly by computer (7 out of every 10 cases get chosen) for Federal review and it took another three weeks to be processed there. I had to wipe out my life savings and had been living off my pension from a previous employer which is almost gone. Finally one month before I lost everything I had worked for the last 30 years of my life—becoming bankrupt, homeless, and losing my health insurance, all the retro pay just showed up in my bank account on May 6th 2003 exactly 1–1/2 years to the day I originally filed. I then started to receive my SSD benefits—yet even that is not enough to live on for the rest of my life. I actually received my official approval letter on May 26th. I finally won by myself with no lawyer representing me.

To draw awareness to the Social Security Disability System and its flaws I have written an essay called "Social Security Disability Nightmare—It Can Happen To You" and I am using what I learned from my experience with the SSD system to help those still struggling get their benefits—offering educational tools, support and trying to get legislative reform of the SSD system. I am now President/Co-Founder of an organization called the Social Security Disability Coalition which I started with a woman in Nashville TN named Stephanie Varnado. She is a social worker/activist I met in January 2003 after she read a letter I posted on Congress.org. She contacted me, offered her services and we now have a website offering knowledge, support and the framework for legislative reform of the SSD system. We have over 480 members so far and have drafted an online petition with signatures from all over the country which will eventually be presented to the US Government. We hope to one day achieve our goal of complete reform of this outdated abusive system. I am now using my experience to help as many other people as I can—I don't want anyone else to suffer the hell that I just endured. This is an important issue that needs to be addressed now, and only our elected officials with your urging can get the funding and help needed to fix this critical problem. Please spread the word to everyone you can, to get this problem corrected immediately, for all the thousands of others that are currently suffering through this horrible process. I did not ask for this fate and would trade places with a healthy person in a minute. Nobody ever thinks it can happen to them. I am proof that it can, and remember disease and tragedy do not discriminate on the basis of age, race or sex. Anyone of you reading this could be one step away from walking in my shoes at any moment!

I have learned a lot from what happened to me and want the world to learn from my experience before I depart from it. Please share this story with your friends and family and feel free to contact me if you have any questions or comments. Thanks for your precious time to let me share this experience with you.

SOCIAL SECURITY DISABILITY REFORM PETITION

Money is taken out of your paychecks every week for Social Security, and SSD and as of January 2003 the US government GAO has designated Social Security Disability a HIGH risk area for 2003. You could face homelessness, bankruptcy and even death trying to get your benefits when you need them the most. Anyone could suddenly find themselves in a situation where they need to access this fund—such as an accident, catastrophic illness, a victim of a crime, military personnel, veterans and now we have the threat of terrorist attacks—these are unfortunate realities of life. Millions of people across the country become disabled unexpectedly—12,000 per week in this country apply for long-term disability benefits. What happens if your work disability insurance runs out, if you don't have it, or worse yet become unemployed? You will then need to turn to the most mismanaged system in the country—the Social Security Disability System. What you will find is that the current system is set up to kill you so they don't have to pay you. Billions of dollars are being spent in foreign lands and on pork barrel programs, and we want the government to focus on and fix this growing problem here at home now. Here are just a few of the major issues we would like to see addressed:

We are concerned about what transpires from the first point of contact, the filing for benefits, and the final outcome or status. Disability benefits determinations should be based solely on the physical or mental disability of the applicant. Neither age, education or any other factors should ever be considered when evaluating whether or not a person is disabled. Discrimination of this form is highly illegal in this country, yet this is a standard practice when deciding Social Security Disability determinations and should be considered a violation of our Constitution. This practice should be addressed and eliminated immediately. Many people who apply for disability don't "look" sick—you can't tell if a person has cancer, heart disease, diabetes or any other debilitating diseases just by looking at them. We did not chose this fate it was forced upon us! Yet we are treated as "disposable people" and often viewed as lazy or frauds. The extraordinary time it takes to process a claim from the original filing date should be eliminated. Why should we have to become homeless, bankrupt, starve, lose our healthcare coverage, suffer untold stress on top of our illnesses, and even die trying to get our benefits? We are now being told that because of the backlog that these are the only circumstances that anyone will even look at our paperwork now no matter how sick we are. Why should we have to file for welfare, food stamps and Medicaid after we have lost everything due to this backlog—another horrendous process—because of the inadequacies in the Social Security Disability offices and then have to pay Social Services back from our measly benefit checks? Nobody else who files for public assistance has to do that—why are disabled people being discriminated against?

If we provide sufficient medical documents when we originally file for benefits why should we ever be denied at the initial stage, have to hire lawyers, wait years for hearings, go before administrative law judges and be treated like criminals on trial? Too much weight at the initial time of filing, is put on the independent medical examiner's opinion who only sees you for a few minutes and has no clue how a patient's medical problems affect their lives after only a brief visit with them. An even worse problem is the poor review of cases by DDS caseworkers which causes too many unjustified delays and denials. Decisions should be based more on the treating physicians opinions, and medical records. The listing of diseases that qualify a person for disability should be expanded and updated more frequently to include newly discovered crippling diseases such as the many autoimmune disorders that are ravaging our citizens.

We have contributed our hard earned money to this system hoping we would never need it until we were ready to retire. Where is the money going that has been robbed from our paychecks every week? Disease and tragedy does not discriminate based upon age, race, sex or any other factor. The disabled citizens of this nation have been forced to tackle a very daunting system. We challenge you to do the same and expose and correct this problem on a national level. The Social Security Administration, a Federal program, administered by the states will admit that our elected officials have the power to reform the system. Why should we have to become homeless, bankrupt, starve, lose our healthcare coverage, suffer untold stress on top of our illnesses and even die trying to get our benefits? We the undersigned say to all members of the US Government:

For everyone of us that starves, becomes homeless or loses our healthcare during this process—we blame you! For everyone of us who files for bankruptcy during this process—we blame you! For the unfathomable stress and suffering we have inflicted upon us during this process—we blame you! For everyone of us who becomes more ill or worse yet dies during this process—we blame you!

We want to know why our elected officials seem to be ignoring this crisis and doing nothing to reform it? We want to know what, if anything is being done to correct this critical issue that affects millions of sick and dying Americans. Please start taking care of the US citizens living in this country whom elected you into office. It is your duty as elected officials to serve all those that voted you into that office and even those of us who didn't. When the next election comes around we will not forget those who have forgotten us. The government may be trying to rob millions of disabled people from their money, and also neglect us, but remember we millions of citizens still have, and will use our right to vote. A country is only as strong as the citizens who live in it. On behalf of the Social Security Disability Coalition we ask, disabled and healthy Americans alike, that you please do something to fix this serious problem now!

SOCIAL SECURITY DISABILITY COALITION

WHO WE ARE:

The Social Security Disability Coalition has been created because we are concerned about what transpires from the first point of contact, the filing for benefits, and the final outcome or status. We are a group of social services representatives and disabled individuals, who are deeply concerned about the way fragile populations in this country are suffering under the SSDI application process. Our objective is to accumulate a constituency and the data necessary to help implement change in this area. We're currently gathering information that will assist us in tracking trends and other information necessary for a full assessment that can be presented to legislators and media. We are working very rapidly to lay a foundation for change.

OUR GOALS:

We want disability benefits determinations to be based solely on the physical or mental disability of the applicant. Neither age, education or any other factors should ever be considered when evaluating whether or not a person is disabled. Discrimination of this form is highly illegal in this country, yet this is a standard practice when deciding Social Security Disability determinations and should be considered a violation of our Constitution. This practice should be addressed and eliminated immediately.

We want to eliminate the extraordinary time it takes to process a claim from the original filing date. Why should we have to become homeless, bankrupt, starve, lose our healthcare coverage, suffer untold stress on top of our illnesses, and even die trying to get our benefits? We are now being told that because of the backlog that these are the only circumstances that anyone will even look at our paperwork now no matter how sick we are. Why should we have to file for welfare, food stamps and Medicaid after we have lost everything due to this backlog—another horrendous process—because of the inadequacies in the Social Security Disability offices and then have to pay Social Services back from our measly benefit checks? Nobody else who files for public assistance has to do that—why are disabled people being discriminated against?

If we provide sufficient medical documents when we originally file for benefits why should we ever be denied at the initial stage, have to hire lawyers, wait years for hearings, go before administrative law judges and be treated like criminals on trial?

Too much weight at the initial time of filing, is put on the independent medical examiner's and caseworker's opinion of your claim. The medical examiner only sees you for a few minutes and has no clue how a patient's medical problems affect their lives after only a brief visit with them. The caseworker never sees you at all! The decision should be based more on the treating physicians opinions and medical records.

The listing of diseases that qualify a person for disability should be updated more frequently to include newly discovered crippling diseases such as the many autoimmune disorders that are ravaging our citizens.

We want to know why our elected officials are ignoring this crisis and doing nothing to reform it? We hope to raise awareness of this problem and join with our elected officials in implementing legislation that will correct this crisis situation.

SOCIAL SECURITY DISABILITY COALITION—SYSTEM REFORM GOALS

We want disability benefits determinations to be based solely on the physical or mental disability of the applicant. Neither age, education or any other factors should ever be considered when evaluating whether or not a person is disabled. Discrimination of this form is highly illegal in this country, yet this is a standard practice when deciding Social Security Disability determinations and should be considered a violation of our Constitution. This practice should be addressed and eliminated immediately.

All SSD case decisions must be determined within three months of original filing date. When it is impossible to do so a maximum of six months will be allowed for appeals, hearings etc—NO EXCEPTIONS. Failure to do so on the part of SSD will constitute a fine of $500 per week for every week over the six month period—payable to claimant in addition to their awarded benefit payments and due immediately along with their retro pay upon approval of their claim. SSD will also be held financially responsible for people who lose property, automobiles, IRA's, pension funds, who incur a compromised credit rating or lose their health insurance as a result of any delay in processing of their claim, which may occur after the initial six month allotted processing period.

Waiting period for initial payment of benefits should be reduced to two weeks after first date of filing instead of the current five month waiting period.

Prime rate bank interest should be paid on all retro payments from first date of filing due to claimants as they are losing it while waiting for their benefits to be approved.

Immediate eligibility for Medicare/Medicaid upon disability approval with NO waiting period instead of the current 2 years.

If we provide sufficient medical documents when we originally file for benefits why should we ever be denied at the initial stage, have to hire lawyers, wait years for hearings, go before administrative law judges and be treated like criminals on trial?

Too much weight at the initial time of filing, is put on the independent medical examiner's and caseworker's opinion of your claim. The medical examiner only sees you for a few minutes and has no clue how a patient's medical problems affect their lives after only a brief visit with them. The caseworker never sees you at all! The decision should be based more on the treating physicians opinions and medical records.

SSD required medical exams should only be performed by board certified independent doctors who are specialists in the disease that claimant has (example—Rheumatologists for autoimmune disorders, Psychologists and Psychiatrists for mental disorders)

ALL doctors should be required by law to have seminars in proper procedures for writing medical reports and filling out forms for Social Security Disability and SSD claimants. This should be made a part of their continuing education program to keep their license. These seminars should be provided to the doctors free of charge by the Social Security Administration.

All forms used by Social Security for Disability Determination purposes should be made available online for claimants, medical professionals and attorneys. The forms and reports should be uniform throughout the system. One universal form for claimants, doctors, attorneys and SSD caseworkers. Reduce duplication of paperwork. They should be more comprehensive for evaluating a claimant's disability and coordinated with the Doctor's Bluebook Listing of Impairments.

Universal network between Social Security, SSD/SSI and all outlets that handle these cases so claimants info is available to caseworkers handling claims no matter what level/stage they are in the system. Will create ease in tracking status and updating info.

Lost records fine—if Social Security loses a claimants records or files an immediate $1000 fine must be paid to claimant.

Review of records by claimant should be available at any stage of the SSD determination process. Before a denial is issued at any stage, the applicant should be contacted as to ALL the sources being used to make the judgment. It must be accompanied by a detailed report as to why a denial might be imminent, who made the determination and a phone number or address where they could be contacted. In case info is missing or they were given inaccurate information the applicant can provide that information before a determination is made.

Independent medical exams requested by Social Security must only be required to be performed by doctors who are located within a 15 mile radius of a claimants residence. If that is not possible—Social Security must provide for transportation or travel expenses incurred for this travel by the claimant.

The listing of diseases that qualify a person for disability should be updated more frequently to include newly discovered crippling diseases such as the many autoimmune disorders that are ravaging our citizens.

Why should we have to file for welfare, food stamps and Medicaid after we have lost everything due to this backlog—another horrendous process—because of the inadequacies in the Social Security Disability offices and then have to pay Social Services back from our measly benefit checks? Nobody else who files for public assistance has to do that—why are disabled people being discriminated against? There should be immediate approval for social services (food stamps, cash assistance, medical assistance, etc) benefits for SSD claimants that does not have to be paid back out of their SSD benefits once approved.

Audio and/or videotaping of Social Security Disability ALJ hearings and during IME exams allowed to avoid improper conduct by judges and doctors.

Strict code of conduct for Administrative Law Judges in determining cases and in the courtroom. Fines to be imposed for inappropriate conduct towards claimants.

A state listing of FREE Social Security Disability advocates to be provided at time of original filing of claim.

We want to know why our elected officials are ignoring this crisis and doing nothing to reform it?

Statement of Dawn L. Sonders, Williamsburg, Virginia

I am a 43 year old white female who suffers from spinal disease and two knees that both did joint replacements which my doctor will not do at this time because of my age as these types of surgeries only last 10–15 years and each surgery after that is harder on the patient and has to be done more often. I have worked since I was 14 years old, babysitting three boys, cooking their meals, doing their laundry and cleaning their house all for $1.00 an hour. At sixteen, I worked at a fast food restaurant, at 17 while in high school, I worked at the Yorktown Naval Weapons Station as a secretary and other than taking time off to raise my children (which, by the way, is one of the most important jobs in the world as I didn't want my children to grow up without supervision thinking that the world owed them something and it was theirs for the taking. I am proud to say both of my children have done very well in school and have never been in trouble) I have always worked. I am one of those rare people who actually like to work with the public and I even worked for several years as a secretary at a mental hospital (Eastern State Hospital). I was 19 at the time and I worked in the adolescent building (they take children from 13–18 years of age) and even though I was just the "secretary" I did a lot of things with this children (took them shopping, to movies and even took four of them to meet a Dallas Cowboys football player), I was actually one of their rewards as they were on a points system and could turn in their positive points to have me spend time with them. I have worked in either retail or the grocery business for the last 15 years and it is hard work. You are constantly lifting, pushing, pulling, bending, climbing, etc. Which, is probably why I have all the physical problems I do today. When my daughter was 10 months old, I left my husband because he was physically abusive to me and when he threw her across the living room onto the couch, that was it, I left. I moved back to Virginia and while I could have applied for food stamps, and welfare, I didn't because I was able to work and I find a job within 3 weeks and while it barely covered living expenses and I could have still received help I didn't because like I said, I was capable of working and I did. Times were hard and we didn't have much but we survived and are all the better for it. Now that I do need the help and I can not work, my government refuses to give me the help that I and others so desperately need. It doesn't seem to matter what your doctor tell them that there is no way you can work, they keep telling you that you can. Since I am 43, they tell me that I am too young to be disabled, only problem is that someone forgot to tell my body that. I used to play golf about four times a month, go dancing every weekend, go bowling twice a month, and play in pool tournaments—I can no longer do anything of theses things and believe if I could, I would love to be back out there living. Because, I am not living my life, I am surviving. Most people who are disabled and have chronic pain also suffer from depression because we often feel as if our lives our spiraling out of control and there is nothing we can do to stop it. All of the roadblocks that SSDI puts in front of us only makes dealing with our disabilities that much harder. There are days I can only get out of bed to use the bathroom and get something to drink and I have to use my walker to do that. While agree that there are people who take advantage of the system (let's say all those immigrants who receive SSDI for up to seven years just because they can not speak English) I believe that most of the citizens applying for SSDI are truly in need. Please believe me Sir when I tell you that I would rather be living my life they way I used to before becoming disabled rather than be at the mercy of a system who could give a damn what happens to all of us who have worked all of lives because we believe in our government and it was the right thing to do. I am asking you now, for each and everyone of you to do the right thing now. Please make the changes that are so desperately needed in this system. No American Citizen should have to wait for years and years to receive they help they need and worked for. No American should have to lose there homes, cars, possessions and some even lose their marriages to a system who has forgotten and seems to no longer care about, those of us who have made American what it is. I have always been proud to be an American but it would be even better to be a proud American who knows that my government is going to start taking care of those of us who need it first and those who are not American Citizens last. The way the system is set up now, it seems like SSDI makes it so hard because they are hoping that you either give up, die from your disability or take you own life because the fight has become to much and make no mistake, people taking their own lives because of this problem happens everyday. Can each of you go home and sleep tonight knowing that not only could you improve the system but that by improving it you just might

be saving a life? A 23 year old "boy" killed himself because of this very thing, SSDI told him he was too young to be disabled (he also suffered from chronic spinal problems) but I guess he wasn't too young to take his own life. I wish that SSDI had to look the family in the eye and tell them that he was too young to be disabled maybe then, these things would not happen. I thank you for your time and listening to the voice of America and for doing the right thing.

Statement of Diane Stone, Columbus, Ohio

I applied for SSD over a year ago! I haven't worked in over 3 Years due to a back injury. I have been told by my physicians that I am permanently and totally disabled, and yet, I cannot draw SSD. I have worked for over 40 years, paying into this with the understanding that I would be able to draw this if I am disabled for more than a year! Imagine my chagrin!

Getting SSD is like trying to catch a gnat with a tennis racquet—nearly impossible! And, add to this that you make matters worse by forcing people to hire attorneys, who then get a nice chunk of the money, if and when, it is approved!

I urge you to look at this system and look at the people—not just statistics—who are in need, and then do some revamping!

Thank you for your consideration!

Statement of Carolyn U. Sullivan, Ozark, Alabama

I am one of the lucky ones. I applied for SSDI 01/03 and got my back pay 07/03. I am an RN of 25 years. I worked until I literally could not bend over to empty a foley catheter bag. My last night worked made me face the reality that I could no longer safely deliver patient care. you see, I have psoriatic arthritis and fibromyalgia as well as scoliosis, diabetes, and hypertension. my hands were so swollen, painful and weak I could not push the cardiac drugs through the iv tubing to a coding patient. luckily, someone was there who took over for me and the patient lived. I would work 2 nights and spend 2 days in bed literally hardly able to get to the bathroom due to my pain and stiffness. why did I continue to work in such shape? because I have children, and everyone knows that the disability process is filled with long drawn out denials and appeals with a physician who has never seen or examined you deciding your fate. as I stated, I was lucky. as a nurse, I had made sure since treatment was initiated on me over 10 years ago that my physicians documented my condition thoroughly. I harassed my physicians until all my paperwork was submitted to SSDI. I had been told verbally over the phone that I was approved but never received any money. finally I got a contact number in Maryland and a very nice woman there discovered that my benefits had not been issued because a data entry error was made and the computer rejected it. rather than correct it, my claim was thrown on someone's desk and forgotten. this kind lady had my money direct deposited for me in 4 days! and that was over the July 4th holiday. I was, again, lucky; my family of 4 did not starve due to the kindness of relatives and coworkers. right before Christmas we were down to no food, in danger of losing our utilities and the 90.00 per month food stamps didn't feed 4 people very well. my point is this: the disability process must be revamped. in this day of lightening fast computer technology, there is no excuse for 6 months to lapse without a decision. if SSDI is not willing to take the personal physician's medical records as an expert evaluation then a quick perusal by a medical professional is deserved. now, even though I am receiving SSDI, I will not be eligible for Medicare benefits until Jan. 05. until that time I have no health benefits. why the wait? I am curious. is the government hoping we will just die and not cost any more money? our government has really dropped the ball in taking care of its disabled citizens. the millions of miles of red tape and bureaucratic hoopla really must be revamped. I appreciate your consideration in this matter and hope that you still have the ability to put yourself in the other person's shoes; empathy is never misspent! Hoping that you restore my faith in the governmental process

Statement of Vicki L. Sullivan, Philadelphia, Pennsylvania

Dear ladies and gentlemen,

Thank you for the opportunity to submit information related to delays in processing claims for SSDI and SSI through the Social Security Administration. I am writing this on behalf of my 22 year old daughter, Allison, and myself.

We filed the initial claim for SSDI & SSI for my daughter when she was 17½ yrs old per the SSA requirements. That was in 1998. My daughter has Juvenile Rheumatoid Arthritis, Fibromyalgia, Irritable Bowel Syndrome, Gastro Esophageal Reflux Disease, Polycystic Kidney Disease, Polycystic Ovary Disease, Cervical Radiculopathy, Hypertension, Bronchial Asthma, Attention Deficit Disorder and is obese as a result of the cortisone with which she has been treated in the past. Allison has recently been diagnosed with Undifferentiated Connective Tissue Disorder while the Rheumatologist waits for her blood test results to come back positive for Systemic Lupus Erythematosus. We have submitted medical documentation repeatedly and been denied repeatedly. We are now awaiting the hearing with the Appeals Court which we have been told may take another 2–3 years.

As is usual the Family Courts have stated that Allison's father is no longer responsible for supporting her since she has not been classified as disabled under SSA guidelines. I have been 100% financially responsible for her support since 1999. What effect has this had on our little family? First, let me tell you that I am a federal employee who was able to carry Allison as a dependent for health insurance purposes until she reached the age of 22 yrs. Again, without a determination from SSA that she is "disabled" the health insurance company cancelled her health insurance coverage without warning. Since she needed medical assistance and I could not afford it out of pocket, we had to apply for Disability Assistance through the Pennsylvania Dept. of Public Welfare. Allison now has medical coverage and we're having to start over with new doctors. More stress, more fatigue, more frustration for Allison and I as we try to have current med! ical evidence sent to SSA for her Appeal. I'm certain that SSA will use this as a reason to delay even longer.

We live in a small apartment in Philadelphia and have no funds for extras. We barely cover basic living expenses. Recently I was required to have surgery and have been unable to work for 6 weeks for part of which I am NOT receiving pay. Allison's SSDI/SSI claim is becoming critical for she and I and our ability to maintain shelter, etc. but SSA says we have to wait another 2–3 years. How?

I can tell you from personal experience that the SSA has not always taken so long to process/approve claims. Back in 1991, my own claim for SSDI took only 5 months from start to finish. During Allison's claim process I can tell you that SSA has contacted us on numerous occasions stating "we did not receive documents" and they'd require that we re-submit them which we did. Two months later, the same story and again, re-submit. We have been told that SSA sent a request for medical documentation to various doctors but received nothing from them. Later, I discovered that all they did was send a letter and when there was no response from the doctor, they did nothing except to deny the claim. Shouldn't they have to do more than just send a single letter? Don't they have an obligation to actually request AND gather medical documentation when the patient is unable to gather that information themselves?

Your requirement that this statement also be faxed to your office is unreasonable. I spend most of my time trying to figure out how I'm going to keep us in a place to live. If I had the money to buy a fax machine, I probably wouldn't be worried enough about SSA to respond to your inquiry. Please don't disregard this statement simply because I can't fax a copy to your office.

I believe that the Social Security Administration has some fairly serious management issues that need to be resolved before we see more disabled people living on the streets, holding signs saying "Waiting for SSI—Please Help me". It's just wrong that anyone should be in this dire position when we live in the "greatest" nation of the world. President Bush wants $87 billion for the rebuilding of Iraq. Allison & I are only asking for her claim to be timely processed so she can receive the $500 monthly benefit to have the "security" of a place to live and medical care. Is this too much to ask? . . . Apparently.

Thank you for your consideration.

Statement of Carolyn Taliaferro, Jersey City, New Jersey

I taught in an inner city school for 28.5 years, and worked part-time 5 years while going to college. The job was very challenging and I loved working with the children.

In September 1997, there was a major change in the district. We got a new superintendent. The administrative personnel were instructed on how to make life difficult for the senior teachers in the system. This was a financial action. You can hire two new teachers in place of one of the veterans. The turnover in young staff members was very high. It seemed to me that no one cared about the children. I endured the severe harassment until October 9, 1998. On that day, I walked away from my job never well enough to return. I used my sick days and retired in July 2000.

I went to my family doctor in October 1998 and was diagnosed with depression and anxiety. My employer sent me to their doctor, a psychiatrist, to have an evaluation to get a medical leave. While waiting for my appointment, I saw a flyer for a support group run by a therapist. I called the number on the flyer and left a message for the person conducting the group. I began seeing a psychiatrist in February 1999, when I had difficulty sleeping at night. I had been a patient of this doctor from February 1999 until October 2002. I am now being treated by another psychiatrist.

In January 2001, I asked the therapist a tough question "could I ever work again"; the answer was you cannot handle the stress of a job. I knew my teaching days were over, but I thought I could get a part time job. It took me a few months to accept this news. During my March appointment with the psychiatrist, I asked about applying for Social Security. He told me I had a temporary problem. I told him temporary problems do not last three years. I remember that day. I was having a relapse of my depression. I was in hell. I had a bad reaction between the medicine for the tremor and the depression. This doctor had decided to take me off the antidepressant six months before. He did not approve of the therapist sending me to see a neurologist for the tremor in my hands.

I called Social Security and had a telephone interview in April 2001. I decided I needed an attorney because, I was too sick to handle the paper work and I have trouble writing. I also knew I needed some legal muscle to handle my psychiatrist. The firm told me the decision would take a year. They made no guarantee that I would win the case. The firm assisted me in filling out all the forms. I did receive a favorable decision.

In February 2002, I had a Mental Status Exam. The exam was done in my town at a center that does tests for Social Security. The exam was done by the book. It lasted 35 minutes. My depression raged for three or four days after this exam. The Disability Determination Service changed the adjudicator working on my case and I went back to this center for a physical exam in April 2002. The exam consisted of tests. I saw the doctor for about one minute. He asked me about one of my medications, and I gave him a very snappy reply. I did not know this doctor's name.

I remember being approved. It was the end of May 2002. I had come home from shopping and had a bag with eggs. I went to get the mail and going into the house I dropped the bag breaking the eggs. I must say the law firm was very professional in working on my case. I would send a copy of the treatment notes to the lawyer's office and they would forward them on to the local Social Security office by certified mail. They would send me a letter when items were placed in my file at Social Security office. I was even sending in notes up until the day I was approved. The psychiatrist and therapist sent their notes directly to the attorney's office.

I am a person who believes in GOD, and fate. I found a therapist and support group from a flyer in a psychiatrist's office. I happen to find an attorney from an ad in my local paper.

Mr. Chairman, why should the process take 14 months from application to approval for a 55 year old person with my physical and psychological impairments of depression, severe anxiety, PTSD, agoraphobia, asthma and tremors of the hands? Just writing this statement is a very painful experience for me. I have to relive the trauma.

Statement of George J. Thorpe, Cochran, Georgia

Dear Sir:

During the upcoming hearings on the Social Security Administration's management of the Office of Hearings and Appeals (OHA), the Committee will probably hear about how OHA has these initiatives that will improve service to the American public.

It will be clearly evident that almost all of these initiatives will be computer based. Thereby placing every process in the Hearing Offices solely dependent upon a smooth functioning computer environment.

The last attempt at this was an utter failure. It was called Hearing Process Improvement, or HPI. All levels of employees, from Administrative Law Judges down to the Hearing Clerks knew it would not work. Now employees are not even supposed to bring up HPI.

Each Hearing Office has a Computer Assistant, GS–9, which is a clerical position, not a Information Technology position, that is totally responsible for the computer system in each Hearing Office. SSA/OHA Management has strongly been opposed to making these IT positions, even though the SSA field office computers are administered by GS–12 IT employees.

The grade of the OHA Computer Assistants was raised from a GS–8 to a GS–9 only months ago. This was in direct response to a large number of grievances, and, the resulting bad publicity in the national press.

If OHA is going to put all it's productivity eggs in the computer technology basket, it needs to maintain competitive IT positions to attract and keep knowledgeable, dedicated employees.

Please ask them to explain these opposing approaches to OHA's attempts to improving the process.

Respectfully submitted.

Statement of Karen Upperton, Janesville, Wisconsin

01/31/97
TERMINATED EMPLOYMENT AT BLACKHAWK TECHNICAL COLLEGE DUE TO DISABLING ILLNESS
02/02/98
INITIAL SOCIAL SECURITY CLAIM FILED (CHRONIC FATIGUE SYNDROME, MULTIPLE CHEMICAL SENSITIVITIES, FIBROMYALGIA) (Representative: The Shaw Group, Belleville, IL)
08/25/98
INITIAL CLAIM DENIED
09/08/98
RECONSIDERATION FILED
11/12/98
RECONSIDERATION DENIED
11/23/98
HEARING FILED
10/20/99
HEARING BY ARTHUR SCHNEIDER, ADMIN. LAW JUDGE (Madison, WI) (Representative: Atty. Donald Becker, Madison, WI)
06/29/00
UNFAVORABLE DECISION BY ALJ, ARTHUR SCHNEIDER
08/31/00
REQUEST FOR REVIEW OF HEARING DECISION/ORDER (I wanted to prove)

- That my case for disability due to chronic fatigue syndrome was not adjudicated according to SSR99–2p
- Legal counsel witheld pertinent evidence & made misrepresentations concerning evidence
- Evaluation of the evidence by ALJ has inaccuracies, is incomplete, inconsistent & biased
- Doctors did not send complete records

11/20/00
NEW COUNSEL REQUESTED DUPLICATE COPIES OF CASSETTES W/COMPLETE COPY OF ADMINISTRATIVE RECORD (Representative, Attorney Barry Schultz, Evanston, IL)
06/06/02
RECEIVED COPIES OF EXHIBITS AND DUPLICATE CASSETTES
07/12/02
SOCIAL SECURITY DISABILITY REQUEST FOR REVIEW

- Ms. Upperton's Multiple Chemical Sensitivites Impairment is Disabling
- The ALJ's credibility determination is insufficient as a matter of law

- The ALJ failed to properly analyze Ms. Upperton's Chronic Fatigue Syndrome and Fibromyalgia and to address the issues raised by SSR 99–2p
- ALJ did not adequately analyze Ms. Upperton's complaints of Pain
- ALJ failed to analyze claimant's obesity and failed to discuss requirements of Ruling 00–3p
- New Evidence (letters from 3 co-workers, Red Blood Cell Analysis, Sleep Study,
- SAT Scores from 1966, which would prove required 15 point drop in IQ

07/25/02
DENIAL BY APPEALS COUNCIL—REQUEST FOR REVIEW OF THE ADMINISTRATIVE LAW JUDGE'S DECISION ISSUED ON JUNE 29, 2000

- My attorney stated it is always frustrating to receive a decision from the Council so soon after sending the argument, and not receiving any rationale for the denial. However, this is typical of the Appeals Council.
- IS THERE FAIR REVIEW BY THE APPEALS COUNCIL?

05/19/03
FILING OF ADMINISTRATIVE RECORD
07/17/03
MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S COMPLAINT
08/19/03
ATTORNEY FOR FEDERAL GOVERNMENT RECOMMENDS REMAND——The attorney for the Regional Counsel's office, who drafts the briefs for the government, is asking the Appeals Council to agree to remand my case back for a new administrative hearing.
09/10/03
I (THE CLAIMANT) AGREE TO REVERSE DECISION OF ALJ AND REMAND FOR A NEW DECISION—According to Attorney Schultz, the Appeals Council could still issue a favorable decision themselves, or, more likely, they will remand to the ALJ for a new decision.

STRUGGLES THAT MY HUSBAND AND I HAVE EXPERIENCED WHILE WAITING FOR SOCIAL SECURITY DISABILITY INSURANCE

1/31/97
LAST DAY OF WORK AT BLACKHAWK TECHNICAL COLLEGE

- No accommodations were allowed
- My long-term career outlook was now over, since because of my illness I was not able to continue the training program that would give me the Counselor's Certificate.
- I was very sick and in a lot of pain. Loss of cognitive abilities the scariest.
- Almost half our household income was now gone
- We were unable to cover our accrued credit card and medical expenses and had no other option but bankruptcy.

Ongoing
EXPENSES

- Doctors/Specialists
- Allergists, Nutripathic, Acupuncture Doctors, (not covered by insurance)
- Vitamins, other nutrients, non-toxic personal and household cleaning products—$200+/mo. (sensitive to medicines)
- Food (organic) $200+/mo. (just for me—allergic to most foods)
- I couldn't go to doctors who specialize in treating Chronic Fatigue Syndrome, and Multiple Chemical Sensitivities because they are in far away states, and they charge too much. If I'd had Social Security, I could have had my wish to see the doctors I wanted to and possibly I could have had treatments that worked.

5/01
AUTO ACCIDENT—My husband was driving at highway speed over the crest of a hill; and there is a car coming from the opposite direction that all of a sudden turns left in front of us. We hit the car on the passenger's side. These were both big cars, and they were 'totaled'. Thank God we were not.

- bought used automobile $14,000—high interest loan
- medical bills and ambulance $7300 (we still owe on these)
- pain and suffering, including reactivated Chronic Epstein Barr Virus (per lab test), which is mono; and considered one of the causes of CFS

11/01

TOXIC MOLD IN OUR HOME—Tests found a hidden leak behind the bathroom wall, it had leaked into the open return air ductwork system. There was also a leak from the roof.—I'd become so ill that we had to move out.—During that time the aerosolized mold from the ductwork attached to everything in the house. (But our insurance does not cover mold.) We got several quotes, and the expense of cleanup and mold remediation for everything was going to be close to what the house was worth. So we did the minimal (with high interest loans).

- motel room (Jan.—Apr. $3,000) my niece was able to get this price for us
- new roof $5,500
- junk company to take possessions that were ruined by mold, household mold cleaning, carpet cleaning, furniture cleaning—$4,000
- mental and physical suffering—immeasurable

4/03

WE GAVE AWAY OUR HOME AFTER NINE YEARS OF PAYMENTS—Because of the existing mold problem and my hyper-sensitivity to mold, which was causing me increasing illness, we had to get out of that house. I also could not stand it during the months of April and November every year when the whole township was full of smoke from burning leaves.—This mold condition presented a legal problem so we utilized a lawyer who teaches real estate to make sure that everything was revealed to the buyers according to the tests that were done.—There was also an impending assessment of $!0,000 for sewer which would have made the house even harder to sell.

WE HAD TO MAKE A MOVE

- We had no money to hire movers
- We now live in a rental duplex in Janesville.

10/03

WE MAY HAVE TO GO BACK IN FRONT OF THE SAME JUDGE

- I feel this judge is discrimining because I didn't have an apparent physical disability; and possibly because I have Chronic Fatigue Syndrome and Multiple Chemical Sensitivities.
- The ALJ relied primarily on the psychological exam by the doctor hired by the court; rather than my own psychologist or any of my own doctors opinions. Chiropractors were not acceptable medical sources.
- ALJ erroneously failed to consider concessions made by vocational expert on cross-examination
- He also states in his decision that I did not require an air purifier at the hearing. However, it is recorded in the beginning where he himself confirmed that I had my air purifier running and asked me to speak up louder to be heard. I said I could turn the fan down with the purifier still on high.
- If you would like, I will provide a copy of the "Memorandum of Law in Support of Plantiff's Complaint by my attorney

THANK YOU FOR YOUR HELP—This has taken FOREVER!!!

Statement of Glenda Videan, Hilton, New York

About 5 years ago I started having trouble with my neck and shoulder and I was seeing a chiropractor for about 2 years when he informed me there was no more he could do for me. I saw my regular physician and it was discovered there were ruptured disc of vertebrae of disc 3, 4 and 5 in my neck.

In March, 2001 disc 3,4 and 5 of my neck were fused together. Immediately after the operation I started to get excruciating headaches and have had them ever since. I have worked for 44 years. Along with these headaches I also have osteoporosis, osteoarthritis, foot problems in both of my feet, lower back problems, depression, and problems with my left leg. When the problems started with the headaches I started missing a lot of time from work at Eastman Kodak Company. I had worked there for 30 years. I was threatened with termination if I did not retire. So I retired at the age of 58.

I cannot even drive to the other side of the city as I get confused as to where I am at. This is from the medication I am on. I can do some driving in the neighborhood but I have to depend on my husband for everything else. I do not sleep well without medication and even then I only sleep for 3 or 4 hours at a time. I am see-

ing a psychologist for the depression I am feeling. But I am still overwhelmed for the way I feel about my life.

I signed up for Social Security Disability. I am on quite a bit of medication including 3 types of antidpressents, and 2 different type of pain medication and still the pain persists. After a year I finally got a hearing and I was denied. So I put in for an appeal. It has taken over a year to even get an appeal date. I was told I would hear from the Social Security Office at the end of November as to when the date for an appeal might be set up. I think this whole scenario of the time constraints is a bit overwhelming to me at this time.

MILWAUKEE, WISCONSIN 53219
October 2, 2003

Subcommittee on Social Security
Honorable E. Clay Shaw Jr.
Room B–318
Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Shaw:

I, Lucinda L. Vobach, on July 16, 2001, applied to the Social Security Office located at 6251 W. Forest Home Avenue, Milwaukee, WI 53220, claims for disability insurance benefits and for supplemental security.

Case Worker, Gigi Petaway, in the Milwaukee District (414/546–9036 ext.1228) assisted me with the case. Ms. Petaway informed me that I will be denied disability insurance because I did not work enough quarters. Ms. Petaway also stated that I cannot apply for supplemental because I had some money in the bank. Ms. Petaway stated that I should attempt to apply for a claim at a later time. I requested that both claims be put on record. Ms. Petaway was a bit upset. I also requested copies of everything I signed. (Ms. Petaway still upset) I feel that Ms. Petaway did not have any authority to tell me I will be denied without getting the claims on record. She does not make the final decisions. If I did not have Ms. Petaway enter the claims into the computer I would be told I never applied. (Ms. Petaway last name on this date was Gigi Johnson)

Ms. Petaway called to setup appointment for December 20, 2001. To go over my places of employment & to review any check stubs that I may have had. I provided employment history from 1990 to February 19, 2000, which was the last day I worked.

Date of Denial: February 20, 2002
Reconsideration: March 13, 2002
Denial: August 29, 2002

I, Lucinda, submitted a claim for Widow Disability on March 13, 2002. (I could not apply any sooner because I was informed that I had to be 50 years old.) Case Worker on that day was, D. Flessner, who informed me that I should hear within 180 days. (Attorney Larry Farris UAW–GM Milwaukee, WI [414/482–7160] attended meeting with me.)

August 29, 2002 I was denied Widow Disability. (Deceased husband, Dale R. Voback, SSN: 388–54–2194, DOB: 10/19/48)

October 8, 2002 I submitted a request for hearing.

I, Lucinda Vobach, have the following medical conditions: Stress; Depression; Anxiety; Loss of Concentration; bad feelings is this worth it any more; Carpel Tunnel on both arms and hands (since 1987 to present due to work); Knee problems right & left; Bone rubbing & Arthritis on both knees; Arthritis in toes; Right foot & ankle have 2 metal pins & large done spur, which causes swelling if over used; Right leg has a laceration in front just below the knew & just above ankle, due to a car accident going back to 1970's; Varicose veins in both legs, right leg is very bad; psoriasis, due to nerves; rash under both breasts; sinus; high blood pressure; liver keeping good follow up with primary Dr. Holliday; high risk for heart problems.

Surgery Carpel Tunnel: On January 5, 1987 Dr. Tyne performed a right elbow ulnar nerve compression. (The Dr. & I tried all methods before surgery) I returned to work sooner than I expected. I worked for a period of time and then pain returned. I felt the same as I felt before the surgery.

I could not take anymore so went for second opinion.

I went to see Dr. R. Stark (1987). I discussed with Dr. Stark the pain I was continuing to feel. Dr. Stark said he would try & help me. (NOTE: Doctors do not go against each other procedures with the methods or surgery.) At the time I did not

care. Anything would be better than the pain, loss of sleep, & loss of work. Dr. Stark & I agreed to try multiple tests & any other methods before doing surgery.

Surgery—Dr. Stark:

January 17, 1988—Median Nerve Compression

February 14, 1989—Right forearm & wrist (right elbow submuscular transposition)

Improvement was the result of these surgeries, however I lost 25% of usage of arm and wrist. I cannot lift anything more than 20 lbs.

I honestly believe that if I had gone to Dr. Stark initially I would not be experiencing the problems that I have now. I do understand that no surgery is guaranteed. I respect Dr. Stark's decision & methods. I will and have been referring anyone with Carpal Tunnel to see Dr. Stark. Regardless, I now know that a second opinion is beneficial to anyone seeking medical attention.

I, Lucinda, have been trying to keep a job. However, as of February 2000, I couldn't take it anymore. I am a person that gives 100% to whatever I do. I try to give the best that I cam. The harder I push the worse the pain gets, which in turn causes me to miss work. I currently have a difficult time doing the simplest of tasks. I admit you don't think about the loss of movement, sensation or other things until you can't do them anymore.

I feel that when people see me they would automatically notice that something is wrong with me. For I do not walk with a cane, not in a wheelchair, I don't use crutches, nor do I have braces supporting my limbs. However, my problems are more internal. I still experience excruciating pain and sure there are scars from surgeries. Most defeating is that when people make judgments of me stating that things cannot be that bad, if I don't have any apparent disabilities. This assumption of others of me is what kills me because I deal with excruciating pain on a daily basis.

I do know that there are those that have lied about their disabilities and that is why truly disabled people have to go through so much to prove their disabilities.

What are the persons who have to wait 2 or 3 years to get approved. We cannot work! Who is going to pay the mounting bills, the accumulating back rent, buy food, and any pending Attorney fees. This is not even including if you have children! In today's world married couples who have children have to have both parents working just to support the household. Should one parent become ill where they are unable to work this puts increased pressure on the other parent and the children.

The plain & simple fact is that one will lose their jobs over any medical complications or problems. If you are ill, you are unable to work. I speak for myself and others, who I know are faced with similar situations.

People work in order to survive. I am not perfect, however I cannot see myself losing everything (as little as it may be) that I have worked so hard for. If I do lose everything because I cannot prove my disability, what do I have to live for?

Yes, I am angry & I apologize if this has come across in this letter, however I don't know how else to verbalize what I am going through. I hope you can understand.

Please do not disregard this next claim. I am speaking for my late husband, Dale R. Vobach.

He died from Cancer. I, again, am not asking for pity nor sympathy. I wanted it noted that he applied for disability on January 29, 2001. Case Worker was Mrs. Dkgravik time 11:47 DOF.26 (not sure about name spelling)

Dale's illness was noticed in February 1998. Dale stopped working in July of 2000. We were informed that a claimant gets paid from the day they applied once you're benefits are awarded. Dale did not receive benefits from the date of his claim. Dale received benefits only from January 2001 to May 2001. I feel that he only received that amount because he was informed by the doctors that he only had 6 months to live. It is a shame that one has to be on their death bed in order to get their entitlements. I speak out of respect for my husband Dale. Dale worked hard all through out his life, which can be noted by simply looking at his work history. I am definitely not blaming anyone for Dale's illness. Dale gave his illness a good fight and continued to work hard even though he was in pain. He only stopped working when the pain became unbearable.

I would say to anyone who has had a loved one suffer this kind of pain; Do not give up their request, speak out. Do not stop asking questions, you have to keep striving until you reach someone who has the authority to right this wrong.

I, Lucinda, & my late husband, Dale Vobach, did not nor plan to scam the Social Security Administration.

Truthfully Signed by,

LUCINDA L. VOBACH

Statement of Dorothy A. Weatherton, Minden, Louisiana

I'm Ms. Dorothy Annise Weatherton,I slipped & fell 1–7–98 while working @ Isle Of Capri Casino,Inc. [E.T. A.L.] causing me to have a back problem,problems with my knee,bruse on my ride & wrist problems from time to time. 3–3–98 I was fired from IOCC *for not being able to do my security officer job* that I had done for *4½ years everyday, working 8 to 16 hours* before the 1–7–98 accident.

I filed for SSI and/or Disability *March of 1998*, but was denied, so I kept appealing it, but always denied, until my 2nd Hearing with Judge Bundy in Shreveport, La March 23, 2002 he told me to my face during the hearing that *I was granted my full disability* & he would get my paper work to me as soon as posible, but when I got my paper work it had denided on the paper. I requested a copy of the court report and/or tape, I was told it would take about 9 months before they can send me a copy of the court report & it would take about 2 more years before they can see whats really going on with my disability. Ms. Glenis Penn in Shreveport, La sent me a letter saying that I could not get SSI because of money I'm all ready getting, I'm not getting any money @ this time @ all, I'm stretching out my medication as much as I can,taking tylenol like it's candy with the medication I do have that the doctor gave me. It's hard not having any money coming in and some tall skinny girl is out parting with money thats mine!!! Let me back up R & B singer Sparkle {real name} Christine Michelle Baldwin and her wife Cassandra Faye Paul Gipson by way of Florida's gay law stole my drivers license and trying to make people think I'm Sparkle, I have never been that skinny & tall. see enclose picture of Sparkle & How Sparkle & her wife CassanDRA getting mail that belong to me only God know @ this time, I have submitted a complaint to the postal system on that matter!!! Isle Of Capri attorney Walter Salley is know for switching paper work & writing trickery papers, I have submitted a copy of a tape that was left outside my door @ my house, with the IOCC lawyer saying I would lose my Workers Compensation case if I filed new paper work for my medical bills etc., I had a hearing with Honorable Jacqueline K. Taylor 3–99 & 4–8–99, Judge Taylor only ruled on what I had on my workers Comp 1008 form which I asked for "cont disabilty". I tired to file adivice Judge Taylor that IOCC failed to pay in a timely manner etc., but Missy Long & James Braddock would not allow me to file any paper work @ IOCC, so I filed a claim with SSA May '1999. My Medical records from Bossier Medical Center when I was in a wreck June 8, 1996 will show that I was not born with a back problem like Dr. Edwin Simonton said and/or wrote in his medical report. However I subpoened my Medical records from Bossier Medical Center in 1998, but the Isle's attorney Walter Salley subpoened them again in 2001 Bossier could not find the medical records for some odd reason, which is proof what I need to get my disability a few years before Judge Bundy hearing. I heard several people say complain about the same thing, "it's taken to long" those of us who really need SSi and/or Disability we have to wait 2 to 5 years to get it, but people who are faking get theres in 3 months are less!!! I use to work 2 to 3 jobs before I slipped & fell, working with Vanessa Bell Armstrong & JJ @ Jive records, I had my own producation company Destin Dorothy Producation up & going before I slipped & fell, but it's on a stand still right now until I get my settlement money etc., hire some one to move my boxes for me due to the fact I can't pick up over 10 to 15 lbs., no sitting low, nor standing long, I have a "tens unit" I use @ home, etc.. Now I do the best I can like my threpasit told me to do @ home because I don't have any money to go back & forth to threapy. It cost $4.00 to $5.00 a day to park and the cost of gas in ver high!!! I have no lights, gas or water @ the house I lived in, I had to move in with my mom until I get some income coming in. Momz has had open heart surgery and a copule of ballons to open her artery. Dad has arthritis real bad. I can tell u what type of storm whether it's a heavy rain or lite, by the way my body feel. I was trying to do mom a favor but do a little work out the other day when I raked the leaves for her, When i finished I just could move/walk. If anybody was videoing me @ that time it would have shown that I was not faking a back problem. Please do something about the length of time we have to wait to get money that we have worked for thats in the system!!! I have submitted letters etc. to Gov. Mike Foster & Senator Ms. Mary Landru on this issue,they are working on getting the issue solved as fast as possible according to the last letter I received.

I wrote a poem in poetry.com,

Titled: "Fixing To Refix"

Gov. Foster passed the bill saying workers com has to pay employees medical bills

Somebody threw away Supreme Court 65 pages of exhibts

Big G ask #3 who damaged the left eye?
It's plan as day the Isle to Comply!
Former Governor Edwards said it's hell inside!
We may have to get with President Bush to let him know the system need a wouch!
Very Truly.

○