

**CLEARING THE DISABILITY CLAIMS BACKLOGS:
THE SOCIAL SECURITY ADMINISTRATION'S
PROGRESS AND NEW CHALLENGES
ARISING FROM THE RECESSION**

HEARING
BEFORE THE
SUBCOMMITTEE ON SOCIAL SECURITY
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
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**CLEARING THE DISABILITY CLAIMS
BACKLOGS: THE SOCIAL SECURITY
ADMINISTRATION'S PROGRESS AND NEW
CHALLENGES ARISING FROM THE RECESSION**

THURSDAY, NOVEMBER 19, 2009

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

The Subcommittee met, pursuant to notice, at 1:54 p.m., in Room B-318, Rayburn House Office Building, the Honorable John S. Tanner [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Subcommittee on Social Security Chairman Tanner Announces a Hearing on Clearing the Disability Claims Backlogs: The Social Security Administration's Progress and New Challenges Arising From the Recession

November 12, 2009

By (202) 225-9263

Congressman John S. Tanner (D-TN), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, today announced a hearing on Clearing the Disability Claims Backlogs: The Social Security Administration's Progress and New Challenges Arising From the Recession. **The hearing will take place on Thursday, November 19, 2009 in Room B-318, Rayburn House Office Building, beginning at 1:30 p.m.**

BACKGROUND:

This hearing continues the Subcommittee's examination of the Social Security Administration's (SSA) efforts to reduce its unprecedented backlog in disability claims. Due in part to prolonged underfunding, the backlog of disability appeals hearings grew significantly in recent years. By December 2008, more than 768,000 Americans were waiting for a hearing decision—a historic high. Total waiting times for a decision on a claim can extend to three or four years, and testimony before the Subcommittee has included personal stories of those who have lost their homes, depleted life savings, or even died while awaiting a decision.

In FY 2008 and 2009, Congress provided SSA with additional administrative funding to begin to reduce the hearings backlog and address other service delivery shortfalls. This allowed SSA to hire additional Administrative Law Judges (ALJ) and hearing office support staff. SSA has also made eliminating the hearings backlog a top agency priority and has taken measures to increase efficiency and productivity. All of these changes have had an impact: since January 2009, the hearings backlog has begun to slowly decline, and dropped below 723,000 by the end of the fiscal year.

SSA is facing new challenges due to the recession, however, that are threatening backlog reduction efforts. In FY 2009, incoming disability claims increased by nearly 15 percent. Incoming claims are projected to increase by an additional 12 percent in FY 2010 and continue at elevated levels through 2013. Congress provided additional funding for FY 2009 and 2010 in the *American Recovery and Reinvestment Act of 2009* (P.L. 111-5) to help SSA process these increased claims.

Even with this funding, however, the capacity of the state Disability Determination Services (DDS)—which process initial disability claims—cannot be expanded quickly enough to keep up with such steep claims increases. This problem is made worse because a number of states have instituted hiring freezes or furloughs for state employees as a way to address state budget shortfalls, and have not exempted DDS employees even though the DDSs are completely federally funded. As a result, SSA now projects that by the end of FY 2010, more than one million Americans will be awaiting a decision on an initial disability claim, up from about 567,000 at the end of FY 2008. The increase in initial claims also affects the DDSs' capacity to process reconsideration appeals and conduct continuing disability reviews, which are important to program integrity.

The steep increase in new disability claims will also result in more appeals to the hearing level that will challenge the capacity of SSA's hearing offices in the next several years. Without sufficient resources in FY 2011, SSA will not be able to stay on track to eliminate the hearings backlog by 2013 while also addressing the emerging DDS backlog and processing the large volume of claims anticipated in FY 2011.

In announcing the hearing, Social Security Subcommittee Chairman Tanner said, **"I am very pleased to see that Congress' commitment to reducing the Social Security Administration's backlog is finally resulting in an overall decline in pending disability hearings. I commend SSA and its hardworking employees for the success of their efforts. However, SSA is now facing large increases in disability claims due to the recession, and this is threatening to undo the hard-won progress we have made. The rapidly growing backlog at the initial claims level is a particularly serious concern. I am committed to ensuring that SSA aggressively addresses these problems, and that the agency has the tools to ensure that Americans who are in dire need of disability benefits can receive prompt consideration of their claim."**

FOCUS OF THE HEARING:

This hearing will focus on the effect of SSA's unprecedented backlog in disability claims on applicants with disabilities, and the agency's efforts to address these challenges, including SSA's recent progress in reducing its hearing backlog and its plans for addressing the emerging backlog at DDSs. The hearing will also examine the impact of the recession on disability claims processing, including projected claims increases, and the need for adequate resources to reduce the backlogs and adjudicate recession-driven claims.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://democrats.waysandmeans.house.gov>, select "*Committee Hearings*". Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, December 3, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and **MUST NOT** exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

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

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

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

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

Chairman TANNER. In the interest of time we will begin now. There will be another series of votes in about an hour, is that correct? So we will start.

Thank all of you for being here. This hearing is both timely and important, as you know. Our hearing today focuses on the oversight of the Social Security Administration's efforts to reduce an unprecedented backlog in disability claims. The backlog works a severe hardship, as many of you know, on those who are waiting. I know that all Members have heard from constituents about it.

There is some good news. The hearing backlog has begun to decline from 768,000 to 718,000, partly because of our investment last year that could have been considered overdue. The bad news is the recession is threatening to overtake what gains we have been able to make in the backlog.

The further complicating problem, of course as you know, is the state Disability Determination Services (DDS). Some are being furloughed, and some are cutting back. As far as I know, none are being enlarged to deal with this, and so, as it relates to the backlog and to the credibility of the program, the continuing disability reviews, it's clear we have a problem. So, in this hearing we are going to try to highlight some things that will help.

We are delighted that we are able to have this hearing now, because we think it's very, very timely.

[The prepared statement of Mr. Tanner follows:]

Prepared Statement of Chairman Tanner

Today's hearing continues the Subcommittee's ongoing oversight of the Social Security Administration's (SSA's) efforts to reduce its huge and unprecedented backlog in disability claims. In 2000, there were about 310,000 Americans awaiting a hearing on a disability claim. By December 2008, that number had more than doubled, reaching 768,000—a historic high. This has led to long wait times for applicants, sometimes as long as three or four years.

Because applicants often have little or no income while awaiting a decision on benefits, the backlog has caused severe hardship to hundreds of thousands of Americans with significant disabilities. We will hear some of their stories today. We also hear about this issue every day from our own constituents in Tennessee who are often in desperate need.

Today we have good news and bad news to report. First, the good news. After many years of growing backlogs in SSA's hearing offices, we have finally turned a corner. Since the beginning of 2009, the hearings backlog has begun to slowly decline, and is now down to 718,000. This shows that Congress' investment in SSA is starting to pay off. The Subcommittee particularly wants to commend all the dedicated SSA employees who have contributed to this success.

The bad news, however, is that this hard-won progress is now being threatened. Due to the recession, new disability claims have increased significantly. From FY

2008 to FY 2009, these claims increased by almost 15 percent, and they are projected to increase by another 12 percent in FY 2010, and to continue at higher levels for several years.

Congress recognized the need to address this problem last year when it provided funds in the *American Recovery and Reinvestment Act* to help SSA process additional recession-driven claims in FY 2009 and 2010. But even with this funding, the state Disability Determination Services (DDSs), which make decisions on initial disability claims, cannot expand their capacity quickly enough to handle this very large, unexpected workload. This problem has been made worse because a number of states have instituted hiring freezes or furloughs for state employees and have not exempted DDS employees, even though the DDSs are completely funded by SSA.

As a result, another severe backlog is emerging, this time at the initial claims level. By the end of FY 2010, an astonishing 1 million Americans will be awaiting a decision on their initial disability claims—nearly double the number that were waiting just two years before. The initial claims backlog has already topped 780,000 nationwide—a 35 percent increase from this time last year. In my own state of Tennessee, we have seen an even bigger increase, with the initial claims backlog increasing by more than 60 percent since last year.

And because the same DDS employees who evaluate initiate claims also perform continuing disability reviews (CDRs) to determine if current beneficiaries remain eligible, the DDS backlog also poses serious challenges to SSA's program integrity efforts. SSA has fallen far behind in conducting CDRs, even though these reviews have been demonstrated to generate considerable savings.

This situation is clearly unacceptable. SSA has expressed its commitment to addressing the DDS backlog problem, and I understand that today the SSA Commissioner will present to us his plan for expanding the agency's capacity to process initial claims. I look forward to hearing it.

Just as alarming is the potential impact of these recession-driven claims on SSA's hearings backlog. The claims increases the DDSs are now seeing will soon result in increased appeals to the hearing level. If SSA's hearing offices do not have the resources to handle this added workload while still tackling the existing backlog, SSA will not be able to fulfill its goal of eliminating the hearings backlog by the end of FY 2013. In fact, the hearings backlog could begin to rise again.

All of this adds up to very significant challenges for SSA in FY 2011. The agency will be faced with three difficult tasks. First, because the impact of the recession on claims is expected to continue, to keep up with incoming claims, SSA will need to process a much higher number of claims than the agency has in the past. Second, it is imperative that SSA begin reducing the initial claims backlog, which by FY 2011 will have reached more than 1 million. Third, we cannot afford to let the hearings backlog reduction plan falter. We must stay on track with this plan's targets even though the recession will bring increased appeals to SSA's hearings offices.

Today we should pause to celebrate the progress that is being made. But we also need to prepare to move forward with even more conviction. I look forward to hearing about SSA's plans for meeting these challenges. And I look forward to the insights of our other witnesses about what is needed—from Congress and from the Administration—to ensure that we do not backslide.

Millions of Americans pay Social Security taxes every year with the promise that if they become severely disabled, Social Security will be there for them. But the lengthy delays many face when they apply for benefits means that we now are falling short on that promise. I am committed to ensuring that these problems are addressed, so that Americans who apply for disability benefits can receive timely consideration of their cases.

Chairman TANNER. Congressman Filner, thank you for coming. We appreciate your interest in this subject today. I have assurance that Mr. Johnson is on his way, so, in the interest of time, I would like to go ahead and recognize you for the purpose of hearing your testimony. If any of our Members have an opening statement, I would ask unanimous consent that it be placed in the record.

Mr. Filner, you are recognized, sir.

STATEMENT OF THE HONORABLE BOB FILNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FILNER. Thank you, Mr. Chairman. I appreciate the opportunity to be here, and your timeliness in holding this hearing. As bad as those backlog statistics that you mentioned are, I think that certainly in my state of California, the backlog may be understated, due to several policies in California that are being implemented, to hide that backlog. I think we need to take action on that.

You guys have, I think, all read the Inspector General reports, and he is going to—he is here today. On March 24th, he testified before the Subcommittee that since January 1st of this year, California's initial claims pending have increased by 9.7 percent, and its reconsideration claims pending by 6.1 percent, as a result of the increased applications and state furloughs.

Unfortunately, since the March 24th Subcommittee hearing, the situation has continued to deteriorate, in California especially, now that the California Disability Determination Services workers are furloughed three days a month.

In a report, in fact just released yesterday, a review by the inspector general shows that the rate of increased applications continued to grow through fiscal year 2009, totaling about 15 percent above the previous year. The growth in new claims has outpaced the DDSs ability to keep up with the new workload.

By the end of fiscal 2009, the number of initial cases pending had grown, as you said, to almost 770,000, about 38 percent higher than the end of fiscal year 2008. Social Security plans to spend \$2 billion in fiscal year 2010 on DDS operations, and expects the DDSs to process almost 4 million claims.

But state furloughs have had an effect on that ability to process. There are nine states, as I understand it, furloughing or considering furloughing the DDS employees for fiscal year 2010, which will result in a significant shortfall of capacity. The OIG expects approximately 69,000 disability cases to be delayed in processing over the next year.

This wait will result in about \$162 million in benefits that will not be paid to disabled beneficiaries during this period that would have been paid, had the furloughs not occurred, and, of course, these states will lose over \$39 million in Administration funding from Social Security because the employees are furloughed.

Now, what doesn't show up in the statistics—in fact, I believe there is a deliberate attempt in California to hide the impact of the furloughs—for example, prior to the furloughs, DDS assigned all initial and reconsideration cases to line unit examiners within 24 to 48 hours. In September 2009, California DDSs began, as they call, staging initial and reconsideration claims.

What this meant was the assigning of a case to a fictional examiner. Those cases are, in essence, a backlog although I don't think they're counted in a backlog. Those cases are simply set aside with no development initiated, until some later point, when they can be assigned to a real person.

California has, in just the last two months, has a staged case category of 15,000 cases. The increased backlog and decreasing work hours because of the furlough have also led to California DDS reinterpreting a Federal regulation that allows cases to be closed, and

denied when a claimant fails to pursue or cooperate with the processing of their claim. This is a change in the state DDS policy from the pre-furlough situation.

Employees of California DDS have been instructed to close and deny claims for disability benefits if, within 20 days of receiving the case, if the claimant fails to complete and return a long, detailed form known as a function report. This form has a supplement which requires the claimant to find a third party to complete a portion of the form. This is a 25-page form, and if it's not in the file case within 20 days, the DDS workers are pressured to close and deny the case without any further case development.

So, the statistics show "case closed." This is despite the fact that the very nature of these disabilities—they can't complete the task in 20 days. These forms are sent to homeless claimants, cancer patients, illiterate claimants, even blind claimants. Their inability to complete these forms is resulting in denial of benefits without a substantive disability determination. This is criminal, in my view.

And, under the pre-furlough days, the workers would go out and help the people develop their claims, help them with this 25-page form. One branch—and I have talked to people in branches all over the state, by the way, Mr. Chairman, I would be happy to provide documentation to your staff of the situation—one branch in Northern California reported that 30 percent of their cases had been closed in this manner. Another California branch, an internal quality review, showed that the quality was at 60 percent, meaning 40 percent of the cases reviewed contained significant errors.

A study of the last three fiscal years on quality reveals a significant decline in case accuracy. Since the inception of the furloughs, the quality has twice dipped below the Federal minimum threshold of 90 percent.

Mr. Chairman, I think the Social Security Administration has some recourse in this. They have asked governors not to do the furloughs. By the way, the furloughs do not save money. Let me make sure everybody understands that. If you furlough a case worker, the Federal pay is just not made. The state doesn't save any money. In fact, the state loses its administration fee for that.

We have begged Governor Schwarzenegger to not do it, but he apparently wants all the workers through the state to be furloughed together, even though it doesn't save them any money, it's costing, I think, thousands of claimants to lose their beneficiary.

I have written a bill, Mr. Chairman, which I will introduce shortly, which tries to deal with the situation. Current Federal law allows the Social Security Administrator to federalize DDS employees if a state "substantially fails" to live up to its responsibility to process claims. My bill, the Don't Delay Services Act, is intended to prevent the state furloughs in this situation. My bill would deem furloughs of DDS employees a substantial failure, triggering the provision of existing Federal law that allows SSA to federalize DDS.

There are some costs and other implications of that. But I think it ought to be studied, get the cost figures, and tell the states that if they don't do this properly, they're going to be federalized. I hope the committee will look at that legislation.

I appreciate the opportunity to be here today.

[The prepared statement of Mr. Filner follows:]

**Prepared Statement of The Honorable Bob Filner,
A Representative in Congress from the State of California**

Mr. Chairman, Thank you for allowing me to testify today before the House Ways and Means Subcommittee on Social Security. I appreciate the opportunity to tell the Subcommittee Members about how state furloughs are impacting my home state of California. I am also interested in letting you know about legislation that I will soon introduce to address this issue.

I understand that the Subcommittee has held hearings on this important issue already. In March, you heard from many distinguished witnesses, including the Social Security Administrator, Michael Astrue, and Inspector General, Patrick O'Carroll.

As you know, Mr. O'Carroll has written several reports about the impact of state furloughs and hiring freezes on disability claims processing. On March 24th, he testified before the Subcommittee that: *"Since January 1, 2009, California's initial claims pending have increased by 9.7 percent and its reconsideration claims pending by 16.1 percent as a result of increased applications and the State furloughs."* Unfortunately, since the March 24th Subcommittee hearing, the situation in California has only gotten worse.

While some states have exempted Disability Determination Service (DDS) employees from the furloughs at the urging of the Social Security Administration, the State of California has not exempted DDS employees. This is despite the fact that DDS employee salaries are fully funded by the Federal Government.

The unnecessary furloughs for California DDS employees are pushing back the decisions on individuals' benefits by months and harming thousands of disabled residents who are needlessly waiting for their claims to be processed. A new report issued by the Inspector General estimates that 53,136 cases will be delayed in 2009 as a result of the State of California's furloughs!

The furloughs are also impacting state DDS employees by reducing their salaries, making it harder for families to make ends meet. Since July 10th, State of California employees have been furloughed 3 days per month for a total of at least 36 days in 2009. These 3 furlough days translate to an approximate 13.8% reduction in monthly pay.

Finally, furloughing DDS employees is actually making the State of California's budget crisis worse because the state has to pay benefits until the federal claim is approved and the state is forgoing income tax revenue from furloughed employees.

Governor Schwarzenegger's insistence on furloughing DDS employees is not helping the people of California, not helping the State of California solve its budget crisis, and is simply an indefensible and illogical policy!

Earlier this year, the Social Security Inspector General released a report outlining several options for addressing the crisis, including working with States to stop DDS furloughs, transferring work to other disability examiners and/or hiring private contractors, and federalizing the DDS.

To date, Vice President Biden and others have succeeded in working with many states to ensure that DDS employees are exempted from furloughs. Unfortunately, the State of California and other states have ignored the facts and continue to furlough DDS employees.

That is why I think it is time for Congress to consider other options to stop the state furloughs.

Current federal law allows the Social Security Administrator to federalize DDS employees if a state "substantially fails" to live up to its responsibilities to process claims. I will soon introduce The Don't Delay Services Act, which is intended to prevent state furloughs of DDS employees.

My bill would deem furloughs of DDS employees a "substantial failure," triggering the provision of existing federal law that allows SSA to federalize DDS. As drafted, the Don't Delay Services Act would not change any provisions of federal law concerning the rights and protections of these workers.

I understand that federalizing DDS employees is not a perfect solution. However, in passing the legislation, Congress would be sending a wake-up call to Governor Schwarzenegger. As the Subcommittee continues to work to eliminate the disability claims processing backlog, I hope the Subcommittee will consider my bill.

Thank you again for allowing me to testify before the Subcommittee.

Chairman TANNER. Thank you, Mr. Filner. We will take your testimony to heart and under advisement, and we will be back with you.

Mr. FILNER. I thank you. Again, I have documentation for your staff of this.

Chairman TANNER. If you could give that to the Subcommittee staff, that would be great. Thank you very much.

Mr. Johnson, in the interest of time we decided to hear Mr. Filner's testimony. Would you like to give your opening statement now?

Mr. JOHNSON. Can I?

Chairman TANNER. Yes, sir. Absolutely, you can.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, Republicans and Democrats alike on this committee have long worked together to make sure Social Security has the resources it needs to effectively administer their benefit programs. During the last two fiscal years, Social Security received funding at levels higher than the President's request, along with an additional \$1 billion to build a new computer system center, and to process rising numbers of claims for disability benefits.

Today, Social Security is going to, again, report to taxpayers what return they are getting on their money. Here, we will see some long overdue good news on the appeals front. Hearing offices have increased productivity, and this has resulted in lower wait times for those who have been waiting well over a year for a decision.

Beyond addressing today's service delivery challenges, lasting returns on investment depend on Social Security modernizing its technology, infrastructure, and consistently addressing program waste, fraud, and abuse, including conducting continuing disability reviews in order to save billions in program dollars and build taxpayer confidence. So, I will be listening for real progress in those areas.

Although clearing disability backlogs is important, today marks the fourth hearing of this Subcommittee this Congress, and the third hearing on backlogs, while we continue to ignore the fiscal challenges that Social Security faces. In August, the Congressional Budget Office reported that Social Security cash surpluses will turn into cash deficits in the next two years, and that the disability insurance trust fund will be unable to pay full promised benefits in just nine years.

President Obama expressed his commitment to advance Social Security reform, and we know the sooner we act, the better it is.

Further, we have had no hearings on other key agency challenges, including the ongoing problem of identity theft and Social Security number misuse by those attempting to work illegally in this country. I hope this committee will turn to those issues, on a bipartisan basis, as soon as possible, and examine the options for change and solutions.

I thank the witnesses for joining us today, and thank you, Mr. Chairman, for allowing me to make this comment.

[The prepared statement of the Honorable Sam Johnson follows:]



**OPENING STATEMENT OF RANKING MEMBER SAM JOHNSON
WAYS AND MEANS SUBCOMMITTEE ON SOCIAL SECURITY
HEARING ON CLEARING THE DISABILITY CLAIMS BACKLOGS
NOVEMBER 19, 2009**

(REMARKS AS PREPARED)

Republicans and Democrats on this Committee have long worked together to make sure Social Security has the resources it needs to effectively administer their benefit programs. During the last two fiscal years Social Security received funding at levels higher than the President's request, along with an additional \$1 billion to build a new computer center and to process rising numbers of claims for disability benefits resulting from the recession.

Today Social Security will again report to taxpayers what return they are receiving on their substantial investment.

I understand we'll hear some long overdue good news on the appeals front. Hearing offices have increased productivity and this has resulted in lower wait times for those who have been waiting well over a year for a decision on their appeal.

Beyond addressing today's service delivery challenges, lasting returns on investment depend on Social Security modernizing its technology infrastructure and consistently addressing program waste, fraud and abuse, including conducting continuing disability reviews, in order to save billions in program dollars and build taxpayer confidence. So I will be listening for real progress in these areas as well.

Although clearing disability backlogs is important, today marks the fourth hearing of this subcommittee this Congress and the third hearing on backlogs while we continue to ignore the fiscal challenges Social Security faces.

In August, the Congressional Budget Office reported that Social Security cash surpluses will turn into cash deficits in the next two years and that the Disability Insurance Trust Fund will be unable to pay full promised benefits in just nine years. President Obama has expressed his commitment to advance Social Security reform and we all know the sooner we act to protect and strengthen Social Security, the better.

Further, we've had no hearings on other key Agency challenges including the ongoing problem of identity theft and Social Security number misuse by those attempting to work illegally in this country.

So I hope this Subcommittee will turn to these issues on a bipartisan basis as soon as possible to examine options for change and find solutions.

I thank the witnesses for joining us today and presenting their testimony.

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Chairman TANNER. Yes, sir. Thank you. Our second panel is the Commissioner, Mr. Astrue, who was sworn in on February 12, 2007 for a 6-year term. Commissioner, you have a long biography here, a highly successful biotechnology lawyer, I see. I don't know, maybe we could use some expertise around here, but, anyway, we're delighted you're here. Without any further ado, I will recognize you, sir, and, if I may, ask for your complete statement to be

put in the record. If you could hold your oral comments to five minutes, we would appreciate it.

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

Mr. ASTRUE. Yes, Mr. Chairman. I have a longer statement for the record, and I will make a brief oral statement.

Mr. Chairman, Mr. Johnson, Members of the Subcommittee, thank you for this opportunity to discuss our progress in driving down the hearings backlog and in managing the emerging backlog at the DDSs.

Overall, the news is good. For my first 22 months, we steadily reduced the rate of increase in pending hearing cases. We hit the turning point this past January. In every month since then, the number of pending cases has dropped. The rate of decline is accelerating in the last three months, we reduced the hearings backlog by a greater percentage than we did in the previous seven months.

We have steadily reduced the number of cases that have waited the longest. In fiscal year 2007, we started by resolving virtually all 65,000 cases pending over 1,000 days. This fiscal year we are ahead of schedule in resolving over 135,000 cases pending 825 days or longer.

Mathematically, our targeted effort with older cases meant that average processing time remained artificially high for a while, but that figure is also starting to drop now. Since June, we have kept it below 500 days, and last month it was 446 days.

Moreover, the average processing time for our most backlogged offices is coming down faster than for other offices. In February 2007, the average processing time for Atlanta was 852 days, and we had 6 offices with processing times between 650 and 820 days. Last month, our most backlogged office was Dayton, at 651 days.

Let me be clear that 651 days for a hearing is not acceptable, but shortly, such performance will be a disturbing piece of history. By the middle of next year, seven new offices will open in Michigan, Ohio, Georgia, North Carolina, and Indiana, our five most congested states. With plans for 25 new hearing offices, 7 new satellite offices, and scores of office modifications and expansions, we are adding the capacity for the cases that continue flooding in.

Our hearing offices should also be very proud of their three consecutive years of greatly improved productivity. Without that achievement, we would not have reduced the backlog this past year.

We have a number of ways to track productivity, but an important bottom-line measure is the percentage of Administrative Law Judges who reach our expectation for a minimum annual disposition of 500 cases. That number is steadily increasing each year. In 2007, 46 percent of our judges reached that level. In fiscal year 2009, 71 percent reached that level. That individual success is also a team success. Each judge now receives support from a recent high average of 4.6 support staff per judge.

Success comes from hard work, better systems, better training, and better business processes. We designed National Hearing Centers to quickly help the most beleaguered offices. More and more applicants in remote locations are asking for video hearings, which

are not only more efficient, but also more professional for judges and applicants than holding hearings in motels or other makeshift places.

Improvements at the DDSs also help with backlog reduction. We are fast-tracking more cases for approval in a matter of days: about 100,000 last year; and about 140,000, we project, this year. A new system called e-CAT improves the quality and consistency of decisions. Every state in the nation will have this upgrade before we move from 54 separate COBOL-based systems to begin testing a common state-of-the-art web-based system in April 2011.

Unfortunately for the DDSs, not all the news is good. Case filings are rising faster than we can hire and train new employees, and the number of pending cases is increasing. State furloughs aggravate the problems created by the recession. As nonsensical as it is for states to respond to fiscal crisis by furloughing DDS employees, many of them have done so. I am grateful to Vice President Biden and the many members of this Subcommittee who have helped me persuade some governors not to take this misguided action.

In short, we have made solid progress. We are applying the same thoughtful planning and best practices from our hearing plan to handle the additional initial disability claims. We are expanding our capacity at the initial level. By the end of fiscal year 2010 we expect to have nearly 2,800 more DDS employees than we had at the end of fiscal year 2008, and we are increasing the number of Federal workers who are reviewing these cases. With your support, we hope to beat our target date of 2013 for elimination of the disability backlog, despite all the new cases from this recession.

We understand, too, that we have many other service challenges—from the work CDR issues, to reduced waiting times, clearer notices, better telephone services, and other areas. We are going to do our best to live up to your expectations.

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

[The prepared statement of Mr. Astrue follows:]

**Prepared Statement of The Honorable Michael J. Astrue, Commissioner,
Social Security Administration**

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

Thank you for the opportunity to discuss our progress in driving down the hearings backlog, our strategy to manage the surge of initial disability applications, and our ongoing efforts to improve service delivery and program integrity.

I am proud to report to you today that last year we improved service across the agency, and we are currently maintaining that momentum as we begin fiscal year (FY) 2010.

For nearly 75 years, our programs and responsibilities have continued to change and expand. Our employees worked hard to keep up by creating new systems and streamlining policies and processes that helped us improve productivity by an average of 3 percent each year over the last 5 years. Even though, until recently, we had not received sufficient funding to keep pace with our increased workloads.

Your help in changing this pattern of chronic underfunding came at a most critical time, just as the recession and the aging Baby Boomers were exacerbating our already fragile situation. We greatly appreciate the funding Congress provided in our FY 2009 appropriation and in the American Recovery and Reinvestment Act of 2009 (Recovery Act). Our use of these additional resources demonstrate—to you, to the President, and most importantly, to the American public—that we are a sound investment.

In FY 2009, we processed more retirement, initial disability, and hearing applications than ever before. We increased our average agency-wide productivity by 4.49 percent over FY 2008.

We made solid and sustained progress in eliminating our hearings backlog by reducing both our pending hearings for the first time in a decade and the time applicants waited for a hearing. These accomplishments are all the more impressive considering that, at the same time, we continued to focus on the oldest, most complex, and time-consuming cases.

In FY 2009, we processed over 175,000 more initial disability claims than we had expected to process in that year. We kept the pending level below 800,000 even though we received nearly 400,000 more applications than we had in FY 2008. We also reduced the initial disability claims average processing time by 5 days. We decided the cases of about 100,000 Americans with the most severe disabilities through our Quick Disability Determination and Compassionate Allowance initiatives in about ten days from the date of receipt in the State Disability Determinations Services (DDS).

We launched our new online application, iClaim, in December 2008. This quick, easy-to-use online service helped us deal with the increase in benefit applications. We decreased waiting times in our field offices and on our 800 Number.

During this difficult economic crisis, Americans are turning to us for help more than ever before. In FY 2010, we expect to receive 1.2 million more claims than we received in FY 2008. I weighed the risks of an uncertain budget against the need to sustain our progress and decided to authorize our components to continue hiring and working maximum overtime during the continuing resolution (CR). Therefore, we are using the multi-year Recovery Act funding to help sustain our momentum this fiscal year during the CR. We, nevertheless, are counting on your support to pass the President's full FY 2010 budget. This budget will help sustain the substantial progress made in the past year.

Plan to Address Rising Workloads

We have detailed, achievable plans in place to address our soaring workloads, and our employees are dedicated to eliminating the hearings backlog by 2013. They are also poised to keep up with the recession-driven increase in initial disability claims. We will not, however, be able to achieve these goals without timely, adequate, and sustained funding.

In FY 2009, Congress provided us with \$126.5 million above the President's budget request and authorized \$500 million of the Recovery Act funds to help us process our rapidly rising retirement and disability workloads and to reduce the hearings backlog.

In FY 2009, we hired approximately 8,600 new employees, most of them in less than six months, which was our largest hiring effort since the creation of the Supplemental Security Income (SSI) program about thirty-five years ago. Management at every level of the agency responded to this hiring opportunity with the urgency that tough times require. Given all of the conditions and hurdles involved with hiring in the civil service and the obstacles created by some governors and State legislatures in staffing the DDSs, this accomplishment is a great testament to the skill and dedication of everyone involved. Along with that hiring, we also maximized the use of overtime across the agency.

We recognize, though, that merely adding employees, while critical to our success, will not solve all of our problems. Expanding our use of technology is essential—we become more efficient as we automate additional processes. We used Recovery Act funds to purchase additional computers for our new employees, as well as video conferencing equipment for hearings and increased bandwidth to improve the availability of our systems. In January 2009, we took possession of our second data support center, and by May, began moving some of our workloads to the new center. These enhancements allowed us to reduce by two-thirds the time our disability systems were down.

In August 2009, we released a request for proposals to expand our use of health IT to gather electronic medical records. Obtaining medical records is one of the most critical and time-consuming aspects of making disability decisions. Health IT holds the promise to drastically reduce our disability processing times. In January 2010, we will use Recovery Act resources to issue \$24 million in contracts with additional medical providers and networks.

Early in my tenure, I recognized the need for a new, state-of-the-art data center. It is vital that we have a stable, reliable data center to protect the sensitive data we maintain and to achieve our ongoing efforts to improve automation and increase the use of online services. In the Recovery Act, Congress gave us \$500 million to build and partially equip a new, modern data center that will incorporate green building technology. It is a complicated process to plan and build a new data center, and it will not be completed until 2013. We have been planning for the new facility for some time, and in August, 2009, the General Services Administration (GSA)

issued a request for expressions of interest for site selection. We anticipate awarding the contract in early 2010.

In addition to handling our customary work, we played a critical role in issuing \$250 economic recovery payments, ahead of the statutory deadline, to over 55 million beneficiaries who received Social Security and Supplemental Security Income benefits. These payments injected more than \$13 billion into the struggling economy.

Maintaining Momentum to Eliminate the Hearings Backlog

As I have said many times, eliminating the hearings backlog is a moral imperative. In FY 2009, we received over 30,000 more hearing requests than in FY 2008. Despite this increase in the number of requests, I am pleased to report the news is good. For my first 22 months, we steadily reduced the rate at which the number of pending cases increased. We hit the turning point this past January, and in every month since then, the number of pending cases dropped. The rate of decline is accelerating—in the last three months, we reduced the hearings backlog by a greater percentage than we did in the previous seven months. By the end of FY 2009, we had reduced our pending hearings by nearly 38,000 cases.

Morally and operationally, we should focus our attention on applicants who have been waiting the longest for their hearings; no one should have to wait years for a decision on their benefit claim. We have steadily reduced the number of cases that have waited the longest. In FY 2007, we started by resolving virtually all 65,000 cases pending over 1,000 days. In FY 2008, we cleared nearly all 135,000 cases pending over 900 days. In FY 2009, we resolved nearly all 166,000 cases pending over 850 days. For FY 2010, we are ahead of schedule in resolving the over 135,000 cases pending 825 days or longer.

Mathematically, our targeted effort with older cases meant that average processing time remained artificially high for a while, but that figure is also now starting to drop. We have kept it below 500 days since June 2009, and last month it was 446 days. Moreover, the average processing time for our most backlogged offices is coming down faster than for other offices. In February 2007, the average processing time for Atlanta was 852 days, and we had six offices with processing times between 650 and 852 days. Last month our most backlogged office was Dayton, Ohio at 651 days.

While 651 days for a hearing is not acceptable, but shortly such performance will be a disturbing piece of history. By the middle of next year, seven new offices will open in Michigan, Ohio, Georgia, North Carolina, and Indiana, our five most congested states. With plans for 25 new hearing offices, 7 new satellite offices, and scores of office modifications and expansions, we are adding the space we need to address the cases that continue flooding in.

The expansion of our physical infrastructure will allow us to accommodate additional ALJs and support staff. While we still have work to do to reach our goal of **an average processing time of 270 days, we have made significant progress and have a clear plan in place to reach that goal.**

In FY 2009, we hired 147 ALJs and over 1,000 support staff in the Office of Disability Adjudication and Review (ODAR), which is responsible for our hearing offices. In FY 2010, we plan to hire another 226 ALJs and maintain an average support staff ratio of at least 4.5 support staff per judge. By the end of FY 2010, we should have about 1,450 ALJs on board.

The Government Accountability Office recently agreed that under our hearings backlog reduction plan, we should be able to reduce our backlog, but noted that reaching our goal by 2013 is largely dependent on our ability to improve ALJ hiring, availability, and productivity. Sufficient resources and a strong pool of candidates from which to hire additional ALJs are vital elements to our success. Office of Personnel Management (OPM) Director John Berry has worked very closely with us to address our need to maintain a qualified pool of candidates through the ALJ examination process. I am extremely appreciative of John's decision to open a new ALJ register because OPM's continued support is critical for us to achieve our ALJ staffing needs.

ODAR should be proud of its three consecutive years of greatly improved productivity. Without that achievement, we would not have reduced the backlog last year.

We have a number of ways to track productivity, but an important bottom-line measure is the percentage of ALJs who reach our minimum annual disposition expectation of 500 cases. The number of ALJs, who reach that level, is steadily increasing. In FY 2007, 46 percent of our ALJs reached that level. In FY 2008, 56 percent reached that level, and in FY 2009, 71 percent reached that level. In fact, last fiscal year 89 percent of the ALJs disposed of over 400 cases. That individual success is a team success because the ALJs need sufficient support staff to prepare

the cases for a hearing and write up the decisions after the hearing has been held. Last year, our ALJs received support from a recent high average of 4.6 support staff per ALJ.

Success has come from hard work, better systems, better training, and better business processes. We designed National Hearing Centers (NHCs) to quickly help the most beleaguered offices. In 2009, we opened three new NHCs, in addition to Falls Church, Virginia; Albuquerque, New Mexico; Chicago, Illinois; and Baltimore, Maryland. In May 2010, we plan to open our fifth NHC in St. Louis, Missouri.

The ALJs in the NHCs hold hearings remotely using video conferencing equipment, providing us the flexibility to better balance pending workloads across the country. We are seeing results in some of the most-backlogged offices that transferred cases to our first NHC in Falls Church, Virginia. Average processing times in Atlanta, Georgia; Cleveland, Ohio; and Flint, Michigan have dramatically improved with the assistance of the NHC. In FY 2009, the NHCs issued over 9,000 decisions.

We continue to expand our use of video technology. We are furnishing more hearing offices with video equipment so offices with available resources can assist offices with the greatest backlogs. More and more claimants in remote locations are asking for video hearings, which are not only more efficient, but also more professional and appropriate for ALJs and claimants than holding hearings in motels or other makeshift places. We are reducing the use of these temporary hearing sites, replacing them with video hearing rooms in field offices and other Social Security facilities. We implemented the Representative Video Project to allow representatives of disability claimants to use their personal equipment to participate in hearings from their own offices.

In addition to processing the most aged cases, we are taking a number of steps to expedite fully favorable decisions. We reinstated the Attorney Adjudicator program to allow our most experienced attorneys in appropriate cases to make on-the-record, fully favorable decisions without a hearing. In FY 2009, attorney adjudicators issued over 36,000 favorable decisions. We have also instituted special Federal Quality Reviewer screening units and a Medical Expert Screening process to help identify cases that we can allow without the need for a hearing.

We identified cases that were likely allowances and electronically transferred them back to the DDSs for further review. As a result of this initiative, the DDSs allowed nearly 15,000 claims in FY 2009, and we were able to dismiss those requests for hearing.

The DDSs will not be able to provide the same level of assistance this year—they will be handling a flood of new initial disability applications. But our backlog reduction plan is not static. We continue to look for new ways to achieve our goals. We are using predictive modeling to help us decide which new techniques will most effectively help eliminate our backlog and improve our business process.

We are testing a new, more sophisticated screening tool to identify cases for senior attorneys to review. We used predictive modeling to help us determine the proper balance between the number of attorneys screening cases and the number who are writing decisions for ALJs. Based on our analysis, we are identifying 100 senior attorneys to work in a virtual screening cadre to review the disability hearing backlog for potential allowances. We believe that this innovative solution using our improved screening methodology and the electronic folder to move work to the members of the virtual unit will identify about 14,600 on-the-record, fully favorable allowances this year. These cases will not require a hearing before an ALJ. This new initiative will allow the DDSs to focus on processing initial disability claims without jeopardizing our progress in reducing the hearings backlog. In addition, we are adding centralized, regional units to pull cases and write decisions to more quickly address emerging issues.

We are working more efficiently in our hearing offices. In FY 2009, we made significant progress to eliminate the remaining paper hearings folders and to transition to an all-electronic environment. In this electronic environment, we are establishing a standardized electronic hearings business process. This process standardizes the day-to-day operations and incorporates best practices for hearings offices nationwide. We began rolling out this process to 30 hearing offices in FY 2009. We will implement it in all hearing offices by the end of FY 2010.

As we increase our capacity to hear and decide cases, we must consider the resulting workload for the Appeals Council (Council). The Council's receipts are outpacing dispositions, with an almost 16 percent increase in receipts in FY 2009 over FY 2008. We expect that receipts will continue to increase by another 12 percent in FY 2010. Last fiscal year, we began preparing for the increase by hiring 16 new administrative appeals judges, 45 new appeals officers, and almost 200 new paralegals and attorney advisers. We revamped the new analyst training course with the goal

of shortening the historic learning curve. The new training curriculum has been a success, and productivity has exceeded expectations for the class of analysts that graduated in July 2009.

In FY 2009, the Council had many successes. It processed over 89,000 requests for review, 7 percent more than it processed in FY 2008. Despite increasing receipts, it exceeded its case processing goal with an average processing time of 261 days, even while eliminating cases over 750 days old.

Since I became Commissioner in 2007, I have repeatedly stated that reducing the hearings backlog is our number one priority, and that is still the case. We have implemented a solid plan and have demonstrated that it is working. With your continued support, I am confident that we will eliminate the hearings backlog by 2013.

Strategy for Unprecedented Increase in Disability Claims

However, we currently face another serious challenge—the flood of initial disability claims resulting from the economic downturn. The unemployment rate affects the number of disability claims we receive, and with the recent unemployment numbers at over 10 percent, the number of our disability applications will peak in 2010 at over 3.3 million. We are using our experience and some of our strategies from the hearings backlog reduction plan to implement a complementary plan to process the additional initial disability claims resulting from the recession.

We expect nearly 700,000 more initial disability claims in FY 2010 than we received in FY 2008. We simply do not have the capacity to process all of the incoming applications with the same timeliness of the past year.

Processing disability claims is our most labor-intensive workload. We cannot address our current challenge without additional staff, particularly disability examiners and medical consultants in the State DDSs. We developed a strategy to increase our capacity and optimize our productivity to return to the pre-recession initial claims pending level by 2013.

The increase in our FY 2009 appropriation and Recovery Act funding allowed us to begin implementing our strategy last fiscal year. We hired 2,600 employees in the DDSs, ending FY 2009 with 1,400 more employees than at the end of FY 2008. While these hires helped us process over 200,000 more disability claims last year than we did in FY 2008, they spent a lot of their time in training and were not fully productive. This year we expect that the additional fully-trained staff will process substantially more cases.

Despite the nearly 17 percent increase in initial disability claims in FY 2009, the DDSs increased productivity by 3 percent, and so far their quality and average processing times are generally holding up well. Average initial disability processing time decreased 5 days to 101 days, and nationally the DDSs achieved the highest level performance accuracy in the past decade.

For the DDSs, not all the news is good. Disability applications are rising faster than we can hire and train, and the number of pending cases is increasing—escalating the pressure on the DDSs. Despite our employees' heroic efforts to process initial disability claims timely and accurately, our pending cases had grown to nearly 780,000 by the end of FY 2009—over 200,000 more cases than at the end of FY 2008. Our pending disability claims could reach as much as 1 million this year. We know this pending level is unacceptable and are working diligently to minimize the increase.

State furloughs aggravate the problems created by the recession. As nonsensical as it is for States to respond to the fiscal crisis by furloughing employees whose salaries and benefits we fully fund, many of them have done so. I have spent a lot of time over the last year trying to educate State officials on the unnecessary and harmful effects of furloughing DDS employees. I have personally spoken to many governors or State officials, and I wrote letters to every governor and to the National Governor's Association. In addition, each of our ten Regional Commissioners has been aggressively pursuing DDS furlough exemptions at the local level.

We have received considerable support from you and the Administration. I am grateful to Vice President Biden and the many Members of this Committee who have helped me persuade some governors not to take this misguided action.

We were successful in gaining exemptions or partial exemptions in several States, like Michigan, Nevada, New York, and Colorado. Other States, such as California, Wisconsin, Ohio, and Hawaii, have ignored our clear logic and have imposed destructive furloughs on our DDS employees. Currently twelve States have implemented furloughs that affect our DDS employees. I know that, like me, you are frustrated by these decisions.

While some States have argued that the furloughs are not affecting their ability to make disability determinations, these assertions are simply not true. For example, California is furloughing DDS employees three days each month. In FY 2010

this decision will delay \$11 million in disability benefits to over 40,000 of California's most vulnerable residents at a time when the State already has one of the highest unemployment rates in the country. There are many clear signs of the deterioration in service. In spite of the hard work of the dedicated DDS employees, the number of initial claims currently pending in California is 22 percent higher than in 2008. The percentage of California cases pending over 90 days has grown. In the first calendar quarter of 2009, California's Initial Claims Performance Accuracy was below the Federal regulatory threshold.

The residents of California should not be penalized for the actions of their officials. We are trying to mitigate the problems in California by deferring 9,000 continuing disability reviews so that the DDS can concentrate on initial applications, maximizing the use of overtime, obtaining medical consultant assistance from another State, and providing Federal assistance with State medical reviews.

As we began developing our strategy to process the additional recession-driven disability claims, we knew that certain States and regions had been harder hit by the recession than others. Since unemployment rates correlate directly with the number of disability claims we receive, we began to take a closer look at the unemployment rates and forecasts of disability receipts at the State level. We are using this information to decide how to allocate our resources—based on not only the current situation, but also on future population and unemployment trends.

In addition, we are analyzing a combination of DDS key indicators to determine a State's ability to keep pace with its current and future receipts. We focus on the indicators that most directly demonstrate the State's ability to handle additional claims, such as how old the cases are, how long they have been pending, the level of receipts, the processing time, the rate at which we are losing our employees, and whether the DDS is under a hiring freeze or furlough. By monitoring these indicators, we can quickly provide assistance to the most overwhelmed States.

This year we will continue to implement our strategy to process the increased receipts. With the President's FY 2010 budget, we plan to add 1,400 new DDS employees. By the end of FY 2010, we expect to have 2,800 more DDS employees on board than we did at the end of FY 2008.

We are using our best practices from the hearings backlog reduction plan to create centralized units—similar to the National Hearing Centers—that will assist States across the Nation. These new units, called Extended Service Teams, will be placed in States that have a history of high quality and productivity and the capacity to hire and train significant numbers of additional staff. In FY 2010, we plan to place 280 new employees in four States (Virginia, Arkansas, Oklahoma, and Mississippi) to help staff the teams that will be able to quickly take cases from the hardest hit States.

We are also expanding our Federal capacity to process cases. We currently have a Federal unit in each of our ten regions and two units in Baltimore that assist the DDSs in processing cases. In FY 2010, we plan to provide 237 additional hires in these units.

In addition to hiring more disability examiners to process the claims, we also need to increase our medical consultant staff to support the examiners. Traditionally, the medical consultants work onsite in the DDSs to review the medical evidence, provide guidance to the examiners on the severity of the applicants' conditions, and, in many cases, sign off on disability determinations.

If we do not have sufficient evidence to make a disability determination, we often send applicants for a consultative examination with a medical professional. These exams can increase the cost and waiting times for a disability decision. It is sometimes challenging to find medical providers with the appropriate specialty necessary for the exam. For example, psychiatry is a specialty that can often be difficult to obtain. We plan to use our video conferencing technology to conduct psychiatric consultative exams remotely. This technology will help us save money and time by reducing the claimants' travel to these exams.

We will continue to enhance our Quick Disability Determination (QDD) and Compassionate Allowances (CAL) initiatives to fast-track cases that are likely allowances. QDD uses a predictive model to identify certain cases that are likely allowances, such as low birth-weight babies, cancer, and end-stage renal disease. CAL allows us to quickly identify applicants, who are clearly disabled based on the nature of their disease or condition. The list of CAL conditions currently contains 25 rare diseases and 25 cancers. We have held five public hearings to obtain critical information to develop and enhance this list of conditions. In July, we held a hearing on Early-Onset Alzheimer's disease, and yesterday in San Francisco, I presided over our latest hearing on schizophrenia. We plan to increase the number of conditions on the CAL list in early calendar year 2010. In 2010, we expect that our enhancements to QDD and CAL will allow us to fast-track about 140,000 decisions for the

most severely disabled Americans while maintaining accuracy. These improvements at the DDSs also help reduce the hearings backlog.

We are also exploring options for expansion of single decision maker (SDM) authority to cases that are identified as QDD or CAL. SDM allows a disability examiner to adjudicate a case without the approval of a medical or psychological consultant.

Another automated tool, the Electronic Claims Analysis Tool (eCAT), is proving to be extremely valuable to the disability decision process. eCAT improves the quality and consistency of our decisions by aiding examiners in documenting, analyzing, and processing the disability claim in accordance with regulations. We expect that the use of eCAT will produce well-reasoned determinations with easy-to-understand explanations of how we reached our decision. This documentation is particularly useful for future case review if an appeal is filed. We are beginning to look at adapting eCAT for use at the hearing level.

In addition to enhancing the documentation, quality, and consistency of our disability decisions, eCAT has been an extremely useful training tool for the many new examiners we are hiring in the DDSs. All states have the training version of eCAT. Training through eCAT is helping new examiners more quickly gain proficiency in processing complicated cases.

We are accelerating the expansion of eCAT since we have determined that it is working well in the DDSs that have piloted it. We have already started rolling it out in eight States, and we are currently planning to roll it out to all DDSs by December 2010.

Every state in the Nation will have this upgrade before we implement the common Disability Case Processing System (DCPS). Currently each of the DDSs has its own unique case processing system, many of them COBOL-based. In April 2011, we will begin beta testing a common, state-of-the-art web-based system that will provide additional functionality and the foundation for a seamless disability process. It will make it easier to implement technology changes and will position us to take advantage of health IT.

For more than a year, we have been piloting the use of health IT to help speed decisions on disability claims. Applicants who have been treated at Beth Israel Deaconess Medical Center in Boston, Massachusetts or at MedVirginia facilities in Richmond, Virginia can authorize their medical records to be transferred electronically to the DDSs. Generally, we receive medical records from these facilities in less than a minute.

In these two pilots, the receipt of electronic medical records has reduced the average DDS processing time to about 48 days, a nearly 50 percent decrease. In fact, we are making medical decisions within 48 hours of taking the claim in 11 percent of the pilot cases.

Using Recovery Act funding, this fiscal year, we are expanding our use of health IT to more health care providers and States. In January, we will award competitive contracts to providers and networks that will give us standard medical data needed to make disability decisions. A key requirement of these contracts is that data must be delivered over the Nationwide Health Information Network that ensures secure transmission of personal health information. We are actively participating in the Department of Health and Human Service efforts to produce technical standards for widespread use, including in our health IT systems.

Improving Service Delivery

We understand, too, that we have many other service challenges—from the work CDR issue that Chairman and Mr. Johnson highlighted last Thursday to prompt telephone service, reduced waiting times, clearer notices, and many other services.

We knew the aging baby-boomers would put pressure on our 800 Number and field offices. As this generation is becoming more comfortable conducting business on the Internet, we must offer more online services to meet their demands and relieve some of the strain on our field offices. In addition, Americans of all ages began turning to us for assistance during this economic crisis. Our online services, automated telephone services, and additional agents answering the 800 Number are providing the public with service options to conduct their business from the comfort of their own homes.

The implementation of iClaim in December 2008, combined with our effective marketing campaign starring Patty Duke, provided an instant spike in both online retirement and disability applications. Online retirement applications increased from 26 percent to 35 percent in less than one month. Online disability applications also increased from 14 percent to 21 percent. We have maintained the increase in Internet claims with online retirement applications currently at 34 percent and disability applications at 22 percent. In FY 2009, over 400,000 more applicants filed

for benefits on the Internet, more than twice as many as the year before.. This increase helped us deal with the additional recession-driven claims and helped us reduce our waiting times in field offices.

Our online applications took the top three rankings in the most recent American Customer Satisfaction Index (ACSI). The ACSI tracks trends in customer satisfaction and provides valuable benchmarking insights of the consumer economy for companies, industry trade associations, and government agencies. Our Retirement Estimator led all scores, iClaim followed closely, and our Medicare Subsidy application came in third place.

This year we are implementing several new projects to improve our current online services and to provide additional online options to the public. In February 2010, we plan to expand the capability of iClaim to allow persons to file for Medicare-only benefits at age 65 if they choose to delay retirement benefits while they continue to work. We plan to increase the number of our online services in Spanish. We will start by creating a Spanish version of our retirement estimator. With enhancements to iClaim and new marketing strategies, we expect to increase the percentage of online retirement applications to 38 percent this year.

Even though we did not market our online disability application when we launched iClaim, online applications for disability have also increased. We expect this positive trend to continue when we release a simplified electronic version of the Adult Disability Report in January 2010. We use this form to obtain basic information on the applicant's medical condition and treating sources. This improvement will reduce the time needed to complete the disability application and improve the quality of the information we receive. We expect to increase the percentage of online disability applications to 25 percent this year.

In October, we began rolling out the first phase of the Appointed Representative Suite of Services. This process allows appointed representatives of disability applicants to view their clients' electronic folders through secure online access. Additional phases of this initiative will provide folder access to more representatives, simplify the process for submitting appeals, and document a representative's appointment. This online service will alleviate workloads in our field offices.

This year we will also pilot a Claims Data Web Service. Each year we receive over 100,000 paper applications and appeals filed by third party organizations, such as representatives, hospitals, and social workers. Our field office employees must manually enter all of this information into our systems. This pilot will allow selected third parties to submit application information electronically to field offices, eliminating the time our employees spend manually keying this data.

Our 800 Number is often the first point of contact the public makes with us. If they are greeted with a busy signal or placed on hold for an extended period of time, they may become frustrated and come into our field offices instead. Last year, we significantly reduced waiting times and busy signals on the 800 Number.

Our 800 Number call volume has been increasing each year, exceeding 82 million calls in FY 2009. To handle the increasing number of calls, we hired about 260 additional telephone agents last year, and we used technology to effectively forecast call volumes, anticipate staffing needs, and better distribute calls across the network. As a result, we improved our speed of answering calls by 25 percent. We answered calls within an average of 245 seconds, the lowest average wait time in 6 years. We also reduced our average busy rate from 10 percent in FY 2008 to 8 percent last year.

As we expect call volumes to increase this year, we plan to hire additional telephone agents to maintain our 800 Number services. To position ourselves for the future, we started exploring click-to-communicate technologies to allow telephone agents to assist users as they use our online services. We started the process to replace our 800 Number system with more-modern technology and began working with GSA to build a new teleservice center in Jackson, Tennessee. The new teleservice center, the first to be opened in more than a decade, will open in 2011.

Even with our efforts to improve our online and telephone service, we have experienced a steady increase in the number of field office visitors. Field offices averaged 806,000 visitors per week in FY 2006, 825,000 in FY 2007, and 854,000 in FY 2008. In FY 2009, we averaged over 866,000 visitors each week.

With the additional funding we received from Congress last year, we were able to add about 1,400 more employees in our front-line operational components and made maximum use of overtime to take claims and answer our 800 Number calls. In addition to processing more claims than ever before, we reduced office wait times despite increasing field office traffic. With the President's FY 2010 budget, we plan to maintain our staffing level and work maximum overtime to minimize wait times and provide the best possible service to the unprecedented number of Americans, who continue to turn to us for assistance in this difficult economic environment.

In addition to using video technology to reduce our hearings backlog, we are exploring ways that it can help us process our initial disability claims, and we are using it in our field offices to connect to persons who live in remote areas or find it difficult to visit a field office. We are piloting video service delivery by using available staff in a less-busy office help other offices that may be overwhelmed with visitors waiting for service. In addition, we are placing video equipment at third-party sites, such as hospitals, community centers, libraries, and Indian reservations to provide field office service.

We continue to pilot self-help computers in our waiting rooms. These computers offer access to our online services. Currently, about 60 offices are testing this service. In addition, we are piloting Social Security TV in some of our field office reception areas. The televisions broadcast information about our programs and services, such as explaining what documents are needed when applying for benefits or a Social Security number. We can tailor the broadcasts to the local demographics, providing information in multiple languages. We currently offer this service in 18 field offices, but we are expanding its use to 150 more offices this year.

Increasing Our Program Integrity Efforts

One of our ongoing challenges is how to effectively balance our important program integrity work with the growing need to serve the public. Both efforts profoundly affect peoples' lives as well as the economic health of the Nation. Sustained, adequate, and timely funding is vital to helping us achieve this balance.

The primary tools we use for ensuring proper payments are continuing disability reviews (CDR), which are work or medical reviews to determine if disability beneficiaries are still disabled, and Supplemental Security Income (SSI) redeterminations, which are reevaluations of the non-medical factors of SSI eligibility.

Recently, however, we have paid the price for the growth in workloads and tight budgets. Resource limitations have reduced the number of CDRs and SSI redeterminations we can handle. We do not want to defer this important work because these reviews help ensure that we pay the right beneficiary the right amount at the right time.

In addition to increasing our capacity to serve the public, the President's FY 2010 budget makes a renewed funding commitment to our program integrity efforts as part of a government-wide initiative to make government more effective and efficient. Specifically, the FY 2010 budget provides \$758 million for our program integrity efforts, an increase of \$254 million from FY 2009. If enacted, this additional funding will assist us in protecting the public's tax dollars.

With the funding proposed in the FY 2010 budget, we can complete a total of 794,000 CDRs, of which 329,000 will be full medical CDRs, and 2,422,000 SSI redeterminations. We estimate that every dollar spent on medical CDRs yields at least \$10 in lifetime program savings.

In FY 2008, our payment accuracy for OASDI was 99.7 percent with respect to overpayments and 99.9 percent with respect to underpayments. For SSI, the rate was 89.7 percent with respect to overpayments and 98.2 percent with respect to underpayments. Clearly, payment accuracy is very high in the OASDI program and with respect to SSI underpayments; nonetheless, we believe we can do better. SSI overpayments accuracy is another story. This is the lowest accuracy rate in the program since its early days. We are committed to improving our payment accuracy and reducing the volume and magnitude of improper payments we make in both programs. I recently appointed an agency executive to enhance our efforts.

CDRs

We initiate work CDRs based on work activity when a beneficiary voluntarily reports that he or she is working, when wages are posted to a beneficiary's earnings record, or when a beneficiary has completed a trial work period. Last year, we completed more than 165,000 work CDRs in our field offices.

Generally, the Social Security Act requires us to conduct medical CDRs on a periodic basis to ensure that only beneficiaries who continue to be disabled receive benefits. In conducting these CDRs, we use one of two methods. We send some cases to the DDSs for a full medical review; others may be completed using the mailer process.

We have seen a rise in our full medical CDRs pending since FY 2002. I must caution that, even with the proposed increase in dedicated funding this year, we project the number of pending full medical CDRs will increase by over 100,000 cases to roughly 1.5 million. We know we need to do better.

We must also ensure that we pay SSI in the correct amounts. One of the ways we ensure accurate payments is by periodically completing redeterminations to re-

view all the non-medical factors of SSI eligibility, such as resource and income levels and living arrangements.

There are two types of SSI redeterminations: scheduled and unscheduled.

Generally we periodically schedule all recipients for a redetermination at least once every six years. Moreover, we target the most error-prone cases each year using a statistical model. We conduct unscheduled redeterminations when recipients report, or we discover, certain changes in circumstances that may affect the SSI payment amount.

In FY 2009, we completed over 1,730,000 SSI redeterminations. This fiscal year, we plan to process nearly 700,000 more redeterminations than last fiscal year.

In addition to CDRs and SSI redeterminations, we have developed other program integrity initiatives that use cost-effective means to help us further manage and protect the programs we administer. Electronic data matching provides a foundation for our ongoing program integrity work. To identify both OASDI and SSI beneficiaries who are no longer eligible for benefits, we match data in our records with over 400 State and local government organizations and 65 Federal agencies.

We are using modern technology in innovative ways to help us detect and prevent payment errors. To maximize our return on investment, we focus on addressing the leading causes of error. For SSI beneficiaries, unreported resources and changes in earnings from work are two significant factors that contribute to payment errors. We have recently expanded two projects targeted to improve our ability to identify bank accounts for SSI applicants and to make it easier and more convenient for beneficiaries to report their wages each month.

The Access to Financial Information project automates our access to financial data. This process allows us to identify and verify bank accounts held by SSI applicants and recipients. We have tested the process in New York, New Jersey, and California.

The President's FY 2010 budget includes up to \$34 million for us to expand this project. We are encouraged by these early results, but there is a lot of work ahead as we expand and continue to develop plans for implementing this project in additional States and accessing data from more financial institutions.

Receipt of wages is another leading cause of SSI overpayments. To make it more convenient and easier for beneficiaries to report wages, we have recently implemented nationally an automated monthly telephone wage reporting process. The process uses both touch-tone and voice recognition telephone technology to collect the wage report. Our software automatically enters the wage data into the SSI system, which is much more efficient than if the beneficiary visited a field office, and we manually enter the report into our system. We are encouraging beneficiaries to use the telephone reporting system.

At the same time, we continue working with the law enforcement community to pursue cases of fraud and abuse in our programs. Through our Cooperative Disability Investigations (CDI) program, a joint venture with the Office of the Inspector General (OIG), DDSs, and State and local law enforcement personnel, we work collaboratively to investigate allegations of fraud and abuse related to initial disability claims. We currently have 20 units in 18 States. We plan to open two new CDI units this year in South Carolina and Missouri. Last year, we estimate that the program yielded an additional \$240 million in program savings. Our Inspector General estimates the CDI program returns \$14 in program savings for every \$1 invested.

Sustaining Momentum Under the President's FY 2010 Budget

Prior to FY 2008, we had been under-funded for 14 straight years by a total of over \$2 billion, and the recession continues to increase our workloads beyond what we projected. We now expect about 100,000 more retirement and 350,000 more disability claims this year than we projected in the FY 2010 President's budget.

Since I became Commissioner, even before the recession hit, I have been informing you that we were facing an avalanche of retirement and disability claims at the same time we were addressing a large hearings backlog. In the past two years, you have heard our pleas and provided additional funding. I greatly appreciate your support.

Recent appropriations have allowed us to hire thousands of new employees and provide the space and equipment they need to serve the public. These new employees are helping us improve our services, but they require extensive training to handle our complex work. This training time delays the positive effect that they will have on our workloads. Thus, our greatest opportunity for success is directly tied to timely, adequate, and sustained funding.

We are acutely aware of the Nation's difficult economic situation, and we take our responsibility very seriously. We have prudently used the additional resources you have provided to make comprehensive improvements to our services to the American

public at a time when they need us most. We have demonstrated sound, yet flexible, planning that we can adapt to the changing economic situation.

Even though we are currently operating under a CR, our Recovery Act funding is allowing us to maintain the momentum we gained in the last year.

For FY 2010, the President proposed a significant investment in us—\$11.6 billion, a 10 percent increase over FY 2009. This increase is essential to maintain our progress. Without it, the hearings backlog will worsen, and we will drown in the flood of additional disability claims.

With the President's FY 2010 budget, we plan to hire a total of about 7,500 employees, which will allow us to maintain our staffing levels in our front-line operational components and add 1,400 employees in the DDSs and 1,300 employees in our hearing offices. We will process nearly 270,000 more initial disability claims than we did in FY 2009. We will minimize the increase in pending initial disability claims, and maintain our course to return the pre-recession pending level by 2013.

We will process nearly 65,000 additional hearing requests and ensure that the hard-earned progress we have made to reduce the backlog is not lost because of the economic downturn. We will remain on track to eliminate the backlog by 2013.

We will make progress on the program integrity workloads that we have deferred processing. Finally, we will continue to modernize our information technology, which will enable us to pursue 21st-century modes of service delivery. All of these investments are critical to ensuring that we can overcome the dual challenges of accurately and efficiently processing our ever-increasing workloads and meeting the public's demand for our services into the future.

In short, we have made solid progress, and hope to beat our target date of 2013 for the elimination of the hearings backlogs despite all of the new cases stemming from the recession. We are committed to working with Congress and the American people to achieve our goals and improve service in the years ahead. With your support, we will successfully overcome our challenges, but it will take a few years, and we will continue to need timely, adequate, and sustained funding.

**Clearing the Disability Claims Backlogs:
The Social Security Administration's Progress
and New Challenges Arising from the Recession**



Statement of

**Michael J. Astrue
Commissioner of Social Security**

Before the

House Committee on Ways and Means

Subcommittee on Social Security

November 19, 2009

Statement of Michael J. Astrue
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Testimony before the House Committee on Ways and Means
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Hearing on Clearing the Disability Claims Backlogs: The Social Security Administration's
Progress and New Challenges Arising from the Recession

November 19, 2009

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

Thank you for the opportunity to discuss our progress in driving down the hearings backlog, our strategy to manage the surge of initial disability applications, and our ongoing efforts to improve service delivery and program integrity.

I am proud to report to you today that last year we improved service across the agency, and we are currently maintaining that momentum as we begin fiscal year (FY) 2010.

For nearly 75 years, our programs and responsibilities have continued to change and expand. Our employees worked hard to keep up by creating new systems and streamlining policies and processes that helped us improve productivity by an average of 3 percent each year over the last 5 years. Even though, until recently, we had not received sufficient funding to keep pace with our increased workloads.

Your help in changing this pattern of chronic underfunding came at a most critical time, just as the recession and the aging Baby Boomers were exacerbating our already fragile situation. We greatly appreciate the funding Congress provided in our FY 2009 appropriation and in the American Recovery and Reinvestment Act of 2009 (Recovery Act). Our use of these additional resources demonstrate – to you, to the President, and most importantly, to the American public - that we are a sound investment.

In FY 2009, we processed more retirement, initial disability, and hearing applications than ever before. We increased our average agency-wide productivity by 4.49 percent over FY 2008.

We made solid and sustained progress in eliminating our hearings backlog by reducing both our pending hearings for the first time in a decade and the time applicants waited for a hearing. These accomplishments are all the more impressive considering that, at the same time, we continued to focus on the oldest, most complex, and time-consuming cases.

In FY 2009, we processed over 175,000 more initial disability claims than we had expected to process in that year. We kept the pending level below 800,000 even though we received nearly 400,000 more applications than we had in FY 2008. We also reduced the initial disability claims average processing time by 5 days. We decided the cases of about 100,000 Americans with the most severe disabilities through our Quick Disability Determination and Compassionate Allowance initiatives in about ten days from the date of receipt in the State Disability Determinations Services (DDS).

We launched our new online application, iClaim, in December 2008. This quick, easy-to-use online service helped us deal with the increase in benefit applications. We decreased waiting times in our field offices and on our 800 Number.

During this difficult economic crisis, Americans are turning to us for help more than ever before. In FY 2010, we expect to receive 1.2 million more claims than we received in FY 2008. I weighed the risks of an uncertain budget against the need to sustain our progress and decided to authorize our components to continue hiring and working maximum overtime during the continuing resolution (CR). Therefore, we are using the multi-year Recovery Act funding to help sustain our momentum this fiscal year during the CR. We, nevertheless, are counting on your support to pass the President's full FY 2010 budget. This budget will help sustain the substantial progress made in the past year.

Plan to Address Rising Workloads

We have detailed, achievable plans in place to address our soaring workloads, and our employees are dedicated to eliminating the hearings backlog by 2013. They are also poised to keep up with the recession-driven increase in initial disability claims. We will not, however, be able to achieve these goals without timely, adequate, and sustained funding.

In FY 2009, Congress provided us with \$126.5 million above the President's budget request and authorized \$500 million of the Recovery Act funds to help us process our rapidly rising retirement and disability workloads and to reduce the hearings backlog.

In FY 2009, we hired approximately 8,600 new employees, most of them in less than six months, which was our largest hiring effort since the creation of the Supplemental Security Income (SSI) program about thirty-five years ago. Management at every level of the agency responded to this hiring opportunity with the urgency that tough times require. Given all of the conditions and hurdles involved with hiring in the civil service and the obstacles created by some governors and State legislatures in staffing the DDSs, this accomplishment is a great testament to the skill and dedication of everyone involved. Along with that hiring, we also maximized the use of overtime across the agency.

We recognize, though, that merely adding employees, while critical to our success, will not solve all of our problems. Expanding our use of technology is essential – we become more efficient as we automate additional processes. We used Recovery Act funds to purchase additional computers for our new employees, as well as video conferencing equipment for hearings and increased bandwidth to improve the availability of our systems. In January 2009, we took possession of our second data support center, and by May, began moving some of our workloads to the new center. These enhancements allowed us to reduce by two-thirds the time our disability systems were down.

In August 2009, we released a request for proposals to expand our use of health IT to gather electronic medical records. Obtaining medical records is one of the most critical and time-consuming aspects of making disability decisions. Health IT holds the promise to drastically

reduce our disability processing times. In January 2010, we will use Recovery Act resources to issue \$24 million in contracts with additional medical providers and networks.

Early in my tenure, I recognized the need for a new, state-of-the-art data center. It is vital that we have a stable, reliable data center to protect the sensitive data we maintain and to achieve our ongoing efforts to improve automation and increase the use of online services. In the Recovery Act, Congress gave us \$500 million to build and partially equip a new, modern data center that will incorporate green building technology. It is a complicated process to plan and build a new data center, and it will not be completed until 2013. We have been planning for the new facility for some time, and in August, 2009, the General Services Administration (GSA) issued a request for expressions of interest for site selection. We anticipate awarding the contract in early 2010.

In addition to handling our customary work, we played a critical role in issuing \$250 economic recovery payments, ahead of the statutory deadline, to over 55 million beneficiaries who received Social Security and Supplemental Security Income benefits. These payments injected more than \$13 billion into the struggling economy.

Maintaining Momentum to Eliminate the Hearings Backlog

As I have said many times, eliminating the hearings backlog is a moral imperative. In FY 2009, we received over 30,000 more hearing requests than in FY 2008. Despite this increase in the number of requests, I am pleased to report the news is good. For my first 22 months, we steadily reduced the rate at which the number of pending cases increased. We hit the turning point this past January, and in every month since then, the number of pending cases dropped. The rate of decline is accelerating—in the last three months, we reduced the hearings backlog by a greater percentage than we did in the previous seven months. By the end of FY 2009, we had reduced our pending hearings by nearly 38,000 cases.

Morally and operationally, we should focus our attention on applicants who have been waiting the longest for their hearings; no one should have to wait years for a decision on their benefit claim. We have steadily reduced the number of cases that have waited the longest. In FY 2007, we started by resolving virtually all 65,000 cases pending over 1,000 days. In FY 2008, we cleared nearly all 135,000 cases pending over 900 days. In FY 2009, we resolved nearly all 166,000 cases pending over 850 days. For FY 2010, we are ahead of schedule in resolving the over 135,000 cases pending 825 days or longer.

Mathematically, our targeted effort with older cases meant that average processing time remained artificially high for a while, but that figure is also now starting to drop. We have kept it below 500 days since June 2009, and last month it was 446 days. Moreover, the average processing time for our most backlogged offices is coming down faster than for other offices. In February 2007, the average processing time for Atlanta was 852 days, and we had six offices with processing times between 650 and 852 days. Last month our most backlogged office was Dayton, Ohio at 651 days.

While 651 days for a hearing is not acceptable, but shortly such performance will be a disturbing piece of history. By the middle of next year, seven new offices will open in Michigan, Ohio, Georgia, North Carolina, and Indiana, our five most congested states. With plans for 25 new hearing offices, 7 new satellite offices, and scores of office modifications and expansions, we are adding the space we need to address the cases that continue flooding in.

The expansion of our physical infrastructure will allow us to accommodate additional ALJs and support staff. While we still have work to do to reach our goal of an average processing time of 270 days, we have made significant progress and have a clear plan in place to reach that goal.

In FY 2009, we hired 147 ALJs and over 1,000 support staff in the Office of Disability Adjudication and Review (ODAR), which is responsible for our hearing offices. In FY 2010, we plan to hire another 226 ALJs and maintain an average support staff ratio of at least 4.5 support staff per judge. By the end of FY 2010, we should have about 1,450 ALJs on board.

The Government Accountability Office recently agreed that under our hearings backlog reduction plan, we should be able to reduce our backlog, but noted that reaching our goal by 2013 is largely dependent on our ability to improve ALJ hiring, availability, and productivity. Sufficient resources and a strong pool of candidates from which to hire additional ALJs are vital elements to our success. Office of Personnel Management (OPM) Director John Berry has worked very closely with us to address our need to maintain a qualified pool of candidates through the ALJ examination process. I am extremely appreciative of John's decision to open a new ALJ register because OPM's continued support is critical for us to achieve our ALJ staffing needs.

ODAR should be proud of its three consecutive years of greatly improved productivity. Without that achievement, we would not have reduced the backlog last year.

We have a number of ways to track productivity, but an important bottom-line measure is the percentage of ALJs who reach our minimum annual disposition expectation of 500 cases. The number of ALJs, who reach that level, is steadily increasing. In FY 2007, 46 percent of our ALJs reached that level. In FY 2008, 56 percent reached that level, and in FY 2009, 71 percent reached that level. In fact, last fiscal year 89 percent of the ALJs disposed of over 400 cases. That individual success is a team success because the ALJs need sufficient support staff to prepare the cases for a hearing and write up the decisions after the hearing has been held. Last year, our ALJs received support from a recent high average of 4.6 support staff per ALJ.

Success has come from hard work, better systems, better training, and better business processes. We designed National Hearing Centers (NHCs) to quickly help the most beleaguered offices. In 2009, we opened three new NHCs, in addition to Falls Church, Virginia: Albuquerque, New Mexico; Chicago, Illinois; and Baltimore, Maryland. In May 2010, we plan to open our fifth NHC in St. Louis, Missouri.

The ALJs in the NHCs hold hearings remotely using video conferencing equipment, providing us the flexibility to better balance pending workloads across the country. We are seeing results in some of the most-backlogged offices that transferred cases to our first NHC in Falls Church,

Virginia. Average processing times in Atlanta, Georgia; Cleveland, Ohio; and Flint, Michigan have dramatically improved with the assistance of the NHC. In FY 2009, the NHCs issued over 9,000 decisions.

We continue to expand our use of video technology. We are furnishing more hearing offices with video equipment so offices with available resources can assist offices with the greatest backlogs. More and more claimants in remote locations are asking for video hearings, which are not only more efficient, but also more professional and appropriate for ALJs and claimants than holding hearings in motels or other makeshift places. We are reducing the use of these temporary hearing sites, replacing them with video hearing rooms in field offices and other Social Security facilities. We implemented the Representative Video Project to allow representatives of disability claimants to use their personal equipment to participate in hearings from their own offices.

In addition to processing the most aged cases, we are taking a number of steps to expedite fully favorable decisions. We reinstated the Attorney Adjudicator program to allow our most experienced attorneys in appropriate cases to make on-the-record, fully favorable decisions without a hearing. In FY 2009, attorney adjudicators issued over 36,000 favorable decisions. We have also instituted special Federal Quality Reviewer screening units and a Medical Expert Screening process to help identify cases that we can allow without the need for a hearing.

We identified cases that were likely allowances and electronically transferred them back to the DDSs for further review. As a result of this initiative, the DDSs allowed nearly 15,000 claims in FY 2009, and we were able to dismiss those requests for hearing.

The DDSs will not be able to provide the same level of assistance this year – they will be handling a flood of new initial disability applications. But our backlog reduction plan is not static. We continue to look for new ways to achieve our goals. We are using predictive modeling to help us decide which new techniques will most effectively help eliminate our backlog and improve our business process.

We are testing a new, more sophisticated screening tool to identify cases for senior attorneys to review. We used predictive modeling to help us determine the proper balance between the number of attorneys screening cases and the number who are writing decisions for ALJs. Based on our analysis, we are identifying 100 senior attorneys to work in a virtual screening cadre to review the disability hearing backlog for potential allowances. We believe that this innovative solution using our improved screening methodology and the electronic folder to move work to the members of the virtual unit will identify about 14,600 on-the-record, fully favorable allowances this year. These cases will not require a hearing before an ALJ. This new initiative will allow the DDSs to focus on processing initial disability claims without jeopardizing our progress in reducing the hearings backlog. In addition, we are adding centralized, regional units to pull cases and write decisions to more quickly address emerging issues.

We are working more efficiently in our hearing offices. In FY 2009, we made significant progress to eliminate the remaining paper hearings folders and to transition to an all-electronic environment. In this electronic environment, we are establishing a standardized electronic

hearings business process. This process standardizes the day-to-day operations and incorporates best practices for hearings offices nationwide. We began rolling out this process to 30 hearing offices in FY 2009. We will implement it in all hearing offices by the end of FY 2010.

As we increase our capacity to hear and decide cases, we must consider the resulting workload for the Appeals Council (Council). The Council's receipts are outpacing dispositions, with an almost 16 percent increase in receipts in FY 2009 over FY 2008. We expect that receipts will continue to increase by another 12 percent in FY 2010. Last fiscal year, we began preparing for the increase by hiring 16 new administrative appeals judges, 45 new appeals officers, and almost 200 new paralegals and attorney advisers. We revamped the new analyst training course with the goal of shortening the historic learning curve. The new training curriculum has been a success and productivity has exceeded expectations for the class of analysts that graduated in July 2009.

In FY 2009, the Council had many successes. It processed over 89,000 requests for review, 7 percent more than it processed in FY 2008. Despite increasing receipts, it exceeded its case processing goal with an average processing time of 261 days, even while eliminating cases over 750 days old.

Since I became Commissioner in 2007, I have repeatedly stated that reducing the hearings backlog is our number one priority, and that is still the case. We have implemented a solid plan and have demonstrated that it is working. With your continued support, I am confident that we will eliminate the hearings backlog by 2013.

Strategy for Unprecedented Increase in Disability Claims

However, we currently face another serious challenge - the flood of initial disability claims resulting from the economic downturn. The unemployment rate affects the number of disability claims we receive, and with the recent unemployment numbers at over 10 percent, the number of our disability applications will peak in 2010 at over 3.3 million. We are using our experience and some of our strategies from the hearings backlog reduction plan to implement a complementary plan to process the additional initial disability claims resulting from the recession.

We expect nearly 700,000 more initial disability claims in FY 2010 than we received in FY 2008. We simply do not have the capacity to process all of the incoming applications with the same timeliness of the past year.

Processing disability claims is our most labor-intensive workload. We cannot address our current challenge without additional staff, particularly disability examiners and medical consultants in the State DDSs. We developed a strategy to increase our capacity and optimize our productivity to return to the pre-recession initial claims pending level by 2013.

The increase in our FY 2009 appropriation and Recovery Act funding, allowed us to begin implementing our strategy last fiscal year. We hired 2,600 employees in the DDSs, ending FY 2009 with 1,400 more employees than at the end of FY 2008. While these hires helped us process over 200,000 more disability claims last year than we did in FY 2008, they spent a lot of

their time in training and were not fully productive. This year we expect that the additional fully-trained staff will process substantially more cases.

Despite the nearly 17 percent increase in initial disability claims in FY 2009, the DDSs increased productivity by 3 percent, and so far their quality and average processing times are generally holding up well. Average initial disability processing time decreased 5 days to 101 days, and nationally the DDSs achieved the highest level performance accuracy in the past decade.

For the DDSs, not all the news is good. Disability applications are rising faster than we can hire and train, and the number of pending cases is increasing - escalating the pressure on the DDSs. Despite our employees' heroic efforts to process initial disability claims timely and accurately, our pending cases had grown to nearly 780,000 by the end of FY 2009 – over 200,000 more cases than at the end of FY 2008. Our pending disability claims could reach as much as 1 million this year. We know this pending level is unacceptable and are working diligently to minimize the increase.

State furloughs aggravate the problems created by the recession. As nonsensical as it is for States to respond to fiscal crisis by furloughing employees whose salaries and benefits we fully fund, many of them have done so. I have spent a lot of time over the last year trying to educate State officials on the unnecessary and harmful effects of furloughing DDS employees. I have personally spoken to many governors or State officials, and I wrote letters to every governor and to the National Governor's Association. In addition, each of our ten Regional Commissioners has been aggressively pursuing DDS furlough exemptions at the local level.

We have received considerable support from you and the Administration. I am grateful to Vice President Biden and the many Members of this Committee who have helped me persuade some governors not to take this misguided action.

We were successful in gaining exemptions or partial exemptions in several states, like Michigan, Nevada, New York, and Colorado. Other states, such as California, Wisconsin, Ohio, and Hawaii, have ignored our clear logic and have imposed destructive furloughs on our DDS employees. Currently twelve States have implemented furloughs that affect our DDS employees. I know that, like me, you are frustrated by these decisions.

While some States have argued that the furloughs are not affecting their ability to make disability determinations, these assertions are simply not true. For example, California is furloughing DDS employees three days each month. In FY 2010 this decision will delay \$11 million in disability benefits to over 40,000 of California's most vulnerable residents, at a time when the State already has one of the highest unemployment rates in the country. There are many clear signs of the deterioration in service. In spite of the hard work of the dedicated DDS employees, the number of initial claims currently pending in California is 22 percent higher than in 2008. The percentage of California cases pending over 90 days has grown. In the first calendar quarter of 2009, California's Initial Claims Performance Accuracy was below the Federal regulatory threshold.

The residents of California should not be penalized for the actions of their officials. We are trying to mitigate the problems in California by deferring 9,000 continuing disability reviews so that the DDS can concentrate on initial applications, maximizing the use of overtime, obtaining medical consultant assistance from another state, and providing Federal assistance with state medical reviews.

As we began developing our strategy to process the additional recession-driven disability claims, we knew that certain States and regions had been harder hit by the recession than others. Since unemployment rates correlate directly with the number of disability claims we receive, we began to take a closer look at the unemployment rates and forecasts of disability receipts at the state level. We are using this information to decide how to allocate our resources – based on not only the current situation, but also on future population and unemployment trends.

In addition, we are analyzing a combination of DDS key indicators to determine a State's ability to keep pace with its current and future receipts. We focus on the indicators that most directly demonstrate the State's ability to handle additional claims, such as how old the cases are, how long they have been pending, the level of receipts, the processing time, the rate at which we are losing our employees, and whether the DDS is under a hiring freeze or furlough. By monitoring these indicators, we can quickly provide assistance to the most overwhelmed States.

This year we will continue to implement our strategy to process the increased receipts. With the President's FY 2010 budget, we plan to add 1,400 new DDS employees. By the end of FY 2010, we expect to have 2,800 more DDS employees on board than we did at the end of FY 2008.

We are using our best practices from the hearings backlog reduction plan to create centralized units – similar to the National Hearing Centers - that will assist States across the Nation. These new units, called Extended Service Teams, will be placed in States that have a history of high quality and productivity and the capacity to hire and train significant numbers of additional staff. In FY 2010, we plan to place 280 new employees in four States (Virginia, Arkansas, Oklahoma, and Mississippi) to help staff the teams that will be able to quickly take cases from the hardest hit States.

We are also expanding our Federal capacity to process cases. We currently have a Federal unit in each of our ten regions and two units in Baltimore that assist the DDSs in processing cases. In FY 2010, we plan to provide 237 additional hires in these units.

In addition to hiring more disability examiners to process the claims, we also need to increase our medical consultant staff to support the examiners. Traditionally, the medical consultants work onsite in the DDSs to review the medical evidence, provide guidance to the examiners on the severity of the applicants' conditions, and, in many cases, signoff on disability determinations.

If we do not have sufficient evidence to make a disability determination, we often send applicants for a consultative examination with a medical professional. These exams can increase the cost and waiting times for a disability decision. It is sometimes challenging to find medical providers with the appropriate specialty necessary for the exam. For example, psychiatry is a

specialty that can often be difficult to obtain. We plan to use our video conferencing technology to conduct psychiatric consultative exams remotely. This technology will help us save money and time by reducing the claimants' travel to these exams.

We will continue to enhance our Quick Disability Determination (QDD) and Compassionate Allowances (CAL) initiatives to fast-track cases that are likely allowances. QDD uses a predictive model to identify certain cases that are likely allowances, such as low birth-weight babies, cancer, and end-stage renal disease. CAL allows us to quickly identify applicants, who are clearly disabled based on the nature of their disease or condition. The list of CAL conditions currently contains 25 rare diseases and 25 cancers. We have held five public hearings to obtain critical information to develop and enhance this list of conditions. In July, we held a hearing on Early-Onset Alzheimer's disease, and yesterday in San Francisco, I presided over our latest hearing on schizophrenia. We plan to increase the number of conditions on the CAL list in early calendar year 2010. In 2010, we expect that our enhancements to QDD and CAL will allow us to fast-track about 140,000 decisions for the most severely disabled Americans while maintaining accuracy. These improvement at the DDSs also help reduce the hearings backlog.

We are also exploring options for expansion of single decision maker (SDM) authority to cases that are identified as QDD or CAL. SDM allows a disability examiner to adjudicate a case without the approval of a medical or psychological consultant.

Another automated tool, the Electronic Claims Analysis Tool (eCAT), is proving to be extremely valuable to the disability decision process. eCAT improves the quality and consistency of our decisions by aiding examiners in documenting, analyzing, and processing the disability claim in accordance with regulations. We expect that the use of eCAT will produce well-reasoned determinations with easy-to-understand explanations of how we reached our decision. This documentation is particularly useful for future case review if an appeal is filed. We are beginning to look at adapting eCAT for use at the hearing level.

In addition to enhancing the documentation, quality, and consistency of our disability decisions, eCAT has been an extremely useful training tool for the many new examiners we are hiring in the DDSs. All states have the training version of eCAT. Training through eCAT is helping new examiners more quickly gain proficiency in processing complicated cases.

We are accelerating the expansion of eCAT since we have determined that it is working well in the DDSs that have piloted it. We have already started rolling it out in eight States, and we are currently planning to roll it out to all DDSs by December 2010.

Every state in the Nation will have this upgrade before we implement the common Disability Case Processing System (DCPS). Currently each of the DDSs has its own unique case processing system, many of them COBOL-based. In April 2011, we will begin beta testing a common, state-of-the-art web-based system that will provide additional functionality and the foundation for a seamless disability process. It will make it easier to implement technology changes and will position us to take advantage of health IT.

For more than a year, we have been piloting the use of health IT to help speed decisions on disability claims. Applicants who have been treated at Beth Israel Deaconess Medical Center in Boston, Massachusetts or at MedVirginia facilities in Richmond, Virginia can authorize their medical records to be transferred electronically to the DDSs. Generally, we receive medical records from these facilities in less than a minute.

In these two pilots, the receipt of electronic medical records has reduced the average DDS processing time to about 48 days, a nearly 50 percent decrease. In fact, we are making medical decisions within 48 hours of taking the claim in 11 percent of the pilot cases.

Using Recovery Act funding, this fiscal year, we are expanding our use of health IT to more health care providers and States. In January, we will award competitive contracts to providers and networks that will give us standard medical data needed to make disability decisions. A key requirement of these contracts is that data must be delivered over the Nationwide Health Information Network that ensures secure transmission of personal health information. We are actively participating in the Department of Health and Human Service efforts to produce technical standards for widespread use, including in our health IT systems.

Improving Service Delivery

We understand, too, that we have many other service challenges – from the work CDR issue that Chairman and Mr. Johnson highlighted last Thursday to prompt telephone service, reduced waiting times, clearer notices, and many other services.

We knew the aging baby-boomers would put pressure on our 800 Number and field offices. As this generation is becoming more comfortable conducting business on the Internet, we must offer more online services to meet their demands and relieve some of the strain on our field offices. In addition, Americans of all ages began turning to us for assistance during this economic crisis. Our online services, automated telephone services, and additional agents answering the 800 Number are providing the public with service options to conduct their business from the comfort of their own homes.

The implementation of iClaim in December 2008, combined with our effective marketing campaign starring Patty Duke, provided an instant spike in both online retirement and disability applications. Online retirement applications increased from 26 percent to 35 percent in less than one month. Online disability applications also increased from 14 percent to 21 percent. We have maintained the increase in Internet claims with online retirement applications currently at 34 percent and disability applications at 22 percent. In FY 2009, over 400,000 more applicants filed for benefits on the Internet, more than twice as many as the year before.. This increase helped us deal with the additional recession-driven claims and helped us reduce our waiting times in field offices.

Our online applications took the top three rankings in the most recent American Customer Satisfaction Index (ACSI). The ACSI tracks trends in customer satisfaction and provides valuable benchmarking insights of the consumer economy for companies, industry trade

associations, and government agencies. Our Retirement Estimator led all scores, iClaim followed closely, and our Medicare Subsidy application came in third place.

This year we are implementing several new projects to improve our current online services and to provide additional online options to the public. In February 2010, we plan to expand the capability of iClaim to allow persons to file for Medicare-only benefits at age 65 if they choose to delay retirement benefits while they continue to work. We plan to increase the number of our online services in Spanish. We will start by creating a Spanish version of our retirement estimator. With enhancements to iClaim and new marketing strategies, we expect to increase the percentage of online retirement applications to 38 percent this year.

Even though we did not market our online disability application when we launched iClaim, online applications for disability have also increased. We expect this positive trend to continue when we release a simplified electronic version of the Adult Disability Report in January 2010. We use this form to obtain basic information on the applicant's medical condition and treating sources. This improvement will reduce the time needed to complete the disability application and improve the quality of the information we receive. We expect to increase the percentage of online disability applications to 25 percent this year.

In October, we began rolling out the first phase of the Appointed Representative Suite of Services. This process allows appointed representatives of disability applicants to view their clients' electronic folders through secure online access. Additional phases of this initiative will provide folder access to more representatives, simplify the process for submitting appeals, and document a representative's appointment. This online service will alleviate workloads in our field offices.

This year we will also pilot a Claims Data Web Service. Each year we receive over 100,000 paper applications and appeals filed by third party organizations, such as representatives, hospitals, and social workers. Our field office employees must manually enter all of this information into our systems. This pilot will allow selected third parties to submit application information electronically to field offices, eliminating the time our employees spend manually keying this data.

Our 800 Number is often the first point of contact the public makes with us. If they are greeted with a busy signal or placed on hold for an extended period of time, they may become frustrated and come into our field offices instead. Last year, we significantly reduced waiting times and busy signals on the 800 Number.

Our 800 Number call volume has been increasing each year, exceeding 82 million calls in FY 2009. To handle the increasing number of calls, we hired about 260 additional telephone agents last year, and we used technology to effectively forecast call volumes, anticipate staffing needs, and better distribute calls across the network. As a result, we improved our speed of answering calls by 25 percent. We answered calls within an average of 245 seconds, the lowest average wait time in 6 years. We also reduced our average busy rate from 10 percent in FY 2008 to 8 percent last year.

As we expect call volumes to increase this year, we plan to hire additional telephone agents to maintain our 800 Number services. To position ourselves for the future, we started exploring click-to-communicate technologies to allow telephone agents to assist users as they use our online services. We started the process to replace our 800 Number system with more-modern technology and began working with GSA to build a new teleservice center in Jackson, Tennessee. The new teleservice center, the first to be opened in more than a decade, will open in 2011.

Even with our efforts to improve our online and telephone service, we have experienced a steady increase in the number of field office visitors. Field offices averaged 806,000 visitors per week in FY 2006, 825,000 in FY 2007, and 854,000 in FY 2008. In FY 2009, we averaged over 866,000 visitors each week.

With the additional funding we received from Congress last year, we were able to add about 1,400 more employees in our front-line operational components and made maximum use of overtime to take claims and answer our 800 Number calls. In addition to processing more claims than ever before, we reduced office wait times despite increasing field office traffic. With the President's FY 2010 budget, we plan to maintain our staffing level and work maximum overtime to minimize wait times and provide the best possible service to the unprecedented number of Americans, who continue to turn to us for assistance in this difficult economic environment.

In addition to using video technology to reduce our hearings backlog, we are exploring ways that it can help us process our initial disability claims, and we are using it in our field offices to connect to persons who live in remote areas or find it difficult to visit a field office. We are piloting video service delivery by using available staff in a less-busy office help other offices that may be overwhelmed with visitors waiting for service. In addition, we are placing video equipment at third-party sites, such as hospitals, community centers, libraries, and Indian reservations to provide field office service.

We continue to pilot self-help computers in our waiting rooms. These computers offer access to our online services. Currently, about 60 offices are testing this service. In addition, we are piloting Social Security TV in some of our field office reception areas. The televisions broadcast information about our programs and services, such as explaining what documents are needed when applying for benefits or a Social Security number. We can tailor the broadcasts to the local demographics, providing information in multiple languages. We currently offer this service in 18 field offices, but we are expanding its use to 150 more offices this year.

Increasing Our Program Integrity Efforts

One of our ongoing challenges is how to effectively balance our important program integrity work with the growing need to serve the public. Both efforts profoundly affect peoples' lives as well as the economic health of the Nation. Sustained, adequate, and timely funding is vital to helping us achieve this balance.

The primary tools we use for ensuring proper payments are continuing disability reviews (CDR), which are work or medical reviews to determine if disability beneficiaries are still disabled, and

Supplemental Security Income (SSI) redeterminations, which are reevaluations of the non-medical factors of SSI eligibility.

Recently, however, we have paid the price for the growth in workloads and tight budgets. Resource limitations have reduced the number of CDRs and SSI redeterminations we can handle. We do not want to defer this important work because these reviews help ensure that we pay the right beneficiary the right amount at the right time.

In addition to increasing our capacity to serve the public, the President's FY 2010 budget makes a renewed funding commitment to our program integrity efforts as part of a government-wide initiative to make government more effective and efficient. Specifically, the FY 2010 budget provides \$758 million for our program integrity efforts, an increase of \$254 million from FY 2009. If enacted, this additional funding will assist us in protecting the public's tax dollars.

With the funding proposed in the FY 2010 budget, we can complete a total of 794,000 CDRs, of which 329,000 will be full medical CDRs, and 2,422,000 SSI redeterminations. We estimate that every dollar spent on medical CDRs yields at least \$10 in lifetime program savings.

In FY 2008, our payment accuracy for OASDI was 99.7 percent with respect to overpayments and 99.9 percent with respect to underpayments. For SSI, the rate was 89.7 percent with respect to overpayments and 98.2 percent with respect to underpayments. Clearly, payment accuracy is very high in the OASDI program and with respect to SSI underpayments; nonetheless, we believe we can do better. SSI overpayments accuracy is another story. This is the lowest accuracy rate in the program since its early days. We are committed to improving our payment accuracy and reducing the volume and magnitude of improper payments we make in both programs. I recently appointed an agency executive to enhance our efforts.

CDRs

We initiate work CDRs based on work activity when a beneficiary voluntarily reports that he or she is working, when wages are posted to a beneficiary's earnings record, or when a beneficiary has completed a trial work period. Last year, we completed more than 165,000 work CDRs in our field offices.

Generally, the Social Security Act requires us to conduct medical CDRs on a periodic basis to ensure that only beneficiaries who continue to be disabled receive benefits. In conducting these CDRs, we use one of two methods. We send some cases to the DDSs for a full medical review; others may be completed using the mailer process.

We have seen a rise in our full medical CDRs pending since FY 2002. I must caution that, even with the proposed increase in dedicated funding this year, we project the number of pending full medical CDRs will increase by over 100,000 cases to roughly 1.5 million. We know we need to do better.

We must also ensure that we pay SSI in the correct amounts. One of the ways we ensure accurate payments is by periodically completing redeterminations to review all the non-medical factors of SSI eligibility, such as resource and income levels and living arrangements.

There are two types of SSI redeterminations: scheduled and unscheduled. Generally we periodically schedule all recipients for a redetermination at least once every six years. Moreover, we target the most error-prone cases each year using a statistical model. We conduct unscheduled redeterminations when recipients report, or we discover, certain changes in circumstances that may affect the SSI payment amount.

In FY 2009, we completed over 1,730,000 SSI redeterminations. This fiscal year, we plan to process nearly 700,000 more redeterminations than last fiscal year.

In addition to CDRs and SSI redeterminations, we have developed other program integrity initiatives that use cost-effective means to help us further manage and protect the programs we administer. Electronic data matching provides a foundation for our ongoing program integrity work. To identify both OASDI and SSI beneficiaries who are no longer eligible for benefits, we match data in our records with over 400 State and local government organizations and 65 Federal agencies.

We are using modern technology in innovative ways to help us detect and prevent payment errors. To maximize our return on investment, we focus on addressing the leading causes of error. For SSI beneficiaries, unreported resources and changes in earnings from work are two significant factors that contribute to payment errors. We have recently expanded two projects targeted to improve our ability to identify bank accounts for SSI applicants and to make it easier and more convenient for beneficiaries to report their wages each month.

The Access to Financial Information project automates our access to financial data. This process allows us to identify and verify bank accounts held by SSI applicants and recipients. We have tested the process in New York, New Jersey, and California.

The President's FY 2010 budget includes up to \$34 million for us to expand this project. We are encouraged by these early results, but there is a lot of work ahead as we expand and continue to develop plans for implementing this project in additional States and accessing data from more financial institutions.

Receipt of wages is another leading cause of SSI overpayments. To make it more convenient and easier for beneficiaries to report wages, we have recently implemented nationally an automated monthly telephone wage reporting process. The process uses both touch-tone and voice recognition telephone technology to collect the wage report. Our software automatically enters the wage data into the SSI system, which is much more efficient than if the beneficiary visited a field office, and we manually enter the report into our system. We are encouraging beneficiaries to use the telephone reporting system.

At the same time, we continue working with the law enforcement community to pursue cases of fraud and abuse in our programs. Through our Cooperative Disability Investigations (CDI) program, a joint venture with the Office of the Inspector General (OIG), DDSs, and State and local law enforcement personnel, we work collaboratively to investigate allegations of fraud and abuse related to initial disability claims. We currently have 20 units in 18 States. We plan to open two new CDI units this year in South Carolina and Missouri. Last year, we estimate that the program yielded an additional \$240 million in program savings. Our Inspector General estimates the CDI program returns \$14 in program savings for every \$1 invested.

Sustaining Momentum under the President's FY 2010 Budget

Prior to FY 2008, we had been under-funded for 14 straight years by a total of over \$2 billion, and the recession continues to increase our workloads beyond what we projected. We now expect about 100,000 more retirement and 350,000 more disability claims this year than we projected in the FY 2010 President's budget.

Since I became Commissioner, even before the recession hit, I have been informing you that we were facing an avalanche of retirement and disability claims at the same time we were addressing a large hearings backlog. In the past two years, you have heard our pleas and provided additional funding. I greatly appreciate your support.

Recent appropriations have allowed us to hire thousands of new employees and provide the space and equipment they need to serve the public. These new employees are helping us improve our services, but they require extensive training to handle our complex work. This training time delays the positive effect that they will have on our workloads. Thus, our greatest opportunity for success is directly tied to timely, adequate, and sustained funding.

We are acutely aware of the Nation's difficult economic situation, and we take our responsibility very seriously. We have prudently used the additional resources you have provided to make comprehensive improvements to our services to the American public at a time when they need us most. We have demonstrated sound, yet flexible, planning that we can adapt to the changing economic situation.

Even though we are currently operating under a CR, our Recovery Act funding is allowing us to maintain the momentum we gained in the last year.

For FY 2010, the President proposed a significant investment in us—\$11.6 billion, a 10 percent increase over FY 2009. This increase is essential to maintain our progress. Without it, the hearings backlog will worsen, and we will drown in the flood of additional disability claims.

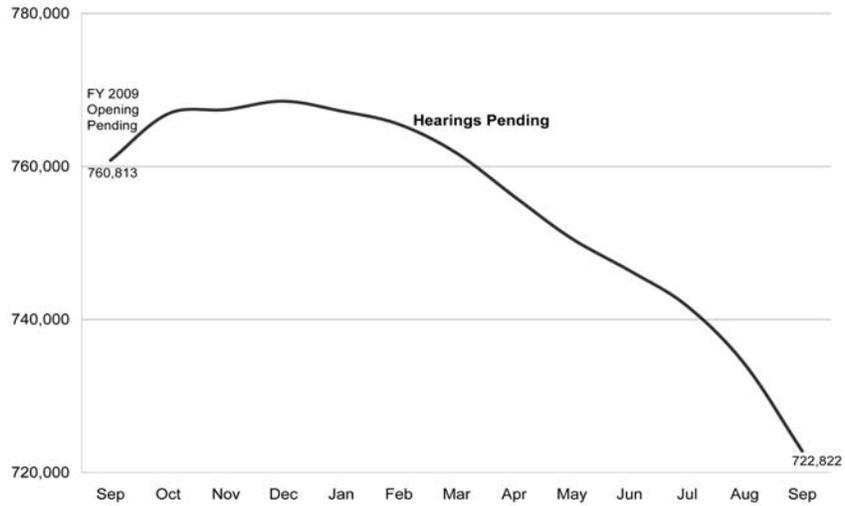
With the President's FY 2010 budget, we plan to hire a total of about 7,500 employees, which will allow us to maintain our staffing levels in our front-line operational components and add 1,400 employees in the DDSs and 1,300 employees in our hearing offices. We will process nearly 270,000 more initial disability claims than we did in FY 2009. We will minimize the increase in pending initial disability claims, and maintain our course to return the pre-recession pending level by 2013.

We will process nearly 65,000 additional hearing requests and ensure that the hard-earned progress we have made to reduce the backlog is not lost because of the economic downturn. We will remain on track to eliminate the backlog by 2013.

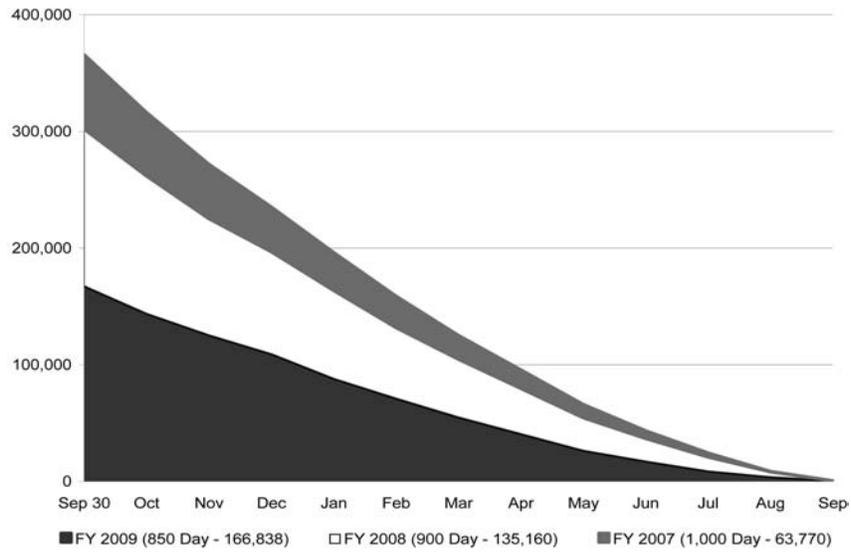
We will make progress on the program integrity workloads that we have deferred processing. Finally, we will continue to modernize our information technology, which will enable us to pursue 21st-century modes of service delivery. All of these investments are critical to ensuring that we can overcome the dual challenges of accurately and efficiently processing our ever-increasing workloads and meeting the public's demand for our services into the future.

In short, we have made solid progress, and hope to beat our target date of 2013 for the elimination of the hearings backlogs despite all of the new cases stemming from the recession. We are committed to working with Congress and the American people to achieve our goals and improve service in the years ahead. With your support, we will successfully overcome our challenges, but it will take a few years, and we will continue to need timely, adequate, and sustained funding.

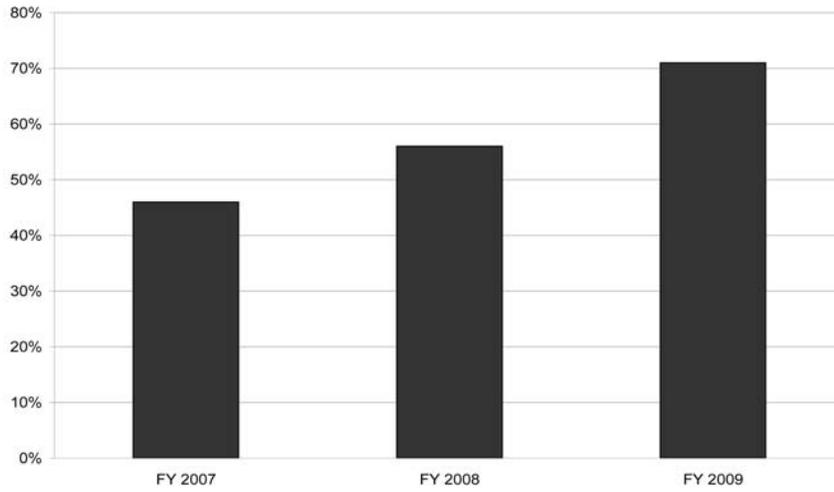
We Ended FY 2009 With Nearly 38,000 Fewer Pending Hearings Than We Began



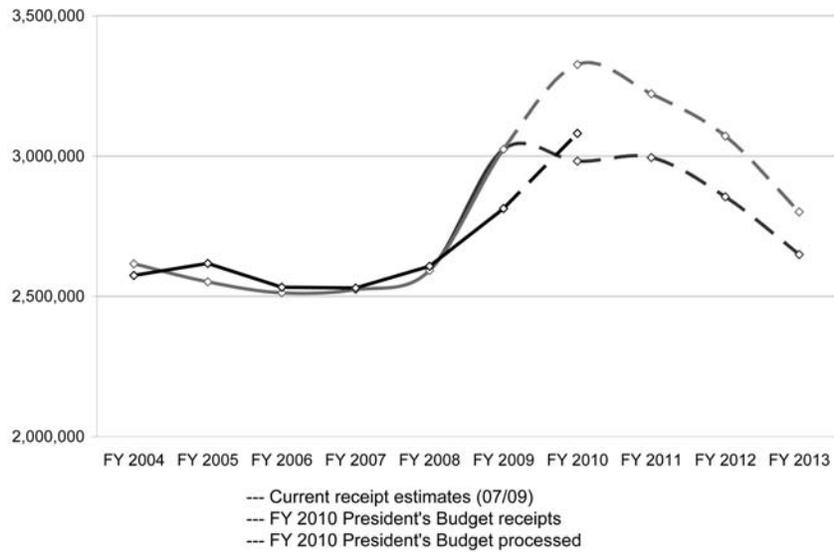
Eliminating the Oldest Hearing Cases



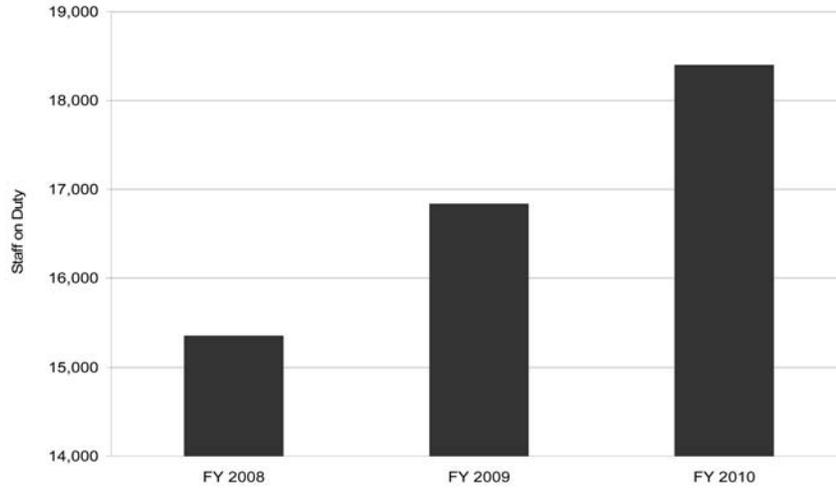
Percentage of ALJs Who Decided
at Least 500 Cases



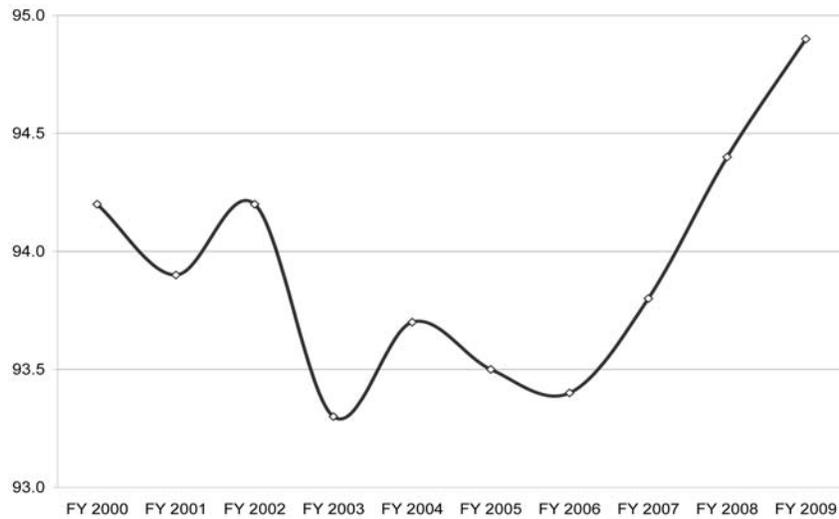
Our July 2009 Estimates Project Even More Initial
Disability Claims Than Only a Few Months Ago



DDS Staffing Has Increased By 19% Since FY 2008

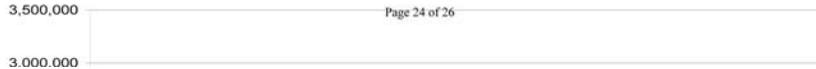


DDS Performance Accuracy is the Highest in the Last Decade



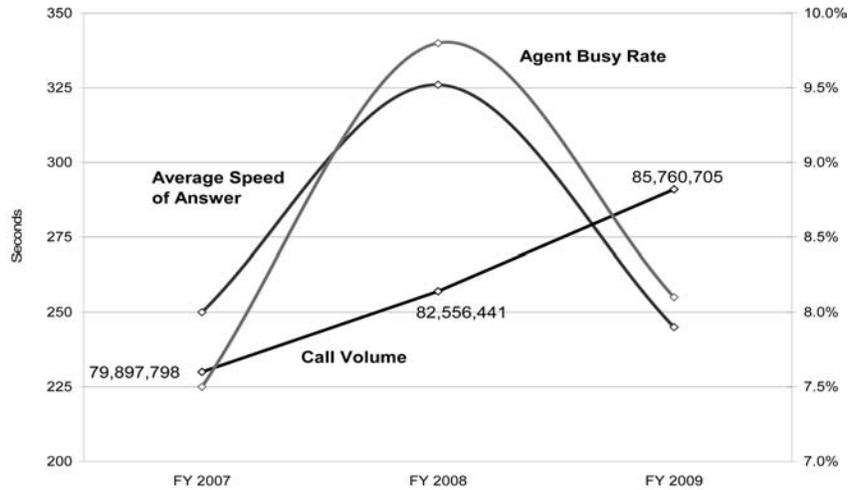
All DDSs currently affected by furloughs						
<i>(State fiscal years run July-June unless otherwise noted)</i>						
Estimated Effects of a One Day Furlough						
State	Number of employees ECFY 2009	TOTAL number of days <i>per fiscal year</i>	Cases	Reduced Administrative Funding	Delayed Benefits	
California	1426	36 days (3 per month)	1,476	\$849,000	\$420,800	
Connecticut	143	3 days total (per fiscal year)	127	\$76,500	\$3,200	
Hawaii	51	18 days FY 2010 24 days FY 2011	41	\$26,500	\$15,400	
Ohio	644	10 days	731	\$345,100	\$149,900	
Oregon	175	10 shutdown days & 2 to 4 more furlough days dependent on salary (Total number of days to occur in 2010 and 2011)	179	\$101,100	\$52,900	
Wisconsin	238	8 days	249	\$124,000	\$83,900	
New Jersey	341	10 days	336	\$212,000	\$121,400	
Rhode Island	58	8 days FY 2010 3-4 days FY 2011	56	\$31,800	\$15,000	
Virginia	374	1 day May 26, 2010	300	\$154,000	\$68,500	
Massachusetts	13 (managers) total staff 345	Up to 9 days based on salary (Impact on MA DDS: 3 managers taking 9 days & 10 managers taking 6 days)	296 Case processing & program dollars not an issue, as only management is impact by furlough	\$167,900	\$102,100	
Maine (partial exemption)	24 total staff 70	10 days	Based on FULL Furlough 68	\$33,200	\$18,000	
Nevada (partial exemption)	9 total staff 107	12 days (1 per month)	Based on FULL Furlough 102	\$53,100	\$32,000	
Colorado (FULL EXEMPTION)						
Maryland (FULL EXEMPTION)						
Illinois (FULL EXEMPTION)						
Iowa (IMPENDING FURLOUGH)		7 day furlough for MCs & Managers				
New Mexico (IMPENDING FURLOUGH)		5 day furlough for all employees				

The Internet Has Helped With Claims Intake



Note: Represents only claims that can be filed online.

Additional Resources Are Improving 800 Number Service



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Chairman TANNER. Thank you, Commissioner. You mentioned the DDS backlog in 2013. The DDS backlog really is a rather recent phenomenon, isn't it?

Mr. ASTRUE. Yes.

Chairman TANNER. Why would it take to 2013?

Mr. ASTRUE. It's a product of the recession, Mr. Tanner. We were hit last year with, I believe about 400,000 more cases than the actuaries originally projected. We will probably take in about 700,000 more cases this fiscal year than were projected. We were just not set up to handle an extra million cases, because we were struggling a bit with staffing. It also takes time to hire and train new employees.

So, we have moved as aggressively as we can. We have beefed up the DDSs as much as we can. We are moving some Federal workers to the processing of cases. There are some states that have looked at other states that are furloughing and understand that there is an issue. They have volunteered to set up special units to handle work from other states.

We have special units called Extended Service Teams in four states that are going to help us pick up from some of the states that are going to be lagging with the furlough issue and the impact of the recession.

Chairman TANNER. Do you have any comment about what Mr. Filner said about the situation in California?

Mr. ASTRUE. The situation in California is a source of great concern. Right now, the number of pending cases is building up, and that's usually what happens right before our average proc-

essing times start to deteriorate. The average processing times have not significantly deteriorated yet, but that's likely to happen in the next few months.

California is a state that has had issues in quality. They're right near the bottom of the States in quality, even before what's been going on lately. We have been having trouble getting clear information about some of the things happening in California. I believe both the director of the DDS and the number two retired recently. It's a little confusing in California. We do have concerns.

We don't have recent, as I understand it, quality review information that would verify some of the complaints that Mr. Filner is making, but we are monitoring it as closely as possible. We certainly share the concern that California may be heading toward a very inappropriate situation.

Chairman TANNER. Well, if the situation is as concerning as Mr. Filner testified, California may deserve some special sort of attention from you. If a judge is instructed to close cases for the wrong reasons, that is very concerning. We are really interested, and would appreciate you letting us know what you find out.

Mr. ASTRUE. We are on this. We are trying to—

Chairman TANNER. It is sort of unusual for a Member to come here with those sorts of statements, so we are concerned.

Mr. ASTRUE. Yes.

Chairman TANNER. It is not something we take lightly.

Mr. ASTRUE. We will report regularly to the Committee on the California situation.

Chairman TANNER. Good.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. Mr. Astrue, we have talked before about the Agency's outdated technology that includes computer programs that are still COBOL-based.

Mr. ASTRUE. Yes.

Mr. JOHNSON. That's 1950s technology.

Mr. ASTRUE. Yes, sir.

Mr. JOHNSON. Today we have got a lot better stuff.

Mr. ASTRUE. We do.

Mr. JOHNSON. Can you tell me what you're doing to modernize your system?

I am told that it could take as long as seven years for you guys to get it updated. Can you talk about that to us?

Mr. ASTRUE. Yes. We are trying to do as much as we can as fast as we can, in terms of systems modernization. It is a daunting task, because, first of all, we have got 38 million lines of COBOL code.

We have to be very careful as we replace code, that we don't disrupt service. A lot of the programs are tied in with each other in intricate ways, and sometimes it's very difficult. When you pull out a piece of it, you have to be very careful that you're not having unintended consequences. We are moving to do that as aggressively as we can.

The first big step is, when we went electronic with the DDSs, we kept the COBOL. That will be replaced. We should have the—

Mr. JOHNSON. When?

Mr. ASTRUE. April 2011 is the target date for when the beta will be ready on that, and then it will probably be a roll-out over another 18 months.

Mr. JOHNSON. Why is that taking so long? Goodness gracious, we've got technology out there. I mean, everybody in this audience can go out there and get a new computer and be upgraded today. Why can't you guys do that?

Mr. ASTRUE. Well, it's not just a question of the hardware. The hardware is fairly simple to do. It's the software that takes a long time to rewrite and to tie in with all of the other software.

To give you some sense, the effort to come up with a much better online retirement form, if I remember correctly took some time. The online retirement form had to cut across 39 separate COBOL-based programs that then had to be retied together. It is a long and difficult task. My sense is we may, over the next three years, be able to replace half of it.

However, I don't think it's realistic, particularly in the core of the program, the data on everybody. That's a big task, and it's going to take us a while to get to that. If we had more resources we could do it faster, but there are trade-offs. There is a lot of pressure to supply—

Mr. JOHNSON. So you're telling me it's true, it might take you seven years to get the program fixed?

Mr. ASTRUE. Yes, sir.

Mr. JOHNSON. That's gross. I think you ought to get into that and figure out how to do it a little better.

You know, you said by early calendar year 2010 you would have enough hardware and software in Durham to build up all the Agency claims and data processing center systems, should there be a catastrophic event at your center in Baltimore. Is that still true? And what does "early calendar year 2010" mean?

Mr. ASTRUE. The situation for the back-up center now is that the building is completed and the equipment is in there. They are moving a little bit faster than, I think, originally planned on getting some of the equipment in.

We are now—let me just double-check. We will be able to fully back up and recover in just a few months, Mr. Johnson. So we are ahead of the old schedule.

Mr. JOHNSON. That's new technology down there?

Mr. ASTRUE. Yes, that is substantially new technology. We try to stay away from—

Mr. JOHNSON. That's a back-up?

Mr. ASTRUE. It's a back-up.

Mr. JOHNSON. Why can't you use it as primary, then?

Mr. ASTRUE. We are going to start using it as partial primary, probably increasingly over the next two years, because we run out of capacity at the National Computer Center in 2012. We won't have the replacement for the National Computer Center completed until then, so we are gradually shifting some functions over to the back-up center, and will be tying together the old National Computer Center and the new back-up center until we have the new National Support Center up and running. That should start coming on probably mid-2013.

Mr. JOHNSON. Mr. Chairman, I think we ought to be getting a report about every six months on the progress of that thing, because I think it's gross to have systems that old that don't work right. My opinion. Thank you, sir. Thank you for your testimony.

Chairman TANNER. We might do it a little more often than six months, if that would be all right.

Mr. JOHNSON. Every month would be fine.

[Laughter.]

Chairman TANNER. That's what I was thinking, too.

Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman. Mr. Astrue, it's nice to see you again. I like the straightforward tone of your testimony. I mean, I don't think you make any bones about it. The backlogs that we have are not acceptable. The Agency performance, certainly with plenty of congressional culpability because of funding, allowed a situation to grow to absolutely unacceptable levels of backlog. I appreciate the headway that you're making.

A couple of interesting items in your testimony. You indicated that in 2009 you hired 8,600 new employees, the largest hiring effort since the creation of the Social Security program.

Mr. ASTRUE. Yes.

Mr. POMEROY. Would you care to elaborate on that?

Mr. ASTRUE. In fact, I think what is more remarkable, and a great tribute to the people in the Agency, is we hired about 8,300 of those in 5½ months. We were on a hiring freeze because of the continuing resolution until early March of this year, and I believe we hired something like 325, 350 employees for the whole agency, from October 1 until mid-March.

With the combination of the funding in the Appropriations bill and the funding in the American Recovery and Reinvestment Act, we went pedal to the metal, and we hired over 10 percent of the agency in 5½ months.

Mr. POMEROY. Are you on track with the resources now given to staff up to where you need to get?

Mr. ASTRUE. We are for now. I don't know yet what the situation is going to be for 2011. There is sort of the good news/bad news with the Recovery Act. Technically that's not part of the baseline budget for the Agency. Therefore, I think, whether you view my request for this year as overly aggressive or fair depends a little bit on how you look at the Recovery Act.

Certainly the Recovery Act money for the new National Support Center, I think, should be conceptualized as a one-off. It would not be fair to view that as part of the baseline. However, I do think that the backlog money, in my view, really is a recognition that that should have been in the baseline all along, and ought to be viewed—

Mr. POMEROY. How is OMB viewing it?

Mr. ASTRUE [continuing]. In context of this—

Mr. POMEROY. Is it being added to baseline?

Mr. ASTRUE. I don't know. We don't have the pass-back yet, so I don't know how they're going to view it.

Mr. POMEROY. That might be something we might want to inquire—I am sure staff is noting this. The staffing component of the stimulus money needs to be continued. No one viewed that that

staffing up was required for the duration of the stimulus bill only, or 2009. It is part of getting the Agency back to where it needed to be.

Mr. ASTRUE. Without talking out of school, I think it's fair to say that that's one of the premises of my budget request.

Mr. POMEROY. I would hope, Mr. Chairman, that the Subcommittee might write a letter of inquiry to OMB, exploring this topic, or I will personally, if the Subcommittee doesn't care to.

Chairman TANNER. We already have.

Mr. POMEROY. We have already? Ah, that's cracker jack staff. [Laughter.]

Mr. POMEROY. Now, speaking of cracker jack staff, let's move to ALJs. As my cracker jack staff was saying, "Ask him how they're doing, relative to when you threw a fit," and so, I will try and— [Laughter.]

Mr. POMEROY. I will try and rephrase that. I believe it was your second day in office, but I was absolutely appalled that the litigation at the early part of the decade, then resolved, didn't break loose hiring because hiring had been frozen for some time. Indeed, three or four more years went on with OPM absolutely screwing this thing up, and the Agency not unscrewing it up.

Actually, as a member of the Committee of oversight, I felt like we were led down a primrose path with representations by everybody that were completely inaccurate, relative to the staffing up of ALJs. How are we doing, relative to where we need to be?

In the end, I absolutely believe this is a critical component of the backlog question.

Mr. ASTRUE. Right. I certainly share your sense it was a rocky start, Mr. Pomeroy, and you had a lot of company in that regard. I do want to thank the Subcommittee as a whole, and you, in particular, as the primary point person for influencing OPM, because certainly it wasn't going very well, just us trying to do it directly. Without your help, I don't think it would have happened.

We had a little bit of a replay of some of those issues recently, but we have an ally in John Berry, the new head of OPM, who is very attuned to these issues. I think he is in sympathy with where the Subcommittee and I are on this. It's a shame that we have had to take some of these issues up to Mr. Berry to get them resolved, but we have had some great progress. They have opened up the register again. They won't tell us how many people were on the register, though we have heard that there were 900 people as of eight o'clock the night they cut it off, and that there are probably 1,200 to 1,400, we're guessing, that are on the register. We don't know, but that should be more than ample for our needs.

We have hired already—well, actually, no, not yet. Tomorrow you will help us swear in 43 more Administrative Law Judges. We are scheduled to hire 226 for the year.

Mr. POMEROY. Where will that bring the number?

Mr. ASTRUE. That will bring the number up to about 1,450. I believe, that is what we're aiming at.

Mr. POMEROY. About 1,450?

Mr. ASTRUE. Let me just make sure I'm getting my years right. Yes. We will be aiming for about 1,450, and the Fiscal Year 2011 budget shoots for a slightly higher number than that.

Right now, as long as OPM does what it needs to do between now and roughly the end of February, it's on the critical path, because the truth is, right now we don't have space to put them. With this class that we're swearing in tomorrow, we're putting judges into pretty much every office that we have available for Administrative Law Judges.

So, the hiring for the summer is predicated on an awful lot of office space being open. It looks like GSA is going to hit the mark on that. Most of it is coming—

Mr. POMEROY. Does this Committee—I know my time is up. Do we need to be corresponding with GSA, as well as OPM on making certain that we don't have an office backlog?

Mr. ASTRUE. I think you can send them a general letter congratulating them on good progress and sharing your concern. We have had a couple of isolated incidents a few places around the country, but generally, the GSA work has really been outstanding on this. I want to give them credit, because when we first started opening up offices, we were about the only game in town. But with the Recovery Act, they have been very busy.

So, we actually have a list of the offices that are supposed to be open. I can append to my testimony. But we have one that—

[The information follows:]

INSERT FOR PAGE 29, LINE 636

This fiscal year, we plan to open the following new offices:

NEW OFFICE LOCATION	PROJECTED OPENING	COMMENT
Anchorage, Alaska	February 2010	
Fort Meyers, Florida	May, 2010	Will be a satellite office
St. Petersburg, Florida	May 2010	
St. Louis, Missouri	May 2010	Will be a National Hearing Center site
Boise, Idaho	June 2010	Will be a satellite office
Toledo, Ohio	June 2010	
Akron, Ohio	June 2010	
Livonia, Michigan	June 2010	
Madison, Wisconsin	June 2010	We are converting the existing satellite office into a hearing office.
Phoenix, Arizona	June 2010	
Las Vegas, Nevada	June 2010	We are expanding the existing hearing office.
Tallahassee, Florida	June 2010	
Covington, Georgia	July 2010	
Topeka, Kansas	July 2010	
Fayetteville, North Carolina	August 2010	
Mt. Pleasant, Michigan	August 2010	
Valparaiso, Indiana	August 2010	
Sioux Falls, South Dakota	August 2010	We are expanding the existing satellite office.
Harlingen, Texas	September 2010	Will be a satellite office

In FY 2011, we plan to open the following new offices:

NEW OFFICE LOCATION	PROJECTED OPENING	COMMENT
Tacoma, Washington	Sept/Nov 2010	
Moreno Valley, California	April, 2011	
Augusta, Georgia	June, 2011	
Columbia, Missouri	June, 2011	
El Paso, Texas	June, 2011	
Franklin, Tennessee	June, 2011	
Hoover, Alabama	June, 2011	
Jersey City, New Jersey	June, 2011	
Lawrence, Massachusetts	June, 2011	
Muncie, Indiana	June, 2011	
Rochester, New York	June, 2011	We are converting the existing satellite office into a hearing office.
St. Paul, Minnesota	June, 2011	
Eureka, California	June, 2011	Will be a satellite office
Helena, Missouri	June, 2011	Will be a satellite office
Marquette, Michigan	June, 2011	Will be a satellite office
Reno, Nevada	June, 2011	Will be a satellite office

Mr. POMEROY. You know, my time is so far over. Mr. Chairman, we might want to consider Subcommittee letters to OPM and GSA both, asking that they do everything possible to facilitate the work of the Agency in getting the ALJ number to where it needs to be.

I thank you, and yield back.
Mr. ASTRUE. Okay.

Chairman TANNER. Thank you, Earl. I agree, and maybe we will have a hearing sooner than later to follow up on some of these questions that are coming out. They are very good.

Ms. Schwartz, please?

Ms. SCHWARTZ. Thank you, Mr. Chairman. Thank you for this hearing. I do want to follow up on what both looks like good work and good progress. Still, the numbers seem really shocking to us. We get calls all the time, of course, in our offices, and I noticed in Pennsylvania, it's still a year wait, basically, you know.

So, it's hard to tell people "If you're lucky, it will be a year," you know?

Mr. ASTRUE. Yes.

Ms. SCHWARTZ. That's kind of where we are. I both want to compliment you on all the progress you're making, and also say it's just not quite enough; we want more. We want it to be better, we want it to be faster.

Mr. ASTRUE. If there were a magic bullet and I could do it faster, I would. I think the problem has been that the system hasn't really been managed carefully. A lot of this is just good management but it takes time.

Then part of it is capacity. It's a combination of the systems in operation not being good enough and not having enough capacity in the right places, which we're also working very hard to try to equalize around the country.

When this large group of new offices start coming on stream this summer, by the end of the year, calendar year, you should see huge differences in certain parts of the country.

Ms. SCHWARTZ. I wanted to follow up on some questions I had at the last hearing on this subject, I guess, in April.

Mr. ASTRUE. Yes.

Ms. SCHWARTZ. It was particularly about the use of the medical exchange of information system.

Mr. ASTRUE. Yes.

Ms. SCHWARTZ. I want to follow up on the exchange of the information through technology, and understanding that you, through the Recovery Act, had additional dollars for the exchange of what is very complicated and sometimes very time consuming information to get, and that is the actual information on the medical condition.

Could you update us on how much of that information is now being transferred or transmitted electronically?

Mr. ASTRUE. Sure.

Ms. SCHWARTZ. Has that, in fact, helped to speed things up?

Mr. ASTRUE. Sure.

Ms. SCHWARTZ. Also, how do you see this process moving forward? To what degree is that sort of universally being applied across the board, and helping in reducing the number of days?

Mr. ASTRUE. I think I and most of the senior people in the Agency are really excited about this development, because this is the one big paradigm changer in disability processing that we see coming forward in the next couple of years.

We spend an enormous amount of our administrative time, money, and effort chasing down medical records, and if that can be more efficient and complete it will help tremendously. Even with-

out trying very hard in the couple of pilots we have been able to actually see what would work, we have been able to cut our processing times roughly in half.

It also is going to improve quality, because a major source of error is we often don't realize that the medical record is incomplete. The claimant's attorneys often don't recognize that it's incomplete; particularly for certain psychiatric and sexually transmitted diseases, claimants are often very reluctant to volunteer that that's really a major issue for them. So, it's huge, in terms of timeliness, it's huge in terms of quality.

What's frustrating is that we're not there yet. It would make my life so much easier, and life for the people we serve so much easier, if they were ready. So what we're trying to do is make sure, with the money, that the systems that are being built by others are going to be compatible with ours.

Ms. SCHWARTZ. Interoperability, yes.

Mr. ASTRUE. Jim Borland has had the lead for SSA over at HHS, as they helped design the standard. We are spending a lot of time with VA and DoD, as they design their standards to try to make sure that it's as seamless as possible.

I am hoping that, at the back end of this recession, there are at least a few early adopters in the private sector that would make our life a lot easier. For instance, Kaiser Permanente seems to be further ahead than a number of others. If they were to have even a third of their members in California on this, it could make a huge difference in fixing the mess in California.

Ms. SCHWARTZ. Well, they are moving ahead, and as you know, the Recovery Act also provided an additional \$19 billion for the private sector doctors and hospitals to implement electronic medical records. Those standards for interoperability and those Federal standards, HHS is moving ahead on that, and should help. Although it's clearly not universal yet.

Could you give us some idea, though, about what percentage or number of records you are now actually being able to obtain electronically?

Mr. ASTRUE. It's time. I am with you on that. I would like to see this today.

Ms. SCHWARTZ. Yes.

Mr. ASTRUE. I am impatient. So we're piloting in Massachusetts with Beth Israel Deaconess, and with Med Virginia, which has been active in building the system that I think everyone is going to be using for the transfer of this kind of health care information.

We have additional pilots that we're using. With the 24 million dollars under the Recovery Act, they're allowed to expand this and accelerate it as quickly as possible, but it's a little premature for actual results yet.

Ms. SCHWARTZ. Because I would certainly like to see SSA, and I mentioned this before, use electronic records similarly to the Veteran's Administration, which does have electronic medical records, and it is interoperable.

Mr. ASTRUE. Yes.

Ms. SCHWARTZ. Any veteran anywhere in the country can access their records, or at least their providers can, so that should

help reduce some of the wait. In many cases, we're obviously trying to push states and networks and regional networks.

But again, maybe not for right now, but I would be interested, as you are monitoring this, to see both how fast it's going—I mean, you can't do this all yourself, you have to have them electronic on the other end, you're absolutely right.

Mr. ASTRUE. Right.

Ms. SCHWARTZ. But to the degree of how much it's helping the Agency, how many days it's saving, it's pretty impressive to think it could cut time in half. That's pretty good.

Mr. ASTRUE. We haven't built changes from this into any of our assumptions yet. I think our actuaries need to see something a little bit more concrete before they're going to do it.

But I think when that curve starts to accelerate, it's going to move a lot of our numbers in a positive direction. It's a very exciting prospect, and that's why we're spending time and money on it now. Because the sooner it gets here, the better it's going to be for everybody.

Ms. SCHWARTZ. I appreciate your efforts on this, and I know that so do so many of our constituents who rely on this information. I thank you, and we will continue to talk about it.

Mr. ASTRUE. Thank you.

Chairman TANNER. Thank you, Ms. Schwartz. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. Mr. Commissioner, good to see you again.

Mr. ASTRUE. Thank you.

Mr. BECERRA. Thank you for the work that you have done. I appreciate that you were able to come back to us and tell us that you have made some progress in reducing the backlogs. We should heed your warnings about what could happen in the future if we don't provide you with the resources that you need.

I want to focus on California. I know you have tried to get the governor in our state of California to exclude the DDS workers from the furloughs that he has instituted for state employees. I know that we all know that he has not done that.

Now, the impact of those three-day furloughs per month is that, essentially, 15 percent of the work is not being done on any given month. If you take into account the size of the backlogs that already exist throughout the country, but certainly in California as well, and you reduce the availability of services by 15 percent, just across the board, not taking into account anything else, along with the fact that you and others have testified and provided information about the increasing caseload that's coming in, the claims that are coming in, an increase of about 15 percent in the last fiscal year from 2008 to 2009, and expecting another 10 to 15 percent over 2009 to 2010. Through probably 2013, I'm told, the estimate is that we will continue to see an increase in case claims coming in for disabilities.

To lose 15 percent for no reason whatsoever—because we're willing to pay the money, the Federal taxpayers are willing to pay each state the money to provide the services; the state of California, the governor is not spending one red cent to provide a salary to the people who would do these determinations—15 percent, more or less, cut right off the top, on top of the fact that you see an ava-

lanche of another 15 percent of claims coming, does that, to you, lead you to conclude that the governor and the State of California are making a good faith effort to provide effective services to California's disability applicants?

Mr. ASTRUE. Well, I think that you can't take an action like this without, at a minimum, harming timeliness, and potentially hurting quality, as well.

A number of states are furloughing managers, but not staff. I do not know what they think that does, but that is surely going to create quality issues, too.

Mr. BECERRA. So, is that an effective way to administer that program?

Mr. ASTRUE. No. This caught me off guard. I don't think any previous Commissioner has had to deal with anything like this before. The first state was California last December. It was, to me, so nonsensical that, I will be honest, I was caught off-guard again, because I thought it was a one-off.

I said, "Well, okay. This is a strange decision. What other state is going to do this?" But then there was a steady pitter pat, and I have probably spent 10 percent of my time this year trying to get states not to do this.

Mr. BECERRA. Your use of the word "nonsensical" is perhaps the best word I have heard so far about this process that the governor in California is implementing.

I can't imagine that it helps with any kind of uniform administration of those disability services when you have people who can't come in to work, simply because the governor said, "You can't come in, even though the Federal taxpayers are paying the salaries of those individuals as well."

Mr. ASTRUE. Oh, yes. It's devastating for morale, and we have seen this. We have had about a dozen states where—

Mr. BECERRA. Right. So let me ask you this, Commissioner. Under the statutes, you have the ability to declare that the governor and the State of California are not fulfilling their obligations under our Federal laws to administer the programs that they have said that they would accept under the Social Security Administration's duties, and under the Social Security Act.

You have written a letter. The response was not positive. You tell me now what you, as a Commissioner of the Social Security Administration, and therefore responsible for those thousands of Californians who are trying to get their claims processed, will do.

Mr. ASTRUE. We have some statutory authority.

Mr. BECERRA. You have lots of statutory authority. I can cite you the section. I can read you the underlying portions or the yellow highlighted portions. You have lots of authority. You said it. The governor has been acting in a nonsensical manner when it comes to the ability of Californians who are disabled, or at least claim to be disabled, to have their claims processed.

With backlogs that take hundreds of days to process, you have a governor who has said, "You're not going to go to work and process the claims of disabled Californians, even though I, as governor, have nothing to do with paying you for the work that you are going to do on behalf of those Californians who work very hard to have a system in place so they could get their claims heard."

Mr. ASTRUE. Right. Certainly there is a factual predicate, where we would have an obligation to step in. I am not sure I particularly want to advertise what that line is right now. I don't think that does anyone any good.

But what I would say is perhaps we should talk offline about what some of the considerations—

Mr. BECERRA. I will give you my personal phone number, if you like.

Mr. ASTRUE. Okay.

Mr. BECERRA. Mr. Chairman, you have been gracious with the time. But, Commissioner Astrue, I hope that you will do something more than just write a letter, because it is unconscionable that a chief of state would tell his people that they will not get services, even though another level of government is providing every single penny to provide those services. I think that is only nonsensical, as you said, it's unconscionable.

I thank you, Mr. Chairman, for the time.

Mr. ASTRUE. If I could just note, Mr. Chairman, we have actually done a lot more than writing a letter, too. We actually have been working very closely with the unions and employee groups. We have intervened and filed, essentially, a friend-of-the-court brief in one of those cases in support of one of the unions.

We have been talking to editorial boards. I was actually in touch with one of the major papers the day before yesterday in California, talking at some length about this issue. So we are trying to work this as best we can.

Mr. BECERRA. I apologize if I made the representation that you were not doing more.

Chairman TANNER. Well, yes, I know you have spoken out in editorial boards on the East Coast, and I would hope that you would do so again on the West Coast.

Mr. ASTRUE. Yes.

Chairman TANNER. Ms. Sánchez.

Ms. SANCHEZ. Thank you, Mr. Chairman. Commissioner Astrue, first I really want to applaud you for the work that SSA has done over the past year, you know, in the face of, obviously, very increased demand. SSA has managed to reduce the backlog, and although it's still longer than many of us would like to see, progress is being made. First of all, I just want to commend you for that.

I also want to commend you on your efforts to fight the furloughs for DDS employees. As somebody from California, obviously that is an issue that is of special concern to me, especially given that, as my colleague, Mr. Becerra, said, California is going to face an increase in the number of applications, and we are actually seeing a decrease in the number of those applications that are being processed.

I, too, agree that the furloughing of employees, when it doesn't cost the state any money to have them working on those days, is completely unconscionable. I was interested in your testimony saying that you at first thought California was kind of an anomaly, and then you had other states come on board. How many states, all together, are furloughing DDS employees?

Mr. ASTRUE. It fluctuates almost on a week-to-week basis. The current count is 9 across the board, and I think it's been higher than that. One of the frustrating things is you put a lot of effort in and sometimes you think you've won the discussion. Then all of a sudden there is another round of fiscal crisis, and then a state legislative meeting and you've lost.

So, we have put a lot of time and effort into it. I think at one point we were as high as maybe 15 states.

Ms. SANCHEZ. So you have had a little bit of success in convincing some of the governors not to do this.

Mr. ASTRUE. We have. Often, to give credit where credit is due, we have gone to the members of our committees of jurisdiction, both here and in the Senate, to ask for help, because often, you carry a lot more weight with governors. Matter of fact, you always carry more weight with governors than I do.

Ms. SANCHEZ. Not to, you know, pat the California delegation on the back, but in February I got members of the California delegation to send a letter to the governor, specifically.

Mr. ASTRUE. Yes, you did.

Ms. SANCHEZ. The letter requested the Governor to not furlough these employees. We got a response back that was pretty much a non-response.

Do you have a more thorough explanation? Are they giving you a rationale for why they want to continue to furlough these employees?

Mr. ASTRUE. Well, the original rationale that they gave us turned out not to be true, which is that the unions were insisting on it. In some states, that turned out to be true, because I think the union positions around the country have been inconsistent. In California, it turned out that that was not, in fact, accurate. We ended up, as I mentioned, supporting litigation from one of the unions in California.

Ms. SANCHEZ. What more can Members of Congress do to help you try to combat this?

Mr. ASTRUE. I think what you can do, which is not easy, and maybe in some cases not even fully appropriate for me to do, is that you are all part of political networks in your home states. Your majority leaders and minority leaders in your state legislatures, they need to hear from you on these things.

Sometimes I can't get to the governors. They get walled off by staff or budget directors, or that type of thing. Usually I can get through, but not always.

You need, I think, if you're in a state that is having these issues, to try to educate the political establishment broadly. Because just getting to one person won't necessarily solve it over the long run. So, anything that you can do in that regard would be enormously helpful to us, and we would be very grateful.

Ms. SANCHEZ. Okay. Switching topics really briefly, last April I read a New York Times article, the title of which is, "Insurers faulted as overloading Social Security."

The story discussed these whistleblower lawsuits against insurance companies who were forcing their beneficiaries number one, to file for disability claims with Social Security, and then to continue to appeal them over and over again if they're denied. Other-

wise, they're not going to pay them benefits under their policies. I was quite surprised and appalled by this sort of movement, and the impact that it has on Social Security resources to process claims.

How much effort is the Administration putting into looking at the role that outside entities are having in adding to that backlog?

Mr. ASTRUE. Sure. This issue has sort of heated up in recent years. We've got a couple of studies going. We've got some results for private insurers. We are also looking at the extent to which states are requiring an application to us as perhaps an inappropriate barrier to welfare benefits in their own states, as well.

Certainly, we don't condone either of these practices. In the qui tam action in Boston that I believe generated a lot of the media coverage, it was a split decision. The insurance companies lost a few of those cases, they won a few of those cases. So, clearly, there is abuse. We don't condone that.

Our take so far is that the workload burden from the private insurance companies from these abuses is relatively small. We are not persuaded yet that, in certain states, the comparable practice on the public side might not be more of a problem. But it has been difficult, getting the data to determine that. It is taking us longer to run those studies.

So, I would say that for private insurance companies, it's an issue, but a very small one. We are not sure yet, with the state agencies, how big a problem it is. We hope by some point next year to have a better answer to that question.

Ms. SANCHEZ. Okay, thank you. Mr. Chairman, I would just ask unanimous consent to be able to enter that article into the record. I will yield back my time.

Chairman TANNER. Without objection.

[The information follows:]

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April 1, 2008

Insurers Faulted as Overloading Social Security

By [MARY WILLIAMS WALSH](#)

The Social Security system is choking on paperwork and spending millions of dollars a year screening dubious applications for disability benefits, according to lawsuits filed by whistleblowers.

Insurance companies are the source of the problem, the lawsuits say. The insurers are forcing many people who file disability claims with them to also apply to Social Security — even people who clearly do not qualify for the government program.

The [Social Security Administration](#) defines “disabled” much more stringently than the insurers generally do, so it rejects most of the applications, at least initially. Often, the insurers then tell their claimants to appeal, the lawsuits say, raising the cost.

The insurers say that requiring a Social Security assessment is a standard practice and that there is nothing wrong with it.

The policies they sell allow them to coordinate their benefit payments with others to make sure no one is paid twice. Thus, if a disabled person can get benefits from somewhere else — like workers' compensation, a disability pension or Social Security — the insurance company can reduce the benefit check by that amount.

The flood of referrals, however, is making it hard for Social Security to respond to people who are truly disabled, said Kenneth D. Nibali, the former top administrator of the Social Security disability program.

“Anybody who is forced to come into this system, and who doesn't need to be there, is affecting someone else,” said Mr. Nibali, who retired in 2002 and is serving as an expert witness for the plaintiffs. “They're holding up cases for the people who have been waiting for months and years, who in many cases are much worse off.”

Already, the disability program is in much worse shape financially than the old-age portion of Social Security. It is projected to run out of money in 2026, 16 years ahead of the old-age trust fund.

The disability caseload is also expected to grow as the work force ages, since recovery time increases with age. The number of people waiting for hearings on their claims by an administrative law judge has more than doubled since 2000, and the average wait has grown to 512 days in that time, from 258 days.

The Social Security Administration is not an active participant in the lawsuits and declined to comment on them. A spokesman, Mark Lassiter, said Social Security does not keep track of how many of its roughly 2.5 million annual applicants for disability are referred by insurance companies. But he cited academic research showing that 18 percent acknowledged privately that they were unqualified, because they could still work. "It is probable that many of these claimants were required to apply," Mr. Lassiter said.

Jessica Ortiz, a 27-year-old gas station attendant in San Diego, said that was what happened to her. Her disability insurer, the Unum Group, called more than 10 times after she was hurt in a car crash, insisting that she apply for Social Security and asking repeatedly where her application stood. Unum was paying her only \$50 a month under her policy, she said, which seemed a small amount to merit so much attention.

She did not need or want money from Social Security, and did not think she was entitled to it. Her doctors had told her she would recover, and Social Security is limited to people whose disabilities are total and permanent. But she applied because Unum insisted, she said.

Ten months after her accident, Ms. Ortiz returned to work. Social Security turned her down, as she had expected. People who can work are by definition unqualified for disability pay from the government. But when she told the Unum representative what had happened, he told her she could still appeal.

"If I were the government, I'd be pretty upset," she said. "No wonder the pot could run out of money."

When the circumstances of Ms. Ortiz's case were described, a spokesman for Unum said he could not comment without reviewing her case file. The spokesman, Jim Sabourin, said the company believed that it always had valid reasons for telling people to apply for Social Security.

Forcing people who are injured to apply for Social Security before paying their claims appears to bolster insurers' profits in several ways. If claimants refuse to apply, the insurers can simply stop paying their benefits, said Dawn Barrett, an employee of the Cigna Corporation, who grew frustrated sending people to Social Security and who is now a plaintiff in one of the lawsuits. More typically, she said, people apply for Social Security when an insurer tells them to. That allows the insurer to reduce its claim reserves, money that is kept in conservative investments for benefit payments. And in the insurance industry, smaller reserves mean bigger profits.

"It's all about the numbers," Ms. Barrett said.

Finally, disability insurers tell many of their claimants to appeal Social Security's rejections again and again, until some are finally accepted. Then the insurers can take those people off their rolls, shifting the cost to the government.

Whistle-blowers have filed lawsuits against the Unum Group, America's largest disability insurer, and Cigna, another large one, though there is no dispute that the Social Security requirement is an industrywide practice. Unum, with revenue of \$10.5 billion, paid disability claims of \$4 billion last year.

Both companies said their claims practices were fair, legal and consumer-friendly.

"Our goal is to ensure that each member receives all of the benefits to which he or she is entitled," said Jill Roman, a spokeswoman for Cigna.

The lawsuits do not fault the idea of coordinating benefits with Social Security and workers' compensation. Instead, they contend that insurers are recklessly dumping people on Social Security's doorstep, without properly screening them to make sure they have a chance of qualifying.

The typical long-term disability policy says workers can collect when they are unable to do their own jobs for some period, usually more than five months. Social Security, by contrast, will pay only those people who are so badly disabled they cannot do any job at all. The disability must be one that will last more than 12 months or that will lead to death within that time.

Mr. Sabourin, the spokesman for Unum, denies the suits' accusations and says that his company does screen people. He said Unum considered it in the best interests of its claimants to try for Social Security, because the federal program offers advantages over

private insurance. Even though the federal requirements are tough, he said, Social Security has certain exceptions and trial programs that Unum's claimants might qualify for.

Unum is also concerned that the lawsuits might lead to changes in federal rules that require Social Security to vet all applications thoroughly. Any changes might drive up the cost of disability insurance premiums, Mr. Sabourin added. Unum plans to file a motion for a summary judgment in its lawsuit, which is in Federal District Court in Boston. The case is to be heard this fall.

Both whistle-blower lawsuits cite the federal False Claims Act, a law that allows affected government programs to recover triple damages. The lawsuits were brought by people contending that the insurers were knowingly committing fraud.

Mr. Nibali, the retired Social Security administrator, says the disability program has "an open-door policy" and is required to seriously consider all applications, even those that might seem improbable. While deciding whether a 65-year-old should get retirement benefits is relatively quick and easy; deciding whether someone should get disability benefits is not. The Social Security Administration compiles detailed medical records, sends applicants to doctors for examinations and tests, reviews their work histories and sometimes interviews their friends and relatives.

Rejections can be appealed again and again.

"A person can come in and file a disability claim with us as many times as they want to," Mr. Nibali said.

Linda Simmond, a 41-year-old mother in Atlanta, has been at it for four years. She worked as the supervisor of 10 Little Caesars pizza shops in Detroit but had to stop when she was found to have carpal tunnel syndrome, a wrist injury, from rolling out pizza dough. Surgery did not help.

Little Caesar Enterprises was insured through Unum, which started paying Ms. Simmond disability benefits of about \$1,780 a month, but told her she had to apply for Social Security. She did so, and was rejected. Ms. Simmond thought that was correct.

"I'm not totally disabled," she said. "I've seen people with one hand, no legs, working, so I know I can do something."

Unum told her to appeal. She refused. Unum stopped sending her checks. After several months with no income, Ms. Simmond relented and filed the appeal. Unum then resumed

her payments — but before long, Social Security rejected her again, and the whole cycle began anew.

Unum is now paying Ms. Simmond her benefits, but warning her that if she does not apply for Social Security again, it will stop her checks a third time, she said. “I need my benefits,” she said. “I have two children. I have a lot of debts. I’m going to have to do it, but I don’t believe in it.”

When Ms. Simmond’s situation was described to him, Mr. Sabourin said he could not comment on it without reviewing her case file.

Mr. Nibali has calculated that it costs \$1,180, on average, to process a single Social Security disability application to the first decision, usually a rejection. If the applicant persists through the first three levels — the initial review, a reconsideration and a hearing by an administrative law judge — the case will cost the system an average of \$4,759, he found. It is possible to appeal even higher, adding further to the cost. Lawyers from the firm Phillips & Cohen, in Washington, who are representing the plaintiffs, have been working with statistical samples. Their numbers suggest that the industry has been sending tens of thousands of dubious claims to Social Security, costing the system hundreds of millions of dollars over the last decade.

Mr. Nibali said he believed that Cigna, Unum and other disability insurers had enough data on their claimants to weed out many meritless applications before sending so many people to Social Security. That would help the program’s finances, he said. “We’re not here to give money away.”

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http://www.nytimes.com/2008/04/01/business/01disabled.html?_r=1&pagewanted=print 12/15/2009

Chairman TANNER. Commissioner, before we move to a non-Californian, may I—

[Laughter.]

Chairman TANNER. May I ask you to provide us with a copy of the legal filing that you all made in the California case?

Mr. ASTRUE. I would be delighted to, thank you.
[The information follows:]

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P. 33/45

INSERT FOR PAGE 47, LINE 1054

We have attached the following legal documents:

1. A "Statement of Interest" that the Department of Justice submitted on our behalf in UAPD v. Schwarzenegger.
2. A "Declaration" that our San Francisco Regional Commissioner, Peter Spencer, submitted in SEIU v. Schwarzenegger. Mr. Spencer also submitted this declaration in UAPD v. Schwarzenegger.

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 2 Assistant Attorney General
 3 JOSEPH P. RUSSONIELLO
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14 Attorneys for the United States

15 **SUPERIOR COURT OF CALIFORNIA**
 16 **COUNTY OF ALAMEDA**

17 **UNION OF AMERICAN PHYSICIANS**
 18 **AND DENTISTS,**
 19
 20 **Petitioner/Plaintiff,**
 21
 22 **v.**
 23 **ARNOLD SCHWARZENEGGER, Governor of**
 24 **the State of California, et al .,**
 25
 26 **Defendants/Respondents.**

27 **CASE NO. RG09456684**
 28 **STATEMENT OF INTEREST OF**
UNITED STATES
BY FAX
 Judge: Hon. Frank Roesch
 Dept: 31

INTRODUCTION

29 Pursuant to 28 U.S.C. § 517, the United States submits this Statement of Interest in the
 30 above matter. In so doing, it is not appearing on behalf of any party, nor does it seek to
 31 intervene. Rather, it seeks to demonstrate that the United States is statutorily authorized to file
 32 this Statement as a nonparty; describe its interests in this case; and explain how these interests

1 affect the legal issues raised by Plaintiff's petition. As discussed below, the action taken by the
 2 State of California that led to this litigation—namely, the furloughing of State employees who
 3 perform functions that are essentially federal in nature and that are funded with federal money—
 4 is not only inconsistent with California's federal legal obligations but unsupported by the
 5 articulated reason for the furloughs in the first place. The Court should therefore rule in favor of
 6 Plaintiff on the question of the legitimacy of the furloughs.

7 **STATEMENT OF THE CASE**

8 In this action, the Union of American Physicians & Dentists (UAPD) challenges
 9 Executive Order S-16-08 ("the Order"), issued by Governor Arnold Schwarzenegger on
 10 December 19, 2008, which mandates furloughs of two days a month for all California state
 11 employees until June 30, 2010.¹ The Order applies to all represented state employees and
 12 supervisors, "regardless of funding sources," even though the reason cited in the Order for
 13 implementing the furloughs is a fiscal crisis arising from a deficit in the state General Fund.
 14 UAPD, which represents state-employed non-management physicians and dentists, seeks a writ
 15 of mandate against the Governor and various state agencies on behalf of UAPD members who
 16 work for defendant agencies and who are paid from sources other than the General Fund.

17 This case is of particular interest to the United States because it involves state employees
 18 who perform an essentially *federal* function. Specifically, UAPD includes employees of the
 19 California Department of Social Services (DSS) who evaluate Social Security Disability
 20 Insurance (SSDI) and Supplemental Security Income (SSI) claims (collectively, Disability
 21 Determination Services Division, or DDS, employees). As explained in greater detail herein,
 22 the salaries of these employees are fully federally funded under the Social Security Act ("Act"),
 23 *see* 42 U.S.C. § 421, and their functions are defined by federal regulations. The United States
 24 contends that the furloughs, which have already had—and continue to have—a significant
 25 adverse impact on the adjudication of disability claims, contravene California's obligations
 26 under federal law.

27
 28 ¹ The Governor subsequently issued another Executive Order (S-13-09), effective July 1, 2009,
 expanding the furloughs to three days per month.

ARGUMENT

I. The United States Has Authority to File a Statement of Interest as a Nonparty to This Action.

28 U.S.C. § 517 authorizes the Attorney General to send any officer of the United States Department of Justice "to attend to the interests of the United States in a suit pending in a court of the United States, or in a court of a State, or to attend to any other interest of the United States." Under this statute, it is not required that the United States intervene in order to represent its interests. Indeed, it is common practice for the United States to choose *not* to become a party but to file a Statement of Interest at the trial level in both federal and state cases, including cases in California state court. *See, e.g.*, Exhibits A, B [California trial court orders reflecting statements of interest filed by U.S.]; *see also Samuel C. Johnson 1988 Trust v. Bayfield Cty*, 2009 WL 1850646 (W.D. Wis. June 26, 2009) ("Although the United States has not moved to intervene... its stake in the outcome of this case is significant...Accordingly, I will treat its arguments as those of an *amici curiae*."); *Weixun v. Xilai*, 568 F. Supp. 2d 35, 35 (D. C. 2008) ("Before the Court are a Suggestion of Immunity and Statement of Interest filed by the United States, who is not a party in this matter"); *Northern Mich. Hospitals, Inc. v. Health Net Fed. Svcs, LLC*, 2008 WL 2233964, *5 (D. Del. May 30, 2008) (holding U.S. was neither real party in interest nor a necessary and indispensable party, and noting that in its statement of interest U.S. "explicitly disclaimed a desire to be a party"); *Tyler v. Smith*, 472 F. Supp. 2d 818, 820 (M.D. La. 2006) (noting U.S. declined to intervene but filed a statement of interest pursuant to 28 U.S.C. § 517); *cf. Sea Hunt, Inc. v. Unidentified Shipwrecked Vessel or Vessels*, 22 F. Supp. 2d 521, 526 (E.D. Va. 1998) (rejecting U.S. attempt to intervene pursuant to 28 U.S.C. § 517 and holding that "the proper way for the United States to assert its interest is through an *amicus* brief or a statement of interest on its own behalf").

Trial courts routinely accept and consider statements of interest submitted by the United States under such circumstances. These statements often prove useful to the court's understanding of specific issues that may be integral to their decision, even in cases where the United States is not a party. *See, e.g.*, Exhibits A, B; *ABC Charters, Inc. v. Bronson*, 2009 WL

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1 1010435, *4-5 (S.D. Fla. Apr 14, 2009) (adopting and incorporating by reference U.S. position
 2 as set forth in its statement of interest); *Samuel C. Johnson 1988 Trust*, 2009 WL 1850646
 3 (finding, after consideration of statement of interest, that U.S. retained reversionary interest in
 4 right of way over plaintiffs' properties); *Gonzalez Paredes v. Vila*, 479 F. Supp. 2d 187, 193
 5 (D.D.C. 2007) (noting U.S. statement of interest entitled to "great deference"); *see also*
 6 *Northern Mich. Hospitals*, 2008 WL 2233964 at *5 (citing U.S. statement of interest); *Weikum*,
 7 568 F. Supp. 2d at 38-39 (same); *S.E.C. v. Nacchio*, 2008 WL 2756941, *2 (D. Colo. July 14,
 8 2008) (same); *Tyler*, 472 F. Supp. 2d at 822, 824, 826, 827, 829 (same); *eSpeed, Inc. v.*
 9 *Brokertec USA, L.L.C.*, 2004 WL 62490, *1, *3 (D. Del. Jan. 14, 2004) (same); *United for*
 10 *Peace and Justice v. City of New York*, 243 F. Supp. 2d 19, 21 & n.3 (S.D.N.Y. 2003) (same).

11 The United States submits that the present case warrants a statement of its interest but not
 12 intervention. Nor is it aware of any California authority that indicates it is precluded from
 13 following this course in California trial court. In fact, as it has already demonstrated, there is
 14 precedent to the contrary. *See* Exhibits A, B; *cf. Jersey Mald Milk Prods. Co., Inc. v. A.A.*
 15 *Brock*, 13 Cal. 2d 661, 665 (1939) (noting that where proposed intervenors did not have
 16 sufficiently direct interest in litigation, they were permitted to file briefs as *amici curiae*).
 17 Accordingly, the United States respectfully requests that the Court consider the Statement set
 18 forth below.

19
 20 **II. California is Responsible for Prompt and Accurate Disability Determinations**
 21 **Under the Social Security Act, and May Not Retain Unused Disability**
 22 **Determination Funds for Any Other Purpose.**

23 The payment of disability insurance and SSI benefits is governed by Titles II and XVI of
 24 the Social Security Act and the regulations implementing the statute. Title II provides disability
 25 insurance benefits to persons who have contributed to the program and are disabled as defined
 26 by the Act, while Title XVI provides SSI benefits to persons with limited income and resources
 27 who are aged, blind or disabled as defined by the Act. *See* 42 U.S.C. §§ 401-434, 1381-1383f.
 28 Under Section 221(a) of the Act, the determination of whether or not an individual is disabled
 under the Act, the date the individual's disability began, and the date on which the individual's

1 disability ceases "shall be made by a State agency...in any State that notifies the Commissioner
 2 of Social Security in writing that it wishes to make" these disability determinations. 42 U.S.C. §
 3 421; *see also* 20 C.F.R. §§ 404.1601 *et seq.*, 416.1001 *et seq.*

4 Under this framework, the state and federal governments each bear specific legal
 5 obligations to ensure efficient, effective processing of disability and SSI claims. The statute
 6 authorizes the Commissioner of Social Security to set regulatory and other standards for
 7 administration of the program and to monitor the state's compliance with these standards. *See*
 8 generally 42 U.S.C. § 421, 20 C.F.R. §§ 404.1603(b), 416.1003(b). In addition, the Social
 9 Security Administration (SSA) provides federal funds to the state to defray all necessary costs of
 10 making disability determinations. *See* 42 U.S.C. § 421(e); 20 C.F.R. §§ 404.1603(b)(3),
 11 404.1626(a), 416.1003(b)(3), 416.1026(a). All such funding must be used for that purpose
 12 alone, and any money that is *not* so used must be returned to the United States. 42 U.S.C. §
 13 421(f); *see also* 20 C.F.R. §§ 404.1626(f), 416.1026(f); *Ditto v. Sternberger*, 145 Md. App. 469,
 14 492-93 (2002) ("[F]ederal funds paid to the state that are earmarked for social security disability
 15 benefits payments may be used only for disability benefits payments. Any excess of funds after
 16 distribution of payments are to be returned to the United States Treasury.").

17 The states, for their part, are "responsible for making *accurate and prompt* disability
 18 determinations," and to that end are required to provide "the organizational structure, qualified
 19 personnel, medical consultant services, and a quality assurance function *sufficient to ensure that*
 20 *disability determinations are made accurately and promptly.*" 20 C.F.R. §§ 404.1620(a) & (b),
 21 416.1620(a) & (b) (emphasis added); *see also* 20 C.F.R. §§ 404.1603(c)(1) & (2),
 22 416.1003(c)(1) & (2). Additionally, a state must, "to the best of its ability, facilitate the
 23 processing of disability claims by avoiding personnel freezes, restrictions against overtime
 24 work, or curtailment of facilities or activities." 20 C.F.R. §§ 404.1621(d), 416.1021(d).

25 In short, in making evaluations of a disability under the Act, the state is acting on behalf
 26 of the federal government. As such, it must follow the applicable standards established by the
 27 federal government. *See* S. Rep. No. 408, 96th Cong., 1st Sess. 55 (1979) (noting that purpose
 28 of 1980 Disability Amendments was to "strengthen Federal management" of the program by

1 giving federal government "the authority to establish, through regulations, the procedures and
 2 performance standards for the State disability determination procedures...States would have the
 3 option of administering the program in compliance with these standards or turning
 4 administration over to the Federal Government."). California, having elected to participate in
 5 the federal disability benefits program, must comply with the mandatory requirements
 6 established by Congress set forth in the Act and with the federal regulations duly promulgated
 7 thereunder. *Id.*

8
 9
 10 **III. The Furloughs Are Inconsistent with California's Obligations Under the Social Security Act.**

11 In the past year, with the worsening national economic crisis, there has been a substantial
 12 increase in applicants for federal disability and SSI benefits. Yet fewer California claims are
 13 processed for each furlough day that is applied to the DDSD employees under the Governor's
 14 Executive Orders, leading to increased delays in the payment of claims to California citizens
 15 who need the assistance these benefits provide. The furloughs have also only exacerbated the
 16 backlog of disability claims, which SSA has prioritized reducing and eventually eliminating in
 17 anticipation of the rise in claims to follow the aging and retirement of the "baby boom"
 18 generation. Moreover, the furloughs undercut the intent of the American Recovery and
 19 Reinvestment Act of 2009, Pub. L. 111-5, Div. A, Title VIII, which specifically directed a part
 20 of its federal stimulus package to support disability claims processing in an effort to reduce the
 21 backlogs and assist disabled Americans in the current difficult economic climate.

22 These negative effects demonstrate that, in implementing the Executive Orders at issue in
 23 this case, California is failing to meet its obligations under the Social Security Act. *See* Section
 24 I, *supra*. The mandatory furloughs undermine California's ability to make prompt and accurate
 25 disability determinations under the relevant federal regulations, and run directly counter to its
 26 responsibility to "facilitate the processing of disability claims by avoiding ... restrictions against
 27 overtime work, or curtailment of facilities or activities." *See id.* It is unavailing for Defendants
 28 to argue that California is fulfilling these responsibilities to the best of its ability, given the total

1 giving federal government "the authority to establish, through regulations, the procedures and
 2 performance standards for the State disability determination procedures...States would have the
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 27 overtime work, or curtailment of facilities or activities." *See id.* It is unavailing for Defendants
 28 to argue that California is fulfilling these responsibilities to the best of its ability, given the total

1 lack of rational justification for its application of the furloughs to DDSD employees who are *not*
 2 being paid out of state funds but who for no other discernible reason are being impeded from
 3 carrying out their duties. Furthermore, the Court should give substantial deference to the SSA
 4 regarding the proper construction of its own regulations. *Thomas Jefferson Univ. v. Shalala*,
 5 512 U.S. 504, 512 (1994) ("Our task is not to decide which among several competing
 6 interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be
 7 given "controlling weight unless it is plainly erroneous or inconsistent with the regulation").
 8 See also *RCJ Med. Svcs., Inc. v. Bonta*, 91 Cal. App. 4th 986, 1010-11 (2001) (applying *Thomas*
 9 *Jefferson* standard to find federal Health Care Financing Administration's construction of its
 10 own regulation regarding delegation of responsibilities by state Medicaid agency was entitled to
 11 deference); *Dep't of Health & Human Svcs. of State of Washington v. Chater*, 163 F.3d 1129,
 12 1133-35 (9th Cir. 1998) (Social Security Commissioner's interpretation of regulation as
 13 precluding SSI benefits to juveniles in privately owned group homes was entitled to deference).

14
 15 **IV. This Case is Distinguishable From the Other Furlough Cases Before This Court and**
 16 **Others Because the Furloughs Are Not Related to the Needs of the DDSD.**

17 While the United States takes no position on the pure state law issues raised by the
 18 Petition, it notes that to the extent Defendants rely on the opinions of Judge Patrick Marlette
 19 denying certain writ petitions that were filed earlier this year in Sacramento County Superior
 20 Court, those cases are clearly distinguishable.² Although Judge Marlette rejected these earlier
 21 challenges to the Order on the grounds that the Governor had statutory authority to reduce the
 22 hours of state employees pursuant to Sections §§ 19851 and 19849 of the California
 23 Government Code, this conclusion was based on his reasoning that

24 ² Three of these suits—*Professional Engineers in Cal. Gov't et al. v. Schwarzenegger* (Case No. 34-
 25 2008-80000126) (hereinafter *PEG*), *Cal. Atty's. Adm'n. Law Judges & Hearing Officers in State*
 26 *Employment v. Schwarzenegger* (Case No. 2009-80000134), and *Service Employees Int'l Union, Local*
 27 *1000 v. Schwarzenegger* (Case No. 2009-80000135)—were filed in close succession in early January in
 28 the Sacramento County Superior Court, were stipulated as being related, and accordingly were heard and
 decided together by Judge Marlette. A fourth case, *Cal. Correctional Peace Officers' Ass'n v.*
Schwarzenegger (Case No. 34-2009-80000137), which was filed slightly later, was also heard and
 decided by Judge Marlette in early February.

1 [u]nder the circumstances of the current fiscal crisis, the reduction in the workweek of
 2 state employees under the furlough order is *indisputably related* to the needs of the
 3 various state agencies, which, from the evidence respondents have submitted to the
 4 Court, run the imminent risk of running out of money and thus being unable to carry out
 their missions, if immediate action is not taken to reduce expenditures.

5 January 30, 2009 Order at 7; February 5, 2009 Order at 5-6 (emphasis added).

6 No such justification exists here. Imposing furloughs on specially funded employees like
 7 the DDSD employees is not reasonably, let alone indisputably, related to the needs of the
 8 defendant agencies, since the money used to administer the DDSD is not part of the state
 9 General Fund.³ Nor is the DDSD in any imminent danger of running out of money, given that
 10 it is fully federally funded. Indeed, the only threat that is preventing the DDSD from carrying
 11 out its mission is not lack of funding but the state's unauthorized imposition of furloughs on
 12 employees who fulfill a federal function. Furloughing DDSD employees only impedes SSA's
 13 ability to provide critically needed federal benefits to some of the most vulnerable members of
 14 California society. Given that the furloughs do nothing to alleviate the State's fiscal problems,
 15 there is simply no reason to enforce them with respect to DDSD employees.

16 **CONCLUSION**

17 For the foregoing reasons, the United States respectfully requests that the Court grant
 18 UAPD's Verified Petition.

19
 20 Dated: October 15, 2009

Respectfully submitted,

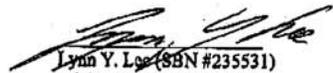
21 TONY WEST
 22 Assistant Attorney General

23 JOSEPH P. RUSSONIELLO
 24 United States Attorney

25
 26 ³ A similar point was apparently raised at oral argument in the *PECG* case, where the petitioners argued
 27 that many of their members were employed by special fund agencies and that the Executive Order, being
 28 targeted at the General Fund deficit, was thus not reasonably related to the needs of those agencies.
 However, Judge Marlette declined to rule on this issue because it was not raised in any of the petitions
 and no evidence had been submitted to support it. 1/30/09 Order at 9 n.10.

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7 Attorneys for Petitioner SEIU Local 1000

8 **SUPERIOR COURT OF CALIFORNIA**
 9 **COUNTY OF ALAMEDA**

11 SERVICE EMPLOYEES INTERNATIONAL
 12 UNION, LOCAL 1000, and YVONNE
 13 WALKER, a taxpayer,

CASE NO. RGO9456750

14 Petitioners/Plaintiffs,

15 vs.

**DECLARATION OF PETER D.
 SPENCER SUBMITTED BY
 PETITIONER**

16 ARNOLD SCHWARZENEGGER as Governor
 17 of the State of California; JOHN CHIANG,
 18 Controller of the State of California; STEVE
 POIZNER, Insurance Commissioner of the State
 19 of California EDMUND G. BROWN, Jr.,
 20 Attorney General of the State of California;
 DAVID GILB as Director of the Department of
 21 Personnel Administration; et al, and Does 1- 100.

Judge: Hon. Frank Roesch
 Date: November 16, 2009
 Time: 9:00 am
 Dept: 31

22 Defendants/Respondent,
 23 Defendants/Respondents.

25 I, Peter D. Spencer, declare as follows:
 26 1. I am Regional Commissioner for the Social Security Administration ("SSA") for
 27 Region IX, which includes California, Nevada, Arizona, Hawaii, Guam, American Samoa, and
 28 the Commonwealth of the Northern Mariana Islands.

1 2. I am very familiar with how the California Department of Social Services, Disability
 2 Determination Services Division ("DDSD") handles disability determinations for SSA's Social
 3 Security Disability Insurance and Supplemental Security Income programs. The determinations
 4 made by the DDSD include ones that involve initial benefit claims, reconsiderations of claims
 5 (appeals of initial determinations), and continuing disability reviews ("CDRs") (medical reviews
 6 of those who were previously awarded benefits).

7 3. I have reviewed Section D of the Statement of Facts in Respondents' Memorandum of
 8 Points and Authorities in Opposition to Petitioner's Request for Writ of Mandate
 9 ("Respondents' UAPD Memorandum") in *Union of American Physicians and Dentists v.*
 10 *Schwarzenegger*, No. RG09456684, filed on November 2, 2009. In addition, I have reviewed
 11 the Declaration of Joe Carlin in Support of Opposition to UAPD's Request for Writ of Mandate,
 12 dated October 28, 2009 ("Carlin Decl.") and the Declaration of Robert Stavits in Opposition to
 13 Petitioner's Writ of Mandate in the instant case.

14 *Continuing Disability Review Targets*

15 4. In the UAPD case, Respondents state that, "[a]s of September 30, 2009 (the end of the
 16 federal fiscal year), the DDSD had processed 22,947 [continuing disability] reviews (only 18
 17 reviews short of complete compliance with our target)." Respondents' UAPD Memorandum,
 18 at 7 (citing Carlin Decl. ¶ 9). Mr. Carlin's statement provides the figure for the reduced CDR
 19 target but not the original, pre-furlough target.

20 5. The DDSD began federal fiscal year 2009 with a target of processing approximately
 21 32,000 CDRs. After the State implemented the furlough days in February 2009, the DDSD
 22 requested that SSA reduce its processing target by 9,000 CDRs so it could give priority to
 23 meeting its target for initial disability determinations. CDRs are mandated by section 221(i) of
 24 the Social Security Act, 42 U.S.C. § 421(i), and the implementing regulations at 20 C.F.R.
 25 §§ 404.1589, 404.1590, 416.989, 416.990 (2009). In order to ensure that the California CDRs
 26 were completed, SSA shifted to other SSA regions the processing of the additional 9,000 CDRs
 27 originally included in the DDSD's processing target.

28 *Case Processing Impacts*

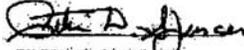
1 6. Processing Times: Respondents' statement that "the DDSD continues to process
 2 claims in a time better than the national average" is misleading. Respondents' UAPD
 3 Memorandum, at 7 (citing Carlin Decl. ¶ 7). While it is true that, as of September 30, 2009, the
 4 DDSD's average processing time for *initial* disability determinations was lower than the
 5 national average, this is only one aspect of DDSD's workload. I am concerned that the ability of
 6 DDSD to handle *all* aspects of its Social Security workload is rapidly deteriorating. For
 7 instance, DDSD is also responsible for processing reconsiderations of initial disability
 8 determinations. From September 30, 2008, to October 2009, the national average processing
 9 time for reconsiderations increased by 3.1 %, or 2.5 days, from 73.3 days to 75.8 days. In
 10 California, over the same period, the DDSD average processing time for reconsiderations
 11 increased by 22.3%, or 13.6 days, from 60.9 days to 74.5 days. Also, SSA estimates that 1,476
 12 fewer California cases are processed for each furlough day that is applied to the DDSD
 13 employees, and that the furloughs delay the payment of claims to California citizens who need
 14 the assistance SSA benefits provide at an average rate of over \$420,800 per day.

15 7. "Pooled" Cases, or Developmental Units: Prior to the furloughs, the DDSD assigned
 16 all initial claim and reconsideration cases to line-unit examiners within 24-48 hours. In
 17 July 2009, DDSD established Development Units and uses these units to assign cases to a
 18 "pool," rather than a specific examiner, to initiate case development. These cases are assigned
 19 to a specific examiner after 30 days in the pooled unit. The volume of cases in the
 20 developmental pool since July 2009 has averaged 3,000 to 5,000 pending cases for any given
 21 week. Such a process requires extra administrative handling, involves multiple examiners in a
 22 single case, and creates inefficient hand-offs that do not exist with direct case assignment.
 23 These additional steps have the net effect of increasing processing time on these cases.

24 8. "Staged" or Backlogged Cases: Prior to the furloughs, the DDSD assigned all cases to
 25 line-unit examiners within 24-48 hours. In September 2009, the DDSD began "staging" initial
 26 claims and reconsiderations. "Staged cases" are, in essence, a backlog, as these cases are simply
 27 set aside with *no* development initiated until some later point when they can be assigned. These
 28 staged cases will eventually cause a significant degradation in processing time. With the

1 are projected to be approximately 8% more than can be processed with available funding. As a
 2 result, the number of pending claims is expected to increase in all state disability determination
 3 services. However, SSA has a national multi-year strategy to reduce the number of pending
 4 claims to an optimal level by 2013. Respondents' continued application of the furloughs to the
 5 federally-funded DDS/D will impede its ability to process claims timely and efficiently. If
 6 DDS/D employees have less production time, they will process less work.

7
 8 I declare under penalty of perjury under the laws of the State of California that the
 9 foregoing is true and correct. Executed on this 9th day of November, 2009, in Richmond,
 10 California.

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 13 PETER D. SPENCER
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Chairman TANNER. Thank you. Mr. Kind, you are recognized.
 Mr. KIND. Thank you. I may not be from California, but my answers may not be any easier. But, first of all, thank you, Mr. Chairman, for holding this very important hearing. Mr. Astrue, thank you for being here.

While progress is being made, and I congratulate you and thank the Agency for the priority you have placed on the backlog issue, it's clear more work needs to be done.

Mr. ASTRUE. Absolutely.

Mr. KIND. I also want to thank you for the quick response that the Agency provided in my request to have video teleconferencing equipment installed in Lacrosse, Wisconsin, which had a large number of backlogs.

But that was quickly responded to. The equipment is in. It's going to reduce now the travel time and the expense and burden for applicants and their representatives, and the administrative judges, as far as moving around the state in order to deal with the huge backlog in western Wisconsin.

Having said that, I also took a chance or a moment before coming over here to take a look at the processing time in Madison and Milwaukee, in particular. I know we're facing some big issues, but if you look at the average processing times for the hearing offices around the country, I see that Madison hearing office has an average processing time of 588 days, which ranks 135 out of 143 offices, nationwide. Milwaukee is 552 days, which is 124 out of 143, both of which have more than doubled the processing time of the fastest office.

And I am wondering if you have any information to share why this is occurring in Wisconsin, why the processing time is so slow there.

Mr. ASTRUE. That's a very fine question. One of the things that I figured out a few months after I became Commissioner was that I was walking into a situation with horrible national backlogs. But when I really had a chance to get deep into the numbers, it was clear that we had a distribution issue around the country.

Essentially, the infrastructure of our hearings office hadn't changed in 20 years. It was the same number of offices in the same locations with the same number of judges, and the demographics of the country have changed enormously in that time period.

As bad as the backlog was in many places in the country, if I you actually take your fingers on a map of the United States—I used Madison, Wisconsin on the west, and the eastern shore of Michigan on the other—and slide down, then start angling to the east, and then end up in Florida, you see case filings per administrative law judge a few years ago of three or four per day. As much as we're pushing for more productivity, no judge is fast enough to decide that many each day.

Mr. KIND. Right.

Mr. ASTRUE. In my lifetime, no judge is going to be deciding, four cases per day. We've got other places, like New Haven, Connecticut, where they're only taking in half a case per judge per day. So, there is a misallocation around the country.

So, we spent a lot of time with the selection of these new offices looking at the demographics of the country for population growth and also looking at filing incidence, because there are some places, like Michigan, that have been in chronic recession since 2001, where the filing rates are very high, and we're trying to equalize that around the country.

Mr. KIND. Well, I am glad to hear that you are sensitive to the caseloads.

Mr. ASTRUE. For Wisconsin, the key thing is that we are upgrading the satellite office in Madison to a full hearing office.

Mr. KIND. Yes.

Mr. ASTRUE. GSA is on schedule for that for June of next year.

Mr. KIND. Well, I appreciate that. Obviously, there are some issues still.

But, Mr. Chairman, I just received, on November the 6th, a letter from a friend, an attorney, who represents many Social Security applicants from western Wisconsin. I would like unanimous consent to have this introduced to the record at this time.

Chairman TANNER. Without objection.

[The information follows:]

JOHN A. KAISER

ATTORNEY AT LAW

November 6, 2009

Social Security Subcommittee
United States House of Representatives

Dear Social Security Subcommittee:

I understand you are holding a hearing on November 19 regarding the disability program and its backlogs. I would like to give you an idea of the severe personal toll the backlog is taking on disabled workers in Western Wisconsin.

Over the past 33 years, I have represented thousands of Social Security applicants. The wait for decisions and payments at all stages of the process have seemed to get longer and longer.

Here are three examples of how these delays are affecting the lives of disabled workers, all of whom had long and productive work lives and have always "played by the rules".

A middle-aged Eau Claire area woman became disabled, when her knees deteriorated to the point where she needed knee replacements. Her knee conditions have led to back problems causing chronic pain for which she has to take highly potent narcotic drugs. After waiting nearly three years for her hearing, the judge granted her benefits after ten minutes. While waiting for her hearing, her family lost its home to foreclosure and had to file for bankruptcy. After the hearing, I asked if they would have lost their home or had to file bankruptcy if she had been getting her Social Security check all along. Tearfully, she replied, absolutely not. (To add insult to injury, I just received a telephone message from her a few days ago. Even though this client's fully favorable decision was dated August 31, 2009, she has still not received either her first check or her back pay. She called the Social Security District Office last week, and was told it could take 90 days for the Payment Center to get her into pay status and to issue her payment for past due benefits.)

Three days ago, a client of mine from Humbird, Wisconsin received his fully favorable decision almost exactly three years after filing his Social Security application. Unfortunately he was served one day later with a Summons and Complaint to foreclose his home. (His monthly payment had been increased from \$327 per month to over \$900 per month, because the mortgage lender had to pay his property taxes last year.) He is now hoping to negotiate a redemption, but it is unclear whether the mortgage holder will do so, or whether he will have to file for bankruptcy. We are hoping that the Social Security payment center will not delay payment of his case, so he will have his

back pay to use in his attempts to work something out with the mortgage holder. (See the following case.)

Yesterday, the husband of a client from Chippewa Falls came to my office to ask if there is anything I can do to move along payment of his wife's benefits. His wife had filed her application in July, 2006. Nearly three years later, she received a fully favorable hearing decision, dated June 19, 2009. Now, nearly five months after the Judge found her disabled, she has still not received either a monthly benefit payment or her back pay. My client and our staff have placed calls to the District Office, and have been told that the hold-up is at the payment center, and all the local office can do is try to prod the payment center staff on.

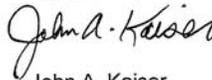
Ladies and gentlemen, these are not isolated examples. I could write a book about how these cases are hurting real people, who have done nothing but work hard and pay their FICA and self-employment taxes, and then one injury or one illness turns their family's life upside down. It would be a collection of tragedies.

As the baby boom generation ages, and considering the raises in the retirement age, simple demographics should predict that more people will be applying for the disability benefits for which they have paid. The demands on the system will increase, and it is important that we provide the Social Security Administration the resources with which to efficiently handle these demands.

When I discuss the backlog with my clients, I repeatedly hear something I want to relay to you: Almost every client asks how trillions can be spent to bail out Wall Street, yet the Social Security Administration is not given enough resources to handle its load in a timely fashion. I have no answer to that question.

Thank you for your consideration of this severe problem.

Respectfully submitted,



John A. Kaiser

Mr. KIND. But I want to also just quote from him. There are some examples of what he has been seeing out there, and in one particular example, he stated, "A middle-aged Eau Claire area woman became disabled when her knees deteriorated to the point where she needed knee replacements. Her knee conditions have led to back problems causing chronic pain, for which she has had to take highly potent narcotic drugs. After waiting nearly three years for a hearing, the judge finally granted her benefits within just 10 minutes. And while waiting for her hearing, her family lost its home to foreclosure, and had to file for bankruptcy. And after the hearing, he had asked her if they would have lost their home and had filed for bankruptcy if she had been getting her Social Security check all along. And tearfully, she replied, absolutely not."

"And to add insult to injury, I just received a telephone message from her just a few days ago, that even though this client's fully favorable decision was dated August 31 of 2009, she has still not received her first check or her back pay. She called the Social Security district office last week, and was told it could take 90 days for

the payment center to get her into pay status, and to issue her payment for past due benefits.”

Now, this is not all that atypical, unfortunately, and this, I think, is the human dimension to the backlog urgency that we’re facing: real people, real problems, and, typically, some of the poorest and most vulnerable members of our society.

So, the more we can concentrate on that the better, and I know we have a dual role here, as far as your implementation and our support in Congress to getting this done. I think it is important that we continue to see that we do everything we can to alleviate this type of suffering throughout the country.

Mr. ASTRUE. I’m in absolute agreement. I do think that when we get through the recession and we go to health IT, we will be able to cut the time at the state level by more than half.

In the strategic plan that we have laid out, the goal is to get to an average processing time of 270 days. We still have a way to go, but that’s what we’re trying to do.

Mr. KIND. Mr. Chairman, with your indulgence, I just received word that one of our outreach rural SSA offices has to be shut down now, because of threats that were being delivered to the staff there, and, therefore, protective services have been brought in. They’re going to investigate and make sure that those threats aren’t carried out, and something bad doesn’t happen, but I hope this isn’t a trend that you are seeing out there, as far as threats of violence.

Mr. ASTRUE. Sadly, it is. We have a violence report when there is an actual assault or a serious threat to an employee. I insist on reading every single one of those. When I started, I was probably seeing about three of those a week. As the economy started to unravel, you could see it in these reports, and I sometimes get 10 a day now. So it’s been a very serious issue.

It is remarkable to me we haven’t had any actual loss of life yet. We have had some very close calls, and it is a scary thing. I think a lot of times people don’t appreciate the courage of the people on the front line in our offices. They face a lot of very disturbed, angry people day in, day out and don’t know what people like that are going to do.

Mr. KIND. I echo that. I thank you for acknowledging the fine work that’s being attempted out there for us, too. Thank you. Thank you, Mr. Chairman.

Chairman TANNER. Thank you. I will call on Mr. Johnson, you are recognized for a follow-up.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, the idea of states preventing people from working, like in California as you just talked about is concerning. How many states are doing that, do you know?

Mr. ASTRUE. We’re up to 10 right now.

Mr. JOHNSON. Ten of them?

Mr. ASTRUE. Mr. Johnson, 10, yes.

Mr. JOHNSON. Have you talked to all of them?

Mr. ASTRUE. I have talked to pretty much all of them, or at least tried to. I—

Mr. JOHNSON. Well, we pay their salaries, don’t we?

Mr. ASTRUE. Yes, and we pay their overhead. Of course, it's also state taxes that are foregone, too. So they're actually directly hitting their coffers, as well.

On top of it—and, again, it is more important than just the fiscal—the people who don't get cash and health benefits from us are often tapping their other state programs, too. So it's just a devastatingly nonsensical thing for states to be doing, from both a moral and fiscal point of view.

Mr. JOHNSON. It's both parties, right?

Mr. ASTRUE. Yes, it's bipartisan. It's split pretty evenly, Mr. Johnson.

Mr. JOHNSON. Yes.

Mr. ASTRUE. That's right.

Mr. JOHNSON. Thank you. Let me ask you another one. In August you responded to a letter where you confirm that 1,700 prisoners received benefits erroneously. We know that over 8,000 payments were sent in error to those who died.

Have you recovered all that? And if Congress decides to send another \$250 payment, can you assure us that those mistakes won't happen again?

Mr. ASTRUE. Not quite. We're almost there, Mr. Johnson. So, first of all, one of the things it's important, I think, to recognize is that not all of the prisoner payments were errors. The legislation was written in a manner that we were supposed to pay some prisoners. We did indicate at the time——

Mr. JOHNSON. I understand that.

Mr. ASTRUE [continuing]. That we didn't have the databases for that, and everyone was in a rush——

Mr. JOHNSON. That's because your computer system isn't up to date.

[Laughter.]

Mr. ASTRUE. Well——

Mr. JOHNSON. Come on.

Mr. ASTRUE. Normally we're not in the business of tracking prisoners. So, I would certainly encourage you, if there is a return to another \$250 payment, which the Administration and I support, that Congress reconsiders the approach to prisoners. That would eliminate the problem, all together.

But we are embarrassed by this. It's not a large amount of money in the context of \$13 billion. We have gone through several exercises to say, "What are the lessons learned," "Are we ready if we're asked to do this again?"

For the widows, there is almost no lost money. That's all pretty much been taken care of. They're whittling down on the prisoners. It's often difficult to get cooperation from the states. I believe—I will confirm this for the record—it's fewer than 500 that we're still working on at this point. It's a work in progress. Hopefully within the next few months we will have done everything that we need to do on that.

[The information follows:]

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As of November 19, we had identified issuance of 1,535 Economic Recovery Payments (ERPs) to ineligible prisoners. Of these payments, the Department of Treasury has reported 280 payments were cashed. Through our debt recovery efforts, we have collected 43 payments. A balance of 237 ERPs to prisoners, with a value of \$59,250, remains outstanding. We are continuing our aggressive collection efforts.

TOTAL P.10

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. ASTRUE. But we're not quite done yet.

Chairman TANNER. Well, in the next few months we want to stay updated. We may have a follow-up right after the first of next year, to see how we're doing and see what we can do with this.

Mr. ASTRUE. Okay.

Chairman TANNER. There are, as Mr. Kind indicated, people suffering.

Commissioner, thank you very much.

Mr. ASTRUE. Thank you, Mr. Chairman.

Chairman TANNER. We will be back in touch with you quite soon.

Mr. ASTRUE. Okay. Thank you, Mr. Chairman. Again, thank you for all your support. We very much appreciate it.

Chairman TANNER. I am going to introduce the next panel while they are taking their place. Ms. Barbara Kennelly, of course, is the President and Chief Executive Officer of the National Committee to Preserve Social Security and Medicare, and she was here for 23 years and survived, so, Barbara, it is always good to see you again. We are always glad to have you back, and we're going to look forward to your testimony.

Also on the panel is Ms. Beth Bates. She works in my district, in Tennessee, and she is a lawyer who is quite knowledgeable in these matters. Beth, we are delighted to have you here.

We also have the Honorable Patrick O'Carroll. Mr. O'Carroll, of course, as you know, is the Inspector General at the Social Security Administration. Mr. O'Carroll, thank you for coming today. I am going to speed this list up.

Ms. Robert, thank you for being here. She is from Chicago, Illinois, and has much experience in matters of this nature.

Mr. Larry Auerbach, who is the Administrative Law Judge at the Social Security Administration in the Atlanta office is also here. We are delighted to have all of you. I apologize for the hurried introductions, but we've got a time problem, and it's not our friend at the moment.

Sam, do you have any comments?

Mr. JOHNSON. No.

Chairman TANNER. Congresswoman, you are recognized.

Ms. KENNELLY. I was not here in Congress for 23 years.

Chairman TANNER. You weren't?

Ms. KENNELLY. No.

Mr. JOHNSON. Turn your mic on.

Chairman TANNER. Let's see. It says, "After a distinguished 23 years" in elected public office. I get it.

Ms. KENNELLY. Yes.

Chairman TANNER. Okay.

Ms. KENNELLY. I was a city councilwoman for many years.

Chairman TANNER. Yes.

Ms. KENNELLY. Then I was Secretary of the State of Connecticut. I was here in Congress for 17 years.

Chairman TANNER. Okay.

Ms. KENNELLY. I was on this Committee.

Chairman TANNER. Well, you escaped all right.

Ms. KENNELLY. Yes. No, no, no. I was on this Committee 16 years.

Chairman TANNER. I know.

Ms. KENNELLY. I loved every single moment that I was here.

Chairman TANNER. Well, we are glad to have you back. Thank you.

Ms. KENNELLY. I want to tell you, Congressman Johnson, I am the Acting Chair of the Social Security Advisory Board, and I was getting prepared for this hearing. I was really kind of nervous about testifying so I studied last night questions you asked Syl Scheiber. They were very good questions. Do you remember them? They were very complicated. I read them three, four, five times.

Now, you're not going to ask me those today, are you?

[Laughter.]

Ms. KENNELLY. They were wonderful questions. I think that's what we have to remember, is how important this Committee is, and how important Social Security is.

Now, I will read my testimony.

**STATEMENT OF BARBARA B. KENNELLY, ACTING CHAIR,
SOCIAL SECURITY ADVISORY BOARD**

Ms. KENNELLY. I am pleased to appear before you today in my capacity as the Acting Chair of the Social Security Advisory Board to discuss the progress SSA has made in clearing the disability backlogs.

Is the Commissioner still here? Well, he has done a very good job. There were some old, old, old cases, and he came in, and he really went at those old cases. I don't have the figures. Kim, do you have them, or does somebody have them? I mean, what he did was exceptional, and I think he should get credit for that.

What I really wanted to thank the Committee for is the active interest it has taken in reducing the disability backlogs. But you only could do it as a result of your work. The appropriation for SSA was nearly \$10.5 billion, and the Recovery Act included an additional \$500 million to address the increased claims due to the recession, and attack the backlog that had been choking the system, forcing applicants to wait for years to receive a Social Security check.

As you know, SSA has long struggled with managing its disability hearings workload. The chief source of the problem has been years of under-funding, coupled with a growing caseload. As a result, the President requested \$11.45 billion for SSA, in administrative costs. If SSA had any chance of keeping up with the influx of claims it will need its full appropriation.

The fiscal year 2011 budget is now being prepared by OMB. It is my hope that the President and the Congress will include sufficient funds in the fiscal year 2011 appropriation to address both current backlog cases and new claims triggered by the recession. SSA will need about \$950 million, just to maintain current staffing. In addition, they will need funds to expand capacity at the disability and the hearing offices to address backlogs and increased claims.

Earlier this year, the Subcommittee sought the perspectives of the Advisory Board on the progress made by SSA in using Recovery Act resources to reduce its disability claims backlog. In the seven months since the hearing, we have been watching closely as the Agency has carried out its backlog reduction initiatives, including 148 new Administrative Law Judges, which is wonderful.

I mean, hiring 1,000 hearing office support staff, establishing three national hearing centers, and eliminating cases that were

over 850—and that’s what the Commissioner did—850 days old. That is unacceptable, absolutely unacceptable. Productivity in the hearings offices has been steadily increased. ALJs have improved their production, and nearly three quarters of the judges are clearing between 500 and 700 cases per year.

The Board was briefed on several initiatives underway at the office of hearings and review that will emphasize data analysis and processes. One initiative was the development of a model that stimulates the current work process in order to identify steps in a process that creates bottlenecks. Some of these initiatives hold promise.

However, in my view, as the Agency continues to streamline the hearing process, it is critical that due process for beneficiaries be maintained. We focused on that when I was on the Committee. The recent gains in reducing the hearings backlog are a significant accomplishment. We anticipate that the Agency will continue to improve its process at that level.

However, SSA is being confronted with a tremendous growth of new claims. This year SSA received 3 million new disability claims, 380,000 more than previously expected. This is already placing significant stress on the DDSs. They have now 783,000 initial claims pending, an 18 percent increase from April.

The rapid increase in unemployment is a major reason for the unexpected increase in disability applications. Historical trends document that disability applications rise and fall in tandem with the unemployment rate. People with disabilities who previously worked despite their medical conditions are now unable to find work, and may decide to apply for disability benefits. These people, combined with the Baby Boomers—I hate that word “Baby Boomers,” it’s overused—who are reaching prime disability age, could raise DDSs claims to 2010 to 3.3 million, according to SSA actuaries.

Although the number of new claims will drop as the recession eases, earlier cases will still be clogging the process. A rapid rise in the backlog claims at the initial stage will have significant consequences for applicants. These are people facing dire economic circumstances, if they do not receive a fair and timely disability decision. SSA has pledged to bring down the current number of initial claims from 783,000 to 525,000 by 2013. But they will need the comprehensive strategy in order to be successful.

Between now and 2013, SSA may realize some gains in productivity and efficiency, as more electronic initiatives come online. But these do not provide relief in the near term. DDS needs to be adequately funded, and have sufficient staff to carry out their mission.

In addition, I must remind you that the state furloughs that have been—you talked about those—are making this problem worse.

As we look down the road, it is clear that 2010 and 2011 will present extraordinary workloads for the Social Security Administration. It is imperative that we have the resources and plans in place to meet the challenge, and to be able to continue to provide the high quality public service for which they are known.

Let me tell you. One of the few regrets I have in my life is I didn’t work harder on Social Security when I was on this Committee. I know you do work hard, Sam. John, you’re Chairman, but

let me tell you, this is a huge program. For years, Social Security was like a nice Subcommittee. It had retirement, it had disability and it had spousal benefits, but you know what? It's got much bigger than that. Social Security benefits are a huge part of our country.

Right now, with the economic situation that we're in, I ask the two of you to work really hard to make sure that the people of this country are taken care of, because I've got to tell you, Social Security is very important to this country.

[The prepared statement of Ms. Kennelly follows:]

**Prepared Statement of The Honorable Barbara B. Kennelly, Acting Chair,
Social Security Advisory Board**

Chairman Tanner, Mr. Johnson, Members of the Subcommittee. I am pleased to have this opportunity to appear on behalf of the Social Security Advisory Board to present the Board's view on the progress made by the Social Security Administration (SSA) in clearing the disability backlogs. As you have noted, the agency is facing unprecedented workloads in the Disability Determination Services at the same time they are diligently working to bring down the backlogs in the hearings offices.

Mr. Chairman, I want to thank the Congress and especially this Subcommittee for the much-needed investment that you have already made in the Social Security Administration. In FY 2009, Congress provided SSA with an administrative budget of \$10.4 billion—\$126.5 million above the President's budget request. I also want to thank you for the enactment of the *American Recovery and Reinvestment Act*, which provided SSA with another \$500 million to process the growing backlog of disability claims. These funds have helped ensure that the agency is able to fulfill its vital role in serving the American public.

Through the services it provides, the Social Security Administration touches the lives of nearly 60 million beneficiaries, 145 million workers and nearly every American. One out of every six individuals receives monthly cash benefits from Social Security or Supplemental Security Income (SSI), the major programs that SSA administers. This fact alone should be an indicator of the importance of continuous, smooth operations of this agency.

Social Security is an important economic lifeline for millions of America's most vulnerable people, including aged individuals and persons with disabilities, as well as their spouses, dependents, and survivors. In fiscal year 2009, 42.6 million people were receiving retirement and survivor benefits and another 15.1 million were receiving disability benefits. SSA processed over 4.7 million retirement and survivor claims, 2.8 million initial disability claims, and 661,000 disability hearings during the fiscal year that has just ended. The agency provided services to the public in general by processing over 19 million requests for new or replacement Social Security cards, posting 273 million earnings items to individual earnings records, answering 67 million calls to its 800-number and receiving over 45 million visitors to the local field offices.

Over the past 74 years, the agency has been a diligent steward of the public's trust, overseeing the benefit programs upon which so many individuals and families depend. In recent years, however, SSA's ability to fulfill its mission has been severely strained. Chronic underfunding despite growing workloads has been the chief source of the problem. In his fiscal year 2010 budget, the President has requested \$11.45 billion for the Social Security Administration. If SSA has any chance of keeping up with its growing workload, it will need this full appropriation. The fiscal year 2011 budget is now being prepared by the Office of Management and Budget. It is my hope that the President and the Congress will include sufficient funds in the fiscal year 2011 appropriation to address the current backlog of cases as well as the new recession-driven claims.

Fiscal Year 2009 Accomplishments

It is well known to this Subcommittee that SSA has long struggled with managing its disability hearings workload. This year, indeed, may well be a watershed year for the hearing process where new business processing and management analysis tools have been developed, electronic service delivery has been improved, and much-needed staff has been added.

The investment made in SSA has had a significant impact on the agency's ability to address the disability backlog. They have been able to do unprecedented hiring—nearly 9,000 new employees. These new personnel have allowed them to replace re-

tiring staff and expand critical front-line service in the field offices, the state disability determination services, and the hearings offices. For the hearings process, this additional funding gave the Office of Disability Adjudication and Review (ODAR) the ability to hire 148 Administrative Law Judges (ALJs), bringing the total ALJ corps up to 1,238 judges as well as adding 1,000 support staff.

Earlier this year, this Subcommittee sought the perspectives of the Social Security Advisory Board on the progress made by SSA in using ARRA resources. When that hearing was held last April, the effects of the recession were not evident in the hearing appeals process. The backlogs and long waiting times for a decision were—and still are—a function of understaffing, lack of a standardized business process, and fledgling electronic tools that were still being tested. At that time over 760,000 people were waiting on average nearly 500 days for disability decisions from Administrative Law Judges.

In the seven months since that hearing, productivity in the hearings offices has steadily increased; each month the number of pending claims has declined and the number of people now waiting for a hearing has decreased nearly five percent. Administrative Law Judges have improved their average daily production. Nearly three-quarters of the ALJs are clearing between 500–700 cases per year; this is a 15 percentage point increase over fiscal year 2008. SSA exceeded its productivity goals by processing almost 14,000 more hearings than originally estimated and ended the fiscal year with an average processing time 25 days lower than anticipated in earlier FY 09 budget estimates.

When SSA developed its hearings backlog reduction plan in 2007, they acknowledged that too many claims had been allowed to languish unadjudicated far too long. This year, under the most recent phase of the “aged case initiative” ODAR has cleared over 166,610 cases that were over 850 days old. At the end of FY 09, less than 1 percent of hearings pending was 850 days or older. The aged case backlog is now sufficiently stabilized that they have been able to incorporate new standard operating business rules that will ensure that the oldest cases are routinely adjudicated first.

In several of the Board’s reports, and most recently in our April 2009 report on improving public service through technology, we stated that SSA needed to do a better job of integrating electronic service delivery options into its business process. Growing workloads coupled with the public’s increasing demand for alternative ways to do business with the agency requires that SSA explore new ways of meeting with claimants and their representatives and holding hearings. With the funding received from Congress, SSA has been able to meet that challenge and the agency has opened three new National Video Hearings Centers to help process workloads for hearings offices with exceptionally large backlogs. This increased capacity has resulted in over 86,000 hearings being held sooner rather than much later.

The recent gains in productivity are a significant accomplishment, and we fully expect the agency to continue to improve its process. However, they are now confronted with a tremendous growth in new claims. As a result, productivity improvements alone will not be sufficient. There needs to be additional investment in staff. SSA projects it may lose up to 44 percent of its current employees by 2016. Within the ALJ corps, 59 percent are retirement-eligible and another 31 percent will become eligible to retire between FY 2010 and FY 2019. Moreover, new workload projections indicate that they will need to add approximately 400 more ALJs, bringing the total ALJ corps up to 1,600.

Last April, the Board was briefed on several new initiatives underway in ODAR. The agency is placing a growing emphasis on data analysis and process management. They have developed an electronic business process model that simulates how work currently is processed, and for the first time, will be able to systematically identify steps in the process that create bottlenecks or do not add value to the process. While this initiative is very new, it holds promise for improving workload management throughout the hearings process. Through this modeling, ODAR will be able to plan proactively for changes in receipts and how to redistribute workload, anticipate the need for changes in staffing mix, and determine what can be mitigated by improved management practices. The current use is focused on assuring the success of the agency’s plan to reduce the backlog. Going forward, it will give ODAR the capability to manage proactively, not just reactively. It is a new direction for ODAR and we hope it will prove effective.

Growth in workload

The hearings backlogs are still of tremendous concern but become even more so when they are coupled with the anticipated rise in claims over the next 10 years. SSA’s workload will increase dramatically. Projections indicate that retirement claims are likely to jump by over 40 percent and disability claims could rise by near-

ly 10 percent. The 2009 OASDI Trustees Report estimated that by 2015 there will be 50 million retirees, widows and widowers, and dependents receiving benefits. Those individuals will be expecting efficient and modern service from the Social Security Administration.

But the anticipated growth in claims does not stop there. The baby boomers are entering their disability prone years and the number of initial disability claims is projected to rise steadily over the next several years, and indeed it has. The Office of the Chief Actuary (OACT) has carefully tracked the anticipated growth in disability claims that will be due to the baby boom population. Projections made in 2007–2008 for the fiscal year 2009 hovered just around the 2.6 million mark. But the reality has been significantly different. In 2009, SSA actually received 3 million new disability claims this year, about 380,000 more than originally expected.

The most obvious factor impacting the volume of disability applications today is the recession with its significant increase in unemployment. Recent history demonstrates that disability applications generally rise and fall in tandem with the unemployment rate. The DI application rate per 1,000 workers among non-elderly adults rose 37% from 1989 to 1993 (from 8.3 per 1,000 workers to 11.5), and by 49% from 1999 to 2003 (from 8.8 per 1,000 workers to 13.1). One exception was seen from 1980 to 1984 when eligibility for disability was significantly curtailed while unemployment soared.

The logic is straightforward. In a recession with widespread unemployment, people with disabilities who previously worked despite their condition may find themselves without a job, especially people with fewer skills or who are approaching retirement. These people may be more likely to apply for disability benefits to support themselves and their families. The recession may speed up an application that might have been made later or it may encourage more individuals who think that they might have a disabling condition to apply for benefits.

What does this mean for SSA's disability workload? The 15 percent increase in new initial claims experienced in fiscal year 2009 has put extraordinary stress on the DDS system. Backlogs are climbing and there are now 783,000 initial claims pending in the DDSs. This is an 18 percent increase since April. And it is anticipated that these backlogs will grow. More recent projections by SSA's actuaries estimate that DDS claims in 2010 will peak at 3.3 million, and stay just above 3 million through 2012. SSA expects pending claims in the DDS to climb to 1 million by the end of 2010. These claims forecasts may increase or decrease as unemployment figures change.

Tackling the Initial Claims Workload

SSA has acknowledged that the pending level of initial claims in the DDSs is unacceptable and they have pledged to bring the pending workload down to 525,000 by fiscal year 2013. Their strategy to reduce this backlog includes additional hiring and overtime in the DDSs. With the additional funding provided by Congress this year, the DDSs were able to hire 1,400 new disability examiners. Even though they were not fully engaged for the entire year, these new hires were instrumental in processing an additional 30,000 claims.

SSA's electronic folder makes it fairly easy to transfer work to other offices. An element of the agency's current plan includes shifting work out of heavily-impacted DDSs and into offices, including the federal quality assurance units, where there is excess capacity. In addition, SSA is in the process of establishing four "mega-DDSs". Similar to the National Hearings Centers, these state mega-DDSs will be able to provide assistance to overloaded DDSs from anywhere in the country.

The agency also continues to improve and expand their "compassionate allowance" and "quick disability decision" processes. These tools, combined with ongoing policy simplification initiatives may help to speed up decision making and free up valuable disability examiners for the more complex cases.

Need for a comprehensive workload strategy

As SSA works to reduce its disability backlog and address the influx of new claims, the agency should be encouraged to develop a comprehensive strategy. This would include establishing a plan for processing initial claims just as it has created a plan for processing appeals in a more timely and efficient manner.

It strikes me that the DDSs are in a position similar to the one that the hearings offices were in about two years ago. They have suffered staffing losses and had some success with electronic adjudication tools. However, electronic tools alone are not enough to offset the reductions in disability examiners and medical staff and the increase in caseloads. SSA has relied to date on shifting workloads across offices and ramping up productivity, but nothing will work without funding for additional staff. We do not want to produce efficiency at the expense of due process.

SSA has a number of electronic initiatives under development including electronic medical evidence (EME) and health information technology (HIT) tools that may hold long-term promise. Recently, the Board was briefed on the scope and timeline for the EME and HIT initiatives. We are encouraged by these initiatives. SSA has a basic plan for development and implementation and is making good use of the ARRA funding. We appreciate the work that is going on within the organization. Over the next three years, SSA should have several projects underway which could greatly enhance the electronic exchange of medical evidence. If effectively implemented, they should improve timeliness of disability decisions and enhance public service.

Similarly, work continues on the development of a single DDS case processing system which will streamline case processing, improve data sharing, and help to improve management.

The longer-range strategies for improving the disability process are necessary, but they do not provide relief in the near term for the hundreds of thousands of vulnerable individuals who have turned to the Social Security Administration for assistance. We believe that a comprehensive backlog reduction plan—similar to the one developed for ODAR—should be instituted for the DDSs. Working with the DDSs, the agency should be able to identify and adapt the best practices from the hearings backlog reduction plan; in addition consideration should be given to accelerating the eCat disability adjudication analysis tool. SSA and its state partners must move swiftly to staff fully the mega-DDSs and establish the criteria that will be used for obtaining workload assistance from these centers.

There is one caution I need to raise: the backlog reduction plan in the DDSs can not come at the expense of well-reasoned and high quality decisions based on a well-developed evidentiary record. Rushing cases out the door to meet production goals does not, in the end, improve service to the American public. DDSs need to be adequately funded and have sufficient staffing to carry out the job. I do not need to remind this Subcommittee that the furloughs that have been imposed by States on nine DDSs slow the progress in reducing the backlogs and undermine the quality of public service. These issues need to be resolved as quickly as possible.

Beyond 2010

It is only a matter of time that the surge in initial claims is felt in ODAR. If the traditional waterfall of appeals occurs, about 45 percent of those denied at the initial level will request reconsideration, and then approximately three-quarters of the individuals who are denied at the reconsideration level will appeal to the ALJ. It takes about 250 days, on average, for an initial claim that has been appealed to reach ODAR and then several more months before the case is on an ALJ's desk. This means that the increased caseloads in the DDSs will begin to materialize in ODAR in the second half of 2010 or in early 2011. Without continuing assistance from the Congress, these disability cases could take several years to work their way through the agency.

As we look down the road, it is clear that fiscal year 2011 will present extraordinary workload levels throughout the Social Security Administration. It is imperative that the agency has the resources and tools in place to meet this challenge and to be able to continue to provide the high-quality public service for which it is known.

Thank you for inviting me to appear before you today. I will be pleased to answer any questions you may have.

Chairman TANNER. Thank you. Thank you for all your service, and your testimony. We will ask unanimous consent that Members may submit written questions to you all if we run out of time here. Thank you.

Ms. Bates, welcome from west Tennessee. You're recognized for five minutes.

STATEMENT OF BETH BATES, CLAIMANTS' REPRESENTATIVE, ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DIS- ABILITIES, JACKSON, TENNESSEE

Ms. BATES. Thank you, Mr. Chairman, Ranking Member Johnson, and Members of the Subcommittee. Thank you for inviting me

to testify here today on behalf of the Consortium for Citizens with Disabilities Social Security Task Force.

I have represented individuals with Social Security and SSI claims for more than 25 years. I would like to thank the Chairman and his district office staff in Union City and Jackson for a great deal of help over the years.

Social Security finds itself at a critical crossroads. For the first time in a decade in fiscal year 2009, the backlog at ODAR, the third level of disability adjudication, was reduced from the previous year. That was both in number of pending cases, the length of time that they pended, and in processing time.

At the same time, we think because of the recession, there was a huge increase in the backlog of cases at the first two levels of adjudication, the State DDSs. About 40 percent, nationwide. I suggest respectfully that this increase in the backlog there, largely due to the numbers of new cases, threaten the goal of Social Security to eliminate the backlog at ODAR by the year 2013.

I am honored to be here, but I am saddened, because I see the suffering caused by the backlog with my clients. My client, Mr. H, who lives in Huntington, Tennessee is all too typical. When I met him in early 2008, he and his teenage son were homeless. They were staying in a dangerous area, and in a motel.

He had a—Mr. H had a history of arthritis, liver disease, coronary artery disease, depression, adult attention deficit disorder. He had worked as a grocery bagger and as a sawmill laborer. He had been out of the work force for some time, caring for his invalid mother, who subsequently became too ill to stay at home, and had to go to a nursing facility.

Unfortunately, Mr. H was turned down twice at the Disability Determination Section, and requested a hearing in January of 2009. He is still waiting. He is waiting at Nashville ODAR. The ODARs where I practice, Nashville and Memphis, while slightly better than Madison and Milwaukee, they had lost ground in the year 2009, and the processing time has actually increased.

I think that Tennessee, unfortunately, is a good example of the problems with the backlog. In 2009, Tennessee's backlog increased from—increased to 66 percent at the first 2 levels. That was in the top 10 in the nation. That was above the 40 percent, nationwide.

The director of DDS has been good to work with. Other advocates, colleagues of mine, have tried to improve the process. But Tennessee is third from the bottom in approvals at the initial and reconsideration stage. I say that's a double whammy that's going to hit the five ODARs in Tennessee, and in particular, Memphis and Nashville, that seem to have the biggest backlog.

I am an optimistic person. But, absent additional resources in 2010, which I think are on target, and 2011, I can't say but that it will get worse, because we have cost of living and overhead type issues there.

I do appreciate what the committee has done, and the Congress has done in 2008 and 2009—as other witnesses have indicated—and have marked up for 2010, but I think we are going to need even more in 2011 to maintain the progress that has been made.

We support many of the other non-dollar initiatives that the Commissioner has suggested, such as increased technology, the

senior attorney adjudicator program. We just have one word of caution, that any proposals—we don't want our clients' due process rights to be jeopardized. We want the folks who are eligible under the law to receive the benefits that they need for their basic necessities of life.

Thank you.

[The prepared statement of Ms. Bates follows:]

Prepared Statement of Beth Bates, Claimants' Representative, on behalf of the Consortium for Citizens with Disabilities, Jackson, Tennessee

Chairman Tanner, Ranking Member Johnson, and Members of the House Ways and Means Social Security Subcommittee, thank you for inviting me to testify at today's hearing on "Clearing the Disability Claims Backlogs: The Social Security Administration's Progress and New Challenges Arising From the Recession." I am honored to testify today but am saddened that the reason is because my clients have waited so long and endured many hardships before receiving the disability benefits to which they are entitled.

I am an attorney in Jackson, TN, and a member of the National Organization of Social Security Claimants' Representatives (NOSSCR). For more than 25 years, I have represented individuals with disabilities in their claims for Social Security and Supplemental Security Income (SSI) disability benefits. I am testifying today on behalf of the Consortium for Citizens with Disabilities (CCD) Social Security Task Force, of which NOSSCR is an active member. CCD is a working coalition of national consumer, advocacy, provider, and professional organizations working together with and on behalf of the more than 54 million children and adults with disabilities and their families living in the United States. The CCD Social Security Task Force (hereinafter CCD) focuses on disability policy issues in the Title II disability programs and the SSI program.

The focus of this hearing is extremely important to people with disabilities. Title II and SSI cash benefits, along with the related Medicaid and Medicare benefits, are the means of survival for millions of individuals with severe disabilities. They rely on the Social Security Administration (SSA) to promptly and fairly adjudicate their applications for disability benefits. They also rely on the agency to handle many other actions critical to their well-being including: timely payment of the monthly Title II and SSI benefits to which they are entitled; accurate withholding of Medicare Parts B and D premiums; and timely determinations on post-entitlement issues that may arise (e.g., overpayments, income issues, prompt recording of earnings).

Because the economic downturn has led to an unexpected surge of new applications, SSA finds itself at a critical crossroads. The wave of new claims is having a very significant impact at the state Disability Determination Services (DDSs) that will eventually affect the hearing level. At the DDS levels (initial and reconsideration), the number of new applications, applications waiting for a decision, and processing times are all on the rise. In fiscal year (FY) 2009, SSA received 385,000 new claims, an increase of nearly 15% since the end of FY 2008. Even more worrisome is the growing backlog of pending initial claims at the DDSs, i.e., those waiting for a decision, up nearly 40% since the end of FY 2008.

In FY 2009, the news was more positive at the hearing level. For the first time in a decade, SSA finished FY 2009 with fewer hearing level cases waiting for a hearing and decision than at the beginning of the year. But we are deeply concerned that any progress in eliminating the hearing level backlog will be delayed as the surge of new applications are denied and then are appealed, putting SSA's plan to eliminate the hearing level backlog by 2013 at risk.

While recent appropriations have allowed SSA to hire some new staff and to reduce processing times at the hearing level, these amounts will not be adequate to fully restore the agency's ability to carry out its mandated services. Given the many years of under-funding and the need for more than a \$600 million annual increase just to keep up with fixed costs, additional funding is required to reduce and eliminate the backlog at the DDS and hearing levels and to provide essential services to the public. While the current situation is dire, without adequate, ongoing appropriations to fund SSA, the forward progress recently made by the agency will deteriorate, leaving people with severe disabilities to wait years to receive the benefits to which they are entitled.

THE IMPACT ON PEOPLE WITH DISABILITIES

As the backlog in decisions on disability claims continues to grow, people with severe disabilities have been bearing the brunt of the delays. Behind the numbers are

individuals with disabilities whose lives have unraveled while waiting for decisions—families are torn apart; homes are lost; medical conditions deteriorate; once stable financial security crumbles; and many individuals die.¹ Numerous recent media reports across the country have documented the suffering experienced by these individuals. Your constituent services staffs are likely to be well aware of the situations faced by people living in your districts and they provide valuable assistance. I have had many contacts with Chairman Tanner's district offices in Jackson and Union City, Tennessee. His staff has been extremely helpful, when they are able to assist.

Backlog in Appeals of Disability Claims: The Human Toll

I have represented individuals in their Social Security and SSI disability claims since 1984 at all administrative and judicial levels. My clients' hearings are held by Administrative Law Judges (ALJs) in the Memphis and Nashville, TN, hearing offices of SSA's Office of Disability Adjudication and Review (ODAR). Like the growing number of initial applications and hearing requests, my client caseload has grown by 40%. I have noticed that my clients are waiting longer and longer for hearings to be scheduled. The experiences of several of my clients illustrate the hardships endured by many claimants waiting for a decision on their claims and for payment of awarded benefits:

- ◆ Mrs. W lives in Dyersburg, TN, with her husband and young family. She is illiterate and reclusive. She and her family receive much assistance from older family members. She applied for disability benefits on August 7, 2008, based on mental retardation. She was denied despite psychological evaluations showing IQ scores in the 60s and deficits in adaptive function. As her attorney, I asked for a decision on the record both at the Disability Determination Services (DDS) and hearing levels. Her claim was denied by the DDS and her hearing request was filed on February 20, 2009. She is still waiting for a hearing date.
- ◆ Mr. H lives in Huntingdon, TN. When he first retained me on April 3, 2008, he and his teenage son were homeless. They were forced to stay in a motel in a dangerous area. I filed an online disability report; Mr. H completed SSI and Social Security disability applications. Mr. H had worked as a sawmill laborer and a grocery bagger. He had been out of the workforce for a time caring for his invalid mother until her health worsened and she had to enter a nursing facility. Mr. H suffers from liver disease, arthritis, coronary artery disease, depression and adult attention deficit disorder. Fortunately, he and his son were able to move into public housing. He was denied at the first two levels by the Tennessee DDS and requested a hearing on January 23, 2009. He is still waiting for a hearing date. Mr. H and his son live on state welfare benefits of approximately \$185 per month plus food stamps.
- ◆ Mr. M is homeless and has been diagnosed with bipolar disorder. He has recent suicide attempts. I began to represent him in April 2008. He had previously requested a hearing while living near Tampa, FL. His brother, who lives in rural western Tennessee, attempted to rescue Mr. M. However, Mr. M decompensated in the summer of 2008 and had to be hospitalized at Western State Mental Hospital in Tennessee. Upon discharge, he was released to a group home in Nashville, some 100 miles away from his brother. He lived for almost a year in the group home and now has a supportive housing apartment. He has no income. Mr. M's hearing is scheduled on December 17, 2009, some 18 months after he came to Tennessee. I have previously requested on the record decisions twice, but have received no response to my requests.

Most claimants' representatives have clients who have faced similar difficult circumstances to those endured by mine, including deteriorating health and even death, due to lack of health insurance and access to necessary medical treatment, sometimes as simple as antibiotics. Foreclosures and bankruptcies have increased, with claimants losing their homes and vehicles and their economic stability. I have

¹ If a claimant dies while a claim is pending, the SSI rule for payment of past due benefits is very different—and far more limited—than the Title II rule. In an SSI case, the payment will be made in only two situations: (1) to a surviving spouse who was living with the claimant at the time of death or within six months of the death; or (2) to the parents of a minor child, if the child resided with the parents at the time of the child's death or within six months of the death. 42 U.S.C. § 1383(b)(1)(A) [Section 1631(b)(1)(A) of the Act]. In Title II, the Act provides rules for determining who may continue the claim, which includes: a surviving spouse; parents; children; and the legal representative of the estate. 42 U.S.C. § 404(d) [Section 202(d) of the Act]. Thus, if an adult SSI claimant (age 18 or older) dies before actually receiving the past due payment and if there is no surviving spouse, the claim dies with the claimant and no one is paid.

included more descriptions of other claimants and the hardships they have faced at the end of my statement, starting on page 12.

SSA'S NEED FOR ADEQUATE RESOURCES TO ADDRESS GROWING BACKLOGS

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

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

We are extremely grateful to Congress for recognizing SSA's need for adequate resources and including additional funds for SSA in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provided SSA with \$500 million to handle the unexpected surge in both retirement and disability applications due to the economic downturn. SSA also received badly needed funds to replace its aged National Computer Center. With the FY 2009 appropriation and the ARRA funding, SSA planned to hire 5,000 to 6,000 new employees, including 147 new ALJs and 850 hearing level support staff. This additional staff undoubtedly led to SSA's ability to make progress on the backlog at the hearing level.

Congress appears to be moving towards providing SSA with an FY 2010 appropriation approximately the same as President Obama's request of \$11.45 billion for SSA's Limitation on Administrative Expenses (LAE), a 10 percent increase over the FY 2009 appropriation. While the agency is operating under a Continuing Resolution, we are optimistic that SSA's final FY 2010 appropriation will be similar to the \$11.45 billion amount, allowing SSA to hire more staff, including 226 additional ALJs and support staff.

WILL THE HEARING LEVEL BACKLOG BE ELIMINATED BY 2013?

The most significant delays in SSA's disability determination process are at the hearing level. The average processing time for cases at the hearing level has increased dramatically since 2000, when the average time was 274 days. In FY 2009, the average processing time for disability claims at the hearing level was 491 days, about 16.5 months. We appreciate the effort by SSA to reduce the processing time, but an average of 16.5 months—close to one and a half years—is still too long for individuals waiting for a hearing decision. In addition, the average processing times at the initial and reconsideration levels are increasing. For individuals with disabilities who have no health insurance, have lost their homes, have declared bankruptcy, or who have died, that is simply too long to wait.

The current processing times in some hearing offices are striking, and much longer than the 491-day average at the end of FY 2009. It is important to keep in mind that this is an "average" and that many claimants will wait longer. In September 2009, the average processing time at 48 hearing offices was above the 491 day national average, with 20 offices over 600 days.

Is the Hearing Backlog Improving? By the end of FY 2009, it was clear that ODAR was making slow but steady process in key areas to address its backlog and improve processing times, thanks to the hard work of ODAR ALJs and staff and the additional resources available due to Congressional appropriations, including the ARRA funding.

- **Pending cases.** For the first time in a decade, ODAR finished FY 2009 with fewer hearings pending than in the prior year. The increased resources, including 147 new ALJs and support staff are having a positive impact at the hearing level. The pending number of cases dropped for nine straight months from a record high of 768,540 in December 2008 to 722,822 in September 2009. This is the lowest pending number of ODAR cases since February 2007. The pending number dropped by 11,377 in September 2009 alone, the biggest drop in FY 2009. The reduction in pending cases is even more notable since the number of requests for hearing increased in FY 2009, up to 625,003, a 5.7% increase over the 591,888 received in FY 2008.
- **Processing times.** The average process time in September 2009 was 472 days, the lowest monthly processing time since November 2005. The average processing time for all of FY 2009 was 491 days, down from 514 days in FY 2008.
- **Dispositions.** The number of dispositions cleared by ALJs on a daily basis was 2,940.47 in September. This is the highest monthly average since records have

been kept, beginning in FY 2004. The increase is concomitant with the record number of ALJs now on duty. For the year, dispositions were up about 20%.

- **Age of pending cases.** The length of time cases are pending is also improving. The percentage of requests for hearing pending over one year was 31% in September 2009. This is the lowest percent since October 2004. The average age of a pending case is 282 days. It peaked this year at 317 days in January 2009.

Improvement Is Not Uniform. Despite the overall improvement in the hearing level statistics, not every hearing office has benefited and some claimants are waiting even longer than one year ago. On one hand, some offices have experienced exceptional improvement in processing times, as much as 4 to 5 months in just one year, for example: Madison, WI; Houston-Bissonet, TX; and Long Beach, CA. In contrast, other offices continue to experience worsening times that are several months longer than last year, for example: Memphis, TN; Louisville, KY; and Bronx, NY. A comparison of processing times at the end of FY 2009 and FY 2008 for hearing offices in or near the districts of Subcommittee Members reflects this disparity and the fact that much work lays ahead.²

California: Los Angeles Downtown: 362 days (FY09) vs. 376 days (FY08); Los Angeles West: 492 days (FY09) vs. 525 days (FY08); Long Beach: 351 days (FY09) vs. 533 days (FY08)

Florida: Tampa: 539 days (FY09) vs. 622 days (FY08)

Kentucky: Lexington: 452 days (FY09) vs. 448 days (FY08); Louisville: 545 days (FY09) vs. 465 days (FY08)

New York: Bronx: 605 days (FY09) vs. 516 days (FY08); Manhattan: 490 days (FY09) vs. 420 days (FY08); Queens: 482 days (FY09) vs. 446 days (FY08)

North Dakota: Fargo: 448 days (FY09) vs. 485 days (FY08)

Ohio: Columbus: 630 days (FY09) vs. 771 days (FY08)

Pennsylvania: Elkins Park: 360 days (FY09) vs. 402 days (FY08); Philadelphia: 350 days (FY09) vs. 386 days (FY08); Philadelphia East: 377 days (FY09) vs. 422 days (FY08)

Tennessee: Memphis: 538 days (FY09) vs. 442 days (FY08); Nashville: 501 days (FY09) vs. 475 days (FY08)

Texas: Dallas Downtown: 367 days (FY09) vs. 463 days (FY08); Dallas North: 331 days (FY09) vs. 403 days (FY08); Fort Worth: 306 days (FY09) vs. 372 days (FY08); Houston-Bissonet: 328 days (FY09) vs. 471 days (FY08); Houston Downtown: 340 days (FY09) vs. 298 days (FY08); San Antonio: 330 days (FY09) vs. 427 days (FY08)

Washington: Seattle: 511 days (FY09) vs. 551 days (FY08)

Wisconsin: Madison: 488 days (FY09) vs. 652 days (FY08); Milwaukee: 627 days (FY09) vs. 658 days (FY08)

SIGNIFICANT INCREASE IN NEW CLAIMS FILED AND GROWING DDS BACKLOGS

Since the end of FY 2008, new disability claims filed have been climbing steadily, up nearly 15% by the end of FY 2009. But what is more troubling is how the increase grew throughout FY 2009: December 2008 Quarter: 6.92%; March 2009 Quarter: 15.23%; June 2009 Quarter: 16.32%; September 2009 Quarter: 20.25%.

The most alarming trend is the increase in the number of pending claims (initial and reconsideration levels), up 38.8% since the end of FY 2008 and climbing from 763,183 to 1,059,241. This means that, at the end of FY 2009, more than 1 million disability applicants were waiting for a decision on their claims at the initial and reconsideration levels. When you add the 722,822 pending cases at the hearing level, nearly 1.75 million people with disabilities were waiting for a decision. If the new applications continue to increase at the higher level seen in recent months, the total number of pending initial applications alone in the DDSs could hit over 1,000,000 claims by the end of FY 2010. This would be an 80% increase in pending initial claims in just one year.

Claimant representatives in some states, including myself in Tennessee, have noticed the increase in processing times. This is not surprising since the percentage increase of pending cases in some states is much higher than the national average. For example, at the initial level, the number of pending claims increased nationwide by 38.1% at the end of FY 2009, compared to the end of FY 2008. However, in my state of Tennessee, the increase was 66.2%. Other states with significantly higher percentage increases in pending initial level claims include: North Dakota (68.5%); Ohio (59.3%); and Texas (55.8%).

What does the increase in applications and pending claims at the DDSs mean for the hearing level? Approximately 22% of the initial claims will result in a hearing

²The processing times reflect the times at the end of September in the respective fiscal year.

request. This means there is a potential increase of 85,000 additional hearings just from the FY 2009 applications, a statistic that underscores the fragility of the ODAR progress accomplished in FY 2009.

Looking more closely at the situation in my state of Tennessee, there is reason to be concerned. The increase in new claims will contribute to worsening a difficult situation at the hearing level. Tennessee had one of the biggest increases in pending claims in FY 2009 (66.2%), which was much higher than the national average. Historically, Tennessee has had one of the lowest DDS allowance rates. In FY 2008, the Tennessee DDS allowed only 25.1% of initial claims (vs. a 36.0% national average) and only 8.7% of requests for reconsideration (vs. a 13.8% average). Out of 52 DDSs, Tennessee rated 50th, slightly better than only Mississippi and Georgia. As noted above, the processing times at both the Memphis and Nashville ODAR hearing offices did not improve in FY 2009 but rather grew worse—Memphis by nearly 100 days or more than 3 months, and Nashville by 26 days or nearly one month. All of these trends—increased applications, a very low DDS allowance rate, and worsening hearing level processing times—do not bode well for my clients and other individuals in the state. As a result, I fear that things will get worse before they get better.

Exacerbating the problem of a significant increase in new claims is the impact on DDSs of state budget crises. Even though DDS salaries, offices, and overhead are fully funded by SSA, some states are imposing hiring restrictions and furloughs of employees, including DDS workers, because of budget problems. Earlier this year, Commissioner Astrue wrote to Governors, asking them to exempt DDSs from hiring freezes and furloughs. In September 2009, Vice-President Biden sent a letter to Gov. Edward Rendell, the Chair of the National Governors' Association, also urging that states exempt DDS employees from state furloughs. These furloughs lead to loss of administrative funding for the state DDSs and, more importantly, delay payment of benefits to disabled beneficiaries.

SSA's ABILITY TO PERFORM OTHER IMPORTANT WORKLOADS

Program Integrity Workloads. The processing of continuing disability reviews (CDRs) and SSI redeterminations is necessary to protect program integrity and avert improper payments. Failure to conduct the full complement of CDRs would have adverse consequences for the federal budget and the deficit. According to SSA, CDRs result in \$10 of program savings and SSI redeterminations result in \$7 of program savings for each \$1 spent in administrative costs for the reviews. However, the number of reviews actually conducted is directly related to whether SSA receives the necessary funds. In addition, it is important, when it conducts work CDRs, that SSA assess whether reported earnings have been properly recorded and ensure that it properly assesses whether work constitutes substantial gainful activity (SGA).

Impact on Post-Entitlement Work. Staffing shortages also have led to SSA's inability to fully carry out many other critical post-entitlement workloads. One area that has slipped, often with a very detrimental impact on people with disabilities, is the processing of earnings reports by beneficiaries. When beneficiaries faithfully notify SSA of earnings or other changes that may reduce their benefit payment amounts, it may be months or years before SSA sends an overpayment notice to the beneficiary, demanding repayment of sometimes tens of thousands of dollars of accrued overpayments. It is shocking to beneficiaries to receive these notices, when they reasonably assumed that SSA had processed the information they submitted, and it is challenging, if not impossible, for someone subsisting on benefits alone to repay the overpayments. Many individuals with disabilities are wary of attempting a return to work out of fear that this may give rise to an overpayment, resulting in a loss of economic stability and health care coverage upon which they rely.

SSA needs to develop a better reporting and recording system and promptly adjust benefit payments—thus preventing these overpayments. It is important to note that, in and of themselves, overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able. The problems arise when reported earnings are not properly recorded and monthly overpayments are not properly adjusted.

CCD RECOMMENDATIONS REGARDING SSA's ADMINISTRATIVE FUNDING

We are optimistic that SSA will receive a final FY 2010 appropriation of \$11.451 billion for SSA's LAE, the same amount proposed by the President. SSA will use this funding and about \$350 million from the ARRA funding to address the growing workloads facing the agency. Based on these funding levels, during FY 2010, SSA

will be spending at least \$11.8 billion to address the current staffing levels and associated costs necessary for the agency to function.

In FY 2011, SSA will be faced with additional costs of nearly \$620 million just to deal with inflationary costs associated with items such as salaries, benefits, rents, and facility security. The resulting funding level, \$12.42 billion will not address the increased number of new claims, the newly created DDS backlog, and SSA's plan to eliminate the hearing level backlog by 2013. To address these workloads, SSA will need additional resources. We estimate that an additional \$780 million will be necessary—at least \$480 million to address the increased number of disability claims and at least \$300 million to continue making progress in reducing and eliminating the hearings backlog by 2013.

To address the unprecedented increase in workloads and to prevent a severe disruption in service delivery, we recommend that a minimum of \$13.2 billion be included in the FY 2011 President's budget request for SSA's administrative funding.

RECOMMENDATIONS FOR IMPROVING THE DISABILITY CLAIMS PROCESS

Money alone will not solve SSA's crisis in meeting its responsibilities. Commissioner Astrue is committed to finding new ways to work better and more efficiently. CCD has numerous suggestions for improving the disability claims process for people with disabilities. We believe that these recommendations and agency initiatives, which overall are not controversial and which we generally support, can go a long way towards reducing, and eventually eliminating, the disability claims backlog.

Caution Regarding the Search for Efficiencies

While we generally support the goal of achieving increased efficiency throughout the adjudicatory process, we caution that limits must be placed on the goal of administrative efficiency for efficiency's sake alone. The purposes of the Social Security and SSI programs are to provide cash benefits to those who need them and have earned them and who meet the eligibility criteria. While there may be ways to improve the decision-making process from the perspective of the adjudicators, the critical measure for assessing initiatives for achieving administrative efficiencies must be how they affect the very claimants and beneficiaries for whom the system exists.

People who find they cannot work at a sustained and substantial level are faced with a myriad of personal, family, and financial circumstances that will have an impact on how well or efficiently they can maneuver the complex system for determining eligibility. Many claimants will not be successful in addressing all of SSA's requirements for proving eligibility until they reach a point where they request the assistance of an experienced representative. Many face educational barriers and/or significant barriers inherent in the disability itself that prevent them from understanding their role in the adjudicatory process and from efficiently and effectively assisting in gathering evidence. Still others are faced with having no "medical home" to call upon for assistance in submitting evidence, given their lack of health insurance over the course of many years. Many are experiencing extreme hardship from the loss of earned income, often living through the break-up of their family and/or becoming homeless, with few resources—financial, emotional, or otherwise—to rely upon. Still others experience all of the above limits on their abilities to participate effectively in the process.

Proposals for increasing administrative efficiencies must bend to the realities of claimants' lives and accept that people face innumerable obstacles at the time they apply for disability benefits and beyond. SSA must continue, and improve, its established role in ensuring that a claim is fully developed before a decision is made and must ensure that its rules reflect this administrative responsibility.

Technological Improvements

Commissioner Astrue has made a strong commitment to improve and expand the technology used in the disability determination process. CCD generally supports these efforts to improve the disability claims process, so long as they do not infringe on claimants' rights. Some of the technological improvements that we believe can help reduce the backlog include the following:

1. **The electronic disability folder.** The initiative to process disability claims electronically has the prospect of significantly reducing delays caused by the moving and handing-off of folders, allowing for immediate access by different components of SSA or the DDS, and preventing misfiled evidence.
2. **Expanding Internet access for representatives.** Under Electronic Records Express (ERE), registered claimant representatives are able to submit evidence electronically through an SSA secure website or to a dedicated fax number, using a unique barcode assigned to the claim. This initiative

holds great promise, given that significant problems with the current process exist.

Under the current process, representatives are to be provided with a CD of the exhibited or “pulled” file shortly before the hearing and earlier in the process after the appeal has been filed but before the file is exhibited. Due to staffing shortages in hearing offices, I have had problems obtaining the CDs and even obtaining barcodes, which allows me to submit evidence electronically. Receiving incomplete CDs leads to problems. I am unable to know what evidence is in the record so that I can determine what evidence I need to obtain and submit. This also can lead to submission of duplicate evidence, which is time-consuming for ODAR staff but is the only way that I can ensure that ODAR has received the evidence. This can cause significant delay both during and after the hearing.

We are optimistic that these problems will be resolved in the near future. I am very much looking forward to having direct access to my clients’ electronic folders. A small group of representatives is involved in an SSA pilot that gives them direct access to their clients’ electronic folders, allowing them to download the contents through the ERE website. SSA has been working on security and authentication issues and has a plan to gradually rollout this initiative. I believe that it will make the hearing process more efficient for all parties involved—claimants, their representatives, and SSA.

3. **Use of video hearings.** Video hearings allow ALJs to conduct hearings without being at the same geographical site as the claimant and representative and have the potential to reduce processing times and increase productivity. We support the use of video teleconference hearings so long as the right to a full and fair hearing is adequately protected; the quality of video teleconference hearings is assured; and the claimant retains the absolute right to have an in-person hearing as provided under current regulations.³ However, we have received complaints from representatives that, in some cases, ALJs are discouraging claimants from exercising their right to an in-person hearing. A new SSA pilot allows representatives to participate in video hearings from their own private offices, with their clients present in the representative’s office. The representative must agree to the terms established by SSA. This pilot provides claimants with another option for their hearings.

Other Improvements at the Hearing Level

1. **The Senior Attorney Program.** This program allows senior staff attorneys in hearing offices to issue fully favorable decisions in cases that can be decided without a hearing (i.e., “on the record”). I have had clients approved for benefits by senior attorneys in both the Memphis and Nashville hearing offices. This cuts off many months in their wait for payment of benefits. I am pleased that Commissioner Astrue decided to authorize the program for at least the next two years.⁴ In FY 2009, senior attorneys decided more than 36,300 cases, a 50% increase over FY 2008. This means that more than 36,000 claimants were able to receive their disability benefits months sooner.

2. **Findings Integrated Templates (FIT).** FIT is used for ALJ decisions and integrates the ALJ’s findings of fact into the body of the decision. While the FIT does not dictate the ultimate decision, it requires the ALJ to follow a series of templates to support the ultimate decision. Representatives can use the FIT template, which is available on the SSA website, to draft proposed favorable decisions. Many representatives are now using the template either when requested by the ALJ or on their own initiative. When the draft proposed decision is submitted to the ALJ, it can lead to a speedier decision.

3. **Increase time for hearing notice.** We have previously recommended that the time for providing advance notice of the hearing date be increased from the current 20 days to 75 days. Based on my experience, I strongly believe that this increase will allow more time to obtain medical evidence before the hearing and makes it far more likely that the record will be complete when ALJ reviews the file before the hearing. The 75-day time period has been in effect in SSA’s Region I states since August 2006⁵ and, based on reports from representatives, has worked well.

³ 20 C.F.R. §§ 404.936 and 416.1436.

⁴ The program is extended through August 10, 2011. 74 Fed. Reg. 33327 (July 13, 2009).

⁵ 20 C.F.R. § 405.315(a).

Improvements at the Initial Levels

CCD supports initiatives to improve the process at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process.

1. New Screening Initiatives. We support SSA's efforts to accelerate decisions and develop new mechanisms for expedited eligibility throughout the application and review process. We encourage the use of ongoing screening as claimants obtain more documentation to support their applications. However, SSA must work to ensure that there is no negative inference when a claim is not selected by the screening tool or allowed at that initial evaluation. There are two initiatives that hold promise:

- **Quick Disability Determinations.** We have supported the Quick Disability Determination (QDD) process since it first began in SSA Region I states in August 2006 and was expanded nationwide by Commissioner Astrue in September 2007.⁶ The QDD process has the potential of providing a prompt disability decision to those claimants who are the most severely disabled. Since its inception, the vast majority of QDD cases have been decided favorably in less than 20 days, and sometimes in just a few days.
- **Compassionate Allowances.** This initiative allows SSA to create "an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both. . . ." SSA has published an initial list of 50 conditions on its website, with more to be added at a later date. Unlike the QDD screening, which occurs only when an application is filed, screening for compassionate allowances can occur at any level of the administrative appeals process. SSA has held recent Compassionate Allowance outreach hearings with expert panels to consider early onset Alzheimer's disease and schizophrenia.

2. Improve development of evidence earlier in the process. In previous testimony, CCD has made a number of recommendations to ensure that disability claims are properly developed at the beginning of the process. Claimants' representatives are often able to provide evidence that we believe could have been obtained by the DDSs earlier in the process. Our recommendations include:

- **Provide more assistance to claimants at the application level.** At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing the application, particularly in light of electronic filings, so that all impairments and sources of information are identified, including non-physician and other professional sources.
- **DDSs need to obtain necessary and relevant evidence.** Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. However, DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating and examining doctors. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to the vocational professionals at DDSs and hearing offices.
- **Increase reimbursement rates for providers.** To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts.
- **Provide better explanations to medical providers.** SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and ask for evidence relevant to the standard.
- **Provide more training and guidance to adjudicators.** Many reversals at the appeals levels are due to earlier erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as: weighing medical evidence, including treating source opinions; the role of non-physician evidence; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings.

⁶20 C.F.R. §§404.1619 and 416.1019.

- **Improve the quality of consultative examinations.** Steps should be taken to improve the quality of the consultative examination (CE) process. There are far too many reports of inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's.

3. Eliminate reconsideration. To create a more streamlined process, we have supported elimination of the reconsideration level and adding some type of pre-decision contact with the claimant. SSA has tested the elimination of reconsideration in ten "prototype" states [AL, AK, CA—Los Angeles, CO, LA, MI, MO, NH, NY—Albany and New York City, PA] for nearly ten years and it was recently extended through September 28, 2012.⁷ Claimants' representatives in those states report that the process works well without a review level between the initial determination and the ALJ level.

ADDITIONAL RECOMMENDATIONS

In addition to addressing the backlog and SSA's funding issues, there are several other legislative proposals that the Subcommittee may be considering this year.

- **Protecting claimants' privacy rights.** We understand that it can be cumbersome for SSA to obtain medical records, as it is for claimants and their representatives, and that SSA is exploring more efficient ways to secure the necessary evidence. While we support ways to make this process more efficient, we believe that claimants' privacy rights must be protected. We will work with SSA to find a way to obtain, as efficiently as possible, a claimant's authorization for release of medical records to SSA, while protecting the individual's privacy rights.
- **Extension of the fee demonstrations in the SSPA.** Access to experienced and qualified representatives through the lengthy and complex application process is critically important to claimants. To this end, we support allowing claimants to enter into voluntary agreements with representatives for fee withholding and direct payment procedures whether under Title II or Title XVI. The Social Security Protection Act of 2004 established two demonstration projects that should be made permanent because they have proven to be effective in increasing claimants' access to effective representation: (1) Extension of the Title II attorney fee withholding and direct payment procedures to SSI claims; and (2) Allowing nonattorney representatives to qualify for fee withholding and direct payment, provided they meet certain requirements. Unless they are extended or made permanent, the demonstrations will sunset March 1, 2010.
- **Increase and indexing of the fee cap.** Rep. John Lewis has introduced H.R. 1093, which contains two provisions regarding the current \$5,300 fee agreement fee cap: (1) Increase the current fee cap to \$6,264.50 (which represents the figure if it had been adjusted for inflation since the last increase in 2002); and (2) Index the fee cap for future years to the annual COLA. We support these changes since they ensure that there will be a knowledgeable, experienced pool of representatives available to represent claimants.
- **Work incentives.** The Ticket to Work and Work Incentives Improvement Act was enacted nearly ten years ago and is overdue for evaluation of its effectiveness in employment of those receiving Title II and SSI disability benefits. We urge renewal, strengthening, and permanent extension of expired/expiring provisions including (1) SSA's Title II demonstration authority to test promising approaches for work incentives and related provisions; (2) Demonstration to Maintain Independence, set to expire this year, to provide Medicaid buy-in coverage to working individuals whose conditions or disabilities are not yet severe enough to qualify them for disability benefits; (3) Protection and Advocacy for Beneficiaries of Social Security to protect the rights of beneficiaries as they attempt to return to work; and (4) Work Incentives Planning Assistance, which provides state grants for outreach and education to individuals with disabilities about supports and services regarding employment.

⁷ 74 Fed. Reg. 48797 (Sept. 24, 2009).

CLAIMANT STORIES PROVIDED BY REPRESENTATIVES IN 2009⁸**CALIFORNIA**

♦ Mr. B is a 57-year-old man from Los Angeles, CA. He worked in construction for over 30 years before he became disabled. He has been unable to work since 2003 and is homeless. His only income is \$221 per month from General Relief. He has congestive heart failure, torn rotator cuffs in both shoulders, severe arthritis in his knees, severe depression, and possible cerebral atrophy. He applied for benefits in October 2007. After his claim was denied, Mr. B obtained representation and he filed a request for a hearing in April 2008. He has been homeless the entire time while he waited for a hearing. During the wait, his depression and physical health have worsened. Mr. B's condition requires him to rest during the day and keep his feet elevated, however he was unable to comply because shelters do not allow residents to remain during the day. Not having a place to rest caused his feet and legs to swell, resulting in a great deal of pain and discomfort. He also was hospitalized after coming down with an infection in one of the shelters.

Mr. B's hearing finally took place in July 2009, more than 14 months after requested. The ALJ issued a favorable decision on November 2, 2009, more than two years after Mr. B applied for benefits. Once he begins to receive benefits, in another 3 or 4 weeks, he will finally be able to find a permanent home and start working on improving his health.

FLORIDA

♦ Mr. M is a 57-year-old man who worked as a Vocational Rehabilitation Specialist for over 20 years in Florida. He developed severe arthritis throughout his body, wears bilateral hand splints, knee splints, has developed severe joint degeneration, spinal cord degeneration, is agoraphobic, depressed, and anxious. He cannot take care of himself and he has no family to help him. He is about to lose his home. Mr. M has exhausted his savings and his attorney writes monthly letters to his mortgage company asking for extensions on his payments while he is waiting for his hearing. Nevertheless, the company is about to foreclose on his home.

NEW YORK

♦ A 46-year-old man from Queens, NY, diagnosed with severe asthma, cardiac disease, and severe depression, requested a hearing in August 2008. He last worked as a truck driver and warehouseman. He died from cancer in September 2009. Based on information received by his attorney, his hearing will not be scheduled any time soon.

NORTH DAKOTA

♦ Mr. N worked as an assistant manager of an automotive/tire shop in Fargo, ND. He was injured while on the job in June 2006. He did not apply for Social Security disability benefits until August 2007. He has severe, chronic myofascial pain and dysfunction syndrome, joint dysfunction, and lumbar and thoracic musculo-ligamentous sprain/strain. He also has severe major depressive disorder and panic disorder related to his injury, which has resulted in hospitalization. Mr. N requested a hearing on March 21, 2008. He was finally found disabled by a decision of an ALJ (without a hearing) on February 19, 2009. Correct payment of his Social Security benefits was delayed due to an erroneous calculation of benefits based on his North Dakota workers compensation claim. Benefits for his wife and dependent children also were miscalculated. He received only a small portion of his regular monthly benefit (less than \$100 per month) and had to wait over seven months before he received his past due benefits and began receiving the correct monthly benefit amount. He was not receiving any wage loss benefits from workers compensation during this timeframe.

OHIO

♦ Mr. N is a 55-year-old former maintenance supervisor who lives in Chillicothe, OH. He has small vessel ischemia, cerebrovascular disease, lumbar scoliosis, degenerative joint disease, vision loss, migraine headaches, depression, anxiety, fatigue, memory loss, and partial paralysis to his left side caused from two strokes. Mr. N filed his request for hearing in September 2007. While waiting for a hearing, he has had five liens put on his home, and does not have medical insurance to receive the

⁸Some of these claimant descriptions appeared in testimony presented by Peggy Hathaway on behalf of the CCD Social Security Task Force at a Joint Hearing of the House Ways and Means Subcommittees on Social Security and Income Security and Family Support on *Eliminating the Social Security Disability Backlog*, March 24, 2009. The testimony is available at <http://democrats.waysandmeans.house.gov/hearings.asp?formmode=view&id=7618>.

medical treatment that he needs. His primary care physician has discussed his treatment options and has explained that his health will continue to decline, and that it is crucial for him to receive treatment as soon as possible.

♦ Mr. W, a 37-year-old fork lift driver from Columbus, OH, has a head injury and bipolar disorder, which prevent him from working. He filed his application for disability benefits in November 2006. While waiting for a hearing, he and his family were evicted from their apartment and his wife left him. He is living in a house with a friend and is unable to pay rent. However, when he is awarded benefits, he will owe back payment for the rent and continues to fall further into debt.

♦ Mr. P, a 60-year-old data entry person who lived in Columbus, OH, had back and knee problems, epilepsy, and a number of infections that kept occurring throughout his body. He filed his application for disability benefits on April 25, 2006. While waiting for a hearing, Mr. P became increasingly ill due to infection and chronic lymphedema. He died on December 11, 2007. An on-the-record favorable decision was made on October 9, 2008, ten months after his death. Mr. P was found disabled as of May 1, 2002 (four years before he applied for benefits) through the date of his death.

PENNSYLVANIA

♦ An attorney in Fort Washington, PA, reports that many clients have difficulties applying for Title II or SSI disability benefits because they do not have health insurance or the means to pay for medical treatment. They cannot treat their impairments, so their conditions get worse, and they cannot prove the existence of disability. If they apply and are denied, there is a two-year wait for a hearing to be scheduled. For SSI applicants awarded benefits, past due benefits are paid in installments, even if they are threatened with eviction or foreclosure or are unable to pay for their medical treatment. One client, a former fast food worker, received an "on the record" decision in November 2008, but received half of her back benefit despite facing a foreclosure and has not yet received the other half of her benefits. She cannot pay for her medication or co-pays. Her attorney suggested she go to the SSA field office, but she is too sick and disabled to travel there and her cognitive impairment prevents her from effectively communicating.

♦ Mr. D lives in Dalmatia, PA. He is a veteran of the Vietnam War and is a victim of Agent Orange and has other war-related health and mental problems. He had obtained a favorable decision on his Social Security disability claim. However, because of a mix-up at SSA, it was nearly two years until his attorney was able to straighten out his payments. He has a son with the same name and the SSA system had the two individuals mixed in with each other. While waiting for his payments, Mr. D's house went up for a Sheriff's sale after foreclosure. Two days before the sale, he called his attorney, crying, and said that he had no more reason to live. Out of sheer desperation, they called Rep. John Kanjorski's office, which was able to help get the Sheriff's sale postponed. Further, within two weeks, someone at SSA was trying to straighten out the mix-up. Within two months, the payments started. Mr. D's attorney notes that he does not believe this would have been accomplished if Rep. Kanjorski's office had not intervened.

♦ Ms. L is 50 years old and lives in Pennsylvania. She has been diagnosed with cirrhosis of the liver caused by Hepatitis C. Although she has finally received a hearing date, the wait has been a struggle for her. She has had her utilities shut off, her car repossessed, and her health has worsened. Ms. L's medical care is very costly. She has been non-responsive to certain treatments for her cirrhosis and is now on the liver transplant list.

TENNESSEE

♦ Mrs. C, a 43-year-old radiology/CT scan tech, lives in Clarksville, TN. She is unable to work due to diabetes, depression, anxiety disorder, fluid and arthritis in her knees, spondylothesis, spinal stenosis, degenerative disc disease, broad based disc bulges and severe pain and weakness in both legs. She filed her application for disability benefits in June 2007. While waiting for her hearing, Mrs. X and her family have been evicted from their home. Both of their vehicles have been repossessed, and they are having extreme difficulties paying for their day to day living. Her husband is on the verge of being laid off and, if that happens, there will be no income at all for this family. Due to the backlog, this claimant and her family may lose everything before she is able to get a hearing date and decision.

♦ Ms. A is 61 years old and lives in Milan, TN. She has Major Depressive Disorder, which prevents her from working. She filed her application for benefits in 2007. Ms. A's hearing has not yet been scheduled but her attorney has requested an on-the-record decision. She and her husband, who is currently employed, were forced to file for Chapter 7 bankruptcy in order to keep their house. The majority

of her husband's check is going to the bankruptcy trustee each pay period, leaving them with only \$4 to \$27 per pay period for all of their other expenses, such as groceries and utilities

- ◆ Mr. D, a 48-year-old man who lives in Gibson County, TN, has musculoskeletal impairments. He filed his application for disability benefits in 2007. Mr. D's hearing has not yet been scheduled. He has lost his home and his wife left him. He is essentially homeless, living with various family members and friends.

- ◆ Mr. W is 53 years old and currently lives in Haywood County, TN. He has been diagnosed with musculoskeletal impairments. He filed his application for disability benefits in late 2004. It was denied and he had to appeal the case to federal district court. The court remanded the case, but not until mid to late 2008. After a remand hearing in 2009, his claim was allowed. However, while waiting for the decision, he lost his home and has had to live with various family members.

TEXAS

- ◆ Ms. A is a resident of Austin, TX, who filed a claim for disability benefits on April 27, 2006, after undergoing a quadruple coronary bypass. Ms. A's claim was denied initially and on reconsideration, and she requested a hearing on April 3, 2007, which was held on February 4, 2008. While awaiting the hearing, Ms. A experienced extreme financial hardship resulting in the foreclosure of her home and increased depression and anxiety. Unfortunately, her claim was denied by the ALJ in a April 2, 2008, decision. She appealed to the Appeals Council, which resulted in a remand order, dated August 27, 2008, for another hearing. As of this date, the remand hearing has not been scheduled, 15 months after the Appeals Council remanded the case. While waiting for her new hearing, Ms. A has continued to experience extreme financial hardship and, on several occasions, homelessness was a very real possibility.

- ◆ Mr. A is 45 years old and lives with his wife in Mission, TX. He has degenerative disc disease of the lumbar spine status post lumbar laminectomy, major depressive disorder, and borderline intellectual functioning, which prevent him from working. He filed his application in September 2003. The claim was denied initially in November 2003 and at reconsideration in February 2004 and he requested a hearing a few days later. While waiting for a hearing, Mr. A's house burned down in November 2004. His hearing was finally held in June 2006, more than two years after he filed his appeal. The hearing was continued in order to obtain a psychological consultative examination and a supplemental hearing was held in July 2007. The ALJ denied the claim and on appeal, the Appeals Council remanded the case back to the ALJ. During this period, Mr. A was forced to file for bankruptcy. He had a remand hearing in February 2009 before the same ALJ who previously denied his case. At the remand hearing, the ALJ announced he would be awarding a fully favorable decision.

- ◆ Mr. R is 48 years old and lives in San Antonio, TX. He has back pain, joint pain, hearing problems, Hepatitis C, and a head injury, which prevent him from working. He filed his application for benefits in January 2007. While waiting for a hearing, he became homeless and cannot receive proper medical attention. Mr. R has to rely on the kindness of friends for his basic necessities.

WISCONSIN

- ◆ A middle-aged Eau Claire area woman became disabled, when her knees deteriorated to the point where she needed knee replacements. Her knee conditions led to back problems, causing chronic pain for which she has to take highly potent narcotic drugs. After waiting nearly three years for her hearing, the ALJ allowed her case after ten minutes. While waiting for her hearing, her family lost their home to foreclosure and she had to file for bankruptcy. After the hearing, her attorney asked if they would have lost their home or had to file for bankruptcy if she had been getting her Social Security disability benefits sooner. Tearfully, she replied, absolutely not. To add insult to injury, her attorney just received a telephone message from her in early November 2009. Even though this client's fully favorable decision was dated August 31, 2009, she has still not received either her first check or her past due benefits. She called the Social Security District Office and was told it could take 90 days for the Payment Center to get her into pay status and to issue her payment for past due benefits.

- ◆ In early November 2009, a man from Humbird, WI, received his fully favorable decision, almost three years after filing his Social Security disability application. Unfortunately, he was served one day later with a Summons and Complaint to foreclose his home. (His monthly mortgage payment had been increased from \$327 per month to over \$900 per month, because the mortgage lender had to pay his property taxes last year.) He is now hoping to negotiate a redemption, but it is unclear

whether the mortgage holder will do so. If not, he will have to file for bankruptcy. His attorney is hoping that the SSA Payment Center will not delay payment of his case, so he will have his past due benefits to use in his attempts to work something out with the mortgage holder.

♦ Also in early November 2009, the husband of a claimant from Chippewa Falls, WI, came to the wife's attorney's office to ask if there is anything the attorney could do to expedite payment of the wife's benefits. His wife had filed her application in July 2006. Nearly three years later, she received a fully favorable hearing decision, dated June 19, 2009. Five months after the ALJ found her disabled, she still has not received either a monthly benefit payment or her past due benefits. The client and the attorney's staff have placed calls to the SSA field office. They have been told that the delay is caused by the Payment Center and that all the field office can do is try to prod the payment center to pay the benefits.

♦ While waiting for his hearing, Mr. L became homeless. He lived in the La Crosse, WI, area and was waiting for a traveling ALJ to schedule his hearing in La Crosse. Over a one and a half year wait, Mr. L's attorney tried to expedite the hearing since he was homeless and winter was approaching. In January 2009, his attorney sent the ALJ another letter indicating that Mr. L was living in a shanty in the woods, hunting rabbit for food, and using a campfire to keep warm. Eventually, his hearing was scheduled for April 2009, but the ALJ approved the case without the need for a hearing. By that time, Mr. L had moved to another state to stay with someone.

* * * *

CONCLUSION

As you can see from the circumstances of these claimants' lives and deaths, delays in decision-making on eligibility for disability programs can have devastating effects on people already struggling with difficult situations. On behalf of people with disabilities, it is critical that SSA be given substantial and adequate funding to make disability decisions in a timely manner and to carry out its other mandated workloads. We appreciate your continued oversight of the administration of the Social Security programs and the manner in which those programs meet the needs of people with disabilities.

Thank you for the opportunity to testify today. I would be happy to answer questions.

ON BEHALF OF:

American Association on Intellectual and Developmental Disabilities
 American Council of the Blind
 American Network of Community Options and Resources
 Association of University Centers on Disabilities
 Bazelon Center for Mental Health Law
 Community Access National Network (TIICANN)
 Epilepsy Foundation
 National Alliance on Mental Illness
 National Association of Disability Representatives
 National Disability Rights Network
 National Health Care for the Homeless Council
 National Organization of Social Security Claimants' Representatives
 National Spinal Cord Injury Association
 Paralyzed Veterans of America
 Research Institute for Independent Living
 The Arc of the United States
 United Cerebral Palsy
 United Spinal Association
 World Institute on Disability

Chairman TANNER. Thank you very much, Ms. Bates. Of course I should mention we will accept all your statements for the record in their entirety.

Mr. Inspector General, welcome. You are recognized, sir.

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

Mr. O'CARROLL. Good afternoon, Mr. Chairman and Mr. Johnson. Thank you for calling this hearing, and giving me the opportunity to testify about SSA's efforts to reduce the backlog of initial disability claims. This has been a challenging time for the American economy and the American people. At such times, people turn to the safety net of Social Security in record numbers.

In fiscal year 2009, SSA received almost 3 million applications for disability benefits, which was an increase of some 15 percent over the previous year. The State Disability Determination Services, or DDSs, were able to process eight percent more claims than the year before. However, this still created a net deficit, leaving the backlog at its current level of three-quarters of a million claims.

One significant threat to SSA's efforts to decrease this backlog has been the furloughing of DDS employees by states struggling with budget issues. Federal regulations discourage, but do not prohibit, this practice. To date, nine states are furloughing all of their DDS employees, and three states are furloughing some of their DDS employees. In states furloughing all DDS employees, this has created a 14 percent shortfall of capacity for processing applications.

In our report, "Impact of State Budget Issues on SSA's Disability Programs," issued earlier this week, we estimate that the furloughs will cause delays in 69,000 claims, and delays in issuance of \$126 million in benefits to those in need.

Also troublesome from an integrity perspective is the resulting increase in the backlog of medical continuing disability reviews, or CDRs. These reviews result in program savings of \$10 for every dollar that's invested. Resources that could be used for CDRs are being reallocated to processing initial claims, and program dollars are lost.

Significant efforts have been made to limit the impact of the furloughs. The Commissioner contacted all the state governors and many state legislators. Vice President Biden wrote to the National Governors' Association. There was even litigation in California that sought to preclude the furloughs.

As a result of these and other efforts, two states exempted their DDSs from the furloughs, and three states partially exempted their DDS employees, saving another 11,000 claims and \$24.4 million from being delayed. SSA has hired 192 new staff for Federal units that process initial claims. The Agency transferred cases facing delays from states to those Federal units to ensure timelier processing.

SSA should be commended for its efforts to minimize the impact of state furloughs and other hiring and staffing issues. Still, these state actions have clearly resulted in delays and increased the backlog.

SSA staffing is another issue critical to the reduction of this backlog. Congress was aware of the increased workload that the economic downturn would engender when it passed the American Recovery and Reinvestment Act. The act provides \$500 million to SSA to process retirement, disability, and survivors insurance workloads, and SSA has put that money to good use.

Of the \$500 million, SSA invested \$251 million in its office of operations, which has now hired 1,531 additional staff. We reviewed SSA's plan for these funds, and found that the plan and the placement of the new hires was appropriate. Most of the other \$249 million was invested in hiring 300 additional staff in the DDSs, and 35 ALJs and 556 support staff in the Office of Disability Adjudication and Review. We are now conducting similar reviews of SSA's use of these funds.

Finally, I would be remiss if I didn't use this opportunity to encourage continued vigilance, with respect to program integrity. In attending to the backlog of initial claims, it is critical that SSA and the DDSs continue to conduct CDRs and refer suspicious claims to the OIG's cooperative disability investigative units and field divisions.

The efforts that Congress, SSA, and the OIG have put forward are important elements in ensuring that the backlog of initial claims is ultimately reduced to an acceptable level. I pledge the OIG's continued support in this effort, and I thank you for the invitation to be here today. I will be happy to answer any questions.

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

**Prepared Statement of The Honorable Patrick O'Carroll, Inspector General,
Social Security Administration**

Good morning, Mr. Chairman, Mr. Johnson, and Members of the Subcommittee. As always, it's a pleasure to appear before you, and I thank you for the invitation to be here today. I've appeared before you several times to discuss the backlog of disability appeals, and the Social Security Administration's (SSA) efforts to reduce that backlog to ensure that appellants eligible for benefits receive them in as timely a fashion as possible. Today, we are looking at SSA's backlog in initial disability claims, a backlog of over three-quarters of a million people currently waiting for sorely needed benefits.

The past two years have been challenging ones for the American people, as the economy struggled. In times such as these, people turn in ever-increasing numbers to the world's largest social insurance program. In Fiscal Year (FY) 2009 alone, SSA received almost 3 million initial disability claims, an increase of 15 percent over FY 2008. These numbers challenge SSA's ability to provide world-class service delivery, creating workloads that exceed resources and causing delays and backlogs. These numbers also create challenges for both SSA and the Office of the Inspector General (OIG) with respect to stewardship, as we strive to ensure that only those eligible for benefits are granted them.

To make the challenges even more daunting, the financial strain on the states caused by the faltering economy have resulted in furloughs that further slow the application process; and the increase in applications has forced the dedication of resources to processing applications, rather than conducting medical continuing disability reviews (CDR) or work CDRs, or taking other steps to ensure integrity.

It is critical that Congress and the American people have reason to be confident that Social Security benefits will be provided to those who need them, and equally confident that their tax dollars are being spent well and wisely. The OIG is at work on both sides of this equation, helping SSA to maintain its high level of service through timely audits and recommendations, while also acting as a watchdog, to ensure that benefits are paid properly, and that appropriated resources are used as intended.

Congress was certainly well aware of the challenges SSA would face in the current economy when it provided SSA with \$500 million under the American Recovery and Reinvestment Act (ARRA) to process disability and retirement workloads, as well as \$500 million to replace the National Computer Center and \$90 million to process one-time economic recovery payments of \$250 to beneficiaries. The OIG received \$2 million to ensure that these funds were used properly, and I'd like to share some of our work in that area today.

The funds provided to SSA to process initial claims were critical. As I mentioned, the current disability backlog stands at over three-quarters of a million applications—some 38 percent higher than a year ago. This resulted from a 15 percent in-

crease in claims filed, against only an 8 percent increase in claims actually processed by the State Disability Determination Services (DDS). These delays are caused not only by the increase in applications, however, but also by State furloughs, staffing problems, and other issues.

The furloughs are particularly troublesome. Federal regulations discourage furloughs of DDS personnel, but this has not stopped furloughs from occurring. To date, nine states are furloughing all their DDS employees and three states are furloughing some DDS employees.

In states that are furloughing all of their DDS employees, this has created a 14 percent shortfall of capacity for processing claims. In our report, *Impact of State Budget Issues on SSA's Disability Programs*, issued earlier this week, we estimate that the furloughs have caused delays in 69,000 claims, and delays in the issuance of \$126 million in benefits to those in need. In addition to the furloughs themselves, other issues are contributing to this impact. Certain states have encountered high attrition rates among DDS employees, others have encountered pay freezes, and still others have hiring practices that are problematic.

The Commissioner has made significant efforts to limit the impact of furloughs, and was able to make some progress. He contacted all of the State Governors and many State legislators. Vice President Biden wrote to the National Governors' Association, and there was even litigation in California that sought to preclude furloughs.

As a result of these and other efforts, two States exempted their DDSs from State employee furloughs, and three States partially exempted DDS employees, saving another 11,000 cases and \$24.4 million from being delayed. Several more States fully or partially exempted DDSs from hiring restrictions. Additionally, SSA hired 192 new staff for Federal units that process initial claims, and transferred cases facing delays from States to those Federal units to ensure timelier processing.

While SSA should be commended for its efforts to minimize the impact of State furloughs and other hiring and staffing issues, it is indisputable that these State actions have resulted in delays and kept benefits out of the hands of those in need.

Staffing at SSA is another critical factor in timely processing of applications, and the ARRA funds provided for that purpose have been put to use. Of the \$500 million allocated to this purpose, SSA allocated \$251 million to its Office of Operations, which is using the funds to process disability and retirement workloads. Operations hired 1,531 new employees, and authorized the use of overtime pay to keep pace with applications.

The Office of Management and Budget issued guidance on spending and accounting for ARRA funds, and this guidance included the publication of detailed plans for use of the funds. The OIG just issued a report evaluating SSA's plan for the \$251 million allocated to the Office of Operations. Overall, we found that the plan was appropriate, and the placement of new hires was based on appropriate factors.

The remaining \$249 million was primarily directed to the DDSs, which hired 300 additional employees, and the Office of Disability Adjudication and Review, which hired 591 employees, of which 35 were Administrative Law Judges and 556 were new support staff. The OIG is conducting audits of the plans for the DDS' and ODAR's use of ARRA funds, similar to the audit conducted of the Operations plan.

SSA's efforts to minimize the impact of State budget shortfalls, and its initial efforts with ARRA funds, have been important steps in ensuring that initial applications encounter as few delays as possible, but more needs to be done. While additional resources would be of significant immediate benefit, there are long-term issues that can be addressed to prevent future backlogs.

For example, SSA received \$500 million in ARRA funds to replace the National Computer Center (NCC), SSA's aging repository for the data and electronic processes that enable SSA to pay benefits to 50 million Americans. Replacement of the NCC is critical to the future of the Social Security system.

The OIG is monitoring SSA's progress. At present, we continue to await specifications for the project, which we intend to subject to rigorous review. Our reports will ultimately be published on our website, as well as Recovery.gov, and we will remain involved in the process until a new data center is complete and operational.

Infrastructure and hardware, however, are only part of the equation, as SSA's primary data applications require modernization. SSA's attempts to upgrade its software to improve service delivery and stewardship are ongoing, but need to be given a higher priority. It is important that SSA consider all software options carefully and ensure that it is taking the best approach. As we point out in our Financial Statement Audit, consideration must be given to the benefits gained from the administrative funds transferred to SSA's IT budget each year. In addition, the OIG strongly supports giving SSA's Chief Information Officer sufficient delegated authority and resources to fulfill required security responsibilities.

Since I have mentioned two of the three ARRA mandates given to SSA, let me briefly state that the OIG also reviewed SSA's use of the \$90 million provided to process one-time \$250 stimulus payments. We found that SSA implemented a comprehensive process to identify and report these costs, and met OMB's requirements for transparency and accountability. The process was not without its challenges, however, including the issuance of checks to some ineligible prisoners and deceased beneficiaries. While perfection is an unreasonable expectation, improvements can be made legislatively and procedurally to tighten the process for future stimulus payments.

The primary focus of this hearing, however, is the disability application backlog, and in addition to the efforts I described earlier, SSA has made other inroads toward streamlining the initial disability determination process, reducing the backlog and, more importantly, getting benefits into the hands of those who qualify, and need them, as quickly as possible:

- Compassionate Allowances provide expedited approval to disability applicants with confirmed diagnoses of certain severe impairments. These Allowances let SSA quickly target the most obviously disabled individuals for benefits based on objective medical information that SSA can obtain quickly.
- Quick Disability Determinations (QDD) are cases that are electronically identified as having a high potential that the claimant is disabled, when evidence of the claimant's allegations can be easily and quickly obtained, and when the case can be processed quickly in the DDS. These cases are prioritized for fast turnaround. We estimate that the Compassionate Allowances and QDD initiatives will account for approximately 3.7 percent of initial disability claims.
- Additional Administrative Law Judges and hearing office support staff have been hired by SSA, and the recommendations from our draft report, Hearing Office Performance and Staffing, are being considered in ensuring that staffing ratios in SSA hearing offices are optimized to make the most of the new ALJ corps.
- SSA is developing a multi-year plan to reduce the initial claim backlog. According to SSA, the key components of this plan are:
 - increased adjudicatory capacity in the DDSs and Federal processing components;
 - improved efficiency through automation;
 - expedited IT investments to optimize systems performance;
 - expanded use of screening tools to assist in identifying likely allowances; and
 - refined policies and business processes to expedite case processing.

The OIG will review the Agency's plan when it is available, and will monitor its progress closely.

- SSA has instituted a Senior Attorney Adjudicator Initiative, which allows attorney adjudicators to issue fully-favorable on-the-record decisions. The goal is to expedite decisions while preserving ALJ resources for the more complex cases that require a hearing.
- SSA has also instituted an Informal Remand Initiative, in which a hearing office can return a denied claim to the DDS for review of the previous determination when there is a strong likelihood that the denial will be reversed, again saving hearing resources for more complex cases.

Finally, I would be remiss if I did not point out that integrity continues to be a primary focus of the OIG. Our continuing support for increasing the number of CDRs has never wavered. As important as it is to ensure that applicants are eligible for benefits at the time of their initial application, it is equally important to ensure that they remain eligible as time goes by. However, SSA is expecting to have a backlog of 1.5 million medical CDRs by the end of FY 2010. SSA had eliminated the CDR backlog when Congress provided the Agency dedicated funding that could only be used for CDRs. After that funding ran out in FY 2002, the backlog grew again. When SSA performs a full medical CDR, it costs about \$1,000, but provides an estimated return on that investment of \$10 to \$1.

Similarly, the Cooperative Disability Investigative program, or CDI, is an important ingredient in the integrity formula. The CDI Program began in Fiscal Year 1998 as a joint effort by the SSA and the OIG, in conjunction with the DDS and State or local law enforcement agencies, to effectively pool resources for the purpose of preventing fraud in SSA's Title II and Title XVI disability programs and related Federal and State programs. In 1998, the CDI Units became operational in 5 states. The program currently consists of 20 units located in 18 states, with 2 additional

units to become operational in FY 2010. Since its inception, the CDI program has closed 26,448 cases, and generated about \$1.35 billion in SSA program savings and another \$829 million in non-SSA savings.

As more individuals apply for benefits, allegations to these 22 CDI units across the country will increase. These units play a key role in ensuring that, while reducing the backlog of disability claims, SSA and the DDSs have an avenue available to them to further explore claims that may be suspicious or lack sufficient information to make a determination. Thus, the CDI program helps maintain the level of accuracy and integrity in these programs that the American public deserves.

In summation, the OIG is dedicated to working with Congress and SSA to reduce the backlog of disability claims, and to ensuring that this takes place in an environment in which efficiency, integrity, and transparency are paramount. SSA's efforts to date are commendable, and we look forward to continuing to assist in this critical undertaking. I thank you again for the invitation to speak with you today, and I'd be happy to answer any questions.

Chairman TANNER. Thank you very much, Mr. Inspector General.

Ms. Robert, we are delighted you are here, and glad to hear from you in your capacity on the Disability Determination Services. So, welcome. Thank you for being here.

STATEMENT OF ANN P. ROBERT, VICE PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS, SPRINGFIELD, ILLINOIS

Ms. ROBERT. Thank you very much, Mr. Chairman, Mr. Johnson. My name is Ann Robert, and I am honored to be here on behalf of the National Council of Disability Determination Directors. The NCDDD is comprised of managers and directors of the State DDSs.

As you have heard today, the state DDSs process all kinds of claims, including initial applications, reconsiderations, and continuing disability reviews. You have also heard today about the increases in the initial applications. While there have been increases in recent years in funding for SSA—and the NCDDD thanks Congress for the resources that the DDSs have received to assist in giving the good public service that they have—those resource needs are certainly going to continue, in light of the increased applications.

What's complicating the Disability Determination Services' ability to handle those increasing workloads are some of the other things that you've heard about today. For example, the furloughs. Despite the Commissioner's efforts to exempt all DDS employees from those furloughs, all of his attempts have not been successful.

What a furlough costs is not just problems in processing time, or problems in working claims, but it also costs dollars from the State. You heard that today. For example, a one-day furlough in the State of Ohio costs the state \$345,000 in administrative funding, \$149,900 in delayed monthly benefits to claimants, and impacts 731 claims. So you can see that the impact of even one day of furlough is significant.

While SSA has authorized hiring in the DDSs, the hiring has not always been optimized, because some other states have freezes and delays in hiring. Other states have been able to hire.

But with hiring, you don't get immediate results for increased capacity or productivity. The Social Security disability program is

complex, and requires significant training to bring an examiner to the point where they're independent and productive. The initial learning curve, coupled with the problems with attrition that the DDSs currently encounter are impacting the DDSs' ability to process this workload.

Now, it's been interesting, as the DDSs move forward, they have always—even with limited resources—processed cases, stepped up to the plate, provided good public service. The days of increased applications currently—and as we move in the future—provide significant challenges to the DDSs, which certainly will require some additional funding.

The Social Security Administration has requested, and Congress has provided, additional funding for technology. Technology forms a very important basis for improving claim processing, and it is critical that that funding continue to provide the capacity and the capability to provide good public service through an efficient and quality case-processing system.

You've heard from the Commissioner today about a couple of the initiatives: the DCPS, or the common case processing system; the QDD and CAL initiatives, and also eCAT. Those initiatives are important. They combine both technology and policy. NCDDD supports the continuation of those initiatives, and will work with SSA for the further development and roll-out of all of those initiatives in the DDSs.

Social Security is working right now on a——

Chairman TANNER. If you did all that from memory, you're pretty impressive.

[Laughter.]

Ms. ROBERT. It's what we lawyers do, isn't it?

Social Security is working right now, as you heard from the Commissioner, on workload planning issues. You have also heard from him how they are creating some ESTs, or extended service teams, which will provide national resources to some of the DDSs needing assistance. It's very critical that the DDS community be involved in every part of this process.

State DDSs are used to doing workload sharing, and helping out with additional workloads. In fact, we helped with the ODAR reduction by taking some informal remand cases. But transferring cases from state to state can be both politically sensitive and technologically challenging. So, this move must move forward with much caution and much collaboration by the DDSs.

NCDDD will continue to work with the SSA in development of an operational plan that is cost efficient, that is cost effective, ensuring success to address the workload while providing good, quality service, and program stewardship.

We want to thank Commissioner Astrue for his collaboration and support of the DDS community. We want to thank this committee for their support of the funding for the Social Security Administration that assists the DDSs, and we also look forward to enhancing the partnership of the Federal-State relationship.

So, in closing, the need for additional resources comes in a variety of ways. Certainly we need funding for staffing. We also need additional funding to continue with the initiatives, and funding for

the robust infrastructure that needs to support this case processing system that can handle all these claims.

So, thank you, Mr. Chairman, for inviting me to come here today, and for all your work in this regard.

[The prepared statement of Ms. Robert follows:]

Prepared Statement of Ann P. Robert, Vice President, National Council of Disability Determination Directors, Springfield, Illinois

Chairman Tanner, Mr. Johnson, Members of the Subcommittee, my name is Ann Robert and I am honored to have this opportunity to appear on behalf of the National Council of Disability Determination Directors (NCDDD) to comment on the effect of SSA's unprecedented backlog of disability claims, the agency's efforts to address those challenges, the impact of the recession on disability claims processing, and the ongoing need for adequate resources to address these issues.

The National Council of Disability Determination Directors (NCDDD) is a professional association composed of the Directors and managers of the Disability Determination Services (DDS) agencies located in each state, the District of Columbia, Puerto Rico, and the Virgin Islands. Collectively, members of the NCDDD are responsible for directing the activities of approximately 15,000 employees who process nearly 4 million claims per year for disability benefits under the Social Security Act. NCDDD goals focus on establishing, maintaining and improving fair, accurate, timely and cost-efficient decisions to persons applying for disability benefits. The mission of NCDDD is to provide the highest possible level of service to persons with disabilities, to promote the interests of the state operated DDSs and to represent DDS directors, their management teams and staff.

The DDSs are entirely federally funded by SSA and make medical determinations for the Social Security disability programs. The DDSs adjudicate various claim types including initial applications, reconsiderations, and continuing disability reviews. Many SSA executives have referred to the DDSs as the "best bang for the buck" in promoting governmental efficiency and effectiveness. NCDDD believes the Federal-State relationship is an important piece of the solution to addressing the increasing backlog of disability claims.

NCDDD appreciates the increases in SSA funding over the past few years and sincerely thanks Congress for the resources to assist the DDSs in providing the needed and necessary service to those Americans reaching out for help in desperate and difficult times. The recent funding increase has resulted in a decrease in the backlog and processing time at the hearings level. The DDSs received additional funding for overtime which they utilized for the Informal Remand process to assist ODAR with the backlog reduction.

The DDSs have seen a significant increase in the filing of initial disability claims which started in early FY 2009 as Baby Boomers predictably began to leave the workforce in their disability prone years and the nation began to experience the consequences of the economic downturn. As workers unexpectedly lost their jobs, they sought any other source of income, including Social Security disability benefits. Between the end of FY 2008 and the end of FY 2009, the number of initial claims has increased 14.8%. The total number of initial pending claims is expected to exceed one million by the end of FY 2010.

The full or partial furlough of DDS staff in several states has added additional hardship to processing the disability workload. These furloughs have continued despite the support of the Administration and the committed leadership and support of Commissioner Astrue to exempt these federally funded DDS employees from the furloughs. Currently there are thirteen (13) states with full or partial furloughs. These furloughs compromise efforts by DDS staff to allow claims, including extreme hardship claims, and the ability of the DDS to provide the necessary public service. A one (1) day furlough can cost a state like Ohio \$345,000 in administrative funding and \$149,900 in delayed monthly benefits while impacting 731 claims. In other cases, DDSs have not been able to optimize all the hiring authorized by SSA due to a state-imposed hiring freeze or state hiring delays.

SSA has requested significant funds to process the disability workloads and Congress has generously provided these funds. While the DDSs have worked to hire to optimal levels, the increasing complexity of the disability program criteria requires approximately 12-18 months of experience in the program for a disability examiner to become fully independent and productive. Therefore, hiring does not immediately translate to increased capacity and productivity. This initial learning curve, coupled with the current attrition in the DDSs (12.3% annually) is a significant challenge for the state DDSs in maintaining a qualified and experienced workforce. Histori-

cally, despite limited resources, the DDSs have worked to provide the much needed public service. However, the rising number of applications and the limited ability to hire and retain qualified and trained staff will have significant negative impact for the DDSs and the public we serve.

SSA has, for the past few years, looked for ways to utilize technology to provide greater capacity and more efficient claim processing. The move to electronic claim processing was a significant task and one that came with some difficulty but much benefit to the disability claimant and to those components adjudicating disability claims. SSA has continued to request funds for technology and those funds have been and continue to be critical to ensuring the necessary capacity and capability to provide not only efficient but also high quality service to which the American public is entitled.

Currently SSA has various initiatives combining policy and technology which have the potential to improve claim processing on several levels. The Disability Case Processing System (DCPS) is a SSA initiative partnering and collaborating with the States to design a case processing system to be used by all Disability Determination components. This case processing system should, when complete, provide a comprehensive process to produce efficiencies. DCPS must have sufficient infrastructure to provide a robust system that is stable, available, and responsive. DCPS should facilitate case processing not only in an individual DDS but when the need arises to assist with future workload challenges between Disability Determination components. The Quick Disability Determination/Compassionate Allowance (QDD/CAL) initiative is a process which allows the system to prioritize cases through technology providing for early identification of cases with a high potential of allowance thereby delivering expeditious service to those in desperate need. Another important but separate initiative of SSA is the Electronic Case Analysis Tool (eCAT). This tool can assist an examiner in working through a complex claim to reach the correct decision at the earliest point in the process. NCDDD supports each of these initiatives and will continue to work with SSA to further develop, refine, and roll out these processes.

SSA has begun planning for the potential to achieve greater capacity to address additional claims. The strategies are, necessarily, multifocal and involve both state and federal components. For example, SSA has funded four DDSs to create Expanded Service Teams (EST) to produce work as a separate entity and as a "national resource" with a yet to be finalized methodology as to how states will quality for assistance and how this process would impact productivity for any affected component.

The DDSs have a long and successful history of working cooperatively to assist with other workloads on an informal basis. With this background of success, the DDS community should be actively involved in all discussions to determine the best methodologies to provide assistance to any state while keeping in mind our primary focus of providing the best public service possible. Transferring work from state to state or to other components is both politically sensitive and frequently a technologically challenging venture that needs to be considered cautiously. Any plan to address the workload should be replete with appropriate mechanisms to assure accountability and consistency in decision-making regardless of which State Agency or federal disability component processes the claim. NCDDD will continue to advocate for DDS involvement in this plan and for a process that is well researched. NCDDD will assist in identifying and resolving potential problems or obstacles to ensure an efficient and effective process for those involved in this work flow process and those affected by it.

SSA is facing unprecedented increases in workload and requires an appropriate level of funding to continue to serve the American public with timely and accurate decisions, for both new applications and continuing disability reviews. SSA and the DDSs must receive adequate resources to provide necessary staffing, continue important initiatives, and provide a robust infrastructure that delivers the system stability and availability for claim processing. NCDDD stands ready to work cooperatively with the SSA in developing an efficient, consistent, and cost-effective operational plan that will ensure the success of addressing this unprecedented workload while continuing to provide quality public service and program stewardship. We would be remiss if we did not publicly acknowledge the outstanding and unwavering support that Commissioner Astrue has provided to the DDS community. His collaboration and partnership have been invaluable to the identification of solutions and successes in the disability process.

Mr. Chairman. On behalf of NCDDD, thank you again for the opportunity to provide this testimony. NCDDD has a long track record of success working with SSA to provide the highest level of service. I hope that this information is helpful to the

Subcommittee. NCDDD is willing to provide any additional assistance you may need and I would be happy to answer any questions you may have.

Chairman TANNER. Thank you very much, Ms. Robert. We agree that your organization has to be a critical part of this.

Judge Auerbach? Your Honor, you are recognized.

**STATEMENT OF LARRY A. AUERBACH, ADMINISTRATIVE LAW
JUDGE, ON BEHALF OF THE FEDERAL BAR ASSOCIATION,
ATLANTA, GEORGIA**

Judge AUERBACH. Thank you, Mr. Chairman. I am Larry Auerbach, from the Atlanta downtown hearing office of Social Security, and I believe I am required to give the disclaimer that I am not speaking on behalf of Social Security or the Federal Bar Association, but rather, the Social Security section of the Federal Bar Association.

There has been, as there has to be, a lot of talk about statistics and data here. That is how we gauge what the problem is, and how we gauge our success in dealing with the problem. But Congressman Kind and Ms. Bates each talked about individuals who suffer because of the delay.

As a judge, it is sadly common that I see individuals who are suffering those losses, individuals whose medical notes indicate that surgery is needed, but can't be done until disability is approved; individuals who are not taking their diabetes medication or their hypertension medication, because of a lack of funds while they are waiting on the approval of their disability.

These people don't just suffer at that time, but their disabilities, which might sometimes be temporary, become permanent disabilities while they are awaiting adjudication. That's a devastating blow to those individuals, and it's also a blow to the American taxpayers, who will then be funding disability payments for these individuals and health care costs for the rest of their lives.

I have seen individuals who have lost their homes, lost their cars while they are waiting on their determination. Without a car, people often don't have access to medical care. Without homes, they lose safety, stability for themselves and their families. Sadly, we find too often that we can't even find the individuals to notify them that their day in court has finally come.

The human face of this is tragic. It has, as has been noted by everyone here, improved dramatically. When I started just three-and-a-half years ago as a judge with Social Security, the average claimant that I saw had applied for benefits about four years before the date of his hearing. Today, I am seeing claimants who applied about two years before the date of the hearing. That's still a really long time, and, tragically, too long.

Progress has been made because of support from Congress and support from this committee, and initiatives that Commissioner Astrue talked about. The Social Security section applauds those. The improved technology has been a great benefit. The increased numbers of Administrative Law Judges and, just as importantly, the increased number of staff, has been vital to reducing the backlog and the wait times.

Judge Cristaudo, who was here earlier, sitting behind the Commissioner, and his team have done a lot to implement the Commissioner's plans, but if you look at the data, some of which are cited in my written testimony, there is a wave of claims being filed now with the state DDSs. The resources now will not accommodate that wave.

What will happen is that the backlogs will increase, the wait times will increase, and the tragic effects on human beings will increase, unless there is decisive action. In my written testimony there are a number of specific recommendations. The DDSs—and I know they are well represented here—they have been overburdened for years. With the increased load, they will be further overburdened.

The Social Security section would support some congressional action to prevent the furloughs at DDS—not any particular bill; I'm not familiar with the specific bill which has been proposed, but we would support some action to prevent these State employees from being furloughed.

We also think there is a need for improved adjudication at DDS to mitigate the problems and the downstream flow that comes to the hearing offices. I believe it was Congressman Becerra who talked about consistency. There really isn't consistency in state DDSs. If a claimant from your home State of Tennessee or my home State of Mississippi were to take the bridge right across the Mississippi River to Arkansas, their chance of initial approval would go up by 50 percent. That's really an unacceptable result. Justice, simple justice, demands that there be more consistency in the program.

And we would urge that Congress ensure that Social Security Administration has the authority and has the mandate from Congress to remedy that. That needs to be done by closer oversight, the resources for that oversight, and enforcement action, training, or whatever is necessary.

We fully support the improved increased technology that Social Security has implemented. It's been a tremendous benefit, having electronic files. I can conduct hearings in three states in one week without ever leaving Atlanta. That's a great benefit. But we have to remember that every case is a human being who needs his day in court, who needs his due process, and who needs to be able to tell an impartial judge his story.

Technology can't do everything. Only people can do it, people who have the time, the ability, and the willingness to stop and listen and understand the details of that individual's case and their medical history.

I believe the inspector general covered most of what I wanted to say about continued disability reviews. But I would like to point out that, beside being a tremendous benefit to the taxpayer, saving \$10 for every \$1 spent, they are also, in a way, are a benefit to the claimants. Claimants who know that they will face a continuing disability review are provided an added incentive to take advantage of medical care, vocational services, and other services to get themselves back into the workforce. Sometimes they need that extra push.

But part of that process is that claimants who disagree with the findings have a right to a due process hearing before an administrative law judge. So we have to understand that when we fund CDRs, we also have to fund the judges and the staff to hear those disability claims.

Thank you, Mr. Chairman, Mr. Johnson, for your time. I would be happy to answer any questions.

[The prepared statement of Judge Auerbach follows:]

Prepared Statement of The Honorable Larry A. Auerbach, Administrative Law Judge, on behalf of the Federal Bar Association, Atlanta, Georgia

I am Larry Auerbach and I am appearing here on behalf of the Social Security Section of the Federal Bar Association. I am an Administrative Law Judge (“ALJ”) in the Office of Disability Adjudication and Review of the Social Security Administration in the Atlanta, Downtown hearing office. While having only been an ALJ for three and one-half years, I have heard and decided approximately 1,700 appeals. Prior to becoming an ALJ, I was an attorney for 27 years with the Office of the Solicitor, U.S. Department of Labor; during the last 12 of those years I served in various management positions, including Deputy Regional Solicitor.

I am pleased to be here today representing the Social Security Section of the Federal Bar Association. My remarks are exclusively those of the Social Security Section and do not necessarily represent the views of the Federal Bar Association as a whole. Moreover my remarks do not reflect the views of the Social Security Administration.

Unlike other organizations associated with Social Security disability practice that tend to represent the interests of one specific group, the Federal Bar Association’s Social Security Section embraces all attorneys involved in Social Security disability adjudication.*

The common focus of the FBA’s Social Security Section is the effectiveness of the adjudicatory process at all phases including hearings in the Office of Adjudication and Disability Review (ODAR), the appeal process before the Appeals Council, and judicial review through the federal courts. Our highest priority is ensuring the integrity, fairness, independence, and effectiveness of the Social Security disability adjudication process to those it serves—both Social Security claimants themselves and the American taxpayers who have an interest in ensuring that only those who meet the criteria for eligibility receive these benefits.

We appreciate the continuing commitment that the Social Security Subcommittee has shown for fair and effective adjudication of disability claims. As we will discuss in more detail below, your support has enabled the Social Security Administration to reverse the long-standing trend toward increased backlogs and longer wait times. Most importantly, this is being done without sacrificing due process. We strongly believe that the growing disability claims workload can, and indeed must, be addressed without limiting claimants’ opportunity for full due process at every stage. In fact, we believe that affording due process at every stage is essential to fulfilling the Commissioner’s objective of reaching the right decision at the earliest possible stage of the process. The ODAR hearing before an impartial judge is the method by which claimants have an opportunity to tell their story. This right must never be abridged.

Increased staff and improved technology have had a dramatic and positive effect on the disability appeals process. By way of example, in October 2009 ODAR had 66,200 case dispositions. This is an increase of almost 60 percent from October 2007 when there were 41,361 dispositions. We applaud Congress for the funding which has made this possible. Nevertheless, delays remain at unacceptable levels. Furthermore, increases in applications will strain even the increased resources. A growing adjudicatory backlog is foreseeable unless significant additional resources are provided.

When we speak of anticipated increases in case filings due to the difficult economy, it is important to note that this is not based on mere speculation. ODAR hears cases which have been appealed from state Disability Determinations Services and

*Our members include Attorney representatives of claimants, Administrative Law Judges, Administrative Appeals Judges, staff attorneys in the Office of Disability Adjudication and Review, attorneys in the Social Security Administration’s Office of General Counsel, U.S. Attorneys and Assistant U.S. Attorneys, U.S. Magistrate Judges, District Court Judges, and Circuit Court Judges.

in 2009 alone, there was a 38 percent increase in the number of disability claims received by these state agencies. As we will discuss in more detail, projections call for even greater increases in coming years.

We thank the Social Security Subcommittee for holding this hearing and for keeping the attention of the American public on the problems faced by hundreds of thousands of Americans who too often wait years for a determination of their claims. The Social Security Administration's Inspector General has reported that the long waits adversely affect as many as 80 percent of all claimants, with 30 percent saying that the long waits impacted their access to health care.

As a judge, I see the human face of these statistics. Few days pass during which I do not see severely disabled individuals who have suffered serious and even irreparable physical, emotional and economic harm while awaiting a decision. It is sadly common to see medical treatment notes which state, for example, that:

1. A claimant is awaiting approval of disability benefits so he can have necessary back surgery.
2. A claimant could not afford his diabetes medication and has now developed irreversible neuropathy or retinopathy.
3. A claimant's psychiatric condition has deteriorated because of the lack of funds for therapy and medication.

It is also common to see individuals who have lost homes and cars while awaiting a benefits determination. The losses do not just result in the loss of creature comforts for claimants. They result in the loss of safe and secure housing, the loss of transportation to medical care, and even the loss of a stable address where claimants can be contacted regarding their health or the status of their disability claim.

It is important to avoid viewing that disability adjudication process as merely cold numbers and statistics. Each case represents a human being, and often a family, whose lives are on hold awaiting a decision. The time spent in each stage of the claims process—from initial application to final determination—is a seemingly endless wait to those in need. The maxim, "Justice delayed is justice denied," is never more true than in the disability adjudication process.

We commend the Commissioner on the great strides which have been made in reducing the backlog and reducing wait times. The Commissioner is in the fourth year of an ambitious program ensuring that those claimants who have waited the longest have their claims adjudicated. In the first year of this program, the Commissioner directed that all claimants whose hearing requests would have been pending for 1000 or more days received ALJ decisions by the end of fiscal year 2007. Each year, the Commissioner has set his goal as shortening this time, and he has achieved each goal.

The current goal is that by the end of fiscal year 2010, ODAR will have held hearings and issued decisions for every claimant whose request for hearing would be 800 days old by that date. The goal is to ensure that all claimants who requested a hearing on or before July 18, 2008 receive an ALJ-issued decision by September 30, 2010. This goal is achievable, but we must note that upon meeting this goal we will still have claimants who have waited for a decision well over two years since their request for hearing. It is also important to remember that these claimants all have been through the mandatory state Disability Determination Service ("DDS") administrative process prior to requesting a hearing, a process that commonly takes six months to one year.

Our testimony today advances five recommendations:

1. **State Disability Determination Services should be provided significantly enhanced resources.**
2. **SSA should continue to hire Administrative Law Judges and support staff, and add needed hearing offices.**
3. **SSA should continue to develop and implement improved technological and other initiatives.**
4. **New efforts are needed to accomplish the Commissioner's goal of making the right decision at the earliest possible stage.**
5. **Continuing Disability Reviews should be fully funded at every stage of the process.**

Let's examine each of these recommendations:

1. **State Disability Determination Services should be provided significantly enhanced resources.**

Initial disability determinations are made by state Disability Determination Services. These state agencies are funded by the Federal Government. Only claimants who are denied fully favorable decisions by these agencies may request

hearings before an Administrative Law Judge in ODAR. These DDS decisions have a major impact on the workload of ODAR and play a vital role in the disability process. In these difficult economic times, the number of disability claims is increasing dramatically. In fiscal year 2009 there were 385,000 more claims filed than in the prior fiscal year. This is a one-year increase of approximately 15 percent. Estimates are that in 2010 there will be 733,000 more disability claims filed than in fiscal year 2008. Current estimates by SSA's Office of Budget indicate that in fiscal years 2009 through 2012 there will be over 2.25 million more disability claims filed than there would have been if the 2008 rate had remained constant. This is a staggering increase in the workload of DDSs.

Aging baby boomers, inadequate healthcare, and decreased jobs in the economy all contribute to the projected increase in the number of claims. The increased numbers of claims do not represent simply unemployed individuals who are capable of competitive work. Many are individuals who, due to mental or physical impairments, were marginally productive workers in years past. In today's struggling economy, businesses find that they simply cannot afford to retain such workers. Of course, all claimants, whether or not they qualify for benefits, are entitled to a fair and timely adjudication of their claims.

The DDSs are overburdened and improved efficiency cannot prevent the increased numbers of applicants from causing delayed decisions by the DDS. Further, increased pressure on state workers to decide more and more cases is likely to decrease the time spent on each determination and thus negatively impact the accuracy of the decisions made. Such a result would be detrimental to the claimants who may be wrongly denied benefits, as well as to American taxpayers who will bear the costs of improperly granted benefits.

The problem is further exacerbated by the many states who, for economic reasons, have furloughed state employees, including DDS workers. Despite the fact that 100 percent of the salaries and overhead expenses of DDS employees is borne by the Federal Government, these states have decreased the number of DDS workdays available to process the increased number of cases. Some governors have continued their "savings" despite the fact that two months ago Vice President Biden sent a letter to Governor Edward Rendell of Pennsylvania, the Chair of the National Governor's Association, urging that DDS employees be exempt from state furloughs.

This situation requires immediate attention. We urge Congress to respond by not only providing adequate funding for DDS, but also requiring full work weeks for DDS employees.

2. SSA should continue to hire Administrative Law Judges and support staff, and add needed hearing offices.

In the last 18 months, SSA has significantly increased the number of Administrative Law Judges and support staff. These increases are ongoing and many of the newest staff are still working their way to full productivity. This increase in resources already has resulted in a dramatic increase in the number of adjudications. It is important to note that ODAR has not simply added people; it has added a corps of highly competent and dedicated individuals. Each decision made by ODAR judges is important to the taxpayers and is critical to the claimant. Our newest judges have shown themselves to be capable adjudicators who understand how important it is to make the right decision and how to do so with speed and efficiency.

The Commissioner has wisely matched increased numbers of ALJs with significant increases in support staff. It is critical that the numbers of ALJs and support staff continue to increase. As I commented at a recent staff meeting, statistics may indicate that I produced a certain number of dispositions, but that is misleading. I do not decide cases by acting alone. There are staff members who organize the evidence and schedule the hearings, others who obtain missing medical evidence and arrange for necessary consultative examinations, and still others who perform a myriad of tasks essential to the adjudicatory process. In addition, staff attorneys and paralegals turn decisional instructions into draft decisions. Each case disposition is the product of a team of individuals.

Commissioner Astrue has recently increased the support staff to ALJ ratio from just over four support staff members per ALJ to about four and one-half support staff members per ALJ. We believe that this increase will add efficiency to the adjudicatory process. We commend the Commissioner for this staffing decision. As we move to greater reliance on technology, it is hard to predict what the most effective and efficient ratio will be. We urge the Commissioner to continue to monitor the staffing ratios so as to maximize the ALJ's ability to produce legally sound and just decisions.

As discussed later, electronic processes have substantially increased efficiency. However, there is a critical limit to this. Each decision requires a judge to analyze and fully understand the medical evidence and other documentation in a file. The judge must then use good judgment to apply the law to the facts he finds. Electronics cannot replace human judgment. No matter how efficient our technological processes become, critical judgments must be made thoughtfully by human beings. If for no other reason, this immutable fact requires that there be increased staffing. Otherwise, the increased number of claims will exacerbate the unconscionable delays which have been faced by citizens who have come to their government in their time of need.

The Commissioner has opened two national hearing offices and plans to open two more. These offices conduct video hearings in states where they are most needed. This has helped reduce the backlog and improve the disposition time. In addition, the Commissioner plans to build 13 traditional hearing offices around the country. If these are properly located and staffed, they should help reduce the backlog of cases.

Efficient and fair adjudication can be advanced through greater use of technology, and SSA is making that happen. But we cannot rely on technology alone. SSA must continue to increase its cadre of well-trained, skilled, motivated, and caring employees—both ALJs and support personnel.

3. SSA should continue to develop and implement improved technological and other initiatives.

SSA is rapidly moving to implement a fully electronic business process. This process has significantly enhanced efficiency. I fully expect that the implementation of newer technology and processes will further enhance efficiency. Electronic files have also helped improve the decisional process by making it easier for the judge to fully review the evidentiary record.

Improved use of technology has also enhanced the efficiency and productivity of ODAR. Funding hardware and software for full implementation of technological advances is undoubtedly expensive. However, we believe that doing so is essential to reduce the hearing backlog. In the long run, technology will save many times its cost and it will greatly assist SSA's ability to provide timely and just decisions.

Video hearings enable judges to conduct hearings without traveling to remote hearing sites. Judges are able to interact with claimants by videoconferencing so that the claimants can be seen and heard as if they were in the hearing room with the judge. This has added to ODAR's flexibility in using resources where they will be most effective in accomplishing our mission and reducing our backlog. As an example, in a single week I have conducted live hearings in Atlanta, Georgia and video hearings with claimants in Greenville, North Carolina and Tampa, Florida. By teleconferencing, I did this without travel expenses and with no work time spent traveling.

Video hearings may not be right for every claimant. Some of the Federal Bar Association Social Security Section's members have expressed concerns that video hearings may make it more difficult for judges to accurately decide issues such as pain or mental health, or may make some claimants unduly nervous or confused. The Commissioner's rules permit claimants who are concerned about video hearings to opt out of such hearings and to have an in-person hearing without undue delay in their cases. This option is an important protection for the claimants' right to due process. If this option were to be eliminated, the credibility of the hearing process would be undermined.

ODAR is rapidly moving to the point where all evidence will be stored electronically and there will be no paper files. The advantages of this are numerous. When working with thousands of paper files, it was too common for staff to have to take valuable time to search for a file that had accidentally been misfiled, was being reviewed by an expert witness, or had simply been mislaid. This wasted time has been eliminated.

In addition, the production of electronic copies of the record for use by claimant's representatives, or medical or vocational experts in advance of the hearing is much easier and faster. In the past, the claimants' representatives had to arrange to review voluminous files in ODAR offices or arrange for them to be copied. Now, in a fraction of the time previously required, an electronic copy can be created for the experts and the claimants' representatives.

ODAR is implementing a technology referred to as the "Representatives Suite of Electronic Services." This will permit claimants' representatives to view the complete up-to-date evidentiary file on their own computers. Security safeguards are being built into this system to prevent unauthorized access to the obviously

highly sensitive documents in claim files. When this system is fully implemented, it will save resources that are now spent providing claimant representatives computer disks with file information. Currently, this often occurs two or more times in a single case to ensure that the representative has current information during preparation. This technology will also reduce time spent in hearings ensuring that all evidence is in the file.

ODAR has a number of judges and decision writers who work flexi-place on a regular basis. This is consistent with Government policies encouraging flexi-place and tele-work. Currently these employees must have computer disks made for each file. This consumes significant time and creates a huge number of disks that have to be destroyed. We recommend that the Commissioner explore improvements in technology to allow SSA employees to have the same secure access to electronic files that claimants' representatives will have.

There are other, as yet unexplored, technological tools that will be of great value. These might include the ability to search all of the medical evidence in a file for key words or dates so that a judge can more readily review all medical evidence related to a particular impairment or a particular time period.

Increased use of senior attorneys has been another important tool in enhancing ODAR's efficiency. We commend the Commissioner for permitting senior attorneys to review files and issue fully favorable decisions when warranted by the evidence. We look forward to the creation of the Virtual Screening Unit, whose establishment is under way. One hundred senior attorneys in this unit will review cases selected by a sophisticated computerized process as potentially appropriate for fully favorable decisions without a hearing. These initiatives involving senior attorneys will enable deserving claimants to get earlier decisions and free up ALJs to hear and decide more difficult cases.

4. New efforts are needed to accomplish the Commissioner's goal of making the right decision at the earliest possible stage.

The DDSs make the initial determinations regarding disability claims and therefore have the first opportunity to make the correct decision. While these agencies operate with federal funds under a uniform set of federal rules and regulations, the outcomes are far from uniform. Even a cursory glance at approval rates by various DDSs shows that there are significant disparities among the states. In fiscal year 2008, Georgia and Tennessee DDSs approved benefits on initial determination in only 25 percent of the claims filed. In contrast, in 2008 Virginia DDS awarded benefits to 44 percent of its claimants on initial application, while New Hampshire DDS granted benefits to 52 percent of its claimants at that stage. These disparities cannot reasonably be explained by state or regional population differences. In 2008, Mississippi DDS approved 24.5 percent of claims at the initial stage while in the neighboring state of Arkansas, the rate was 36 percent (almost 50 percent higher.) Similarly Connecticut DDS's rate was 33 percent approval compared to its neighboring states of New York (44 percent), Massachusetts (46 percent), and Rhode Island (38 percent).

My own personal experience is based upon a relatively small sampling of primarily Georgia disability claims. I do not see claims in which benefits are awarded by the state DDS, but I have had the opportunity to review a large number of claims that have been denied by the Georgia DDS. Other members of the Federal Bar Association have shared their experiences with me as well. Based upon this experience, it appears that all too often, the DDS has paid scant attention to the effect of pain and fatigue on a claimant's ability to work. This occurs despite Social Security Rulings that mandate consideration of these factors.

The disparities among states should be addressed for a number of reasons. The first and foremost is basic justice. The outcome of a claimant's case should not depend on his or her state of residence. In addition, improper early stage denials cause undue hardship to claimants and increase the workload, and thus the backlog, of hearing offices. If higher approval rates are the result of improper approvals, this places an unnecessary burden on American taxpayers.

SSA has a quality review process that is designed to ensure that state DDSs follow federal rules. This process should be enhanced to ensure accurate and fair determinations. Where SSA review shows a significant error rate, the Commissioner should take, or be required to take, action. This should include the delivery of enhanced training to DDS staff and management and closer oversight of the state's work until significant progress is made. For the benefit of the claimant and the taxpayer, SSA needs to receive and be a good steward of the resources and authority provided by Congress, and Congress needs to continue to exercise the necessary oversight.

5. Continuing Disability Reviews should be fully funded at every stage of the process.

SSA conducts Continuing Disability Reviews (CDRs) to assure that recipients of disability benefits continue to satisfy eligibility requirements. CDRs serve two important purposes. First, they save taxpayer money. As Commissioner Astrue noted in his March 24, 2009 testimony before this subcommittee, every dollar spent on CDRs yields ten dollars in program savings. Second, CDRs provide recipients an incentive to fully utilize available medical care, vocational rehabilitation services, and job training to help them re-enter the workforce.

Because of inadequate funding levels for over a decade, SSA has accumulated a significant backlog of nearly 1.6 million full medical Continuing Disability Reviews. The failure to timely conduct these reviews has significantly affected the federal budget and the deficit. It has been estimated that, if these CDRs had been conducted on a timely basis, over \$20 billion in long-term Social Security program savings would have been achieved. Unfortunately, current estimates project that SSA will only be able to conduct 329,000 full CDRs in FY 2010.

Funding of CDRs will not reduce the hearing backlog and, in fact, it may add to it. When benefit recipients are found to no longer be eligible for benefits, some will seek hearings challenging these determinations. These hearings are an important due process right that should not be abridged. Full funding for CDRs must include additional funding for ODAR to adjudicate CDR appeals. This will require funding above that needed to eliminate the backlog of initial claims. When considering this additional funding, it is important to keep in mind the savings created by CDRs. Conducting continuing disability reviews is the right thing to do for the taxpayers and for the recipients of benefits.

Mr. Chairman, thank you once again for the opportunity to appear before you and the subcommittee today. The Social Security Section of the Federal Bar Association looks forward to working with you and the Social Security Administration in improving the disability adjudication process. I would be happy to answer any questions you may have.

Chairman TANNER. As I said earlier, if you all would agree, Members will submit questions following the hearing. Would that be acceptable?

Judge AUERBACH. Absolutely.

Chairman TANNER. We got here late because of votes, we've got to leave early because of votes. I have got to say, and I know Mr. Johnson agrees because we have talked about this, we take this obligation very seriously. Your testimony will be carefully and closely considered and utilized. We appreciate you very much being here.

Ms. KENNELLY. Mr. Chairman.

Chairman TANNER. Barbara, do you want to say something?

Ms. KENNELLY. Yes, I want to say one thing, and Ranking Member Johnson talked about it. The technology at Social Security is behind the times. When you're talking about hundreds and hundreds of thousands of cases that need to be determined, I feel we are not doing enough about the technology.

You know what we're going to do? We're losing money, we're losing taxpayers' money about this. The COBOL system is terrible, and you two can change it. You could do it. That's all.

[Laughter.]

Mr. JOHNSON. It's going to take seven years to fix it.

Ms. KENNELLY. No, you know Sam, you could do it.

Chairman TANNER. We are trying, let me say that.

I thank all of you all for being here, and we very much appreciate your efforts to alleviate what is the backbone, really, in many ways, of our society. Thank you a lot. We stand adjourned.

[Whereupon, at 3:33 p.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]

[The questions submitted to the Honorable Michael J. Astrue from Chairman John Tanner for the Record follow:]

JOHN S. TANNER, TENNESSEE, CHAIRMAN
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Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515
SUBCOMMITTEE ON SOCIAL SECURITY

December 15, 2009

The Honorable Michael J. Astrue
Commissioner
Social Security Administration
500 E Street, SW, Suite 850
Washington, DC 20254

Dear Commissioner Astrue:

Thank you for your testimony before the Subcommittee on Social Security of the Committee on Ways and Means on November 19, 2009 at the hearing on Clearing the Disability Claims Backlogs: The Social Security Administration's (SSA's) Progress and New Challenges Arising From the Recession. In order to complete the record of the hearing, please respond to the following questions from Chairman John S. Tanner by Friday, January 15, 2009.

DDS Capacity and Initial Claims Processing

During the hearing, the Commissioner discussed SSA's strategy for increasing the capacity of the state Disability Determination Services (DDSs) to process disability claims. Please provide the following information regarding this strategy.

General

1. When did SSA begin implementing this strategy?
2. How long does SSA expect it will take for the strategy to reduce the backlog of initial claims to pre-recession levels? What is the targeted number of pending initial claims?
3. What milestones has SSA established to ensure that the agency is on track to reach the targeted number of pending initial claims by the target date?
4. From what states were cases shifted in FY 2009? From what states do you expect to shift cases in FY 2010?
5. How many cases are being shifted from one state to another? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs). How does

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SSA track these cases?

6. With respect to processing time, reductions in pending levels, and accuracy, what benefits have resulted from SSA's ability to shift cases between states?

Extended Service Teams

7. When does SSA expect the four Extended Service Teams to start processing cases?
8. How many cases will be assigned to each team in FY 2010? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs).
9. How are cases assigned to the Extended Service Teams?
10. What is the expected processing time for initial claims processed by these teams?
11. What was the allowance rate for initial claims, averaged over FY 2007 through FY 2009, in each of the four states chosen to house Extended Service Teams? How does this compare to the allowance rate nationally over the same period?

Expanding Federal Capacity

12. How many cases did SSA shift from state DDSs to Federal adjudicators in FY 2009, and how many cases does SSA anticipate shifting to Federal adjudicators in FY 2010? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs). How does SSA track these cases?
13. What was the average processing time in FY 2009 for initial claims processed by Federal adjudicators? What does SSA expect the average processing time to be for such cases in FY 2010?
14. What was the allowance rate for initial claims, averaged over FY 2007 through FY 2009, for Federal units processing DDS workloads?
15. With respect to processing time, reductions in pending levels, and accuracy, what benefits have resulted from SSA's ability to shift cases from states to the Federal level?

Quick Disability Determination and Compassionate Allowance Initiatives

16. Please provide, for each of the categories listed below: 1) the percent of total initial claims it represents (not including technical denials); and 2) the average processing time

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in FY 2009 and projected for FY 2010.

- Quick Disability Determination (QDD) cases
 - Compassionate Allowance (CAL) cases
 - Cases not identified as QDD or CAL (excluding technical denials)
 - All initial claims (excluding technical denials)
17. According to SSA's "Justification of Estimates for Appropriations Committees" for FY 2010, SSA's budget supported a total of 14,369 DDS work years for FY 2009 and 15,128 for FY 2010. What were the total DDS workyear savings in FY 2009 resulting from the QDD initiative? From the CAL initiative? What are the total DDS workyears savings anticipated in FY 2010 due to each of these initiatives?
18. If the QDD and CAL initiatives were not in place, how many of these cases would have resulted in appeals to the hearings level, thereby contributing to the hearings backlog?

Hearings Backlog Reduction Plan

19. Ms. Kennelly's testimony states that, due to updated workload projections, SSA will need to expand its corps of Administrative Law Judges (ALJs) to 1600. You testified that you plan to have about 1450 ALJs on board by the end of FY 2010. Do you agree that an additional 150 ALJs will be needed to handle the coming surge of appeals that will hit SSA's hearing offices, while still keeping on track with the hearings backlog reduction plan?
20. If additional ALJs (beyond 1450) are needed, when would you like to have these ALJs on board? How many additional support staff will you need to hire, beyond attrition, to ensure that these additional ALJs are fully productive?
21. You said that in FY 2010 you plan to maintain a hearing office staff-to-ALJ ratio of at least 4.5 to 1. Have you done any studies or analyses to assess whether 4.5 to 1 is the right ratio to ensure that each ALJ is as productive as possible? Might a higher ratio be a more cost-effective way to achieve the goal of working down the hearings backlog as quickly as possible, while ensuring that the time of highly-paid ALJs is used in the most effective manner?

The Committee relies on electronic submissions for printing the official hearing record, therefore, please send an electronic submission in a Word or Word Perfect attachment to hearingclerks.waysandmeans_d@mail.house.gov and to jennifer.beeler@mail.house.gov.

Letter to Mr. Astrue
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If you have any questions concerning this request, please feel free to contact the Subcommittee on Social Security at (202) 225-9263.

Sincerely,

A handwritten signature in cursive script that reads "Kathryn Olson".

Kathryn Olson
Staff Director



February 5, 2010

The Honorable John S. Tanner
Chairman, Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Thank you for your December 15, 2009 letter requesting additional information to complete the record for the hearing on clearing the disability claims backlogs. This hearing was held on November 19, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Judy Chesser, our Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Astrue", is written over the word "Sincerely,".

Michael J. Astrue

Enclosure

**Questions for the Record
For the November 19, 2009 Hearing
On Clearing the Disability Claims Backlogs
Questions from Chairman John Tanner**

DDS Capacity and Initial Claims Processing

During the hearing, the Commissioner discussed SSA's strategy for increasing the capacity of the State Disability Determination Services (DDS) to process disability claims. Please provide the following information regarding this strategy.

General

1. When did SSA begin implementing this strategy?

Even before we received our FY 2009 appropriation, we began analyzing economic forecasts and unemployment trends to determine where additional resources would be most needed. As soon as we received our appropriation, we began increasing staffing in the DDSs and Federal processing components. In FY 2009, we provided State DDS's with added resources to hire 1,400 new employees. For fiscal year (FY) 2010, we gave DDS agencies full one-for-one replacement hiring authority and an additional 1,400 hires. We also hired 237 additional Federal adjudicators.

2. How long does SSA expect it will take for the strategy to reduce the backlog of initial claims to pre-recession levels? What is the targeted number of pending initial claims?

With the resources provided by our FY 2009 and FY 2010 appropriations and through the American Recovery and Reinvestment Act (ARRA), we are moving aggressively to increase our capacity to process initial disability claims. Initial claims pending levels rose throughout FY 2009. We expect pending levels to peak by the end of FY 2010. With adequate and timely funding, we are committed to returning to pre-recession levels of 525,000 by the end of 2014.

3. What milestones has SSA established to ensure that the agency is on track to reach the targeted number of pending initial claims by the target date?

Our goal is to reach pre-recession pending levels. We continually monitor a number of critical performance measures, including decisional quality, processing time, pending claims level, and the number of initial claims processed. We will reallocate resources as necessary based on our progress toward meeting these performance measures.

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4. From what states were cases shifted in FY 2009? From what states do you expect to shift cases in FY 2010?

In FY 2009, the following 17 States sent claims to other offices for adjudication: Alaska, California, Colorado, Kansas, Louisiana, Michigan, Missouri, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Pennsylvania, South Dakota, Tennessee, Washington, and Wisconsin.

In FY 2009, the following 26 DDSs sent claims to other offices to obtain medical ratings only: Arizona, California, District of Columbia, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Since the DDS workloads and staffing levels can fluctuate, it is difficult to project workload transfers. We expect to see an increase in the number of transfers in FY 2010 due to our increased capacity to provide nationwide assistance. To ensure we provide resources to those States most affected by the surge in initial claims, we will analyze workload data on an ongoing basis.

5. How many cases are being shifted from one state to another? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs). How does SSA track these cases?

Thus far in FY 2010, there have been 2,786 claims transferred to and from State DDSs for determinations and medical review. These transfers included the following States: Alabama, Arizona, Georgia, Illinois, Indiana, Michigan, Minnesota, Nebraska, South Carolina, and Tennessee.

Since we currently use a manual reporting process that does not classify claim transfers by type, we do not have a ready breakout of the number of initial, reconsideration, and continuing disability reviews (CDR) that the States have transferred. We plan to formalize the claim transfer report process, thereby allowing us to more precisely track transferred workloads.

6. With respect to processing time, reductions in pending levels, and accuracy, what benefits have resulted from SSA's ability to shift cases between states?

Transferring claims allows us to maximize the use of all available resources, reduce the impact of State furloughs, reduce waiting times in the State and Federal adjudicating components, and achieve and maintain manageable caseloads and accuracy.

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Extended Service Teams

7. When does SSA expect the four Extended Service Teams to start processing cases?

The Extended Service Teams (EST) are currently completing hiring, training, and site preparations. The Arkansas EST will begin processing claims early in the third quarter of FY 2010. We expect the other three ESTs (Mississippi, Oklahoma, and Virginia) to start processing claims by the end of the third quarter of FY 2010.

8. How many cases will be assigned to each team in FY 2010? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs).

We do not have a precise number of claims that we intend to assign to each EST at this time. We will assign the number of claims to the ESTs based, in part, on the number of employees assigned to the EST and the learning curve necessary for new disability examiners in each EST.

We created the ESTs to assist those States most affected by the initial claims surge; therefore, the ESTs will focus on initial claims. Furthermore, it takes a new disability examiner approximately two years to be fully trained in processing the full range of claims. Since we will staff the ESTs primarily with new examiners, we do not expect them to process reconsiderations or CDRs, which are more complex claims, in FY 2010.

9. How are cases assigned to the Extended Service Teams?

We will compile and analyze specific workload and performance data to determine to which States national resources will be directed. We will determine the level of assistance each State needs and where capacity exists among the ESTs. When assigning claims to the ESTs, we will consider a number of factors, including the ESTs' locations relative to the State(s) being assisted (due to time zone differences), as well as the ESTs' capacity levels.

10. What is the expected processing time for initial claims processed by these teams?

The ESTs will adopt the business processes of the States they are assisting; consequently, we expect their processing times to be similar to those States. We will closely monitor the ESTs' processing times, using the same metrics we use when we monitor State DDS processing times.

11. What was the allowance rate for initial claims, averaged over FY 2007 through FY 2009, in each of the four states chosen to house Extended Service Teams? How does this compare to the allowance rate nationally over the same period?

The chart below contains the requested information.

	FY2007	FY2008	FY2009	Average
National	34.6%	36.0%	36.9%	35.8%
Arkansas	34.3%	36.1%	37.1%	35.8%
Mississippi	23.4%	24.5%	26.6%	24.8%
Oklahoma	37.9%	39.7%	38.6%	38.7%
Virginia	39.7%	39.0%	40.4%	39.7%

Expanding Federal Capacity

12. How many cases did SSA shift from state DDSs to Federal adjudicators in FY 2009, and how many cases does SSA anticipate shifting to Federal adjudicators in FY 2010? Please break down by initial claims, reconsiderations, and continuing disability reviews (CDRs). How does SSA track these cases?

In FY 2009, State DDSs transferred a total of 44,513 claims to Federal adjudicators. The breakdown of claims was as follows:

	Initial	Recon	CDR
Nation	36,008	2,347	6,158

In FY 2010, Federal adjudicators will focus primarily on initial claims, thereby assisting States that have been greatly affected by the initial claim surge. Since Federal components are increasing their staffing, we expect them to increase their production with a goal of deciding 64,000 claims this fiscal year.

To track these claims, we use manual management information (MI) reports compiled by our regional offices. The regional offices send these reports to Headquarters for consolidation into a workload database.

13. What was the average processing time in FY 2009 for initial claims processed by Federal adjudicators? What does SSA expect the average processing time to be for such cases in FY 2010?

In FY 2009, the Federal adjudicators' initial disability claim processing time was 104.2 days for Title II claims and 99.8 days for Title XVI claims.

We expect average Federal adjudicators processing times to be slightly higher than processing times for DDS initial disability claims because of increases in initial claims and the learning curve for new employees.

14. What was the allowance rate for initial claims, averaged over FY 2007 through FY 2009, for Federal units processing DDS workloads?

	FY 2008	FY 2009	Average
Nation	36.0%	36.9%	36.5%

We did not track allowance rates or other MI for DPBs until FY 2008. Federal units have only recently begun to focus on initial claims.

15. With respect to processing time, reductions in pending levels, and accuracy, what benefits have resulted from SSA's ability to shift cases from states to the Federal level?

We have experienced benefits similar to those described in our response to Question 6.

Quick Disability Determination and Compassionate Allowance Initiatives

16. Please provide, for each of the categories listed below: 1) the percent of total initial claims it represents (not including technical denials); and 2) the average processing time in FY 2009 and projected for FY 2010.

- Quick Disability Determination (QDD) cases
- Compassionate Allowance (CAL) cases
- Cases not identified as QDD or CAL (excluding technical denials)
- All initial claims (excluding technical denials)

Table 1 provides the percent of total initial claims by QDD or CAL category for FY 2009 and our projections for the end of FY 2010. Since we were unable to accurately exclude technical denials, we did not exclude them from our estimates.

Table 1. Percent of total initial claims by QDD/CAL category

Category	FY 2009*	FY 2010**
QDD only claims	2.2%	2.7%
CAL only claims	0.4%	0.5%
Both QDD and CAL claims	1.0%	1.3%
Total QDD and CAL claims	3.6%	4.5%
Claims not Identified as QDD/CAL	96.4%	95.5%
All Initial Claims	100%	100%

* CAL began on October 27, 2008; therefore, these data represent the percent of cases for all of FY 2009 beginning with October 27. Our Annual Performance Plan goal for FY 2009 was 3.8, which we met, but that goal is for the last month of the fiscal year not the entire year, hence the discrepancy in the two numbers.

** Projections for last month of FY 2010. Our FY 2010 performance measure is to achieve 4.5 percent of initial disability claims identified as QDD or CAL for the last month of the fiscal year. We do not have a performance measure encompassing the entire fiscal year because we are incrementally increasing the volume of claims identified for QDD and CAL throughout FY 2010. We expect that the incremental

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increase will result in an average for FY 2010 of 4.1 percent of total initial claims identified as CAL or QDD.

Table 2 displays the available information for average DDS processing times for CAL/ODD claims.

Table 2. Average Disability Determination Services (DDS) Time, FY2009

Category	Days	Comments
QDD	11.7	This time represents claims that were identified as "QDD" claims and claims that were both "QDD & CAL."
CAL	12.3	This time represents claims that were identified by the predictive model (PM) that were "CAL only" and claims that were both "QDD & CAL."
CAL Manual	5.8	This time represents claims that were manually identified as CAL. It is possible that some of these claims were also QDD.

17. According to SSA's "Justification of Estimates for Appropriations Committees" for FY 2010, SSA's budget supported a total of 14,369 DDS work years for FY 2009 and 15,128 for FY 2010. What were the total DDS workyear savings in FY 2009 resulting from the QDD initiative? From the CAL initiative? What are the total DDS workyears savings anticipated in FY 2010 due to each of these initiatives?

QDD and CAL help those who are clearly disabled by reducing the time their claims are pending in the DDS, but these initiatives do not affect task times and we do not realize any workyear savings.

18. If the QDD and CAL initiatives were not in place, how many of these cases would have resulted in appeals to the hearings level, thereby contributing to the hearings backlog?

We estimate that, for FY 2009, approximately 2,060 cases, or two percent of the cases, selected for CAL and QDD would have gone to the hearing level in the absence of those processes.

Hearings Backlog Reduction Plan

19. Ms. Kennelly's testimony states that, due to updated workload projections, SSA will need to expand its corps of Administrative Law Judges (ALJs) to 1,600.

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You testified that you plan to have about 1,450 ALJs on board by the end of FY 2010. Do you agree that an additional 150 ALJs will be needed to handle the coming surge of appeals that will hit SSA's hearing offices, while still keeping on track with the hearings backlog reduction plan?

Based on our review of projected claims, this fiscal year we adjusted our target ALJ corps from 1,250 to 1,450. We may change that target level in future years after a careful review of updated receipt projections and ALJ productivity data.

Hiring ALJs is a lengthy and difficult process that requires the assistance of the Office of Personnel Management (OPM). We appreciate the attention that John Berry, the Director of OPM, has placed on this issue. In December 2009, OPM opened the register for new applicants. It is imperative that OPM move quickly to provide us with a list of suitable candidates so that we can hire the necessary ALJs and support staff to maintain our progress at working down the backlog. OPM has informed us that we will not be able to obtain a certificate from the ALJ register until early May, making it difficult for us to meet our hiring targets by the end of the fiscal year.

20. If additional ALJs (beyond 1,450) are needed, when would you like to have these ALJs on board? How many additional support staff will you need to hire, beyond attrition, to ensure that these additional ALJs are fully productive?

We continually reassess projected hearing requests and other factors, and we will adjust the number of ALJs we hire and our support staff as necessary to ensure we meet our goal to eliminate the hearings backlog and prevent its recurrence.

21. You said that in FY 2010 you plan to maintain a hearing office staff-to-ALJ ratio of at least 4.5 to 1. Have you done any studies or analyses to assess whether 4.5 to 1 is the right ratio to ensure that each ALJ is as productive as possible? Might a higher ratio be a more cost-effective way to achieve the goal of working down the hearings backlog as quickly as possible, while ensuring that the time of highly-paid ALJs is used in the most effective manner?

As with the 500 annual disposition expectation for ALJs, the 4.5 national average is not a requirement or a quota. We believe that, as long as we can provide the right combination of job functions, including case pullers and writers, an average of approximately 4.5 support staff for each ALJ will allow us to continue reducing the backlog. At some point, there is a diminishing return to additional support staff.

[The questions submitted to the Honorable Michael J. Astrue from the Honorable Sam Johnson for the Record follow:]

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Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515
SUBCOMMITTEE ON SOCIAL SECURITY

December 1, 2009

The Honorable Michael J. Astrue
Commissioner of Social Security
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Commissioner Astrue:

Thank you for your November 19th testimony to the Committee on Ways and Means, Subcommittee on Social Security at its hearing on clearing the disability claims backlogs. In order to complete our hearing record, I would appreciate your response to the following questions:

1. Please provide a detailed explanation and accompanying timeline explaining what needs to be done, by when, and at what cost regarding the replacement of the COBAL-based computer programs. Also, why aren't performance goals related to this and other technology improvements included in the Performance and Accountability Report?
2. Please update the Subcommittee as to:
 - The status and operational capacity of the data center in Durham.
 - The date when the Agency will have enough hardware and software in Durham to bring up claims and data processing systems should there be a catastrophic event at the National Computer Center in Baltimore and whether Durham will be able to take on 100% of the National Computer Center work at that time.
 - Once Durham has the capability to restore full computer operations and in essence serve as the primary data center for the Agency, what impact, if any, will this have on the replacement of COBAL-based programs?

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 December 1, 2009

3. Experts have told the Agency that the National Computer Center will no longer be viable after 2012, and \$500 million has been made available for a new computer center. According to staff reports, that center is expected to be completed by October 2013, but all systems won't be up and running until July 2015, six years from now.
 - Are you satisfied with this timetable?
 - If not, what's being done about it?
 - Are building plans still within budget? Please update the Subcommittee as to what all costs are projected to be, by general category.
 - The Office of the Inspector General (OIG) is planning a thorough review of the progress of the new national computer center as they are required to do by law - yet they are waiting for specifications from your Agency. Please explain this delay.
4. Please provide the Subcommittee with information regarding how requests for technology changes are processed within the Agency:
 - What information is included in the request, and how are cost, savings, schedule, and performance goals included?
 - Who reviews the requests, and what criteria are used to evaluate each request?
 - How are priorities determined?
 - What follow-through is completed after the request is fulfilled to verify whether projected savings have occurred and whether the information included in the request was accurate?
5. An OIG report entitled *Opportunities and Challenges for SSA* (A-08-09-29152) issued to Chairman Tanner and Chairman Lewis included the following statements regarding verifying information technology investment results:

"As a part of the Agency's ITAB process, SSA typically estimates the potential number of full time equivalents (FTE) and related dollar savings that will result by implementing IT projects. As indicated in the chart below, in FYs 2007 through 2009, SSA reported that between 58 and 84 new and continued projects would save at least 68,650 FTEs over a 7 year period. The projected dollar savings for these projects were significant-ranging from about \$10 to \$20 billion over a 7-year period."

"While the projected FTE and dollar savings are impressive, we are concerned that these estimates are not realistic and do not reconcile to SSA's annual productivity statistics. For example, if SSA saves almost 70,000 FTEs over a 7-year period, the Agency ostensibly could use 10,000 FTEs each year to increase productivity in other SSA workloads. Using 10,000 of the Agency's approximately 60,000 FTEs (or 17 percent) for other workloads should result in significant productivity increases in areas that may have been previously neglected because of a lack of resources. Yet, in FY 2007, SSA recorded a productivity increase of only about 2 percent. While this may be a simplistic example of a far more complex process, the disparity between the projected FTE savings and actual productivity increases is marked."

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“Accordingly, we believe post-implementation reviews (PIRs) would enable the ITAB to determine whether many of the IT projects it assessed and approved resulted in SSA achieving the projects’ functionality and cost savings. Furthermore, without verification of this information, the ITAB cannot demonstrate that the Agency is receiving value for its IT investments. In response to a draft of this report, SSA stated that, beginning in April 2009, it will have a process in place to ensure PIRs are performed on incremental releases of larger projects.”

Why did post-implementation reviews not take place? Please describe the process now in place to ensure these reviews are being done. Is this process in place for all projects?

6. Explain the process by which transfers are made from administrative funds to the SSA’s IT budget each year:
 - How are decisions made in terms of what amounts are transferred and how IT funds are spent?
 - What amounts have been transferred in each of the past five years?
7. With respect to those workers filing claims due to the recession:
 - Were these individuals previously working with a disability? Or are workers filing for benefits as a last resort?
 - Will more claims be denied in the short-run?
 - What quality reviews are in place to ensure eligibility decisions are accurate?
8. The FY 2009 appropriation included funding (a base appropriation of \$264 million and an adjustment for an additional \$240 million) to conduct continuing disability reviews which save \$11 for every \$1 invested, according to the President’s 2010 budget request. You said in your testimony (page 14) that the number of full medical Continuing Disability Reviews (CDRs) pending is expected to reach 1.5 million this year.
 - How much money could be saved by working down this backlog?
 - What is your plan to address this backlog?
 - Given the focus on processing other growing workloads, how can you assure the Subcommittee that these critical program integrity workloads that save billions and increase taxpayer confidence will not take a back seat to other work as they have in the past?
 - What can Congress do to help?
9. You have worked with Disability Determination Services (DDS) parent agency heads and other State executives, including Governors, to try to prevent State furloughs and hiring freezes. To your credit, you have had some success.
 - What have you learned?
 - Are there changes to regulations or to the law that are being considered to prevent this from happening in the future?

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10. During this past fiscal year ending in September, the Agency hired over 9,100 employees. When attrition is factored in, the net number of new hires is about 4,200.
 - Are these numbers correct?
 - Please provide more detail regarding the positions for which individuals were hired and where the positions are located.
 - Will all of these hires serve on the front lines directly processing claims?
11. Please describe any additional process changes you are considering in the early stages of claim filing to reduce the number of decisions that are appealed.
12. It has come to my attention that there have been continued delays by the SSA in revising the medical listings as they apply to individuals affected by Huntington's Disease. I'm told that in 2004 the SSA began the rule-making process to revise the medical criteria for all neurological conditions, but there have since been multiple delays. I am also told that the final guidelines will be issued no sooner than December 2010 with implementation likely to occur in 2012. This is not acceptable. Please provide a summary of what has happened, the current status, and the reason for delay.
13. In a November 10th article in the *Washington Post* ("The retirement problem", Johnson and Kwak) an MIT professor and Yale law student tried to use the online benefit calculator for some of their calculations. As Andrew Biggs has pointed out, their results were too low because they did not understand that the calculator uses wage-indexed dollars.
 - If a professor and a law student from two prestigious universities cannot use this calculator, how do you expect average Americans to be able to use it for their planning purposes?
 - Are you looking at any changes to clarify how to interpret its results?
14. Some of our caseworkers have seen a fair amount of inquiries from individuals who have lawyers, saying their lawyers haven't been passing on relevant medical information and/or keeping their clients informed.
 - What recourse do claimants have when this occurs?
 - Does the Agency keep track of these complaints?
 - Please explain what process is in place for the Agency to address such complaints and share any data summarizing the results of these efforts.

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I would appreciate your response to these questions by December 15, 2009. Please send your response to the attention of Kim Hildred, Staff Director, Subcommittee on Social Security, Committee on Ways and Means Republicans, U.S. House of Representatives, B-316 Rayburn House Office Building, Washington, D.C. 20515. In addition to a hard copy, please submit an electronic copy of your response in WordPerfect or Microsoft Word format to Jennifer.Beeler@mail.house.gov and Mike.Stober@mail.house.gov.

Thank you for your leadership at the SSA and thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Kim Hildred at (202) 225-4021.

Sincerely yours,

A handwritten signature in black ink that reads "Sam". The signature is written in a cursive, slightly stylized font.

Sam Johnson
Ranking Member



February 5, 2010

The Honorable Sam Johnson
Ranking, Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
Washington, D.C. 20515

Dear Ranking Member Johnson:

Thank you for your December 1, 2009 letter requesting additional information to complete the record for the hearing on clearing the disability claims backlogs. This hearing was held on November 19, 2009. Enclosed you will find the answers to your questions.

I hope this information is helpful. If we may be of further assistance to you or your staff, please do not hesitate to contact Judy Chesser, our Deputy Commissioner for Legislative and Regulatory Affairs, at (202) 358-6030.

Sincerely



Michael J. Astrue

Enclosure

**Questions for the Record
For the November 19, 2009 Hearing
On Clearing the Disability Claims Backlogs
Questions from Representative Sam Johnson**

1. **Please provide a detailed explanation and accompanying timeline explaining what needs to be done, by when, and at what cost regarding the replacement of the COBOL-based computer programs. Also, why aren't performance goals related to this and other technology improvements included in the Performance and Accountability Report?**

There are solid business reasons for us to transition our COBOL systems to more modern programming languages. Modern languages provide flexibility for incorporating modern technologies. In addition, most of the employees we are hiring now and will hire in the near future work with web-based systems, and these web technologies are more user-friendly.

We have made solid progress in our modernization efforts. We are converting the databases that contain enumeration, earnings, benefit, and demographic data to modern, industry-standard databases. We have already converted two-thirds of these data and will complete the rest by 2012. During our conversion process, we run the new and old databases parallel to each other for several months to mitigate risk and minimize disruptions of daily operations. So far, we have had no outages, processing delays, or lost data. We build all of our new systems using modern languages, such as JAVA. Currently, 40 percent of our software inventory is in JAVA, and it is the standard language we now use for writing software code.

Rather than simply rewriting our COBOL code, we are taking the opportunity to redesign our systems for the 21st century. For example, we are currently replacing the 54 COBOL systems used by State disability determination services (DDS). If we merely rewrote these systems using JAVA, we would end up with 54 independent web-based systems with many of the same limitations we have today. Instead, we are building one common web-based system that all DDSs can use and that integrates case-analysis tools and health information technology. While it takes longer to create a common system, we believe that it is time well spent, and we will end up with a more efficient system.

Since replacing COBOL is interconnected with related systems upgrades and redesigns, we cannot break out the costs of replacing COBOL from those activities.

Below is our current timeline for shifting our programs and applications into a more modern infrastructure:

- **Electronic Disability Applications** - Completed
- **Modernized Enumeration System** - Completed

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- **Disability Control File** – Fiscal year (FY) 2011 Completion
- **DCPS (DDS Systems)** – FY 2013 Completion
- **Legacy Administrative System** – FY 2014 Completion
- **Unified Earnings Correction Process** – FY 2014 Completion
- **Wage Reporting Backend Processing** – FY 2014 Completion
- **Title II Modernized Claims System** – FY 2014 – 2017 (Phased development to minimize risk)
- **Modernized Title XVI Claims System** – FY 2014 – 2017 (Phased development to minimize risk)
- **Earnings Use System** – FY 2014 – 2017 (Phased development to minimize risk)

Pursuant to Office of Management and Budget (OMB) guidance, our performance goals in our Performance and Accountability (PAR) report are all tied directly to our strategic goals set out in the Agency Strategic Plan (ASP). While we considered improvements to our information technology (IT) infrastructure to be a foundational element needed to achieve all of our strategic goals, we did not consider these improvements themselves to be strategic goals. Accordingly, we did not include any performance goals for IT improvements in our PAR. Nevertheless, we did specifically address our need to replace the 54 COBOL-based DDS systems in Goal 2 of our ASP. We discuss our plans to implement a common case processing system for the DDSs in our ASP on page 11 and provide a description of this outcome on page 14. (See attachment.)

2. Please update the Subcommittee as to:

- **The status and operational capacity of the data center in Durham.**

That data center, which we refer to as the Second Support Center (SSC), opened in January 2009 and is fully operational as a major IT center, serving our IT operations 24 hours a day, 7 days a week. In May 2009, we began processing mission critical workloads at the SSC.

The SSC now contains:

- Medical images for electronic disability folders;
- Four mainframe computers;
- Billions of characters of data storage;
- Magnetic tape robots to create backup copies of critical data and provide the capability to use those copies to restore that data in the event of data corruption or data loss;
- Fully-redundant telecommunications connections to all of our offices, the Internet, and the National Computer Center (NCC) in Woodlawn, Maryland;

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- A mirrored IT operations control center synchronized with the NCC; and
- A full-time staff of about 120 employees and contractors.

When we moved these workloads to the SSC, we reduced our potential data loss by 50 percent. We also improved our ability to sustain operations because the SSC supports our employees' access to:

- Our network and the Internet in all offices;
- Essential Blackberry communications services;
- E-mail (including access from the Internet);
- Connectivity to SSANet for traveling employees; and
- Our program policy web-site.

The SSC also houses one of four service delivery points for our new Voice over Internet Protocol (VoIP) telephone system. At this time, it is the primary site for approximately 100 offices and can assume full operation of VoIP in the event of a disaster at the NCC site.

- **The date when the Agency will have enough hardware and software in Durham to bring up claims and data processing systems should there be a catastrophic event at the National Computer Center in Baltimore and whether Durham will be able to take on 100% of the National Computer Center work at that time.**

By the end of calendar year 2012, the SSC will be able to restore services within 24 hours in the event of an NCC disaster, and the systems will be current within one hour of the disaster.

To mitigate the vulnerability between now and the end of 2012, we have purchased the hardware and software necessary to support the claims and data processing systems presently housed in the NCC. This equipment is now operational. In the event of a disaster at the NCC, we would take the backup tapes to the SSC and use them to restore operations. It would take 7 days to restore services; however, once up, we would be able to handle all claims and data processing workloads and would not have to ration services to either our employees or the public.

From January 2010 to July 2010, we will refine and test our current disaster recovery procedures to utilize the SSC rather than a commercial hot site. Thereafter, we will perform an actual disaster recovery exercise in the SSC.

By the end of October 2010, the necessary physical infrastructure will be operational to support our non-critical workloads. Non-critical workloads have lower priority and include management information, forecasting, cyclical, regional, and end-user developed applications. In the event of a disaster, we will be able to bring up these non-critical workloads within a couple of weeks.

We will fully synchronize our data centers by the first half of 2012. Fully synchronized data centers will provide a failsafe in case of problems due to the aging NCC infrastructure. Even with full synchronization, though, the SSC could not restore services within 24 hours in the event of an NCC disaster until the end of 2012.

- **Once Durham has the capability to restore full computer operations and in essence serve as the primary data center for the Agency, what impact, if any, will this have on the replacement of COBOL-based programs?**

Since we will build any new or converted applications to run in either the SSC or the NCC, the SSC will not affect our initiative to replace COBOL-based programs.

3. **Experts have told the Agency that the National Computer Center will no longer be viable after 2012, and \$500 million has been made available for a new computer center. According to staff reports, that center is expected to be completed by October 2013, but all systems won't be up and running until July 2015, six years from now.**

- **Are you satisfied with this timetable?**

I believe we should have started on this activity earlier but we are moving as fast as we can consistent with high quality work. Since Lockheed Martin (LM) issued its February 8, 2008, report on the NCC, we have implemented several initiatives at the NCC to reduce risks until our new data center is operational. LM noted in its evaluation that we managed and executed our facility maintenance practices ably and that practice should continue to sustain the NCC beyond 2012.

In March 2009, when we received approval to build the new data center, we immediately began working with the General Services Administration (GSA) to develop a timeline for the project. The timeline follows Federal procurement guidelines and incorporates expedited methods to complete the process without compromising quality. We continue to work with GSA to track the project and, where possible, will implement additional expedited processes. The timeline is:

February 2010 - Select Site
March 2010 - Purchase Site
March 2011 - Award Design-Build Construction

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October 2011 - Start General Construction (full building construction)
October 2013 - Substantial Completion
November 2013 - Final Commissioning and Punch List corrections
January 2014 - Complete Commissioning
July 2015 - Complete IT migration

To sustain infrastructure support for IT operations until calendar year 2014 or later, we have initiated or completed the following projects:

- We continue to perform maintenance during the annual shut-down on Columbus Day.
- We purchased spare Uninterruptible Power Supply (UPS) parts in April 2009. The service provider agreed to extend the maintenance contract on the UPS system through 2015.
- In May 2009, we replaced critical electrical feeders between the Utility and NCC building to avoid possible failure due to age and deterioration.
- We will complete a 3-phase NCC Riser Panel project to upgrade electrical capacity by July 2010, replacing 256 electrical riser panels. We completed phase one over the 2009 Columbus Day weekend. Additional shutdown dates are:
 - President's Day weekend 2010
 - Memorial Day weekend 2010
 - Independence Day weekend 2010 (contingency date)
- We will install additional UPS Risers (for computer equipment) and general house power risers (for additional cooling equipment) by or before January 2011 based on opportunities to shut down operations.
- We will renovate and expand the SSN Card Print Room by June 2010.

In 2009 we invested in projects ranging from redesigning space within the NCC to upgrading the power by adding four additional feeder cables (two for the data center and two for house power). The feeder upgrade will allow us to install an additional 80 servers in the NCC. Reconfiguration and renovations to the NCC inner core have resulted in approximately 4,000 square feet of available space for the additional server cabinets necessary to support our workloads by September 2010.

In each fiscal year, we have a placeholder for \$500,000 to renovate and improve the NCC. In FY 2010, we have an additional \$300,000 to establish a new Security Operation Center lab. In FY 2011, we have a placeholder for \$18

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million for design and construction of new air handlers if needed. We expect the existing air handlers will remain operational until 2015.

- **If not, what's being done about it?**

We are making changes as quickly as we can, given funding limitations, consistent with doing the work well.

- **Are building plans still within budget? Please update the Subcommittee as to what all costs are projected to be, by general category.**

The project remains within the estimated budget. Although the specifics of the estimated costs remain confidential to ensure the equity, fairness, and integrity of the GSA procurement process, to date we have issued \$2.1 million in Reimbursable Work Authorizations to GSA for planning activities. Other costs include \$14 million for site acquisition and \$2.4 million for site studies related to the National Environmental Building Act and utility needs.

- **The Office of the Inspector General (OIG) is planning a thorough review of the progress of the new national computer center as they are required to do by law - yet they are waiting for specifications from your Agency. Please explain this delay.**

We have not found any request for specifications from OIG that had not already been provided. We are currently consulting with OIG staff to ensure they receive all information necessary to complete their review.

4. Please provide the Subcommittee with information regarding how requests for technology changes are processed within the Agency:

- **What information is included in the request, and how are cost, savings, schedule, and performance goals included?**

Our IT Advisory Board (ITAB) handles requests for human resources for technology investments. The Chief Information Officer (CIO) chairs the ITAB, and its membership comprises our most senior executives. Every request to the ITAB includes a statement of the objective and scope of the investment and an estimate of required resources developed by the Office of Systems. Development project requests also include a cost-benefit analysis or business-value analysis.

We organize these investments by portfolios. Each portfolio is aligned with an Agency Strategic Objective, is sponsored by a Deputy Commissioner, and is supported by a portfolio management staff led by a senior executive or other designee.

We are currently undertaking changes in our processes that will move responsibility for the process from Systems to the CIO.

- **Who reviews the requests, and what criteria are used to evaluate each request?**

The portfolio management staff and the Office of Systems review every request for resources. If a request will also benefit a component other than the sponsoring component, that component also reviews the request. In every case, the staff reviews basic information including the investment's purpose or objective, the expected cost, the expected benefit (quantitative or qualitative), an assessment of the risk, and other factors.

Since the objectives of the portfolios vary, the portfolio management staff and sponsor determine the weight to be given the different criteria. For example, the decision to make an investment to reduce disability processing times will weigh heavily on the return-on-investment in terms of labor savings; while an investment designed to improve our financial accounting transparency is likely to weigh heavily on cost and the extent to which the investment is aligned with our strategic and tactical approach.

- **How are priorities determined?**

We determine priorities at two levels—the ITAB level and the portfolio level. Every April, ITAB members allocate resources to each portfolio based on a review of the portfolio's strategic importance relative to other portfolios for the upcoming year. The portfolio's objective and our goals shape this review. They consider many other factors, including the portfolio's objective and whether there are major investments currently underway that require additional resources for completion.

At the portfolio level, each portfolio management staff ranks proposals within its purview and allocates resources to them according to the judgment of the sponsor and staff. Since the portfolio sponsor is also responsible for attaining that portfolio's agency strategic objective, this approach ensures that the technology investments are in line with our overall approach to that strategic objective.

- **What follow-through is completed after the request is fulfilled to verify whether projected savings have occurred and whether the information included in the request was accurate?**

Currently, our follow-through reviews happen at two levels—the Office of Systems conducts a post-release review (PRR) after completing an ITAB project, and the CIO conducts a post-implementation review (PIR) for some projects. The PRR focuses on the systems development process and the end users' acceptance of the product. Our CIO has developed a framework for conducting PIRs, which

are broader reviews that address business outcomes as well as a full assessment of the costs and benefits. The CIO will develop a specialized staff to manage IT investment performance measures. This staff will integrate PIRs into the overall investment management process and apply the lessons learned to improve the quality of subsequent projects.

5. An OIG report entitled **Opportunities and Challenges for SSA (A-08-09-29152)** issued to Chairman Tanner and Chairman Lewis included the following statements regarding verifying information technology investment results:

"As a part of the Agency's ITAB process, SSA typically estimates the potential number of full-time equivalents (FTE) and related dollar savings that will result by implementing IT projects. As indicated in the chart below, in FYs 2007 through 2009, SSA reported that between 58 and 84 new and continued projects would save at least 68,650 FTEs over a 7 year period. The projected dollar savings for these projects were significant-ranging from about \$10 to \$20 billion over a 7-year period."

"While the projected FTE and dollar savings are impressive, we are concerned that these estimates are not realistic and do not reconcile to SSA's annual productivity statistics. For example, if SSA saves almost 70,000 FTEs over a 7-year period, the Agency ostensibly could use 10,000 FTEs each year to increase productivity in other SSA workloads. Using 10,000 of the Agency's approximately 60,000 FTEs (or 17 percent) for other workloads should result in significant productivity increases in areas that may have been previously neglected because of a lack of resources. Yet, in FY 2007, SSA recorded a productivity increase of only about 2 percent. While this may be a simplistic example of a far more complex process, the disparity between the projected FTE savings and actual productivity increases is marked."

"Accordingly, we believe post-implementation reviews (PIRs) would enable the ITAB to determine whether many of the IT projects it assessed and approved resulted in SSA achieving the projects' functionality and cost savings. Furthermore, without verification of this information, the ITAB cannot demonstrate that the Agency is receiving value for its IT investments. In response to a draft of this report, SSA stated that, beginning in April 2009, it will have a process in place to ensure PIRs are performed on incremental releases of larger projects."

Why did post-implementation reviews not take place? Please describe the process now in place to ensure these reviews are being done. Is this process in place for all projects?

As explained in our answer to the prior question, we have only recently begun implementing the PIR process. We have developed a PIR framework and executed our

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first two PIRs using that framework. With the additional resources we are committing to this effort, we will conduct PIRs to assess whether the reviewed project achieved the functionality and cost savings originally estimated.

Going forward with the revisions to the ITAB we will be designating certain initiatives as subject to a PIR. The designation may happen at initiative initiation or at any point in the life cycle. The initiatives will be selected based on factors such as size, cost, complexity, strategic criticality, and technological innovativeness. Basically, we will select the ones that are most risky or strategically critical, and we will select those that we could learn the most from. We are now developing the guidance to support the selection and oversight process.

Explain the process by which transfers are made from administrative funds to the SSA's IT budget each year:

- **How are decisions made in terms of what amounts are transferred and how IT funds are spent?**

The first step in our annual IT budget formulation process is to determine the overall level of IT funding required for the fiscal year. Then, we review the level of unobligated administrative funds from prior fiscal years that we could transfer to the IT account before determining the level of new budget authority that we will request for the year.

We spend IT funds on hardware, software, telecommunications, and contractor support for our systems work. The CIO maintains the IT project list, which allocates IT resources to the many new and ongoing automation projects that we undertake.

- **What amounts have been transferred in each of the past five years?**

The table below lists the transfers for the past five years:

<u>Fiscal Year</u>	<u>Transfer (\$ millions)</u>
2005	\$ 80
2006	\$142
2007	\$184
2008	\$168
2009	\$170

7. With respect to those workers filing claims due to the recession:

- **Were these individuals previously working with a disability? Or are workers filing for benefits as a last resort?**

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We have not conducted a targeted study to determine the reasons for the surge in disability benefit applications due to the recession; therefore, we do not know whether the applicants were previously working with a disability, applied for benefits as a last resort, or sought disability benefits due to a state statutory requirement or for some other reason.

- **Will more claims be denied in the short-run?**

Since more disability claims were filed in FY 2009 as a result of the recession, there will be both more denials and more allowances. However, at this time, our Chief Actuary assumes that the additional applications will not significantly affect the percentage of disability applications that are ultimately allowed.

- **What quality reviews are in place to ensure eligibility decisions are accurate?**

To ensure that disability decisions are correct, we conduct the following quality reviews:

- Quality Assurance Reviews: We review a random sample of 70 denials and 70 allowances per DDS per quarter. This review provides a measurement of the DDSs' decisional accuracy.
- Pre-Effectuation Review: The Social Security Act requires us to perform a targeted review of 50 percent of initial and reconsideration allowances.
- Random Denial Review (RDR): We began this review of a random sample of denial cases from each DDS in December 2008. The approximate annual sample size for FY 2009 was 40,000 cases.
- Targeted Denial Review (TDR): The TDR will sample denial cases with higher than normal probability of error. We will begin a gradual rollout of this review early in calendar year 2010. Ultimately, it will replace the RDR. When we complete the rollout, we expect the yearly sample size to be the same as the RDR sample.
- Senior Attorney Advisor (SAA) Review: We conduct a post-effectuation quality review of SAA fully favorable decisions. This review has been in existence for about 2 years and consists of a national random sample of 85 fully favorable SAA decisions per month.

8. The FY 2009 appropriation included funding (a base appropriation of \$264 million and an adjustment for an additional \$240 million) to conduct continuing disability reviews which save \$11 for every \$1 invested, according to the President's 2010 budget request. You said in your testimony (page 14) that the number of full medical Continuing Disability Review (CDRs) pending is expected to reach 1.5 million this year.

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- **How much money could be saved by working down this backlog?**

Since the financial effects of doing CDRs vary depending on the mix of cases reviewed in a given year, it is very difficult to estimate the additional savings that might result from working down the current backlog of CDR cases. However, based upon our experience over more than ten years, we estimate that every dollar spent on medical CDRs yields at least \$10 in lifetime program savings.

- **What is your plan to address this backlog?**

The FY 2010 President's Budget provided an additional \$485 million in a discretionary allocation adjustment (above the cap) for our program integrity efforts in FY 2010. With this additional funding, we will be able to continue to reverse the overall decline in completing our key program integrity workloads. We are pleased that Congress included the full amount of the President's request for program integrity work in the enacted appropriations legislation.

- **Given the focus on processing other growing workloads, how can you assure the Subcommittee that these critical program integrity workloads that save billions and increase taxpayer confidence will not take a back seat to other work as they have in the past?**

The FY 2010 appropriations legislation specifies that we may use the additional \$485 million for designated program integrity work only; thus, we cannot use these funds to process initial claims or other work and will use it solely for program integrity work.

- **What can Congress do to help?**

Congress can help us protect taxpayer dollars by continuing to provide timely, sustained, adequate funding so that we can effectively balance our service and stewardship work. With the additional funding Congress provided to us in FY 2009, we were able to increase our program integrity efforts as well as process more claims and hearings for the American public. Since we received full funding of our FY 2010 budget, we will be able to process over 30 percent more medical CDRs than we completed in FY 2008.

9. You have worked with Disability Determination Services (DDS) parent agency heads and other State executives, including Governors, to try to prevent State furloughs and hiring freezes. To your credit, you have had some success.

- **What have you learned?**

We have learned the value of consistent communication and education, which have been common factors in each success story. We have provided governors,

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legislators, and State officials with information explaining the unique relationship that we have with the DDSs, emphasizing the fact that DDSs are fully federally-funded. We have provided the States with examples of the consequences of a one-day furlough on the States, the DDS employees and, most importantly, the citizens with disabilities in the States. We have shared this information in personal conversations with governors and in interviews with the media. In addition, our Regional Commissioners have had similar conversations with governors, their staffs, and legislators. Our DDS administrators and their parent agencies have educated the governors and legislators as well.

In addition to personal contacts, I have sought and received the support of the Vice President Biden in an effort to increase this issue's visibility. Vice President Biden strongly expressed to the NGA the need for governors to make the right decision and exempt federally-funded agencies from destructive furloughs and hiring freezes. In several instances, our unified efforts to educate the States have been successful. Even in States with furloughs, we have been largely successful in avoiding hiring freezes. Through our efforts and those of the DDS administrators, we have been able to get hiring approved on a case-by-case basis in those States where we have not been able to avoid a hiring freeze. Unfortunately, in many States, budgetary, political, or labor considerations have led to full or partial furloughs in spite of our efforts. In addition, we are learning that many states are proposing pay cuts, reducing benefits, and initiating early retirement incentives.

- **Are there changes to regulations or to the law that are being considered to prevent this from happening in the future?**

At this time, we have just started considering whether there are any regulatory changes that could strengthen our hand here, but much of this area is governed strictly by statute. The Administration has not proposed legislation to address the issue. However, we are eager to work with Congress to prevent future furloughs and hiring freezes. These state budget strategies will result in the loss of experienced staff and lower morale, which will ultimately diminish service provided by the DDSs.

10. During this past fiscal year ending in September, the Agency hired over 9,100 employees. When attrition is factored in, the net number of new hires is about 4,200.

- **Are these numbers correct?**

In FY 2009, we hired approximately 8,600 new full-time permanent employees, including new State DDS employees. This was our largest hiring effort since the implementation of the SSI program over thirty-five years ago. Along with that hiring, we also maximized the use of overtime across the agency. Overall agency

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attrition was about 4,400 full-time permanent employees, including State DDS employees. The net number of new full-time employees was 4,200.

- **Please provide more detail regarding the positions for which individuals were hired and where the positions are located.**

Out of the total 8,600 full-time permanent hires, more than 6,400 were front-line positions directly related to processing workloads such as claims representatives in field offices, teleservice representatives in our teleservice centers, and disability examiners in the State DDSs. In addition, we hired about 1,350 full-time permanent employees for hearings offices, which includes a net increase of 87 administrative law judges (ALJs) as well as the necessary support staff.

For more detailed hiring information, please refer to the charts (attachment) that follow these responses. The numbers in the charts represent our employees (not just our full-time permanent hires) and exclude DDS hires. Therefore, the totals differ slightly from the figures above.

- **Will all of these hires serve on the front lines directly processing claims?**

The vast majority—over 90 percent—were hired to serve on the front lines handling claims, hearings, or in other capacities directly serving the public.

- 11. Please describe any additional process changes you are considering in the early stages of claim filing to reduce the number of decisions that are appealed.**

In addition to the process changes discussed at the hearing, we have also established the Integrated Disability Process (IDP). The IDP is a multi-component initiative that will enable us to address and resolve important disability policy and procedural issues. The process will also help us address differences and difficulties in applying policy and procedures at all adjudicatory levels. The IDP team is working to simplify, clarify, and streamline some of the most complex policy issues in the disability program, including the assessment of past relevant work, the content of the medical source statements, and the creation of a Unified Disability Training Package.

Currently, ten States are testing a modification to the disability process that eliminates the reconsideration step. We are considering reinstating the reconsideration step in these States, which would reduce the number of hearing requests we receive. We are also considering a rule change to permit DDS disability examiners to make fully favorable determinations without requiring the input of a medical or psychological consultant in certain disability claims.

- 12. It has come to my attention that there have been continued delays by the SSA in revising the medical listings as they apply to individuals affected by Huntington's Disease. I'm told that in 2004 the SSA began the rule-making process to revise the medical criteria for all neurological conditions, but there have since been multiple delays. I am also told that the final guidelines will be**

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issued no sooner than December 2010 with implementation likely to occur in 2012. This is not acceptable. Please provide a summary of what has happened, the current status, and the reason for delay.

Updating our listings is an important part of streamlining our disability claims process, and we strive to update them as quickly as possible. We have found that revising the neurological body system Listings, which include Huntington's Disease, has posed unique challenges and has proven much more difficult than we originally anticipated. We understand that the delay in publishing new guidelines has been frustrating for many stakeholders.

To clarify a point in this question, we do not plan to issue final guidelines for the neurological listings in December 2010. Rather, in December 2010, we plan to publish a Notice of Proposed Rule Making (NPRM), which invites public comment on our planned revisions.

We published an Advanced Notice of Proposed Rule Making (ANPRM) for the neurological listings on April 13, 2005. The comment period for the ANPRM ended on June 13, 2005. We received almost 300 separate public comments in response to the ANPRM, which raised a wide variety of neurological impairment and adjudicative issues we need to address. In July 2005, we also held a public outreach conference in New York City, where we received additional comments from patients, medical experts, and advocates, including the Huntington's Disease Society of America.

Neurological impairments include many different kinds of disorders; we have 17 adult and 9 childhood neurological listings, several of which include more than one kind of neurological disorder. As we continue to learn more about the diagnosis, symptoms, and treatment of neurological disorders with outreach hearings, such as with the Compassionate Allowances initiative, we try to incorporate what we have learned into the revision.

We are taking other steps to improve all of our Listings. Under our strategic plan, we will update all Listings as needed at least every 5 years. We also have an ambitious effort underway to expand the listings to include many rare diseases and conditions. Furthermore, we have entered into a 3-year contract with the National Academy of Sciences, Institute of Medicine (IOM), to establish a standing committee of medical experts to ensure that our Listings are medically supportable, relevant, and technologically current. As part of our contract with IOM, the standing committee will evaluate medical literature, major studies, and emerging technologies to inform the agency of potential listings revisions. The IOM will also provide reports on specific body systems that we will use to revise the Listings.

13. In a November 10th article in the Washington Post ("The Retirement Problem," Johnson and Kwak) an MIT professor and Yale law student tried to use the online benefit calculator for some of their calculations. As Andrew Biggs has

pointed out, their results were too low because they did not understand that the calculator uses wage-indexed dollars.

- **If a professor and a law student from two prestigious universities cannot use this calculator, how do you expect average Americans to be able to use it for their planning purposes?**

As part of our commitment to providing the best possible financial planning tools for the public, we unveiled our current online Retirement Estimator in July 2008. Prior to launching the online Retirement Estimator, we conducted focus groups with financial planners and the public. These focus groups looked at the overall usability and understandability of the application and considered carefully the best approach to providing future estimates.

The Retirement Estimator is simple and interactive, allowing users to compare different retirement options. For example, a person can change retirement dates or expected future earnings to better determine the impact on future benefits and decide the best time to retire. The Retirement Estimator does not display the earnings that are used in the calculation; it displays only benefit estimates.

We chose wage-indexed values in part because using wage-indexed values allow the public to compare estimated future benefits to their average or recent earnings, and thus have a sense of how much of their earnings will be replaced by Social Security retirement benefits. Adequate replacement rates are typically the goal of retirement planning. The Retirement Estimator uses the same system that produces estimates for the Annual Social Security Statements.

Our Retirement Estimator has been a huge success. We have provided over four million personalized retirement estimates to Americans since its launch last year. We cannot explain Professor Johnson's and Mr. Kwak's difficulty with the program; customer satisfaction scores have consistently ranked our Retirement Estimator among the highest government-wide applications, according to American Customer Satisfaction Index (ACSI) surveys.

- **Are you looking at any changes to clarify how to interpret its results?**

We are reviewing the language on the online benefit calculator for possible clarifications of how to interpret its results.

14. Some of our caseworkers have seen a fair amount of inquiries from individuals who have lawyers, saying their lawyers haven't been passing on relevant medical information and/or keeping their clients informed.

- **What recourse do claimants have when this occurs?**

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Claimant representatives must comply with our Rules of Conduct and Standards of Responsibility for Representatives (Rules of Conduct). Several of our Rules of Conduct apply to situations where an attorney or non-attorney representative fails to submit relevant medical information or keep the claimant adequately informed about his or her case.

For example, representatives must obtain the information and evidence that the claimant wants to submit in support of the claim and forward it to us as soon as practicable. Representatives also must deal with us in a manner that furthers the efficient, fair, and orderly conduct of the decision-making process. This responsibility includes providing competent representation and acting with reasonable diligence and promptness in responding to our requests for information. Moreover, representatives may not deceive or knowingly mislead claimants regarding their rights under the Social Security Act.

Claimants who have complaints about their representatives should bring them to the attention of their local field office or hearing office. Those offices will investigate the complaint and forward their findings to our Office of the General Counsel (OGC). If the investigation reveals evidence of a Rules of Conduct violation, OGC may initiate an administrative action against the representative and seek his or her suspension (for a period of from one to five years) or disqualification from representing claimants before us.

- **Does the Agency keep track of these complaints?**

We have electronic and paper records of the complaints we receive, but we do not track complaints by the specific violation alleged. Therefore, we do not have any data on the number of complaints alleging that a representative has failed to submit relevant medical information or keep the claimant adequately informed about the claimant's case.

- **Please explain what process is in place for the Agency to address such complaints and share any data summarizing the results of these efforts.**

If OGC files a suspension or disqualification action against a representative, that representative has the right to answer the charges and have a hearing before one of our ALJs. After the ALJ issues a decision, either we or the representative may ask our Appeals Council to review that decision.

If we disqualify or suspend a representative, OGC forwards the representative's name to our regional commissioners and the Office of Disability Adjudication and Review and adds the representative's name to a list of sanctioned representatives. We also forward the name to the office that referred the complaint to OGC. In addition, if the representative is an attorney, OGC will inform the attorney's State court or State bar disciplinary authority of the suspension or disqualification.

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Since we do not track complaints by the type of violation, we do not have any data summarizing the number of complaints or subsequent suspensions or disqualifications for violations involving a failure to submit relevant medical information or keep a claimant adequately informed about the claimant's case.

[The questions submitted to the Honorable Patrick P. O'Carroll from Chairman John Tanner for the Record follow:]

JOHN S. TANNER, TENNESSEE, CHAIRMAN
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Congress of the United States
House of Representatives
COMMITTEE ON WAYS AND MEANS
WASHINGTON, DC 20515

SUBCOMMITTEE ON SOCIAL SECURITY

December 15, 2009

The Honorable Patrick O'Carroll
Inspector General
Social Security Administration
6401 Security Boulevard, Suite 300
Baltimore, MD 21235

Dear Mr. O'Carroll:

Thank you for your testimony before the Subcommittee on Social Security of the Committee on Ways and Means on November 19, 2009 at the hearing on Clearing the Disability Claims Backlogs: The Social Security Administration's (SSA's) Progress and New Challenges Arising From the Recession. In order to complete the record of the hearing, please respond to the following questions from Chairman John S. Tanner by Friday, January 15, 2009.

1. Do positions filled and locations for Operations new hires make sense?
2. Do you expect SSA to be able to achieve its hearings backlog reduction goal by 2013?
3. What are the desired national staffing ratios and staffing mix for SSA's hearing offices? Are all hearing offices meeting these goals?
4. You discussed two SSA initiatives to "fast track" initial disability cases: Compassionate Allowance cases and Quick Disability Determinations. What total percentage of disability claims are handled by these two initiatives? How many of these cases would end up in the hearings backlog otherwise?

The Committee relies on electronic submissions for printing the official hearing record, therefore, please send an electronic submission in a Word or Word Perfect attachment to hearingclerks.waysandmeans_d@mail.house.gov and to jennifer.beeler@mail.house.gov.

If you have any questions concerning this request, please feel free to contact the Subcommittee on Social Security at (202) 225-9263.

Sincerely,



Kathryn Olson
Staff Director
Subcommittee on Social Security



SOCIAL SECURITY
Office of the Inspector General

January 13, 2010

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

Attention: Kathryn Olson

Dear Chairman Tanner:

This is in response to your December 15, 2009 correspondence asking questions for the record, further to my testimony on November 19, 2009 before the Subcommittee on Social Security at a hearing on *Clearing the Disability Claims Backlogs: The Social Security Administration's Progress and New Challenges Arising From the Recession*. I appreciate the opportunity to provide additional information regarding this critical issue. Below are responses to your specific questions.

1. Do positions filled and locations for Operations new hires make sense?

Yes. We found that the Office of Operations developed an appropriate plan for its *American Recovery and Reinvestment Act of 2009* (ARRA) funds. The 1,531 newly hired employees are in front-line positions that will be trained to process disability and retirement workloads. Operations determined where the new employees should be placed based on several factors including:

- projected workloads,
- the number of permanent staff on-duty,
- projected attrition, and
- unique staffing shortages within specific regions.

The Social Security Administration (SSA) considered the needs of all its Office of Operations components (field offices, teleservice centers, program service centers, etc).

2. Do you expect SSA to be able to achieve its hearing backlog reduction goal by 2013?

Currently, we are updating our own estimates. In our August 2009 review, *Office of Disability Adjudication and Review Management Information* (A-09-08-18047), we noted that it appeared SSA would achieve the desired pending hearings level by FY 2013 based on

the currently projected level of receipts and assuming continued ALJ hiring and productivity. However, the projected level of receipts has changed since we issued this report. Moreover, ALJ hiring has been slower than anticipated. As a result, we are currently reviewing the backlog projections based on this new information as part of a request from Senator Claire McCaskill. Fortunately, the Office of Disability Adjudication and Review (ODAR) made good progress in tackling the backlog in Fiscal Year (FY) 2009, which brings SSA closer to its ultimate goal.

3. What are the desired national staffing ratios and staffing mix for SSA's hearing offices? Are all hearing offices meeting these goals?

SSA has established ratios in both areas and is showing progress in achieving these goals. In March 2009, the Commissioner of Social Security testified that about 4.5 staff per administrative law judge (ALJ) (referred to as the staffing ratio) was necessary to maximize the number of legally sufficient hearings and ALJ decisions. In this context, "staff" represents both decision writers and other support staff. At the time of our review (July 2009), ODAR's staffing ratio was about 5.1, exceeding the Agency's national goal of 4.5 staff per ALJ. However, not all hearing offices have been able to attain this staffing ratio. Our review of ODAR's staffing reports found that 42 hearing offices did not meet the national staffing ratio goal, and 7 of those hearing offices had staffing ratios below 4.0. In our draft report to the Agency, we recommended that, to the extent possible, ODAR consider adding new hires to hearing offices below the 4.0 staffing ratio before offices already above this ratio.

In terms of staffing mix, ODAR's Deputy Commissioner issued guidance in FY 2009 to the Regions to achieve a hiring goal of 1.5 decision writers per ALJ and 2.5 other support staff per ALJ (referred to as the staffing mix ratio), thereby giving additional definition to the Commissioner's staffing ratio goal. In terms of the staffing mix at hearing offices, we found that the hearing offices that met or exceeded the 1.5 decision writers per ALJ staffing mix goal had, on average, almost a 9 percent higher productivity rate than those hearing offices with a ratio less than the goal. We did not find similar productivity differences for the other support staffing mix goal. However, at the time of our review, we found that 36 hearing offices did not meet the decision writer staffing mix goal, including most of the hearing offices in the San Francisco Region. Again, we plan to recommend that ODAR continue to review the staffing mix when new allocating new hires.

We have noticed other positive trends with regard to ODAR staffing, including central pulling and writing units that will provide hearing offices with additional resources to handle short-term shifts in available staff and workloads. At the end of FY 2009, ODAR had three centralized pulling units and eight centralized writing units. In our draft report to the Agency, we recommended ODAR continue expanding the use of centralized pulling and writing centers to assist hearing offices in processing pending claims.

4. You discussed two SSA initiatives to "fast track" initial disability cases: Compassionate Allowance cases and Quick Disability Determinations. What total percentage of

Page 3—The Honorable John Tanner

disability claims are handled by these two initiatives? How many of these cases would end up in the hearing backlog otherwise?

In October 2009, the Commissioner reported that compassionate allowance (CAL) and quick disability determination (QDD) claims represent about 3.8 percent of all initial disability claims. The Agency's goal is to reach 4.5 percent in 2010 and 6 to 9 percent in 2012 by improving the automated selection criteria. We plan to begin a review of the CAL initiative soon. For our review, SSA provided a list of 16,383 individuals with claims selected for CAL processing between October 24, 2008 and September 30, 2009. During this time period, SSA received 2,783,934 initial disability claims. Also, we issued a report on QDD in May 2009, which can be found on our website at www.ssa.gov/oig/ADOBEPDF/A-01-09-19030.pdf.

—We believe there would be little impact on the ODAR backlog if CAL and QDD were not in place. The evidence for the case determines whether it is an allowance or denial. The CAL and QDD initiatives expedite the processing of the case, but has no impact on the actual decision, since the evidence still has to support the allowance or denial decision in the case. For both initiatives (CAL and QDD), the evidence should be readily available and SSA should work the case quickly. Therefore, the claimant is likely to find out if they are being allowed or denied benefits sooner. Regardless of whether these initiatives were in place, the allowance or denial decision would still be the same and there would be little impact on the backlog.

Thank you for the opportunity to clarify these issues for the Subcommittee on Social Security. I trust that I have been responsive to your request. If you have further questions, please feel free to contact me, or your staff may contact Misha Kelly, Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,



Patrick P. O'Carroll, Jr
Inspector General

[The questions submitted to the Honorable Patrick P. O'Carroll from the Honorable Sam Johnson for the Record follow:]

May 20, 2010

The Honorable Patrick O'Carroll
Inspector General
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Mr. O'Carroll:

Thank you for your April 15th testimony to the Committee on Ways and Means, Subcommittee on Social Security at its hearing on Social Security Administration (SSA) field office service delivery. In order to complete our hearing record, I would appreciate your response to the following questions:

1. What is the current backlog of full medical continuing disability reviews (CDRs) and work-CDRs?
2. How many redeterminations should be done each year, and how many redeterminations is the SSA actually completing?
3. How would you assess the SSA's actions on completing redeterminations?
4. What work is in progress or planned related to the issues raised at this hearing? When may we expect a final report?

I would appreciate your response to these questions by June 4, 2010. Please send your response to the attention of Kim Hildred, Staff Director, Subcommittee on Social Security, Committee on Ways and Means Republicans, U.S. House of Representatives, B-316 Rayburn House Office Building, Washington, D.C. 20515. In addition to a hard copy, please submit an electronic copy of your response in WordPerfect or Microsoft Word format to Jennifer.Beeler@mail.house.gov and Mike.Stober@mail.house.gov.

Committee on Ways and Means Republicans
Subcommittee on Social Security
Page 2
May 20, 2010

Thank you for taking the time to answer these questions for the record. If you have any questions concerning this request, you may reach Kim at (202) 225-4021.

Sincerely yours,

Sam Johnson
Ranking Member



SOCIAL SECURITY

December 18, 2009

The Honorable Sam Johnson
Ranking Member, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives
B-316 Rayburn House Office Building
Washington, D.C. 20515

Attention: Kim Hildred

Dear Mr. Johnson:

This is in response to your December 1, 2009 correspondence asking questions for the record, further to my testimony on November 19, 2009 before the Subcommittee on Social Security at a hearing on *Clearing the Disability Claims Backlogs: The Social Security Administration's Progress and New Challenges Arising From the Recession*. I appreciate the opportunity to provide additional information regarding the critical issue of eliminating the Social Security disability claims backlog. Below are responses to your specific questions.

1. Your office continues to identify investment in information technology (IT) infrastructure to support current and future workloads as a top management and performance challenge.

- **On page four of your testimony, you say that the Agency's attempt to improve service delivery and stewardship needs to be given a higher priority. How did you reach this conclusion? Please provide examples of how the Agency could give a higher priority to software updates.**

Based on an ongoing review, *Conversion of the Social Security Administration's Legacy File Management System* (final report expected January 2010), we believe the Social Security Administration (SSA) should have managed the conversion of its current file management system to the DB2 Data Base Management System (DBMS) as a major IT investment. This conversion is critical to SSA's mission and function because it ensures the continued availability of SSA's major data files. The conversion is also a high-risk project because delay or failure will impose unacceptable risk on SSA.

The conversion meets the Office of Management and Budget's (OMB) definition of a "major investment" (Circular No. A-11, Part 7). If SSA had managed the conversion as a major investment, SSA would be required to submit annually to OMB a *Capital Asset Plan and Business Case Summary*; and would be required to report the results of or verify that it performed required project management activities for the major investment in this document. SSA reviews all major IT projects to ensure that accurate information is reported to OMB. This process assures that both the Chief Information Officer and OMB are directly involved in the capital planning process.

Major IT projects also receive additional oversight through various reporting mechanisms and reviews. These include quarterly reporting to the Information Technology Advisory Board (ITAB), Office of Systems project reviews, and the Office of the Chief Information Officer Systems Procurement Request milestone review. These reviews would provide higher Agency management attention to the conversion. Further, if SSA would have identified and managed this conversion as a major IT investment, it would have performed an Alternative Analysis as required by OMB.

- **Given the Agency's reliance on effective IT supporting Agency operations, should there be more transparency regarding plans to update IT software and hardware? If so, how should such transparency be achieved?**

We believe SSA's plans to update software and hardware should be more transparent. We have previously reported that SSA does perform some IT strategic planning. However, SSA does not have a comprehensive Agency Information Infrastructure Plan to meet potential processing needs for the next 20 years, and to allow the Agency to recover quickly if major components of its processing infrastructure fail or are destroyed.

For example, during our ongoing review, *Conversion of the Social Security Administration's Legacy File Management System*, we discussed with SSA representatives that we believe the Agency should have developed a comprehensive, long-term strategic plan for the conversion of its current file management system to DB2. SSA's planning and analysis to date has been limited to Phase I of the conversion—SSA does not have planning documents for Phases II or III. Phases II and III will involve significant application reprogramming efforts. For these Phases, SSA did not perform sufficient strategic planning to cover the system development lifecycle of the project.

Moreover, establishing a Post Implementation Review (PIR) process would create transparency by documenting actual cost to develop a system and/or application versus planned benefits. SSA has established a PIR policy for verifying planned benefits of its IT projects that generally meets OMB's requirements. However, SSA has not been conducting PIRs to verify functionality and cost savings. PIRs would help ITAB determine whether many of the IT projects it approved achieved the functionality and cost savings as estimated. Moreover, without verifying functionality and cost savings information, ITAB lacks information on where dollars should be spent.

2. Your testimony reported that the Financial Statement Audit included the fact that consideration must be given to benefits gained from administrative funds transferred to SSA's IT budget each year.

- **What's the balance of this budget and how much funds have been transferred in each of the past five years?**

As of September 30, 2009, \$314 million was the balance available to transfer to the Information Technology Systems (ITS) budget from SSA's Limitation on Administrative Expenses for fiscal years (FY) 2004 through 2008. For those FYs, \$611 million has been transferred to the ITS budget: \$111 million for FY 2004; \$240 million for FY 2005; \$175 million for FY 2006; \$85 million for FY 2007; and \$0 for FY 2008.

- **What funding sources exist for IT expenditures? How does the Social Security Administration (SSA) prioritize requests for IT expenditures, including software updates? What return on investment have these changes had over the past five years?**

SSA's funding for IT projects comes from four different sources: the ITS Fund, Recoveries of Prior Year Unpaid Obligations, Regular Appropriations, and Non-Expenditure Transfers. In FY 2009, the Agency budgeted the following:

ITS Fund (Balance Brought forward from prior FYs)	\$219 million
Recoveries of Prior Year Unpaid Obligations	\$ 17 million
Regular Appropriations	\$725 million
Non-Expenditure Transfers	\$170 million
Total	\$1.1 Billion

As mentioned previously, ITAB is the governing body for SSA's IT planning process and is responsible for developing the Agency's IT Plans. ITAB reviews a variety of SSA's IT projects, categorized by investment portfolios, each of which contains a list of projects. These projects support objectives in SSA's Strategic Plan. Portfolio teams, led by an Agency executive as the portfolio manager, coordinate with stakeholders to prioritize projects based on their role in achieving the related strategic objective. After IT projects are prioritized, ITAB decides how SSA resources will be assigned to the projects, based on the portfolio priorities and cost-benefit analyses provided by the sponsoring components. Such information includes return on investment, full-time equivalent savings, dollar savings, and cost avoidance.

As a part of the ITAB process, SSA typically estimates the potential number of full-time equivalents (FTE) and related dollar savings from implementing IT projects. As indicated in the chart below, in FYs 2007 through 2009, SSA reported that between 58 and 84 new and continued projects would save at least 68,650 FTEs over a 7-year period. The projected dollar savings for these projects were significant, ranging from about \$10 to \$20 billion.

SSA's Return on Investment Summary				
Savings Reflect the Total Savings Over a 7-Year Span				
Fiscal Year Cost Savings Estimated	Total Projects (New and Continued)	Number of Projects (New and Continued) with FTE Savings over 100	Total FTE Savings for Projects (New and Continued) With FTE Savings over 100	Net Dollar Savings for the Total Projects (in Millions)
2007	195	58	70,121	\$12,444
2008	196	84	80,516	\$20,771
2009	189	67	68,650	\$10,591

While the projected FTE and dollar savings are impressive, we are concerned that these estimates are not realistic and do not reconcile to SSA's annual productivity statistics. For example, if SSA saves almost 70,000 FTEs over a 7-year period, SSA could ostensibly use 10,000 FTEs each year to increase productivity in other workloads. Using 10,000 of the Agency's approximately 60,000 FTEs (or 17 percent) for other workloads should result in significant productivity increases in areas that may have been previously neglected because of a lack of resources. Yet, in FY 2007, SSA recorded a productivity increase of only about 2 percent. While this may be a simplistic example of a far more complex process, the disparity between projected FTE savings and actual productivity increases is marked.

3. Please provide the following information about the Cooperative Disability Investigative (CDI) program:

- **How is the program working today?**

The CDI Program began in Fiscal Year (FY) 1998 as a joint effort by SSA and the Office of the Inspector General (OIG), in conjunction with the Disability Determination Services (DDS) and State or local law enforcement agencies, to pool resources and specialized knowledge effectively for the purpose of preventing fraud in SSA's Title II and Title XVI disability programs and related Federal and State programs. The CDI mission is to obtain evidence that can resolve questions of fraud related to SSA's disability programs. In FY 2009, the CDI Program nationwide resulted in a projected \$240.2 million in savings to SSA and \$139.2 million savings to other agencies. From its inception through October 2009, CDI efforts have resulted in \$1.4 billion in projected savings to SSA and \$829 million to non-SSA programs.

- **What are the most common allegations and how often are they substantiated?**

The most common allegations referred to the CDI Units are allegations involving mental and physical impairments, conflicting medical evidence/statements, multiple or frequent re-applications by the claimant and/or family members, and similar claims submitted.

- **What actions are taken against those who are found to have committed fraud during the CDI process?**

There are many outcomes for disability fraud cases; however, depending on the circumstances of the investigation, the OIG can seek criminal prosecution, civil prosecution, Civil Monetary Penalty actions, or administrative sanctions imposed by SSA. SSA and the DDSs may also use CDI reports of investigation in making certain administrative determinations, such as allowing or denying initial claims; or ceasing, suspending, or terminating benefits for those in current pay status.

- **Are there lessons learned from closed cases that could be applied earlier in the disability process to prevent fraud?**

On many occasions, CDI Units have provided training to educate DDS administrators, SSA District Managers, and SSA and DDS employees regarding the case referral process. In general, CDI team members encourage these partners to consider referring cases containing inconsistencies in the disability alleged versus medical evidence submitted; inconsistent claimant statements or behavior; multiple applications for disability benefits for the same or different disabilities; and multiple family members filing claims.

4. **Unprocessed stewardship workloads could be costing taxpayers billions of dollars. These include not only medical CDRs, but also work CDRs, SSI redeterminations, and fraud.**

- **What staff resources are needed to address these stewardship workloads separate and apart from addressing the disability backlogs?**

We have not specifically identified the staff resources necessary to address stewardship workloads. However, SSA informed us earlier this year that with the staff resources provided by the Recovery Act and its FY appropriations, the Agency will be able to conduct more CDRs and redeterminations. SSA estimates a backlog of 1.5 million full medical CDRs at the end of FY 2010; at a cost of \$1,000 each, the total cost would be \$1.5 billion. In its most recent CDR report to Congress (November 2008), SSA now estimates the ratio of program savings to cost is roughly \$10.50 to \$1. This ratio considers the savings to the Old-Age, Survivors and Disability Insurance; Medicare; and Medicaid programs. As a result, we estimate savings of about \$15.75 billion if SSA conducted all 1.5 million CDRs in FY 2010 (\$1.5 billion times \$10.50 = \$15.75 billion).

- **Has the Agency put together a plan that clearly addresses these additional staffing needs to ensure this work gets done?**

We are not aware of any Agency staffing plan that specifically addresses stewardship workloads. However, SSA advised us it plans to increase stewardship activities in FY 2010—including increasing the number of full medical CDRs by 4 percent and the number of SSI redeterminations by close to 50 percent over FY 2009.

5. **A January 8, 2009 OMB report entitled “Improving the Accuracy and Integrity of Federal Payments” indicates that 12 programs accounted for approximately 90 percent of reported improper payments for a total of an estimated \$65 billion in FY 2008.**

- **What are the main causes of improper payments and what percent were in the SSA's programs?**

SSA's two programs which involve improper payments are the OASDI and SSI programs. OASDI improper payments are mainly caused by computation errors. The main cause for SSI improper payments is recipients' failure to provide accurate and timely reports of new or increased wages. SSA accounts for about 12 percent (\$7.97 billion) of improper payments government-wide.

- **What is SSA doing to reduce the number of improper payments?**

SSA has implemented many programs to reduce improper payments. First, the Agency has developed automated tools to address payment computation issues. SSA has also completed a feasibility test and begun to roll-out large-scale monthly wage reporting using touch-tone and voice recognition telephone technology, as well as using Access to Financial Institutions to identify undisclosed financial accounts of SSI recipients with balances over the resource limit. Finally, SSA has informed us that resources provided by the Recovery Act and FY appropriations will allow more work CDRs to be conducted.

- **What can Congress do to help with this effort?**

Congress can continue to provide SSA with needed resources to continue development of programs and automated systems that will improve the process for collecting and reducing improper payments. Congress could also move forward on a legislative proposal to establish a self-funding program integrity fund for SSA, which we support. Such a proposal was drafted in 2008 by SSA, containing the following elements:

- Provide authority for SSA to expend a portion of actual collections of erroneous payments on activities to prevent, detect, and collect erroneous payments. The proposal would establish permanent indefinite appropriations to make available to SSA up to 25 percent of overpayments collected during the base FY, and make available to the OIG up to 2.5 percent of those overpayments.
- Establish a revolving fund to be financed from SSA's stewardship activities' projected lifetime savings. That is, SSA would be permitted to deposit up to 50 percent of the estimated future lifetime program savings from processing such program integrity activities as (but not limited to) CDRs, SSI redeterminations, CDI Units, and Special Office of the General Counsel prosecutions. The Commissioner could fund initiatives yielding a 150-percent return on investment over 10 years.

6. **To what degree has the SSA recovered erroneous economic recovery payments to prisoners and those who are deceased? Can we be confident that these mistakes won't be made should Congress provide another similar payment?**

There will always be unavoidable instances in which SSA will send payments to deceased beneficiaries and prisoners, due to delays in receiving reports of death or incarceration. However, two ongoing OIG audits have identified some possible areas for improvement.

Payments to Deceased Beneficiaries – Our preliminary review has identified approximately 67,000 economic recovery payments sent to deceased beneficiaries. We will conclude that SSA could have reduced these erroneous payments by reviewing its records for death information prior to certifying payments. When SSA issued payments in May 2009, it relied only on payment records to determine whether beneficiaries were alive. Preliminary data shows that prior to certification, SSA had about 7,600 death reports recorded on its Numident record for beneficiaries who were subsequently issued an economic recovery payment.

The recovery of erroneous payments to deceased beneficiaries could also be improved. Our preliminary review has found that about 50 percent of the 67,000 erroneous payments have been returned to Treasury. However, Treasury does not currently have the authority to reclaim payments sent to deceased beneficiaries. Should another economic recovery payment be authorized, Treasury should have the authority to reclaim erroneous payments.

Recovery of Erroneous Payments to Prisoners – According to SSA, approximately 18,000 economic recovery payments were sent to beneficiaries in prison; however, only 1,700 may have been erroneous. Of those, over 1,200 payments (71 percent) have been returned. We are currently reviewing SSA data to determine whether it properly identified all payments sent to beneficiaries in prison. We are also evaluating whether SSA should have reviewed prisoner information in its Prisoner Update Processing System prior to certifying payments.

The recovery of erroneous payments to beneficiaries in prison could also be improved. The Recovery Act precludes any subsequent redetermination of entitlement after a payment has been certified to Treasury. Thus, SSA could not recover payments issued before it learned a beneficiary was imprisoned. If another such payment is authorized, SSA should have the authority to redetermine entitlement when it learns of beneficiary imprisonment.

7. Page three of your testimony includes a statement that the Agency should be commended for its efforts to minimize the impact of State furloughs.

- **Is there anything else the Agency can do to prevent furloughs in the States?**

No. SSA does not have the authority to stop States from furloughing.

- **Are changes to the law or regulations needed in your view?**

Legislation would be needed to federalize State DDSs so that SSA could have complete control over the disability process and not be subject to the States' decisions.

8. Given rising workloads due to the economic downturn:

- **Are those here illegally being prevented from receiving benefits?**

Based on recent audits, SSA is complying with laws restricting benefit payments to noncitizens who worked in the United States illegally. However, current laws do provide loopholes through which individuals who worked illegally may receive credit for the

work. As we have previously recommended, these laws should prevent all noncitizens who have worked illegally from benefiting from these earnings.

- **What fraud vulnerabilities still exist in the Agency’s application process, and what can be done to address those vulnerabilities?**

The greatest fraud risk remains individuals who make false statements as to their earnings or medical condition in order to qualify for benefits. This is why our CDI units are a key factor in identifying and preventing these individuals from being approved for benefits.

- **What’s being done to stop those with fake IDs?**

SSA has procedures to verify the authenticity of certain documents presented to support benefit and SSN applications. For example, SSA verifies the authenticity of most immigration documents with the Department of Homeland Security before assigning a Social Security number or awarding Title II benefits; and verifies birth certificates with the issuing State. Currently, SSA does not verify the authenticity of driver’s licenses or non-driver identification with each State. Rather, they visually verify security features, which may not always identify counterfeit documents.

9. **Do you think the Agency is measuring or tracking its progress in addressing its challenges in a manner that is transparent and informative to the public?**

SSA could improve its reporting of progress made towards addressing some challenges. For example, the Agency lacks meaningful performance measures that address its efforts to improve its inefficient IT infrastructure. While SSA’s Strategic Plan states that its plans depend on a strong 21st century data center to replace the National Computer Center, neither the Agency’s Strategic Plan nor its Annual Performance Plan contains a performance measure to help the public track SSA’s progress in constructing a new data center. Similarly, SSA’s Strategic Plan states that its IT infrastructure rests on a foundation of aging computer programs, which will make it difficult to implement new business processes and service delivery models without needed updates. While SSA identifies this as a critical workload to provide service models needed to meet an increasing demand, it does not have a performance measure that tracks its progress in updating its computer programs.

As another example, SSA’s performance measures related to the disability claims process do not provide a meaningful assessment of waiting time from a claimant’s perspective—SSA only measures different portions of the time a claimant may wait. SSA has a performance measure, “Achieve the budgeted goal for average processing time for hearings,” with a goal of 516 days in FY 2009. While 516 days seems like a long time to wait after requesting a hearing, the overall time a claimant waits for a decision is much longer. When the cumulative wait times are added, as the claimant experiences the process, a claimant may wait 811 days, or 2.2 years, from the initial application to receipt of a hearing decision.

10. **You noted that SSA has only one performance measure to estimate the success of its Operations plan - the number of retirement and survivors claims processed. What**

additional performance measures should the SSA use to provide a more complete assessment of the use of Recovery Act funds?

The Operations sole performance measure does not provide a complete assessment of all anticipated benefits of Recovery Act funds. Operations hired 1,531 new employees using Recovery Act funds: 1,183 employees in local field offices; 247 in program service centers; and 101 in teleservice centers. SSA is also using Recovery Act funds for overtime work. All of these employees will process a wide range of disability and retirement workloads.

We found that SSA has several existing performance measures contained in its annual Performance and Accountability Report that track Operations progress in meeting its goals and objectives. These include the following performance measures related to Operations employees' processing of disability and retirement workloads.

1. Minimize average processing time for initial disability claims to provide timely decisions.
2. Improve service to the public by optimizing the speed in answering 800-number calls.
3. Improve public service by optimizing the 800-number busy rate for calls offered.
4. Process SSI non-disability redeterminations to reduce improper payments.
5. Number of periodic CDRs processed to determine continuing entitlement based on disability to help ensure payment accuracy.
6. Percent of SSI payments free of overpayment and underpayment error.
7. Percent of OASDI payments free of overpayment and underpayment error.

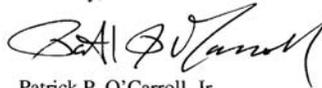
Including these additional performance measures will provide a more complete assessment of the use of Recovery Act funds.

11. Please explain why your testimony on the dollar impact of furloughs on the SSA's disability programs differed slightly from the Commissioner's testimony.

We used a slightly different methodology to account for the difference in the Federal FY vs. the State FY. Although the Federal FY runs October 1 through September 30, most State FYs run July 1 through June 30. For our calculations of delayed benefits, we assumed the current State furloughs would continue throughout the Federal FY; whereas SSA's calculations only account for 9 months of the Federal FY (through June).

Thank you for the opportunity to clarify these issues for the Subcommittee on Social Security. I trust that I have been responsive to your request. If you have questions, please feel free to contact me, or your staff may contact Misha Kelly, Congressional and Intra-Governmental Liaison, at (202) 358-6319.

Sincerely,



Patrick P. O'Carroll, Jr.
Inspector General

[Submissions for the Record follow:]



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Statement for the Record

by the

Council of State Administrators of Vocational Rehabilitation (CSAVR)

for the

**Hearing on
Clearing the Disability Claims Backlogs:
The Social Security Administration's
Progress and New Challenges Arising From the Recession**

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

November 19, 2009

Membership consists of the chief administrative officers of the state rehabilitation agencies responsible for administration of the state-federal rehabilitation programs in each of the states.

The Council of State Administrators of Vocational Rehabilitation is pleased to submit this statement for the record for the November 19, 2009, House Ways and Means Social Security Subcommittee's hearing on the progress SSA has made in clearing the disability backlog.

CSAVR's members are the Administrators of 80 state agencies that provide vocational rehabilitation services to persons with disabilities. For over 80 years the State-Federal Vocational Rehabilitation program has been providing a wide range of services to people with disabilities. The program has helped millions of people with significant disabilities return to work and live better and more productive lives.

The VR program is a cost effective program with a proven track record. In 2007 the Public VR program and its partners helped over 200,000 people with disabilities find, return to, or retain employment. VR customers earned over \$3.0 billion in wages, paid \$966 million in federal, state, & local taxes, and generated 36,000 new jobs. In fact, on average every person VR helps find or retain employment will "pay back" through taxes the cost of their rehabilitation services in just two to four years.

The VR program and the Social Security Administration have a long and mutually beneficial partnership helping people with disabilities on SSDI and SSI return to work. SSA reimburses VR agencies for the cost of services VR provides to SSDI and SSI beneficiaries after a beneficiary is at work for nine months. VR agencies are also strong partners in SSA's Ticket-to-Work program. The most recent data from the Social Security Administration reveals that for every dollar SSA reimburses VR, SSA has saved seven dollars in benefits that it would have paid out. This results in an annual net savings of \$754 million to the Social Security (SSDI) and Supplemental Security Income (SSI) programs.

CSAVR's interest in this hearing and on the issue of the backlog stems from the fact that nearly 60 percent of SSA's state Disability Determination Service (DDS) agencies are under the direction of state VR agencies. Our members see every day the growing burden caused by the lack of funding and the expanding demand for benefits caused by the current economic downturn.

CSAVR has strongly supported the Subcommittee's efforts to boost appropriations for clearing the disability backlog at all levels. We applaud Commissioner Astrue and his team for their dedication to aggressively resolving this problem. This issue is extremely important to people with disabilities.

Title II and Title XVI cash benefits, along with the related Medicaid and Medicare benefits, are the means of survival for millions of individuals with severe disabilities. They rely on the Social Security Administration (SSA) to promptly and fairly adjudicate their applications for disability benefits. They also rely on the agency to handle many other actions critical to their well-being including: timely payment of the monthly Title II and Title XVI benefits to which they are entitled; accurate withholding of Medicare Parts B and D premiums; and timely determinations on post-entitlement issues that may arise (e.g., overpayments, income issues, prompt recording of earnings).

Because the economic downturn has led to an unexpected surge of new applications, SSA finds itself at a critical crossroads. The wave of new claims is having a very significant impact at the state Disability Determination Services (DDSs) that will eventually affect the hearing level. At the DDS level (initial and reconsideration), the number of new applications, applications waiting for a decision, and processing times are all on the rise.

In fiscal year (FY) 2009, SSA received 385,000 new claims, an increase of nearly 15% since the end of FY 2008. Even more worrisome is the growing backlog of pending initial claims at the DDSs, i.e., those waiting for a decision, up nearly 40% since the end of FY 2008.

In FY 2009, the news was more positive at the hearing level. For the first time in a decade, SSA finished FY 2009 with fewer hearing level cases waiting for a decision and a hearing than at the beginning of the year. But we are deeply concerned that any progress in eliminating the hearing level backlog will be delayed as the surge of new applications that are denied are appealed, putting SSA's plan to eliminate the hearing level backlog by 2013 at risk.

While recent appropriations have allowed SSA to hire some new staff and to reduce processing times at the hearing level, these amounts will not be adequate to fully restore the agency's ability to carry out its mandated services. Given the many years of underfunding and the need for more than a \$600 million annual increase just to keep up with fixed costs, additional funding is required to reduce and eliminate the backlog at the DDS and hearing levels and to provide essential services to the public. While the current situation is dire, without adequate, ongoing appropriations to fund SSA, the forward progress recently made by the agency will deteriorate, leaving people with severe disabilities to wait years to receive the benefits to which they are entitled.

THE IMPACT ON PEOPLE WITH DISABILITIES

As the backlog in decisions on disability claims continues to grow, people with severe disabilities have been bearing the brunt of the delays. Behind the numbers are individuals with disabilities whose lives have unraveled while waiting for decisions – families are torn apart; homes are lost; medical conditions deteriorate; once stable financial security crumbles; and many individuals die.¹ Numerous recent media reports across the country have documented the suffering experienced by these individuals. Your constituent services staffs are likely to be well aware of the situations faced by people living in your districts and provide valuable assistance and help, where possible.

SSA'S NEED FOR ADEQUATE RESOURCES TO ADDRESS GROWING BACKLOGS

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

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

¹ If a claimant dies while a claim is pending, the SSI rule for payment of past due benefits is very different – and far more limited – than the Title II rule. In an SSI case, the payment will be made in only two situations: (1) to a surviving spouse who was living with the claimant at the time of death or within six months of the death; or (2) to the parents of a minor child, if the child resided with the parents at the time of the child's death or within six months of the death. 42 U.S.C. § 1383(b)(1)(A) [Section 1631(b)(1)(A) of the Act]. In Title II, the Act provides rules for determining who may continue the claim, which includes: a surviving spouse; parents; children; and the legal representative of the estate. 42 U.S.C. § 404(d) [Section 202(d) of the Act]. Thus, if an adult SSI claimant (age 18 or older) dies before actually receiving the past due payment and if there is no surviving spouse, the claim dies with the claimant and no one is paid.

CSAVR is extremely grateful to Congress for recognizing SSA's need for adequate resources and including additional funds for SSA in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provided SSA with \$500 million to handle the unexpected surge in both retirement and disability applications due to the economic downturn. SSA also received badly needed funds to replace its aged National Computer Center. With the FY 2009 appropriation and the ARRA funding, SSA planned to hire 5,000 to 6,000 new employees. This additional staff undoubtedly led to SSA's ability to make progress on the backlog at the hearing level.

Congress appears to be moving towards providing SSA with an FY 2010 appropriation approximately the same as President Obama's request of \$11.45 billion for SSA's Limitation on Administrative Expenses (LAE), a 10 percent increase over the FY 2009 appropriation. While the agency is operating under a Continuing Resolution, we are optimistic that SSA's final FY 2010 appropriation will be similar to the \$11.45 billion amount, allowing SSA to hire more staff.

SIGNIFICANT INCREASE IN NEW CLAIMS FILED AND GROWING DDS BACKLOGS

Since the end of FY 2008, new disability claims filed have been climbing steadily, up nearly 15% by the end of FY 2009. But what is more troubling is how the increase grew throughout FY 2009: December 2008 Quarter: 6.92%; March 2009 Quarter: 15.23%; June 2009 Quarter: 16.32%; September 2009 Quarter: 20.25%.

The most alarming trend is the increase in the number of pending claims (initial and reconsideration levels), up 38.8% since the end of FY 2008 and climbing from 763,183 to 1,059,241. This means that, at the end of FY 2009, more than 1 million disability applicants were waiting for a decision on their claims at the initial and reconsideration levels. When you add the 722,822 pending cases at the hearing level, nearly 1.75 million people with disabilities were waiting for a decision. If the receipts continue to increase at the higher level seen in recent months, the total number of pending initial applications in the DDSs could hit over 1,000,000 claims by the end of FY 2010. This would be an 80% increase in pending claims at the initial level in just one year.

What does the increase in applications and pending claims at the DDSs mean for the hearing level? Approximately 22% of the initial claims will result in a hearing request. This means there is a potential increase of 85,000 additional hearings from the FY 2009 applications, a statistic that underscores the fragility of the Office of Disability Adjudication and Review (ODAR) progress accomplished in FY 2009.

Exacerbating the problem of a significant increase in new claims is the impact on DDSs of state budget crises. Even though DDS salaries, offices, and overhead are fully funded by SSA, some states are imposing hiring restrictions and furloughs of DDS workers because of budget problems. Earlier this year, Commissioner Astrue wrote to Governors, asking them to exempt DDSs from hiring freezes and furloughs. In September 2009, Vice-President Biden sent a letter to Gov. Edward Rendell, the Chair of the National Governors' Association, also urging that states exempt DDS employees from state furloughs.

State budgets not likely to see improvement in the near term. According to the National Governors Association/National Association of State Budget Officers (NGA/NASBO) Fall 2009 Report, *Fiscal Survey of States-Preliminary Data, November 12, 2009*,

“Fiscal conditions significantly deteriorated for states during fiscal 2009, with the trend continuing through fiscal 2010 and even into 2011 and 2012. The severe national recession drastically reduced tax revenues from every revenue source during fiscal 2009 and revenue collections are forecasted to continue their decline in fiscal 2010. As state revenue collections historically lag behind any national economic recovery, state revenues will remain depressed throughout fiscal 2010 and likely into fiscal years 2011 and 2012. The economic recession, which began in December 2007, has significantly affected state spending, as more than half the states decreased their General Fund expenditures in fiscal 2009, and two-thirds of states enacted fiscal 2010 budgets with decreased General Fund spending.”

“The weakening of state fiscal conditions is also reflected in the fact that states will have faced \$250 billion in budget gaps between fiscal year 2009 and fiscal year 2011. Of this \$250 billion, states closed \$72.7 billion in budget gaps during fiscal 2009 and \$113.1 billion prior to the enactment of their fiscal 2010 budgets in order to bring them into balance with drastically declining revenues. However, even after solving these gaps, an additional \$14.5 billion in budget gaps remains in fiscal 2010 and states face at least \$21.9 billion in budget gaps for fiscal 2011. In order to help close these gaps, 42 states cut their enacted fiscal 2009 budgets by \$31.2 billion and 33 states cut their fiscal 2010 expenditures by \$53.5 billion. Additionally, states enacted tax and fee increases of \$23.8 billion along with additional increases in other revenue measures of \$7.7 billion for fiscal 2010.”

Despite this bleak fiscal picture in the states and in the face of furloughs and hiring freezes, some state agencies have been successful in working around the problem of DDS furloughs by negotiating overtime and other work arrangements that allow DDS staff to keep their caseload as current as possible. However, even these stopgap measures will become more difficult to maintain as fiscal pressures continue to mount within state budgets and the number of new claims increase.

WILL THE HEARING LEVEL BACKLOG BE ELIMINATED BY 2013?

The average processing time for cases at the hearing level has increased dramatically since 2000, when the average time was 274 days. In FY 2009, the average processing time for disability claims at the hearing level was 491 days, about 16.5 months. We appreciate the effort by SSA to reduce the processing time, but an average of 16.5 months – close to one and a half years – is still too long for individuals waiting for a hearing decision. In addition, the average processing times at the initial and reconsideration levels are increasing. For individuals with disabilities who have no health insurance, have lost their homes, have declared bankruptcy, or who have died, that is simply too long to wait.

The current processing times in some hearing offices are striking, and much longer than the 491-day average at the end of FY 2009. It is important to keep in mind that this is an “average” and that many claimants will wait longer. In September 2009, the average processing time at 48 hearing offices was above the 491 day national average, with 20 offices over 600 days.

Is the Hearing Backlog Improving? By the end of FY 2009, it was clear that ODAR was making slow but steady process in key areas to address its backlog and improve processing times, thanks to the hard work of ODAR ALJs and staff and the additional resources available due to Congressional appropriations, including the ARRA funding.

- **Pending cases.** For the first time in a decade, ODAR finished FY 2009 with fewer hearings pending than in the prior year. The increased resources, including 147 new

ALJs and support staff are having a positive impact at the hearing level. The pending number of cases dropped for nine straight months from a record high of 768,540 in December 2008 to 722,822 in September 2009. This is the lowest pending number of ODAR cases since February 2007. The pending number dropped by 11,377 in September 2009 alone, the biggest drop in FY 2009. The reduction in pending cases is even more notable since the number of requests for hearing increased in FY 2009, up to 625,003, a 5.7% increase over the 591,888 received in FY 2008.

- **Processing times.** The average process time in September 2009 was 472 days, the lowest monthly processing time since November 2005. The average processing time for all of FY 2009 was 491 days, down from 514 days in FY 2008.

- **Dispositions.** The number of dispositions cleared by ALJs on a daily basis was 2,940.47 in September. This is the highest monthly average since records have been kept, beginning in FY 2004. The increase is concomitant with the record number of ALJs now on duty. For the year, dispositions were up about 20%.

- **Age of pending cases.** The length of time cases are pending is also improving. The percentage of requests for hearing pending over one year was 31% in September 2009. This is the lowest percent since October 2004. The average age of a pending case is 282 days. It peaked this year at 317 days in January 2009.

Improvement Is Not Uniform. Despite the overall improvement in the hearing level statistics, not every hearing office has benefited and some claimants' areas are waiting even longer than one year ago. On one hand, some offices have experienced exceptional improvement in processing times, as much as 4 to 5 months in just one year. In contrast, other offices continue to experience worsening times that are several months longer than last year.

SSA's ABILITY TO PERFORM OTHER IMPORTANT WORKLOADS

Program Integrity Workloads. The processing of CDRs and SSI redeterminations is necessary to protect program integrity and avert improper payments. Failure to conduct the full complement of CDRs would have adverse consequences for the federal budget and the deficit. According to SSA, CDRs result in \$10 of program savings and SSI redeterminations result in \$7 of program savings for each \$1 spent in administrative costs for the reviews. However, the number of reviews actually conducted is directly related to whether SSA receives the necessary funds. SSA's Budget Justification refers specifically to CDRs based on medical factors. It is important when SSA conducts work CDRs that it assess whether reported earnings have been properly recorded and ensure that they properly assess whether work constitutes substantial gainful activity (SGA).

Impact on Post-Entitlement Work. Staffing shortages also have led to SSA's inability to fully carry out many other critical post-entitlement workloads. One area that has slipped, often with a very detrimental impact on people with disabilities, is the processing of earnings reports by beneficiaries. When beneficiaries faithfully notify SSA of earnings or other changes that may reduce their benefit payment amounts, it may be months or years before SSA sends an overpayment notice to the beneficiary, demanding repayment of sometimes tens of thousands of dollars of accrued overpayments. It is shocking to beneficiaries to receive these notices, when they reasonably assumed that SSA had processed the information they submitted, and it is challenging, if not impossible, for someone subsisting on benefits alone to repay the overpayments. Many individuals with disabilities are wary of attempting a return to work out of fear that this may give rise to an overpayment, resulting in a loss of economic stability and health care coverage upon which they rely.

SSA needs to develop a better reporting and recording system and promptly adjust benefit payments—thus preventing these overpayments. It is important to note that, in

and of themselves, overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able. The problems arise when reported earnings are not properly recorded and monthly overpayments are not properly adjusted.

RECOMMENDATIONS REGARDING SSA's ADMINISTRATIVE FUNDING

CSAVR is optimistic that SSA will receive a final FY 2010 appropriation of \$11.451 billion for SSA's LAE, the same amount proposed by the President. SSA will use this funding and about \$350 million from the ARRA funding to address the growing workloads facing the agency. Based on these funding levels, during FY 2010, SSA will be spending at least \$11.8 billion to address the current staffing levels and associated costs necessary for the agency to function.

In FY 2011, SSA will be faced with additional costs of nearly \$620 million just to deal with inflationary costs associated with items such as salaries, benefits, rents, and facility security. The resulting funding level, \$12.42 billion will not address the increased number of new claims, the newly created DDS backlog, and SSA's plan to eliminate the hearing level backlog by 2013. To address these workloads, SSA will need additional resources. We estimate that an additional \$780 million will be necessary – at least \$480 million to address the increased number of disability claims and at least \$300 million to continue making progress in reducing and eliminating the hearings backlog by 2013.

To address the unprecedented increase in workloads and to prevent a severe disruption in service delivery, we recommend that a minimum of \$13.2 billion be included in the FY 2011 President's budget request for SSA's administrative funding.

RECOMMENDATIONS FOR IMPROVING THE DISABILITY CLAIMS PROCESS

Money alone will not solve SSA's crisis in meeting its responsibilities. Commissioner Astrue is committed to finding new ways to work better and more efficiently. CSAVR has numerous suggestions for improving the disability claims process for people with disabilities. We believe that these recommendations and agency initiatives, which overall are not controversial and which we generally support, can go a long way towards reducing, and eventually eliminating, the disability claims backlog.

Caution Regarding the Search for Efficiencies

While we generally support the goal of achieving increased efficiency throughout the adjudicatory process, we caution that limits must be placed on the goal of administrative efficiency for efficiency's sake alone. The purposes of the Social Security and SSI programs are to provide cash benefits to those who need them and have earned them and who meet the eligibility criteria. While there may be ways to improve the decision-making process from the perspective of the adjudicators, the critical measure for assessing initiatives for achieving administrative efficiencies must be how they affect the very claimants and beneficiaries for whom the system exists.

People who find they cannot work at a sustained and substantial level are faced with a myriad of personal, family, and financial circumstances that will have an impact on how well or efficiently they can maneuver the complex system for determining eligibility. Many claimants will not be successful in addressing all of SSA's requirements for proving eligibility until they reach a point where they request the assistance of an experienced representative. Many face educational barriers and/or significant barriers inherent in the disability itself that prevent them from understanding their role in the adjudicatory process and from efficiently and effectively assisting in gathering evidence. Still others are faced with having no "medical home" to call upon for assistance in

submitting evidence, given their lack of health insurance over the course of many years. Many are experiencing extreme hardship from the loss of earned income, often living through the break-up of their family and/or becoming homeless, with few resources - financial, emotional, or otherwise - to rely upon. Still others experience all of the above limits on their abilities to participate effectively in the process.

Proposals for increasing administrative efficiencies must bend to the realities of claimants' lives and accept that people face innumerable obstacles at the time they apply for disability benefits and beyond. SSA must continue, and improve, its established role in ensuring that a claim is fully developed before a decision is made and must ensure that its rules reflect this administrative responsibility.

Technological Improvements

Commissioner Astrue has made a strong commitment to improve and expand the technology used in the disability determination process. CSAVR generally supports these efforts to improve the disability claims process, so long as they do not infringe on claimants' rights. Some of the technological improvements that we believe can help reduce the backlog include the following:

1. The electronic disability folder. The initiative to process disability claims electronically has the prospect of significantly reducing delays caused by the moving and handing-off of folders, allowing for immediate access by different components of SSA or the DDS, and preventing misfiled evidence.

2. Expanding Internet access for representatives. Under Electronic Records Express (ERE), registered claimant representatives are able to submit evidence electronically through an SSA secure website or to a dedicated fax number, using a unique barcode assigned to the claim. This initiative holds great promise, given that significant problems with the current process exist.

Under the current process, representatives are to be provided with a CD of the exhibited or "pulled" file shortly before the hearing and earlier in the process after the appeal has been filed but before the file is exhibited. Due to staffing shortages in hearing offices, representatives have had problems obtaining the CDs and even obtaining barcodes, which allows me to submit evidence electronically. We are optimistic that these problems will be resolved in the near future.

3. Use of video hearings. Video hearings allow ALJs to conduct hearings without being at the same geographical site as the claimant and representative and have the potential to reduce processing times and increase productivity. We support the use of video teleconference hearings so long as the right to a full and fair hearing is adequately protected; the quality of video teleconference hearings is assured; and the claimant retains the absolute right to have an in-person hearing as provided under current regulations.² However, we have received complaints from representatives that, in some cases, ALJs are discouraging claimants from exercising their right to an in-person hearing. A new SSA pilot allows representatives to participate in video hearings from their own private offices, with their clients present in the representative's office. The representative must agree to the terms established by SSA. This pilot provides claimants with another option for their hearings.

Other Improvements at the Hearing Level

1. The Senior Attorney Program. This program allows senior staff attorneys in hearing offices to issue fully favorable decisions in cases that can be decided without a

² 20 C.F.R. §§ 404.936 and 416.1436.

hearing (i.e. “on the record”). This eliminates many months in the wait for payment of benefits. We are pleased that Commissioner Astrue decided to authorize the program for at least the next two years.³ In FY 2009, senior attorneys decided more than 36,300 cases, a 50% increase over FY 2008. This means that more than 36,000 claimants were able to receive their disability benefits months sooner.

2. Findings Integrated Templates (FIT). FIT is used for ALJ decisions and integrates the ALJ’s findings of fact into the body of the decision. While the FIT does not dictate the ultimate decision, it requires the ALJ to follow a series of templates to support the ultimate decision. Representatives can use the FIT template, which is available on the SSA website, to draft proposed favorable decisions. Many representatives are now using the template either when requested by the ALJ or on their own initiative. When the draft proposed decision is submitted to the ALJ, it can lead to a speedier decision.

3. Increase time for hearing notice. We recommend that SSA provide advance notice of the hearing date 75 days prior to the hearing date rather than the current 20 days. The 75-day time period has been in effect in SSA’s Region I states since August 2006⁴ and, based on reports from representatives, has worked well.

Improvements at the Initial Levels

CSAVR supports initiatives to improve the process at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process.

1. New Screening Initiatives. CSAVR supports SSA’s efforts to accelerate decisions and develop new mechanisms for expedited eligibility throughout the application and review process. We encourage the use of ongoing screening as claimants obtain more documentation to support their applications. However, SSA must work to ensure that there is no negative inference when a claim is not selected by the screening tool or allowed at that initial evaluation. There are two initiatives that hold promise:

- **Quick Disability Determinations.** CSAVR supports the Quick Disability Determination (QDD) process, first begun in SSA Region I states in August 2006 and expanded nationwide by Commissioner Astrue in September 2007.⁵ The QDD process has the potential of providing a prompt disability decision to those claimants who have most serious disabilities. Since its inception, the vast majority of QDD cases have been decided favorably in less than 20 days, and sometimes in just a few days.
- **Compassionate Allowances.** This initiative allows SSA to create “an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both....” SSA has published an initial list of 50 conditions on its website, with more to be added at a later date. Unlike the QDD screening, which occurs only when an application is filed, screening for compassionate allowances can occur at any level of the administrative appeals process. SSA has held recent Compassionate Allowance outreach hearings with expert panels to consider early onset Alzheimer’s disease and schizophrenia.

2. Improve development of evidence earlier in the process. Claimants’ representatives are often able to provide evidence that we believe could have been obtained by the DDSs earlier in the process. Our recommendations include:

³ The program is extended through August 10, 2011. 74 Fed. Reg. 33327 (July 13, 2009).

⁴ 20 C.F.R. § 405.315(a).

⁵ 20 C.F.R. §§ 404.1619 and 416.1019.

- **Provide more assistance to claimants at the application level.** At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing the application, particularly in light of electronic filings, so that all impairments and sources of information are identified, including non-physician and other professional sources.
- **DDSs need to obtain necessary and relevant evidence.** Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. However, DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating and examining doctors. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to the vocational professionals at DDSs and hearing offices.
- **Increase reimbursement rates for providers.** To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts.
- **Provide better explanations to medical providers.** SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and ask for evidence relevant to the standard.
- **Provide more training and guidance to adjudicators.** Many reversals at the appeals levels are due to earlier erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as: weighing medical evidence, including treating source opinions; the role of non-physician evidence; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings.
- **Improve the quality of consultative examinations.** Steps should be taken to improve the quality of the consultative examination (CE) process. There are far too many reports of inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's.

ADDITIONAL RECOMMENDATIONS

In addition to addressing the backlog and SSA's funding issues, there are several other legislative proposals that the Subcommittee may be considering this year.

- **Protecting claimants' privacy rights.** We understand that it can be cumbersome for SSA to obtain medical records, as it is for claimants and their representatives, and that SSA is exploring more efficient ways to secure the necessary evidence. While we support ways to make this process more efficient, we believe that claimants' privacy rights must be protected. We will work with SSA to find a way to obtain, as efficiently as possible, a claimant's authorization for release of medical records to SSA, while protecting the individual's privacy rights.
- **Extension of the fee demonstrations in the SSPA.** Access to experienced and qualified representatives through the lengthy and complex application process is critically important to claimants. To this end, we support allowing claimants to enter into voluntary agreements with representatives for fee withholding and direct payment procedures whether under Title II or Title XVI. The Social Security Protection Act of 2004 established two demonstration projects that should be made permanent because they have proven to be effective in increasing claimants' access to effective representation: (1) Extension of the Title II attorney fee withholding and direct payment procedures to SSI claims; and (2) Allowing non-attorney representatives to qualify for fee withholding

and direct payment, provided they meet certain requirements. Unless they are extended or made permanent, the demonstrations will sunset March 1, 2010.

- **Increase and indexing of the fee cap.** Rep. John Lewis has introduced H. R. 1093, which contains two provisions regarding the current \$5,300 fee agreement fee cap: (1) Increase the current fee cap to \$6,264.50 (which represents the figure if it had been adjusted for inflation since the last increase in 2002); and (2) Index the fee cap for future years to the annual COLA. We support these changes since they ensure that there will be a knowledgeable, experienced pool of representatives available to represent claimants.
- **Work incentives.** The Ticket to Work and Work Incentives Improvement Act was enacted nearly ten years ago and is overdue for evaluation of its effectiveness in employment of those receiving Title II and Title XVI disability benefits. We urge renewal and permanent extension of expired/expiring provisions including (1) SSA's Title II demonstration authority to test promising approaches for work incentives and related provisions; (2) Medicaid Infrastructure Grants (MIGs) used by States to build comprehensive approaches to removing employment barriers by forming linkages between Medicaid services and other non-Medicaid programs; (3) Demonstration to Maintain Independence, set to expire this year, to provide Medicaid buy-in coverage to working individuals whose conditions or disabilities are not yet severe enough to qualify them for disability benefits; (4) Protection and Advocacy for Beneficiaries of Social Security to protect the rights of beneficiaries as they attempt to return to work; and (5) Work Incentives Planning Assistance, which provides state grants for outreach and education to individuals with disabilities about supports and services regarding employment. However, it is critical that future efforts be devoted to permanently extending and strengthening these important return to work supports.

Statement of the Corporation for Supportive Housing Advocacy and Training Center

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

Thank you for the opportunity to submit written testimony on the issue of the Social Security Administration's disability claims backlog.

Our organizations are committed to providing housing, services and advocacy to individuals who have no or limited income and who have disabilities, especially those involving serious mental illness and/or co-occurring disorders. As part of this commitment, we particularly focus on individuals who have been or are homeless, many of whom have experienced homelessness for years. We appreciate the recent efforts of the Social Security Administration (SSA) to address the disability claims backlog, specifically those claims awaiting hearing level decisions. The reduction in this backlog that has started and the ongoing efforts to reduce it are commendable.

We believe that aspects of the disability determination that contribute to denials for people who are homeless and, therefore, to the need for appeals include, the following:

- Lack of access to medical care and evaluations needed to document individuals' physical and mental health conditions;
- Need for case managers or other community staff to conduct outreach and to help homeless individuals to navigate the complex disability determination process;
- Difficulties in accessing benefits for people who have co-occurring disorders that include substance use;
- For people who have mental illness and/or cognitive disorders, lack of recognition of long-term homelessness as an indicator of marked functional impairment;
- General inability of individuals with serious mental illness to access the innovative and creative strategies that SSA has implemented such as Quick Disability Determination and compassionate allowances;

- Need for specialized training of SSA and DDS staff in understanding homelessness and its impact on individuals' health; and
- Failure to identify claimants as homeless and failure to flag claims from homeless individuals as in need of expedited processing.

To address some of the needs of this population, we advocate for changes that only Congress can enact as well as changes that are underway or could be considered at SSA. These include:

SSA:

- Include schizophrenia and homelessness as a compassionate allowance category, something already considered by SSA as evidenced by the recent compassionate allowance hearing on schizophrenia held in San Francisco on November 18;
- Consider compassionate allowances for homeless individuals with other specified impairments, such as bipolar disorders and certain cognitive impairments;
- Partner with community mental health and other health providers to assist people who are homeless with navigating the SSA disability application process. This would include training such providers in the completion of the SSI application (SSA-8000) (until the SSI application is possible to do on-line) so that such providers could submit such applications on behalf of individuals without having to have the applicant come into the SSA office;
- Implement promising practice models such as SOAR to serve populations who need special assistance, adults who are homeless and who have mental illness and partner with other federal agencies including, SAMHSA, to coordinate implementation of such models
- Conduct specialized training for SSA and DDS staff in homelessness, mental illness, and co-occurring disorders, and in identifying and expediting claims of individuals who are homeless;
- specific staff at the SSA local offices and encourage state Disability Determination Service offices to assign DDS staff to expedite and do medical reviews of homeless claimants, so as to have staff who become specialized in providing services to people who are homeless and who have mental illness and/or co-occurring disorders;
- Provide specific direction to the DDS regarding the interpretation of current requirements for the consideration of people with co-occurring disorders to improve consistency and generate greater understanding of these requirements across the country;

Congress:

- Re-visit the 1996 statutory change regarding substance use in the SSA disability determination process. Currently, if a person has substance use that is deemed "material" to one's disability, that individual is denied. Such a consideration is often virtually clinically impossible in the face of ongoing substance use. Most treating physicians do not and cannot make this determination, let alone medical reviewers who are asked to create this distinction based on an individual's paper record. In addition, many individuals who have these disorders use substances to address symptoms of mental illness, e.g., auditory hallucinations, significant depression, manic symptoms, etc. Much documentation proves the link between mental illness and substance abuse. Yet, because of the difficulty in deciding whether a person's substance abuse is material to an individual's disability, homeless people who are, in fact, disabled are often denied. Current statutory requirements are contrary to the evidence regarding assessment and treatment of people who have these disorders. It would be an important step for Congress to reconsider this statute and its impact after 13 years of its implementation.
- Provide funding to SSA to partner with community providers to offer the necessary assistance to help individuals who are homeless and who have serious mental illness and/or co-occurring disorders with navigating the SSA disability application process.

- Begin to conduct a dialogue on the array of public benefits that need to be available to assist individuals and families to exit long-term poverty, and help these individuals address poverty that results from loss of jobs, poor education, health difficulties that do not rise to the level of eligibility for SSA benefits.

We thank you for the consideration of our comments.

Sincerely,

Corporation for Supportive Housing Advocacy and Training Center

Statement of Council of State Administrators of Vocational Rehabilitation

The Council of State Administrators of Vocational Rehabilitation is pleased to submit this statement for the record for the November 19, 2009, House Ways and Means Social Security Subcommittee's hearing on the progress SSA has made in clearing the disability backlog.

CSAVR's members are the Administrators of 80 state agencies that provide vocational rehabilitation services to persons with disabilities. For over 80 years the State-Federal Vocational Rehabilitation program has been providing a wide range of services to people with disabilities. The program has helped million of people with significant disabilities return to work and live better and more productive lives.

The VR program is a cost effective program with a proven track record. In 2007 the Public VR program and its partners helped over 200,000 people with disabilities find, return to, or retain employment. VR customers earned over \$3.0 billion in wages, paid \$966 million in federal, state, & local taxes, and generated 36,000 new jobs. In fact, on average every person VR helps find or retain employment will "pay back" through taxes the cost of their rehabilitation services in just two to four years.

The VR program and the Social Security Administration have a long and mutually beneficial partnership helping people with disabilities on SSDI and SSI return to work. SSA reimburses VR agencies for the cost of services VR provides to SSDI and SSI beneficiaries after a beneficiary is at work for nine months. VR agencies are also strong partners in SSA's Ticket-to-Work program. The most recent data from the Social Security Administration reveals that for every dollar SSA reimburses VR, SSA has saved seven dollars in benefits that it would have paid out. This results in an annual net savings of \$754 million to the Social Security (SSDI) and Supplemental Security Income (SSI) programs.

CSAVR's interest in this hearing and on the issue of the backlog stems from the fact that nearly 60 percent of SSA's state Disability Determination Service (DDS) agencies are under the direction of state VR agencies. Our members see every day the growing burden caused by the lack of funding and the expanding demand for benefits caused by the current economic downturn.

CSAVR has strongly supported the Subcommittee's efforts to boost appropriations for clearing the disability backlog at all levels. We applaud Commissioner Astrue and his team for their dedication to aggressively resolving this problem. This issue is extremely important to people with disabilities.

Title II and SSI cash benefits, along with the related Medicaid and Medicare benefits, are the means of survival for millions of individuals with severe disabilities. They rely on the Social Security Administration (SSA) to promptly and fairly adjudicate their applications for disability benefits. They also rely on the agency to handle many other actions critical to their well-being including: timely payment of the monthly Title II and SSI benefits to which they are entitled; accurate withholding of Medicare Parts B and D premiums; and timely determinations on post-entitlement issues that may arise (e.g., overpayments, income issues, prompt recording of earnings).

Because the economic downturn has led to an unexpected surge of new applications, SSA finds itself at a critical crossroads. The wave of new claims is having a very significant impact at the state Disability Determination Services (DDSs) that will eventually affect the hearing level. At the DDS level (initial and reconsideration), the number of new applications, applications waiting for a decision, and processing times are all on the rise. In fiscal year (FY) 2009, SSA received 385,000 new claims, an increase of nearly 15% since the end of FY 2008. Even more worrisome is the growing backlog of pending initial claims at the DDSs, i.e., those waiting for a decision, up nearly 40% since the end of FY 2008.

In FY 2009, the news was more positive at the hearing level. For the first time in a decade, SSA finished FY 2009 with fewer hearing level cases waiting for a decision and hearing than at the beginning of the year. But we are deeply concerned that any progress in eliminating the hearing level backlog will be delayed as the surge of new applications that are denied are appealed, putting SSA's plan to eliminate the hearing level backlog by 2013 at risk.

While recent appropriations have allowed SSA to hire some new staff and to reduce processing times at the hearing level, these amounts will not be adequate to fully restore the agency's ability to carry out its mandated services. Given the many years of under-funding and the need for more than a \$600 million annual increase just to keep up with fixed costs, additional funding is required to reduce and eliminate the backlog at the DDS and hearing levels and to provide essential services to the public. While the current situation is dire, without adequate, ongoing appropriations to fund SSA, the forward progress recently made by the agency will deteriorate, leaving people with severe disabilities to wait years to receive the benefits to which they are entitled.

THE IMPACT ON PEOPLE WITH DISABILITIES

As the backlog in decisions on disability claims continues to grow, people with severe disabilities have been bearing the brunt of the delays. Behind the numbers are individuals with disabilities whose lives have unraveled while waiting for decisions—families are torn apart; homes are lost; medical conditions deteriorate; once stable financial security crumbles; and many individuals die.¹ Numerous recent media reports across the country have documented the suffering experienced by these individuals. Your constituent services staffs are likely to be well aware of the situations faced by people living in your districts and provide valuable assistance and help, where possible.

SSA'S NEED FOR ADEQUATE RESOURCES TO ADDRESS GROWING BACKLOGS

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

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

CSAVR is extremely grateful to Congress for recognizing SSA's need for adequate resources and including additional funds for SSA in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provided SSA with \$500 million to handle the unexpected surge in both retirement and disability applications due to the economic downturn. SSA also received badly needed funds to replace its aged National Computer Center. With the FY 2009 appropriation and the ARRA funding, SSA planned to hire 5,000 to 6,000 new employees. This additional staff undoubtedly led to SSA's ability to make progress on the backlog at the hearing level.

Congress appears to be moving towards providing SSA with an FY 2010 appropriation approximately the same as President Obama's request of \$11.45 billion for SSA's Limitation on Administrative Expenses (LAE), a 10 percent increase over the FY 2009 appropriation. While the agency is operating under a Continuing Resolution, we are optimistic that SSA's final FY 2010 appropriation will be similar to the \$11.45 billion amount, allowing SSA to hire more staff.

¹ If a claimant dies while a claim is pending, the SSI rule for payment of past due benefits is very different—and far more limited—than the Title II rule. In an SSI case, the payment will be made in only two situations: (1) to a surviving spouse who was living with the claimant at the time of death or within six months of the death; or (2) to the parents of a minor child, if the child resided with the parents at the time of the child's death or within six months of the death. 42 U.S.C. § 1383(b)(1)(A) [Section 1631(b)(1)(A) of the Act]. In Title II, the Act provides rules for determining who may continue the claim, which includes a surviving spouse; parents; children; and the legal representative of the estate. 42 U.S.C. § 404(d) [Section 202(d) of the Act]. Thus, if an adult SSI claimant (age 18 or older) dies before actually receiving the past due payment and if there is no surviving spouse, the claim dies with the claimant and no one is paid.

SIGNIFICANT INCREASE IN NEW CLAIMS FILED AND GROWING DDS BACKLOGS

Since the end of FY 2008, new disability claims filed have been climbing steadily, up nearly 15% by the end of FY 2009. But what is more troubling is how the increase grew throughout FY 2009: December 2008 Quarter: 6.92%; March 2009 Quarter: 15.23%; June 2009 Quarter: 16.32%; September 2009 Quarter: 20.25%.

The most alarming trend is the increase in the number of pending claims (initial and reconsideration levels), up 38.8% since the end of FY 2008 and climbing from 763,183 to 1,059,241. This means that, at the end of FY 2009, more than 1 million disability applicants were waiting for a decision on their claims at the initial and reconsideration levels. When you add the 722,822 pending cases at the hearing level, nearly 1.75 million people with disabilities were waiting for a decision. If the receipts continue to increase at the higher level seen in recent months, the total number of pending initial applications in the DDSs could hit over 1,000,000 claims by the end of FY 2010. This would be an 80% increase in pending claims at the initial level in just one year.

What does the increase in applications and pending claims at the DDSs mean for the hearing level? Approximately 22% of the initial claims will result in a hearing request. This means there is a potential increase of 85,000 additional hearings from the FY 2009 applications, a statistic that underscores the fragility of the ODAR progress accomplished in FY 2009.

Exacerbating the problem of a significant increase in new claims is the impact on DDSs of state budget crises. Even though DDS salaries, offices, and overhead are fully funded by SSA, some states are imposing hiring restrictions and furloughs of DDS workers because of budget problems. Earlier this year, Commissioner Astrue wrote to Governors, asking them to exempt DDSs from hiring freezes and furloughs. In September 2009, Vice-President Biden sent a letter to Gov. Edward Rendell, the Chair of the National Governors' Association, also urging that states exempt DDS employees from state furloughs.

Nor are State budgets likely to see improvement in the near term. According to the National Governors Association/National Association of State Budget Officers (NGA/NASBO) Fall 2009 Report, *Fiscal Survey of States-Preliminary Data, November 12, 2009*, "Fiscal conditions significantly deteriorated for states during fiscal 2009, with the trend continuing through fiscal 2010 and even into 2011 and 2012. The severe national recession drastically reduced tax revenues from every revenue source during fiscal 2009 and revenue collections are forecasted to continue their decline in fiscal 2010. As state revenue collections historically lag behind any national economic recovery, state revenues will remain depressed throughout fiscal 2010 and likely into fiscal years 2011 and 2012. The economic recession, which began in December 2007, has significantly affected state spending, as more than half the states decreased their General Fund expenditures in fiscal 2009, and two-thirds of states enacted fiscal 2010 budgets with decreased General Fund spending.

The weakening of state fiscal conditions is also reflected in the fact that states will have faced \$250 billion in budget gaps between fiscal year 2009 and fiscal year 2011. Of this \$250 billion, states closed \$72.7 billion in budget gaps during fiscal 2009 and \$113.1 billion prior to the enactment of their fiscal 2010 budgets in order to bring them into balance with drastically declining revenues. However, even after solving these gaps, an additional \$14.5 billion in budget gaps remains in fiscal 2010 and states face at least \$21.9 billion in budget gaps for fiscal 2011. In order to help close these gaps, 42 states cut their enacted fiscal 2009 budgets by \$31.2 billion and 33 states cut their fiscal 2010 expenditures by \$53.5 billion. Additionally, states enacted tax and fee increases of \$23.8 billion along with additional increases in other revenue measures of \$7.7 billion for fiscal 2010."

Despite this bleak fiscal picture in the states and in the face of furloughs and hiring freezes, some state agencies have been successful in working around the problem of DDS furloughs by negotiating overtime and other work arrangements that allow DDS staff to keep their caseload as current as possible. However, even these stopgap measures will become more difficult to maintain as fiscal pressures continue to mount within state budgets and the number of new claims increase.

WILL THE HEARING LEVEL BACKLOG BE ELIMINATED BY 2013?

The average processing time for cases at the hearing level has increased dramatically since 2000, when the average time was 274 days. In FY 2009, the average processing time for disability claims at the hearing level was 491 days, about 16.5 months. We appreciate the effort by SSA to reduce the processing time, but an average of 16.5 months—close to one and a half years—is still too long for individuals waiting for a hearing decision. In addition, the average processing times at the initial and reconsideration levels are increasing. For individuals with disabilities who

have no health insurance, have lost their homes, have declared bankruptcy, or who have died, that is simply too long to wait.

The current processing times in some hearing offices are striking, and much longer than the 491-day average at the end of FY 2009. It is important to keep in mind that this is an “average” and that many claimants will wait longer. In September 2009, the average processing time at 48 hearing offices was above the 491 day national average, with 20 offices over 600 days.

Is the Hearing Backlog Improving? By the end of FY 2009, it was clear that ODAR was making slow but steady process in key areas to address its backlog and improve processing times, thanks to the hard work of ODAR ALJs and staff and the additional resources available due to Congressional appropriations, including the ARRA funding.

- **Pending cases.** For the first time in a decade, ODAR finished FY 2009 with fewer hearings pending than in the prior year. The increased resources, including 147 new ALJs and support staff are having a positive impact at the hearing level. The pending number of cases dropped for nine straight months from a record high of 768,540 in December 2008 to 722,822 in September 2009. This is the lowest pending number of ODAR cases since February 2007. The pending number dropped by 11,377 in September 2009 alone, the biggest drop in FY 2009. The reduction in pending cases is even more notable since the number of requests for hearing increased in FY 2009, up to 625,003, a 5.7% increase over the 591,888 received in FY 2008.
- **Processing times.** The average process time in September 2009 was 472 days, the lowest monthly processing time since November 2005. The average processing time for all of FY 2009 was 491 days, down from 514 days in FY 2008.
- **Dispositions.** The number of dispositions cleared by ALJs on a daily basis was 2,940.47 in September. This is the highest monthly average since records have been kept, beginning in FY 2004. The increase is concomitant with the record number of ALJs now on duty. For the year, dispositions were up about 20%.
- **Age of pending cases.** The length of time cases are pending is also improving. The percentage of requests for hearing pending over one year was 31% in September 2009. This is the lowest percent since October 2004. The average age of a pending case is 282 days. It peaked this year at 317 days in January 2009.
- **Improvement Is Not Uniform.** Despite the overall improvement in the hearing level statistics, not every hearing office has benefited and some claimants’ areas are waiting even longer than one year ago. On one hand, some offices have experienced exceptional improvement in processing times, as much as 4 to 5 months in just one year. In contrast, other offices continue to experience worsening times that are several months longer than last year.

SSA’S ABILITY TO PERFORM OTHER IMPORTANT WORKLOADS

Program Integrity Workloads. The processing of CDRs and SSI redeterminations is necessary to protect program integrity and avert improper payments. Failure to conduct the full complement of CDRs would have adverse consequences for the federal budget and the deficit. According to SSA, CDRs result in \$10 of program savings and SSI redeterminations result in \$7 of program savings for each \$1 spent in administrative costs for the reviews. However, the number of reviews actually conducted is directly related to whether SSA receives the necessary funds. SSA’s Budget Justification refers specifically to CDRs based on medical factors. It is important when SSA conducts work CDRs that it assess whether reported earnings have been properly recorded and ensure that they properly assess whether work constitutes substantial gainful activity (SGA).

Impact on Post-Entitlement Work. Staffing shortages also have led to SSA’s inability to fully carry out many other critical post-entitlement workloads. One area that has slipped, often with a very detrimental impact on people with disabilities, is the processing of earnings reports by beneficiaries. When beneficiaries faithfully notify SSA of earnings or other changes that may reduce their benefit payment amounts, it may be months or years before SSA sends an overpayment notice to the beneficiary, demanding repayment of sometimes tens of thousands of dollars of accrued overpayments. It is shocking to beneficiaries to receive these notices, when they reasonably assumed that SSA had processed the information they submitted, and it is challenging, if not impossible, for someone subsisting on benefits alone to repay the overpayments. Many individuals with disabilities are wary of attempting

a return to work out of fear that this may give rise to an overpayment, resulting in a loss of economic stability and health care coverage upon which they rely.

SSA needs to develop a better reporting and recording system and promptly adjust benefit payments—thus preventing these overpayments. It is important to note that, in and of themselves, overpayments do not indicate fraud or abuse as beneficiaries are encouraged to work if they are able. The problems arise when reported earnings are not properly recorded and monthly overpayments are not properly adjusted.

RECOMMENDATIONS REGARDING SSA'S ADMINISTRATIVE FUNDING

CSAVR is optimistic that SSA will receive a final FY 2010 appropriation of \$11.451 billion for SSA's LAE, the same amount proposed by the President. SSA will use this funding and about \$350 million from the ARRA funding to address the growing workloads facing the agency. Based on these funding levels, during FY 2010, SSA will be spending at least \$11.8 billion to address the current staffing levels and associated costs necessary for the agency to function.

In FY 2011, SSA will be faced with additional costs of nearly \$620 million just to deal with inflationary costs associated with items such as salaries, benefits, rents, and facility security. The resulting funding level, \$12.42 billion will not address the increased number of new claims, the newly created DDS backlog, and SSA's plan to eliminate the hearing level backlog by 2013. To address these workloads, SSA will need additional resources. We estimate that an additional \$780 million will be necessary—at least \$480 million to address the increased number of disability claims and at least \$300 million to continue making progress in reducing and eliminating the hearings backlog by 2013.

To address the unprecedented increase in workloads and to prevent a severe disruption in service delivery, we recommend that a minimum of \$13.2 billion be included in the FY 2011 President's budget request for SSA's administrative funding.

RECOMMENDATIONS FOR IMPROVING THE DISABILITY CLAIMS PROCESS

Money alone will not solve SSA's crisis in meeting its responsibilities. Commissioner Astrue is committed to finding new ways to work better and more efficiently. CSAVR has numerous suggestions for improving the disability claims process for people with disabilities. We believe that these recommendations and agency initiatives, which overall are not controversial and which we generally support, can go a long way towards reducing, and eventually eliminating, the disability claims backlog.

Caution Regarding the Search for Efficiencies

While we generally support the goal of achieving increased efficiency throughout the adjudicatory process, we caution that limits must be placed on the goal of administrative efficiency for efficiency's sake alone. The purposes of the Social Security and SSI programs are to provide cash benefits to those who need them and have earned them and who meet the eligibility criteria. While there may be ways to improve the decision-making process from the perspective of the adjudicators, the critical measure for assessing initiatives for achieving administrative efficiencies must be how they affect the very claimants and beneficiaries for whom the system exists.

People who find they cannot work at a sustained and substantial level are faced with a myriad of personal, family, and financial circumstances that will have an impact on how well or efficiently they can maneuver the complex system for determining eligibility. Many claimants will not be successful in addressing all of SSA's requirements for proving eligibility until they reach a point where they request the assistance of an experienced representative. Many face educational barriers and/or significant barriers inherent in the disability itself that prevent them from understanding their role in the adjudicatory process and from efficiently and effectively assisting in gathering evidence. Still others are faced with having no "medical home" to call upon for assistance in submitting evidence, given their lack of health insurance over the course of many years. Many are experiencing extreme hardship from the loss of earned income, often living through the break-up of their family and/or becoming homeless, with few resources—financial, emotional, or otherwise—to rely upon. Still others experience all of the above limits on their abilities to participate effectively in the process.

Proposals for increasing administrative efficiencies must bend to the realities of claimants' lives and accept that people face innumerable obstacles at the time they apply for disability benefits and beyond. SSA must continue, and improve, its established role in ensuring that a claim is fully developed before a decision is made and must ensure that its rules reflect this administrative responsibility.

Technological Improvements

Commissioner Astrue has made a strong commitment to improve and expand the technology used in the disability determination process. CSAVR generally supports these efforts to improve the disability claims process, so long as they do not infringe on claimants' rights. Some of the technological improvements that we believe can help reduce the backlog include the following:

1. The electronic disability folder. The initiative to process disability claims electronically has the prospect of significantly reducing delays caused by the moving and handing-off of folders, allowing for immediate access by different components of SSA or the DDS, and preventing misfiled evidence.

2. Expanding Internet access for representatives. Under Electronic Records Express (ERE), registered claimant representatives are able to submit evidence electronically through an SSA secure website or to a dedicated fax number, using a unique barcode assigned to the claim. This initiative holds great promise, given that significant problems with the current process exist.

Under the current process, representatives are to be provided with a CD of the exhibited or "pulled" file shortly before the hearing and earlier in the process after the appeal has been filed but before the file is exhibited. Due to staffing shortages in hearing offices, representatives have had problems obtaining the CDs and even obtaining barcodes, which allows me to submit evidence electronically. We are optimistic that these problems will be resolved in the near future.

3. Use of video hearings. Video hearings allow ALJs to conduct hearings without being at the same geographical site as the claimant and representative and have the potential to reduce processing times and increase productivity. We support the use of video teleconference hearings so long as the right to a full and fair hearing is adequately protected; the quality of video teleconference hearings is assured; and the claimant retains the absolute right to have an in-person hearing as provided under current regulations.² However, we have received complaints from representatives that, in some cases, ALJs are discouraging claimants from exercising their right to an in-person hearing. A new SSA pilot allows representatives to participate in video hearings from their own private offices, with their clients present in the representative's office. The representative must agree to the terms established by SSA. This pilot provides claimants with another option for their hearings.

Other Improvements at the Hearing Level

1. The Senior Attorney Program. This program allows senior staff attorneys in hearing offices to issue fully favorable decisions in cases that can be decided without a hearing (i.e. "on the record"). This eliminates many months in the wait for payment of benefits. We are pleased that Commissioner Astrue decided to authorize the program for at least the next two years.³ In FY 2009, senior attorneys decided more than 36,300 cases, a 50% increase over FY 2008. This means that more than 36,000 claimants were able to receive their disability benefits months sooner.

2. Findings Integrated Templates (FIT). FIT is used for ALJ decisions and integrates the ALJ's findings of fact into the body of the decision. While the FIT does not dictate the ultimate decision, it requires the ALJ to follow a series of templates to support the ultimate decision. Representatives can use the FIT template, which is available on the SSA website, to draft proposed favorable decisions. Many representatives are now using the template either when requested by the ALJ or on their own initiative. When the draft proposed decision is submitted to the ALJ, it can lead to a speedier decision.

3. Increase time for hearing notice. We recommend that SSA provide advance notice of the hearing date 75 days prior to the hearing date rather than the current 20 days. The 75-day time period has been in effect in SSA's Region I states since August 2006⁴ and, based on reports from representatives, has worked well.

Improvements at the Initial Levels

CSAVR supports initiatives to improve the process at the initial levels so that the correct decision can be made at the earliest point possible and unnecessary appeals can be avoided. Improvements at the front end of the process can have a significant beneficial impact on preventing the backlog and delays later in the appeals process.

²20 C.F.R. §§ 404.936 and 416.1436.

³The program is extended through August 10, 2011. 74 Fed. Reg. 33327 (July 13, 2009).

⁴20 C.F.R. § 405.315(a).

1. New Screening Initiatives. CSAVR supports SSA's efforts to accelerate decisions and develop new mechanisms for expedited eligibility throughout the application and review process. We encourage the use of ongoing screening as claimants obtain more documentation to support their applications. However, SSA must work to ensure that there is no negative inference when a claim is not selected by the screening tool or allowed at that initial evaluation. There are two initiatives that hold promise:

- **Quick Disability Determinations.** CSAVR supports the Quick Disability Determination (QDD) process, first begun in SSA Region I states in August 2006 and expanded nationwide by Commissioner Astrue in September 2007.⁵ The QDD process has the potential of providing a prompt disability decision to those claimants who are the most severely disabled. Since its inception, the vast majority of QDD cases have been decided favorably in less than 20 days, and sometimes in just a few days.
- **Compassionate Allowances.** This initiative allows SSA to create "an extensive list of impairments that we [SSA] can allow quickly with minimal objective medical evidence that is based on clinical signs or laboratory findings or a combination of both . . ." SSA has published an initial list of 50 conditions on its website, with more to be added at a later date. Unlike the QDD screening, which occurs only when an application is filed, screening for compassionate allowances can occur at any level of the administrative appeals process. SSA has held recent Compassionate Allowance outreach hearings with expert panels to consider early onset Alzheimer's disease and schizophrenia.

2. Improve development of evidence earlier in the process. Claimants' representatives are often able to provide evidence that we believe could have been obtained by the DDSs earlier in the process. Our recommendations include:

- **Provide more assistance to claimants at the application level.** At the beginning of the process, SSA should explain to the claimant what evidence is important and necessary. SSA should also provide applicants with more help completing the application, particularly in light of electronic filings, so that all impairments and sources of information are identified, including non-physician and other professional sources.
- **DDSs need to obtain necessary and relevant evidence.** Representatives often are able to obtain better medical information because they use letters and forms that ask questions relevant to the disability determination process. However, DDS forms usually ask for general medical information (diagnoses, findings, etc.) without tailoring questions to the Social Security disability standard. One way to address this would be for SSA to encourage DDSs to send Medical Source Statement forms to treating and examining doctors. These simple forms translate complex, detailed medical source opinions into practical functional terms useful to the vocational professionals at DDSs and hearing offices.
- **Increase reimbursement rates for providers.** To improve provider response to requests for records, appropriate reimbursement rates for medical records and reports need to be established. Appropriate rates should also be paid for consultative examinations and for medical experts.
- **Provide better explanations to medical providers.** SSA and DDSs should provide better explanations to all providers, in particular to physician and non-physician treating sources, about the disability standard and ask for evidence relevant to the standard.
- **Provide more training and guidance to adjudicators.** Many reversals at the appeals levels are due to earlier erroneous application of existing SSA policy. Additional training should be provided on important evaluation rules such as: weighing medical evidence, including treating source opinions; the role of non-physician evidence; the evaluation of mental impairments, pain, and other subjective symptoms; the evaluation of childhood disability; and the use of the Social Security Rulings.
- **Improve the quality of consultative examinations.** Steps should be taken to improve the quality of the consultative examination (CE) process. There are far too many reports of inappropriate referrals, short perfunctory examinations, and examinations conducted in languages other than the applicant's.

⁵20 C.F.R. §§ 404.1619 and 416.1019.

ADDITIONAL RECOMMENDATIONS

In addition to addressing the backlog and SSA's funding issues, there are several other legislative proposals that the Subcommittee may be considering this year.

- **Protecting claimants' privacy rights.** We understand that it can be cumbersome for SSA to obtain medical records, as it is for claimants and their representatives, and that SSA is exploring more efficient ways to secure the necessary evidence. While we support ways to make this process more efficient, we believe that claimants' privacy rights must be protected. We will work with SSA to find a way to obtain, as efficiently as possible, a claimant's authorization for release of medical records to SSA, while protecting the individual's privacy rights.
- **Extension of the fee demonstrations in the SSPA.** Access to experienced and qualified representatives through the lengthy and complex application process is critically important to claimants. To this end, we support allowing claimants to enter into voluntary agreements with representatives for fee withholding and direct payment procedures whether under Title II or Title XVI. The Social Security Protection Act of 2004 established two demonstration projects that should be made permanent because they have proven to be effective in increasing claimants' access to effective representation: (1) Extension of the Title II attorney fee withholding and direct payment procedures to SSI claims; and (2) Allowing nonattorney representatives to qualify for fee withholding and direct payment, provided they meet certain requirements. Unless they are extended or made permanent, the demonstrations will sunset March 1, 2010.
- **Increase and indexing of the fee cap.** Rep. John Lewis has introduced H. R. 1093, which contains two provisions regarding the current \$5,300 fee agreement fee cap: (1) Increase the current fee cap to \$6,264.50 (which represents the figure if it had been adjusted for inflation since the last increase in 2002); and (2) Index the fee cap for future years to the annual COLA. We support these changes since they ensure that there will be a knowledgeable, experienced pool of representatives available to represent claimants.
- **Work incentives.** The Ticket to Work and Work Incentives Improvement Act was enacted nearly ten years ago and is overdue for evaluation of its effectiveness in employment of those receiving Title II and SSI disability benefits. We urge renewal and permanent extension of expired/expiring provisions including (1) SSA's Title II demonstration authority to test promising approaches for work incentives and related provisions; (2) Demonstration to Maintain Independence, set to expire this year, to provide Medicaid buy-in coverage to working individuals whose conditions or disabilities are not yet severe enough to qualify them for disability benefits; (3) Protection and Advocacy for Beneficiaries of Social Security to protect the rights of beneficiaries as they attempt to return to work; and (4) Work Incentives Planning Assistance, which provides state grants for outreach and education to individuals with disabilities about supports and services regarding employment. However, it is critical that future efforts be devoted to permanently extending and strengthening these important return to work supports.

Statement of Eunmi Choi

Eunmi Choi
PAD 5106 PUBLIC ORGANIZATIONS
Nevin Smith
December 2, 2009

THE REQUIREMENT TO IMPLEMENT THE PUBLIC OPTION:

**New Network and New Organization as an administrator,
 negotiator and consultant**

The introduction of the public option where public sector could compete with private sector for selling health care insurances at the same market will need the well-structured network system as a major variable. The current situation in the United States is the worst health care system operated by the principle of market competition admitted as ideal type in everywhere. In other words, the optional insurance purchasing depending on one's own ability eventually causes the asymmetric structures of health care system and the national problems beyond the expected efficiency of market competition. At this point, the public option could be a watershed

for health insurance reform, only if the health care network system execute adequately and fairly across each sector among public, private, and non-for-profit organizations. To implement the public option, there are several requirements the nation might need. Therefore, I am going to state about the current health care system in the United States and the ideal configuration of the network system with a new organization where the public option might be implemented.

HEALTH CARE SYSTEM

Part 1. Government

Federal Government and state governments are involved in health care plan through either way, even though the government cannot cover all population in the United States. On the one hand, "Medicare" is regarded as a federal program with no insurance companies under Federal Government, which covers most persons aged 65 or elder, certain people on Social Security disability, and which is composed of a hospital insurance plan and a supplementary medical insurance plan. However, it is not limited by individual demand, but a single-payer system as an entitlement program. Firstly, Medicare hospital insurance (called Part A) assists patients in covering cost in-hospital, post-hospital nursing home care, and home care, and it is subsidized by Social Security payroll taxes. Secondly, Medicare medical insurance (called Part B) supplements welfare providing diagnostic laboratory costs, physical therapy, and surgeon service; moreover, it is associated with the hospital insurance plan. Thirdly, Medicare prescription drug coverage (called Part D) supports the costs of prescription medications in a bit.

On the other hand, "Medicaid" is also a federal program, but it is administered by state government with different rules, which is for low-income and vulnerable people with children, under age 65, as well as over who already tired out their Medicare benefits. This Medicaid program provides fundamental medical services—e.g. hospital, nursing facility and home health care, and physical remedy Medicare does not cover, as well as family planning, preventive care, outpatient prescription drug, and eyeglasses. For instance, each state has a protection and advocacy agency funded from the Federal Center for Mental Health Services. The agencies have to provide the protections for mental illness people and conduct the investigations in order to care for them.

The Medicare and Medicaid program are supported by Federal Government and state governments providing premiums, deductibles and share of costs. In addition, their finance is appropriated by general tax structure. While Federal Government is responsible of the general provision of health care plans, state governments support more specific services that are not covered by Federal Government.

Part 2. Non-for-profit

As contracting out or privatization, the entire organization in non-for-profit sector is associated with linkage partners either directly or indirectly. As third-sector closely interrelated with governments or private sector, non-for-profit organizations play a major role to provide health care services, to allocate health plans through networks, and to provide multiple services that are fairly different among the organizations. Their funds are derived from federal, state, and county governments and they also reinvest their earnings in to their infrastructure. In other words, their pure premium is supposed to invest on actual health care services, not administrative costs. Through federal regulations, managerial responsibility and administration are transferred from the governments to non-for-profit organizations in order to improve health care services. For instance, the Health Care Financing Administration (HCFA) as the one of the state agencies in Kansas State rendered the administrative responsibility, case management, to nonprofit Area Agencies on Aging. Non-for-profit aims at reduce state payroll expenses and shrink the size of the state Medicaid bureaucracy. In addition, it is required to change clientele type, the volume of cases, and the urgency of care for those clients (Barbara S. Romzek and Jocelyn M. Johnston, 1999, p. 112)

Non-for-profit organizations usually subcontracted with federal program under the governments to provide upgraded services, trustworthy services, and lower-price services unlike Medicaid program; on the other side, they in practice provide more beneficial services and build safer health care network than for-profit agencies do.

Part 3. For-profit

Health care in for-profit sector is usually operated by one or two monopolistic mechanism rather than competitive mechanism. Almost private companies such as insurance agencies, private hospital, medical laboratory, pharmacy and so forth intend to focus on their benefit and profit of them in that they are designed with a variety of ways and for distinctive purposes. However, some quality of health plans

by for-profit organizations tends to against high costs, which is far from ideal market in terms of laissez-faire. Moreover, their policy inclined to vary depending on customers (divided into age, sex, and health status). According to Organizing the Health Insurance Market (1992), Peter Diamond indicates common pattern of health insurance companies. One is a variety of insurance premiums for people in different categories, with a wide range of premiums. Second is the underwriting, which is the technical term for screening applicants in order to determine risk class and acceptability, including the possibility of refusing to sell to individuals because they are not viewed as profitable given the risk classification and rates used. Third, in some state, there is a government organized residual pool, without underwriting so that everyone in that state can buy some coverage. These phenomena lead uninsured people and unfair tradeoff.

Health plans through for-profit sector can be selected by certain customers who do not choose the public sector or non-for-profit sector, and then they usually expect the different policy and the more qualified services compared to prices. Therefore, for-profit sector can be operating through premium and marginal benefit, especially market incentives relied on their profit.

THE GOAL OF THE PUBLIC OPTION

The public option mentioned below is based on President Barack Obama's Health Care Speech to Congress on September 12, 2009.

The public option as per choice and competition will provide more realistic security and stability to those who have health insurance and to those who do not have yet. The public option will reduce the growth of health care costs for the families, businesses, and governments and then it gives responsibility to the government and insurance companies, as well as employers and individuals, which is related to multiple-payer environment.

First, nothing in this plan will require changing the coverage, if one already has health insurance through job, Medicare, Medicaid, or individual acquisition. Rather, this plan will make better health care condition; for example, insurance companies cannot drop the coverage any more whatsoever having severe illness. It means there will be no more arbitrary cap of coverage. Besides, insurance companies will have to serve preventive care and routine checkups. All in all this plan will lead saving money and lives in terms of more security and stability.

Second, this plan will guarantee affordable and qualified insurance to everyone, if one has not health insurance, if lose one's job or change, or if have small business. For this plan, a new insurance exchange will be established for individuals and small businesses to purchase health insurance at competitive prices. In case of disability to afford the low-priced insurance, tax credits based on one's need will be provided. Therefore, insurance companies will be in the participation of the new insurance exchange having an incentive that can recruit millions of new customers. Based on second plan, improvement of health care system can work only if everyone has health insurance either way.

In sum, three outlines are followed: (1) consumer protections with insurance, (2) an exchange where purchasing affordable coverage by individuals and small businesses, and (3) an obligation for affordable people to buy insurance.

TODAY'S PROBLEM

Those who live in threatened bankruptcy are extraordinary hardships to have health insurance. They are not welfare people, but middle-class Americans. Most of them cannot afford high costs that are three times if one is self-employed rather than employer. Or, in spite of the fact that there are persons who are able or willing to pay, they are often denied to purchase insurance because of high risky to cover. While some purchase health insurance from public or non-for-profit sector, others obtain from private sector. However, it leads a number of problems such as low quality services, insufficient services, high price insurance, and so forth.

As a rising costs problem in the United States, insurance premium is almost three times than wages. The reason is that small businesses require for their employees to pay high premium or give up the entire coverage. Moreover, hidden tax due in part to uninsured people causes the rising costs in emergency room or charitable care.

These health care systems of nowadays mentioned above give disabilities deprivation and taxpayers tremendous burden. These problems cause greater costs to Medicare and Medicaid programs in terms of the red operation due in part to increased needs. Furthermore, there exist contradictory opinions. On the left, they argue that a single-payer system that acutely separates the private insurance market and the government provision to the whole like Canada's is the solution. On the right, they

insist that the employer-based system should be quit and then individuals should buy health insurance by themselves.

IDEAL NETWORK AMONG PUBLIC, PRIVATE, AND NON-FOR-PROFIT SECTOR

For the public option, the new network is required to combine public, private, and non-for-profit sector with a new organization. This is because the size of health care system will be enlarged more than ever. The public option will be based on customers' choice and agencies' competition at the market. Public sector for the whole customer, private sector for qualified service, and non-for-profit sector for fairer trade should be established under the new network. Besides, goal consensus, efficient service delivery, and professional association through the adaptable policy are needed to implement the public option.

First of all, the public option is to guarantee beneficiaries to keep security and stability. This goal can affect all sectors and then the organizations in public, private, and non-for-profit sector have to remind of it, not focus more on their lucrative results or marginal costs. While the governments are to merely provide subsidies from general taxation into Medicare and Medicaid programs and to contract with non-for-profit organization, companies in private are to only seek profits regardless of social equity so far. The result could lead serious national problems like the gap between wealth and poverty. When all of the organizations reach the same consensus, the goal of the public option will be enhanced. The policy among all sectors needs to include the definition of the goal, even though they compete with each other at the same market.

Second, the network of public, private, and non-for-profit sector is required inter-relating for efficient service delivery, not merely delivery focused on health care expenditure. This is because public sector will hire partial employees from private sector in order to implement the public option. On the public side, the governments do not provide direct service, but support the overall programs; non-for-profit organizations contracted with the government intend to provide specific service than the governments. On the other side, private agencies can supply the best service to only limited customers who pay high costs or are healthier with no serious problems. At this point, incentive depending on each sector's characteristic will be a versatile solution in the new network. As a technical assistance incentive—e.g. intensive-service unit, concerted programs or education and advice-monitoring, non-for-profit organizations can supply the improved service to customers who prefer the non-for-profit sector to others. As a participatory incentive in the new insurance exchange, private organizations can attract new customers in terms of their capacity, and public organizations also can be motivated in competition with private organizations. These incentives will affect to policymaker among the organizations.

Finally, professional association related to all sectors will make the network as the whole. It means that through the new network, professional association can share the value of providers and the intention toward buyers, which will be able to build stronger relationship among them. It leads the similar tasks or reproductions in the new network as institutional isomorphism or internal structural similarities. Furthermore, they can negotiate to implement the public option with a kind of guidelines from professional association and then understand the reason of the implementation of the public option. As a result, professional association will be able to avoid disparity of the health care system

FOR THE PUBLIC OPTION, THE NEW ORGANIZATION AS AN ADMINISTRATOR, NEGOTIATOR, AND CONSULTANT

The new organization will aim to cover full-scale, which limits exclusion of customers who cannot afford or already have health problems, which stimulates low quality services to improve and which controls exorbitant prices at health insurance, hospital, doctor, and etc. The new organization with new national programs is to execute health care reform, cover young adults, protect retiree health benefits, and generate a new federal grant for implementation of the public option.

At health insurance exchange derived from health care reform, the new insurance market will be open to individuals and employers to purchase health insurance by their choice from the competition among public, private non-for-profit sector, even new health insurance cooperatives (co-ops). The new organization for the implementing public option will have to keep an eye on the health insurance exchange whether to be transparent or equitable to every participant. If necessary, the negotiation related to the prices would be required within all sectors. It does not mean of price-fixing or the formation of Cartel. All of agencies in public and private, even non-for-profit sector will appear their own policy to new customers. Moreover, these operations will be self-supporting by their profit and premium like present-day in-

insurance agencies. In health care system, the methods of funding originate in direct payments, general tax payments and subsidies or donations. This is where the new organization will control the policy including the range of customers and the prices of health insurance in order to implement the public option appropriately.

In addition, the new organization will be able to put pressure on the new network of public, private, and non-for-profit sector in order to make them to have their responsibility, as well as every individual and every employer having either small or big business. Again, public sector will have all-inclusive responsibility to implement the public option by encouraging high quality including the improvement of Medicare and Medicaid programs. Especially, state governments can decide on opt-in or opt-out system.¹ Either way, they cannot avoid their accountability to provide health services and products. Private sector will conduct more fairly under the public option. Because for-profit agencies will have to compete with public sector, their monopoly will turn into reasonable trade market.

What is more important thing is the new organization will blur the service boundary of public, private and non-for-profit sector if various health programs are gave the sector, respectively. This organization will be toward better health care system. It means that the same direction to new health care system can bring a successful result of supply-driven services away from obviously separated sectors, as if the one organization encourages providing qualified health service and as if the clearly separated sectors are the divided divisions within the one organization. It also means that the new organization will not impose the same rules and ways to deliver health services, but induce the same enthusiasm for better health care system in terms of the public option. On the other side, each individual or employer will purchase the health insurance through the new network. They will also need some advice to figure out which will be suitable to their own conditions. This is where the new organization will be applied as a consultant, which means the new organization should not merely determine the certain health insurance to the certain customer, but support to decide the proper health insurance with much information.

Finally, in the new network with the new organization, insurance purchasing will be operated by customized health care in that all sectors are interrelated under the new organization as well as every individual and employer receive the guidelines or suggestions from the new organization. This new network will be within the market where public, private and non-for-profit sector will compete together, which leads the insurance industry.

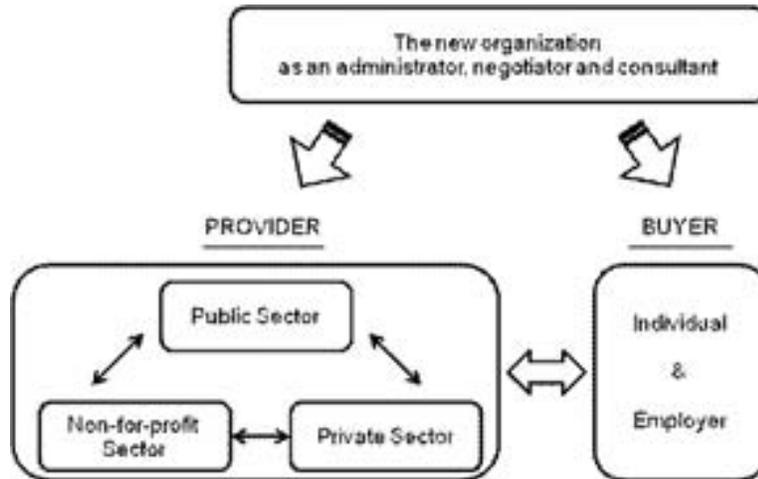


Figure 1. The ideal network with the new organization: the new organization in the new network can control overall sectors to successfully implement the public option. As the provider, public, private and non-for-profit sector will serve various health programs and health insurance at the same market; as the buyer, each indi-

¹ While opt-in system is that state governments can produce a public plan or vice-versa, opt-out system the state governments have to set up a public option, however, they can stop providing the public plan.

vidual and self-employed will be able to purchase health insurance depending on their ability and give health care programs at the market.

CONCLUSION

To rebuild health care system, trust from customers and conscience among each organization as organization-to-organization perspective are important. The public health care option announced by the president Barack Obama would deserve everyone in the United States. All of the programs related to health care are performed by the Federal Government and state government, for-profit organizations, and non-for-profit organizations respectively. As a result, it brings national problems and gives the realization to improve overall health care system. For successful implementation of the public option, the new organization that is not involved in public, private, or non-for-profit sector, but one of the administrators, negotiators and consultants could be required. If the ideal model I mentioned the new network with the new organization is possible, I would expect that every customer in the United States will have their own health insurance without any fear of contemporary health care system, as the nation tends to encourage the public option in spite of critical opposition that it is merely extended Medicare plan, and that if any policies implemented at national level should be accepted, it would acknowledge the big government leads the increased tax revenues and thereby it would restrict individual decision whether to purchase health insurance or not.

To sum up, it is necessary to concern about the new network or the new organization to alternate the original system. The entire network system can be changed by the radical purpose or the social demands. Therefore, well-constructed network system can improve the overall efficiency, quality and acceptability.

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Statement of Ibrahim Dere

A healthcare system network design proposal for the U.S.:
 “No uninsured left behind”
 Ibrahim Dere PAD 5106—Public Organizations, Fall Semester
 Instructor Nevin Smith
 December 2, 2009

1. INTRODUCTION

The healthcare system reform in the U.S. has been a hot topic from beginning of the 2008 presidential election campaign. The president Barrack Obama has prom-

ised to passed comprehensive health reform in order to control rising health care costs, guarantee choice of doctor, and assure high-quality, affordable health care for all Americans (**The White House, retrieved on 11/25/2009 from <http://www.whitehouse.gov/issues/health-care>**).

In this paper, I will try to design a healthcare system network in which the public organizations will actively participate in both policy regulation level and provision level in the healthcare industry and running by a public, private, and not for profit organizations collaboration.

2. THE CONCEPTUAL FRAMEWORK

a. The necessity of public-private-NPO partnership

They are well known facts that, about 16% of the entire population has no health insurance in the U.S. (**retrieved on 11/25/2009 from <http://www.gallup.com/poll/121820/one-six-adults-without-health-insurance.aspx>**) and healthcare is more expensive than many industrialized country. The reform should also aim to reduce the general level of price in health industry. Unavailability of the healthcare or accessing to the healthcare with unreasonable prices has some disadvantages for not only for individuals but also for the entire society.

Public option is a type of service provision of not only healthcare, but also other public services, such as education, national security, etc. Public service production and/or provision is generally done by a collaboration of the governmental, for profit, and not profit organizations. Of course, like any goods and service, in healthcare issue, whole service can be served or ant necessary goods, such as medicine, drug, prosthesis, etc. can be provided by the government by health professionals who are working for government in the health institutions owned by the government. In this kind of provision option, "public option" would be regarded just as an "ideal type" or a "pure type". Max Weber suggest "an ideal type is formed by the one sided *accentuation* of one or more points of view" according to which "*concrete individual phenomena . . . are arranged into a unified analytical construct*"; in its purely fictional nature, it is a methodological "utopia [that] cannot be found empirically anywhere in reality." (**Stanford Encyclopedia of Philosophy, Aug 24, 2007, retrieved on 11/25/2009 from <http://plato.stanford.edu/entries/weber/#IdeTyp>**).

Even in the national security which has been regarded as the "pure public service," the ideal type does not exist. More or less private or nongovernmental stakeholders involve in the service provision process. No matter what kind of system will be implemented after the healthcare reform bill passed, not only the uninsured who will utilize the projected the system, but also under the insured individuals will be affected the healthcare reform. Therefore, all of the stakeholders, including private insurance companies, private health institutions, pharmaceutical industry, and medical industry will be affected positively or negatively. It is not an unexpected that such interest groups will make effort to influence policy making process to maximize their interest.

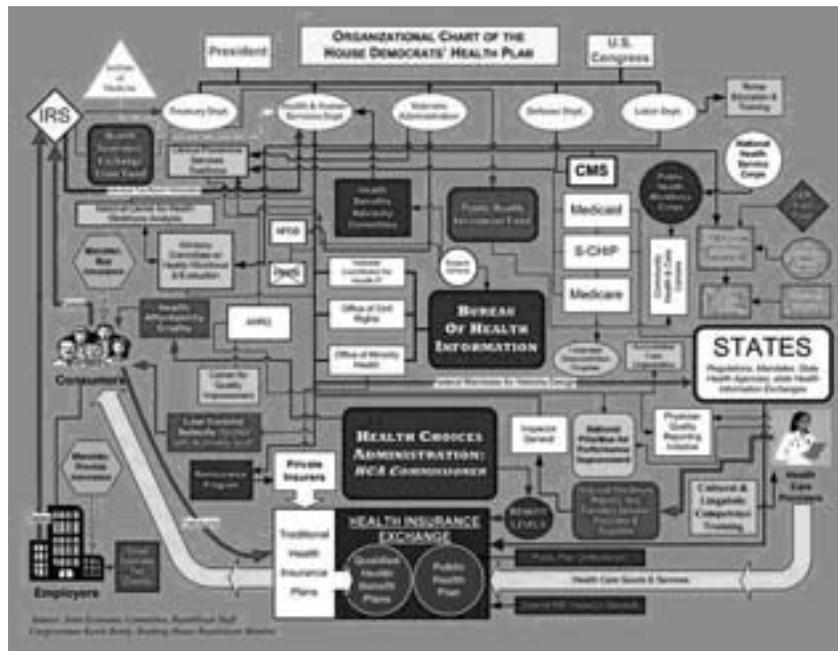
According to Bozeman's dimensional model, *few* complex organizations are purely public or purely private. Instead, some mix of public and private authority influences the behavior of most organizations. If publicness is independent of the formal legal status of the organization, it is convenient to think that some government organizations are "more public" than others, that some business organizations are "more private" than others, and that it is possible for specific business organizations to be "more public" "in some respects than specific government organization. Chaordic system thinking view emphasizes that systems flow or change naturally and perceives work organizations as complex adaptive systems. They also suggest that Chaordic system thinking perceives the member of an organization (a unit of the healthcare system) as operating in both horizontal (e.g. cross departmental) and vertical (e.g. cross-hierarchical) heterarchical system aggregates in which more complex structures and mental models may develop (**Bozeman & Bretschneider, 1994**).

According to William F. West, bureaucratic structures are means of political control and political actors choose administrative institutions that will perpetuate their interests in the future. He also quotes from Terry Moe (1989 and 1990) has described the relationship between interest groups and bureaucratic structure in a more systematic way than traditional pluralist theory provides. Whereas members of the general public (and even well-informed voters) know little about the implications of administrative procedures and organizational arrangements, groups are highly attentive to issues of program design: Interest groups take an active part in the politics of structural choice, and politicians have strong incentives to be sensitive to their interests and demands (**West, 1997**).

b. The necessity of intergovernmental labor division

If we consider the facts that the U.S. is one of the most populous and wealthiest nations in the world in terms of GDP and GDP per capita, and private healthcare and health insurance system have been dominated by the private entities/insurers throughout its history, the proposed healthcare design should include the private (nongovernmental) parties, more or less. Besides that the United States has a Federal Governmental system and it has been strong local government tradition.

Amendment 10 of the U.S. Constitution Ratified on 12/15/1791 states that *“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”* (Retrieved on 11/25/2009 from <http://www.house.gov/house/Constitution/Amend.html>). The layers of government: in the U.S. three layers of government with sovereignty of their own (not a single government) provide public services, levy taxes, and borrow money. Indeed, there are more than 86,000 governments in the U.S., counting federal, state, and local entities (Frederickson, 1997). Additionally, private and nonprofit stakeholders the proposed healthcare system will be a complex organizational network. The proposed healthcare systems in which the government involved has been illustrated as below in order to show how it will be complex by a Republican Congressman, Kevin Brady, 8th District of Texas. (Retrieved on 11/25/2009 from http://www.house.gov/apps/list/press/tx08_brady/71509_hc_chart.html).



Any complex organization is made up of a number of subsystems [governmental layers], which in turn consist of sub-subsystems [departmental sections of the governments]. The smallest system level of any organization may be defined as the role performed by each contributing member, with the system parts consisting of those aspects of his personality required for role performance. These role-based sub-systems should not be confused with organizational subdivisions, such as hospitals, insurers, physicians, or individuals (Lyden, 1975).

c. The necessity of governance and networking

[Public service] [p]rovision means government intervention to ensure availability or, generally, to finance the service; it does not require production by the government.” (Mikesell, 2007). Where traditional public administration emphasizes the internal dynamics of public agencies, the newer forms of action often involve elaborate partnership arrangements with nongovernmental actors (Salamon, 1989).

Frederickson defines the governance as a wide range of types of organizations and institutions that are linked together and engaged in public activities and the patterns of interaction of multiple-organizational systems or network (**Frederickson, 1997**). Newer tools [in public administration] share a significant common feature: they are highly indirect they rely heavily on wide assortment “third parties”— . . . private hospitals . . . , to deliver publicly financed services and pursue publicly authorized purposes. The upshot is an elaborate system of third-party government in which crucial elements of public authority are shared with a host of non-governmental or other governmental actors. . . . In a sense, the “public administration problem” has leaped beyond the borders of the public agency and now embraces a wide assortment of “third parties” that are intimately involved in the implementation, and often the management, of the public’s business. . . . many countries in western Europe have non-profit sectors quite a bit larger than that in the U.S., financed largely through grants and contracts from the state. In shifting the focus in public problem solving from agencies and programs to generic tools, the new governance also shifts the attention from hierarchic agencies to organizational networks. The defining characteristics of many of the most widely used, and most rapidly expanding, tools is their indirect character, their establishment of interdependencies between public agencies and a host of third-party actors. As a result, government gains important allies, but loses the ability to exert complete control over the operation of its own programs, instead of sharp division between the public and private spheres, [the new government tools] blend the two together (**Salamon, 2002**). In public private partnerships, contracts replace hierarchy. Instead of chain of authority from policy to product, there is a negotiated document that separates policy-maker from policy output. (**Donald F. Kettl, p 21**).

In most industries, routines, programs, goals, public accounts, and structures are subject to both competitive and institutional isomorphic pressures. Such pressures presumably dampen such behavioral consequences of legal form as might otherwise exist. Competition among for profit and nonprofit healthcare providers, for example, is said to make the latter more socially responsible and the former more efficient than they would otherwise be. Hollingsworth & Hollingsworth report declining differences on a range of structural and performance variables of nonprofit, for profit, and public hospitals between 1935 and 1979. Thus form-related differences might emerge more strongly in comparisons among industries with differing compositions in one society, or between the same industries in different places (**DiMaggio & Anheiner, 1990**). Kessler & McClellan suggest that areas with a presence offer-profit hospitals have approximately 2.4% lower levels of hospital expenditures, but virtually the same patient health outcomes. They conclude that for-profit hospitals have important spillover benefits for medical productivity. (**Kessler & McClellan, 2002**).

La Porte suggests that modern organizational life is characterized increasingly by a growing number of *intra-*, *inter-*, and *trans-organizational relationships*. These phenomena are signaled by terms for (i) structure, such as complex systems, coalitions, various forms of federalism, for example, marble cake federalism, communication nets, and allusion to the computer/electric circuitry metaphor, (i.e., as networks); (ii) characteristics of component relationships, such as inter-dependence, tight (or loose) coupling, multiple horizontal or vertical relationships between elements/members of a network; and (iii) dynamics or process, such as bargaining, action, or information flows, and resource exchanges between net members. He adds that the metaphor of networks advances the descriptive discussion at least one useful step toward more specificity in characterizing the webs, interconnected systems, and interdependencies of modern public organization. He continues that the network metaphor connotes relationships, between net members, that are cooperative, and to a significant degree self-reinforcing. The networks are likely to be large, spread over wide geographies. Salient descriptive characteristics would include (i) the scale and general structure of the net, (ii) the properties of its ties or connectivity, (iii) the patterns of exchanges among net members, and (iv) the problem more salient in public networks than in private, economic one (**La Porte, 1996**).

Lee, Alexander, and Bazzoli suggest that health institutions which are affiliated with health systems and more diversified systems or networks (legally integrated or connected with a loosely and voluntarily network) tended to be more responsive to the communal needs compared to freestanding communal hospitals (**Lee, Alexander, and Bazzoli, 2003**). It can be argued that scale economics and high level of diversity in a network enhance the skills and resource for the health institutions.

d. Necessity of a self adaptive system

Kira and Eijnatten suggest that, in order to promote work-organizational sustainability, they consider organizations as *chaordic* open systems and propose to extend the foundations of socio technical system (purposefully designed and controlled to generate services or products) from operational ST to chaordic ST chaordic system thinking. At the work-organizational level, sustainability means an ability to find ways to deal with challenges and capability to create new opportunities for a productive existence (Kira & Eijnatten, 2008).

3. NETWORK DESIGN PROPOSAL

I propose a public health insurance model that both governmental, for profit and non for profit organizations are acting their roles within a harmony to sustain the healthcare system which has been one the most complex industries in the U.S.

The health insurance system is an inseparable part of the healthcare system in the U.S. In my model, every citizen, including legal residents must have at least one full coverage health insurance policy (primary policy). In addition to the existing private insurance companies, the Federal Government will create a publicly-owned insurance company which will be the last resort for obtaining a health insurance and the first source for the public employees. Individuals may purchase the policy either from private insurers or governmental health insurance company individually. Employers must purchase health insurance policy for their employees from either from private insurers or governmental health insurance policy. In this case, the half-cost of the primary policy will be charged to the employee. Employee's part will be retained/checked off from the employees' salaries and transferred to the insurer on behalf of the employee. Primary insurance policy will cover the employee's spouse—if the spouse is not working-, children under 18 years old. For each extra family member, the employee's part will increase slightly. Public employers will purchase the health insurance policy from the governmental health insurance company. Self employers will be subject to the rules which are applied to the employees. The employers cannot hire a part time employee who has no health insurance. Partial amount of the policy will be paid to the employee. Governmental insurance will cover all of the medical expenses including, medicine, eye care, dental plan. Aesthetics procedures will be out the policy unless there is medical necessity and will be paid by the patients. Governmental insurance policy will be purchased by the government for unemployed people or people who has no income or fortune. Federal Government will create a fund in order to subsidize the governmental health insurance company. By subsidization of the governmental health insurance for destitute individuals, the government will apply *redistributive policy* by transferring fiscal resources from one class or group to another (Lowi, 1972).

The governmental health insurance company will collect its premium revenues just like the tax revenues and nonpayment of the governmental health insurance premiums will be evaluated like tax offense.

None of the medical service or treatment will be provided free or co-pay free by the government. If the patients has no salary to pay for the co-pay, this amounts will be met by the government. Even in this case, the patients will pay a “symbolic price, i.e. \$1” for each service as co-pay. The government will pay the insurance expenses instead of the medical expenses to the medical institutions.

The healthcare service will be a federal issue. But the Federal Government will not be the healthcare service provider. It will be responsible for supervising the governmental health insurance company, organizing and supervising the healthcare system. The Federal Government will set the tariffs as price cap for each medical examination and medical supplies which will be applied by the governmental health insurance company to make payment to the health institutions. While this tariff will not be binding for private health insurance companies, private hospitals, and drug companies, it will be used in order to prevent the application exorbitant price policy for private entities. In other words, the government will not set the price of the services or medical materials, but it will limit to the governmental health insurance company for the payment of each payment. By doing this the government will apply a *regulative policy* to set standards in terms of price (Lowi, 1972). All of the stakeholders, such as representatives of consumers' organizations, pharmaceutical industry, private hospitals, and insurance companies, will participate in the regulatory process in accordance with the *governance*.

The laws, rules, and regulations flexible as much as possible in order to create a well adaptive system to meet the requirement of new unpredictable circumstances.

The public health institutions will be classified as three or four categories. “The first category health institutions” will take care of the basic health problems for instance tonsillitis etc. The second one will take care of more complex health problems that are not solved in the first step. Finally, at the third step, complex problems

that are not solved health problems will be taken care of. Except for military institutions, the first and second category public health institutions will be transferred to the local governments, and the third category health institutions will be under the responsibility of the states. These facilities will be funded by the governmental health insurance company. If these institutions accept patients who hold private insurance policy, the co-pay's will be transferred by the institution and the private insurers' part will be transferred to the governmental insurance company by the private insurers.

Healthcare system providers will consist of governmental, private, and nonprofit organizations. Private health insurance holders will keep going to the private institutions. The governmental health insurance holders will have three options:

- 1-They will have option to go to the public health institutions by paying reasonable co-pay.
- 2-They will have option to go to the nonprofit health institutions by paying co-pay, if the institution applies.
- 3-They will have option to go to the private health institutions by paying co-pay. But in this case co-pay will not be fewer than the amount that public institutions apply. Private health institutions will must charge and collect the co-pay from the patients who hold the public health insurance policy.

The existing programs Medicare, Medicaid, the Children's Health Insurance Program and the Veterans Health Administration will be merged in the governmental health insurance program. Wealthy senior citizen will have to purchase their own health insurance. **(Richard Epstein, retrieved on 11/25/2009 from <http://healthaffairs.org/blog/2008/03/13/health-care-disparities-deregulation-first-redistribution-last/>).**

Every individual will have a medical record which is kept in a federal institution and every transaction will be recorded within the account. (Medical record privacy misuse will be a federal offense to protect privacy.) Every insurer, including the governmental company will notify each member's personal information, especially whether or not he or she has a valid policy. Frictional uninsured interims will be covered by the governmental health insurance company.

The government (federal, state, and local) or governmental health insurance company will not produce or sell drugs or medical supplies. They will pay the governmental insurance policy holders medical expenses to the private providers such as private hospitals, pharmacies, medical supplies sellers, etc. Public health insurer, having a huge negotiation power, may obtain the medication from the drug companies from cheaper prices.

In case of epidemic or pandemic, which is declared by the Federal Governmental nationwide or in partial in the country, urgent and/or compulsory health expenses for every citizen will be paid by the governmental health insurance company regardless of valid policy.



4. CONCLUSION

As a conclusion, I propose a public option model which will coexist private health insurance companies, private health institutions, private pharmaceutical companies, and nonprofit health institutions together with the public entities that are functioning at regulatory and/or street level. This model will be a public umbrella that provides a full coverage health insurance both to uninsured individuals together with people who utilizing the existing public medical aid programs and suffering from the unaffordable health insurance policies. Due to the fact that, in the public option, private and not for profit organizations will keep playing their important roles, governance will be a key concept to cooperate all three sectors in order to sustain the healthcare system. Instead of sharp division between the domains of public, private, and not for profit, they will form a self evolving -as much as possible- and complex structure. Redistribution will be another key characteristic of the system due to the fact that enlarging public interference/portion in the healthcare system will necessitate extra fiscal resources and taxpayers will have to pay more. In order to built up and pursue the good governance patterns, a well defined, well functioned, comprehensive, and adaptable organizational and technological networks should be created by beginning from the federal level through to the bottom level and from the governmental domain to the private and not for profit domains.

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Statement of James F. Allsup, President, CEO and Founder of Allsup

Chairman Tanner and Members of the Subcommittee, thank you for considering my written testimony today regarding the Social Security Administration's challenges in managing the massive disability claim backlog during the current economic downturn.

My name is James Allsup, and I am a former employee of the Social Security Administration and the founder and CEO of Allsup Inc., the largest non-attorney Social Security Disability Insurance (SSDI) representation company. Since 1984, we have helped more than 120,000 individuals obtain disability benefits.

A Grave New Threat

Earlier this year, I provided written testimony before the full Ways and Means Committee, commenting on an increasingly grave threat to the SSDI system, and most importantly, to hundreds of thousands of disabled individuals. Despite the best efforts of the Social Security Administration and policymakers to address an exploding backlog of claims at the hearing level, the highest unemployment levels in 25 years were causing desperate Americans to flood the Social Security Administration with disability claims at an unprecedented rate.

From 2004 through 2007, application levels were stable, with the SSA processing between 2.1 million and 2.2 million SSDI applications each year. Those numbers began increasing in 2008—when for the first time more than 2.3 million applications

were filed. They grew even more dramatically, to more than 2.7 million, in the recently completed FY 2009.

It's amazing the difference one year can make. For years, disability advocates have been working to raise awareness of the massive backlog of claims at the hearing level. Congress and the Administration should be commended for providing the resources needed by the SSA to begin addressing that challenge. The men and women of the SSA deserve praise for using those resources wisely to reduce the number disability hearings pending for the first time since 1999.

Unfortunately, the current crush of applications will undo that progress. The SSA recently reported that the level of initial claims pending now exceeds 1 million people—that's nearly a 40 percent increase over the level from FY 2008. It is quite clear that even as the backlog improves at the hearing level, the line for benefits continues to grow rapidly at the front end of the system.

If They Only Knew

The long wait for benefits imposes real costs to applicants, according to a recent national claimant survey conducted by Allsup. People with disabilities experience financial crises, extreme stress and declining health while stuck in the federal disability backlog. An overwhelming majority of SSDI applicants face grave setbacks and wish they would have known from the start that expert representation was available to assist them.

Arthur Blair, of Gaithersburg, MD., was a program manager at a group home before a combination of osteoarthritis, severe back pain and depression made it impossible for him to keep working. During his two-year wait for SSDI benefits, Mr. Blair tapped deep into his savings and had to sell his home after he and his wife were unable to make their mortgage payments. His condition also worsened.

According to Mr. Blair: "I think the process takes away our humanity. There are no resources to help you. You are in a financially devastating position, and by the time you're approved, you have accumulated so much debt and lost everything you've worked for. It's almost impossible to recuperate what you lost."

Mr. Blair's experience is typical, according to Allsup's 2009 survey of SSDI claimants. Of the nearly 300 successful SSDI claimants who came to Allsup for representation, 90 percent said they faced negative repercussions while waiting for their SSDI award. These included:

- Stress on family—63 percent
- Worsening illness—53 percent
- Draining of retirement/savings—35 percent
- Lost health insurance—24 percent
- Missed mortgage payments—14 percent
- Foreclosure—6 percent
- Bankruptcy—5 percent

Nearly 80 percent of respondents reported facing "barriers to handling the SSDI process on [their] own," including problems with understanding (48 percent) and completing (61 percent) the necessary forms. Three-fourths (75 percent) said the level of stress they experienced while applying for SSDI benefits was either "extreme" (39 percent) or "significant" (36 percent).

Only half (51 percent) of all applicants knew third-party representatives could help them apply for SSDI benefits. Almost nine in 10 (85 percent) survey respondents said they would have found it useful for the SSA to inform them in advance of their options for receiving help with their SSDI application. Another 83 percent would have found it helpful or valuable if the SSA had provided them with a list of authorized third-party representatives from which to choose.

Unfortunately, because applicants often are unaware help is available, too many initial claims are denied for reasons that have nothing to do with the applicant's disability status. If applicants only knew third-party assistance was available to professionally review their application and help properly and accurately document their disability, thousands of claimants could be processed faster and applicants could avoid the painful financial and personal repercussions of being stuck in the system.

Collaboration, Not Privatization

As always, I emphasize that increasing the assistance offered by third-party SSDI representatives is not, as some have charged, a step toward privatization. It is a way for government to leverage the existing capabilities of expert disability representatives to help address a real and growing crisis. It is very similar to the Internal Revenue Service's acknowledgement of tax preparation professionals, who provide valuable assistance to taxpayers in navigating a complex tax system.

Literally hundreds of thousands of government worker-hours could be saved if more applications processed by the Social Security Administration were professionally documented before being submitted. This would leave these employees free to accomplish their primary mission—reviewing applicants, adjudicating appeals and administering the SSDI process.

Chairman Tanner and Members of the Subcommittees, I commend you for holding this hearing to raise awareness of these issues. Thank you again for the opportunity to provide testimony. I look forward to working with you to address this growing crisis.

Statement of Leri Harper

The Social Security Administration's approach to disability, past and present, fails to address the problems and inadequacies of processing claims via the state Disability Determination Services (DDS), where there is ample evidence of regional differences in claims processing. AFGE strongly believes that if problems with inconsistent decisions at the initial claims level are addressed, appeals will diminish. Disability claimants deserve consistent initial claims decisions and payments as soon as possible in the claims process.

The concurrent disability process shows inexplicable variable allowance rates depending on the state of residence. There is no evidence to show that residents of some states are twice as susceptible to become disabled as residents in other states. Obviously, different state initial claims approval rates have more to do with the bifurcated system than the health of residents of these states. Claimants are entitled to consistent decisions regardless of their state of residence or whether they are filing for Social Security or SSI disability benefits. The SSA Office of Quality Performance (OQP) is tasked with keeping track of nationwide consistency of disability claims, and their own studies reveal the disability process shows inexplicable variable allowance rates depending on the state of residence. For instance a study for fiscal year 2009 revealed that if a claimant applies in New Hampshire, they have nearly a 52% chance of being allowed at the initial level. If a claimant applies in Tennessee, they have a 24% chance of being allowed. These inequities have never been addressed, and there is an inherent inconsistency between states in what is supposed to be a national disability program with consistent program standards.

<http://ssahost.ba.ssa.gov/pmr/index.aspx>.

Regional differences are apparent, with many southern states at the low end of the spectrum for approving initial disability decisions; while many east and west coast states are at the high end for initial allowance determinations.

The SSA Office of Quality Performance is the enforcer of the national disability claims standards, who are tasked to review initial disability claims under the same nationwide rules. We reviewed the most recent initial disability claim quality report from the Disability Quality Branch (DQB) of the Office of Quality Performance. Interestingly, no matter what state DDS is measured, the states' quality performance is all rated at a quality level of 91.5% or above in accuracy levels. All state DDS agencies are declared by OQP/DQB to provide good quality decisions, no matter how divergent their allowance or denial rate of initial claims. <http://quality.ba.ad.ssa.gov/hq/direports/qaper/pdf/itable1.pdf>.

During the past two years, the Office of Quality Performance decided to institute a change in the Disability Quality Review Branch process to try and iron out differences in their own national review process. In an attempt to resolve these inconsistencies, the Disability Quality Branch of the Office of Quality Performance now requires their employees to review cases from any state in the Union.

Prior to this change in policy, Disability Quality Review branch employees were limited to reviewing cases only from their individual regions, meaning that the same federal reviewing staff would consistently review the same state DDS offices for whom they were responsible. These regional Disability Quality Branches reinforced the inequitable allowance rates time and again, which they recognized as a problem that needed resolution.

Despite the Office of Quality Performance attempts to create a national virtual national review process, where Disability Quality Branch workers are called on to review cases from any state, we see no significant change in the state DDS' divergent allowance rates, meaning that the review program is ineffective. Even though we have a national quality review component that is well aware of the discrepancy, they have not been able to solve the problem, even with extensive hiring of new examiners during the past two years.

We believe that policing the state DDS adjudication practices is a lot like herding cats, with various policy inconsistencies, political influences, and regional differences that have no place in a national disability adjudication program.

Unfortunately, the chances for a claimant to be approved at the initial level have a lot to do with where they live and their income rather than the nature of their disability. That is inherent in the system. Each state has different criteria for hiring Disability Examiners. Each state provides them with different pay and benefit packages. Some state DDS offices are unionized, while others are not. Each state provides different training to their DDS employees. Employee retention rates vary dramatically from state to state. In effect, there are 50 different disability programs when there should be one.

There is no evidence to show that residents of some states are twice as susceptible to become disabled as residents in other states. Obviously, different state initial claims approval rates have more to do with the bifurcated system than the health of residents in these states. Claimants are entitled to consistent decisions regardless of their state of residence or whether they are filing for Social Security or SSI disability benefits.

According to the Government Accountability Office (GAO), a majority of DDS' do not conduct long-term, comprehensive workforce planning, which should include key strategies for recruiting, retaining, training and otherwise developing a workforce capable of meeting long-term goals. The State DDS agencies lack uniform minimum qualifications for Disability Examiners and have high turnover rates for employees and do not provide ongoing training for Disability Examiners. It is a key problem that must be reconciled in order to reform the disability system.

Although the State DDS system is fully subsidized by SSA, state budgetary problems adversely affect the ability of SSA to provide disability services. For example, California State DDS workers were forced to accept weekly 8 hour furloughs due to the budget deficit situation in the State. Michigan DDS workers along with other MI State employees were furloughed due to State budget shortfalls even though DDS worker salaries were also fully funded by SSA.

As many participants in the hearing testified, multiple state DDS offices followed suit, furloughing employees that were supposed to be earmarked for federal workloads, causing SSA to lose valuable initial case processing time, and resulting in worsening the disability backlog considerably.

Social Security Commissioner Astrue recently made a decision to solve the initial case backlog by taking away work from states where there are average to high allowance rates, and creating mega-DDS offices in states where the allowance rates are lower. These states include Oklahoma, Mississippi, Arkansas, and Virginia. The Commissioner plans to reassign cases from states that supposedly need assistance. Commissioner Astrue calls these "Extended Service Teams" and says ". . . they will be placed in States that have a history of high quality and productivity and the capacity to hire and train significant numbers of additional staff." However Mississippi has an initial disability allowance rate of 26.6%, Arkansas 37.1%, Virginia 40.4%, and Oklahoma 38.6%.

Interestingly, we noticed the Commissioner decided to locate these new centers in right-to-work states where union representation is absent. This will result in getting the work done more cheaply, but we think SSA will get a poorer quality of work and less well-documented claims that will ultimately end up at the hearings level. This will require the ODAR staff to obtain additional documentation and consultative exams that will again build more case processing delays into those claims.

While we are concerned with the loss of union jobs nationwide, we are more concerned with consistency and fairness in the disability determination process. We would like to point out that Commissioner Astrue created this tier of mega-DDS offices "under the radar" without input from the congressional representatives whose states are affected, and this may be of concern to those representatives.

AFGE predicts this backlog of disability claims will end up in multiple appeals that will glut the ODAR system once again. Because additional work will now be funneled to mega-DDS offices that have a historically low allowance rates, we predict the numbers of appeals will rise dramatically once the initial claims backlog is unclogged with the proposed temporary, stop-gap measures. This is not the best course of action for lasting change, consistency of decisions, and smooth workflow.

We understand that everyone want to solve the problem of backlogged disability cases, but piecemeal solutions will not work when the underlying problem of consistency between the state DDS disability adjudication practices versus the federal adjudication rules are not addressed. The bifurcation of the disability program between Federal and State workers is an anachronism dating to 1956 when the SSA disability program was created by Congress. It is time to modernize and create a unified, comprehensive Federal disability system. AFGE recommends the federaliza-

tion of the State Disability Determination Services; keeping the jobs in the states but supplying these skilled workers with federal jobs. At that point, national standards and training can occur where SSA actually has control of their own process. This will bring consistency to the initial claims decisions in the same way that the Supplemental Security Income program (that was federalized from the states in 1974) created a uniform system of benefits for low income, blind, disabled and aged population.

AFGE believes the time to act is now to federalize DDS workers and provide consistent oversight and training that will bring timely, consistent nationwide decisions for the vulnerable disabled claimants that we are committed to serve in an unbiased and equitable fashion.

Submitted by,

Leri Harper
Disability Examiner/Social Insurance Specialist
For AFGE Local 3937
Seattle, WA

Statement of the National Council of Social Security Management Associations

I am the President of the National Council of Social Security Management Associations (NCSSMA). I have been the District Manager of the Social Security office in Newburgh, New York for eight years and have worked for the Social Security Administration for 29 years. On behalf of our membership I am pleased to have the opportunity to submit this written statement for the record to the Committee.

NCSSMA is a membership organization of nearly 3,500 Social Security Administration (SSA) managers and supervisors who provide leadership in 1,262 Field Offices and 35 Teleservice Centers throughout the country. We are the front-line service providers for SSA in communities all over the nation. We consider our top priority to be a strong and stable Social Security Administration, one that delivers quality and prompt community based service to the people we serve, your constituents.

We are certainly concerned about the tremendous challenges facing the Social Security Administration. We wholeheartedly agree with Commissioner Astrue's statement that it is a moral imperative that the disability backlogs be eliminated. On a daily basis, employees in our offices speak to thousands of individuals throughout the country who are desperate to receive a decision on their claims for disability benefits.

We are very appreciative of the support that the House Ways and Means Social Security Subcommittee has provided to improve SSA's budget situation. The additional funding SSA received in FY 2008 and FY 2009 has helped significantly to prevent workloads from spiraling out of control and assisted with improving service to the deserving American public. As an example, SSA has been able to provide additional resources for our Teleservice Center (TSC) operations, and recently announced the opening of a new TSC in Jackson, Tennessee, to assist in reducing our National 800 Number Network busy rates. We are also grateful for the Subcommittee's support for the President's proposed FY 2010 budget for SSA. If this budget is approved by Congress, it will help SSA continue to make progress on the numerous workloads we are challenged with, and maintain the momentum that was so difficult to achieve.

As a result of inadequate budgets received over the past decade through FY 2007, the number of staff in SSA Field Offices declined significantly. In fact, SSA's staffing levels were, until just recently, at the lowest levels since the SSI program started in 1974. Because SSA workloads were growing during this period, customer waiting times increased and call answering rates declined. With the more adequate funding for SSA in FY 2008 and FY 2009 there have been significant efforts to restore staffing levels to near where they were in FY 2004, but they are still lower than in previous years. This additional staff, along with the significant amounts of overtime we have been authorized to work, have assisted greatly with addressing our rapidly growing workloads and increased number of customers and callers.

The following is a brief overview of the workload challenges that are confronting Field Offices.

1. **Additional Claims and Appeals.** Field Offices are expected to receive 1.04 million more retirement claims and 1.08 million more disability claims in FY 2009 and FY 2010 above FY 2008 levels. In addition to the higher volume of disability

claims received by Field Offices, as the DDSs and the Hearing Offices reduce their backlogs, many more additional claims are being approved and must be adjudicated to pay benefits due. The Hearing Offices' cases can require extensive development and are particularly time consuming for Field Offices to process.

2. Improving SSI Quality and Additional SSI Redeterminations. According to a November 2009 OMB report, in FY 2009 SSA paid out approximately \$45.0 billion to SSI recipients. However, there was an improper payment rate of \$5.436 billion or nearly 12.1%, one of the largest in the Federal Government. A November 2009 study by the SSA Office of Inspector General stated that for the 5-year period ending in FY 2008 SSA paid \$204.5 billion to SSI recipients. Of that total, \$16.6 billion was overpaid, representing 8.1% of outlays. Underpayments during this same 5-year period totaled \$3.4 billion or 1.7% of outlays. Given the significant overall dollars involved in SSA's payments, even the slightest errors in the overall process can result in millions of dollars in improper payments.

The SSA Office of Inspector General stated that completing additional SSI redeterminations will help to reduce this error rate because SSA will identify these incorrectly paid dollars earlier. *In FY 2010, Field Offices will work about 1.1 million more SSI redeterminations than FY 2008.* This is nearly a 100% increase in SSI redeterminations. The staffs processing these cases are working at a very high rate of production. In fact, SSA productivity increased by 3.17% in FY 2009. However, we are concerned that despite this increased production, there is insufficient time to review the cases adequately for accuracy. Improving the process means not only doing more SSI redeterminations, but also having sufficient time to review the work for accuracy.

3. Medical Continuing Disability Reviews. Field Offices are also processing more medical Continuing Disability Reviews (CDRs). In FY 2008 SSA processed 235,000 medical CDR cases. In both FY 2009 and FY 2010, we are scheduled to process 329,000 cases. This increase in processing medical CDRs will assist significantly with addressing program integrity concerns. However, there is currently a backlog of 1.5 million medical CDRs pending processing. Accomplishing this medical CDR backlog has the potential to save the American taxpayers approximately \$20 billion. Additional resources will be needed in Field Offices and the DDSs to process medical CDRs and to ensure program integrity.

4. Work Continuing Disability Reviews. Field Offices are also making a concerted effort to address the volume of work CDRs that are awaiting processing. Since April 2009, the number of pending work CDRs in Field Offices has been reduced from about 66,000 cases to the current 55,000 cases. During the same period, the number of "over one year old" cases has been reduced from approximately 7,650 to under 700 cases. Reducing the number of pending work CDRs will help to minimize the large overpayments often encountered on these cases.

5. Field Office Customers. Field Offices have worked diligently to redirect resources to reduce the amount of time a claimant waits to see an SSA interviewer. We are making significant progress despite our many challenges. In October 2009 a claimant waited an average of 19 minutes, as compared to 22.8 minutes a year earlier. This is a significant accomplishment considering the fact that the number of customers visiting SSA Field Offices continues to increase. In FY 2009, there were over 45 million customers, an increase of 600,000 customers from FY 2008.

6. Field Office Telephone Calls. Field Offices are struggling to answer telephones with the increased workload demands. We handled about 58 million calls in Fiscal Year 2009. This is an increase of 4 million calls from FY 2008. SSA studies by the Office of Quality Performance state Field Office telephone busy rates were about 58% in Fiscal 2009, which is an increase of 3% from the prior year. Many offices must direct staff to handle walk in traffic to reduce waiting times, and as a result have insufficient staff to answer telephone calls.

7. Training. Field Office management is having difficulty with allocating sufficient time for ongoing staff training. Workload demands necessitate that direct staff be assigned to accomplish production work at the expense of much needed training.

8. eServices or Internet. SSA is transitioning more work processes to electronic service delivery. The FY 2010 goal is to have 38% of Retirement claims and 25% of Title II Disability claims filed on the Internet. SSA Field Offices have had to address significant issues resulting from the increased volume of claims filed electronically. Almost all Disability Internet applicants must be recontacted to perfect the application. For Retirement claims, many claimants must be recontacted to address the error prone area of month of election. While electronic services have assisted Field Offices significantly with the unprecedented high number of SSA applications received, it is important to note that staff must still spend significant time processing many of these electronically initiated actions. Also, electronic services provide only minimal relief to inner city offices, offices with rural service areas, and areas

with a high percentage of non-English speaking applicants, because these areas have populations not as likely to use or have access to computers or the Internet.

It is essential that SSA continues to receive positive budgets to ensure that Field Offices are able to adequately serve the American public and to process important workloads. As illustrated above, even with the recent more favorable SSA budgets, Field Offices are still struggling with tremendous workload demands. We are also especially concerned about the program integrity workloads and the billions of dollars that are being lost due to the backlog of medical CDRs and overpayments in the SSI program.

Commissioner Astrue's testimony indicates that Field Offices are expected to maintain their current staffing levels in FY 2010 and about 2,700 additional positions are scheduled to be added to the Hearing Offices and DDSs. While additional staff is much needed for the Hearing Offices and DDSs to address the disability backlogs and these positions should not be reduced, additional staff for Field Offices would yield significant improvement in service to the American public and assist with the disability backlog. Our network of 1,262 community based Field Offices is an integral part of SSA's service delivery system, and the Field Office is where the disability process begins and ends. Increased staff for Field Offices would reduce workload backlogs, address program integrity concerns, improve SSI accuracy performance, and allow for the transmittal of a more accurate and complete disability product that would assist with expediting disability decisions.

SSA's flexibility to continue to provide necessary resources in FY 2010 will be determined much by the President's proposed budget in FY 2011 and future years. If these budgets are not adequate to address the workload challenges, the progress made in the past two years will be eroded. Field Offices could redirect some of the overtime dollars currently expended to hire additional temporary or permanent employees if flexibility is provided due to the expectation of a favorable SSA budget in FY 2011.

We believe a minimum of \$13.2 billion is needed for SSA's FY 2011 administrative funding. This level of funding would provide SSA with the resources necessary to continue the progress made, while at the same time protecting many Americans from severe and unnecessary economic hardship. Our community based staffs are very committed to serving the American public, but we must have the tools and resources to do so. We sincerely appreciate your ongoing support to provide adequate funding for the Social Security Administration. We remain confident that this increased investment in SSA will benefit our entire nation.

On behalf of the members of NCSSMA I thank you for the opportunity to submit this written statement to the Subcommittee. NCSSMA members are not only dedicated SSA employees, but they are also personally committed to the mission of the agency and to providing the best service possible to the American public.

Linda Fullerton's Letter

Members of the Committee:

My name is Linda Fullerton, President/Co-Founder of the Social Security Disability Coalition, and it is again with great sadness, anguish and despair that I submit this testimony to you today as I have done several times in the past. But as usual my testimony apparently must not ever be read by anyone there, from what I can tell, based on what I saw. I watched this entire hearing on the internet, and each hearing that I see continues to be a source of major frustration for me. It happened that this hearing took place on my 54th birthday. Most people would have celebrated their birthday doing joyous types of things. Unfortunately since I filed for my own Social Security Disability benefits on December 6th 2001, I no longer have reason to celebrate much of anything anymore.

My life was permanently destroyed with the stroke of pen by a neglectful government employee, to whom I was just an SS number, and it is more than I can bear. So now, not only will I never recover from my illnesses, but I will never recover from the permanent financial and physical devastation this has had on my life. After fighting and waiting for 1½ years, and losing all my life savings, pension money and any chance of ever having financial security again, my claim was finally approved. Even though a person may eventually get their benefits, the devastation does not miraculously disappear once the checks start coming. It often leaves a permanent scar on one's life. The stress I endured during that time and continue to deal with, every day living on the edge of total ruin, on top of all my illnesses is unbearable beyond belief and it is killing me. My health problems have become worse, and new ones have arisen as a result of all this stress. Each day is worse

than the one before, with no hope in sight for any type of relief. I don't know how I am going to survive without some miracle like winning the lottery. My "American Dream" will never be realized. I have now been forced to live the "American Nightmare" for the rest of my days, because I happened to get sick, and file a claim for Social Security Disability benefits, a Federal insurance policy that I was forced to pay into for over 30 years. I am now doomed to live in poverty for the rest of my life, in addition to all my medical concerns. I will never be able to own a home, or get another car. My current vehicle which is on death's door, is the ONLY method of transportation I have for survival. When things break down now, I cannot fix them and have to do without. I struggle every day to pay for food, medicines, healthcare, gas etc. having to decide which things I can do without till the next check comes, since I live strictly on the inadequate, monthly SSDI check I receive, always teetering on the brink of disaster. I did not ask for this fate and would trade places with a healthy person in a minute.

As a result of that horrible experience, I thought it was extremely important to watch the hearing that you held on this issue that affects the very lives of millions of this nation's most vulnerable citizens. I would not wish this hell on anyone, and I did nothing wrong to deserve it, I just happened to get sick in America. I was forced to pay for an insurance policy out of my paycheck every week, and when I needed that benefit the most, the Federal Government tried to prevent me from getting it. Even more sad than my situation, are the ones who have died while waiting to get their benefits approved.

During 2006 and 2007, at least 16,000 people fighting for Social Security Disability benefits died while awaiting a decision (CBS News Report—Disabled And Waiting—1/14/08). This is almost more than 4 times the number of Americans killed in the Iraq war since it began.

During 2007, two-thirds of all applicants that were denied—nearly a million people—simply gave up after being turned down the first time (CBS News Report—Failing The Disabled—1/15/08).

PLEASE NOTE—I personally was the source behind these CBS News reports and was featured in the broadcast of "Disabled And Waiting."

Something is seriously wrong, when even one person in this country should have to be put through this nightmare. You may think I am bitter but nothing could be further from the truth. I believe everything happens for a reason, and I learned a lot from this experience. I want to turn it into something positive, and use this knowledge I have gained to make sure that nobody else suffers again, when they need help from the SSA. In fact, in order to do that more effectively, I actually reached out to the SSA, in spite of my bad experience, and have met some wonderful people there as a result, who are in fact very dedicated and hard working individuals. I am forever grateful for their concern for our problems, but we need many more of them. I testify today, not to get your pity, but so you can get an accurate picture of what is really happening to the most vulnerable citizens of this nation. I want to illustrate how decades of neglect, lack of oversight, and under funding of the Social Security Administration's Disability program, has a very negative impact on the lives of disabled Americans such as myself whom you were elected to serve and protect. Therefore, I must ask: When are you going to stop this abuse?

Call For Open Congressional/SSA Disability Hearings

I have been following these hearings, for over five years now, and I find it deeply disturbing, and glaringly obvious, that not one panelist/witness selected to appear, is an actual disabled American who has tried to get Social Security Disability benefits, and who has experienced this nightmare for themselves. Unfortunately this continues to be the case with this hearing as well. While the witnesses you continually rely on may be very reputable in their fields, unless you have personally tried to file a claim for Social Security Disability, you cannot begin to understand how bad this situation really is, and therefore the panelists you continue to rely on are not fully qualified to be the only authority on these issues.

I was forced to watch this hearing on the internet, because my repeated requests over the last several years to testify in person, have been blatantly ignored. I have made it very clear in previous written testimony submitted for the hearing record, through faxes, e-mails and phone calls, to all the Congresspeople in my district, others on this Subcommittee, and many others in both the House and the Senate Committees that affect the Social Security Disability Program in any way, that I want to testify in person at these important hearings that directly affect me and others like myself. As an actual disabled American, I again make the same request today, as I have in the past, that in future Congressional hearings on these matters, that I be allowed to actively participate instead of being forced to always submit testi-

mony in writing, after the main hearing takes place. For some reason beyond my comprehension, you still will not let me do that.

I often question whether anybody even bothers to read the written testimony that is submitted when I see the continued lack of results after previous hearings. I am more than willing to risk my very life for the opportunity to testify, should I be permitted to do so, since I believe so strongly in the importance of this program. In fact, I ask that you call another hearing, and allow me to be the sole witness, since the eye opening information I have to share with you would fill the entire 1- 2 hours, since this program is so badly broken, and filled with corruption at every level. I have also come up with solutions to all the problems as well, which I would also be discussing at that time. I want a major role in the Social Security Disability reformation process, since any changes that occur have a direct major impact on my own well being, and that of millions of other disabled Americans just like me. I also propose that Congress immediately set up a task force made up of SSDI claimants, such as myself, who have actually gone through the claims process, that has major input and influence before any final decisions/changes/laws are instituted by the SSA Commissioner or members of Congress. This is absolutely necessary, since nobody knows better about the flaws in the system and possible solutions to those problems, then those who are forced to go through it and deal with the consequences when it does not function properly.

As a result of my repeatedly denied requests to testify, it is my opinion, that you don't want to know what is REALLY going on. Since my last written testimony I have released a video on the internet called:

American Nightmare—It Can Happen To You!

I made it to alert the American people to the ugly realities of what it is like to try and get the SSDI benefits that they have been forced to pay for, and may never survive to actually collect. They need to know how the Federal Government continually breaks its social contract with them on a daily basis. It seems to me that if you do not have to face someone such as myself, that has barely lived through this horrible nightmare, and has had their whole life permanently devastated as a result of continued neglect of this program, we remain just a bunch of SS numbers whose lives can be destroyed without guilt. We are in fact, your mothers, fathers, sisters, brothers, children, grandparents, friends, neighbors, and honorable veterans who have served this country. Something is severely wrong with this picture!

When you question the SSA Commissioner at these hearings, why have you not ordered him to provide the data on how many Americans have actually died each year, or have been forced to use state provided services, while waiting for their SS Disability claims to be processed? Since the SSA also pays out a one time death benefit to a survivor's family, and contracts out the medical portion of disability claims to the states who provide the Social Service programs that disability applicants often need to use, this data should be readily available if you bothered to ask for it. These are important questions that need to be answered, but it seems to me you don't care enough about the disabled to ask them. How can you get an accurate handle on this situation without all the facts and appropriate witnesses who wish to testify? Who better to give feedback at these hearings than those who are actually disabled themselves, and directly affected by the program's inadequacies! It seems you have forgotten that WE are the customers, and the SSA and Congress work to serve us. I find it hard to believe that these hearings cannot be scheduled in such a way that different and more appropriate witnesses could be allowed to testify. If you continue to do the same thing over and over again, as you have for the past several years, you will continually get the same poor results, which is exactly what is happening. You ask the same questions, of the same people, and wonder why there is little to no, improvement between hearings. There is a major piece of the puzzle missing—the people you have been elected to serve—and until you really commit to getting the ALL the information needed to fix the Social Security Disability program, you are making decisions based on a lack of important information, which can be very detrimental, and the problems are going to continue to escalate, no matter how much money you put toward fixing them.

There are five main reasons for the disability hearing backlogs:

- Lack of communication and educating the public
- States of denial
- State and private disability companies forcing claimants to file disability claims with SSA or risk losing private coverage
- Lack of oversight
- Lack of funding

Lack Of Communication Between Claimants, Doctors And SSA, Lack Of Education On What Is Needed For A Claimant To Prove A Disability Claim

Currently there is little to no communication between the SSDI claimant and the SSA caseworkers handling their claims. More communication is needed and review of records by the claimant should be available at any time during all stages of the disability 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. Also many times medical records submitted are lost or totally ignored.

In case info is missing, or the SSA was given inaccurate information, the applicant can provide the corrected or missing information, before an actual determination at any level is made. This would eliminate many cases from having to advance to the hearing or appeals phase.

Also many times doctors, hospitals etc often do not respond to SSA requests for medical information in a timely manner, or sometimes ignore these requests entirely. ALL doctors, and medical professionals including those at the VA should be required by Federal or State law, to fill out any medical forms and submit documents requested by the SSA within strict timelines or they will not be allowed to practice medicine in this country. Also as part of their continuing education program in order to keep their licenses, doctors should also be required to attend seminars provided free of charge by the SSA, in proper procedures for writing medical reports and filling out forms for Social Security Disability and SSI claimants.

The major criteria used by the SSA to decide a disability claim, is residual functionality and the "Blue Book Of Listings," yet this is not usually information that the general public is privy to when filing a disability claim. In fact it is a pretty well kept secret unless you know enough to do some research. In other words since the process is so nebulous from beginning to end, the deck is purposely stacked against a claimant from the very start. When the average person files a claim they seem to think that all they have to do is mention what is wrong with them, get their doctors to back up their medical claims, say they are disabled and cannot work, fill out a few forms and the checks will start coming in the mail. While in a ideal world the process should be that simple, nothing could be further from the truth. They do not realize, and are never told, that they must not only list their illnesses, but more importantly describe HOW their illnesses prevent them from doing work and daily activities. They are not told to list EVERYTHING that is wrong with them, and often only file a claim for one condition, that in itself may not be disabling, when they have several of them, that in combination, may in fact render them totally disabled. Many file claims because they cannot perform the job they have been doing for years, or cannot work as many hours that used to before they get sick. They do not fully understand that they have to not be able to work ANY job in the national economy, and that the SSA does not pay for partial disability. The SSA needs to do a much better job of educating the public at the onset of filing a disability claim to avoid confusion.

States Of Denial—The REAL Reason Behind The Social Security Disability Hearing Backlogs

Since Social Security Disability is a Federal program, where you live should not affect your ability to obtain benefits. Sadly this is not the case. While funding is a major problem that SSA faces, the other primary reason for these hearing backlogs, continues to be ignored during these proceedings, and that is the initial phase of the disability qualification process which is handled by the individual state DDS/Disability Determination Services offices. There, the most crucial part of your disability claim, the medical portion, is reviewed by a caseworker/adjudicator and medical doctor on their staff who never sees you, and in most cases never even communicates with you at all. Too much weight at the initial time of filing, is put on the SS caseworker's opinion of a claim. There needs to be more oversight that disability decisions be based with controlling weight given to the claimant's own treating physicians opinions and medical records in accordance with (DI 24515.004) SSR 96-2p: Policy Interpretation Ruling Titles II And XVI: Giving Controlling Weight To Treating Source Medical Opinions. Even though this policy ruling is in place, this is very often not happening.

Excerpts from GAO-09-511T—Further Actions Needed to Address Disability Claims and Service Delivery Challenges—3/24/09:

Although SSA is responsible for the program, the law calls for initial determinations of disability to be made by state DDS agencies. The work performed

at DDS offices is federally financed and carried out under SSA disability program regulations, policies, and guidelines. See 42 U.S.C. § 421(a)(1).

From September 1998 to January 2006, over 20 percent of disability examiners hired during that period left or were terminated within their first year. DDS officials said the loss of experienced staff affects DDS' ability to process disability claims workloads because it generally takes newly hired examiners about 2 years to become proficient in their role.

For example in November 2009:

- **Mississippi had the lowest percentage of approvals at the initial level of 24.4%**
- **Alaska and Colorado had the lowest percentage of approvals at the reconsideration level of 0%**
- **Puerto Rico had the highest percentage of approvals at the initial level of 61.9%**
- **Massachusetts had the highest percentage of approvals at the reconsideration level of 30.5%**

Source: Social Security Administration—November 2009.

That is a major fluctuation depending on what state you happen to apply for benefits in. Something is extremely wrong with this picture and proves the inconsistency of decision making by the state DDS offices in handling Federal disability claims.

What would be an incentive for states to deny Federal claims? Since many Social Security Disability claims are SSI or both SSI/SSDI combined claims and many states offer to supplement SSI payments at a higher benefit amount, therefore they want to keep as many off the rolls as possible so they do not have to pay out this supplement. Also since there is a different pay scale for government vs state employees who are often underpaid, lack training, are overworked, and must meet quotas of cases processed, the tendency is greater to rubber stamp denials to move claims off their desk when a case needs too much development. Thus the explanation for the fluctuation in denial/approval/backlog rates by state. Unfortunately there is very little if any training or oversight on the state DDS offices to make sure they are making the proper decisions on disability claims. This is why so many claimants appeal to the hearing level where a huge percentage of bad claims decisions are overturned and cases are finally approved. Anyone who doesn't see that a "Culture Of Denial" has become a pervasive part of an SSDI claimants encounter with the SSA, is either totally out of touch with reality or is reacting evasively to the subject.

Excerpts from GAO Report GAO-04-656—SSA Disability Decisions: More Effort Needed To Assess Consistency of Disability Decisions—Washington—July 2004:

"Each year, about 2.5 million people file claims with SSA for disability benefits . . . About one-third of disability claims denied at the state level were appealed to the hearings level; of these, SSA's ALJ's have allowed over one-half, with annual allowance rates fluctuating between 58 percent and 72 percent since 1985. While it is appropriate that some appealed claims, such as those in which a claimant's impairment has worsened and prohibits work, be allowed benefits, representatives from SSA, the Congress, and interest groups have long been concerned that the high rate of claims allowed at the hearing level may indicate that the decision makers at the two levels are interpreting and applying SSA's criteria differently. If this is the case, adjudicators at the two levels may be making inconsistent decisions that result in similar cases receiving dissimilar decisions."

"Inconsistency in decisions may create several problems . . . If deserving claimants must appeal to the hearings level for benefits, this situation increases the burden on claimants, who must wait on average, almost a year for a hearing decision and frequently incur extra costs to pay for legal representation . . . SSA has good cause to focus on the consistency of decisions between adjudication levels. Incorrect denials at the initial level that are appealed increase both the time claimants must wait for decision and the cost of deciding cases. Incorrect denials that are not appealed may leave needy individuals without a financial or medical safety net . . . An appeal adds significantly to costs associated with making a decision. According to SSA's Performance and Accountability Report for fiscal year 2001, the average cost per claim for an initial DDS disability decision was about \$583, while the average cost per claim of an ALJ decision was estimated at \$2,157 . . . An appeal also significantly increases the time re-

quired to reach a decision. According to SSA's Performance and Accountability Report for fiscal year 2003, the average number of days that claimants waited for an initial decision was 97 days, while the number of days they waited for an appealed decision was 344 days . . . In addition, claimant lawsuits against three state DDS's have alleged that DDS adjudicators were not following SSA's rulings or other decision making guidance . . . However, according to DDS stakeholder groups, SSA has not ensured that states have sufficient resources to meet ruling requirements, which they believe may lead to inconsistency in decisions among states. Furthermore, SSA's quality assurance process does not help ensure compliance because reviewers of DDS decisions are not required to identify and return to the DDS's cases that are not fully documented in accordance with the rulings. SSA procedures require only that the reviewers return cases that have a deficiency that could result in an incorrect decision."

Excerpts from: Statement For The Record Of The National Association Of Disability Examiners—Georgina Huskey, President—Prepared For Subcommittee on Social Security/Subcommittee on Income Security and Family Support Of the Committee on Ways and Means Joint Hearing on Eliminating the Social Security Disability Backlog—March 24, 2009:

"Even at the DDS level, where few backlogs are publicly reported and where the average processing time for an initial claim is nearly 100 days, the stark reality is that there are tremendous backlogs pending. Just because disability claims have been assigned does not mean they are being worked and disability examiners who carry caseloads two, three and even four times the number deemed reasonable are, in essence, housing a backlog of claims at their desk. Unfortunately, this backlog of claims can lead to mistakes in case development and contribute to mistakes in judgment, resulting in the potential for erroneous decisions."

"As experienced staff walk out the door, either due to retirement or because of career changing decisions, SSA and the DDSs have struggled in many parts of the country to attract the kind of new hires that will keep the Agency at a level of competence required in its service delivery. Prior to the recent economic downturn, DDSs were reporting an annual attrition rate approaching 15% with more than 22% of newly hired disability examiners leaving by the end of their first year. The result has been an increasing lack of experienced personnel to process increasingly more complex disability claims and forcing the DDSs to utilize limited training funds to continually hire new staff, rather than provide ongoing training for existing staff."

Furloughs By States Of DDS Workers/Federalizing DDS Workers

There has been a movement in many states over the past several months to furlough the DDS workers in an effort to "save money" for the states due to their increasing budget problems. What is not often communicated properly to the public is that these workers are in fact paid by the Federal Government and not the states. Therefore no actual money is saved by these furloughs and the public is harmed greatly due to their inability to be able to work. If federal disability claims take longer to process, then there becomes a greater need for these claimants to file for state services such as Medicaid, food stamps and cash assistance and in fact causes the more burden to the states. It amazes me that the state governments continually fail to see this connection.

404.1640 Performance Standards—General

The following sections provide the procedures and guidelines we use to determine whether the State agency is substantially complying with our regulations and other written guidelines, including meeting established national performance standards. We use performance standards to help assure effective and uniform administration of our disability programs and to measure whether the performance of the disability determination function by each State agency is acceptable. Also, the standards are designed to improve overall State agency performance in the disability determination process and to ensure that benefits are made available to all eligible persons in an accurate and efficient manner. We measure the performance of a State agency in two areas—processing time and quality of documentation and decisions on claims. State agency compliance is also judged by State agency adherence to other program requirements. [56 FR 11020, Mar. 14, 1991]

404.1641 Standards of performance

(a) General. The performance standards include both a target level of performance and a threshold level of performance for the State agency. The target level rep-

resents a level of performance that we and the States will work to attain in the future. The threshold level is the minimum acceptable level of performance. Performance below the threshold level will be the basis for the Commissioner's taking from the State agency partial or complete responsibility for performing the disability determination function. Intermediate State agency goals are designed to help each State agency move from its current performance levels to the target levels.

(b) The target level. The target level is the optimum level of performance. There are three targets—one for combined Title II and Title XVI initial performance accuracy, one for Title II initial processing time, and one for Title XVI initial processing time.

(c) The threshold level. The threshold level is the minimum acceptable level of performance. There are three thresholds—one for combined Title II and Title XVI initial performance accuracy, one for Title II initial processing time, and one for Title XVI initial processing time.

(d) Intermediate goals. Intermediate goals are levels of performance between the threshold levels and the target levels established by our appropriate Regional Commissioner after negotiation with each State agency. The intermediate goals are designed to help the State agencies reach the target levels. Failure to meet these goals is not a cause for considering the State agency to be substantially failing to comply with the performance standards. However, failure to meet the intermediate goals may result in consultation and an offer of optional performance support depending on the availability of our resources. [46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991; 62 FR 38452, July 18, 1997]

404.1642 Processing time standards

(a) General. Title II processing time refers to the average number of days, including Saturdays, Sundays, and holidays, it takes a State agency to process an initial disability claim from the day the case folder is received in the State agency until the day it is released to us by the State agency. Title XVI processing time refers to the average number of days, including Saturdays, Sundays, and holidays, from the day of receipt of the initial disability claim in the State agency until systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) Target levels. The processing time target levels are:

- (1) 37 days for Title II initial claims.
- (2) 43 days for Title XVI initial claims.

(c) Threshold levels. The processing time threshold levels are:

- (1) 49.5 days for Title II initial claims.
- (2) 57.9 days for Title XVI initial claims. [46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

404.1643 Performance accuracy standard

(a) General. Performance accuracy refers to the percentage of cases that do not have to be returned to State agencies for further development or correction of decisions based on evidence in the files and as such represents the reliability of State agency adjudication. The definition of performance accuracy includes the measurement of factors that have a potential for affecting a decision, as well as the correctness of the decision. For example, if a particular item of medical evidence should have been in the file but was not included, even though its inclusion does not change the result in the case, that is a performance error. Performance accuracy, therefore, is a higher standard than decisional accuracy. As a result, the percentage of correct decisions is significantly higher than what is reflected in the error rate established by SSA's quality assurance system.

(b) Target level. The State agency initial performance accuracy target level for combined Title II and Title XVI cases is 97 percent with a corresponding decision accuracy rate of 99 percent.

(c) Intermediate Goals. These goals will be established annually by SSA's regional commissioner after negotiation with the State and should be used as stepping stones to progress towards our targeted level of performance.

(d) Threshold levels. The State agency initial performance accuracy threshold level for combined Title II and Title XVI cases is 90.6 percent.

404.1650 Action we will take if a State agency does not meet the standards

If a State agency does not meet two of the three established threshold levels (one of which must be performance accuracy) for two or more consecutive calendar quarters, we will notify the State agency in writing that it is not meeting the standards. Following our notification, we will provide the State agency appropriate perform-

ance support described in 404.1660, 404.1661 and 404.1662 for a period of up to 12 months. [56 FR 11020, Mar. 14, 1991]

404.1670 Substantial Failure—General

After a State agency falls below two of three established threshold levels, one being performance accuracy, for two consecutive quarters, and after the mandatory performance support period, we will give the State agency a 3-month adjustment period. During this 3-month period we will not require the State agency to meet the threshold levels. Following the adjustment period, if the State agency again falls below two of three threshold levels, one being performance accuracy, in two consecutive quarters during the next 12 months, we will notify the State that we propose to find that the State agency has substantially failed to comply with our standards and advise it that it may request a hearing on that issue. After giving the State notice and an opportunity for a hearing, if it is found that a State agency has substantially failed to make disability determinations consistent with the Act, our regulations or other written guidelines, we will assume partial or complete responsibility for performing the disability determination function after we have complied with 404.1690 and 404.1692. [56 FR 11021, Mar. 14, 1991]

404.1690 Assumption of Disability Determination function when we make a finding of substantial failure

(a) Notice to State. When we find that substantial failure exists, we will notify the State in writing that we will assume responsibility for performing the disability determination function from the State agency, whether the assumption will be partial or complete, and the date on which the assumption will be effective.

(b) Effective date of assumption. The date of any partial or complete assumption of the disability determination function from a State agency may not be earlier than 180 days after our finding of substantial failure, and not before compliance with the requirements of 404.1692.

All phases of disability claims processing should be moved to and handled out of the Social Security individual field offices, including the DDS phase which is the medical determination phase currently handled by the states, and all hearing phases of the disability process. All people who process Social Security disability claims should be employees of the Federal Government to ensure accuracy and uniform processing of disability claims under Federal regulations and Social Security policies which is currently not the case. If the states are to continue to handle the DDS phase of the disability process, then all state employees handling Social Security claims should be required to receive a minimum of 3 months standardized training by the Social Security Administration, in SSA policies and Federal regulations governing SSDI/SSI claims processing. If more time and effort were put forth to communicate with claimants, and to make the proper decision at the onset, there would be no need for all these cases to be appealed to the hearings level in the first place. That in itself would be a huge factor in reducing the hearing backlogs, but this fact has been greatly ignored. Until you properly devote the time and energy to look into and reform this crucial part of the problem, the hearing backlogs will continue to grow at an uncontrollable rate, no matter how much money you give to the SSA.

Social Security Disability Program Problems—Contributing Burden Factor on Medicaid/Social Service Programs For States

There seems to be a relationship, between SSDI claims processing issues/backlogs, and the need for claimants to also apply for state funded Medicaid/Social Service programs. Many are forced to file for Medicaid, food stamps and cash assistance, another horrendous process. For example in New York State, about half the 38,000 people now waiting on disability appeals, for an average of 21 months, are receiving cash assistance from the state (New York Times 12/10/07). Those who file for these programs while waiting to get SSDI benefits, in many states, have to pay back the state out of their meager benefit checks once approved. As a result they're often kept below the poverty level, almost never able to better themselves since they can't work, and now are forced to rely on both state and federally funded programs instead of just one of them. This practice should be eliminated.

Regulation Is Necessary To Avoid Improper Social Security Disability Claim Filings Due To State And Private Insurance Company Policies

There is a growing number of claims being filed by people who may not actually qualify for disability benefits under Social Security guidelines, but who are being forced to file Social Security Disability/SSI claims by their private disability and state disability carriers or risk not being eligible for benefits under those programs. Recently there has been media coverage on this issue which can be found here:

Insurers Faulted As Overloading Social Security—NY Times—Mary Williams Walsh—4/1/08

<http://www.nytimes.com/2008/04/01/business/01disabled.html>

Exhibit D—Letter To Senator Charles Grassley From Disability Claimant Who Was Required By Private Insurer To File Claim For Social Security Disability Regardless Of Eligibility Or Risk Loss Of Private Disability Insurance Benefits—1/21/09

<http://grassley.senate.gov/private/upload/Exhibit-D.pdf>

Exhibit E—Letter From SSA Commissioner To FTC Chairman Regarding Private Disability Companies Requiring Their Claimants To File For Social Security Disability Benefits—11/26/08

<http://grassley.senate.gov/private/upload/Exhibit-E.pdf>

Congress and the SSA needs to look into this issue and this practice needs to be stopped immediately as this too greatly adds to the disability backlog problem. In this case the claimants should not be penalized but the insurance companies should be.

Lack Of Oversight Which Is Crucial To Resolving The Hearing Backlogs

It is obvious that for decades oversight of SSA practices has been greatly lacking which is one of the major reasons we have the enormous hearing backlog you are dealing with today. At the hearing you asked the Commissioner why he was not using the Federal regulations listed above to help the states and claimants deal with the furlough issue and he had no good answer. The incredibly high denial rates at the initial and reconsideration levels, are highly suspect, and eventual approval of a majority of these cases at the hearing level proves that lack of oversight at these phases contributes to the hearing backlog as well. In an editorial letter from SSA Commissioner Astrue dated 8/21/08 to the Atlanta Journal Constitution in regards to the severe hearing backlogs it was stated that “We have taken a big step toward resolving that problem by bringing onboard 175 additional administrative law judges and additional staff to support them.”

In reality:

At the end of fiscal year 2007 the amount of ALJ's available to hear cases was at 1006, and at the end of fiscal year 2008 the amount of ALJ's available to hear cases dropped to 960.13. In fiscal year 2009 there were in fact only 1056.63 ALJ's available to hear cases.

Source: Social Security Administration Reports

The 175 new ALJ's that the SSA Commissioner hired has in reality only added 50 judges over the fiscal year 2007 level. Basically this is still inadequate amount of ALJ's, since it does not account for the fact that more judges may continue to leave for various reasons (retirement etc), and that the level of disability claims continues to increase instead of decrease, based on past history. The Commissioner has failed to publicly account for this fact, so he makes it sound like there is going to be several additional ALJ's above and beyond previous years, when he is in reality replacing judges who are leaving and not actually increasing by any substantial amounts, the number of the additional staff he truly needs. Also very often these judges have not even been allocated to the areas that have the largest hearing backlogs and there is no oversight on the SSA Commissioner to make sure they go where they are needed most. So the likelihood of the claims backlog being resolved with this so called “fix” is slim to none. In other words “this is like putting a band aid on a gushing wound.” More investigation of this problem by Congress, the Inspector General and GAO needs to happen immediately!

Horrendous Customer Service—Where Is The Oversight?

In a January 2007 Harris poll designed to evaluate the services provided by 13 federal agencies, the public rated SSA at the bottom of the public acceptance list and it was the only agency that received an overall negative evaluation. SSA Field Offices have lost over 2,500 positions since September 2005 and nearly 1,400 positions since September 2006. In 2007 SSA Field Offices saw about 43 million visitors a week, and that number is expected to increase by over a million more in 2008. Constituents visiting these local Field Offices continue to experience lengthy waiting times and the inability to obtain assistance via the telephone.

Here is just a small sampling of some of the major problems with the current Social Security Disability program and State Disability (DDS) offices who process the initial phase/medical portion of disability claims:

- Severe under staffing of SSA workers at all levels of the program Claimants waiting for weeks or months to get appointments, and hours to be seen by caseworkers at Social Security field offices Extraordinary wait times between the different phases of the disability claims process
- Very little or no communication between caseworkers and claimants throughout the disability claims process before decisions are made.
- Employees being rude/insensitive, not returning calls, not willing to provide information to claimants or not having the knowledge to do so
- Complaints of lost files and in some states, case files being purposely thrown in the trash rather than processed properly
- Security Breaches—Complaints of having other claimants information improperly filed/mixed in where it doesn't belong and other even worse breaches
- Fraud on the part of DDS/OHA offices, ALJ's, IME's—purposely manipulating or ignoring information provided to deny claims, or doctors stating that they gave medical exams to claimants that they never did.
- Claimants being sent to doctors that are not trained properly, or have the proper credentials in the medical field for the illnesses which claimants are being sent to them for.
- Complaints of lack of attention/ignoring—medical records provided and claimants concerns by Field Officers, IME doctors and ALJ's.
- Employees greatly lacking in knowledge of and in some cases purposely violating Social Security and Federal Regulations (including Freedom of Information Act and SSD Pre-Hearing review process).
- Claimants cannot get through on the phone to the local SS office or 800 number (trying for hours even days)
- Claimants getting conflicting/erroneous information depending on whom they happen to talk to at Social Security—causing confusion for claimants and in some cases major problems including improper payments
- Proper weight not being given to claimants treating physicians according to SSA Federal Regulations when making medical disability determinations on claims.
- Complaints of ALJ's "bribing" claimants to give up part of their retro pay (agreeing to manipulation of disability eligibility dates) or they will not approve their claims
- Poor/little coordination of information between the different departments and phases of the disability process
- Complaints of backlogs at payment processing centers once claim is approved

Federal Quality Review process adding even more wait time to claims processing, increasing backlogs, no ability to follow up on claim in this phase.

NOTE: These complaints refer to all phases of the SSDI claims process including local field offices, state Disability Determinations offices, CE/IME physicians, Office of Hearings and Appeals, the Social Security main office in MD (800 number).

Improper CE/IME Medical Exams Ordered By Social Security Result In Higher Rate Of Denials, Hearings And Appeals

Too much weight at the initial time of filing, is put on the independent medical examiner's opinion of a claim. CE/IME examiners are paid a fee by Social Security for each person they see, so the more claimants they process, the more money they make. Often times they are caught saying they performed exams that they in fact never performed, make mistakes, or make false, misleading statements about claimants. Many times the DDS offices or ALJ's are sending claimants to doctors that have very limited knowledge of their specific health conditions, who are not specialists, or even the proper type of doctor, to be examining a claimant for the type of medical conditions that they have. These doctors have no real idea how a patient's medical problems affect their lives after only a brief visit with them, and yet their opinion is given greater authority than a claimant's own treating physician who sees them in a much greater capacity? Something is way out of line with that reasoning, yet it happens every day. Even though a claimant's treating physicians are supposed to be given greater weight in decision making, this is often not the case. Whenever SSA required medical exams are necessary, they should only be performed by board certified independent doctors who are specialists in the disabling condition that a claimant has (example—Rheumatologists for autoimmune disorders, Psychologists and Psychiatrists for mental disorders). Common sense dictates that these poorly executed, and often unnecessary, medical exams result in a waste of time, money

and energy, for both the claimants and the SSA, especially when the claimant ends up appealing a denial based on these improper SSA ordered examinations.

Utilize Hearing On The Record/Pre-Hearing Review Option To Reduce Backlogs

More emphasis and support staff need to be devoted to the pre-hearing review process which could greatly reduce the current hearing backlog. This would obviously and should require more communication between hearing office staff and claimants or their representatives to update case files. Once the files have been updated, many would be able to be decided solely on the records in the file without having a full hearing in front of an ALJ.

Changes/Proper Funding Necessary For SSA To Accomplish It's Goals And Properly Serve Disabled Americans

I continually hear talk at these hearings about increasing the funding for the SSA, and you asking witnesses for answers, on how much the SSA will need to fix the current problems, and prevent new ones from arising in the future. One thing is said at the hearings, but when push comes to shove to vote for the SSA budget money, other programs or projects become higher priority, even though properly funding the SSA is literally a matter of life and death for millions of Americans. Nothing is more important than the health and well being of the American people, and as elected officials it is crucial that you never lose sight of that priority! Still I see that the SSA is under funded almost every year, and there is a continued challenge to get the money that the SSA requests. SSA should not have to compete each year for funding with the Departments of Labor, HHS and Education which are highly publicized and therefore, often more popular programs. All money that is taken out of American's paychecks for Social Security should not be allowed to be used for anything else other than to administer the program and pay out benefits to the American people.

As stated in the previous testimony provided by Witold Skierwczynski—President—National Council Of Social Security Administration Field Operation Locals to the House Ways And Means Committee on 4/23/08 it is recommended that:

Congress should enact off budget legislation including SSA administrative expenses with benefits which are already off budget. Congress should retain appropriations and oversight authority albeit unencumbered by artificial budget caps and scoring restrictions.

Congress should enact legislation requiring the Commissioner to submit the SSA appropriation request directly to Congress.

Congress should support the House Budget Committee recommendation to increase the SSA administrative budget by \$240 million over the President's budget request.

Social Security Disability Claimants Face Permanent Devastation And Death Resulting From The SSDI Claims Process

Social Security Disability is an insurance policy which was created to be a safety net for millions of disabled Americans, and for many such as myself, it has become their only lifeline for survival. Unbearable stress, severe depression and suicidal thoughts are very common side effects of the disability claims process. I know this not only from my own personal experience, but from thousands of others that have contacted me to tell me their horror stories. The abuse and worry that applicants are forced to endure, causes even further irreparable damage to their already compromised health, and is totally unacceptable. Due to the total devastation on their lives and health as a result of the SSDI claims process, use of the SS Ticket to Work program, or any future chance of possibly getting well enough to return to the work force, even on a part time basis, becomes totally out of the question. Plus there is always the stress of having to deal with the SS Continuing Disability Review Process every few years, where the threat of having your benefits suddenly cut off constantly hangs over your head.

I must report with great sadness and disgust, that all these hearings have not brought about much progress, if any at all, and things continue to worsen by the day. In our country you're required to have auto insurance in order to drive a car, you pay for health insurance, life insurance etc. If you filed a claim against any of these policies, after making your payments, and the company tried to deny you coverage when you had a legitimate claim, you would be doing whatever it took, even suing, to make them honor your policy. Yet the government is denying Americans their right to legitimate SSDI benefits everyday and this is an outrage! I continually hear you talk about hearing waiting times 200 days vs 600 days, like it was nothing but a number. Everyday that a disabled American must wait for their benefits, is

a day that their life hangs on by a thread, or worse yet, they do not survive. The stress from that alone is enough to kill anyone. Since it has been proven over the years that the average American has about two weeks worth of savings, anything over a 14 day waiting period in any phase of the SSDI process is totally unacceptable. Cutting hearing wait times down to even 30 days, is nothing to tout as some great accomplishment on your part, as it still puts claimants lives in jeopardy. If any other private company/organization operated with as poor customer service, and processing times that the SSA currently does, subjecting people to hours, days, weeks, months, and worse yet years, to get their issues resolved, all employees would be fired, and they would be shut down within weeks. Nobody would even attempt to give them their business, yet Americans are held hostage to the SSA since they are required to pay for their services out of their wages, and rightfully expect to get what they have paid for. This is outrageous when something this serious, and a matter of life and death, could be handled in such a poor manner. Common sense would also lead you to the conclusion, that there is a strong correlation between the crisis that disabled Americans face while trying to get their benefits, and the housing, and economic meltdown this country is in the midst of. I challenge anyone of you to try and live for more than two weeks, not relying on your assets (since many SSDI applicants lose all their assets while waiting for a decision on their claims), with absolutely no income, and see how well you survive. Also keep in mind that you are not disabled on top of it, which adds its own challenges to the problem. Based on my own experience, and the experiences of thousands of others which have been shared with me, and current conditions, I firmly believe that the SSDI/SSI program is structured to be very complicated, confusing, and with as many obstacles as possible, in order to discourage and suck the life out of claimants, hoping that they "give up or die" trying to get their disability benefits! The statistics at the beginning of this testimony back up my statement:

Disabled Americans Unite For Reform Of Social Security Disability Insurance Program

The Social Security Disability Coalition, of which I am President/Co-Founder, is made up of Social Security Disability claimants and recipients from all over the nation. It was born out of the frustration of my own experience, and the notion that others may be dealing with that same frustration. I was proven to be totally correct beyond my wildest imagination. Our group is a very accurate reflection and microcosm of what is happening to millions of Social Security Disability applicants all over this nation. We fill a void that is greatly lacking in the SSDI/SSI claims process. While we never represent claimants in their individual cases, we are still able to provide them with much needed support and resources to guide them through the nebulous maze that is put in front of them when applying for SSDI/SSI benefits. In spite of the fact that the current system is not conducive to case worker, client interaction other than the initial claims intake, we continue to encourage claimants to communicate as much as possible with the SSA in order to speed up the claims process, making it easier on both the SSA caseworkers and the claimants themselves. As a result we are seeing claimants getting their cases approved on their own without the need for paid attorneys, and when additional assistance is needed we connect them with FREE resources to represent them should their cases advance to the hearing phase. We also provide them with information on how to access available assistance to help them cope with every aspect of their lives, that may be affected by the enormous wait time that it currently takes to process an SSDI/SSI claim. This includes how get Medicaid and other State/Federal programs, free/low cost healthcare, medicine, food, housing, financial assistance and too many other things to mention here. We educate them in the policies and regulations which govern the SSDI/SSI process and connects them to the answers for the many questions they have about how to access their disability benefits in a timely manner, relying heavily on the SSA website to provide this help. If we as disabled Americans, who are not able to work because we are so sick ourselves, can come together, using absolutely no money and with very little time or effort can accomplish these things, how is it that the SSA which is funded by our taxpayer dollars fails so miserably at this task?

Social Security Disability Coalition—offering FREE information and support with a focus on SSDI reform.

<http://groups.google.com/group/socialsecuritydisabilitycoalition>

Please visit the Social Security Disability Coalition (ARCHIVE) website, or the Social Security Disability Reform petition website:

Archive Of Old Social Security Disability Coalition MSN Group Website

<http://ssdcoalitionarchive.multiply.com>

Sign the Social Security Disability Reform Petition—read the horror stories from all over the nation:

<http://www.petitiononline.com/SSDC/petition.html>

At these two sites you will see thousands of stories and over 8000 signatures and comments on our petition, from disabled Americans whose lives have been harmed by the Social Security Disability program. You cannot leave without seeing the excruciating pain and suffering that these people have been put through, just because they happened to become disabled, and went to their government to file a claim for disability insurance that they worked so very hard to pay for.

Fraud/Program Integrity—The Stigma Encountered By Social Security Disability Claimants

SSDI is not welfare, a hand out, reward, golden parachute or jackpot by any means, and most people would be hard pressed to survive on it. Yet, often claimants are treated like criminals—viewed as frauds trying to scam the system, and that the SSA must “weed out” them out by making it as hard as possible to get benefits. Yes, I’m well aware as I write this, that there’s some who’ve abused the system and that’s a shame, because it casts a bad light on those who really need this help. The percentage of claims that in fact, aren’t legitimate is very miniscule. In March 2009, the average monthly Social Security Disability Insurance (SSDI) benefit was only \$1061.86. Nobody in their right mind would want to go through this process, and end up living in poverty on top of their illnesses, if they could in fact work. I have heard nothing in these hearings or this hearing today that addresses the fraud on the part of the Federal Government used to deny deserving claimants their benefits. I have heard nothing about the rubber stamping of denials, the tossing out of claimant files, the security breaches of highly sensitive data, the total disregard of overwhelming evidence by claimants treating physicians, subjecting claimants to unnecessary fraudulent CE/IME exams, and the cases of ALJ’s “bribing” claimants to give up years of back benefits or they will not approve them. All these things are criminal at best. Most Americans do not know their rights under the law, that they are allowed to get copies of their SSA claim files. If more people exercised this right, they would be horrified to know what was happening behind their backs, and the true perpetrators of fraud would come to light, in a major way. The SSA currently spends way more resources to evaluate cases (Federal Quality Review Process) that are approved, more than any that are denied unjustly.

In closing, in spite of my own horrible experience, I have vowed to do everything humanly possible to get total reform of the Social Security Disability program so that nobody else will ever have to endure the hell that I have had to. I ask that you please:

Introduce and pass the: Fullerton—Edwards Social Security Disability Reform Act:

<http://groups.google.com/group/socialsecuritydisabilitycoalition/web/fullerton-edwards-social-security-disability-reform-act>

Since my time is quickly running out, I hope you will join me soon in my quest to accomplish this final lifetime goal, to make our country a better place for our most vulnerable citizens. Thank you for your time and consideration.

Sincerely,

Linda Fullerton—President/Co-Founder—Social Security Disability Coalition

Social Security Disability Nightmare—It Could Happen To You!

<http://www.frontiernet.net/~lindaf1/SOCIALSECURITYDISABILITYNIGHTMARE.html>



Statement of The Huntington Disease Society of America

On behalf of the Huntington Disease Society of America (HDSA), thank you to Chairman Tanner, Ranking Member Johnson, and distinguished Members of the Subcommittee for holding this important hearing and for the opportunity to submit written testimony today.

Filing for Social Security Disability Insurance (SSDI) is a complex, burdensome process, especially for those living with a rare disease such as Huntington's Disease (HD). HD is a genetic neurodegenerative disease that causes total physical and mental deterioration over a 10 to 25 year period. The disease affects 30,000 Americans, while another 250,000 are at risk of inheriting it from an affected parent. Symptoms of HD can include involuntary movement, dementia, obsessive-compulsive behavior, depression, mood swings, inability to concentrate and immobility. There is currently no cure for HD, and while medications may temporarily reduce the intensity of some symptoms, none halt the progression of the disease. Eventually, every person diagnosed with HD will lose the ability to live independently as the disease advances and ultimately claims their life.

Documenting a disability like HD can be difficult because of the complexity of problems that prevent an individual from working. Given the often subtle onset of symptoms, it is hard to pinpoint exactly when a person with HD first became disabled. Further, the neurological listings under the *Disability Evaluation Under Social Security*, (also known as the Blue Book), have not been comprehensively revised in more than 20 years. As a result, people with HD who apply for Social Security disability benefits experience numerous delays and denials due to the continued use of outdated and insufficient medical criteria.

The symptoms of HD that are absent from the current listing and result in the highest incidence of delays and denial of benefits are behavioral and cognitive impairments. These impairments include distortions of mood, and perception. Under the current Blue Book listing, HD is referred to as "Huntington's Chorea," a name that captures the physical impairments typical of the latter stages of the disease but fails to recognize the triad of symptoms that include the less profound but equally debilitating cognitive and behavioral symptoms now widely accepted as characteristic of HD. Since HD affects each individual differently, these declines are often more debilitating than motor abnormalities. Despite this fact, the lack of visible dysfunction of motor abnormalities has caused many people affected by HD to remain undiagnosed and unable to receive badly needed benefits. A revised definition that captures the complex nature of the disease and its many emotional and cognitive manifestations beyond the "chorea" is needed to reduce the number of delays and reapplications of genuinely disabled HD individuals.

In 2004, the SSA began a formal rule-making process to revise the medical criteria for all neurological conditions; a process that has been plagued with ongoing delays. According to SSA personnel the proposed final guidelines will be issued no sooner than December 2010 with implementation likely to occur in 2012. The primary source of the delay is SSA need to revise the criteria for all neurological conditions. We believe that in order to successfully facilitate HD applicants through the disability process, clear and separate guidelines for determining disability due to HD are needed. By separating the guidelines for HD from the general neurological listings, the unique symptoms of HD will be identified and addressed. The backlog of disability claims will be decreased by allowing HD individuals to apply one time for disability rather than force them to make multiple applications.

In furtherance of this goal, Representatives Bob Filner (D) and Brian Bilbray (R) of California introduced H.R. 678, the Huntington's Disease Parity Act of 2009. This legislation would direct the SSA to immediately revise the medical criteria for determining disability as a result of HD. It would also eliminate the two year waiting period. Currently, there are 56 Representatives who have cosponsored H.R. 678.

As Congress and SSA look for ways to reduce the growing backlog of disability claims, we ask that the Administrator expedite the rule-making process, and update the medical criteria and outdated guidelines for HD. Updating the medical criteria of HD will support SSA's efforts to make timely and accurate disability determinations. Further, updating the guidelines would save time, money, resources and emotional energy on the part of the Social Security Administration and the individuals and families it serves who suffer the effects of this disease. Thank you again for holding this important hearing and for the opportunity to provide Members of the Subcommittee with written testimony this afternoon.

