"Do Private Long-Term Disability Policies Provide the Protection They Promise?"

Statement of

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Introduction

Chairman Baucus, Ranking Member Grassley, and Members of the Committee:

Thank you for inviting me to discuss our disability claims process and the scope of review at each level of the process. The Social Security Act (Act) provides cash benefits to persons with disabling physical and mental disorders under two major programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

SSDI provides benefits to workers with disabilities and to their dependents and survivors. Workers become insured under the SSDI program based on contributions to the Social Security trust funds through taxes on their wages and self-employment income. Under the Act, most disability beneficiaries must be entitled to SSDI benefits for 24 months before they may receive Medicare.

As defined by the Act, we can find claimants disabled only if their medical condition(s):

- Prevents them from performing their previous work;
- Prevents them from performing other work that exists in significant numbers in the national economy, considering their age, education, and past work experience; and
- Their disability has lasted or is expected to last for at least one year or result in death.

SSI is a Federal program funded by general tax revenues (not wage and self-employment income taxes) designed to provide cash assistance to aged, blind, and disabled persons with little or no income to meet their basic needs for food, clothing, and shelter. When determining whether an adult claimant for SSI is disabled, we use the same definition of disability as we do for SSDI. In 1996, Congress enacted a unique definition of disability for children.

In addition to cash payments, most SSI beneficiaries receive Medicaid health insurance coverage from the States.

Our disability programs assist some of the most vulnerable members of our society. In fiscal year (FY) 2009, we paid $115 billion in SSDI benefits and over $40 billion in Federal SSI benefits based on disability or blindness. As of December 2009, over 9 million Americans were collecting SSDI benefits and over

6 million Americans were collecting SSI based on disability or blindness. Indeed, our disability programs constitute a crucial part of the fabric of the Nation's social safety net.

Disability Claims Process

Our disability process consists of several stages. When we receive a disability claim, we generally send the claim to a State disability determination service (DDS), which is responsible for developing medical evidence and making the initial determination of whether a claimant meets our definition of disability. We fully fund all costs associated with making these determinations, including the salary and benefits of DDS employees.

If the claimant is dissatisfied with the initial disability determination, our regulations provide for three levels of administrative review. The levels are as follows: a reconsideration by the DDS; a hearing before an administrative law judge (ALJ); and a request for review by our Appeals Council. If the Appeals Council denies the request for review (or if the Appeals Council issues a decision), the claimant may appeal to Federal district court. We are currently testing a prototype project in ten states that authorizes the disability examiner to make the initial disability determination alone (instead of working with a medical or psychological consultant) in some cases and eliminates the reconsideration step.

I will explain each of these steps in more detail. As you know, we face a surge in disability claims due to the economic downturn and the aging of the baby boomers. Therefore, I will also briefly touch upon the steps we are taking to address these workload issues. Thanks to Congress' support, we are currently on-track to reduce pending initial disability claims to a pre-recession level by 2014 and to eliminate the hearings backlog in 2013.

Initial Determination

A claimant can apply for disability benefits online, by telephone, or in a field office. An SSA claims representative interviews all claimants filing their claims by telephone or in a field office. During this interview, the claims representative explains the definition of disability and our disability claims process and obtains all required applications and forms. When claimants file online, our system provides the definition of disability and an explanation of the claims process, and a field office employee reviews the information the claimant provided. Our system will generate alerts when the information appears incomplete or incorrect, and a

claims representative may contact the claimant. If a claim does not require a medical determination, the claims representative may make an initial determination; however, in most cases, the claims representative forwards both paper and electronic claims to the DDS to make a disability determination.

When a disability claim reaches the DDS, a disability examiner handles the claim. The examiner requests evidence, schedules follow-ups, verifies that all medical documentation is complete, and verifies that there is enough medical evidence to make a disability determination. If the examiner needs additional medical evidence, he or she will re-contact the claimant, re-contact the medical source, or schedule a consultative exam.

Once there is sufficient medical evidence to make a determination, the examiner works with a medical or psychological consultant to determine whether the claimant is disabled. Depending on the nature of the disability alleged by the claimant, this medical consultant is a licensed physician, optometrist, podiatrist, or a qualified speech language pathologist. A psychological consultant is a psychologist who has the same responsibilities as a medical consultant, but who can evaluate only mental impairments. When deciding the claim, the examiner and medical or psychological consultant must consider all of the evidence in the file and make a determination based on a preponderance of the evidence. In some States, experienced examiners, known as single decision makers, may make certain disability determinations on their own.

If the DDS finds the claimant to be disabled, we notify the claimant and alert the field office to begin payment effectuation. If the DDS does not find the claimant disabled, the DDS sends the claimant a denial notice that explains the determination and provides the claimant with additional information, such as how to appeal the determination. Any claimant dissatisfied with the initial determination may appeal it by requesting reconsideration.

Nationwide, we expect to receive more than 3.2 million initial disability applications in FY 2010, which represents over 600,000 more than in FY 2008. Through our hard work and improved processes, we will keep initial disability claims pending below the FY 2010 target. However, there will still be approximately 860,000 claims pending at the end of FY 2010.

To keep pace with our increasing initial workloads, we implemented technology solutions, updated and simplified program rules, and adopted initiatives that are helping us reduce our hearings backlog. For example, in FY 2009, we

implemented our easy-to-use online application, iClaim, which allows claimants to file for benefits online at their own pace and at their own convenience. iClaim helps us adjudicate more claims and reduces field office waiting times. We also expanded our adjudicative capacity by hiring additional front-line staff and creating extended service teams to help States keep pace with the increase in disability claims.

Under the President's FY 2011 Budget, we expect to decide over 3.3 million initial disability claims in FY 2011 and begin to reduce the initial claims disability backlog.

As I explained earlier, we fully fund all costs associated with making disability determinations, including salaries and benefits of DDS employees. Nevertheless, some States have furloughed or imposed hiring restrictions on these employees in a misguided attempt to respond to their financial crises. These furloughs succeed only in slowing benefits to some of our most vulnerable citizens, while providing no fiscal relief to the States. We believe the furloughs are unwarranted and would be pleased to further discuss the issue with you.

Reconsideration

The reconsideration stage is the first level of appeal in our disability claims process. A team consisting of a disability examiner and a medical or psychological consultant, neither of whom were involved in making the initial determination, reviews the claimant's case. If necessary, the team will request additional evidence or a new consultative examination.

Like the team that makes the initial determination, the team that makes the reconsideration determination bases the determination on a preponderance of the evidence. The team is not bound by the determination made at the initial level, but rather reviews the evidence *de novo*, with a fresh set of eyes. The reconsideration determination is independent, made without reference to the initial determination.

If the claimant is dissatisfied with the reconsidered determination, the claimant has 60 days after the date he or she receives notice of the determination to request a hearing before an ALJ.

We are seeing a steady increase in our reconsideration workload, which is a direct result of the increase in the number of initial disability claims. Reconsideration

filings rose about 14.3 percent, or 88,897, over this time last year. Despite these challenges, the DDSs have handled 698,071 reconsiderations through August 2010. We fully expect to handle the budgeted level of approximately 722,000 reconsideration claims by fiscal year-end. We are encouraged that we have dramatically increased the number of average weekly reconsideration cases handled throughout the fiscal year from 11,800 in October 2009 to 14,000 in August 2010, an increase of 18.6 percent.

As I noted earlier, we currently are running a prototype project in ten States that eliminates the reconsideration step. The States using this prototype are: Alaska, Alabama, California (Los Angeles West and North Branches), Colorado, Louisiana, Michigan, Missouri, New Hampshire, New York, and Pennsylvania. In these States, a claimant dissatisfied with his or her initial determination may proceed directly to the hearing level by requesting a hearing before an ALJ.

Hearing Level

When a hearing office receives a request for a hearing, the hearing office staff prepares a case file, assigns the case to an ALJ and schedules a hearing. If review of the evidence suggests that we can issue a fully favorable decision without holding a hearing, an ALJ or attorney adjudicator may issue an on-the-record fully favorable decision.

At the hearing, all testimony is taken under oath or affirmation. The claimant may appear in person at the hearing or, under appropriate circumstances, via video. The claimant may have a representative (either an attorney or non-attorney) who can submit evidence and arguments on the claimant's behalf, may testify, and may call witnesses to testify. The ALJ may call vocational and medical experts to offer opinion evidence, and the claimant or the claimant's representative may ask these witnesses questions. An ALJ hearing is a non-adversarial proceeding; the agency is not represented at the hearing.

Following the hearing, the ALJ will take all necessary post-hearing development steps, such as ordering a consultative exam. The ALJ considers all of the evidence in the file when making a decision, including newly submitted evidence and hearing testimony and decides the case based on a preponderance of the evidence. The ALJ decides the case *de novo*; he or she is not bound by the determinations made at the initial and reconsideration levels.

If the claimant is dissatisfied with the ALJ's decision, the claimant has 60 days after he or she receives the decision to request that the Appeals Council review the decision.

Over the last 20 months, we have reduced the number of pending hearings by almost 9 percent despite an increase in hearing requests. Through August 2010, we received over 30,000 more hearing requests in FY 2010 than we received in all of FY 2009. As of August 2010, we had slightly more than 700,000 pending cases, and earlier this year, we reduced the number of pending cases pending below 700,000 cases for the first time since 2005. Over the last four years, we have decided more than half a million cases that were 825 days or older. Even as we eliminated the oldest, most time-consuming cases, we reduced the average time it takes to issue a decision by more than four months. Through August 2010, it has taken us an average of 429 days in FY 2010 to decide a case, which is 56 days below our projected end-of-year target.

Much of our success in reducing the number of pending hearing requests flows from our efforts to hire more employees and open new offices. Congressional support plays an especially critical role in this regard. To date this year, we have hired 229 ALJs and approximately 1,300 additional support staff, allowing us to complete significantly more hearings. With full funding under the President's FY 2011 Budget, we will continue to hire ALJs to maintain an ALJ corps of over 1,400 and to hire the necessary support staff to allow us to eliminate the hearings backlog by the end of FY 2013. To accommodate this additional staff, we opened 18 new offices this year and plan to open 16 new offices next year. Our goal is to reduce the hearings backlog by another 50,000 cases next fiscal year.

Appeals Council

Upon receiving a request for review, the Appeals Council evaluates the ALJ decision, all of the evidence of record, including any new and material evidence that relates to the period on or before the date of the ALJ's decision, and any arguments the claimant or his or her representative submits. The Appeals Council may grant review of the ALJ's decision or it may deny or dismiss a claimant's request for review. The Appeals Council will grant review in a case if there appears to be an abuse of discretion by the ALJ; there is an error of law; the actions, findings, or conclusions of the ALJ are not supported by substantial evidence; or if there is a broad policy or procedural issue that may affect the general public interest.

If the Appeals Council grants a request for review, it may issue a new decision, remand the case to an ALJ, or issue a dismissal of the request for hearing for any reason the ALJ could have dismissed the request. When it reviews a case, the Appeals Council considers all the evidence in the ALJ hearing record (as well as any new and material evidence in certain cases), and when it issues its own decision, it bases the decision on a preponderance of the evidence.

The Appeals Council is also beginning to see a rise in its workload. Through August 2010, the Appeals Council received 114,159 requests for review, which is more than a 6 percent increase over FY 2009. To address this increase, we authorized substantial recruitment and hiring for the Appeals Council during the second half of FY 2009. We revamped our training programs to take advantage of recent technological improvements, and many of our employees have exceeded performance expectations during their training period. As the newly hired employees have become more productive, Appeals Council dispositions have begun to approach the level of requests for review. We expect dispositions to outpace receipts during FY 2011. We are also striving to reduce court orders of remand by improving the overall quality and legal sufficiency of our decisions through training, quality assurance efforts, and the expanded use of electronic case analysis tools.

If the claimant has completed our administrative review process and is dissatisfied with our final decision, and the final decision is not an Appeals Council dismissal, the claimant may seek review of that final decision by filing a complaint in Federal district court.

Federal District Court

If the Appeals Council makes a decision, that decision is the final agency decision. If the Appeals Council denies the claimant's request for review of the ALJ's decision, the ALJ's decision becomes our final decision. A claimant who wishes to appeal a decision by the Appeals Council or its denial of a request for review has 60 days after receipt of notice of the Appeals Council's action to file a complaint in Federal district court. When we file our answer to that complaint, we also file with the court a certified copy of the administrative record developed during our adjudication of the claim for benefits.

The Federal district court considers two broad inquiries when reviewing one of our decisions: whether we have followed the correct legal standard and whether our decision is supported by substantial evidence of record. On the first inquiry –

whether we have applied the correct law – the court will consider issues such as whether the ALJ applied the correct legal standard for evaluating credibility or a treating physician's opinion, whether we followed the correct procedures, or whether our interpretation of a relevant statutory provision is correct. Since these issues are issues of law, the court will consider them *de novo*, but should give our views on these issues substantial deference.

The court will also consider whether our decision is supported by the factual evidence developed during the administrative proceedings. The court does not review our findings of fact *de novo,* but rather considers whether those findings are supported by substantial evidence. This "substantial evidence" standard is prescribed by the Act, which provides that, on judicial review of our decisions, our findings "as to any fact, if supported by substantial evidence, shall be conclusive." The Supreme Court has defined substantial evidence as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion," and characterized it as more than a mere scintilla, but less than a preponderance. The reviewing court will consider evidence that supports the ALJ's findings as well as evidence that detracts from the ALJ's decision. However, if the court finds there is conflicting evidence which could allow reasonable minds to differ as to the claimant's disability, and the ALJ's findings are one of those possible interpretations of the evidence, the court must affirm the ALJ's findings of fact.

If, after reviewing the record as a whole, the court concludes that substantial evidence supports the ALJ's findings of fact and the ALJ applied the correct legal standards, the court will affirm our final decision. If the court finds either that we failed to follow the correct legal standards or that the our findings of fact are not supported by substantial evidence, the court may remand the case back to us for further administrative proceedings, or in some instances, reverse our final decision and find the claimant disabled.

Conclusion

Since 1956, Social Security disability benefits have provided a vital safety net for those Americans who constitute the most vulnerable segment of society. Our administrative review process has been described by the Supreme Court as "unusually protective" of the claimant and strives to ensure that a person who truly needs disability benefits receives them.

Reducing the disability claims backlog remains our top priority. Full funding under the President's FY 2011 Budget will allow us to take the next step in reducing our backlog over the next several years.