

Prepared Remarks of Senator Tom Coburn
Hearing of the Permanent Subcommittee on Investigations
Social Security Disability Programs:
Improving the Quality of Benefit Award Decisions
September 13, 2012

I would like to thank Senator Levin for holding this hearing and his staff for putting so much work into both this investigation and this report. This Subcommittee has a rare history of bipartisanship and a respect for the investigative process. Without the support of Chairman Levin, this investigation would not have been possible.

We are here to discuss a new investigative report which examines how the Social Security Administration approves claims for both Social Security Disability Insurance and for Supplemental Security Income.

Introduction. Over the last several years, it has become clearer that the disability programs are teetering on financial bankruptcy. According to the Congressional Budget Office, as soon as three or four years from now, there may not be enough money to keep paying out full benefits.

The Social Security Trustees – a body that reports on the programs’ financial condition – have also concluded the disability insurance program may go bankrupt as early as 2015. The reason is that the rolls have grown faster than anticipated.

Since January 2009, SSA has added 5.9 million Americans to the disability rolls. In 2011, 10.6 million people were receiving over \$128 billion in disability insurance payments.

The question is: are benefits going only to those who are supposed to be getting to them?

Millions of our neighbors depend on these programs to replace a portion of the income they earned before they became disabled. For many of them, the disability programs are a lifeline, without which they would be overwhelmed.

For the past 18 months, the Subcommittee has conducted a bipartisan investigation into how well the Social Security Administration is running these programs. Our hope is that where we find problems, we might also offer solutions.

We decided to take a detailed look at a random selection of 300 case files, all of which came from three counties and represented a broad mix of disability applicants.

We carefully chose three areas of the country that had different concentrations of people receiving disability benefits – from high to low. We worked closely with the Social Security Administration to develop a methodology that would yield meaningful results.

One of the places we looked at was Oklahoma City in my own home state. It was and is my firm belief that if Congress is going to get serious about reforming government, oversight must start at home.

Unfortunately, some of the worst problems I saw were in my own home state.

The good news is that Oklahoma is also home to a disability success story. The Oklahoma Department of Rehabilitation Services is helping set individuals on disability back into the work force and become productive, self-sufficient Americans. One individual there, Jason Price, developed a system of giving

monetary incentives to vocational rehabilitation counselors who found work for disability recipients through the Ticket to Work program. In 2010 alone, Price's initiatives resulted in 135 severely disabled individuals going back to work, ending their dependence on disability payments. The state recouped over \$2.3 million. I am proud of his work and hope other states look to Oklahoma to see how to get even the severely disabled back into the work force.

Background. To understand the problems we uncovered, it is important to explain how someone gets disability benefits. The first step is that a person applies at his or her local Social Security office. They are eligible for benefits starting the day their disability began, not simply on the date they apply. To support their claim, they can submit medical records if they have them. If they do not have them the agency will pay for them to go to a "consultative exam." This forms SSA's basis of evaluating someone's initial claim.

The local office does not make the initial decisions. Rather, this is done by the state-level Disability Determination Service, or DDS. There is one DDS office in each state, and it is here that nearly 2.5 million applications are first dealt with each year.

If it is denied at the DDS level, a person can ask DDS to have different doctors take a second look – a process called "reconsideration." If it is denied again, the person can appeal once more to request a hearing before an administrative law judge.

At this level, a claimant's case is supposed to get a fresh review by an impartial judge, who has independence to decide cases on their merits, and is not bound by the prior DDS decisions. Social Security has more than 1,300 ALJs, who handle the 700,000 appeals they get each year.

If an ALJ denies a case, a claimant can appeal to the Social Security Appeals Council, and from there any unresolved cases go to Federal court. In all, a person can have their claim heard at five levels of review. The Subcommittee focused only on the four levels of review within the Social Security Administration, but not the Federal courts.

Findings. The results of our inquiry were deeply troubling. Our investigation found poor quality decisions being made about cases at every level of review. Over and over again, this investigation found that the Social Security Administration failed to follow program rules and procedures.

The importance of SSA getting decisions right cannot be overstated. Every disability award is estimated to cost \$300,000 in lifetime benefits.

Moreover, the agency rarely checks to see if a person's condition improves. While it is supposed to perform "continuing disability reviews" to see if someone is still disabled, the agency simply sends out postcards asking the person how they're doing.

When benefits go to people who are not entitled to them, it weakens the whole program.

Overall, the Subcommittee found serious flaws in more than a quarter of the 300 cases we reviewed. So, while I'm not sure if their decisions were right or wrong, I do know they didn't follow the rules.

Throughout the 300 case files, we found:

- cases with contradictory medical evidence that went unexplained;
- cases in which the medical records did not match the claimed disability;
- cases that lacked any relevant medical evidence at all;

- cases in which someone’s doctor noted that they were non-compliant with prescribed treatments, but awarded benefits anyway; and
- cases where the agency failed to properly address a person’s drug and alcohol abuse.

The most concerning findings involved decisions made by a few of the agency’s Administrative Law Judges. This was consistent with a review recently done by the agency itself. In 2011, SSA’s Appeals Council found a 22 percent error rate in cases it reviewed that were made by ALJs.¹ In the Dallas region, which includes Oklahoma City, the ALJ error rate was over 26 percent.

The kinds of problems we found with ALJ cases were both numerous and troubling. ALJs approved people that had conflicting, missing and insufficient evidence.

First, in several claimants’ own doctors accused them of “malingering” – a medical term for exaggerating symptoms – but judges disregarded it.

Second, many judges held perfunctory hearings at which claimants didn’t even say a word. Despite involving some of the most complicated cases, some hearings lasted only three minutes – leaving barely enough time to gavel in and gavel out.

A third problem involved judges using late-arriving evidence, which the agency discourages. Some ALJs raised red flags about what they called “dead man’s reports” and “store bought opinions.”

Fourth, some ALJs would ask vocational experts leading questions that could result in only one answer: that a person was disabled.

While SSA officials interviewed by the Subcommittee acknowledged that all of these were significant problems, they said there was little they could do about it. By law, ALJs are given a lot of independence to make their decisions.

The result is a tension between the agency’s ability to control the quantity and quality of a judge’s work. Many people we interviewed said this tension was evident in how the Social Security Administration tried to reduce its enormous disability case backlog.

Nearly everyone we talked to said there was enormous pressure on judges to push through as many cases as possible. In May 2007, Commissioner Michael Astrue told Congress he would end the growing wait time for an ALJ hearing. To reduce this wait time the agency encouraged judges, where appropriate, to consider skipping hearings and write decisions “on the record.”

One judge we encountered in our investigation played a big role in this effort. Between 2007 and 2009, ALJ Howard O’Bryan, from the Oklahoma City office, single-handedly decided 5,401 cases - almost all of them on the record and without a hearing. His decision rate was nearly four times faster than the average judge’s. In terms of cost, Judge Howard O’Bryan alone awarded **an estimated \$1.62 billion dollars** in lifetime benefits to claimants in just three years.

I was at first astounded that one person could decide 1,800 cases per year – especially since each case is nearly 500 pages long. On average, he decided five cases per day, 365 days per year.

¹ Office of Appellate Operations, Executive Director’s Broadcast, Vol. 3, Special Ed. – Quality Review (January 13, 2012).

I soon learned, though, that he could move through them so quickly because the quality of his work left so much to be desired. Unlike the other ALJs, Judge O’Bryan’ simply cut-and-pasted electronic images of medical evidence into his decisions. To speed up the process even more, instead of specifically listing and discussing all of a claimant’s medical impairments, he would just write “etc, etc, etc.”

Worse still, the images Judge O’Bryan would paste into his opinions would sometimes have nothing to do with a person’s claim for disability. In several cases, the records he pasted said the opposite of his findings. For example, in one case he found someone could no longer work, but pasted in a medical record that concluded the, “Claimant can adapt to a work situation.”

Judge O’Bryan was eventually asked by the agency to improve his decision writing. But, instead of reducing his caseload to a manageable level, the agency began shipping him cases from around the nation. He told us that at one point he was asked to do 500 cases just from Little Rock, Arkansas – an average judge’s caseload for the an entire year. When he finished those, he was sent cases from Atlanta, Houston, Greenville, Des Moines and Yakima, Washington.

Why the Social Security Administration did this is a question I hope to have answered today. My suspicion is that they wanted to erase the backlog, and cared little how they got it down.

The problems we found were not limited to ALJs, though. The Subcommittee also identified a number of issues with the cases the state Disability Determination Services were making at the initial application and reconsideration levels as well.

One of the biggest problems was in how the agency used its Medical-Vocational Rules. This complex set of rules – also known as the “grids” – are for people who do not qualify under the more difficult “medical listings,” but might still be disabled.

The grids contain a variety of factors – such as a person’s age, education and work experience – laid out in a large set of charts. Depending on whether a claimant can perform sedentary, light, medium or heavy work, agency decision-makers can use the charts to find out whether someone is “disabled” or “not disabled.” Finding someone disabled this way is referred to in the agency as “gridding.”

While most disability awards were at one time made to people who met the medical listings, today it is the opposite. A recent analysis by the agency found that ALJs awarded benefits through the vocational grids four times more often than through the medical listings.²

Another problem is that the grids are easily skirted. Frequently, the Subcommittee found that even if the grid found someone “not disabled,” ALJs would overrule it and award disability benefits, anyway.

The most frequently seen problems involved the use of a claimant’s age. The grids relax the rules for claimants once they turn 50 and then again at 55, making it progressively easier for applicants to be accepted when they hit these ages.

In a lot of cases, the grids found someone was too young when their ailment started, and so they were not disabled. The ALJs, then, would just change the disability onset date to the claimant’s 50th or 55th birthday. By doing so, the claimant now qualified under the grids. Nothing indicated that the person was more disabled on their 50th birthday than they were the day before.

² Office of Appellate Operations, Executive Director’s Broadcast, Vol. 3, Special Ed. – Quality Review (January 13, 2012).

Conclusion. The purpose of this program is to make sure that all Americans have a safety net if they become disabled and can no longer work. It should be remembered, though, that by law being disabled means “being unable to work any job in the national economy” – this is a high bar to meet. The agency must make sure it is not awarding benefits to people who are not entitled to them. If something doesn’t change, and the programs continue to operate this way, there won’t be a safety net left for those who have no other choice but to rely on it.

Today’s Subcommittee investigation lays out problems and offers solutions. But, it is also a plea for Congress to start doing its job. Some basic reforms, many of which are outlined in this report, would go a long way in helping the agency make these tough decisions.

We can start by putting a government attorney in ALJ hearings, which would enhance the accuracy of ALJ decision-making and make sure someone represents the taxpayer. This one reform alone would provide a much needed balance, since 94 percent of claimants are represented. Such a reform is already supported by the ALJ Union and has been a long-time recommendation of the Social Security Advisory Board, the bi-partisan board created to advise the President and Congress of changes needed to the agency’s programs.

Other simple changes would also go a long way:

- The evidentiary record should close at least a week before the ALJ hearing, which would let everyone have time to review the files. Late evidence would simply mean rescheduling a hearing.
- The vocational grids must be eliminated or reformed so that someone who is fifty years old is no longer “approaching advanced age in the United States.”

These, and other reforms, are outlined in today’s report.

I want to thank the witnesses for being here today and look forward to their testimony.