NOSSCR | NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
ESTABLISHED 1979

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Commissioner Martin O'Malley
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

Dear Commissioner O'Malley,

Thank you for taking on the responsibility of leading the Social Security Administration as Commissioner. We trust that you will succeed in enhancing the delivery of SSA's critical services to millions of Americans, having witnessed your impressive record of accomplishments as Mayor of Baltimore and Governor of Maryland.

The National Organization of Social Security Claimants' Representatives (NOSSCR) is a specialized bar association of thousands of attorneys and advocates who represent Social Security disability claimants nationwide throughout the adjudicative process. Given our dedicated practice area, we are uniquely positioned to work with you, and SSA generally to provide timely and accurate disability decisions, due process appeals, with successfully modernized customer service.

NOSSCR identifies several challenges facing SSA's disability adjudication process, and we write to provide this outline of our proposed solutions.

These topics require that SSA remain open to collaboration with stakeholders. NOSSCR and other advocacy groups are eager to work with SSA to deliver world-class service to claimants, while not sacrificing accuracy. NOSSCR has experienced varying levels of openness during the terms of Commissioners, and we are confident that your approach will include this valuable outside investment.

Some of these proposed solutions are put forward not only by advocates, but also by the federal judges who review thousands of disability decisions. An orientation to Social Security law includes the term "nonacquiescence."[1] Too often, SSA's judges are left to violate the laws as interpreted (often for many years, repeatedly) by circuit courts of appeal—on such basic issues as whether SSA should favorably consider opinions from treating doctors or decide claims using reliable vocational information.[2]

[1] Generally, "nonacquiescence" is "the intentional failure by one branch of the government to comply with the decision of another." https://en.wikipedia.org/wiki/Nonacquiescence
[2] https://www.washingtonpost.com/politics/2023/05/25/social-security-disability-denials-court-remands/

Issue 1: Growing claims backlog

NOSSCR raised the alarm about extreme delays and a growing claims backlog two years ago,[3] and the problem has now grown beyond remedies to be found in staffing levels or funding. Significant policy corrections need to be made. As NOSSCR testified in a recent Ways and Means hearing, near-term solutions are available and within your authority.[4]

Despite a significant decrease in the overall volume of disability claims,[5] the average initial-stages processing time has increased substantially.[6] From 2010 to 2022, Disability Insurance claims sent for review to a state Disability Determination Services (DDS) declined by 37%.[7] In the same period Supplemental Security Income (SSI) disability claims dropped by 49%.[8] This historic decline in workload far outpaced changes in SSA staffing, SSA appropriations, DDS staffing, and DDS costs.

Solution: Use statutory authority to take over the substantially failing DDS programs

SSA regulations provide for disability claim adjudication "standards of performance" at the initial stages where SSA engages with state DDS agencies.[9] SSA's "threshold level"—the "minimum acceptable level of performance"—is 49.5 days for SSDI claims and 57.9 days for SSI claims.[10] These regulations provide steps SSA can take to address poor-performing DDS agencies. Since 1981, when these standards were first established, the threshold level of days has *never* been met, and yet SSA has *never* used its statutory authority to take over for a "substantially failing" DDS.[11]

From 2013 through 2018, the average time from initial claim filing to determination was consistently around 110 days. SSA added another ten days to this process in both 2019 and 2020. Then, in 2021, the average processing time jumped to 165 days, then 184 days in 2022, followed by 217 days in 2023. While field offices closed in the early days of the pandemic, the processing delays were already on the rise in 2019 and have continued to increase dramatically since SSA reopened in April 2022.[12]

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[3] https://nosscr.org/were-fast-approaching-one-million-people-awaiting-decisions/ ; https://nosscr.org/a-grim-milestone-more-than-one-million-pending-disability-cases/
[4] https://waysandmeans.house.gov/event/social-security-subcommittee-hearing-on-one-million-claims-and-growing-improving-social-securitys-disability-adjudication-process/
[5] https://www.ssa.gov/open/data/program-service-centers.html; https://www.ssa.gov/oact/STATS/dibStat.html
[6] https://www.ssa.gov/open/data/Combined-Disability-Processing-Time.html
[7] https://www.ssa.gov/oact/STATS/dibGraphs.html
[8] https://www.ssa.gov/OACT/ssir/SSI23/index.html
[9] 20 C.F.R. § 404.1641
[10] 20 C.F.R. § 404.1642
[11] https://www.ssab.gov/research/social-security-and-state-dds-agencies-partnership-in-need-of-attention/
[12] https://blog.ssa.gov/social-security-administration-to-resume-in-person-services-at-local-social-security-offices/

SSA should use the authority detailed in 20 C.F.R. §§ 404.1641, 404.1642 to take over the plainly failed DDS programs in South Carolina, Florida, eastern Virginia, and eastern Oklahoma, where claimants now wait more than 300 days to receive a decision at the initial level of the disability claim process.[13]

Solution: Eliminate reconsideration

Half of the processing time at the initial (DDS) stages is consumed by the optional second step—"reconsideration." For almost 40 years, Congress and experts have urged SSA to consider eliminating reconsideration, and SSA has formally questioned the efficacy and efficiency of continuing the reconsideration stage.[14] SSA has piloted alterations and eliminations of reconsideration several times since 1984. In 1994, SSA planned to eliminate reconsideration by 1998, but it did not do so.[15] SSA announced in 1999 a pilot program eliminating reconsideration in 10 states—covering 20% of applicants—and successfully did so for nearly 20 years.[16] SSA's rationale for elimination of reconsideration still applies: "better determinations at the initial level … claimants were able to receive benefits months sooner … the quality of our determinations improved … permitted the State agencies to redirect their resources so that the individuals who formerly worked on reconsideration claims could work on initial claims … permitted increased contact with the claimants and improved documentation…."[17]

All these efforts point to the same conclusion—eliminating reconsideration would make the initial stage more meaningful, promoting greater decisional fairness, consistency, efficiency, and integrity while conserving costs and staff time.[18] NOSSCR members know reconsideration is merely a "rubber stamp," adding months to the process and resulting in identical findings on more than 90% of claims. Reconsideration findings—despite having been provided by a different paid consultant—normally mirror initial findings word-for-word over several pages. As SSAB recently observed, "stakeholders report that

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[13] https://www.ssa.gov/foia/readingroom.html, Initial and Reconsideration Processing Times Data as of 2-24-23.

[14] *See, e.g.,* 58 F.R. 54533 (Oct. 22, 1993), discussing 1984 study requirements unmet (https://www.federalregister.gov/citation/58-FR-54533).

[15] *Process Re-engineering Program, Disability Reengineering Project Plan*, 59 F.R. 47887 (Sep. 14, 1994).

[16] *Modifications to the Disability Determination Process; Disability Claims Process Redesign Prototype*, 64 F.R. 47218, 47219 (Aug. 20, 1999).

[17] *New Disability Claims Process*, 66 F.R. 5494, 5495 (Jan. 19, 2001).

[18] Jon C. Dubin, "Social Security Disability Adjudicative Reform: Ending the Reconsideration Stage of SSDI Adjudication after Sixteen Years of Testing and Enhancing Initial Stage Record Development," *SSDI Solutions*, Committee for a Responsible Federal Budget, 2016, 3-4: "the reconsideration stage lacks meaningful or sound public policy justification. It mandates devotion of agency resources for an entire additional adjudicative stage with attendant personnel and administrative costs for three quarter of a million annual reconsideration decisions, imposes significant delays in adjudicative results for a vast majority of claims initially denied, and produces limited tangible adjudicative benefits."

reconsideration does not typically involve more new [medical evidence] or new impairments and leads to a relatively small percentage of claims being allowed…."[19]

Rarely is a problem accompanied by the possibility of such a direct solution. You have authority to cut the claims delay in half while upgrading quality and allowing for reallocation of existing resources. NOSSCR is interested in building a partnership with SSA that encourages more representative involvement at the initial claim level, thereby ensuring that claims are properly submitted with the required documentation, allowing for more accurate and timely decision-making at the initial level.

Issue 2: Excessive number of overpayments with collection practices and policies that fail to consider equity and good conscience

SSA's overpayments and collection practices have recently received increased scrutiny—both politically and in the media.[20] NOSSCR agrees with Senator Wyden that there are far too many "overpayments and clawbacks," and with Representative Ferguson that we must not "continue to go down the road" of more and more overpayments based on inefficient systems, poor communication, and policies that fail to include SSA's existing authority to consider equity and good conscience.

Solution: Obtain payroll data directly from payroll providers

Most overpayments are of SSI benefits, and the largest cause of SSI overpayments is the extremely difficult process of reporting wages to SSA and getting SSA to make timely adjustments.

For SSI purposes, income is counted monthly.[21] Claimants must report earnings to SSA, hoping for those submissions to be processed within days and resulting in an updated SSI payment in the following month. NOSSCR's advocates know that reporting anything to SSA can take multiple attempts—and pay stubs are no exception. Even with successful reporting, SSA rarely updates SSI eligibility within six months (almost never as of the following month)—creating predictable overpayments for SSI claimants attempting a return to work.

This problem was already solved by authorizing SSA to obtain data directly from payroll providers. That was in the Bipartisan Budget Act of 2015,[22] which became law on November 2, 2015. Eight years later, we await SSA's implementation.

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[19] https://www.ssab.gov/research/medical-evidence-collection-in-adult-social-security-disability-claims/

[20] https://www.cbsnews.com/news/preventing-social-security-overpayments-60-minutes/; https://kffhealthnews.org/news/article/senator-ron-wyden-social-security-administration-monthly-meetings/; https://www.cbsnews.com/news/social-security-overpayment-notices-kijakazi-congress-kff/; https://kffhealthnews.org/news/article/federal-government-to-review-social-security-overpayments/

[21] 20 C.F.R. §§ 416.1100, 416.1111

[22] https://www.ssa.gov/legislation/legis_bulletin_110315.html

Solution: Educate claimants about work incentives

SSA's failure to modernize wage reporting has a negative ripple effect through the various work incentives provisions provided by Congress to allow claimants to return to work safely.

For example, the first $65 of earned income in a month does not reduce an SSI payment.[23] This could serve as an excellent way for SSI recipients to start a return to work, but they are often advised to ignore such provisions—there is little point in taking advantage of work incentives if work activity produces a complete cessation of eligibility many months later when a backlog of paystubs produces a "clawback" notice.

For another example, the Ticket to Work program provides free access for beneficiaries to employment and vocational rehabilitation services. In comparison to the large number of claimants who attempt returns to work, a much smaller number do so while assisted by the statutory protections of a "Ticket."[24] An aggressive marketing campaign is needed—to make sure all beneficiaries with a desire to return to work understand that they can do so without the normal risks of a disability review, loss of cash benefits, or loss of health insurance.

NOSSCR is preparing to help SSA educate beneficiaries about the Ticket to Work program, along with best practices to prevent overpayments or seek waivers—through the advocates who helped them obtain eligibility for benefits. For the first time in NOSSCR's history, we are devoting a full day of our annual conference to overpayments and the work incentives that could prevent them—Saturday, May 11, 2024 in Nashville. We invite SSA's participation.

Solution: Update regulations to acknowledge the role of SSA's mistakes, allowing for full consideration of equity and good conscience

Current SSA policy is to ignore SSA's role in creating an overpayment—despite many of them being created following failures to process information, inaccurate advice, or poor communications to beneficiaries.[25] NOSSCR proposes that SSA's regulations be amended to remedy this lack of fair assessment of waiver requests.

[23] 20 C.F.R. § 416.1112(c)(5)
[24] https://www.gao.gov/products/gao-22-104031
[25] https://www.ssa.gov/OP_Home/cfr20/404/404-0507.htm

SSA should add to 20 C.F.R. § 404.509: "It shall be presumed that recovery would be against equity and good conscience if the substantial facts resulting in the overpayment occurred more than 18 months prior to your receipt of notice of the overpayment, or if you provide evidence that you gave SSA information reasonably sufficient for SSA to have calculated your benefits accurately."

SSA should strike from 20 C.F.R. § 404.507: "Although the Administration may have been at fault in making the overpayment, that fact does not relieve the overpaid individual or any other individual from whom the Administration seeks to recover the overpayment from liability for repayment if such individual is not without fault." SSA should strike from section 416.552: "The overpaid individual (and any other individual from whom the Social Security Administration seeks to recover the overpayment) is not relieved of liability and is not without fault solely because the Social Security Administration may have been at fault in making the overpayment." Both of these lines should be replaced with: "The Administration may have been at fault in making the overpayment, and if so that fact will be considered in our analysis of whether the overpaid individual or any other individual is at fault."

Solution: Acknowledge what claimants believe they are communicating to SSA

A reasonable person assumes that SSA is automatically notified of earnings—without needing to send SSA a copy of the pay stub. Regardless of the abbreviations used by a payroll service, all payroll reports describe some funds going from each paycheck into the Social Security system. NOSSCR's members know that beneficiaries are often stunned to learn that SSA doesn't know about every paycheck automatically—"they got money from it, how could they not know." This is both rational and predictable, and yet SSA's policies assume that SSA does not have any access to this payroll information, while simultaneously burdening the recipient with seemingly redundant reporting requirements that even when met are frequently missed by SSA (mailed documents are often not acknowledged).

SSA's regulations must be adjusted to acknowledge this simple logic. Beneficiaries are not trying to hide earnings when they are paying into the disability Trust Fund. Commonsense dictates that SSA has already been informed about the money they received. Thus, any resulting overpayments are not the beneficiary's fault.

Solution: Better notices

SSA's overpayment notices fail to provide claimants with a clear month-by-month accounting and all options available for a waiver, payment plan, or direct appeal of the underlying facts. Overpaid claimants would better understand their options and whether SSA's actions were correct if they were given informative notices, a full copy of all documents considered by SSA, with guidance on next steps. NOSSCR and other advocacy organizations are eager to work with SSA on improving this process.

Issue 3: Representation fees that limit access to quality advocates, and the failure to annually adjust the representative fee cap

Quality advocacy for disabled claimants requires that their representatives can earn reasonable fees that are periodically adjusted for inflation. While the representative "fee cap" was adjusted in 2022, it was only a partial increase, immediately followed by extraordinary inflation.

Solution: Raise the fee cap to $9,200 and establish an annual cadence

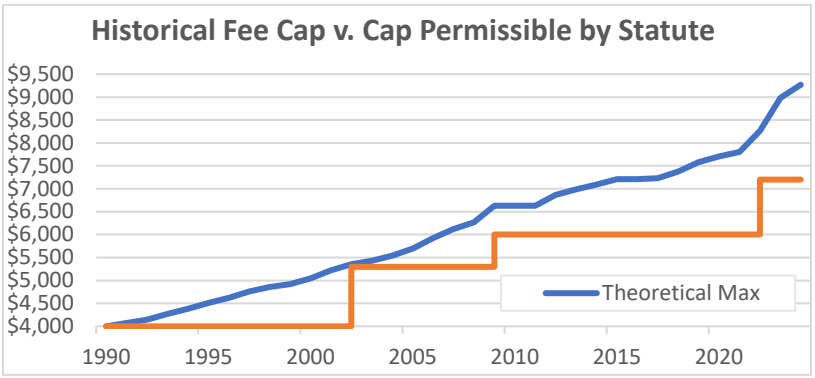
As you stated during your confirmation hearing, "people in the disability advocacy community, and also people who for a living represent people when they are filing appeals, that's a wealth of information that can come back to improve this process, eliminate redundancies, and get people the justice and the help they deserve." We absolutely agree, and that is why we write to encourage you to use your power as Commissioner under Section 206(a(2)(A) of the Social Security Act to update the fee cap, so that our members can continue this vital work. The fee cap is the maximum dollar amount a representative can receive for successful representation of a claimant. The authority to make adjustments to this cap was granted to the Commissioner by the Omnibus Budget Reconciliation Act (OBRA) of 1990. Commissioner Barnhart exercised this authority in 2002, Commissioner Astrue in 2009, and most recently, Commissioner Kijakazi in 2022. However, despite the previous adjustments, the current fee cap fails to keep up with the rate of inflation, thereby denying adequate compensation to representatives and drastically limiting claimants' access to valuable representation.

In 1990, the fee cap was $4,000. To match the purchasing power of the 1990 fee cap, the current fee cap should now be $9,200. By not matching the rate of inflation, the existing $7,200 fee cap falls short in covering representatives' required inflation-based expenses such as hiring skilled staff, purchasing technology, advancing payments for claimants' medical records, and managing other necessary costs to ensure that claimants receive the high-quality representation they deserve. The gap between the fee cap and the Commissioner's statutory authority to recognize inflation—the "cap gap"—is devastating for claimants' representatives, most of whom are small business owners who have been forced to reduce the type of case they can take, have laid off staff, or have left the practice of disability law altogether.

By raising the fee cap to the statutorily permitted amount of $9,200, you can improve access to representation for vulnerable individuals navigating the complex Social Security system. This, in turn, ensures that claimants receive the necessary assistance to obtain the benefits they rightfully deserve. Enhancing access to representation aligns with the agency's goal of streamlining processes and delivering fair determinations to claimants.[26]

[26] Representation rates are declining at steps of the disability claims process where representation is vital. https://www.ssa.gov/foia/resources/proactivedisclosure/2023/Representative%20Rates%20by%20Adjudicative%20Level%20FY%202014%20-%20FY%202023.pdf

Adjusting the fee cap has zero cost to Social Security's trust funds or to general revenues. There would be no change to SSA's ability to oversee and authorize fees, or to the Social Security Act's limitation on fee agreements to the lesser of 25% of past-due benefits or the fee cap.



We are eager for you to make this necessary change as soon as possible, for the benefit of disability claimants and those who represent them. We appreciate your attention to this critical issue and look forward to your continued dedication to improving the lives of individuals who rely on the Social Security system for their well-being.

Issue 4: SSA policies unfairly harm disability claimants, slow the process, and increase costs

In recent years, SSA has increased the complexity of disability analysis regulations—almost always to the detriment of claimants—while removing simple methods for saving time and money.

Solution: Restore the treating physician rule

In recent years, SSA has refused to trust the expert opinions of treating physicians—slowing decisionmakers and reducing accuracy.[27] Until 2017, adjudicators were permitted to give weight to opinions provided by a claimant's treating physician—honoring expertise, the benefits of repeated examinations, longitudinal history, and specialization.[28] Now, those opinions are largely disregarded—SSA will "not defer or give any specific evidentiary weight" to opinions from treating physicians.[29] Restoring the treating physician rule would help adjudicators quickly identify meritorious claims and rule on them while considering the most reliable evidence.

[27] https://www.ssab.gov/research/social-security-and-state-dds-agencies-partnership-in-need-of-attention/ at 17, *citing* "a survey of DDS directors" confirming "greater adjudicative complexity through regulatory revisions" cause "strain on the system."
[28] 20 C.F.R. § 404.1527
[29] 20 C.F.R. § 404.1520c

Solution: Remove bias against veterans

The same rule change (concerning treating physician evidence) has created a bias against veterans in the SSA disability claims process. SSA no longer requires adjudicators to consider the findings of other agencies—particularly the Department of Veterans Affairs (VA). Adjudicators are no longer required to provide analysis of VA findings, and the VA's decisions are declared "neither valuable nor persuasive."[30] This has caused veterans—including those already found 100% disabled by the VA—to be denied at higher rates than non-veterans. NOSSCR has provided data to Ways and Means confirming that having served in our nation's armed forces, including having been found 100% disabled by the VA, causes SSA to be more likely to deny the claim. This is fundamentally offensive and must be remedied immediately.

Solution: Prioritize obtaining existing evidence before spending on consultants

Regulations require SSA to request and receive medical records from all of a claimant's medical providers.[31] Most records are requested using a medical release form (SSA-827)[32] and sending the request by postal mail or fax.[33] Per the regulations, SSA will make "every reasonable effort" to obtain treating source evidence. They will submit an initial request for records, and "at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, [DDS] will make one follow-up request to obtain the medical evidence necessary to make a determination."[34] Thereafter, the source will have a minimum of ten days from the date of the follow-up request to reply.

According to HIPAA, healthcare providers can take up to 30 days to deliver records—longer with extensions.[35] But per the SSA regulations it is possible the DDS examiner is only waiting 20 days for the records without attempts to verify that the requests were received.[36] When medical records are not received within this timeline, DDS will often send the claimant to a paid consultant for examination.[37] The agency's guidelines indicate that the "claimant's own medical source(s) is generally the preferred [examination] source;"[38] however, it is NOSSCR's practical experience that this is not DDS practice. Informal surveys of our members confirm that we have never seen it done. DDS always opts to use a paid contractor without asking the treating physician first.

Consultative examiners have no treating relationship with the claimant and often review no other evidence. In contrast, treating physicians are more familiar with the claimant's medical history, longitudinal treatment, and prognosis.

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[30] 20 C.F.R. § 404.1520b(c)
[31] 20 C.F.R. § 404.1512(b)
[32] https://www.ssa.gov/forms/ssa-827.pdf
[33] https://secure.ssa.gov/poms.nsf/lnx/0422505006
[34] 20 C.F.R. § 404.1512(b)(i)
[35] https://www.healthit.gov/how-to-get-your-health-record/get-it/
[36] 20 C.F.R. § 404.1512(b)(i)
[37] POMS DI 22510.005
[38] POMS DI 22510.010

SSA's Limitation on Administrative Expenses (LAE) confirms SSA is not tracking whether exams are conducted by treating providers. Purchasing consultative examinations cost more than $300,000,000 in 2021.[39] In practice, SSA could first ask treating providers to perform examinations to determine functional limitations.

This practical change could improve the integrity of the information DDS receives and reviews in evaluating claims, resulting in greater decisional accuracy. Ongoing litigation and complaints filed against doctors and other entities performing contracted examinations suggest that SSA is not adequately monitoring its contractors. Midwest CES, a contractor in the Kansas City region, repeated word-for-word important paragraphs in reports for hundreds of claimants. A lawsuit describes that Midwest CES reported that claimants could use their hands and fingers to button and unbutton a shirt and turn a doorknob, for claimants in t-shirts and in an office without a doorknob. SSA paid Midwest CES over $900,000 in 2022.[40]

Relying on examinations done by treating physicians would help SSA make faster, more accurate medical determinations.

Solution: Rely on modern vocational data

In determining whether claimants can return to their past work or perform other work in the national economy, SSA relies on the *Dictionary of Occupational Titles* (DOT), which was last updated in 1991.[41] Changes to occupations in the last thirty-two years cannot be found in the DOT. To put this into perspective, the last time the DOT was updated, George H. W. Bush was President. In 1991, less than 50% of Americans used a computer at home or work.[42] NOSSCR is told that there are no remaining copies of the DOT in the Department of Labor's offices, and they no longer support using it.[43]

A replacement for the DOT has already been paid for and produced for SSA's use by the Department of Labor—the Occupational Information System (OIS).[44] NOSSCR's members use it to question vocational witnesses. However, despite having spent more than $239 million[45] on the project thus far, SSA has still not told adjudicators to use it.

[39] https://www.ssa.gov/budget/assets/materials/2023/2023LAE.pdf
[40] https://www.kansascity.com/news/local/article264793779.html
[41] https://www.dol.gov/agencies/oalj/topics/libraries/LIBDOT
[42] https://www.pewresearch.org/internet/2014/02/27/part-1-how-the-internet-has-woven-itself-into-american-life/
[43] https://www.dol.gov/agencies/oalj/topics/libraries/LIBDOT
[44] https://www.bls.gov/ors/
[45] https://www.ssa.gov/disabilityresearch/documents/Fact%20Sheet%20-%20Occupational%20Information%20System%20Project.pdf

Instead, SSA relies on occupational data from generations ago to get decisions wrong. Many of the DOT occupations are obsolete. For example, a tube operator (DOT 239.687-014) "[r]eceives and routes messages through pneumatic-tube system." This occupation was replaced by email, and yet SSA routinely cites it to claimants. Often SSA cites "addresser" (DOT 209.587-010). An addresser "[a]ddresses by hand or typewriter, envelopes, cards, advertising literature, packages and similar items for mailing." Courts agree that this isn't done in modern computerized times. In *Hardine v. Comm'r of Soc. Sec.*, the district court found: "Why the vocational experts continue to rely on this particular [obsolete] job rather than so many others provided in the enormous DOT is a puzzle, but the Court will not accept it any more than it would accept the job of lamplighter."[46]

SSA must switch to the OIS immediately, allowing for reliable decisions and resulting in fewer appeals. NOSSCR expects SSA's use of modern vocational data will produce greater confidence in SSA's findings, fewer appeals, and conserve SSA's resources.

Solution: Revise the "all evidence" rule

Since 2015, claimants must provide "all evidence" that "relates" to the claim. This is much more evidence than the prior standard requiring "relevant" evidence. While seemingly a minor change in one word—the difference between "relates" and "relevant" evidence is hundreds and sometimes thousands of pages. A claimant may have an irrelevant need for eyeglasses, and yet this evidence must be purchased and submitted because it "relates" despite being irrelevant to disability. SSA's rules do not clarify what constitutes a duplicate, causing cautious advocates to submit additional pages. The Social Security Advisory Board (SSAB) recently found some "stakeholders report that the volume of evidence in claim files has increased in part due to duplicative or irrelevant submissions to assure compliance…."[47]

The "all evidence" rule adds a substantial number of irrelevant pages to claim files without increasing accuracy. Revising and clarifying this rule would control file sizes and reduce processing time.

[46] No. 4:19-cv-147-DAS, 2021 WL 1098483, at *1 (N.D. Miss. Feb. 26, 2021).
[47] https://www.ssab.gov/research/medical-evidence-collection-in-adult-social-security-disability-claims/ at 7.

Solution: Recognize firms as representatives

SSA currently only recognizes individuals as appointed representatives[48] rather than entities such as law firms.[49] Most law firms employ several representatives who may work on any given claim. Because SSA fails to recognize the practical reality of how firms operate, each time one of the employee-representatives from within the firm must enter an appearance on the claim, that representative must execute and submit new appointment of representative paperwork, which includes getting another signature from the claimant. SSA must process each of these forms, creating more administrative burden.

Recognition of firms as representatives would significantly reduce the administrative burden on SSA.

Solution: Redraft sickle cell disease policy

In 2015 SSA revised the hematological disorders "listing" that addresses sickle cell disease. Rather than merely updating terminology and clarifying the rules, the changes resulted in a shocking decline in the number of approvals of children suffering from sickle cell disease. Prior to the rule change, the rate of approval was 37%. Following the change, that rate plummeted to 24%, producing a racial disparity harming thousands of impoverished children. SSA must review all recent sickle cell disease denials using the flexible "medical equivalence" standard, while redrafting language that would accomplish the stated goals without harming the children intended to be covered.

Solution: Simplify the SSI application

SSI applicants face several disadvantages, resulting in fewer claims completed by those with severe mental conditions, barriers to using the mail (such as homelessness), and less access to advocacy services. Without an online way to apply, SSI claimants complete and mail (not fax, as discussed below) a lengthy form. This form—the SSA-8001-BK—requires the claimant to research and provide answers to questions that are not necessary to start the SSI claim.

For example, more than two pages and dozens of fields invite the applicant to provide immigration status details that are not relevant to most applicants. This should be one simple question, where claimants who were not a US citizen at birth receive later follow-up inquiries aided by SSA's access to data from available databases. For another example, the form invites the applicant to detail ownership status and dollar values for "resources," including life insurance and burial funds, and complicated information about asset transfers. These answers require difficult and time-consuming research. The SSI applicant should be permitted to make a summary assertion that the total value of resources are within statutory limits, providing detail later—allowing for the claim to be filed and other issues to be developed simultaneously.

[48] 20 C.F.R. § 404.1705
[49] 20 C.F.R. § 404.1703

A practical approach to the SSI application would be to test it with homeless potential claimants suffering from mental health disorders—a population intended to be addressed by the program, but which is currently excluded due to the practical difficulty of the SSI application. The reduction in SSI claims to 49% of prior levels is not explained by changes in demographics or healthcare.[50] A simplified SSI application is urgently needed.

Solution: Restore claimants' rights to an impartial ALJ

In the early 1980s, a version of SSA's "Bellmon Review Program" was declared unconstitutional because it pressured ALJs to reduce the percentage of claim allowances in a manner that denied claimants' rights to an impartial judge.[51] While SSA must review some favorable decisions not appealed by the claimant, selecting which decisions to review by targeting individual judges produced a system that deprived claimants of an independent judge able to resolve claims without pressure to keep an overall "pay rate" under a percentage. Following this constitutional correction, SSA successfully implemented the statute and reviewed some favorable decisions without targeting individual ALJs—through random selection and post-decision reviews.

However, for the last decade SSA has been conducting an increasing number of "Focused Reviews" and other "quality" reviews of individual ALJs—in a manner that convinces the ALJs that they are targeted for lesser authority, workload increases, flexibility reductions, and constrained independence—all due to a rate of favorable decisions. Added complexity to the criteria for selection of these ALJs does not account for the fact that the ALJs no longer feel independent, or that they may decide cases on their individual merits without keeping a wary eye on an overall percentage. Albeit in a more complicated structure, SSA has nevertheless returned to the unconstitutional method of Bellmon reviews addressed by the courts decades ago.

Focused Reviews and associated ALJ disciplinary procedures should be reviewed and corrected with help from the ALJ union (AALJ) and the outside stakeholders who are observing this decline in ALJ independence (including recently separated ALJs who left SSA due to Focused Reviews).

[50] https://www.ssa.gov/OACT/ssir/SSI23/index.html

[51] *See, e.g., Barry v. Heckler*, 620 F.Supp. 779 (N.D. Ca. Apr. 18, 1985).

Issue 5: SSA lacks modern systems

Advocating for disability claimants in the SSA appeals process can feel like a trip back in time. As discussed below, we currently hope to recover effective use of SSA's *fax machines*. Where other agencies and courts establish and update portals, API, and security protocols, NOSSCR's members and their clients must visit offices in person, rely on the mail, submit documents multiple times, and wait on hold. We recognize that SSA's programs operate at a large scale and change can be difficult—but we have identified several key changes that require new or redoubled initiatives.

Solution: Reduce the burden of medical records costs and maximize use of Heath Information Technology (HIT)

Claimants are responsible for obtaining and submitting medical evidence to SSA. Claimants' representatives are required to assist. Representatives advance the costs of medical records, yet ethical rules require that the ultimate financial burden be on the claimant. All patients pay for access to medical records in their initial billing, and charging claimants again for access to their evidence is an issue of recent concern to HHS. Some state laws allow medical records costs to reach hundreds of dollars per set (often exceeding $500 for all evidence needed in a claim), while other states have barred these charges. This results in worsened outcomes for claimants in some states. Where medical records costs are high, SSA ultimately considers less evidence, cases are delayed, hearings are postponed, and representation is less common—particularly for SSI claims and children.

SSA's use of HIT is a partial solution, partially implemented. As of May 2023, SSA had at least one HIT exchange in each state and counted 229 health systems and 35,996 participating providers.[52] Use of HIT has a clear effect on processing time. "SSA systems automatically compare treating/medical sources listed in a claimant's application to identify HITMER providers upon receipt. Participating sources are then queried for records once a patient-provider match is confirmed, and the claimant's medical authorization is accepted. [Medical evidence] then populates the electronic claim folder, sometimes even before the claim transfers from the SSA field office to the DDS."[53] The success of properly utilizing HIT in claims processing is illustrated in Iowa where two of the largest health systems in the nation, plus the Mayo Clinic in neighboring Minnesota, all share records via HIT. Iowa's initial stage processing times are far below average: 139 for initial and 118 for reconsideration.[54] This matches prior reports from SSA that claims with some HIT evidence were processed 10% faster than claims without any such evidence.[55]

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[52] https://www.ssa.gov/hit/materials/pdfs/HealthITPartnerOrganizations.pdf

[53] https://www.ssab.gov/research/medical-evidence-collection-in-adult-social-security-disability-claims/ at 8.

[54] https://www.ssa.gov/foia/readingroom.html, Initial and Reconsideration Processing Times Data as of 2/24/2023.

[55] House Subcommittee on Social Security, "Post-Hearing Questions for the Record Submitted to Patricia Jonas Deputy Commissioner Office of Analytics, Review, and Oversight SSA From Representative John B. Larson," *Hearing on Examining Changes to Social Security's Disability Appeals Process*. July 25, 2018, 4.

However, a 2022 OIG analysis revealed SSA "reduced the number of staff and contractors involved in health IT outreach and did not fully fund projects to increase electronic medical evidence."[56] SSA agreed with OIG's recommendation to reverse that decision, and NOSSCR hopes your office will follow up. SSA's use of HIT saves time and money.

Solution: Accept signed faxed applications

For many years, SSA accepted signed applications that were submitted via fax. While faxing is becoming less popular, claimants dealing with SSA consider faxing a positively modern step. In August 2023, SSA announced that they would no longer be accepting signed faxed applications.[57] SSA cited no rationale other than the end of the pandemic, although using fax machines to file applications predated the pandemic. Faxing applications, particularly for SSI benefits, is a reliable point of access for our most vulnerable claimants. While these claimants may not have reliable permanent addresses or means to visit and wait at local SSA offices, they can typically access a fax machine at a shelter, church, or public library.

As with the electronic signature verification process, SSA implemented unnecessary and costly steps to a system that could work efficiently. Accepting faxed applications saves agency time since claimants are less reliant on making in-person appointments or spending more than an hour on the phone to complete applications. Since SSA's announcement that faxed applications will not be accepted, representatives have had to resort to faxing (to mark the date) then mailing the application with the fax confirmation sheet, and then repeating that cycle until SSA finally acknowledges the submission. This adds weeks or months to a process that was already functional.

Solution: Improve phone call assistance

SSA publishes its average hold time for its 1-800 number. In 2022, the average hold time was 32.7 minutes. [58] For 2023, the average hold time was 36.3 minutes. In 2023 SSA received 42,733,577 calls and 8.7% of calls resulted in a busy signal.[59] When a representative has successfully connected with SSA staff after this wait, the representative can inquire about only a single claimant. To inquire about more than one claimant requires the representative to end the call, call SSA again, hold for another 30+ minutes, and connect with another (or the same) SSA staff person. If representatives could inquire about more claimants per call, it would significantly reduce the total call volume.

As a standard practice, SSA should provide representatives with the phone number and extension for the SSA staff person managing a claimant's file. This would allow representatives to more efficiently provide or receive updates or communicate other important information to SSA.

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[56] https://oig.ssa.gov/assets/uploads/a-01-18-50342.pdf
[57] https://www.ssa.gov/news/dcl/2023/#8-2023-3
[58] https://www.ssa.gov/open/data/800-number-average-speed-to-answer.html
[59] https://www.ssa.gov/open/data/FO-Answer-Busy-Rate.html

Solution: Improve electronic verification of representation

When a representative files an application on behalf of a claimant or is hired to assist a claimant on an existing application, the representative must wait for SSA to process the representative paperwork (SSA-1696)[60] and attach it to the claimant's file before the representative can access any information about the claim electronically. According to SSA's "Tips and Best Practices for Appointed Representatives," after submitting this paperwork, a representative must "wait 30 days before contacting by phone your client's servicing SSA field office or workload support unit (WSU) to follow up on a submitted SSA-1696, unless you have an urgent need."[61] Unfortunately, after 30 days, many representatives find that their paperwork still has not been processed, resulting in important missed notices and deadlines.

Moreover, the mechanism to determine if the representative has been attached to the claimant's file is inherently flawed, resulting in hours of extra work for the agency, the representative, and additional costly delays for the claimant.

To determine if the representative paperwork has been processed, the representative has two options. The first option requires the already overburdened telephone system.[62] The representative can regularly call each field office to verbally verify whether they have been attached to each claim. As you are aware, SSA struggles to answer the phones,[63] making this a burdensome option. Typically, after an extensive hold time, if a representative connects with an SSA staff member without their call being dropped (and no hangup), the staff person only allows for one case inquiry per call. This creates a time-consuming process of calling, waiting, and repeating. With thousands of claimants applying for benefits yearly, the administrative burden on both SSA and the representatives is too high.

The second option that most representatives employ is to attempt to electronically access the claimant's file. This process requires a representative to log in to SSA's Appointed Representative Services[64] system using a unique representative identification provided by SSA (after a verification process) and a unique (and frequently changing) password. After login, the representative must receive a code as part of a dual-factor authentication process before they can attempt to access the claimant's eFolder by inputting the claimant's Social Security number. If the representative paperwork has not been processed, the representative cannot access the claim, and there is a "strike" against their login. A representative can only have ten "strikes" against their login in a twenty-four-hour period before they are locked out of their account. The remedy to being locked out is for the representative to call SSA's Help Desk to unlock the account.

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[60] Form SSA-1696

[61] https://www.ssa.gov/representation/documents/Best%20Practices%20and%20Tips.pdf

[62] SSA's data recorded average telephone wait times over 2,000 seconds for every month in 2023, https://www.ssa.gov/open/data/800-number-average-speed-to-answer.html

[63] https://waysandmeans.house.gov/wp-content/uploads/2022/05/WAMR-Ltr-to-Neal-SSA-Hearing-Request-04072243.pdf

[64] https://www.ssa.gov/ar/

NOSSCR regularly meets with SSA's teams connected to this issue, including the Office of Electronic Services and Systems Integration (OESSI). We look forward to SSA's development of modernized solutions.

Solution: Provide representatives with electronic status updates at the initial and reconsideration levels

Currently, when a claim is at the hearings or Appeals Council levels, an appointed representative can log in and check the status of each claim for which they are appointed. The representative can also run a report of all claim statuses. These efficiencies give appointed representatives the information they need without calling SSA.

However, this status report is not universally available at the initial or reconsideration levels. This results in repeated calls to SSA, limited to one claim per call, simply to assess the status of the claim. This represents hundreds of hours of calls for local SSA field offices.

SSA already has the platform and capacity to make a status report available at the initial and reconsideration levels. It is already functioning well at later stages. Including such a status report at the first stages would reduce status-update calls to SSA, saving hundreds of hours of agency time per office.

Solution: Define mySocialSecurity status updates and provide representatives with the same claim status information as claimants

Even though SSA does not currently provide electronic status updates for representatives at the early stages, claimants with *my*SocialSecurity[65] accounts can view the progress of their applications. This information is provided in both a percentage complete and an estimated number of days it will take to complete review. Unfortunately, SSA has not published a guideline explaining what these percentages mean. For example, if an application is 40% complete, does it mean that SSA has collected all the required medical evidence, the evidence from 40% of the providers, or something else entirely?

Without real definitions, claimants are left with more questions than answers. To get these answers, they call SSA or, if represented, their representative to get more information. As representatives, we want to guide our claimants through the process, ultimately reducing the burden on the agency. However, in addition to failing to define these status percentages, SSA does not make the same status information available to representatives. Thus, when claimants call their representatives with questions about their status, representatives cannot provide meaningful information and the needed clarity a claimant deserves. As a result, the representative again calls SSA to clarify the claimant's status update, using more staff time and causing more delay.

[65] https://www.ssa.gov/myaccount/

Additionally, many of the most vulnerable claimants cannot perform basic tasks online because SSA's *my*SocialSecurity platform requires verification of a physical address. Individuals who are homeless could readily make use of SSA's online services (at public libraries, churches, shelters, etc.) if SSA would verify identity another way.

Solution: Accept electronic signatures without requiring a subsequent verification call

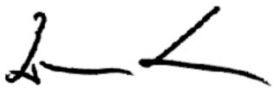
Pursuant to EM-20022 REV 3,[66] SSA accepts electronic signatures on multiple forms, including applications and representative appointment forms.

Despite this leap forward, which NOSSCR hopes will become permanent, SSA uses staff to call claimants to verify their electronic signatures. This is an extraordinary waste of resources, particularly since electronic signatures are verified by the electronic signature platform that includes the signer's name, email address, phone number, and IP address. This impedes the processing of valid documents since many claimants don't answer the call or don't have reliable access to a phone.

Removing the requirement that electronic signatures be verified by phone would immediately save staff resources and speed up claims processing.

Thank you for considering NOSSCR's proposed solutions, as well as those from the courts and other organizations. We look forward to working with you and SSA's leadership in the coming year to strengthen SSA and further its vital mission.

Sincerely,



David Camp
Interim Chief Executive Officer
National Organization of Social Security Claimants' Representatives

[66] https://secure.ssa.gov/apps10/reference.nsf/links/11122021125633PM