OFFICE OF
THE INSPECTOR GENERAL

SOCIAL SECURITY ADMINISTRATION

IMPACT OF STATUTORY BENEFIT CONTINUATION ON DISABILITY INSURANCE BENEFIT PAYMENTS MADE DURING THE APPEALS PROCESS

December 2006 A-07-05-15094

AUDIT REPORT

Mission

By conducting independent and objective audits, evaluations and investigations, we inspire public confidence in the integrity and security of SSA's programs and operations and protect them against fraud, waste and abuse. We provide timely, useful and reliable information and advice to Administration officials, Congress and the public.

Authority

The Inspector General Act created independent audit and investigative units, called the Office of Inspector General (OIG). The mission of the OIG, as spelled out in the Act, is to:

- **Conduct and supervise independent and objective audits and investigations relating to agency programs and operations.**
- **Promote economy, effectiveness, and efficiency within the agency.**
- **Prevent and detect fraud, waste, and abuse in agency programs and operations.**
- **Review and make recommendations regarding existing and proposed legislation and regulations relating to agency programs and operations.**
- **Keep the agency head and the Congress fully and currently informed of problems in agency programs and operations.**

To ensure objectivity, the IG Act empowers the IG with:

- **Independence to determine what reviews to perform.**
- **Access to all information necessary for the reviews.**
- **Authority to publish findings and recommendations based on the reviews.**

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SOCIAL SECURITY

MEMORANDUM

Date: December 21, 2006 Refer To:

To: The Commissioner

From: Inspector General

Subject: Impact of Statutory Benefit Continuation on Disability Insurance Benefit Payments Made During the Appeals Process (A-07-05-15094)

OBJECTIVE

Our objective was to evaluate the financial impact on the Disability Insurance (DI) Trust Fund when beneficiaries continue to receive DI payments, while appealing a medical cessation decision.[1]

BACKGROUND

Table 1
Disabled Workers, Continuing Disability Reviews, and Cessations

	2003	2004
Disabled Workers (CY)	5,873,673	6,201,362
Full Medical CDRs (FY)	215,008	224,980
CDR Cessations (FY)	25,662	25,727

Title II of the Social Security Act (Act) allows disabled individuals who are insured for DI benefits, have not reached retirement age, and are determined to be disabled according to Social Security Administration (SSA) regulations to receive DI benefits.[2] DI benefits are financed from the DI Trust Fund of the United States Treasury.[3] At the end of Calendar Year (CY) 2004, there were over 6 million disabled workers receiving DI benefit payments (see Table 1).

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[1] The audit *Impact of Statutory Benefit Continuation on Supplemental Security Income Payments Made During the Appeals Process* (A-07-05-15095) issued May 10, 2006, projected that the Social Security Administration could have avoided overpayments of $105.8 million for Fiscal Years 2003 and 2004 if the processing time for Supplemental Security Income claims at the reconsideration and Administrative Law Judge levels of appeal was decreased to 60 and 90 days, respectively.

[2] The Social Security Act § 223, *et seq.*, 42 U.S.C. § 423 *et seq.* *See also* 20 C.F.R. §§ 404.130 through 404.133.

[3] The Social Security Act § 201(b), 42 U.S.C. § 401(b).

Once SSA establishes that an individual is eligible for disability benefits under the DI program, SSA turns its efforts toward ensuring only those who remain disabled continue to receive benefits. Continuing disability reviews (CDR) are performed on DI beneficiaries to assess whether individuals remain medically eligible for DI payments.[4] A decision to discontinue benefits is made when a CDR reveals that the beneficiary no longer meets the medical requirements for disability benefits; these are referred to as medical cessation decisions.[5] Medical cessation decisions are made by disability examiners in the Office of Central Operations and State Disability Determination Services (DDS), as well as by disability specialists in the program service centers.[6] During Fiscal Year (FY) 2004, over 200,000 full medical CDRs were conducted for DI beneficiaries with nearly 26,000 beneficiaries receiving a cessation decision following the CDR (see Table 1). See Appendix B for additional background information on CDRs.

Once a decision has been made that an individual is no longer eligible for disability benefits, SSA informs the beneficiary of its decision. Payments continue for 2 months after cessation.[7] The beneficiary may appeal the decision within 60 days of the date he or she receives notice that SSA has determined that the individual's disability has ceased, or any time thereafter, if good cause is shown for late filing.[8]

The current appeals process has three administrative levels of review. First, the beneficiary can request that the DDS reconsider the cessation decision.[9] Second, if the individual is dissatisfied with the DDS decision at the reconsideration level, the beneficiary may request a hearing before an Administrative Law Judge (ALJ) in the Office of Disability Adjudication and Review.[10] Third, the beneficiary may appeal the

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[4] Generally, the frequency of medical CDRs is dependent upon SSA's assessment of the likelihood of medical improvement. 20 C.F.R. § 404.1590(d).

[5] SSA, POMS, DI 28001.001.

[6] SSA, POMS, SM 00614.001.

[7] Id.

[8] SSA, POMS, GN 03101.010.

[9] Reconsideration hearings are held before a disability hearing officer who reviews the evidence considered in making the initial decision and any other evidence received. Based on this evidence, a decision is made.

[10] The ALJ considers the evidence that is in the file and any new evidence, provides an opportunity for a hearing, applies the SSA disability standards, and issues a new decision, which affirms or reverses the initial decision.

ALJ's decision to the Appeals Council (AC). The AC may deny, dismiss, or grant the request for review. If the AC grants the request for review, the AC either issues a decision or remands the case back to an ALJ.[11]

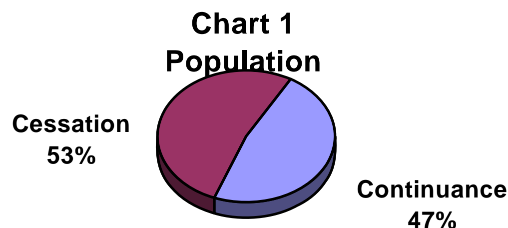
Section 223(g) of the Act[12] provides the individual the option for benefit continuation through the reconsideration and ALJ hearing levels of appeal in medical cessation decisions.[13] The option to elect continued benefits also applies to auxiliaries receiving benefits on the record of the primary disability beneficiary.[14] Benefit payments made during the appeals process are considered overpayments if the cessation decision is upheld. See Appendix C for the Scope and Methodology of our review.

RESULTS OF REVIEW

We estimate that SSA paid approximately $86.4 million in DI payments to beneficiaries who received an appeals decision from an ALJ between October 1, 2002 and September 30, 2004.[15] Of this amount, we project that about $43.9 million became overpayments when an ALJ affirmed the decision that the beneficiary was no longer eligible to receive DI benefits. These large overpayments were incurred because SSA's process for making decisions on medical cessation appeals is not as efficient as it could be.

SECTION 223(g) OF THE ACT

Forty-seven percent of the beneficiaries in our population whose benefits were continued as a result of Section 223(g) of the Act received a continuance by an ALJ (see Chart 1 and Appendix D, Table 1).[16] For these beneficiaries, the intent of the



[11] SSA, POMS, GN 03101.001.

[12] Section 223(g) was added to the Act as a temporary provision by Public Law 97-455 § 2, and was made permanent by the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508 § 5102.

[13] Payments are ceased 2 months after the DDS makes a disability cessation decision and the appeal period is over, or in the month of a cessation decision by an ALJ, but they can be reinstated when a request for appeal to the reconsideration or ALJ hearing level is filed and benefit continuation is requested timely. Furthermore, payments are not continued if the individual is dissatisfied with the decision issued by an ALJ and the case goes to the AC. However, if the AC remands the case back to an ALJ, benefits can be reinstated. SSA, POMS, DI 12027.001 and DI 12027.020.

[14] SSA, POMS, DI 12027.007.

[15] This includes payments made to auxiliaries on the record of the disabled beneficiary. All remaining dollar amounts in this report include amounts paid or overpayments attributable to both the disabled beneficiary and auxiliaries on the record.

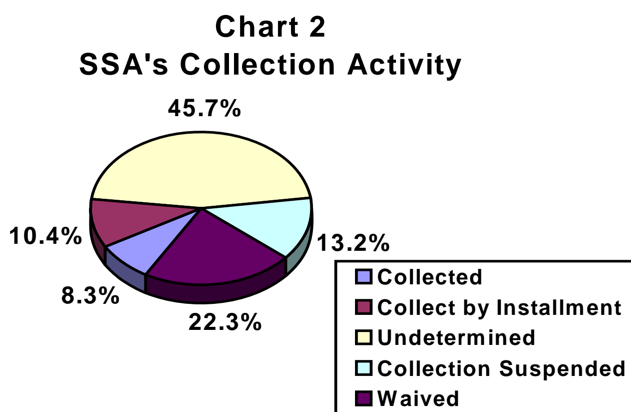
[16] A continuance means that it was determined the individual remains medically eligible to receive DI benefits.

law—to help prevent financial hardship to beneficiaries who appeal a medical cessation decision—was achieved. However, for the remaining 53 percent of the beneficiaries who received a cessation decision on their appeal, we project the application of the law resulted in the beneficiaries being overpaid approximately $43.9 million (see Chart 1).[17]

Section 223(g) of the Act was enacted in 1983 to protect DI beneficiaries from being financially disadvantaged while problems in the disability decision and appeals process were addressed—specifically, problems in the lack of uniformity of DDS and ALJ decisions. At that time, approximately 65 percent of DDS medical cessation decisions were reversed by an ALJ, which placed an undue financial burden on the majority of claimants whose benefits were terminated as a result of a CDR. For the 6,571 beneficiaries in our population, the ALJ reversal rate for DI medical cessation appeals was 47 percent.[18] Therefore, it appears there has been some improvement in the uniformity of DDS and ALJ decisions, possibly due to SSA's enhancements to the disability determination process, such as process unification.[19]

OVERPAYMENTS RESULTING FROM CESSATION DECISIONS

Of the projected $43.9 million in overpayments identified for our cessation population, we project that only about $3.6 million (8.3 percent) was collected, and approximately $4.6 million (10.4 percent) is in the process of being collected through installment payments (see Chart 2 and Appendix D, Table 2).[20]



[17] A cessation means that the ALJ confirmed the DDS' decision that the individual is no longer medically eligible for DI benefits.

[18] An ALJ affirmed the medical cessation decision for 3,450 beneficiaries in our population and reversed the medical cessation decision for 3,121 beneficiaries (see Appendix D).

[19] The goal of process unification is to achieve correct, similar results in similar disability cases at all stages of the administrative review process.

[20] For the purposes of this report, we considered both collections by installment payments and DI check adjustment to be collections by installment payments. Until the approximately $4.6 million is actually collected, there remains the possibility that these monies will never be collected.

Furthermore, we project that SSA has not yet determined what action to take on approximately $20.1 million (45.7 percent) of the overpayments. We project that the remaining $15.6 million (35.5 percent) in overpayments were waived or collection of the overpayment was suspended.

Waived

We project that SSA waived approximately $9.8 million (22.3 percent) of the overpayments identified in our population (see Chart 2 and Appendix D, Table 2). When overpayments are waived the beneficiary is relieved from ever having to repay the funds to SSA. Accordingly, the funds will never be returned to the DI Fund. SSA grants overpayment waivers when the individual is not at fault for the overpayment and recovery would:

- be against equity and good conscience or
- defeat the purpose of DI.[21]

Collection Suspended

We project that collection was suspended for approximately $5.8 million (13.2 percent) of the overpayments identified in our population (see Chart 2 and Appendix D, Table 2). SSA, in certain situations, may suspend collection of an overpayment when repayment cannot be arranged and civil suit is not appropriate.[22] Debt that is suspended remains eligible for recovery from future benefits payable to the beneficiary.[23,24]

LENGTH OF APPEAL

SSA's process for making decisions on medical cessation appeals could be more efficient to help reduce the amount of overpayments beneficiaries incur during the appeals process. Specifically, SSA does not require medical cessation appeals to be given processing priority at the reconsideration level, even though they involve benefit outlays. Furthermore, although Hearing Office Chief ALJs are instructed to assign medical cessation cases to ALJs immediately to avoid or minimize overpayments,[25] the

[21] SSA, POMS, 02250.001.

[22] SSA, POMS, GN 02215.235 A.

[23] SSA, POMS, GN 02215.250 A.

[24] SSA does not maintain statistics that isolate the dollar value of collections attributable to DI debt in which collection was suspended.

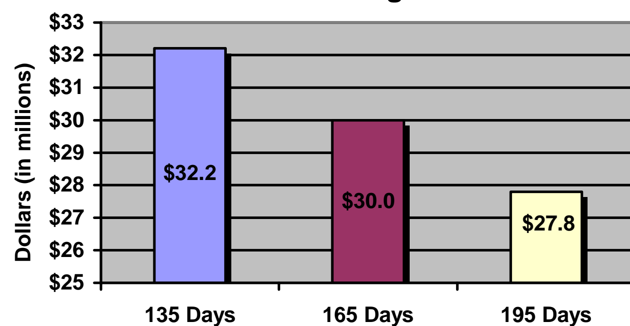
[25] HALLEX I-2-1-55.

results of our review show that these cases need to be expedited more than the instructions currently require.[26]

For beneficiaries in our sample who ultimately received a cessation decision from an ALJ, the overall average processing time was 648 days from the date the beneficiary requested a reconsideration to the date an ALJ made a decision.[27] A process with such a lengthy average processing time is not financially efficient for claimants who are receiving benefit payments.

Since reconsideration and ALJ appeals are not being processed timely and they involve benefit outlays, large overpayments are incurred. Given that medical cessation appeals often result in large overpayments, they should not be processed in the same manner as those cases that are not receiving payments. Therefore, to the extent possible, appeals that involve benefit payments should be processed separately from those that do not involve payments to avoid or minimize overpayments.

Of the projected $43.9 million in overpayments incurred by individuals who were determined to be no longer eligible for DI payments, we project that overpayments of approximately $27.8 million to $32.2 million could have been avoided if SSA would have completed the entire appeals process (both reconsideration and ALJ hearing) within 135 to 195 days (see Chart 3 and Appendix D, Table 3).[28] These



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[26] The average processing time for ALJ hearings resulting in a cessation decision in our sample was 411 days while the average processing time for all cases involving ALJ hearings was 371 days in FY 2004. We recognize that beneficiaries can increase the processing time for ALJ decisions by delaying the hearing, which will ultimately result in a larger overpayment. However, we did not consider this characteristic during our audit to determine how frequently this occurs, as it was outside the scope of our audit.

[27] The shortest appeal took a total of 187 days while the longest appeal took a total of 1,476 days from the date the beneficiary requested reconsideration to the date an ALJ made a decision on the medical cessation hearing. The total median processing time was 607 days. The median processing time represents the middle of the distribution of the total number of days for the beneficiaries in our sample. Half of the beneficiaries' appeals took 607 days or more while half of the beneficiaries' appeals took 607 days or less. Conversely, average processing time represents the sum of the total processing time for the beneficiaries in our sample, divided by the number of beneficiaries.

[28] We were unable to determine the amount of overpayments attributable to each of the reconsideration and ALJ hearing levels of appeal due to our methodology for obtaining overpayment information. We reviewed the overpayment amounts as displayed on the Master Beneficiary Record (MBR) for medical cessations. The MBR only displays the total overpayment amount and the date the overpayment was posted, but does not identify the specific time periods when the overpayment was incurred.

appeals times are based on SSA completing reconsiderations for medical cessations within 60 days[29] and ALJ hearings for medical cessations within 60 to 120 days[30] and allowing 15 days for beneficiaries to request benefit continuation during an appeal after reconsideration.[31]

The Commissioner's Disability Service Improvement process proposes enhancements to the disability determination process. However, the new process, as it was presented in the Federal Register, does not change SSA's process for medical cessation appeals.[32]

CONCLUSION AND RECOMMENDATION

We found that 53 percent of individuals in our population, who appealed a medical cessation decision and continued to receive payments throughout the appeals process, were overpaid. The overpayments were increased because SSA's process for deciding medical cessation appeals is not financially efficient. Medical cessation appeals should not be processed in the same manner as cases not receiving payments. Therefore, to the extent possible, appeals that involve benefit payments should be processed separately from those that do not involve payments to avoid or minimize overpayments.

The President's Management Agenda introduced the initiative of improved financial performance throughout Government agencies.[33] By making SSA's process for medical cessation determinations more efficient it would be better aligned with the President's vision. If SSA would develop a process for making decisions on medical cessation appeals in a timely manner, financial performance of the DI program could be greatly increased. For example, if SSA decreased the processing time on medical cessation appeals (both reconsiderations and ALJ hearings) to 165 days, we project

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[29] Most of the evidence needed for a reconsideration should have been obtained during the CDR process, unless additional evidence is needed for the reconsideration decision. Therefore, if SSA's business process allowed these cases to be processed immediately upon receipt, little additional evidence would need to be obtained and it would be reasonable to expect reconsideration decisions on medical cessations within 60 days.

[30] Because the claimant is awaiting a hearing before an ALJ, and depending on the length of time that has elapsed since the acquisition of evidence obtained during the CDR, it may not be reasonable to expect an ALJ appeal decision in less than 60 days. However, if SSA's business process allowed for medical cessation appeals to be processed immediately upon receipt at the hearing office, less additional evidence would need to be obtained for the ALJ hearing and it would be reasonable to expect the decision within 60 to 120 days.

[31] SSA, POMS, DI 12027.008.

[32] *Administrative Review Process for Adjudicating Initial Disability Claims*, Federal Register, Volume 71, Number 62 (16424-16462) March 31, 2006.

[33] See www.whitehouse.gov/omb/budget.

overpayments of approximately $30 million could have been avoided for FY 2003 and 2004. Based on the average of these 2 years, we estimate SSA could have avoided about an additional $15 million in overpayments in FY 2005.

The President's Management Agenda also emphasizes the Government's need to reform its operations in how it conducts business and how it defines business. SSA owes it to the American people to ensure that the resources entrusted to the Federal Government are well managed and wisely used. It is not only beneficial, but necessary for SSA to increase performance and citizen satisfaction by expediting cases that receive payments during the appeals process.

To operate more efficiently, SSA needs to develop a new business process for cases in which benefits are being continued throughout the appeals process. We recommend that SSA enhance the business process to allow more timely decisions on medical cessation appeals.

AGENCY COMMENTS

SSA agreed with our recommendation. The full text of SSA's comments is included in Appendix E.

Patrick P. O'Carroll, Jr.

Appendices

APPENDIX A – Acronyms

APPENDIX B – Background

APPENDIX C – Scope and Methodology

APPENDIX D – Population and Sample Results

APPENDIX E – Agency Comments

APPENDIX F – OIG Contacts and Staff Acknowledgments

Acronyms

AC	Appeals Council
ALJ	Administrative Law Judge
CDR	Continuing Disability Review
C.F.R.	Code of Federal Regulations
CY	Calendar Year
DDS	Disability Determination Services
DI	Disability Insurance
FY	Fiscal Year
HALLEX	Hearings, Appeals, and Litigation Law Manual
MBR	Master Beneficiary Record
ODAR	Office of Disability Adjudication and Review
POMS	Program Operations Manual System
SSA	Social Security Administration
SSI	Supplemental Security Income
U.S.C.	United States Code

Background on Continuing Disability Reviews

The Social Security Administration (SSA) is required to conduct periodic continuing disability reviews (CDR) on individuals who receive Disability Insurance (DI) benefits. The purpose of CDRs is to assess whether individuals remain medically eligible for DI benefits. CDRs are conducted at various intervals. Specifically:

- Individuals with a significant potential for medical improvement are selected for review within the first 6 to 18 months of eligibility;
- Individuals with a lower probability of medical improvement are reviewed every 3 years; and
- Individuals with no expectation of medical improvement are scheduled for review every 7 years.[1]

SSA is required to report to Congress the number of CDRs performed each year to meet legislative and regulatory requirements:

- Title II of the Social Security Act requires SSA to report to Congress annually on the results of periodic CDRs under the DI program.[2]
- Title XVI of the Social Security Act requires SSA to report on the number of Supplemental Security Income (SSI) CDRs and redeterminations in an annual report on the SSI program.[3]

Processing CDRs

SSA conducts CDRs using one of two methods:

- full medical reviews; or
- mailers (questionnaires).

[1] 20 C.F.R. § 404.1590(d).

[2] The Social Security Act § 221(i), 42 U.S.C. § 421(i).

[3] The Social Security Act § 1637(a)(6), 42 U.S.C. § 1383f(a)(6).

Full Medical Reviews

Full medical reviews are primarily conducted by Disability Determination Services (DDS) located in each State and the District of Columbia in accordance with Federal regulations.[4] SSA's field offices send CDR cases to the DDSs throughout the year for processing. SSA initiates these CDRs for various reasons, including:

- routine scheduling of a medical review (This is sent out as a "direct release.");
- responses to a CDR mailer indicating that the individual's medical condition may have improved;
- receipt of information that an individual's condition has improved and/or the individual has been working (This is sent out as a "work CDR."); or
- testing the reliability of SSA's systems and/or verifying assumptions through a full medical review.

SSA's folder processing centers send the case folder (which contains background and medical information on the individual) selected for a full medical CDR to the appropriate SSA field office for development. Field office personnel review the information in the case folder, interview the individual, and update pertinent facts in the folder prior to sending the case to the DDS for a full medical review. DDS medical examiners, using information in the case folder, determine if additional tests are necessary. Based on this information, a decision is made as to whether the individual is still disabled.

CDR Mailers (Questionnaires)

CDR mailers are questionnaires sent to disabled individuals asking whether the beneficiary has been employed, attended school or training, been told by a doctor whether he or she can work, has gone to a doctor or clinic for treatment, or has been hospitalized or had surgery.[5] If the answers to the questions indicate the individual's condition may have improved, the case is referred to a DDS office for a full medical review to determine whether the individual is still disabled.[6]

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[4] 20 C.F.R. § 404.1601 *et seq*.

[5] Normally, only individuals determined to have a low likelihood of medical improvement are sent mailers. Cases that are profiled as having a mid-range to high likelihood of medical improvement are scheduled for full medical CDRs rather than mailers (questionnaires).

[6] CDR mailers were not included in our review because the review focused on medical CDRs in which the initial DDS decision was a medical cessation. If SSA sends out a mailer, and based on the information supplied in the response, it feels it is possible the beneficiary's disability has ceased, then it will open the case for a full medical review.

Scope and Methodology

To accomplish our objective we:

- Reviewed applicable Federal laws and regulations, pertinent parts of the Social Security Administration's Program Operations Manual System, and other criteria relevant to continuing disability reviews (CDR), appeals, and overpayments.

- Reviewed prior Office of the Inspector General audit reports related to overpayments and CDRs.

- Interviewed Social Security Administration (SSA) staff from the Office of Disability Programs, Office of Disability Determinations, and the Office of Disability Adjudication and Review (ODAR) to obtain an understanding of the (1) CDR process, (2) appeals process for disability cessations, and (3) treatment of overpayments.

- Obtained a file from the Office of Disability and Income Security Programs of all 6,836 individuals who received an Administrative Law Judge (ALJ) decision for medical cessation between October 1, 2002, and September 30, 2004. From this file, we identified a population of 6,571 individuals who continued receiving Disability Insurance benefits while appealing SSA's CDR decision that they were no longer disabled.

- Separated the population of 6,571 into 2 groups:

  - 3,121 beneficiaries (47 percent) who received a continuation at the ALJ level of appeal and
  - 3,450 beneficiaries (53 percent) whose cessation was affirmed at the ALJ level of appeal.

- Selected a random sample of 250 cases from each of the 2 groups for a total sample size of 500 cases.

- Analyzed beneficiary information available on SSA's electronic systems—including the Master Beneficiary Record (MBR),[1] the Payment History Update System, and the ODAR query—and projected our results to the population.

[1] We relied on the overpayment amount that was posted by SSA and displayed on the MBR; therefore, we did not determine if the posted overpayments were accurate.

We conducted our audit in Kansas City, Missouri between February 2005 and July 2006. We determined that the data used for this audit was sufficiently reliable to meet our audit objective. The entity audited was ODAR and SSA field offices and program service centers under the Office of Central Operations. We conducted our audit in accordance with generally accepted government auditing standards.

Population and Sample Results

Of the 6,836 beneficiaries who received an Administrative Law Judge (ALJ) decision for medical cessation between October 1, 2002 and September 30, 2004, we identified a population of 6,571 beneficiaries who continued to receive Disability Insurance benefit payments during the appeals process. An ALJ affirmed the cessation decision for 3,450 beneficiaries and continued benefits for 3,121 beneficiaries.

Our analysis of 250 cases where benefits were ceased identified 216 beneficiaries who, along with any auxiliaries, received payments during the appeals process totaling approximately $3.2 million that were subsequently considered overpayments. In addition, we conducted analysis on the overpayments to determine what the Social Security Administration's (SSA) recovery activities were for each case. Our analysis of 250 cases allowed to continue to receive benefits identified 221 beneficiaries who, along with any auxiliaries, received payments during the appeals process totaling approximately $3.4 million. The following tables reflect the sample results and projections based on our audit.[1]

Table 1: Population and Sample Size			
	Continuance	Cessation	Total
Population size	3,121	3,450	6,571
Percent of total population	47%	53%	100%
Sample size	250	250	500
Number of Cases			
Cases Identified in Sample	221	216	437
Point Estimate	2,759	2,981	5,740
Lower Limit – Quantity	2,643	2,845	
Upper Limit – Quantity	2,854	3,095	
Associated Dollar Amount			
Payments Identified in Sample	$ 3,404,294	$3,179,186[2]	$6,583,480
Point Estimate	$42,499,208	$43,872,771	$86,371,979
Projection Lower Limit	$38,939,967	$39,405,527	
Projection Upper Limit	$46,058,449	$48,340,014	

[1] All projections in the following tables were calculated at the 90-percent confidence level.

[2] Approximately $350,000 (11.1 percent) of this amount was payments made to beneficiaries who received an ALJ decision in our timeframe, but has since re-appealed the decision. Since these cases are still in appeal, the overpayment will be reversed if the final decision is favorable.

Table 2: Overpayment Recovery Activities					
	Collected	Collection In Process	Waived	Collection Suspended	Undetermined
Identified in Sample	$263,912	$331,988	$710,177	$419,500	$1,453,609[3]
Percent of Sample[4,5]	8.3%	10.4%	22.3%	13.2%	45.7%
Point Estimate	$3,641,982	$4,581,431	$9,800,448	$5,789,105	$20,059,805
Projection Lower Limit	$2,660,771	$2,945,440	$7,260,983	$4,165,788	$16,456,367
Projection Upper Limit	$4,623,193	$6,217,421	$12,339,914	$7,412,422	$23,663,243

Table 3: Savings			
	Reconsideration and ALJ Appeal Complete in:		
	135 Days	165 Days	195 Days
Identified in Sample	$2,335,233	$2,173,784	$2,017,251
Percent of Sample[4]	73.5%	68.4%	63.5%
Point Estimate	$32,226,211	$29,998,215	$27,838,069
Projection Lower Limit	$28,416,449	$26,325,865	$24,303,734
Projection Upper Limit	$36,035,973	$33,670,565	$31,372,404

[3] Approximately $37,000 (2.6 percent) of this amount are payments that SSA has not recognized as an overpayment due to appeal proceedings and input errors. Until there is action taken to assess the overpayment, SSA will not attempt to collect the funds.

[4] This is a percentage of the total overpayments for cessation decisions identified in the sample ($3,179,186).

[5] Percentages do not add to 100 percent due to rounding.

Agency Comments

SOCIAL SECURITY

MEMORANDUM

Date: December 11, 2006 Refer To: S1J-3

To: Patrick P. O'Carroll, Jr.
Inspector General

From: Larry W. Dye /s/
Chief of Staff

Subject: Office of the Inspector General (OIG) Draft Report, "Impact of Statutory Benefit Continuation on Disability Insurance Benefit Payments Made During the Appeals Process" (A-07-05-15094) -- INFORMATION

We appreciate OIG's efforts in conducting this review. Our comments on the draft report content and recommendations are attached.

Let me know if we can be of further assistance. Staff inquiries may be directed to Ms. Candace Skurnik, Director, Audit Management and Liaison Staff, on extension 54636.

Attachment:
SSA Response

COMMENTS ON THE OFFICE OF THE INSPECTOR GENERAL (OIG) DRAFT REPORT, "IMPACT OF STATUTORY BENEFIT CONTINUATION ON DISABILITY INSURANCE BENEFIT PAYMENTS MADE DURING THE APPEALS PROCESS" (A-07-05-15094) -- INFORMATION

Thank you for the opportunity to review and comment on the draft report.

We have reservations about the fact that the report considers only the financial aspect of the targeted caseload. We disagree with the general conclusion that statutory benefit continuation cases should be processed separately from cases for claimants who are not in pay status, inferring that the former should receive priority handling. Financial efficiency is not the single goal of the Social Security programs, especially when it comes to disabled individuals. We have a duty to serve all citizens in a timely and efficient manner. We also have a duty to follow the requirements of law as set forth in statutes, Agency regulations and Federal court decisions, which may dictate priorities that are at odds with financial efficiency considerations alone. Thus, two of our top goals are to: (1) deliver high-quality, citizen-centered service in a timely and efficient manner; and (2) ensure superior stewardship of Social Security programs and resources. Although it is important to protect the trust fund, SSA is also directed by statute and Agency directives to prioritize the processing of cases based on other factors that are not so easily measured. These cases include, for example, claimants who are terminally ill, in dire need, homeless, or cases that come under a time-limited court remand.

On page 6, the draft report states, "SSA does not require medical cessation appeals to be given processing priority at the reconsideration level." This comment is difficult to understand since the reconsideration process for continuing disability reviews is completely different from that for initial claims. Furthermore, it is unrealistic to suggest that reconsiderations of medical cessations can be completed within 60 days or that hearing decisions by an Administrative Law Judge (ALJ) on such cases can be completed within 60 to 120 days. With regard to reconsiderations, it appears from footnote 29 (page 7) that the report has overlooked the fact that a beneficiary who requests reconsideration of a medical cessation must be offered the opportunity for a face-to-face evidentiary hearing with a disability hearing officer employed by an adjudicatory unit other than the one that made the decision being appealed (20 C.F.R. §404.914ff). Scheduling, sending the required notice at least 20 days before the hearing, and holding an evidentiary hearing only adds time to a process where initial disability decisions currently average over 90 days to process. It is also incorrect to suggest in footnotes 29 and 30 (page 7) that reconsiderations and ALJ hearings on medical cessations primarily consist of a reexamination of existing evidence.

As for ALJ hearings on medical cessations, this report offers no basis for the assumption that such hearing decisions currently can be successfully completed within 60 to 120 days. SSA has a current pending workload of 720,000 cases and the lowest staffing ratios in the Agency's history of appeals work. Unless SSA hires additional ALJs or senior attorneys, hearings offices would have to pull existing resources from initial claims hearings to handle disability cessation hearings. While this would achieve the goal of processing cessation appeals more timely, it would exacerbate the problem of people waiting an inordinate amount of time to get a decision on their initial claim. We do not believe that we should redirect resources to making timely

cessation appeal decisions at the expense of making timely decisions on initial claims appeals. We have to balance both of these processes.

We also believe the report significantly underestimates the recovery of overpayments. The report's estimate of overpayment recovery begins at a time not far removed from the final cessation decision. However, recovery increases with the passage of time. Further, the report implies that suspended recovery effectively renders the overpayment unrecoverable. Yet, if a terminated disabled-worker beneficiary later becomes a retirement beneficiary, the overpayment would be withheld from those later benefit payments.

SSA is committed to fairly serving all facets of the public by providing accurate and timely disability decisions, continuing to process all non-disability cases, and protecting the trust fund, in keeping with the Agency's overall mission to advance the economic security of the nation's citizens through compassionate and vigilant leadership.

Our response to the report's recommendation is provided below.

Recommendation

SSA [should] enhance the business process to allow more timely decisions on medical cessation appeals.

Response:

We agree. Improvements to the timely processing of medical cessation cases involving benefit continuation should be done. However, in making such improvements, consideration should be given to current staffing levels and the ability to maintain the timely processing of other priority workloads. A balanced approach in managing all workloads with an eye on receipt patterns is important while making enhancements to improve the processing of medical cessation appeals. Further, current backlogs of medical cessation hearing cases may have to be reduced before any improvements are realized.

Accordingly, we will provide additional guidance and direction to our managers to: identify statutory benefit continuation cases upon receipt in the hearing office (HO); use management information that enables managers to track benefit continuation cases; provide procedures, to the extent possible, for accelerated movement within the HO; and alert the appropriate component to cease benefits when an affirmation is issued.

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Office of Audit

OA conducts and/or supervises financial and performance audits of the Social Security Administration's (SSA) programs and operations and makes recommendations to ensure program objectives are achieved effectively and efficiently. Financial audits assess whether SSA's financial statements fairly present SSA's financial position, results of operations, and cash flow. Performance audits review the economy, efficiency, and effectiveness of SSA's programs and operations. OA also conducts short-term management and program evaluations and projects on issues of concern to SSA, Congress, and the general public.

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Office of the Chief Counsel to the Inspector General

OCCIG provides independent legal advice and counsel to the IG on various matters, including statutes, regulations, legislation, and policy directives. OCCIG also advises the IG on investigative procedures and techniques, as well as on legal implications and conclusions to be drawn from audit and investigative material. Finally, OCCIG administers the Civil Monetary Penalty program.

Office of Resource Management

ORM supports OIG by providing information resource management and systems security. ORM also coordinates OIG's budget, procurement, telecommunications, facilities, and human resources. In addition, ORM is the focal point for OIG's strategic planning function and the development and implementation of performance measures required by the Government Performance and Results Act of 1993.