COMMUNITY LEGAL SERVICES
OF PHILADELPHIA

December 28, 2007

Michael J. Astrue
Commissioner
Social Security Administration
P.O. Box 17703
Baltimore, MD 21325-7703

RE: Amendments to the Administrative Law Judge, Appeals Council, and Decision Review Board Appeals Levels; Proposed Rule
RIN 0960-AG52\
Docket Number SSA-2007-0044
72 Fed. Reg. 61218 (October 29, 2007)

Dear Commissioner Astrue:

Community Legal Services, Inc. of Philadelphia (CLS) submits these comments of behalf of our thousands of disabled clients who apply for benefits under Titles II and XVI of the Social Security Act and who will no doubt be adversely affected by the proposed regulations. These rules will dramatically alter the decisional process and the submission of evidence in ways that will harm claimants and beneficiaries.

For more that 40 years CLS has represented thousands of low-income disabled individuals in their efforts to obtain and retain benefits under the Social Security Act. While CLS has represented individuals at all levels of the process from initial application to federal court, the vast majority of our advocacy efforts focus on representing eligible clients at the ALJ level. We serve mostly clients who are unable to find private lawyers to handle their case. All our clients are indigent and virtually all of them live in extreme poverty. Most are homeless, mentally ill, cognitively impaired or have language barriers that prevent them from navigating the complicated system that administers benefits.

As a legal aid program serving only low-income individuals, CLS does not charge any legal fees to our clients. CLS also focuses on applicants for Supplemental Security Income benefits under Title XVI of the Social Security Act and many of our clients are the most vulnerable individuals in society, who have extraordinary difficulties interacting with governmental agencies. These difficulties largely result from the very disabilities that render them disabled within the meaning of the Social Security Act and thus eligible for benefits.

The Commissioner estimates that the Social Security Administration anticipates a reduction in federal expenditures resulting from this proposal in the amount of $1.5

billion over ten years. Saving money, however, should not be the motivation for addressing the many problems that face the disability adjudicative system. Given the paucity of evidence to support these proposed changes, such action cannot be countenanced. The Commissioner should abandon this cynical attempt to reduce the disability payments to eligible individuals in the name of administrative efficiency. Our reasons for opposing the proposed rulemaking are set forth below.

1. Closing the record forever at the ALJ level

The proposed rule, 20 C.F.R. § § 404.972-.983, 416.1472-.1483, would close the record permanently at the Administrative Law Judge level. Thus, if the case was subsequently reversed at the Review Board level or the federal courts on appeal, the record would be permanently closed so that a remand hearing could not take into account further evidence that dates to a time later than the ALJ decision. The justification for this policy is an appeal to "efficiency," and the rulemaking estimates that this change along with other restrictions will save approximately $2.5 billion, primarily through reduced allowances, 72 Fed. Reg. at 61225-6. The rulemaking goes on to suggest that individuals who pursue appeals should promptly file a new application if they wish to receive benefits on an ongoing basis. There is no mention how this multiplication of applications will improve the efficiency of an already overburdened system.

Although subject to public criticism for delay and arbitrary decision making, the Social Security/SSI process has profited from its adherence to the values of informality and a non-adversarial process. While the rulemaking acknowledges the importance of these values, the proposal actually does much violence to these principles, while doing little to resolve the criticisms of delay and an overly long process. The proposal would move the system toward a more formal, inflexible and poorly understood program and would pit the individual seeking benefits against a system rife with pitfalls and traps for the unwary or unsophisticated.

It is our experience that, the true gravity of medical conditions often becomes clear over time. Cancer, sickle cell disease, mental illness and many other chronic conditions afflicting our clients only become clear when viewed longitudinally. Contrary to the assertions in the proposed rulemaking, allowing the record to remain open so that a longer view can be obtained is a more efficient way to arrive at the truth and determine whether an impairment is truly disabling. For example, the gravity of conditions affecting children often become clear only over time -- some conditions resolve while other worsen. Over time some conditions show themselves to be less serious and some are amenable to treatment. These conditions are appropriately turned down or awarded a closed period of disability where the severity requirements are met only for a defined period of time. In other cases, the longer view demonstrates a more serious condition exists and benefits are correctly awarded for the entire period. In all such cases, justice is done and the purposes of the Social Security Act are fulfilled. Moreover, the adjudications are done in the most efficient way. Artificially dividing the claim will not achieve just results.

The proposed rule, if adopted, would turn this arrangement on its head. It would force the adjudicator to don blinders and ignore medical evidence of disability that should be dispositive, and is often much better and more conclusive than anything that was in the record prior to the remand. For example, in one case recently pursued by CLS, the ALJ turned down an application based on his finding that the claimant's serious hypertension was controlled. The claimant appealed, a remand was ordered and a new hearing was held. On remand, further medical records were obtained that conclusively demonstrated that the hypertension was not controlled, except for a very short period around the time of the first decision and that the hypertension was not controllable despite sophisticated medical care. With the benefit of this new evidence, the ALJ reversed his previous opinion and benefits were awarded. In short, justice was served.

Similarly, we often represent families with low birth weight babies who are awarded SSI benefits for their first year of life, based on 20 C.F.R. § 416.926a(m)(7)&(8). Some children overcome this difficult first year and thrive, while others do not. Closing the record and not allowing adjudicators to look at the bigger picture only makes for an inefficient system and may award benefits to those who are not disabled, while denying benefits to others that deserve benefits. Truncating such cases and forcing the adjudicatory system to hear them separately is not only inefficient but will lead to incorrect results.

The proposal to truncate the record will also make for more work for the Social Security Administration as a new application would have to be taken, the medical records of disability will have to be obtained and the entire decision making process will have to be pursued. Any failure of the claimant to file simultaneously will lead to a loss of benefits to which they would otherwise be entitled.

Additionally, such a proposal will be particularly difficult to administer in situations which the proposed rulemaking ignores. These situations include:

1. standard Continuing Disability Reviews (CDRs)
2. reevaluations of 18 year olds receiving SSI
3. situations where a new or previously undiscovered condition arises during the application process but has not lasted for a year by the time of the hearing
4. cases where timing of onset or some other event is crucial, such as cases where there in an issue of date last insured or trial work
5. impairments where there is a review after one year (e.g. low birth weight babies, organ transplant cases).

Not only does the proposal fail to acknowledge these complications, but the proposal as designed would violate the statute in several places.

No where are the shortcomings of the proposed rule clearer than in the case of Continuing Disability Reviews. See 20 C.F.R. § 404.1593; 416.994 & .994a. In such cases, if a claimant lost at the ALJ level, subsequently appealed and got a remand, the proposal would stop the inquiry at the date of the first ALJ hearing. Yet the whole point of such cases is to determine whether the person is eligible for continuing benefits, not just for a closed period. Congress was so concerned with the way that SSA handled such

cases that it enacted the Social Security Disability Benefits Reform Act of 1984, Pub. L. 98-460, 98 Stat. 1994 and established a detailed process for determining whether there had been medical improvement that warranted termination.

Indeed, part of the medical improvement inquiry requires that SSA not only determine whether the claimant's condition has improved but also whether any other condition had since arisen or worsened that justified an award of continuing benefits. 20 C.F.R. § 404.1579 (f)(5). The whole point of such an inquiry is to evaluate the person longitudinally rather than take a snapshot approach. Under the proposed rule benefits up to the day of the hearing would be controlled by evidence prior to the hearing and the beneficiary would have to file a new application in order to receive ongoing benefits. Such an approach violates the longitudinal approach mandated by the SSDBRA and makes little sense.

Requiring a second application in CDR cases makes no sense. However, even if CDRs are made an explicit exception to the new rule, the problem does not stop there. Assuming the new rule excepts CDRs, how does one apply the CDR principle to "regular" cases where the question of ongoing eligibility needs to be resolved? That is, if the ALJ on remand eventually awards benefits, what import does that award have for the new case, that is, the one concerning ongoing benefits in the future? Under current rules, for the adjudicator to award benefits only for a closed period, he or she must make a finding that there has been medical improvement. Under the proposed rule, is the adjudicator to make a similar finding or is the proposal thought to be an adequate authorization to make an award for only a closed period without a determination of improvement? In other words, is the second adjudicator to treat the finding of disability as final and then make a determination based on medical improvement? Such a result argues strongly against the efficiency of the entire approach of bifurcating the decision making. Yet if medical improvement is not used, isn't this directly contradictory to the Congressional rejection of the snapshot approach?

Similar question come up in the evaluation of 18 year olds. See 20 C.F.R. 416.987. Even though the medical improvement test is not used, a longitudinal approach is crucial to correct decision making. How are ongoing benefits to be authorized if a second application is required? Given that ongoing benefits are the main reason for the appeal, how can SSA justify a termination of benefits for those who are not sophisticated enough to understand that they must file a second application in order to obtain ongoing benefits?

Third, it is not uncommon for a new impairment to be diagnosed during the disability process. Current practice suggests that the most efficient way to deal with this is to evaluate all such impairments as they are discovered (this also avoids endless disputes about whether and when the new impairment was initially raised). However, for many individuals, their hearing will come up in less than a year, which in some cases can make it difficult to determine whether the one year durational limit has been met. (CLS has handled such a case within the last year.) The proposal to close the record would prevent the adjudicator from determining duration in the most reliable way possible – by

evaluating the new evidence to determine if it actually lasted for a year. In what possible way could such an artificial divison be said to be efficient?

Date last insured is a crucial question in many Title II cases. By closing the record, the proposed regulation will prevent a second adjudicator from being able to make a decision that relates back to the crucial DLI. Because of the recency of work test, the worker's insured status may have expired during the pendency of the first application and the worker may never be eligible when a new application is filed. If the issue of the disability onset date in the new claim is the same as in the first, the doctrine of *res judicata* will bar consideration of the subsequent application.

Moreover, under the proposal to close the record individuals with disabilities will lose access to important work incentives. Eligibility for only time-limited, closed period benefits means that these individuals would not have access to most of the Title II and SSI work incentive provisions, which are available only if the individual remains medically disabled. SSI claimants would lose their connection to the § 1619(a) and (b) programs, which offer smooth transition for people with severe, chronic disabilities that are subject to periods of remission and allow them to seamlessly go between SSI cash benefits and Medicaid, when they can work and without filing new applications. Title II claimants would not be eligible for the trial work period, the extended period of eligibility, extended Medicare coverage, and expedited reinstatement. Both SSI and Title II claimants would not be eligible to participate in the Ticket to Work program.

Finally, there are several categories of disability where initial eligibility is revaluated after one year[1] or where a longitudinal evaluation is crucial.[2] Artificially dividing the inquiry is not only inefficient but it will do positive harm and result in incorrect and unfair decisions.

2. Submission of Evidence

The restrictions upon the submission of evidence unduly limit how a claimant may submit relevant evidence and impose particularly burdensome requirement on unrepresented claimants.

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[1] See, e.g. Listing 6.02.B (kidney transplant); 4.09 (heart transplant); 3.11 (lung transplant).

[2] See the "C" criteria in the Mental Health Listings. The Commissioner's own regulations state:

Need for longitudinal evidence. Your level of functioning may vary considerably over time. The level of your functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of your impairment(s) must take into account any variations in the level of your functioning in arriving at a determination of severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication to establish your impairment severity. Listing 12.00.D.2.

Similarly the Listings also state:

...The results of a single examination may not adequately describe your sustained ability to function. It is, therefore, vital that we review all pertinent information relative to your condition, especially at times of increased stress.... Listing 12.00.E.

The NPRM requires that a claimant submit evidence at least 5 business days before a hearing, with very limited exceptions. The NPRM offers no specific substantive reasons for this draconian limitation, but rather cites general concepts of administrative efficiency and avoiding delays in decision making caused by the need to reschedule hearings as the basis for a rule that will inevitably lead to the exclusion of material evidence and the denial of meritorious claims. The preface does not claim that this evidence is somehow less valuable or probative in determining disability. Rather, instead it indicates weakly that "late submission" of evidence "significantly impedes our ability to issue hearing decisions in a timely manner" and results in the need to reschedule hearings. Such administrative convenience reasons do not justify the exclusion of otherwise material and possibly critical evidence.

Closing the record before the hearing violates the Social Security Act. The Act provides the claimant with the right to a hearing with a decision based on "evidence adduced at the hearing." 42 U.S.C. § 405(b)(1). The current regulations reflect the statute, providing that "at the hearing" the claimant may submit new evidence. 20 C.F.R. § 404.929. A previous proposal to set a due date for submission of evidence was abandoned by SSA because it appeared to close the record in contravention if the statute. See 68 Fed. Reg. 41411-12 (Aug. 4, 1998)(final rule on Rules of conduct and standards of responsibility for representatives, codified at 20 C.F.R. § 404.1740).

Separate and apart from this statutory requirement, practicality and fairness preclude closing the record at an arbitrary point prior to the hearing and ALJ decision. Administrative efficiency goals pale in comparison to the ALJ's duty to develop a full and complete record. The proposed time limit on submitting evidence fails to take into account claimants who seek representation fewer than 20 days before the hearing. Based upon our experience and that of our colleagues, that scenario is fairly typical. Up until they retain counsel, many claimants understand neither the need nor the process for obtaining representation. The ALJ hearing is the claimant's first in-person contact with an adjudicator and the ALJ is required to explain the right to representation and postpone the hearing if an unrepresented claimant wishes to seek a legal representative. The NPRM does not even begin to address this situation, particularly in light of representative's key role in obtaining evidence. Moreover, this requirement of submitting evidence 5 business days in advance of the hearing imposes an excessive burden upon the unrepresented claimant, given that is the Social Security Administration's obligation to develop a full and fair record.

While the submission of evidence as early as possible is obviously preferable, many legitimate reasons exist that prevent its submission earlier. Excluding such evidence by closing the record prematurely will hurt claimants who are disabled within the meaning of the Social Security Act. These reason include: (1) a worsening or clarified diagnosis of the medical condition which forms the basis of the claim (e.g. lupus; multiple sclerosis; chronic fatigue syndrome); (2) factors outside the claimant's control, such as beleaguered or uncooperative medical sources who simply do not respond promptly to requests for records from either the claimant or the claimant's

representative; and (3) the need to keep the process informal.[3] In the vast majority of cases, there are justifiable reasons why evidence is not submitted earlier in the process.

Many of our clients are incapable of obtaining their own medical records and they come to us shortly before the hearing. In addition, it can take a week or two to make an appointment to review the ODAR file and determine what evidence is missing. Even after the missing evidence is identified, it is often in the possession of busy, overworked and occasionally uncooperative clinics that require precisely filled out HIPAA forms[4] and at least 45 days notice to produce reports. Often we find we are pursuing the same evidence that state agency that made the initial denial was unable to obtain.

The NPRM also places additional limits on holding the record open following the evidentiary hearing, but before the decision is rendered. Currently, the record remains open until a decision is made by the ALJ. The NPRM offers no substantive reason to change current practice.

Under the NPRM, the submission of new and material evidence to the Review Board is further unfairly curtailed. The NPRM imposes severe restrictions with only with narrow exceptions and high procedural hurdles to overcome. The claimant must show "a reasonable probability that the evidence would change the outcome of the decision," in addition to a "good reason" for not submitting the evidence previously.

These stringent restrictions on the submission of relevant and material evidence are not justified. The already existing regulations and statute are very specific in limiting that ability at later levels of appeal following an ALJ decision. At the Appeals Council level, new evidence will not be considered unless it relates to the period before the ALJ decision and is "new and material." At the federal court level, the record is closed and the court will not consider new evidence. The court does have the authority to remand the case for SSA to consider the additional evidence, but only if the new evidence is (1) "new" and (2) "material" and (3) there is "good cause" for the failure to submit it in the prior administrative proceedings. The current restrictions on submitting evidence after the ALJ decision are more than sufficient.

3. Requesting an ALJ Hearing

The NPRM proposes that the claimant "should include a statement of the medically determinable impairment(s) that he or she believes prevents him or her from

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[3] In those rare cases where an advocate unreasonably delays submitting evidence in his or her possession, the Social Security Administration can take appropriate action against the representative. It is manifestly improper to punish a claimant for late submission of records by excluding those records when the very purpose of the process is to make an accurate determination whether the claimant is disabled within the meaning of the Social Security Act.

[4] Many health care providers will only honor their own HIPAA forms, and often require perfectly filled out forms that require intialing in numerous places; still other providers insist that the claimant sign the HIPAA release in their presence. All of these restrictions make it extremely difficult to obtain medical evidence.

working." While there appears to be no penalty for failing to comply with this provision, it is simply unrealistic to expect claimants who are unrepresented to be able to precisely set forth their "medically determinable impairments." Indeed, it seems unlikely that claimants will have any reasonable understanding of this requirement. It is one thing to ask a claimant to explain why he or she cannot work – it is quite another to expect a claimant set forth the impairment(s) in technical language.

4. Prehearing Statements and Conferences

The NPRM adds an amended provision for pre- and post- hearing conferences. It specifically allows for such conferences to be conducted by telephone. It also includes a provision allowing for dismissal of the hearing request if neither the claimant nor the representative appears for the prehearing conference. While prehearing conferences and statements may be extremely valuable in certain cases, allowing dismissal for failure to attend is yet another trap for unwary claimants, especially those without representation. This problem would surely be exacerbated for phone conferences, where any number of problems would result in the claimant's inability to complete the phone call. Many of our clients have only sporadic access to phone service, as they juggle utility bills, especially in the winter. Since many of our clients will likely be unrepresented prior to the scheduling of the hearing, it is extremely likely that their cases will face dismissal because they fail to attend telephone prehearing conferences.

Moreover, requiring only "reasonable" notice rather than a set minimum time for advance notice for the scheduling of such conferences also invites significant problems and disputes over subsidiary issues. Inevitably, significant resources will be diverted to litigating these subsidiary issues rather than assessing whether a claimant is disabled within the meaning of the Social Security Act.

5. Changing the role of the final step in the administrative process

We are very concerned by the NPRM's observation that SSA views the Review Board as more like a Court of Appeals. Such and approach is inconsistent with the goals of the program to be informal and non-adversarial. Given that a majority of claimants are unrepresented, such a change in policy is apt to adversely affect their ability to obtain justice in their administrative claim. The fact of the matter is that the role of Courts of Appeal is actually already being filled by the Circuit Courts. There is simply no statutory authority for transforming the Review Board into a judicial body.

6. The contents of the appeal to the Review Board (RB).

The proposal dictates that the appeal to the RB must be in writing and the NPRM lists what "should" be included: a written statement that identifies the ALJ's errors, explains why it should be reversed or modified, and cites applicable law and specific facts in the record. These requirements are very formal and legalistic, and assume that the claimant is represented by an experienced legal representative who has access to the

administrative record. Many times we are asked to represent individuals who have filed their own requests for review and only come to us after the initial filing. Certainly there should be leeway to allow for legal representatives to craft a brief that covers these questions even if the individual's appeal is filed more than 10 days before the brief can be submitted.

Moreover, the NPRM seems to imply that the failure to raise issues in the appeal statement waives the right to have them considered by the RB. Such a position, especially in cases of the unrepresented, will work a considerable injustice. Even in represented cases, there is no pleadings requirement in the Act that requires that only those matters raised before the Review Board are subject to review by the courts. There are strategic and practical reasons to limit the filings to the Review Board – requiring the raising of all possible issues will create a trap for the unwary and will bog the Review Board down with much longer briefs and analyses of case law that the RB has no inclination of reviewing.

7. Submission of new evidence.

The proposed rule is would require a stricter standard for the submission of new evidence to the RB than the statute itself requires for the submission of new evidence to the federal court. Under the NPRM, the RB will accept the new evidence only if: (1) SSA's action misled the claimant; the claimant has a physical, mental, educational, or linguistic limitation; or some other "unusual, unexpected, or unavoidable circumstance beyond the claimant's control" prevented earlier filing; *and* (2) there is a "reasonable probability" that the evidence, when considered alone or with the other evidence of record, would "change" the outcome of the claim. Such a set of constraints will lead to more litigation, and in a small but significant number of cases lead to injustice, as newly discovered evidence is turned away despite its probative value.

8. Payment required for a copy of the record.

Under the NPRM, for an appeal to the Review Board, the claimant must pay for copies of the record or the hearing recording, unless there is a "good reason" not to pay. One very good reason is that almost all SSI claimants cannot afford it, almost all of whom are surviving on small state general assistance programs (in Pennsylvania such claimants must subsist on $205 per month). Their advocates, often legal services programs like ours, have no budget to defray these costs. The end result will be that such records will not be requested, making it harder for the RB to properly evaluate the claim and making it almost impossible to comply with the new requirements for RB briefs.

9. Submitting argument to the Review Board.

In addition to the strict limits for submitting new evidence to the RB, the NPRM requires that the claimant "must submit" a statement with the additional evidence explaining why he or she believes the strict criteria are met. This will turn into a trap for unrepresented claimants. Will the RB refuse to consider the additional evidence if such a

statement is not submitted, even though the evidence is otherwise relevant and possibly even dispositive? Federal courts will be left with the task of reviewing evidence that should have been reviewed by the RB, adding still more delay and formality to the process.

In addition, while the claimant must meet strict limits for submitting new evidence under the NPRM, the RB is free to obtain new evidence either by remanding the case to the ALJ or by obtaining it on its own if it can be done "more quickly" and would not "adversely affect" the claimant's rights. There is no further explanation and there is no requirement that the RB proffer the new evidence to the claimant before issuing a decision.

10. Standard of review.

The NPRM includes a new "harmless error" rule under which the RB would not change factual or legal errors unless, in the RB's opinion, there is a "reasonable probability that the error, alone or when considered with other aspects of the case, changed the outcome of the decision." Such criteria are so broad that they invite abuse and will lead to contentious litigation. Further, the RB will only act on "significant" errors of law. There is no further clarification or guidance. What is a "significant" error? Is the RB "harmless error" standard more strict than that used by the federal courts? These standards will lead to more filings in federal court and lengthen an already burdensome process.

Conclusion

For all of the above reasons, we urge the Commissioner to reject the proposed rulemaking in its entirety; in the alternative, we suggest that substantial changes be made to the proposed rulemaking to preserve the laudable goals of the Social Security Act.

Respectfully submitted,

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