



January 29, 2020

Submitted via www.regulations.gov

Commissioner Andrew Saul
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235-6401

Re: Notice of Proposed Rulemaking on Rules Regarding the Frequency and Notice of Continuing Disability Reviews, 84 Fed. Reg. 36588 (November 18, 2019), Docket No. SSA-2018-0026

Dear Commissioner Saul:

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for people with low-income. We work at both federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty.

CLASP submits the following comments in opposition to the Social Security Administration's (SSA's) proposal to create a new "Medical Improvement Likely" (MIL) category which will be subject to increased frequency of continuing disability reviews (CDRs). Under the proposed rule, SSA would review most people every two years, leading to an additional 1.1 million full medical reviews over the next ten years, and additional 1.5 million smaller-scale reviews, over and above normal CDR reviews. Altogether, SSA would be required to conduct 19.3 million reviews in the next decade. SSA fails to provide any data or evidence that supports these reclassifications, so the public cannot evaluate them. We therefore urge SSA to withdraw this rule since it fails to comply with the requirements of the Administrative Procedure Act (APA).

Rather than supporting the health and well-being of individuals living with disabilities, this rule would reduce the number of people receiving disability benefits by imposing additional bureaucratic hassles. Although SSA does not include any estimates of how many people will lose benefits, disability policy experts calculate that 2.6 million people could be at risk of losing benefits due to this new policy. This will create additional burdens for people with disabilities who cannot work and are struggling with income insecurity.

SSA has tried to use CDRs to terminate large groups of people once before, with disastrous results. Between 1981 and 1984, SSA undertook mass eligibility reviews of disability benefits recipients with the goal of saving money, and nearly 485,000 recipients were cut off (judges later reinstated about 60% of

the recipients). After a massive public outcry, Congress forced SSA to adopt the current “medical improvement” standard for CDRs.

We submit the following comment to oppose the proposed rule, explain our concerns with the agency’s assumptions, and provide insight on the deep and lasting harm that this change would generate for individuals living with disabilities.

The Proposed Rule Would Impose Significant Burdens on Individuals with Disabilities

It is important to recognize the burden that increased CDRs impose on individuals who are receiving benefits. Under the Work Support Strategies (WSS) project, CLASP worked closely with six states that sought to dramatically improve the delivery of key work support benefits to low-income families. From this work, we learned that every additional step in the application and renewal process both increased burden on caseworkers and made it harder for families to access and retain the full package of supports that they need to thrive in work and school.¹ While requirements to complete paperwork and submit documentation at the risk of losing monetary benefits and health care would be challenging for anyone, they are likely more difficult, stressful, and time-consuming for disability beneficiaries, who as a group are older,² poorer,³ and sicker than the general population.

Under the proposed rule, even beneficiaries who SSA already knows from the original process of awarding disability benefits have unstable housing situations, intellectual disabilities, limited educations, inability to leave their homes, difficulty reading or writing, or other barriers to receiving, completing, and mailing back CDR documents must comply with the new requirements. If they do not, they will become part of an increasing number and percentage of CDR recipients⁴ whose disability benefits are terminated for “failure to cooperate” with the CDR process.

Although the Notice of Proposed Rulemaking (NPRM) estimates it will take beneficiaries 60 minutes to complete the full medical CDR form (SSA-454-BK), it is likely to take some beneficiaries far longer; those who have the greatest disabilities will be most likely to struggle to complete the form without significant assistance. The form is 15 pages long and requires short essays about the beneficiary’s use of assistive devices, daily activities, and hobbies or interests. It requires a list of all medical providers with their contact information, the dates of the first and most recent appointments, and any treatments provided. All medications and tests, education, and vocational rehabilitation must be listed as well. Most recipients will be unable to answer this information without assistance from their health care providers or other service providers. This will create a great burden on both the individuals subject to the CDR and to the medical professionals who serve them. In many cases, it will also create a cost burden on clients, as they will need to have additional appointments, including travel time, to complete these forms. Moreover, in some states, health care providers are required to provide medical records at no cost for the initial Social Security application, but are permitted to impose a fee for medical records requested for CDRs. For people who are employed, there will also be a burden on employers to help complete the form.

There is No Reason to Believe Increased CDRs Will Identify People Who Should Not Be Receiving Benefits

It is important to recognize that, by definition, everyone who is subject to a CDR has already been determined by SSA to have at least one severe and medically determinable impairment expected to last at least 12 months or to be fatal. The U.S. already has one of the most stringent disability benefit systems in the developed world.⁵ Only about one in three applicants are approved for Supplemental Security Income (SSI) benefits⁶ and about two in five applicants for Social Security Disability Insurance (SSDI).⁷ Individuals who are denied benefits typically have extremely limited employment in the years following their rejection,⁸ suggesting that if anything, the criteria are being applied too narrowly, leaving out people truly in need of assistance.

SSA already conducts CDRs at scheduled intervals for people who receive benefits. Termination for medical improvement as a result is rare: in Fiscal Year 2018, SSA initiated over 1.3 million periodic CDRs for disabled workers,⁹ but in calendar year 2018, only 45,285 terminations of disabled workers for medical improvement occurred; in comparison, more than five times as many disabled workers died that year and more than ten times as many reached full retirement age.¹⁰

Even when medical improvement is initially found in a CDR, it is frequently overturned on appeal. According to SSA's annual report to Congress, 71.6% of initial cessations of disabled worker benefits in FY 2015 that were appealed were overturned at reconsideration, with additional cases overturned after ALJ hearings, Appeals Council review, or federal court appeals.¹¹ This indicates that if SSA increases the number and frequency of CDRs, the agency will impoverish more people who will ultimately demonstrate their benefits should have continued.

Research by SSA staff shows that people whose benefits are terminated for medical improvement are unlikely to be able to perform substantial gainful activity, even with every financial incentive to do so. While 70% of those whose disabled worker benefits were terminated for medical improvement had some earnings in the five years after cessation, 63% had at least one year with no earnings at all, and only 20% earned more than the substantial gainful activity threshold in all five years.¹²

SSA fails to provide any data or evidence that supports these reclassifications, so the public cannot evaluate them

In this NPRM, the Social Security Administration fails to include the criteria the agency used to identify the impairments it proposes to include in the newly created Medical Improvement Likely (MIL) CDR category. Nor does the proposed rule share the data, evidence, or studies, the agency relied on in selecting the impairment or beneficiary types (e.g. those awarded benefits at step 5 of the sequential disability evaluation process, children turning 6 or 12 years old) it opted to place in the new category. The proposed rule fails to state the CDR categories that would be used for many of the most common impairments, making it impossible to determine what changes would occur, what the rationale is for them, and what the effect would be on disability beneficiaries and others. The failure to provide the public with all but the most rudimentary information about its rationale or process creates an impermissible procedural error under the APA, making it impossible for the public to make meaningful comments regarding the time frames proposed in the NPRM or the classification of impairments into CDR categories.

People of Color May Be Disproportionately Impacted

Research suggests that people of color, in particular Black people, may be negatively impacted by racial bias in pain assessment and treatment recommendations, which would affect their ability to receive benefits based on health conditions. One study found individuals with at least some medical training hold false beliefs about race that inform medical judgements, which may contribute to racial disparities in pain assessment and inadequate treatment recommendations for Black patients' pain.¹³ Further, the Government Accountability Office (GAO) found in the early-1990s that Black people with serious ailments were much more likely than White people to be rejected for benefits under Social Security disability programs.¹⁴ While this particular analysis has not been repeated recently, there remains widespread evidence of inequities in medical treatment. These findings suggest that people of color may be less likely to receive appropriate diagnoses based on health conditions, and are at greater risk of losing benefits due to increased CDRs.

The proposed rule would particularly increase the number of CDRs required of children with disabilities. This imposes a significant burden on their parents. People of color are disproportionately likely to be employed in jobs that do not provide paid time off,¹⁵ and where they may be fired or have their hours cut if they limit their hours of availability.¹⁶ Therefore, parents may be forced to choose between their jobs and the appointments needed to ensure that their children retain disability benefits.

Loss of Benefits Would Cause Deep and Lasting Harm

The proposed rule would particularly target children receiving SSI benefits for increased CDRs. Loss of SSI benefits for children with disabilities would cause deep harm with long-term consequences. SSI's modest financial support helps low-income families offset some of the costs of raising a child with a disability, such as meeting the child's basic needs for food, clothing, and shelter; paying for special therapies, specially trained child-care workers, medically prescribed diets, diapers for older children, adaptive equipment, and transportation to doctors; as well as the loss of income when a parent must take time off to take the child to medical appointments or reduce work hours to care for the child.¹⁷ Families raising children with disabilities are more than twice as likely as other families with children to face material hardships such as homelessness, food insecurity, and utility shutoff.¹⁸ SSI is cost-effective, allowing families to care for children with disabilities in their own homes instead of in harmful, costly institutions. SSI benefits also help families maximize a child's opportunity to achieve an independent, rewarding, productive life including work in adulthood.

The financial support provided by SSI has direct benefits for children, including on their health outcomes. A recent study found that, over the first 8 years of their lives, children who qualified for SSI because they were born with birthweights just below the automatic eligibility threshold are less likely to be admitted to hospital, have shorter hospital stays when admitted, and use fewer specialist services, and have reduced rates of diagnosis across a range of both acute and chronic conditions in early life.¹⁹

Because of SSI's strict income and asset limits, the overwhelming majority of recipients live in households with incomes under the poverty line. Loss of benefits would cause individuals and families to fall even further into poverty, which has long-lasting adverse outcomes, in particular for children.²⁰ SSDI also provides critical income support for workers experiencing great hardship. Without it, nearly half of disabled workers would be poor. Even with disability benefits, about 1 in 5 disabled workers are poor

and many are near poor.²¹ Termination of financial benefits will create hardship, and can lead to acute crises such as eviction, homelessness, bankruptcy, or incarceration, which have significant costs on individuals as well as society as a whole.

Loss of disability benefits will also cause some adults to lose their health insurance coverage, especially in states that have not adopted the expansion of Medicaid, where many adults who lose SSI will fall into the “coverage gap” between Medicaid and Marketplace subsidies.²² Even in expansion states, individuals with disabilities are at high risk of losing coverage due to the work reporting requirements that a number of states are seeking to impose under waivers as a condition of eligibility for Medicaid. While these policies are not supposed to be applied to individuals with disabilities, this is often determined based on receipt of government disability benefits.

Similarly, adults who are cut off from SSI or SSDI may also be at risk of losing their SNAP benefits due to the time limit for unemployed “able bodied adults without dependents.” Many individuals characterized as able-bodied adults in fact may have physical or mental limitations which impede them from employment. In a Franklin County, Ohio report, approximately one-third of individuals characterized as able-bodied reported having a “physical or mental limitation.”²³ Of those, 25 percent indicated that the condition limited their daily activities, and nearly 20 percent had filed for Disability/SSI within the previous 2 years.²⁴ BLS reported that half of working-age adults with a disability who were not working reported barriers to employment, including a lack of transportation and the need for accommodations in a workplace.²⁵ Another BLS report shows that workers with disabilities are nearly twice as likely as workers with no disability to be employed part-time.²⁶

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely than those with continuous coverage to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care, and more likely to have unmet medical or prescription drug needs.²⁷ A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.²⁸

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.²⁹ Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of \$239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.³⁰

The proposed rule would also likely increase waits for disability determinations for new applicants. Even as the number of new applicants has declined, in 2018, applicants who appealed an initial rejection had to wait an average of 595 days, more than a year and a half, for a hearing on their appeal, and 858,000

cases were pending a hearing.³¹ These historic waits lead to extreme hardship: while awaiting a hearing, many struggle to pay rent or meet basic needs. Some lose their homes or go into bankruptcy, and in 2017 approximately 10,000 people died while waiting for a hearing.³²

Nearly All of “Savings” Under the Proposed Rule Would Go to Increased Administrative Costs

The proposed rule estimates that spending on disability benefits would decrease by \$2.6 billion over 10 years, and that administrative costs would increase by \$1.8 billion over that time period. This simple calculation indicates that more than two-thirds of the savings would immediately be consumed by increased administrative costs of SSA. Moreover, the calculation does not take into account the fact that when people lose their disability benefits, in many cases they will become eligible for other needs-based benefits or qualify for larger amounts of benefits. While this has the potential to slightly offset the loss of benefits to individuals, it will also increase the administrative burden to participants as well as the administrative and direct costs of other programs.

Similarly, the rule fails to take into account how the loss of income will lead to increased health care costs. For low-income children, who will remain eligible for Medicaid, these costs will be incurred by the government. For example, the recent study of the benefits of childhood SSI found that, over the first 8 years of their lives, children who qualified for SSI because they were born with birthweights just below the automatic eligibility threshold incurred Medicaid expenditures 30% lower than do those born just above the threshold. Their families were able to use the SSI funds in ways that reduced the incidence of illness, through investments in things like healthy food and apartments without allergens. Reductions in Medicaid spending associated with SSI eligibility offset increased cash transfer payments by an astonishing ratio of 3.3:1.³³ As a whole, the rule would reduce the cash benefits available to individuals with disabilities with little savings to taxpayers.

Conclusion

Our comments include citations to supporting research and documents for the benefit of SSA in reviewing our comments. We direct SSA to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

Thank you for the opportunity to submit comments on proposed rule. Please do not hesitate to contact me (elowerbasch@clasp.org) to provide further information.

All sources accessed January 2020.

¹ Julia B. Isaacs, Michael Katz, Ria Amin, *Improving the Efficiency of Benefit Delivery Outcomes from the Work Support Strategies Evaluation*, Urban institute, November 2016, <https://www.urban.org/research/publication/improving-efficiency-benefit-delivery>.

² More than 75% of SSDI beneficiaries are age 50 or older, over 35% are age 60 or older, and nearly 6% are age 65. “Disabled Worker Beneficiaries in Current Payment Status at the End of December 2016, Distributed by Age and Sex,” *Social Security*, January 2017, https://www.ssa.gov/OACT/ProgData/benefits/da_age201612.html.

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- ³ 1% of Title II disability beneficiaries have household income below 300% of the poverty level; 20% were in poverty. Among SSI recipients, the poverty rate was 34% for children and 43% for adults aged 18-64. Michelle Stegman Bailey and Jeffrey Hemmeter, *Characteristics of Noninstitutionalized DI and SSI Program Participants, 2013 Update*, Social Security, September 2015, <https://www.ssa.gov/policy/docs/rsnotes/rsn2015-02.html>.
- ⁴ According to SSA's annual CDR reports to Congress, in 2013 there were 2,256 failure to cooperate (FTC) terminations, reflecting less than 2% of all terminations after CDRs. By 2016, these had increased to 9,956 FTC terminations, 5.1% of all CDR terminations.
- ⁵ OECD, *Sickness, Disability and Work: Breaking the Barriers*, Organization for Economic Cooperation and Development (OECD), November 2010, <http://www.oecd.org/publications/sickness-disability-and-work-breaking-the-barriers-9789264088856-en.htm>.
- ⁶ "Supplemental Security Income (SSI)," *Center on Budget and Policy Priorities*, n.d., <https://www.cbpp.org/research/social-security/supplemental-security-income-ssi>.
- ⁷ Rebecca Vallas and Shawn Fremstad, *Social Security Disability Insurance*, Center for American Progress, June 2015, https://cdn.americanprogress.org/wp-content/uploads/2015/06/SSDI_update-brief-6.16.pdf.
- ⁸ Kathy Ruffing, "Denied Disability Applicants Fare Badly in the Labor Market," *Center on Budget and Policy Priorities*, August 2018, <https://www.cbpp.org/blog/denied-disability-applicants-fare-badly-in-the-labor-market>.
- ⁹ "Social Security Administration (SSA) Annual Data for Periodic Continuing Disability Reviews (CDR) Processed & Backlog," *Social Security*, 2018, <https://www.ssa.gov/open/data/Periodic-Continuing-Disability-Reviews.html>.
- ¹⁰ "Annual Statistical Report on the Social Security Disability Insurance Program, 2018," Social Security, n.d., https://www.ssa.gov/policy/docs/statcomps/di_asr/2018/sect03f.html.
- ¹¹ Letter from Andrew Saul to Congress, Social Security, August 2019, <https://www.ssa.gov/legislation/FY%202015%20CDR%20Report.pdf>. Table B2. Most FY15 cases had not completed ALJ review by the time the report was published in 2019. However, in years where a majority of ALJ hearings had been completed, approximately one-third to one-half resulted in continuation of benefits.
- ¹² Jeffrey Hemmeter and Michelle Stegman Bailey, "Earnings After Di: Evidence From Full Medical Continuing Disability Reviews," *IZA Journal of Labor Policy*, 2016, <https://izajolp.springeropen.com/articles/10.1186/s40173-016-0066-9>.
- ¹³ Kelly Hoffman, Sophie Trawalter, Jordan R. Axta, et al., "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites," *University of Virginia*, March 2016, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843483/>.
- ¹⁴ Stephen Labaton, "Benefits Are Refused More Often To Disabled Blacks, Study Finds," *The New York Times*, May 1992, <https://www.nytimes.com/1992/05/11/us/benefits-are-refused-more-often-to-disabled-blacks-study-finds.html>.
- ¹⁵ Tanya L. Goldman and Pronita Gupta, "Paid Family and Medical Leave is Critical for Low-wage Workers and Their Families," Center for Law and Social Policy, December 2018, <https://www.clasp.org/publications/fact-sheet/paid-family-and-medical-leave-critical-low-wage-workers-and-their-families>.
- ¹⁶ Julia Kortrey, *Paid Family and Medical Leave: A Racial Justice Issue – and Opportunity*, National Partnership for Women and Families, August 2018 <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/paid-family-and-medical-leave-racial-justice-issue-and-opportunity.pdf>.
- ¹⁷ CCD Social Security Task Force, "Preserve Supplemental Security Income: A Vital Part of Our Social Security System," *Consortium for Citizens with Disabilities*, January 2018, <http://www.c-c-d.org/fichiers/Preserve-SSI-for-People-with-Disabilities.pdf>.
- ¹⁸ Susan Parish, Roderick Rose, Michal Grinstein-Weiss, et al., "Material Hardship in Us Families Raising Children With Disabilities," *Exceptional Children*, 2008, https://sww.unc.edu/files/web/pdf/ExceptChildrenMaterial_Hardship.pdf.
- ¹⁹ Hansoo Ko, Renata E. Howland, Sherry A. Glied, et al., "The Effects of Income on Children's Health: Evidence from Supplemental Security Income Eligibility under New York State Medicaid," *NBER Working Paper*, 2020, <https://www.nber.org/papers/w26639>.
- ²⁰ National Academies of Sciences, Engineering, and Medicine, *A Roadmap to Reducing Child Poverty*, National Academies Press, 2019, <https://www.nap.edu/catalog/25246/a-roadmap-to-reducing-child-poverty>.
- ²¹ "Policy Basics: Social Security Disability Insurance," *Center on Budget and Policy Priorities*, updated July 2019, <https://www.cbpp.org/research/retirement-security/policy-basics-social-security-disability-insurance>.
- ²² Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, Kaiser Family Foundation, January 2020, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid>.
- ²³ *Franklin County Work Experience Program*, Ohio Association of Foodbanks, 2015,

http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_2014-2015-v3.pdf.

²⁴ Ibid.

²⁵ U.S. Department of Labor, "Persons with a Disability: Barriers to Employment, Types of Assistance, and Other Labor-Related Issues—May 2012," *Bureau of Labor Statistics*, April 2013,

https://www.bls.gov/news.release/archives/dissup_04242013.pdf.

²⁶ U.S. Department of Labor, "Persons with a Disability: Labor Force Characteristics—2016," *Bureau of Labor Statistics*, June 2017, <https://www.bls.gov/news.release/pdf/disabl.pdf>.

²⁷ Jennifer Haley and Stephen Zuckerman, "Is Lack of Coverage A Short or Long-Term Condition?" *Kaiser Family Foundation*, June 2003, <http://kff.org/uninsured/issue-brief/is-lack-of-coverage-a-short-or/>.

²⁸ Ibid., 17.

²⁹ Ibid., 18.

³⁰ Ibid., 19.

³¹ Jack Smalligan and Chantel Boyens, *Improving the Social Security Disability Determination Process*, Urban Institute, July 2019,

https://www.urban.org/sites/default/files/publication/100710/improving_the_social_security_disability_determination_proces_0.pdf.

³² Ibid., 17.

³³ Ibid., 19.