December 20, 2007

Michael J. Astrue
Office of the Commissioner
Social Security Administration
P.O. Box 17703
Baltimore, MD 21235-7703

Filed at: www.regulations.gov

Re: Docket No. SSA-2007-0044, Proposed Rule on Amendments to the Administrative Law Judge, Appeals Council, and Decision Review Board Appeals Levels

Dear Commissioner Astrue:

On behalf of the National Alliance on Mental Illness (NAMI), I am pleased to submit the following comments on the **Proposed Rule on Amendments to the Administrative Law Judge, Appeals Council, and Decision Review Board Appeals Levels,** 72 Fed. Reg. 61218 (Oct. 29, 2007)("NPRM").

NAMI is the nation's largest organization representing individuals living with mental illness and their families, with 210,000 members and 1,200 affiliates in all 50 states, the District of Columbia and Puerto Rico. NAMI is a member of the Consortium for Citizens with Disabilities (CCD) and is a signatory organization to comments on these proposed rules that CCD will be submitting. As you can see, the comments included below closely follow the concerns raised by CCD with respect to ensuring that efforts to expedite decision making does not compromise either accuracy or fairness in the process.

NAMI concurs with the Commissioner's view that reducing the backlog and processing time must be a high priority and we urge commitment of resources and personnel to reduce delays and to make the process work better for the public. We strongly support changes to make the process more efficient so long as those changes do not affect the fairness of the procedures used to determine a claimant's entitlement to benefits. The notice of proposed rulemaking provides some positive changes. However, NAMI's overarching concern is that many aspects of the proposed process elevate speed of adjudication above accuracy of decision-making. Based on our perspective as claimants and family members, this is problematic and not appropriate for a non-adversarial process.

On balance, NAMI would urge the Commissioner not to implement this NPRM unless significant changes are made to protect the rights and interests of people with

disabilities. Our measure is whether the process will be fair. While there are some positive proposed changes, e.g., a 75-day hearing notice (the current rule provides only a 20-day notice) and retaining a claimant's right to administrative review of an unfavorable ALJ decision, we believe that these proposals, individually identified here but also as a package, if not improved, will result in more decisions that are not based on full and complete records and are not fair.

NAMI is very concerned that claimants will be denied not because they are not disabled, but because they have not had an opportunity to present their case. It is appropriate to deny benefits to an individual who is found not eligible, if that individual has received full and fair due process. It is not appropriate to deny benefits to an eligible individual simply because he or she has been caught in a procedural tangle. Especially vulnerable will be unrepresented claimants. However, even those who secure able representation at some point in the process will fall into the traps that would be set by the proposed procedural barriers in the NPRM.

While the current system is far from perfect, it does provide a great deal more flexibility to address and resolve problems in a claim. While this may lead to additional processing time for an individual case, it also means that the final decision will be more accurate, which should be the priority in a non-adversarial, truth-seeking process. NAMI shares CCD's view that SSA can (and already is beginning to) speed up the process without sacrificing this basic concept of fairness.

Improving the Process with New Technology and Early Development of the Evidence

Changes at the "front end" of the process can have a significant beneficial impact on improving the backlogs and delays later in the appeals process, by making correct disability determinations at the earliest possible point. Before addressing specific reactions to the NPRM, NAMI would like to highlight two important issues that are not part of the NPRM, but could significantly improve the decision making process and decrease processing times in ways that benefit both claimants and SSA.

First, NAMI shares CCD's general support for SSA's technological initiatives to improve the disability claims process, so long as they do not infringe on claimants' rights. The initiative to process disability claims electronically, eDIB, has the prospect of significantly reducing delays by eliminating lost files, reducing the time that files spend in transit, and preventing misfiled evidence. Claimants' representatives are able to obtain a single CD that contains all of the evidence in the file which provides early access to the record in order to determine what additional evidence is needed. Eventually, they will be able to access the claimant's folder through a secure website.

Second, for many years, CCD and its member organizations have supported better development of the record at the beginning of the claim so that the correct decision can be made at the earliest point possible. Claimants should be encouraged to submit evidence as early as possible. The benefit is obvious: the earlier a claim is adequately developed, the sooner it can be approved. However, critical pieces of evidence are often

missing when claimants first seek representation (often not until some time at the ALJ stage) and the burden falls on the representatives to obtain this evidence. This situation was confirmed by medical, legal, and lay witnesses at the recent "Compassionate Allowances Outreach Hearing" held by the Commissioner on December 4 and 5, 2007.

As supported by the testimony of the witnesses at the December 2007 Compassionate Allowances Outreach Hearing, CCD has made the following recommendations to improve the development of evidence including: (1) SSA should explain to the claimant in writing, at the beginning of the process, what evidence is important and necessary; (2) DDSs need to obtain necessary and relevant evidence, especially from treating sources, including non-physician sources (therapists, social workers) who see the claimant more frequently than the treating doctor and have a more thorough knowledge of the claimant; (3) Improve provider response rates to requests for records, including more appropriate reimbursement rates for medical records and reports; and (4) Provide better explanations to medical providers, in particular treating sources, about the disability standard and ask for evidence relevant to the standard.

Why Are the Proposed Changes Detrimental for People with Disabilities?
For decades, Congress, the United States Supreme Court, and SSA have recognized that the informality of SSA's process is a critical aspect of the program. Creating unreasonable procedural barriers to eligibility is inconsistent with Congress' intent to keep the process informal and non-adversarial, and with the intent of the program itself, which is to correctly determine eligibility for claimants, awarding benefits if a person meets the statutory requirements.

For people with mental illness and other disabilities, it is important that SSA improve its process for making disability determinations. NAMI strongly supports efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as the steps proposed do not affect the fairness of the process to determine a claimant's entitlement to benefits. Any changes to the process must be measured against the extent to which they ensure fairness and protect the rights of people with disabilities.

The most significant proposed change in this NPRM would close the record to new evidence in two ways by: (1) Restricting the submission of evidence at the ALJ and Review Board (the replacement for the Appeals Council) levels regardless of its relevance to proving a claimant's disability; and (2) Limiting a claimant's ability to correct an erroneous ALJ decision after remand by the Review Board or the federal court. Exacerbating the adverse effect of these changes, SSA would advise claimants to file new applications, potentially with detrimental consequences, and restrict their ability to reopen prior claims.

NAMI also shares CCD's concern that the real purpose of the changes is to reduce allowances. The proposed rule assumes that fewer claims would be allowed, with a more than $1.5 billion reduction in benefit payments over the next ten years. However, the actual benefit payment reduction may be much higher. The NPRM measures the savings against the current Disability Service Improvement process, which would be gradually

implemented nationwide, one region at a time. But when the NPRM is measured against the current process, which is currently in effect in the vast majority of the country, the SSA actuaries have estimated that the program savings would be more than $2 billion. From our perspective as advocates for claimants with disabilities, this is not acceptable.

I. Closing the Record to New Evidence Is Unfair To People With Disabilities

A. Significant New Restrictions on the Submission of Evidence

The NPRM creates strict limits and procedures for submission of new and material evidence. For many claimants who meet the statutory definition of disability, the result could well be a denial based on an incomplete record, which is inconsistent with the goal of the disability determination process to ensure that adjudicators have a complete record when deciding a claim.

Under the NPRM, the record essentially closes five business days before the hearing. Evidence submitted after that date is considered "late" and is subject to new rules:

- **Within five business days of the hearing or at the hearing:** The ALJ may accept the new evidence if the claimant shows that: (1) SSA's action misled the claimant; (2) the claimant has a physical, mental, educational, or linguistic limitation that prevented the claimant from submitting the evidence earlier; or (3) some other "unusual, unexpected, or unavoidable circumstance beyond the claimant's control" prevented earlier filing.

- **After the hearing but before the hearing decision:** The ALJ may accept and consider new evidence if (1) one of the three exceptions above is met **and** (2) there is a "reasonable possibility" that the evidence, when considered alone or with the other evidence of record, would "affect" the outcome of the claim.

Under these proposed changes, the ALJ has the discretion to ignore any evidence submitted less than five business days before the hearing. The exceptions are within the discretion of the ALJ and if the ALJ finds that the exceptions are not met, a claimant will have no recourse to have the evidence considered other than to file an appeal to the Review Board and to federal court from the agency's "final decision" or to abandon their claim. Such a result conflicts with the goal of ensuring that there is a complete record, especially since there is no claim in the NPRM or the preface that this evidence is somehow less valuable or probative in determining disability.

The preface describes another exception that allows the ALJ to hold the record open, but this basis too is completely within the ALJ's discretion: (1) The claimant is "aware" of any additional evidence that could not be timely obtained and submitted before or at the hearing or (2) the claimant is scheduled to undergo additional medical evaluation after the hearing for any impairment that forms the basis of the disability claim. The claimant "should inform the ALJ of the circumstances during the hearing." But as far as keeping the record open if a request is made for one of these circumstances, there is no

requirement that the ALJ do so: "[T]he ALJ could exercise discretion and choose to keep the record open for a defined period of time …." 72 Fed. Reg. 61220.

The proposed limits do not provide a mechanism to ensure that an ALJ who refuses to accept evidence within 5 business days of the hearing or later does not violate a claimant's right to a full and fair hearing. The requirements in the proposed rule for "late" submission are discretionary and there are no criteria to guide ALJ decisions. For example, an ALJ could find that unsuccessful efforts to obtain evidence or other unforeseen circumstances, e.g., hospitalization, do not meet the exceptions to the five-day rule. Under the proposed changes, claimants will be at the mercy of ALJs. Some ALJs may rigidly enforce the 5-day deadline, refuse to consider any evidence after that date, and deny the claim based on an incomplete record. If the ALJ's discretion is abused, a claimant would be forced to appeal first to the Review Board and possibly to federal court simply to have the evidence considered.

The NPRM fails to recognize that there are many legitimate reasons, often beyond the claimant's or representative's control, why evidence is not submitted earlier and thus why closing the record or creating unreasonable procedural hurdles is not beneficial to claimants. We have many concerns – both legal and practical – regarding the impact of the proposed restrictions on claimants with disabilities.

If an ALJ believes that a representative has acted contrary to the interests of the client/claimant, remedies other than closing the record exist to address the representative's actions. SSA's current Rules of Conduct already require representatives to submit evidence "as soon as practicable" and to act with "reasonable diligence and promptness" and establish a procedure for handling complaints.[1] We have heard claims, generally from SSA staff, that some representatives withhold evidence, waiting to file it at some later date. If this happens, we believe that it is rare and unjustifiable. Furthermore, SSA has the tools to penalize the representative for this behavior without doing irreparable harm to claimants. However, this NPRM would punish the claimant rather than the representative.

There are a number of concerns regarding restrictions on submission of new evidence to the ALJ are discussed below.

1. **Closing the record before the hearing is inconsistent with 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). Our position is that the proposed changes conflict with the statute. Current regulations comply with the statute

[1] 20 C.F.R. §§ 404.1740 and 416.1540. In a 1999 letter report to Rep. E. Clay Shaw, Jr., when he was chairman of the Social Security Subcommittee, and to Rep. Mac Collins, the Government Accountability Office (GAO) found "no definitive evidence … that representatives were improperly delaying proceedings or that the presence of representatives led to delays." *Social Security: Review of Disability Representatives*, GAO/HEHS-99-50R (Mar. 4, 1999), at 4. The GAO further noted that SSA does have tools to deter delay, including reducing representatives' fees or use of the Rules of Conduct. *Id.* at 8.

by providing that "at the hearing" the claimant "may submit new evidence." 20 C.F.R. §§ 404.929.

This position is consistent with concerns noted by the Congressional Research Service (CRS). Following publication of the July 27, 2005 NPRM on the Disability Service Improvement (DSI) process, 70 Fed. Reg. 43590 (July 27, 2005) the House Ways and Means Subcommittee on Social Security asked CRS for information regarding the changes proposed in the NPRM. In its September 21, 2005 memorandum, CRS discussed "a possible conflict between the new [sic] rules and the Social Security Act." *The Proposed Changes to the Social Security Disability Determination and Appeals Process* (CRS, Sept. 21, 2005), p. CRS-2. The CRS memorandum notes that proposed 20 C.F.R. § 405.311 "may be in conflict with Section 205(b)(1) of the Social Security Act." p. CRS-6. More specifically, the CRS memorandum states:

> The legal issue here is whether the requirement that evidence be submitted 20 days before the ALJ hearing [the time limit in the proposed version of 20 C.F.R. § 405.311] is consistent with the requirement that the Commissioner (or an ALJ delegated by the Commissioner) make a decision "on the basis of evidence adduced at the hearing." p. CRS-6.

Further, there is congressional support for a position that restrictions on submission of evidence before the hearing are inconsistent with the Act. A bipartisan October 25, 2005 letter was sent in response to the July 2005 DSI NPRM, by the former Chairman and the former Ranking Member of the House Ways and Means Subcommittee on Social Security, Rep. Jim McCrery and Rep. Sander M. Levin, respectively. The letter discussed several issues that were raised at the Subcommittee's oversight hearing on September 27, 2005, "which we believe may negatively impact claimants' rights, may result in further processing delays, and could lead to unfair outcomes." One of these issues was the "new procedural requirements and deadlines for introducing evidence." In commenting on testimony presented at the hearing, Rep. McCrery and Rep. Levin noted that:

> [I]nstituting strict new limitations on introduction of evidence may, in some instances, conflict with statute [sic], and ignores the well-documented difficulty in obtaining evidence timely that both the SSA and claimant representatives experience.

In addition, in December 1988, the House Ways and Means Committee held a hearing on a draft NPRM that included a number of procedural changes, including restrictions on submission of evidence similar to those in the current NPRM. The Committee leadership sent letters to then Secretary of Health and Human Services Otis Bowen expressing their concerns regarding the draft NPRM. Following this Congressional criticism, the draft NPRM was not published.

Further, a previous proposal to set a pre-hearing due date for submission of evidence was abandoned by SSA because it appeared to close the record in contravention of the statute.

See 63 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 and 416.1540).

2. The proposed changes eliminate the ALJ's duty to fully and fairly develop the record.

The United States Supreme Court has held that ALJs have a "duty of inquiry" based on a claimant's constitutional and statutory rights to due process. Restrictions on the submission of evidence are inconsistent with the well-established case law in all federal circuit courts of appeal that ALJs have a duty to develop the record, which includes both obtaining sufficient medical evidence and conducting sufficiently detailed questioning at the hearing. The ALJ's failure to fully develop the record may be found to be a legal error and result in a court remand to obtain the missing information. And, because the SSA appeals process is not adversarial, this duty exists whether a claimant is unrepresented, or is represented by either an attorney or a non-attorney representative. It is not possible for the ALJ to meet this important responsibility if the requirement/presumption is that all (or virtually all) evidence must be submitted 5 business days before the hearing. As a result, this duty would be vitiated by the time limits for submitting evidence.

3. The proposed changes will force claimants to file more appeals to federal court.

The Social Security Act, 42 U.S.C. § 405(g), allows a federal court to remand a case and require SSA to consider additional evidence if (1) it is "new" and "material"; and (2) there is "good cause" for the failure to submit it earlier. The proposed requirements for "late" submission of evidence are more restrictive than the Act, which creates the anomalous situation that federal courts would deal with new evidence that should have been considered administratively. The statutory standard is less strict than the restrictions proposed in the NPRM.

Both claimants and the courts would be adversely affected by the NPRM: Claimants will be forced to file appeals just to have SSA consider evidence that was improperly excluded earlier in the process. The courts could see a dramatic increase in filings. Because some ALJs will reject any evidence that is submitted after the 5-day pre-hearing deadline, claimants will be forced to file suit in federal court. The district court judge will be asked to decide not whether the evidence proves disability but whether the ALJ or RB was wrong to refuse to consider the evidence. As a result, the restrictions will lead to unnecessary litigation.

4. The proposed changes are inconsistent with the realities of claimants obtaining representation.

Claimants seek and obtain representation shortly before, or even after, the ALJ hearing date. Many claimants do not understand the complexity of the rules or the importance of being represented until just before their hearing date. Many are overwhelmed by other demands and priorities in their lives and by their chronic illnesses. As a practical matter, when claimants obtain representation shortly before the hearing, the task of obtaining medical evidence is even more difficult. Even a 75-day hearing notice, a change that we

strongly support, will not be sufficient if the claimant seeks representation shortly before the hearing. How will the evidence submission restrictions affect an individual who obtains representation within 5 business days of the hearing? Under the NPRM, the ALJ would have the discretion to exclude new and relevant evidence.

5. The proposed changes are inconsistent with the realities of obtaining medical evidence.

While NAMI strongly supports early submission of evidence, representatives have great difficulty obtaining necessary medical records due to circumstances beyond their control. There are many legitimate reasons why the evidence is not provided earlier. The proposed 75-day hearing notice will be a great help in submitting evidence earlier, but there is no requirement that medical providers turn over records within that time period. In addition, cost or access restrictions, e.g., HIPAA requirements, may prevent the ability to obtain evidence in a timely way.

Another factor, often outside the claimant's control, is the problem with obtaining records and information from medical sources. NAMI strongly supports the submission of evidence as early as possible, since it means that a correct decision can be made at the earliest point possible. However, as confirmed by medical, legal, and lay witnesses at the recent "Compassionate Allowances Outreach Hearing" held by the Commissioner on December 4 and 5, 2007, there are many legitimate reasons why the evidence is not provided earlier. For example:

- DDS examiners fail to obtain necessary and relevant evidence. Further, the DDSs do not use questionnaires or forms that are tailored to the specific type of impairment or ask for information that addresses the disability standard as implemented by SSA. Witnesses at the Compassionate Allowances hearing noted this "language" barrier and how it causes delays in obtaining evidence, even from supportive and well-meaning doctors.

- Neither SSA nor the DDS explains to claimants or providers what evidence is important, necessary and relevant for adjudication of the claim.

- Claimants are unable to obtain records either due to cost or access restrictions, including confusion over HIPAA requirements. We have heard from representatives that medical providers have different interpretations of HIPAA requirements and as a result require use of their own forms for authorization to disclose information. This can lead to delays since repeated requests for medical information must be submitted, including delays caused by the need to obtain the claimant's signature on various versions of release forms. Frequently, if the medical records staff finds a problem with the request for information, e.g., it is not detailed enough or a different release form is required, the new request goes to the end of the queue when it is resubmitted.

  Claimants – and many representatives – also face difficulties accessing medical evidence due to the cost charged by providers. Medical facilities often require upfront payment for medical records, which many claimants cannot afford. Some

states have laws which limit the charges that can be imposed by medical providers; however, many states have no limits. And while some representatives have the resources to advance the costs for their clients, some representatives and many legal services organizations do not.

- Medical providers delay or refuse to submit evidence. Disability advocates have noted that requests for medical evidence are given low priority by some providers. The primary reasons are inadequate reimbursement rates and lack of staff in non-direct care areas, such as medical records. Despite extensive efforts by representatives, such as hiring staff whose sole job is to obtain medical evidence, numerous obstacles and lengthy delays are still encountered in a significant number of cases. Even those representatives who have staff solely dedicated to obtaining medical evidence encounter problems. And, while it may appear to be easier to obtain evidence in "quick disability determination" (QDD) cases, these claims cannot be viewed as representative of all claimants' situations. By definition, these are claims where "allegations will be easily and quickly verified…." 20 C.F.R. § 404.1619.

- Reimbursement rates for providers are inadequate.

- There also are cases in which the evidence has been provided early, but it has been misplaced by the hearing office. Representatives tell us that they often have supplied evidence to SSA before the hearing, only to arrive for the hearing and find that the evidence is not in the file. As a result, some bring another copy of the evidence to submit at the hearing, just in case SSA has not associated it with the file. In fact, some ALJs, or hearing office staff, ask the representatives to bring paper copies of the evidence to the hearing.

  This problem also has occurred with some frequency in cases involving electronic folders. Many representatives have told us that evidence submitted prior to the hearing does not appear on the CD received shortly before the hearing or when they review the electronic file on the day of the hearing. As a result, they must resubmit the missing evidence on the day of the hearing.

  Presumably, SSA now currently treats these situations as filing evidence on the date of the hearing. How will SSA treat these cases if time limits are implemented?

While a five-business-day requirement is imposed on claimants under the NPRM, nothing requires medical providers to turn over records this quickly. A claimant would be at the mercy of an ALJ to find that an exception to "late" submission of evidence has been met. Some ALJs will do so. But others may rigidly enforce the new five-business-day deadline and refuse to consider any medical evidence submitted within that time limit and even deny the claim based on an incomplete medical record. And, if the ALJ abuses his or her discretion -- which happens -- the claimant will have limited recourse within the agency, and in many cases will need to file suit in federal court where a district court judge will be asked to decide not whether the evidence proves disability, but whether the

ALJ was wrong to refuse to consider the evidence. As a result, the five-business-day time limit will result in decisions based on incomplete records, which will lead to unnecessary litigation. These results are not only unfair to claimants but also are administratively inefficient and thus do not advance the Commissioner's goals.

6. The proposed changes are inconsistent with the realities of claimants' medical conditions.

Claimants' medical conditions may worsen over time and/or diagnoses may change. Claimants undergo new treatment, are hospitalized, or are referred to different doctors. Some conditions, including serious mental illness, may take longer to diagnose definitively. The severity of an impairment, and the limitations it causes, may change due to a worsening of the medical condition, e.g., what is considered a minor cardiac problem may be understood to be far more serious after a heart attack is suffered. It also may take time to fully understand and document the combined effects of multiple impairments. Further, some claimants may be unable to accurately articulate their own impairments and limitations, either because they are in denial, lack judgment, simply do not understand their disability, or because their impairment(s), by definition, makes this a very difficult task. By their nature, these claims are not static and a finite set of medical evidence does not exist.

Further, as with some claimants who seek representation late in the process, their disabling impairments make it difficult to deal with the procedural aspects of their claims. Claimants may have difficulty submitting evidence in a timely manner because they are too ill, or are experiencing an exacerbation, or are simply overwhelmed by the demands of chronic illness, including the time and logistical demands of a caregiver or advocate to help submit evidence.

B. Closing the Record Limits A Claimant's Ability to Correct An Erroneous ALJ Decision

The NPRM restores the claimant's right to request administrative review of an unfavorable ALJ decision (eliminated under the Disability Service Improvement process), a change that we strongly support. However, that right is severely curtailed by new and significant limits on review by the Review Board (RB) and by the federal courts and the ALJ's ability to correct a prior erroneous decision.

If the RB or federal court finds the ALJ decision legally erroneous and remands the case for a new hearing, the NPRM limits the scope of review in the remand proceedings. Even though the original ALJ decision would be vacated either by the RB or the federal court and is remanded for a new hearing, "the proceedings on remand will consider your case only with regard to the period ending on the date of the original [ALJ] decision in your case." Proposed 20 C.F.R. § 404.972.

Under current procedures, the first ALJ decision is reversed and vacated when the court (or the Appeals Council) remands for a legal error. As a result, there is no "final decision of the Commissioner" in place per section 205(g) of the Social Security Act and

claimants are able to submit new evidence regarding any changes in the severity of their impairment(s). During the subsequent proceedings on remand, the ALJ may decide, based on the new evidence and by correcting the prior legal errors, that the claimant is now disabled. The ALJ also may adjust the onset date according to the new (and old) evidence of disability.

In the preface to the NPRM, SSA explains that the current process must be changed because a disability decision can be based (1) on evidence "submitted well after the evidentiary record should have closed," (2) on evidence that relates to a period of time after the first ALJ decision, or (3) based on new impairments. SSA believes that "[t]his open-ended approach is administratively very inefficient, as we often are reviewing ALJ decisions based on evidence not presented to the ALJ."[2] There is no allegation by SSA that this approach leads to inaccurate disability determinations. Indeed, the current approach is consistent with the intent of a non-adversarial and truth-seeking process.

The agency goes on to state in the preface that "this proposed closing of the record will not unduly disadvantage claimants." But it most certainly will. As an alternative, under the NPRM, SSA would urge a claimant to file new application if his or her condition worsens during the time between the ALJ's decision and the review proceedings.[3] However, a new application, in many cases, is a poor and even disadvantageous substitute for an appeal. For all claimants, benefits could be lost from the effective date of the first application. Title II claimants would be particularly harmed as cash benefits would be delayed by the 5-month waiting period and Medicare benefits could be delayed because of the 24-month Medicare waiting period. Many Title II workers could be permanently foreclosed from eligibility for benefits if their insured status had expired. Our concerns regarding the filing of multiple applications are described in the next section of our comments.

The NPRM represents a significant change from current policy regarding the scope of review on federal court and Appeals Council remands. It raises preservation of the original ALJ decision to higher importance than determining whether the individual is disabled and entitled to benefits under the Act. If implemented, this new and untested proposed change will not only have a detrimental impact on individuals with disabilities, but also will adversely affect SSA and the federal courts: Claimants will lose valuable rights and face a much more complex process; SSA will face increased workloads due to the filing of multiple applications; and the federal courts will encounter limits on the scope of their review that are not statutorily mandated.

The proposal to limit the ability of claimants who appeal to correct erroneous ALJ decisions has never been tested. It was not proposed or included in the March 2006 final regulations governing the Disability Service Improvement process now in place in SSA Region I states. However, it was included in the unpublished 1988 draft NPRM that was the subject of the December 1988 House Ways and Means hearing. A New York Times article on the draft NPRM succinctly described the impact of this provision on disabled

[2] 72 Fed. Reg. 61222.
[3] *Id.*

claimants by noting that it would preclude submission of new evidence of an impairment or new impairments in the appeals process. The situation is analogous to the current NPRM and the article provides as an example a claimant who is disabled by a tumor that later is determined to be cancerous. Under the 1988 draft NPRM and under the current NPRM, this claimant would not be able to provide evidence of the cancer diagnosis without filing a new application. How can this be fair to people with disabilities? We do not believe that this situation is consistent with Congressional intent for the disability claims process.

Our other concerns with the proposed change restricting a claimant's ability to correct erroneous ALJ decisions are described below.

1. The proposed change can be interpreted as establishing time-limited benefits. The language of the proposed regulation is ambiguous. On remand, the ALJ would not be able to consider an increase in severity of the original impairment(s) or the development of a new impairment. At best, it means that a claimant, on remand, will be limited to establishing onset of disability no later than the date of the first (and now vacated) ALJ decision. But at worst, the regulation can be interpreted to mean that the claimant could be found eligible for a time-limited period, ending no later than the date of the original ALJ decision. Under either scenario, the claimant would be forced to file a new application for ***any*** change in his or her condition that occurs after the date of the original ALJ decision, even if related to the original impairment(s) considered by the ALJ.

Both interpretations of the regulation will have a negative impact on claimants with disabilities. However, if the proposed change leads to a process where the claimant on remand will be limited to a time-limited period of benefits, there will be very severe, adverse repercussions:

- **Claimants who appeal to court would be punished.** A claimant who has the misfortune of receiving an erroneous ALJ decision and who must appeal to federal court will be placed in a worse situation than a similarly situated claimant who receives a legally correct ALJ decision and is found eligible for ongoing benefits.
- **Claimants would not be protected by use of the medical improvement standard.** The individual will not be eligible for the protection of the medical improvement standard – benefits will end, even though the medical condition has worsened. This result may be legally inconsistent with the statutory provisions on medical improvement.[4]
- **Individuals with disabilities will lose access to critical health care benefits.** SSI and Title II eligibility are the links to Medicaid and Medicare, which along with the cash benefits are the means of survival for millions of persons with disabilities. If found eligible for a time-limited period, individuals will not be automatically eligible for

[4] The medical improvement standard provides that a disability beneficiary may be determined no longer entitled to benefits only if there is a finding of medical improvement and he or she is now able to engage in substantial gainful activity. 42 U.S.C. §§ 423(f) and 1382c(a)(4).

Medicaid and will have limited ability to comply with the 24-month Medicare waiting period.

- **Individuals with disabilities will lose access to important work incentives.**

Eligibility for time-limited 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.

2. The proposed change is inconsistent with the Social Security Act and limits the ability of courts to order remedies for the agency's legal errors.

The proposed regulation raises serious questions regarding how federal court remands will be effectuated and whether it is consistent with the statute. Before filing an appeal to the federal court, Section 205(g) of the Act requires a "final decision of the Commissioner of Social Security made after a hearing." Federal courts are statutorily authorized to "affirm, modify, or reverse" the agency's decision, with or without remanding the case, due to legal errors committed by the ALJ. In a remand situation, the court reverses the underlying "final decision" of the Commissioner, usually the ALJ decision (if the Appeals Council denies review). Since there no longer is a "final decision," the claim remains open until there is a new "final decision."

From a legal perspective, the court has the authority to order that the agency, on remand, correct the previous errors and consider the claimant's current eligibility for benefits. Given the fact that the claim remains open, the ALJ has the authority to make a new decision based on new evidence regarding any worsening of the claimant's impairments since the last ALJ decision. Further, from a practical perspective, this approach is the most efficient for ALJs, since the NPRM raises many thorny implementation questions including: What happens if the court remands for consideration of "new and material evidence" that was not available in the prior administrative proceedings? What if it relates to a worsening of the impairment(s) which formed the basis of the original claim but is dated after the first ALJ decision? What if the court reverses and specifically states in its remand order that the agency must consider new evidence? Does the proposed change attempt to limit the court's authority by restricting the scope of review it can order for remand proceedings?

C. Forcing Claimants to File Multiple Applications Is Neither Fair Nor Efficient

By closing the record to new evidence and limiting the period that can be considered to determine eligibility, claimants would unnecessarily be forced to file multiple applications. A claimant would be required to file a new application for consideration of any change in disability after the date of the original ALJ decision, even if the change is

related to the impairment(s) considered in the prior application. This is an onerous burden to place on claimants. Why would the agency force an individual to file additional applications when the claim for disability could be resolved by making the decision based on a complete record?

In the preface to the proposed regulations, SSA states that it intends to encourage claimants whose claims are denied by ALJs to file new applications if their conditions worsen or they experience new impairments. To that end, SSA intends to modify its notices to "ensure that claimants are aware that they can file new applications" and "welcome[s] comments from the public" regarding how the agency can best "ensure that claimants understand their right to file new applications…." 72 Fed. Reg. 61222.

NAMI joins CCD in opposing a change in denial notices that encourages individuals to file new applications rather than pursue appeals. As explained below, claimants may jeopardize their eligibility, possibly forever, by reapplying rather than appealing. For many years, primarily before 1991, SSA's denial notices informed claimants that they could either appeal or reapply, and misled claimants regarding the consequences of reapplying in lieu of appealing an adverse decision. Congress responded and legislation enacted in 1990 requires SSA to include clear and specific language in notices describing the adverse consequences of reapplying. 42 U.S.C. §§ 405(b)(3) and 1383(c)(1). Congress has previously corrected this problem and it is inappropriate for SSA to now suggest reapplication for claimants who receive decisions that may well have been decided based on incomplete records. More than 15 years after Congress acted on this problem, it is troubling that the concept is still imbedded in SSA's thinking and used as a justification for preventing the consideration of all evidence relevant to the claim.

NAMI shares CCD's further concern that the impetus for these changes is a reduction in allowances since the NPRM makes clear that closing the record is intended to result in a $1.5 billion reduction in benefit payments over the next ten years. 72 Fed. Reg. 61225-26. Does this mean that SSA assumes that claimants will be confused and discouraged and will not file new applications? Do the "savings" include those claimants who file new applications and lose benefits from the effective date of the first application or are permanently foreclosed from eligibility? If so, this is a particularly inappropriate and harmful change.

- **Claimants may jeopardize eligibility by reapplying.** Requiring claimants to file new applications simply to submit new evidence relevant to their impairments may severely jeopardize, if not foreclose, eligibility for benefits. Benefits could be lost from the effective date of the first application. Workers who are eligible for Title II disability benefits are particularly harmed. Cash benefits could be delayed further because of the Title II 5-month waiting period and Medicare benefits could be delayed because of the 24-month Medicare waiting period.

By reapplying rather than pursing an appeal, eligibility may be foreclosed forever because of the Title II recency of work test. Under this test, to be eligible for disability insurance benefits, the worker must have worked 20 of the last 40 quarters to be insured.

This means that onset of disability must occur during the insured status period, which usually ends 5 years (20 quarters) after work stops. If the worker's insured status expired before the first ALJ's decision, the worker will not be eligible when a new application is filed. The following example describes the dilemma faced by individuals under the proposed change.

Example: The claimant files for Title II benefits in January 2007, based on a heart condition. The claimant's insured status expires December 31, 2007. The first ALJ decision is issued in January 2008, finding that the claimant was not disabled before her insured status expired. One month later, the claimant has a serious heart attack. After recuperating for several months, she files a new application. The new application will be denied because there is a final decision – the ALJ decision – that she was not "disabled" prior to December 31, 2007, the date her insured status expires.

Under current procedures, if the claimant appeals to federal court and asks for a remand based on new and material evidence that was not available earlier, the court has the authority to remand the case to have SSA consider the new evidence. On remand, the ALJ is able to find that the later evidence shows that her original impairment was more serious and that she in fact was disabled before her insured status expired. Under the NPRM, the ALJ would be precluded from considering the new evidence and, if a new application is filed, it likely would be denied.

- **Requiring new applications is administratively inefficient and will increase SSA's workload.** The proposed change is administratively inefficient because it would require SSA to handle even more applications at a time when it otherwise expects an increase in filings and would cause further congestion in the front end of the process. Many individuals, who are unable to avail themselves of the online application process, will require the personal involvement of SSA claims representatives. This is particularly problematic at a time when the agency is faced with its lowest staffing level in more than 30 years.

Recommendations

NAMI joins CCD in offering the following recommendations regarding the proposals to close the record:

- **No time limit to submit evidence before the hearing.** This is consistent with the claimant's statutory right that a decision be based on evidence "adduced at a hearing." The current rule, which allows evidence to be submitted until the hearing, should be retained.

- **Submission of post-hearing evidence.** If the record is closed after the hearing, there should be a good cause exception that allows a claimant to submit new and material evidence after the hearing, including evidence submitted to the Review Board.

- **Early and easy access to the exhibit file.** This allows the representative to promptly review what is already in the record and to determine what other medical evidence

needs to be obtained. We believe that this part of the process will be vastly improved with the implementation of eDIB, the electronic folder.

- **Do not penalize claimants for circumstances outside their control.** The rules should recognize the realities of claimants' medical conditions and obtaining medical evidence.

- **Retain current rules for cases that are remanded by the federal courts or the Review Board.** During subsequent proceedings on remand by the federal courts or the Review Board, the ALJ should be allowed: (1) to decide, based on new evidence and after correcting prior legal errors, that the claimant is now disabled; and (2) to adjust the onset date according to the new (and old) evidence of disability, even if the onset date is after the date of the first ALJ decision.

- **NAMI would oppose a change in denial notices that encourages individuals to file new applications rather than pursue appeals.**

II. Individuals Would Be Limited In Their Ability to Reopen Prior Applications.

Reopening situations currently do not arise that often, but when they do, they usually have compelling fact patterns involving claimants who did not understand the importance of appealing an unfavorable decision. Often they are claimants with mental impairments.

Under current law, a claimant may request reopening for any reason within one year of the date of the initial determination. 20 C.F.R. §§ 404.988 and 416.1488. Reopening for good cause may occur within two years (SSI) or four years (Title II) of the initial determination. Good cause includes the availability of new and material evidence. 20 C.F.R. §§ 404.989 and 416.1489. Reopening is discretionary and cannot be required but it can be used to right obvious wrongs.

The NPRM eliminates the ability of the ALJ or Review Board to reopen earlier an ALJ or Review Board decision based on new and material evidence, even if it establishes that the claimant was disabled at an earlier time. Proposed § 404.989. According to the NPRM, the reason for this change is so that claimants cannot "circumvent," 72 Fed. Reg. 61222, the strict new limits for submitting evidence after the record is closed. The NPRM does not affect the reopening of initial or reconsideration level decisions.

The result of the proposed change will be a loss of benefits and perhaps a total loss of eligibility, if the "date last insured" status has expired. This is unfair for claimants in a number of situations, such as: claimants who are not able to get a proper diagnosis for a considerable period of time (multiple sclerosis, for example); claimants whose cases were poorly developed at the DDS and were not appealed and who then filed new applications; claimants with mental impairments that prevent or inhibit their ability to cooperate with development of claims; cases where physicians refuse to provide medical records until unpaid bills are paid; and bankrupt hospitals who are unable to provide records.

Reopening a prior application can be very important for people with disabilities who clearly meet the disability standard but were unable to adequately articulate their claim in the first application, were unable to obtain evidence, or have an impairment that is difficult to diagnose, such as multiple sclerosis or certain mental impairments. Unrepresented claimants with mental impairments frequently reapply instead of appealing and eventually their representatives, on a subsequent claim, will obtain new and material evidence that established disability as of the earlier application. For the same reasons discussed above, reapplying is not a viable option.

Recommendation: The current reopening rules work well and do not affect the timeliness of decisions and they should be retained. It is vitally important that claimants have a fair and reasonable ability to have new and material evidence considered.

III. Other Proposed Changes Make the Process Too Formal and Unfair to People With Disabilities.

A. Proposed Changes at the Administrative Law Judge Level

The NPRM includes some provisions that benefit claimants including retaining the *de novo* hearing before an administrative law judge (ALJ). Also, the time for providing notice of the hearing date is increased from 20 to 75 days. This increase in time will allow more time to obtain medical evidence before the hearing. However, as described above, it will not completely resolve this problem, which will be exacerbated by essentially closing the record five business days before the hearing.

NAMI shares CCD's concerns regarding other procedural changes that are disadvantageous to claimants with disabilities are discussed below.

1. Time limits

There are many new time limits, beyond normal appeal deadlines, with limited or no exceptions, which make the process overly complicated and legalistic. These time limits may well become procedural traps for unrepresented claimants, or those who obtain representation late in the process, especially since many of the time limits have no "good cause" exception:

- 30 days after receiving the hearing notice to object to time or place of hearing [proposed § 404.939(a)]. Current rule: "at the earliest possible opportunity" per 20 C.F.R. § 404.936.
- 5 days after receiving hearing notice to acknowledge receipt [proposed 20 C.F.R. § 404.938(c)]. Current rule: no provision
- 5 business days before hearing to object to issues in the hearing notice [proposed § 404.939(b).]. Current rule: "at the earliest possible opportunity" per 20 C.F.R. § 404.939.

- 20 days before hearing to request subpoenas for production of documents or witnesses [proposed § 404.935(d)]. Current rule: 5 days before hearing per 20 C.F.R. § 404.950(d).

Some of the specific time limits will be discussed below as they impact on specific NPRM provisions.

Recommendation: These time limits are too formal and should be eliminated, and at a minimum, there should be a good cause exception for all time limits. However, it should be emphasized that simply inserting good cause exceptions in these rules will not solve the problems of unfairness and traps for the unwary that the various rules will create.

2. Issues to be decided by the ALJ

The NPRM has a new requirement that the claimant should include a statement of "the medically determinable impairment(s) that you believe prevents you from working" in the written request for a hearing before an ALJ. Proposed § 404.933(a)(4). Does this limit the impairments that the ALJ will consider? Will some ALJs improperly use this requirement to limit impairments that can be considered? Will some ALJs use the failure to list all impairments against the claimant, e.g., finding the claimant is not credible because the impairment was not listed?

Claimants should not be limited only to those impairments listed at the time of their appeal. Impairments often emerge or become clearer as the hearing process evolves, for instance, as additional evidence is obtained and submitted or when representation is obtained. In addition, this requirement would be extremely problematic for unrepresented claimants who might not understand the exact nature of their impairments, cannot articulate the nature of their impairments, or are in denial about their diagnoses. And what would happen if a claimant who is unrepresented at the time the hearing request is filed obtains legal representation later in the process? Would the representative be precluded by the ALJ from raising additional impairments?

Recommendation: SSA should clarify that claimants will not be penalized if all medical impairments that prevent work are not listed in a statement with the request for hearing.

3. Objecting to issues in hearing notice

The NPRM requires that the claimant object to issues in the hearing notice within 5 business days of the hearing. Proposed § 404.939(b). There is no opportunity to extend this time limit. The current regulation provides flexibility, stating that the objections should be raised "at the earliest possible opportunity." 20 C.F.R. § 404.939. What happens if the claimant obtains legal representation within 5 days of the hearing? Is the representative precluded from raising issues? This is inconsistent with due process.

Recommendation: SSA should retain the current regulation language that encourages claimants to object to issues in the hearing notice "at the earliest possible opportunity."

4. Objections to time and/or place of hearings.

Claimants' unforeseeable circumstances may require a change in the time and/or place of the hearing. Current regulations recognize this reality and provide criteria when an ALJ is required to change the hearing time/place and when an ALJ may change the time/place for "good cause." 20 C.F.R. § 404.936(e) and (f). For example, the ALJ "will" find "good cause" to change the hearing time/place if the claimant or representative is unable to attend due to a serious physical or mental condition, incapacitating injury, or death in the family, or if severe weather conditions make travel impossible.

If these circumstances do not exist, the ALJ "will" consider a list of factors that include, but are not limit to: (1) additional time needed to obtain representation; (2) the representative was appointed within 30 days of the hearing and needs additional time to prepare; (3) the representative has a prior commitment in court or in another hearing on the same date; (4) transportation is not readily available; and (5) the claimant is unrepresented and is unable to respond to the hearing notice because of any physical, mental, educational, or linguistic limitations.

The NPRM completely removes the current claimant-oriented criteria and instead focuses on SSA-efficiency criteria. The NPRM deletes subsections (e) and (f) in current 20 C.F.R. § 404.936(e). A new proposed § 404.939(a) merely says that the ALJ "will consider your reason(s)" for requesting the change but adds "and the impact of the proposed change on the efficient administration of the hearing process." The factors the ALJ would consider are not focused at all on the claimant's circumstances but on agency efficiency: "the effect on the processing of other scheduled hearings, delays which might occur in rescheduling your hearing, and whether we previously granted to you any changes in the time or place of your hearing."

The proposed change places nearly total discretion in the ALJ. It allows an ALJ to deny a request to change the time/place of the hearing for virtually any reason and without regard to the claimant's circumstances. This change will almost certainly result in more denials of valid requests to change the time/place of the hearing and will lead to more inappropriate dismissals of hearings because the claimant is unable to attend.

Recommendation: The current regulations regarding objections to the time and/or place of a scheduled hearing should be retained.

5. Video and telephone hearings.

The NPRM provides that the claimant will be informed in the hearing notice if the hearing is to be held by video teleconference or by telephone. The proposed rule retains the claimant's right to object to appearing by video teleconference, in which case the hearing will be re-scheduled to allow appearance in person. Proposed § 404.936(c)(1). NAMI supports CCD's recommendation to retain the claimant's absolute right to have an in-person hearing.

However, for the first time, the NPRM authorizes the ALJ to direct the claimant to appear by telephone "under certain extraordinary circumstances" where (1) appearance in person is not possible, e.g., the claimant is incarcerated and the facility will not allow a hearing

to be held at the facility; and (2) video teleconference is not available. Proposed § 404.936(c)(1)(i) and (ii). Unlike the right to object to a video hearing, there is no provision in the proposed rule that allows a claimant to object to a hearing scheduled to be held by telephone. Without the opportunity to object, the proposed rule is likely to be subject to abuse. For example, the proposed rule could allow an ALJ to determine that "extraordinary circumstances" exist and require that the hearing be held by telephone. How would a claimant or representative with a hearing impairment be able to object to a telephone hearing? The failure to include the opportunity to object violates the claimant's rights to a full and fair hearing.

Recommendation: While a telephone hearing provides a less than optimal hearing situation, there may be certain "extraordinary circumstances" where it is the only way to proceed. However, if the telephone hearing provision is retained, the regulation must include an opportunity for the claimant to object.

6. Pre-hearing statements.

The proposed regulation regarding pre-hearing statements, proposed § 404.961(b), is generally acceptable so long as it is not subject to abuse by ALJs. Concerns have been raised about current pre-hearing "orders" issued by certain ALJs, which include requirements that are not consistent with the statute, regulations, or HALLEX (Hearings, Appeals, and Litigation Law Manual). The proposed section says that "you may submit" or the ALJ "may order you to submit" a prehearing statement. Subsection (b)(2) says that the statement "should discuss" the five items listed in that subsection.

Recommendation: A clarification is needed to ensure that a pre-hearing statement is not subject to rejection if it excludes one or more of the items listed in the regulation.

7. Dismissal for failure to appear at pre- or post-hearing conferences.

If neither the claimant, nor the representative, appears at a pre-hearing or post-hearing conference, the ALJ would have the discretion to dismiss the appeal. Proposed § 404.961(a). Dismissal on these grounds should not be left to the ALJ's discretion. There is only a "reasonable notice" requirement, with no specific advance notice time limit. Under current regulations, the ALJ must provide 7-day notice. 20 C.F.R. § 404.961.

Could an ALJ find that a very short notice is "reasonable," resulting in neither the claimant nor the representative being able to appear, and then dismissing the hearing request? Dismissal of the request for hearing is an extreme penalty that should be reserved only for missing the actual hearing without good cause

Recommendation: SSA should retain the current rule that allows dismissal of the request for hearing only if neither the claimant nor the representative appears and there is no good cause.

8. Subpoenas

The current regulation allows a subpoena to be requested 5 days before the hearing. 20 C.F.R. § 404.950(d). The NPRM would increase that time limit to 20 days. Proposed §

404.935(d). There is no explanation in the NPRM preface for the increase in the time limit. While subpoenas may be a useful tool where a medical provider fails to respond to requests, our members report that ALJs rarely issue subpoenas or submit those that are issued for enforcement. However, given the proposed change restricting the submission of evidence before the hearing, it is possible that representatives will be forced to request more subpoenas for any requested medical evidence that has not been received 20 days before the hearing. This is inefficient as it will lead to more work for ALJs.

Recommendation. SSA should retain the current regulation that allows a subpoena to be requested 5 days before the hearing.

9. Oral bench decisions

NAMI joins CCD in expressing general support for proposed § 404.953 regarding oral bench decisions as they will expedite processing of favorable decisions.

B. Proposed Changes at the Review Board

NAMI strongly supports the retention of claimant-initiated administrative review of unfavorable ALJ decisions. While the current process is for the most part fair and efficient, there are concerns that the NPRM severely curtails a claimant's right to administrative review of erroneous ALJ decisions. Many of the proposed changes regarding an appeal to the Review Board (RB), from a claimant's perspective, are far more complicated and formal, than those that currently exist for the Appeals Council.

1. The contents of the appeal to the Review Board

The appeal to the RB must be in writing "and must clearly indicate that you are appealing a specific unfavorable [ALJ] hearing decision or dismissal." Proposed § 404.969(c). In addition, 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.

In contrast, the current regulation requires only that a request for review by the Appeals Council be in writing. 20 C.F.R. § 404.968. Under the NPRM, will the failure to raise issues in the appeal statement waive the right to have them considered by the RB? Will the RB pay less attention to appeals that do not include a statement meeting these requirements?

Recommendation: SSA should retain the current rule that require only that the request for review be in writing.

2. Briefs or written statements

Under the NPRM, a brief or written statement "should" be submitted with the appeal or within 10 days. Proposed § 404.974(b). There is no provision for extending the 10-day time limit for "good cause." Further, previously unrepresented claimants would be at a disadvantage since new representatives would need to obtain a copy of the hearing record

before submitting arguments. In contrast, the current regulation provides that the claimant be given a "reasonable opportunity" to submit a written statement. 20 C.F.R. § 404.975. The Appeals Council's operating procedures "routinely allow" 40 days to submit evidence and arguments. HALLEX I-3-0-85A.

Recommendation: SSA should retain the current rule that gives the claimant a "reasonable opportunity" to submit a written statement. If a time limit is instituted, it should be for a longer period of time with an extension for "good cause" to allow for unforeseen circumstances.

3. Payment required for a copy of the record

For an appeal to the Review Board under the NPRM, the claimant would be required to pay for copies of the record or the hearing recording, if requested, unless there is a "good reason" not to pay. The NPRM may violate the Privacy Act which grants an individual the right of access to his or her own records. The current procedure, HALLEX I-3-0-84 C.1, complies with the Privacy Act since the Appeals Council does not charge for a duplicate hearing recording or a copy of the claims file.

Recommendation: Consistent with the Privacy Act, SSA should retain the current procedure that provides the claimant with a copy of the hearing record at no cost.

4. Submitting evidence to the Review Board

The strict standard for submitting evidence to the Review Board under the NPRM is far more stringent than current procedures. Under the NPRM, the RB will consider new evidence only if the claimant shows that: (1) SSA's action misled the claimant; (2) the claimant has a physical, mental, educational, or linguistic limitation that prevented the claimant from submitting the evidence earlier; or (3) 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. Proposed § 404.973(b). As discussed below, the new evidence must be accompanied by a statement describing how it meets these criteria. Proposed § 404.973(b)(4). Evidence that does not satisfy the criteria will be returned to the claimant. Proposed § 404.973(c).

Under the current rules, "new and material evidence" can be submitted to the Appeals Council. 20 C.F.R. §§ 404.970(b) and 404.976(b). Under these rules, the new evidence will be considered if it relates to the period before the ALJ decision and is "new and material." These rules should be retained.

As discussed above, the NPRM's proposed standard is more difficult to meet than the standard in the Act for district court remands based on new and material evidence that was not available earlier in the process. The current Appeals Council rules limit the new evidence that will be considered. However, rather than implementing a standard that is more strict than that used by the federal courts, the agency should consider adopting the "good cause" standard used by the federal courts. Such a standard is fair and would

allow a claimant to submit new and material evidence to the Review Board to ensure that the disability determination is based on a complete record.

It is important that the regulations do ***not*** include an exhaustive list of reasons since each case turns on the facts presented. The "good cause" exception for district court "sentence six" remands under Section 205(g) of the Act for new and material evidence is well-developed. A review of published court decisions shows a wide variety of reasons why evidence was not submitted prior to the court level, including:

- Medical evidence was not available at the time of the hearing.
- The claimant was unrepresented at the hearing and the ALJ did not obtain the evidence.
- Medical evidence was requested but the medical provider delayed or refused to submit evidence earlier.
- The claimant underwent new treatment, hospitalization, or evaluation.
- The impairment was finally and definitively diagnosed.
- The claimant's medical condition deteriorated.
- Evidence was thought to be lost and then was found.
- The claimant's limited mental capacity prevented him from being able to determine which evidence was relevant to his claim.
- The existence of the evidence was discovered after the proceedings.
- The claimant was unrepresented at the hearing and lacked the funds to obtain the evidence.

There are many permutations, depending on the circumstances in each case.

Recommendation: SSA should retain the current regulations that allow the consideration of new and material evidence. If the record is closed after the hearing, adopt a "good cause" standard similar to that used by the federal courts under the Social Security Act.

5. Statement explaining additional evidence

In addition to the strict limits for submitting new evidence to the RB, the NPRM states that the claimant "must submit" a statement with the additional evidence explaining why he or she believes the strict criteria are met. Proposed § 404.973(b)(4). This is another overly complicated and legalistic requirement. Will this turn into a trap for unrepresented claimants? Will the RB refuse to consider the additional evidence if such a statement is not submitted?

Recommendation: SSA should not include a requirement that the claimant explain how the criteria for submission of new evidence are met.

6. New evidence obtained by the Review Board

While the claimant must meet strict limits for submitting new evidence under the NPRM, must submit a statement explaining how the limits are met, and must submit a brief within 10 days of filing the appeal, the RB is free to obtain new evidence on its own if it

can be done "more quickly" than remanding to an ALJ and would not "adversely affect" the claimant's rights. Proposed § 404.974(d). There is no further explanation and there is no requirement that the RB send the new evidence to the claimant or permit the claimant to respond with additional evidence or to present a rebuttal. This is not consistent with due process.

Recommendation: SSA should include a requirement that any evidence obtained by the Review Board is provided to the claimant with an opportunity to present additional evidence and/or a rebuttal.

7. Standard of review and actions by the Review Board

The NPRM includes a standard of review that is more strict and provides the RB with less authority than the Appeals Council currently has for administrative appeals of unfavorable ALJ decisions. For example, the NPRM has 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." Proposed § 404.971(c). Further, the RB will only act on "significant" errors of law. Proposed § 404.975(a). 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? Will these standards lead to more appeals to federal court?

Recommendation: SSA should clarify the standard of review by the Review Board and the actions that the Review Board may take on a claim to ensure that the process is fair to claimants and does not result in more appeals to federal court.

CONCLUSION

NAMI joins CCD in expressing strong support for efforts to reduce unnecessary delays for claimants and to make the process more efficient, so long as they do not affect the fairness of the process to determine a claimant's entitlement to benefits. However, many aspects of the proposed regulations have enormous potential to impair the rights of claimants to have their cases fully considered, and could result in denials of benefits to claimants who meet the statutory definition of disability, but who cannot comply with the harsh rules and strict time limits of these rules. NAMI supports CCD's recommendation for the Commissioner not to implement the NPRM unless significant changes are made to protect the interests of people with disabilities. It is critical that the process be fair and that claimants receive a full and fair decision based on a complete evidentiary record.

Respectfully Submitted,

Andrew Sperling
Director of Legislative Advocacy
National Alliance on Mental Illness
2107 Wilson Blvd., #300
Arlington, VA 22201
andrew@nami.org