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January 31, 2020

Social Security Administration
Office of Regulations and Reports Clearance
Social Security Administration
3100 West High Rise Building
6401 Security Boulevard
Baltimore, Maryland 21235-6401

VIA ELECTRONIC SUBMISSION

RE: RIN 0960-AI27: Rules Regarding the Frequency and Notice of Continuing Disability Reviews

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the proposed **Rules Regarding the Frequency and Notice of Continuing Disability Reviews**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

Medicare Rights strongly opposes this proposed rule. Applicants and beneficiaries are already burdened by complex and arcane rules that lead to far too many people losing or never gaining the benefits they need and for which they qualify. Rather than finalizing this rule, which would exacerbate a punitive and error-prone application and review system, we urge the Social Security Administration (SSA) to instead streamline these processes and eliminate the backlog of applications and review. No additional reviews can ethically be added while the backlog exists.

On our National Consumer Helpline, we hear from people with disabilities who need Medicare and who are struggling to access Social Security Disability Income (SSDI) benefits. In addition, we hear from those who have the benefit but worry about losing it, or used to have the benefit and need to regain it.

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The nature of disability, as defined for SSDI eligibility purposes, is that it impedes work.¹ Since employment is the primary route most people have for earning the money they need to pay for health care, many people with disabling conditions, because they are unable to work, can experience barriers to affordable care. As the proposed rule states, people with such unmet needs are unlikely to receive adequate treatment for any disabling condition or to show any medical improvement.²

It often takes several months, or even longer, for SSDI applicants to receive an eligibility determination, and the process can be incredibly burdensome, involving a great deal of paperwork, physician statements, and bureaucratic hurdles. Many people find they cannot navigate the process without an attorney, but affording that help or finding a legal aid or pro bono attorney can be difficult.

Once approved, applicants may still have to endure part or all of a 24-month waiting period before they are eligible for Medicare coverage.³ This can leave people uninsured for months or years, especially if they live in a state that has not expanded Medicaid.

Medical Improvement Likely (MIL)

Currently, people who are receiving SSDI are separated into three categories: (1) Medical Improvement Expected, (2) Medical Improvement Possible, and (3) Medical Improvement Not Expected. The categories are supposed to represent the likelihood the SSDI beneficiary will show medical improvement such that they are no longer eligible for SSDI. Each category has its own timeline for review: Medical Improvement Expected reviews every 6-18 months; Medical Improvement Possible reviews every 3 years; and Medical Improvement Not Expected reviews every 5-7 years.

The proposed rule would create a new category, Medical Improvement Likely (MIL). It would be wedged between the Medical Improvement Expected and Medical Improvement Possible categories.⁴ The new MIL category as proposed would have reviews every 2 years.

Significantly, the new MIL category would include “cases in which [SSA makes] a favorable determination or decision based on the inability to adjust to other work (i.e., allowances at step 5 of the sequential evaluation process).”⁵ The sequential evaluation process walks applicants and SSA employees through 5 steps to determine if an applicant is eligible for SSDI. Each step asks a question about the applicant’s ability to work, work history, or disability. Applicants may be rejected at Steps 1, 2, or 4 or accepted at Steps 3 or 5. When an applicant is accepted at Step 3, they often have very severe disabilities that clearly fit into an SSA definition of a disabling condition. For others, eligibility comes at Step 5, which takes into account the applicant’s disability, and also their work history, education, and age. Step 5 of the evaluation process asks if the applicant or beneficiary can do any type of work that “exists in significant numbers in the national economy that he or she can make an adjustment to,

¹ Social Security Administration, “Disability Benefits” (last accessed January 29, 2020), <https://www.ssa.gov/benefits/disability/>.

² Fed. Reg. 84 63588, 63591.

³ Medicare Interactive, “Medicare eligibility for those under 65,” Medicare Rights Center (last accessed January 30, 2020), <https://www.medicareinteractive.org/get-answers/medicare-basics/medicare-eligibility-overview/medicare-eligibility-for-those-under-65>.

⁴ Fed. Reg. 84 63588, 63590.

⁵ Fed. Reg. 84 63588, 63592-63593.

considering the limiting effects of the individual's impairment, age, education, and work experience.”⁶ Currently, SSA judges that the closer the individual is to 65, the less likely they are to transfer their skills to other work.⁷

By including Step 5 cases in the new MIL category, SSA is targeting older adults with limited education who the agency has already determined to be unable to find any work because they have impairments and also lack transferable skills. Claiming this population is “likely” to see improvement in their ability to find work is extremely troubling, and suggests that the new definition is not being proposed in good faith.

Additional Concerns

Policy changes must not exacerbate the problems people have in applying for or keeping SSDI, or increase the time or likelihood that an individual will spend with no health coverage or inadequate health care.

But the proposed rules would do just that. They would increase the number of people caught in the time-consuming and burdensome redetermination process by adding new reviews—an additional 1.1 million full medical reviews over the next ten years, and an additional 1.5 million smaller-scale reviews—over and above those currently planned.⁸ Altogether, SSA would conduct 19.3 million reviews in the next decade under the proposed rule.⁹ Already, there are lengthy backlogs in disability hearings, with over 800,000 people waiting an average of 538 days (18 months) as of early 2019.¹⁰ And hearings only occur after initial rounds of application and rejection that already take months.

We are concerned that increasing the number of reviews will push even more people into a broken, error-ridden system. While the error rate for SSA disability determinations is unknown, we can find some clues in SSA’s own statistics. In the proposed rule, SSA argues that some people who have lost SSDI eligibility in the past have gone on to have some income: “Overall, about 22 percent returned to work at an SGA [Sustainable Gainful Activity] level during the first three years following benefit termination.”¹¹ This means that 78% of those terminated did not return to SGA. SSA makes no attempt to account for this massive number or explain what percentage of that 78% were terminated in error. In addition, another SSA-cited study shows that few of those terminated are consistently able to meet SGA.¹² The new proposal is likely to increase those numbers by widening the net for review, which is likely to capture many people who would have, and should have, maintained coverage under the current review system.

⁶ Tom Johns, “SSA’s Sequential Evaluation Process for Assessing Disability,” Social Security Administration (last accessed January 30, 2020),

<https://www.ssa.gov/oidap/Documents/Social%20Security%20Administration.%20%20SSAs%20Sequential%20Evaluation.pdf>.

⁷ 20 CFR §§: Part 404, Subpart P, Appendix 2 “Medical-Vocational Guidelines” https://www.ssa.gov/OP_Home/cfr20/404/404-app-p02.htm.

⁸ Fed. Reg. 84 63588, 63596.

⁹ Fed. Reg. 84 63588, 63596.

¹⁰ Mike Stein, “More Than 800,000 Waiting for Social Security Disability Hearings, Wait Times Are Declining But Still Average 18 Months” (February 12, 2019), <https://www.globenewswire.com/news-release/2019/02/12/1720954/0/en/More-Than-800-000-Waiting-for-Social-Security-Disability-Hearings-Wait-Times-Are-Declining-But-Still-Average-18-Months.html>.

¹¹ Fed. Reg. 84 63588, 63591.

¹² Hemmeter, J. and Bailey, M. S., “Earnings after DI: evidence from full medical continuing disability reviews,” *IZA Journal of Labor Policy*, vol. 5 (1), 1 - 22. doi:<http://dx.doi.org/10.1186/s40173-016-0066-9>.

The proposal does little to allay these fears. SSA states “We believe that there may be positive employment effects as a result of these proposed rules, although we cannot currently quantify them.”¹³ What is quantified is the expected cost to the agency and taxpayers. SSA predicts that the rule will cost the agency \$1.8 billion over 10 years in administrative costs. This additional expense is no guarantee that SSA will be able to process the new reviews in a timely way or reduce the existing backlog.

But there is more quantification. The agency predicts the reviews will cut SSDI benefits by \$2 billion and SSI benefits by \$0.6 billion,¹⁴ extremely high numbers given the modest benefits the programs provide. The average SSDI individual benefit is \$1,258 per month in 2020, which means the \$2 billion in SSDI savings would represent a termination of benefits for over 1.5 million people.¹⁵ The maximum SSI individual benefit is \$783 per month, so the \$0.6 billion in SSI savings mean over 750,000 people—at least—would lose needed assistance. These are sobering numbers that would create significant burdens and disruptions for the impacted individuals. Further, there is no guarantee that these decisions would be correct, or that those kicked out of SSDI or SSI would be able to enjoy unquantified “positive employment effects.”

The impact of losing health coverage can be dire, both for the individual and family and for the health system as a whole. The health of patients with unmet needs is often compromised, and limitations on access to care exacerbate this problem across a person’s whole lifespan. A lack of quality coverage can

¹³ Fed. Reg. 84 63588, 63591.

¹⁴ Fed. Reg. 84 63588, 63596.

¹⁵ Social Security Administration, “Fact Sheet: 2020 Social Security Changes” (last accessed January 30, 2020), <https://www.ssa.gov/news/press/factsheets/colafacts2020.pdf>.

lead to reduced well-being for entire families;¹⁶ poorer health;¹⁷ lack of access to care;¹⁸ economic devastation;¹⁹ and higher Medicare costs when they are ultimately eligible.²⁰

As these findings demonstrate, the stakes are very high for SSDI and SSI applicants. We have grave concerns that this proposal would harm the very people those programs are meant to serve. And we are particularly worried that the proposed rule would disproportionately harm older adults nearing

¹⁶ Committee on the Consequences of Uninsurance, Board on Health Care Services, “Health Insurance is a Family Matter,” INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, Chapter 5 (2002), <https://www.nap.edu/catalog/10503/health-insurance-is-a-family-matter> (“Davidoff and colleagues (2002) analyzed the NSAF 1999 data set and found that having an uninsured parent decreased the likelihood that a child would have any medical provider visit by 6.5 percentage points and the likelihood of a well-child visit by 6.7 percentage points, compared with having an insured parent. In addition, this analysis found that a parent without health insurance is less likely to have confidence in the family’s ability to get medical care when needed. As would be expected, the effects of having uninsured parents are smaller than the effects of the children themselves being uninsured. Still, they add to the mounting body of evidence that links parents’ well-being to that of their children”; “The weight of the studies just discussed suggest that neglecting financial access to care for adults may have the unintended effect of diminishing the impact of targeted health insurance programs for children”).

¹⁷ David W Baker, Joseph Feinglass, Ramon Durazo-Arvizu, Whitney P Witt, Joseph J Sudano, & Jason A Thompson, “Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare,” *J Gen Intern Med*. 2006 Nov; 21(11): 1144–1149 (2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/> (“Adults in late middle age may be particularly vulnerable to adverse health consequences that result from lack of health insurance and impaired access to care because of their higher prevalence of chronic disease and higher chance of suffering major, debilitating illnesses such as heart attack and stroke. Previous studies have shown that adults age 51 to 61 years old who lack health insurance have higher risk-adjusted rates of decline in their overall health and physical functioning and higher risk-adjusted mortality...”).

¹⁸ Committee on the Consequences of Uninsurance, Board on Health Care Services, “Health Insurance is a Family Matter,” INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, pp 91-106 (2002), <https://www.nap.edu/catalog/10503/health-insurance-is-a-family-matter> (“Uninsured adults in poor health are especially likely to encounter access problems in obtaining care for themselves; they are two to three times as likely to go without needed care and are twice as likely to lack a regular source of care as healthier uninsured adults (Schoen and Puleo, 1998; Duchon et al., 2001). Uninsured adults in fair or poor health are more likely to have experienced a time without needed care than are continuously insured adults of comparable health status. Schoen and Puleo (1998) find that the worse the health status, the greater is the likelihood of access problems when insurance status is controlled in the analysis.”)

¹⁹ Rohan Khera, Jonathan C. Hong, Anshul Saxena, Alejandro Arrieta, Salim S. Virani, Ron Blankstein, James A. de Lemos, Harlan M. Krumholz, & Khurram Nasir, “Burden of Catastrophic Health Expenditures for Acute Myocardial Infarction and Stroke Among Uninsured in the United States,” *CIRCULATION*, 2018;137:00–00 (2018), <https://www.ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.117.030128> (“In summary, before the Affordable Care Act, >1 in 8 AMI and stroke hospitalizations among nonelderly adults occurred among those without insurance. In this vulnerable group of patients, in-hospital expenditures alone would be expected to cross the threshold to define a catastrophic expense in the large majority. Because many of these patients will have additional hospitalizations and health expenditures, they may easily exceed their annual income while being deprived of work during the illness. The potentially devastating financial impact of these events on the uninsured is considerable.”)

²⁰ David W Baker, Joseph Feinglass, Ramon Durazo-Arvizu, Whitney P Witt, Joseph J Sudano, & Jason A Thompson, “Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare,” *J GEN INTERN MED*, 2006 Nov; 21(11): 1144–1149 (2006), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/> (“Because of their higher risk-adjusted rates of health decline, many uninsured adults who reach age 65 and enroll in Medicare enter the program in worse health than they would have if they had continuous health insurance coverage before gaining Medicare. As a result, lack of health insurance during the preretirement years could lead to higher Medicare costs.”); Jack Hadley and Timothy Waidmann, “Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries,” *HEALTH SERV RES*, 2006 Apr; 41(2): 429–451 (2006), <https://www.ncbi.nlm.nih.gov/pubmed/16584457> (“Continuous insurance coverage is associated with significantly fewer deaths prior to age 65 and, among those who survive, a significant upward shift in the distribution of health states from fair and poor health with disabilities to good to excellent health. Treating insurance coverage as endogenous increases the magnitude of the estimated effect of having insurance on improved health prior to age 65. The medical spending simulations suggest that if the near-elderly had continuous insurance coverage, average annual medical spending per capita for new Medicare beneficiaries in their first few years of coverage would be slightly lower because of the improvement in health status. In addition, total Medicare and Medicaid spending for new beneficiaries over their first few years of coverage would be about the same or slightly lower, even though more people survive to age 65.”)

Medicare eligibility. Most older adults qualify for disability benefits by showing they cannot work due to their age, limited education, and limited work history. These rules were put in place because, as people with disabilities age, it becomes increasingly difficult for them to work. As discussed above, the proposed MIL category specifically targets people who qualify for benefits this way, so older adults who cannot work because of their disabilities would be disproportionately harmed.

For all of the reasons identified in these comments, we urge SSA to abandon this proposal in its entirety.

Thank you again for this opportunity to comment. We look forward to working together to advance policies that truly ensure the health and well-being of people with disabilities while removing bureaucratic burdens. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

A handwritten signature in cursive script that reads "Fred Riccardi".

Frederic Riccardi
President
Medicare Rights Center